

Medicaid managed care initiatives. For EQR, regional office staff may review the State's most recent RFP for external review services, the EQR contract, or the EQR reports.

*Comment:* One commenter asked that a review of the current EQR process under section 1902(a)(30)(C) of the Act be performed by an independent review body to assist the Secretary in deciding whether current contractors are performing adequately.

*Response:* Section 1932(c)(2)(A)(ii) of the Act clearly instructed us, in consultation with States, to establish a method to identify entities qualified to conduct EQR. We chose to pursue a method that would allow States to have access to the greatest number of entities with the qualifications necessary to perform EQR and EQR-related activities. Therefore, we did not limit ourselves to a review of current contractors permitted to perform review under section 1902(a)(30)(C) of the Act, but attempted to discern all types of contractors that States have found capable of performing EQR-related activities. We believe this will provide States with much needed flexibility to promote greater competition and improvement among potential EQR contractors.

*Comment:* One commenter supported the provisions in the proposed rule that allowed for a variety of organizations to serve as an EQRO, but cautioned that EQRO criteria should include an unbiased approach to managed care. The commenter expressed concern that an anti-managed care organization could be awarded the contract, and that this would adversely affect the organization's ability to objectively make an assessment of MCO strengths and weaknesses and making recommendations for improvement.

*Response:* A State may contract with any entity to conduct EQR as long as the entity meets the competency and independence criteria. EQR is an important component of a State's quality strategy, and we trust that States will select entities to conduct EQR that will perform objective reviews.

*Comment:* Many commenters supported this provision because it provides States with more flexibility to contract with a range of organizations while still obtaining the 75 percent matching rate currently limited to contracts with QIOs, and entities that meet the requirements to contract as QIOs. Several of these commenters specifically supported the competence and independence standards proposed. One commenter agreed that the regulation should require organizational qualifications.

One commenter, however, found the requirements vaguely defined, and recommended that we stipulate additional requirements, such as proper licensure or certification from accrediting organizations for performance of validation of performance measures and surveys. Another commenter expressed concern that the proposed competency criteria would encourage the use of entities that are less qualified than the QIOs with which most States currently contract. The commenter believed that QIOs as nonprofit organizations, were independent, objective, and had access to needed physicians and experience in quality improvement. The commenter recommended that § 438.354(b)(1) be revised to read, "require an organization to have staff with appropriate credentials and demonstrated experience."

*Response:* The BBA required us to work in consultation with States to establish a method for the identification of entities qualified to conduct EQR. We believe that had the Congress desired to retain the three categories of entities allowed to perform EQR under section 1902(a)(30)(C) of the Act, it would have done so. Similarly, the Congress could have easily stated that only QIOs should perform EQR. The Congress chose neither of these approaches, but instead asked us to establish a method to identify qualified entities. We believe that the Congress chose to respond to States' frequently stated desires to have a greater range of organizations with which to contract. Therefore, under the auspices of the National Academy for State Health Policy (NASHP), we worked with States, consumer advocates, and other stakeholders to provide us with their recommendations on a methodology to identify qualified entities. Many commenters strongly supported the competency provisions we proposed under § 438.354(b). Therefore, the final rule retains these requirements from the proposed rule. We leave it up to States to determine if they would like to impose additional requirements such as certified vendors. We agree that demonstrated experience should be required of an EQRO, and in response to this comment, we have changed § 438.354 (b)(1) to require staff with demonstrated experience.

We also made some revisions to proposed § 438.354(a) to clarify that these provisions apply to those entities a State contracts with as an "EQRO," regardless of whether the EQRO performs EQR or specific EQR-related activities.

*Comment:* One commenter felt that the proposed conflict of interest

requirements failed to recognize that since the State contracts with the EQRO, the EQRO would be reluctant to tell the State what it may not want to hear. The commenter recommended having the EQRO funded by an external Federal agency, such as AHRQ (formerly AHCPR), or to require or create financial incentives to have the State report on comparable performance measures for all MCOs licensed in the State.

*Response:* Section 1932(c)(2) of the Act explicitly requires States that contract with Medicaid MCOs to provide for an EQR of each MCO, and provides for an enhanced Federal match rate for this review. We believe that it is clear that the Congress intended that States share the costs of EQR, and be the contracting party. We do not agree with the commenter's assumption that the State will not want to be informed if an MCO or PIHP is not performing adequately. We believe the provisions in this rule will encourage States to use EQROs to conduct numerous quality activities, both because of the flexibility that the rule provides to States, and because of the availability of the 75 percent enhanced match for these activities without regard to whether the entity performing review is a QIO or meets the requirements to contract as a QIO.

*Comment:* One commenter requested that EQROs be required to include clinical staff with pediatric training in order to be qualified to review a Medicaid MCO. One commenter recommended that the entity be required to have staff with knowledge of section 504 of the Rehabilitation Act of 1973, and of titles II and III of the ADA, based on the commenter's research suggesting that individuals who have mobility impairments routinely encounter physical barriers to care. The commenter's research also indicated that access to preventive care was significantly lower for individuals who use wheelchairs, and few PHPs know which of their clinicians are accessible to patients with mobility or sensory impairments.

*Response:* We do not agree that it is necessary to include specific requirements for EQROs to have clinical staff with pediatric training in order to qualify to review an MCO or PIHP. Section 438.354(b)(3) requires that the organization have the clinical skills necessary to carry out the EQR activity, which we believe requires that the EQRO or its subcontractor have the necessary training. We also do not agree with the commenter's suggestion that we specifically require an entity to have staff with knowledge of the Rehabilitation Act or the ADA. While