

accreditation review be provided annually. We are not requiring that Medicare or accreditation reviews be conducted annually. If no new information is obtained in a specific year, it is not necessary for the MCO or PIHP to provide the State information provided the previous year. If a State chooses to exempt the MCO or PIHP, this does not relieve the State from ensuring that access to timely and quality services is being provided. Findings from a Medicare or accreditation review will provide the State a useful source of information to determine access to quality services for Medicaid beneficiaries. To better explain the types of information we are requiring be provided if a State chooses this option, and to address situations in which an entity is accredited by a private accrediting body approved by CMS under § 422.158, we have added clarifying language that makes a distinction between when a Medicare review is conducted by us or our contractor and when an accreditation review based on deemed compliance by such an approved entity. The findings of an accreditation review of an MCO or PIHP must be from a review of the Medicare line of business as this provision only applies to an M+C organization.

Comment: Many commenters recommended that MCOs that have established distinct provider networks for Medicaid and Medicare beneficiaries not be exempt from EQRs.

Response: As explained in an earlier response, we attempted to address differences inherent in Medicare and Medicaid contracts by requiring the contracts to have some geographic overlap. We do not believe, however, it is necessary or appropriate to require that Medicare and Medicaid beneficiaries of the MCO or PIHP use the same providers. We believe that an MCO or PIHP that demonstrates satisfactory compliance in M+C external review has demonstrated that it has appropriate quality safeguards in place, and that these would extend to all providers, whether seen by Medicare, Medicaid, or commercial enrollees.

We note that in providing for this exemption in section 1932(c)(2)(C) of the Act, the Congress did not require that Medicare and Medicaid enrollees use the same providers. It did require, however, that the entity have 2 years of Medicaid contracting experience. Under our interpretation of this requirement, discussed in a previous comment response, an MCO or PIHP would be required to demonstrate satisfactory results from 2 years of Medicaid EQR under part 438 before it would be

eligible for the exemption under § 438.362. Thus, even if different providers are used by Medicaid enrollees than Medicare enrollees, the MCO or PIHP would have demonstrated for 2 years that the Medicaid providers performed satisfactorily in EQR before being exempted from this review. Having already demonstrated that its Medicaid providers met quality standards, the fact that it continues to satisfy quality standards in future years under Medicare external review is an indication that the entity is continuing its level of commitment to quality.

Comment: Many commenters recommended that the regulations specify that in the case of mergers and acquisitions, MCOs be treated as new contractors in the Medicaid program, and be subject to an EQR.

Response: We do not agree with the commenter that the regulations should specify that all MCOs and PIHPs that have been acquired or merged with another MCO or PIHP be treated as new contractors. There are a variety of scenarios that occur when a merger or acquisition occurs as indicated by the complex rules that govern how private accrediting organizations address these situations. In addition, States have their own laws and regulations governing mergers and acquisitions. We, therefore, believe the States are in the best position to determine quality improvement requirements for newly formed entities and this regulation provides States the option to allow for the exemption as long as all the provisions in this section are met.

Comment: One commenter asked that we revise § 438.362(b)(1) to specify that the State agency must require each exempted MCO to provide it annually with copies of Medicaid reviews performed by State agents or any private accrediting organization with respect to the quality, timeliness, and access to services instead of Medicare review findings.

Response: We are not revising § 438.362(b)(1) to require Medicaid review findings be submitted to the State because if a State or its agent conducted a review, there would be no need to require the MCO or PIHP to submit the review findings, as the State would already have this information. There is a need, however, for the MCO or PIHP to submit Medicare review findings if a State chooses to exempt an MCO or PIHP from EQR, which is why this requirement is included in § 438.362(b). The exemption provision does not relieve a State from the responsibility for ensuring the adequacy of care provided by an MCO or PIHP, and the data from Medicare quality

reviews are a source of information that will be necessary for States to use to determine the appropriateness of exempting an MCO or PIHP from an EQR the following year.

Comment: One commenter recommended allowing States the flexibility to decide if their Medicaid services can properly be evaluated by a Medicare review.

Response: States have the flexibility to determine if Medicaid services can be appropriately evaluated by a Medicare review. This provision provides States with the option to exempt an MCO or PIHP from EQR. It does not require the exemption.

J. External Quality Review Results (§ 438.364)

In § 438.364, we proposed a requirement that the product of EQR be a detailed technical report, containing (1) a detailed assessment of each MCO's and PIHP's strengths and weaknesses with respect to quality of the health care services furnished to Medicaid enrollees, (2) recommendations for improving the quality of the services furnished by each MCO and PIHP, (3) comparative information about all MCOs and PIHPs as determined appropriate by the State agency, and (4) an assessment of the degree to which each MCO and PIHP addressed effectively the recommendations for quality improvement, as made by the EQRO during the previous year's EQR. Proposed § 438.364 also specified that the State must provide the results of the EQR to members of the general public upon request, and that the information released may not disclose the identity of any patient.

Comment: One commenter suggested that, because of the differing nature of adult and child health care needs, all data produced during the course of an EQR should be available by age groups so that parents may choose an MCO on the basis of the provision of quality pediatric care.

Response: This rule requires information from a variety of activities to be provided to an EQRO and included in the analysis and evaluation of the care provided by MCOs and PIHPs. Not all of the EQR activities provide detailed information that can be broken out by age groups or other categories. For example, a review for compliance with structural and operational standards would not yield beneficiary specific information. However, encounter data could potentially provide that information. In addition, the populations served by MCOs and PIHPs are likely to vary along multiple dimensions, including age,