

above, however, if a State uses entities other than EQROs to perform activities, the 75 percent match rate under section 1903(a)(3)(C)(ii) of the Act would not be available. We hope and anticipate that States will coordinate the EQR and EQR-related activities with other State quality activities currently in place.

Comment: Many commenters believed that direct Medicaid agency external reviews should always be performed with respect to grievance systems because these commenters believe that the Medicaid fair hearings process is unique.

Response: The EQRO is not responsible for reviewing the State's fair hearing process. It must review information about the MCO or PIHP internal grievance system. In order for a State to use a Medicare or accreditation compliance determination to substitute for a Medicaid review of the MCO's or PIHP's grievance system, the State will need to address in its quality strategy the basis for considering the Medicare or accrediting organization's standard comparable to the State's grievance processes standard that needs to comply with the provisions of subpart F of the Medicaid managed care final rule.

Comment: One commenter expressed concern that we excluded Medicare beneficiaries who are eligible for Medicaid as a result of spenddown requirements from the definition of dually eligible persons.

Response: We have not excluded from the definition of dually eligible those Medicare beneficiaries who are eligible for Medicaid as a result of spenddown requirements. We consider any person who is receiving both Medicare and Medicaid benefits as a "dually eligible" person.

Comment: One commenter believed that the meaning of MCO in proposed § 438.360, and § 438.362 was not clear. The commenter noted that corporate entities may be wholly owned subsidiaries of other corporate entities, and may hold multiple licenses. The commenter also noted that in some cases a plan may have a large Medicaid product and a very small Medicare product, calling into question the assumption that adequate management of the Medicare enrollees is an appropriate proxy for their Medicaid enrollees. The commenter recommended a more complete definition of MCO, as it relates to the MCO's Medicare and Medicaid product lines being incorporated into the rule.

Response: The definition of MCO as used in this regulation is defined in § 438.2 of the Medicaid managed care final rule. According to this definition, an MCO is the entity that holds the

Medicaid comprehensive risk contract. We believe that this definition addresses the commenter's concern, as the Medicare review provisions will only apply if the same entity that holds the Medicaid contract holds the Medicare contract.

Comment: One commenter recommended that we make clear that a State may undertake optional EQR activities, even if it has exempted an MCO from a portion of or all of the mandatory activities.

Response: A State may conduct the optional EQR activities when it uses Medicare or accreditation review findings for the mandatory activities. As long as the State uses the protocols developed by us or protocols consistent with ours, the information derived from the optional activities can be used in the EQR.

Comment: One commenter believed that when an MCO is accredited by a private accrediting body, the States should be strongly encouraged not to duplicate the review performed by the private accrediting body.

Response: The final rule provides States the option to use the findings of an accrediting body instead of conducting its own review of MCO or PIHP compliance with certain standards, if the MCO or PIHP has been accredited by a national accrediting organization recognized by us. We believe that States should have the discretion to make this decision, and individuals who believe that this option should be adopted should encourage States to do so.

I. Exemption From External Quality Review (§ 438.362)

Proposed § 438.362 provided an option for a State agency to exempt an MCO or PHP from the EQR requirements in section 1932(c)(2)(A) of the Act if: (1) The MCO or PHP has a current Medicare contract under part C of title XVIII or under section 1876 of the Act; and (2) for at least 2 years, the MCO or PHP has satisfied EQR requirements under section 1932(c)(2)(A) of the Act with respect to its Medicaid contract. In addition, we proposed that the Medicaid and Medicare contracts be required to cover all or part of the same geographic area. We also proposed that the State agency require each exempted MCO and PHP to annually provide the State with copies of all Medicare reviews performed by us, by our agent or any private accrediting organization, with respect to the quality, timeliness, and access to its services.

Comment: Many commenters opposed this exemption of certain MCOs from

EQR. One of the commenters felt that this provision completely abrogates the responsibility of the States and CMS to monitor the quality of Medicaid managed care systems for children. One commenter agreed with this provision, as long as it was an option for States.

Response: In the BBA, the Congress expressly provided States with the option of exempting from EQR those MCOs that provide Medicare services and also have had experience serving the Medicaid population. This provision, however, does not exempt States from monitoring MCOs and PIHPs for compliance with the mandatory activities listed in § 438.358. These activities, required of MCOs and PIHPs under our Medicaid managed care final rule, are essential to ensure the quality of services provided to Medicaid beneficiaries by MCOs and PIHPs. For example, the BBA requires that States have a quality strategy in place when contracting with MCOs and PIHPs. States will still need to ensure MCO and PIHP compliance with the BBA provisions and our regional offices will continue to monitor States for compliance regardless of whether or not an EQR is conducted.

Comment: One commenter asked how this provision would impact a Medicaid plan that gave up its M+C product. Specifically, the commenter asked if there would be an immediate requirement for an EQR review.

Response: Under § 438.362(a)(1), the MCO and PIHP must have a current Medicare contract. Therefore, as EQR is an annual requirement, the year following the termination of the M+C plan, the State is required to contract with an EQRO to, at a minimum, review and analyze information from the validation of performance improvement projects conducted by the MCO or PIHP and performance measures calculated by the MCO or PIHP that year. The State will also need to ensure MCO or PIHP compliance with structural and operational standards. If the MCO or PIHP had been reviewed by Medicare or an accrediting organization within the previous 3 years, that information could be used in the EQR. If this were the year that the MCO or PIHP was to be reviewed for structural and operation standards, the State or its contractor, or the EQRO would have to conduct a review.

Comment: Several commenters asked us to clarify who we considered appropriate to determine whether an MCO or PIHP performed acceptably in previously conducted EQRs, as this was not a requirement under the section 1902(a)(30)(C) of the Act EQR requirements. Some of the commenters