

THE IMPACT OF THE MEDICARE MODERNIZATION ACT'S CONTRACTOR REFORM ON FEE-FOR-SERVICE MEDICARE

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The contentious and partisan debate surrounding the Medicare Modernization Act (MMA)¹ and the subsequent political, media, and public discussion focused on the high profile provisions relating to prescription drug coverage and the new Medicare Advantage plans.² However, the legislation also contained little-noticed and relatively non-controversial provisions to reform the role of Medicare contractors.³ These reforms and their subsequent implementation by the Centers for Medicare and Medicaid Services (CMS) affect fee-for-service (FFS), or “traditional,” Medicare through which a majority of Medicare beneficiaries receive their medical services.⁴

This article (1) discusses the roots of the original Medicare contractor structure and traces its evolution from 1965 until the passage of the MMA; (2) examines the MMA contractor reform legislation and its implementation to date; and (3) analyzes the strengths and weaknesses of the reform and its implications for the future of FFS Medicare.

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1. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C. and 26 U.S.C.).

2. See, e.g., Robert Pear & Robin Toner, *Partisan Arguing and Fine Print Seen as Hindering Medicare Law*, N.Y. TIMES, Oct. 11, 2004, at A1, available at www.nytimes.com/2004/10/11/politics/11medicare.html?ex=1255233600&en=87d60bcfe109b4b3&ei=5088&partner=rssnyt (last visited Oct. 27, 2007).

3. Medicare Prescription Drug, Improvement, and Modernization Act §§ 911-912, 117 Stat. at 2378-88.

4. See THE HENRY J. KAISER FAMILY FOUND., MEDICARE: MEDICARE ADVANTAGE (Sept. 2005), available at www.kff.org/medicare/upload/Medicare-Advantage-April-2005-Fact-Sheet.pdf (last visited Sept. 15, 2007) (noting that 88% of Medicare beneficiaries have their health bills paid by the traditional FFS program); cf. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: ISSUES IN A MODERNIZED MEDICARE PROGRAM 60 (2005) (discussing membership trends in Medicare private plans declining from 17% in 1999 to 12% in 2004).

I. BACKGROUND: THE ROLE OF CONTRACTORS FROM 1965-2003

The political debates leading up to the passage of the Medicare Act in 1965 were bitter and protracted.⁵ A major barrier to passing the legislation was the hospitals and organized medicine's opposition to perceived governmental interference with their unfettered freedom to practice medicine.⁶ In order to secure these key constituencies' support, Congress designed the Medicare program to allow private insurers to contract with the government.⁷ These contractors would process providers' claims for payment, essentially serving as a "buffer between the hospital and the federal government."⁸

The 1965 Medicare statute defined two different contracting structures to correspond to the separation of Part A (hospital services) and Part B (physician services). Section 1816 of the Social Security Act authorized the Secretary of Health, Education, and Welfare⁹ to establish agreements with fiscal intermediaries (FIs) nominated by individual hospitals to make Medicare payments to these providers.¹⁰ Section 1842 authorized the Secretary to enter into contracts with health insurers (referred to as carriers) to make Medicare payments to physicians, practitioners, and other healthcare entities.¹¹ The Part B contracts were organized by geographic regions; one carrier had exclusive jurisdiction within the contract's region, thus all Part B claims in that region were submitted to that carrier.¹²

The statute specifically set out certain terms and conditions of the contracting agreements for FIs and carriers, including how the contracts were to be awarded and terminated, cost-based reimbursement provisions for contractor services, the required claims processing and related activities,

5. See generally JUDITH M. FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* (1977) (discussing the influence politics and the political administration had on making the Social Security Administration responsible for Medicare); THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* (1973) (discussing the various players and kinds of legislative activity involved in Congress enacting controversial legislation such as Medicare); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

6. See FEDER, *supra* note 5, at 37-38.

7. See *id.* at 37.

8. *Id.* (quoting a former Social Security Administration official's explanation of the Department of Health, Education, and Welfare Secretary's testimony before the Senate Finance Committee in 1965).

9. In 1980, the Department of Health, Education, and Welfare became the Department of Health and Human Services. See History of HHS, www.hhs.gov/faq/about/department/1894.html (last visited Nov. 8, 2007).

10. See Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 102, § 1816, 79 Stat. 286, 297 (codified at 42 U.S.C. § 1395h).

11. See *id.* sec. 102, § 1842, 79 Stat. at 309-10.

12. See ROBERT J. MYERS, *MEDICARE 181-82* (1970).

as well as performance standards for contractors.¹³ The statutory specificity reflected the need to reassure the providers how the government planned to use private insurers to manage the interface with hospitals and doctors.¹⁴

A. *Implementation and Evolution of Contractors*

After the Medicare Act was passed, the program's administrators implemented the new contracting process for FIs and carriers.¹⁵ The American Hospital Association, then affiliated with Blue Cross, selected the national Blue Cross and Blue Shield Association (BCBSA) as the prime contractor for all member hospitals. BCBSA, in turn, subcontracted with local Blues plans to perform the services.¹⁶ Most hospitals selected Blue Cross as their FI; however, a few hospitals selected one of the five other national insurance companies or an independent hospital association as their FI.¹⁷ Others chose to deal directly with the Social Security Administration.¹⁸

To implement the Part B contracting plan, the administration divided the country into sixty-four regions.¹⁹ Only 49 of the 140 organizations, including Blue Shield plans and commercial insurers, that submitted proposals to be carriers received contracts.²⁰ Many of the geographic regions for a single carrier contract were whole states. However, some large states or states where there were multiple applicants were carved into several jurisdictions.²¹

Although the statute contained some specific provisions that remained constant from 1965 to 2000, the Medicare program evolved over time within the original statutory framework. In the 1960s, the contractor structure depended on the existing private insurance system.²² As private insurers changed, so did Medicare contractors. The number of contractors

13. See sec. 102, § 1842, 79 Stat. at 309-10.

14. See MYERS, *supra* note 12, at 179-80 (discussing how "fiscal intermediaries" was narrowly defined regarding power and responsibility).

15. See Susan Bartlett Foote, *Focus on Locus: Evolution of Medicare's Local Coverage Policy*, 22 HEALTH AFF. 137, 137-145 (2003) (discussing the legislative history and administrative implementation of Medicare's local coverage policy).

16. ROBERT CUNNINGHAM III & ROBERT M. CUNNINGHAM JR., *THE BLUES: A HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM* 147 (1997).

17. See MYERS, *supra* note 12, at 179.

18. *Id.*

19. *Id.* at 181.

20. *Id.*

21. See *id.* at 181-182 (discussing the regional design of the carriers).

22. U.S. GEN. ACCOUNTING OFFICE, *MEDICARE CONTRACTORS: DESPITE ITS EFFORTS, HCFA CANNOT ENSURE THEIR EFFECTIVENESS OR INTEGRITY* 43 (1999), available at www.gao.gov/archive/1999/he99115.pdf (last visited Oct. 9, 2007).

has been reduced considerably over time. The General Accounting Office²³ (GAO) reported that there were 75 FIs and 43 carriers in 1980. The numbers dropped to 36 FIs and 22 carriers in 1999 and then to 25 FIs and 18 carriers in 2005.²⁴ These changes largely reflect consolidations in the private insurance industry, especially among local and regional Blue Cross and Blue Shield plans.²⁵ In addition, some plans left the business to concentrate on their “core insurance market functions,” while others were accused of fraud and abuse, faced criminal and civil settlements, and withdrew from the program.²⁶ Successful contractors took advantage of departures to acquire additional carrier and FI contracts to build multi-contract networks.²⁷ The growth of multi-state networks led to significant variations in the size, sophistication, resources, and productivity of contracting services.²⁸

Over time the responsibilities of the remaining contractors expanded as did the regulatory framework in which contractors operated. Originally, contractors focused on processing claims for payment, serving essentially as a bill paying service.²⁹ However, as the Medicare program grew and became more complex, the contractors took on greater responsibilities for medical provider education, local coverage policy development, and other public communication.³⁰

The original statutory provisions surrendered major management control of the Medicare program to the contractors.³¹ However, as costs exploded and complexities grew, the administration exercised greater control over contractors, as evidenced by increasing procedural requirements and

23. In 2004, the General Accounting Office’s name changed to the Government Accountability Office. U.S. GAO, GAO’s Name Change and Other Provisions of the GAO Human Capital Reform Act of 2004, <http://gao.gov/about/namechange.html> (last visited Oct. 27, 2007).

24. U.S. GEN. ACCOUNTING OFFICE, *supra* note 22, at 45 fig.3.1; MICHAEL O. LEAVITT, REPORT TO CONGRESS – MEDICARE CONTRACTING REFORM: A BLUEPRINT FOR A BETTER MEDICARE I-2 (2005), available at www.cms.hhs.gov/MedicareContractingReform/Downloads/report_to_congress.pdf (last visited Oct. 9, 2007).

25. See Foote, *supra* note 15, at 140.

26. *Id.*

27. See *id.* at 141.

28. See generally Susan Bartlett Foote et al., *Resolving the Tug-of-War Between Medicare’s National and Local Coverage*, 23 HEALTH AFF. 108 (2004) (discussing the evolution of multi-state networks and analyzing variation among Medicare contractors).

29. See Susan Bartlett Foote & Gwen Wagstrom Halaas, *Defining a Future for Fee-for-Service Medicare*, 25 HEALTH AFF. 864, 865 (2006).

30. See *id.* at 865 (discussing current responsibilities of local contractors).

31. See Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 102, §§ 1816, 1842, 79 Stat. 286, 297, 309-10 (codified at 42 U.S.C. §§ 1395h, 1395u).

performance oversight.³² GAO reports strongly criticized the contractors' performance.³³ Continual tension between federal regulators and the contractors existed over management and oversight responsibilities.³⁴

B. Early Efforts for Contractor Reform

For over twenty-five years, periodic efforts have been made to amend the statutory contracting rules. As early as 1980, the deputy administrator of the Health Care Financing Administration testified that the program "'do[es] not contain sufficient incentives for efficient, innovative . . . operations.'"³⁵ Since 1993, proposals have been made to amend the legislation to increase competition for contracts and to provide more flexibility in the contract relationships.³⁶ During the 107th Congress, the Health Subcommittee of the House Ways and Means Committee again focused on the issue. In a rare demonstration of bi-partisanship, Subcommittee Chairman Nancy Johnson (R-CT) and Ranking Member Fortney (Pete) Stark (D-CA) introduced the "Medicare Regulatory

32. The Health Care Financing Administration (HCFA), the agency preceding CMS, issued manuals for the FIs and carriers that contain regulations, guidance documents, and other directives that the contractors must follow. CMS frequently revises the Manuals to reflect changing administrative policies and procedures. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., CMS MANUAL SYSTEM PUB 100-104: MEDICARE CLAIMS PROCESSING (May 2, 2005) (discussing changes made to Medicare Claims Processing Manual regarding FI claim adjudication), available at www3.cms.hhs.gov/Transmittals/downloads/R555CP.pdf (last visited Nov. 9, 2007).

33. See generally U.S. GEN. ACCOUNTING OFFICE, *supra* note 22, at 20-42 (explaining how weak oversight of contractors makes Medicare vulnerable since several contractors have misrepresented their performance to HCFA and been involved in qui tam actions and other Department of Justice investigations).

34. See STARR, *supra* note 5, at 379-80 (explaining that until the 1970s, the health system had the authority to run its own affairs; however, during the 1970s as costs rose, tensions grew between the medical care system's expansion and a state and society that were requiring control over medical expenditures and the health system).

35. *Patients First—A 21st Century Promise to Ensure Quality and Affordable Health Coverage: Joint Hearing Before the Subcomm. on Health & the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 107th Cong. 4 (2001) [hereinafter *Joint Hearing*] (statement of Thomas A. Scully, Administrator, Centers for Medicare and Medicaid Services), available at <http://energycommerce.house.gov/reparchives/107/action/107-52.pdf> (last visited Nov. 10, 2007) (quoting a 1980 statement by former Deputy Administrator of HCFA, Earl Collier).

36. See *The Medicare Regulatory and Contracting Reform Act of 2001: Hearing on H.R. 2768 Before the Subcomm. on Health of the H. Comm. On Ways & Means*, 107th Cong. 43 (2001) (statement of Leslie G. Aronovitz, Director, Healthcare Program, Administration and Integrity Issues, U.S. General Accounting Office), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_house_hearings&docid=f:76025.pdf (last visited Nov. 10, 2007).

Contracting Reform Act of 2001" (H.R. 2768) on August 2, 2001.³⁷ The Ways and Means Committee favorably reported the bill on October 4, 2001.³⁸ After review by the Energy and Commerce Committee, a revised version of the bill (H.R. 3391) passed the House on a 408-0 vote on December 4, 2001.³⁹

Similar to prior reform efforts, the key purpose of the House bill was to provide Medicare with management tools to operate more efficiently.⁴⁰ These tools included competitive contracting rules, consolidating Part A and Part B contractors, and allowing contracts for specific services such as claims processing or education.⁴¹ The Bush administration strongly supported these efforts.⁴² During the debate in 2001, then CMS Administrator Tom Scully specifically criticized the large number of contractors and the inconsistencies in the way they processed claims.⁴³ He stated that the Secretary of Health and Human Services (HHS), Tommy Thompson, specifically directed him to "fix" the contractor system.⁴⁴ The Senate took no action on the issue, and the bill died.⁴⁵ However, the Medicare Modernization and Prescription Drug Act that passed the House in 2002 incorporated most of the House bill's provisions.⁴⁶

II. THE MMA INCORPORATES CONTRACTOR REFORM

A. *The MMA Provisions*

During the 108th Congress, Chairman Johnson and Representative Stark reintroduced Medicare contractor reform in a freestanding bill.⁴⁷ Entitled the "Medicare Regulatory and Contracting Reform Act of 2003," H.R. 810 was nearly identical to H.R. 3391 that had passed in the House in

37. H.R. REP. NO. 108-74, pt. 1, at 39 (2003).

38. *Id.*

39. *Id.*

40. See H.R. REP. NO. 107-288, pt. 1, at 22 (2001) (noting that a purpose of H.R. 2768 was to streamline the regulatory process).

41. *Id.*

42. *Id.* at 22-23.

43. See Foote, *supra* note 15, at 143.

44. See *Joint Hearing, supra* note 35 (explaining that Secretary Thompson continually asked Administrator Scully to "fix" the way the Medicare contracting system works).

45. See U.S. House Comm. on Ways & Means, Status of Bills & Resolutions Within the Jurisdiction of the Comm. on Ways & Means on Which Legislative Action Was Taken, 107th Congress, at <http://waysandmeans.house.gov/media/graphics/status107.htm> (last visited Nov. 10, 2007) (showing Senate took no action on H.R. 3391).

46. H.R. REP. NO. 108-74, pt. 1, at 39-40 (2003).

47. H.R. REP. NO. 108-74, pt. 1, at 40 (2003).

the previous session.⁴⁸ The Senate was much less involved with the contractor reform part of the MMA.⁴⁹ Senator Orrin Hatch (R-UT) introduced S. 1332⁵⁰ as a companion bill to H.R. 810, but the Senate took no action. However, the final version of the MMA did incorporate the contractor reform language developed in the House bill.⁵¹

The contractor reform provisions aim to improve what legislators termed “an antiquated, inefficient, and closed system” that “has failed to keep pace with integrated delivery in the private sector.”⁵² Section 1874A directs the Secretary to merge the Part A FIs and Part B carriers into new Medicare Administrative Contractors (MACs).⁵³ The legislation also permits greater contracting flexibility by allowing a wider range of entities to participate in the program and allowing separate “functional” contracts.⁵⁴ The Secretary is given the authority to take performance quality, price, and other factors into account in a competitive bidding process to award MAC contracts and can renew these contracts for up to five years.⁵⁵ The legislation requires the Secretary to provide reports detailing the agency’s plan for implementing these provisions.⁵⁶

B. Implementation Begins: The Leavitt Report

In February of 2005, HHS Secretary Michael Leavitt gave Congress the department’s required report recounting the progress in implementing the contracting provisions.⁵⁷ Secretary Leavitt’s report recites Congress’ reform objectives and notes that the main goal of contractor reform is to streamline

48. *Id.* at 39.

49. See U.S. House Comm. on Ways & Means, Status of Bills and Resolutions Within the Jurisdiction of the Comm. on Ways & Means On Which Legislative Action Was Taken, 108th Congress, at <http://waysandmeans.house.gov/media/graphics/status108.htm> (last visited Oct. 16, 2007) (showing Senate took no action on H.R. 810).

50. Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, S. 1332, 108th Cong. (2003).

51. Compare Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173 §§ 911-912, 117 Stat. 2066, 2378-88 with H.R. 810, 108th Cong. (2003).

52. H.R. REP. NO. 107-288, pt. 1, at 23 (2001).

53. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, sec. 911(a)(1), § 1874A, 117 Stat. 2066, 2378 (codified at 42 U.S.C. § 1395kk-1).

54. See *id.* at sec. 911(a)(1), § 1874A(a) (giving the Secretary authority to contract with “any eligible entity” and allowing an entity to enter into a contract to perform a particular function).

55. *Id.* at sec. 911(a)(1), § 1874A, 117 Stat. 2066, 2379-81.

56. *Id.* at sec. 911(a)(1), § 1874A, 117 Stat. 2066, 2386.

57. LEAVITT, *supra* note 24.

Medicare's FFS operations.⁵⁸ HHS began with reducing the number of contractors by merging Part A and Part B contractors.⁵⁹ Accordingly, HHS also reduced the number of regions by redrawing the lines to correspond to the new MACs.⁶⁰ HHS planned to "award 15 Primary A/B MACs servicing the majority of all types of providers, 4 specialty MACs servicing . . . home health and hospice (HH) providers, and 4 specialty MACs servicing durable medical equipment (DME) suppliers."⁶¹ Although some variation exists among the fifteen regions, they were carved out to balance the number of FFS beneficiaries and Medicare providers in each region and create a more equalized distribution of workload than was present under the FI and carrier assignment system.⁶² The goals for the new MAC contractors in these regions are to integrate claims processing activities, improve customer service and operations, reduce claims processing error rates, and implement new information technology to modernize and update antiquated financial management and fragmented accounting systems.⁶³

Secretary Leavitt's report describes the new MAC selection schedule. Between 2005 and 2009, CMS will choose the MACs from the pool of competing contractors.⁶⁴ The first new A/B MAC and four DME MACs were awarded in 2006,⁶⁵ and the full FFS workload transition will be completed by October 2009.⁶⁶

III. ANALYSIS

CMS administrators and their predecessors sought the contractor reform provisions in the MMA for many years.⁶⁷ Should these provisions be considered a victory for FFS Medicare? Will these modifications to the original contractor legislation ensure that Medicare FFS is, as Secretary

58. *See id.* at i.

59. *See id.* at III-2.

60. *Id.* at III-2, III-3.

61. *Id.*

62. *See* LEAVITT, *supra* note 24, at III-3.

63. *See id.* at Chapter III.

64. *See id.* at III-3. The process of replacing old contracts is still underway as of this writing.

65. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) JURISDICTIONS FACT SHEET 4 (Sept. 2007), *available at* www.cms.hhs.gov/MedicareContractingReform/Downloads/MAC_Jurisdiction_Facts.pdf (last visited Nov. 9, 2007).

66. LEAVITT, *supra* note 24, at III-3.

67. *See Joint Hearing, supra* note 35 (quoting then HCFA Deputy Administrator's speech in the 1980s which called for contracting reform).

67. LEAVITT, *supra* note 24, at III-3.

Leavitt has stated, "a premier health plan that allows for comprehensive, quality care and world-class beneficiary and provider service"⁶⁸

Analyzing the legislative design and its implementation reveals that while many of the efficiency goals may succeed, barriers exist to the realization of Secretary Leavitt's assertion. These barriers include the limited scope of the legislation and the manner in which it is being implemented. Both reflect the influence of the ideology held by the Republicans in Congress and the administration when the MMA was enacted.

The legislative provisions already emphasize efficiency in claims processing,⁶⁹ and many of the changes the Secretary envisioned are important to achieving efficiency. Who can argue with upgraded information systems, less fragmentation, and improved service incentives? However, the Medicare FFS infrastructure must go beyond efficiency in order to meet the needs of the twenty-first century Medicare program. Improving FFS Medicare demands more than speedy claims processing; it requires a comprehensive redesign of the role of Medicare contractors. New tools are also needed if Medicare is to ensure quality of care for beneficiaries. In order to evaluate provider performance and outcomes, contractors need an infrastructure to acquire and analyze data that goes beyond the current claim forms.⁷⁰ They also need tools to encourage and enforce appropriate utilization of services and performance.⁷¹ Contractors need to be rewarded for raising quality and not just for achieving efficiency in claims processing.⁷² It is quite challenging to conceptualize how to create quality management within an essentially unmanaged FFS program. However, creative efforts to design those tools, through either redesign of the contractor roles or other mechanisms, must be undertaken.⁷³

There are also barriers to a robust FFS future embedded in the implementation of the MAC regions. Prior to the MMA, the carrier and FI regions were drifting into incoherence.⁷⁴ The original sixty-four carrier

68. *Id.* at i.

69. *See supra* text accompanying notes 52-56 (discussing legislative methods for increasing efficiency).

70. *See* LEAVITT, *supra* note 24, at III-7 (discussing the key role data centers play in claims processing and the need for a modernization of data center operations); *see also* Foote & Halaas, *supra* note 29, at 867 (discussing the need to invest in FFS infrastructure).

71. *See* Foote & Halaas, *supra* note 29, at 866-67 (discussing possible quality improvement measures that Medicare contractors could adopt).

72. *See id.*

73. *See id.* at 865-867 (discussing the current role of local contractors and offering recommendations on contractor reform).

74. *See Joint Hearing, supra* note 35 (describing the existing contractor environment and resulting patchwork of networks); Foote, *supra* note 15, at 141 (discussing formation of multi-state and multi-contract networks).

regions reflected the underlying insurance infrastructure at the time.⁷⁵ The conventional wisdom likely was that the regions were designed in part to reflect the tremendous variation in the use and quality of Medicare services across the country.⁷⁶ However, the creation of multi-contract networks was a response to contracting opportunities rather than continuing development of coherent regions.⁷⁷ The variation in the size and resources of contractors also created corresponding differences in their efforts.⁷⁸ The fifteen new regions are similarly incoherent. CMS drew them to equalize region size based on number of beneficiaries and providers⁷⁹ rather than practice patterns or referral patterns that would provide a basis for measuring quality improvement.

Multiple regional designs in the MMA based on different principles exacerbated these problems. The MACs are designed for efficiency.⁸⁰ However, a completely different set of values underlies the new Medicare Advantage Preferred Provider Organization (PPO) regions and the freestanding prescription drug plans (PDPs) regions.⁸¹ Therefore, the program cannot coherently incentivize regional improvements in quality because the regional designs of the two delivery models are not coherent. It is challenging to run a national program that has parallel delivery structures and the Medicare Payment Advisory Commission (MedPAC) recognized that two competing delivery models might encourage better performance from each as they compete for beneficiaries.⁸² However, making rational

75. See U.S. GEN. ACCOUNTING OFFICE, *supra* note 22; MYERS, *supra* note 12, at 181 (discussing the formation of the original sixty-four carrier regions and how thirty-three Blue Shield Plans covered the majority of regions).

76. For a discussion of geographic variation in Medicare spending, see John E. Wennberg et al., *Geography and the Debate Over Medicare Reform*, 2002 HEALTH AFF. (WEB EXCL.) W96, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.96v1.pdf> (last visited Sept. 25, 2007).

77. See Foote, *supra* note 15, at 140 (discussing motivations for reducing the number of contractors).

78. See *id.* at 143 (discussing variations in contractor policies).

79. See LEAVITT, *supra* note 24, at III-3 (discussing the rationale behind formation of the fifteen regions).

80. See *id.* at I-3 (discussing how the reforms grew out of a realization that Medicare needed to be more efficient and effective to adequately service beneficiaries and healthcare providers).

81. See Susan Bartlett Foote & Peter J. Neumann, *The Impact of Medicare Modernization on Coverage Policy: Recommendations for Reform*, 11 AM. J. OF MANAGED CARE 140, 140 (2005) (discussing formation of Medicare Advantage PPOs); Covington & Burling, *CMS Establishes PDP and MA Regions* (Dec. 2004), available at www.cov.com/listall.aspx?showpubitems=true&archiveyear=2004 (follow article's title hyperlink) (last visited Feb. 25, 2008) (explaining the key considerations used by CMS in establishing PDP regions).

82. See MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 4.

comparisons is difficult, if not impossible, as the two models operate in different silos within the program.

The ideology underlying the MMA plays a role in these challenges. The Republican authors of the legislation clearly favored the Medicare Advantage health plans over the FFS part of the program,⁸³ reflecting their support for "privatizing" Medicare by moving the program from FFS administered pricing to premium support for health plan choices.⁸⁴ The MMA delivers greater financial resources in support of Medicare Advantage, including paying the plans premiums that exceed the FFS payments to doctors and hospitals.⁸⁵

IV. CONCLUSION

The contractor reform provisions in the MMA were long sought in order to create greater flexibility and efficiency in the administration of the FFS side of Medicare. While they do provide opportunities for necessary improvements, they fall far short of truly "modernizing" the popular and important FFS infrastructure. Advocates of FFS must seek reforms that will provide the necessary tools and infrastructure to promote improvements in quality and must ensure that FFS receives fiscal parity with the Medicare Advantage side of the program.

83. See Robert A. Berenson, *Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,'* 2004 HEALTH AFF. (WEB EXCL.) W4-572, W4-577, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.572v1.pdf> (last visited Sept. 25, 2007).

84. See *id.* at W4-576-77.

85. See *id.* at W4-577.

