

**§ 438.362**

**42 CFR Ch. IV (10–1–03 Edition)**

(1) The MCO or PIHP serves only individuals who receive both Medicare and Medicaid benefits.

(2) The Medicare review activities are substantially comparable to the State-specified mandatory activities in § 438.358(b)(1) and (b)(2).

(3) The MCO or PIHP provides to the State all the reports, findings, and other results of the Medicare review from the activities specified under § 438.358(b)(1) and (b)(2) and the State provides the information to the EQRO.

(4) In its quality strategy, the State identifies the mandatory activities for which it has exercised this option and explains its rationale for why these activities are duplicative.

**§ 438.362 Exemption from external quality review.**

(a) *Basis for exemption.* The State may exempt an MCO or PIHP from EQR if the following conditions are met:

(1) The MCO or PIHP has a current Medicare contract under part C of title XVIII or under section 1876 of the Act, and a current Medicaid contract under section 1903(m) of the Act.

(2) The two contracts cover all or part of the same geographic area within the State.

(3) The Medicaid contract has been in effect for at least 2 consecutive years before the effective date of the exemption and during those 2 years the MCO or PIHP has been subject to EQR under this part, and found to be performing acceptably with respect to the quality, timeliness, and access to health care services it provides to Medicaid recipients.

(b) *Information on exempted MCOs or PIHPs.* When the State exercises this option, the State must obtain either of the following:

(1) *Information on Medicare review findings.* Each year, the State must obtain from each MCO or PIHP that it exempts from EQR the most recent Medicare review findings reported on the MCO or PIHP including—

(i) All data, correspondence, information, and findings pertaining to the MCO's or PIHP's compliance with Medicare standards for access, quality assessment and performance improvement, health services, or delegation of these activities;

(ii) All measures of the MCO's or PIHP's performance; and

(iii) The findings and results of all performance improvement projects pertaining to Medicare enrollees.

(2) *Medicare information from a private, national accrediting organization that CMS approves and recognizes for Medicare+Choice deeming.*

(i) If an exempted MCO or PIHP has been reviewed by a private accrediting organization, the State must require the MCO or PIHP to provide the State with a copy of all findings pertaining to its most recent accreditation review if that review has been used for either of the following purposes:

(A) To fulfill certain requirements for Medicare external review under subpart D of part 422 of this chapter.

(B) To deem compliance with Medicare requirements, as provided in § 422.156 of this chapter.

(ii) These findings must include, but need not be limited to, accreditation review results of evaluation of compliance with individual accreditation standards, noted deficiencies, corrective action plans, and summaries of unmet accreditation requirements.

**§ 438.364 External quality review results.**

(a) *Information that must be produced.* The State must ensure that the EQR produces at least the following information:

(1) A detailed technical report that describes the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. The report must also include the following for each activity conducted in accordance with § 438.358:

(i) Objectives.  
(ii) Technical methods of data collection and analysis.  
(iii) Description of data obtained.  
(iv) Conclusions drawn from the data.

(2) An assessment of each MCO's or PIHP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients.

(3) Recommendations for improving the quality of health care services furnished by each MCO or PIHP.

(4) As the State determines, methodologically appropriate, comparative information about all MCOs and PIHPs.

(5) An assessment of the degree to which each MCO or PIHP has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

(b) *Availability of information.* The State must provide copies of the information specified in paragraph (a) of this section, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO or PIHP, recipient advocacy groups, and members of the general public. The State must make this information available in alternative formats for persons with sensory impairments, when requested.

(c) *Safeguarding patient identity.* The information released under paragraph (b) of this section may not disclose the identity of any patient.

**§ 438.370 Federal financial participation.**

(a) FFP at the 75 percent rate is available in expenditures for EQR (including the production of EQR results) and EQR-related activities set forth in § 438.358 conducted by EQROs and their subcontractors.

(b) FFP at the 50 percent rate is available in expenditures for EQR-related activities conducted by any entity that does not qualify as an EQRO.

**Subpart F—Grievance System**

**§ 438.400 Statutory basis and definitions.**

(a) *Statutory basis.* This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds

necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) *Definitions.* As used in this subpart, the following terms have the indicated meanings:

*Action* means—

In the case of an MCO or PIHP—

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service;

(4) The failure to provide services in a timely manner, as defined by the State;

(5) The failure of an MCO or PIHP to act within the timeframes provided in § 438.408(b); or

(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

*Appeal* means a request for review of an action, as "action" is defined in this section.

*Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

**§ 438.402 General requirements.**

(a) *The grievance system.* Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.