

stated that it would not be appropriate for the State to make the determination, as the independent nature of the EQR might be compromised. Many commenters asked us to clarify what we consider to be acceptable performance and recommended that an MCO or PHP be required to perform acceptably on quality, timeliness, and access in order for a State to allow for the exemption.

*Response:* Whether an MCO or PIHP has performed acceptably is determined by the State based on the results of the EQR, which must include a detailed assessment of each MCO's and PIHP's strengths and weaknesses with respect to quality, timeliness, and access to health care services provided to Medicaid beneficiaries. If a State elects to exempt an MCO or PIHP from an EQR it must, as specified in § 438.362(a)(3), ensure that an MCO or PIHP not only have had a Medicaid contract for 2 years but that the MCO or PIHP has also been subject to an EQR as specified in this rule. This effectively means that no MCO or PIHP could be exempted under § 438.362 until EQR under this final rule is in effect for at least 2 years. As long as the provisions under this section are met, the State will determine the length of time for which it will exempt an MCO or PIHP from EQR. The State will be able to use information obtained from the Medicare or accreditation reviews, as the submission of Medicare review findings is required under § 438.362(b).

*Comment:* One commenter was concerned that similar geographic coverage areas do not necessarily ensure similar administration, networks, benefits, and quality improvement projects for the different beneficiaries who are served by the Medicare and Medicaid programs. Another commenter agreed with the requirement that the two contracts cover the same geographic area, but was concerned that practice patterns tend to vary geographically for given clinical topics and specific types of treatment. The commenter suggested we change the geographic requirement to require similar or identical service areas instead of overlapping areas. Two commenters supported the requirement that the two contracts cover all or part of the same geographic area, but suggested that we include additional requirements that the two contracts must (1) include the same provider networks and (2) offer the same or similar benefit and services to consumers. The commenters believe this is important because M+C plans serve markedly different populations, provide different benefit packages, and often offer different provider networks than Medicaid plans. One commenter asked us to clarify whether the

Medicaid and Medicare services areas have to be identical for MCOs and PHPs to qualify for exemption.

*Response:* Under § 438.362(a)(2), we require that the Medicare and Medicaid contracts cover all or part of the same geographic area in order for a State to exempt the MCO or PIHP from EQR. We required an overlap of service areas in this provision because we believe this will increase the likelihood that the findings from the Medicare review will serve as a proxy indicator of the care delivered to the MCO's or PIHP's Medicaid beneficiaries. We have made some clarifying language changes to the regulations text in the final rule to more clearly state our intent that the contracts must cover all or part of the same geographic area within the State that is allowing the MCO or PIHP exemption from EQR. However, we think that requiring identical service areas or the same or similar benefit packages is too restrictive, and may effectively exclude the use of an exemption intended by the Congress.

*Comment:* Several commenters asked that we not restrict the exemption provision to M+C organizations, but also allow it to apply to MCOs and PHPs that have undergone or achieved "excellent" status by a private accreditation review.

*Response:* In the BBA, the Congress applied the total exemption in section 1932(c)(2)(C) of the Act only to M+C organizations. Consequently, we have not applied this provision to commercial MCOs and PIHPs. However, we address nonduplication provisions related to EQR activities as they apply to private accreditation under § 438.360.

*Comment:* Several commenters concurred with the requirement that an MCO or PHP must demonstrate acceptable performance determined by the EQR for the 2-year period before exemption. One of these commenters, however, was concerned that the regulation appears to allow exempt status to last indefinitely, and noted that it is not unusual for plan performance to vary significantly from year to year due to organizational changes. Several commenters recommended that States be required to develop mechanisms to periodically re-evaluate an MCO's exempt status, and to re-institute EQR if accreditation, Medicare, or State oversight indicate potential quality problems. One commenter opposed our proposal to require that the MCO have complied with EQR requirements for 2 prior years. This commenter believed that this interpretation was unduly restrictive, and inappropriately limited the discretion given to State agencies to exempt MCOs based on the State

agencies' experience with the MCOs or PHPs.

*Response:* We believe that the language in this rule properly reflects congressional intent to allow States the option to exempt a Medicare MCO from EQR. Once an entity is exempted, and continues to meet the criteria for exemption, we believe that the Congress intended that the Medicare quality review requirements serve as a proxy for the Medicaid EQR requirements. Because the State will have access under § 438.362(b) to data from these reviews, any problems that develop should be recognized through this process. We thus do not believe it would be appropriate to require States affirmatively to re-evaluate an MCO's or PIHP's EQR-exempt status.

With respect to our requirement that 2 years of success in Medicaid EQR be required, as noted in the preamble to the proposed rule, we considered several interpretations of the statutory provision that requires at least 2 years of Medicaid contracting in order for this exemption to apply. We concluded that the Congress' intent in requiring 2 years of Medicaid contracting experience was to ensure that the MCO had sufficient quality measures in place to meet Medicaid EQR standards before it could be exempted from Medicaid review. Since these EQR standards are new, this necessarily would require that an MCO have a Medicaid contract for 2 years under these EQR requirements before the exemption in § 438.362 would apply. This ensures that all MCOs and PIHPs have been subject to Medicaid EQR at some point, and have been found to be compliant with Medicaid standards in this review.

We emphasize again, however, that the EQR requirements, from which MCOs and PIHPs can be exempted under § 438.362 are only one part of the Quality Strategy provided for in the BBA. Other BBA provisions require States contracting with MCOs to ensure the quality and appropriateness of care and services furnished to Medicaid beneficiaries. We believe that if States find MCOs or PIHPs not to be providing appropriate quality care, they would exercise their option to require an EQR.

*Comment:* Many commenters agreed that MCOs should be required to submit copies of reviews performed by Medicare or an accrediting organization. One commenter did see the benefit in receiving Medicare review reports. One of the commenters cautioned that accreditation reviews are generally performed less frequently than annually.

*Response:* We only require that information from the Medicare or