Supporting Statement – Part A
Medicaid Managed Care Quality including Supporting Regulations in
§§438.310, 438.330, 438.332, 438.334, and 438.340
CMS-10553, OMB 0938-1281

Note: The currently approved title of this collection of information request is, "Medicaid Quality and Performance Improvement Programs, State Review of Accreditation Status, Medicaid Managed Care Quality Rating System, and Quality Strategy (QS) and Supporting Regulations in 438.310, 438.330, 438.332, 438.334, and 438.340." For practical purposes and to accommodate system character limitations, we have revised the title as indicated above.

Background

Our May 6, 2016 (81 FR 27498) final rule (RIN 0938-AS25, CMS-2390-F) set out new and revised quality and quality strategy requirements that apply to states that contract with MCOs, PIHPs, PAHPs and certain PCCM entities to deliver Medicaid services. The burden for elements previously captured in CMS-10108 (OMB 0938-0920), related to quality strategy and quality assessment and performance improvement (QAPI) programs were moved under this 0938-1281 OMB control number, as the final rule has re-codified non-EQR portions of the quality regulations from Section 438 Subpart D into Subpart E. This PRA package now includes the Medicaid Quality Assessment and Performance Improvement Programs, State Review of Accreditation Status, Medicaid Managed Care Quality Rating System, and Quality Strategy (QS).

This 2022 collection of information request is a revision that proposes to adjust our cost estimates to account for current BLS wage figures, update state and plan counts, remove certain state burden estimates, and remove all private sector requirements and burden given that they are no longer applicable. Overall, this iteration reduces our active burden estimates by minus 3,786 responses, minus 18,820 hours, and minus $1,101,841.

A. Justification

1. Need and Legal Basis (Social Security Act)

Section 1932(c)(1) requires states to develop and implement quality assessment and improvement strategies for their managed care arrangements.

Section 1902(a)(4) requires such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan.

Section 1902(a)(6) requires that the State agency will make such reports (e.g. state quality strategy effectiveness evaluation), in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports.

Section 1902(a)(19) requires safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a

manner consistent with simplicity of administration and the best interests of the recipients.

2. Information Users

States develop quality strategies and quality strategy effectiveness evaluations. States use the information from these documents to help monitor and assess the performance of their Medicaid managed care programs. This information may assist states in comparing the outcomes of quality improvement efforts and can assist them in identifying future performance improvement subjects.

States engage with stakeholders when developing these documents and make the documents available for public comment. Medicaid beneficiaries and stakeholders use the information collected and reported to understand the state's quality improvement goals and objectives, and to understand how the state is measuring progress on its goals.

States must submit these documents to CMS for review. CMS uses this information as a part of its oversight of Medicaid programs.

3. Use of Information Technology

States will post on their Medicaid websites reviews of the accreditation status of all managed care plans, their managed care plan quality ratings under the Medicaid and CHIP Quality Rating System, and final state quality strategies including effectiveness evaluations of their strategies. This will ensure the public has electronic access to this information. States have discretion regarding their use of information technology for the public engagement process.

While there is discretion, we expect that states will generally submit their state quality strategies and applications for alternative quality rating systems to CMS for review via email. No signature, electronic or written, is required for these documents.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

Not applicable. All respondents are States.

6. Less Frequent Collection

States must review and revise the managed care state quality strategy at least once every three years. If this were to occur less frequently, progress on goals and the identification of new goals might not occur regularly, which would limit the utility of the strategy. The state quality strategy is a tool to help states drive quality improvement, and as such should not be allowed to stagnate.

States must at least annually post a quality rating for each MCO, PIHP and PAHP for Medicaid

managed care enrollees to use in making informed choices about their managed care plan. If this were to occur less frequently, enrollees would not have current quality information when choosing a health plan, either for the first time or during the annual open- enrollment period.

7. Special Circumstances

There are no special circumstances. More specifically, this information collection does not do any of the following:

-Require respondents to report information to the agency more often than quarterly;
-Require respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;
-Require respondents to submit more than an original and two copies of any document;
-Require respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
-Is connected with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
-Require the use of a statistical data classification that has not been reviewed and approved by OMB;
-Includes a pledge of confidentiality that is not supported by authority established in statue or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
-Require respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect die information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

The 60-day notice published in the Federal Register on May 11, 2022 (87 FR 28831). We did not receive any comments.

The 30-day notice published in the Federal Register on August 5, 2022 (87 FR 48032). Comments must be received by September 6, 2022

9. Payments/Gifts to Respondents

There are no payments/gifts to respondents.

10. Confidentiality

The information received by CMS is not confidential and its release would fall under the Freedom of Information Act. Additionally, states are required under these regulations to maintain the current state quality strategies on their websites, where they must also post the findings of the state quality strategy effectiveness evaluations conducted at least once every three years.

11. Sensitive Questions

There are no sensitive questions associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimates (Hours & Wages)

This section describes the requirements and burden for the Medicaid Quality Assessment and Performance Improvement (QAPI) Programs, State Review of Accreditation Status, Medicaid Managed Care Quality Rating System (QRS), and State Quality Strategy (QS). We estimate 46 state government respondents.

12.1 Wage Estimates

To develop our cost estimates, we used data from the U.S. Bureau of Labor Statistics' May 2021 National Industry-Specific Occupational Employment and Wage Estimates https://www.bls.gov/oes/current/oes_dc.htm). In this regard, the following table presents BLS' mean hourly wage, our estimated cost of fringe benefits (calculated at near 100 percent of salary), and our adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialist	13-1000	38.64	37.66	77.28
Office and Administrative Support Worker	43-9000	18.98	18.41	37.96

As indicated, we are adjusting our employee hourly wage estimates by a factor of nearly 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

12.2 Collection of Information Requirements and Associated Burden Estimates

Section 438.330 Quality Assessment and Performance Improvement Program

Section 438.330(e)(1) requires the state to review the impact and effectiveness of each MCO's, PIHP's, PAHP's, and PCCM entity's QAPI at least annually. We estimate an annual state burden of 15 hr at $77.28/hr for a business operations specialist to assess the performance of a single MCO, PIHP, PAHP, or PCCM entity. In aggregate, we estimate **8,670 hours** (578 MCOs, PIHPs, PAHPs, and PCCM entities x 15 hr) and **$670,017.60** (8,670 hr x $77.28/hr) (Estimate 12.12).

Under §438.330(e)(1)(ii), states will include outcomes and trended results of each MCO's, PIHP's, and PAHP's PIPs in the state's annual review of QAPI programs. We estimate an annual state burden of 1 hr to conduct the additional annual review of the outcomes and trended results for each of the 568 MCOs, PIHPs, and PAHPs (416 MCOs, 120 PIHPs, 32 PAHPs). In aggregate, we estimate **568 hr** (568 MCOs, PIHPs, and PAHPs x 1 hr) and **$43,895.04** (568 hr x $77.28/hr) (Estimate 12.14).

Section 438.330(e)(1)(iii) requires the state (in its annual review) to assess the results of any efforts to support state goals to promote community integration of beneficiaries using LTSS in place at the MCO, PIHP, or PAHP. We estimate an annual burden of 1 hr for the assessment of rebalancing efforts of each of the 179 MLTSS plans. In aggregate, we estimate **179 hr** (179 MLTSS plans x 1 hr) and **$13,833.12** (179 hr x $77.28/hr) for the assessment (Estimate 12.16).

Section 438.332 State Review of the Accreditation Status of MCOs, PIHPs, and PAHPs

Under §438.332(a), states must confirm the accreditation status of contracted MCOs, PIHPs, and PAHPs once a year. We estimate an annual state burden of 0.25 hr at $77.28/hr for a business operations specialist to review the accreditation status of each of the estimated 568 MCOs, PIHPs, and PAHPs. In aggregate, we estimate an annual burden of **142 hr** (0.25 hr x 568 MCOs, PIHPs, and PAHPs) and **$10,973.76** (142 hr x $77.28/hr) (Estimate 12.17).

Section 438.334 Medicaid Managed Care Quality Rating System

Section 438.334(a) requires each state that contracts with an MCO, PIHP or PAHP to adopt a Medicaid managed care QRS to generate plan ratings annually. States must either adopt the Medicaid managed care QRS developed by CMS in accordance with §438.334(b) or an alternative Medicaid managed care QRS in accordance with §438.334(c).

We assume each state will create a single Medicaid managed care QRS for all of the state's contracted MCOs, PIHPs, and PAHPs. We are aware of 8 states that currently operate a Medicaid managed care QRS or quality report card for the state's Medicaid managed care program; we assume that these states may want to continue to use their existing system given the investments already made in these systems. We also assume that a couple of states may determine that a state-specific approach is most suitable for them. Therefore, we estimate that of the 40 states that contract with MCOs, PIHPs, and PAHPs, 30 states will elect to adopt the Medicaid managed care QRS developed by CMS in accordance with §438.334(b), while the remainder (10 states) will elect to utilize an alternative Medicaid managed care QRS in accordance with §438.334(c). We further estimate that 75 percent (426) of MCOs, PIHPs, and PAHPs operate in these 30 states. We assume that, given the robust public engagement process CMS will use to develop the Medicaid managed care QRS in accordance with §438.334(b), states electing to adopt the CMS-developed QRS will not need to conduct additional public engagement and will require less time to develop their QRS as compared to states which elect to adopt an alternative QRS consistent with §438.334(c).

Section 438.334(c)(3) outlines the process for a state to make changes to an approved alternative Medicaid managed care QRS. We estimate that it will require 5 hr at $37.96/hr for an office and

administrative support worker and 25 hr at $77.28/hr for a business operations specialist to complete the public comment process, and an additional 5 hr at $77.28/hr from a business operations specialist to seek and receive approval from CMS for the change. While we have no data to estimate how frequently a state may elect to alter an approved alternative Medicaid managed care QRS, we estimate that CMS will revise the Medicaid managed care QRS under §438.334(b) on average approximately once every three years. We assume that states will revise their alternative Medicaid managed care QRS on a similar frequency (once every three years) to ensure that the alternative Medicaid managed care QRS continues to yield substantially comparable information regarding MCO, PIHP, and PAHP performance, and apply this assumption here. Therefore, we estimate an aggregate annual burden of **116.7 hr** [(10 states x 35 hr) / 3 years] and **$8,360.67** [(10 states x ((5 hr x $37.96/hr) + (30 x $77.28/hr))) / 3 years] (Estimate 12.22).

Under §438.334(d), each year states will rate each MCO, PIHP, or PAHP with which they contract. We estimate 40 hr at $77.28/hr for a business operations specialist for a state to rate a MCO, PIHP, or PAHP. We believe this burden will be similar for states regardless of if they adopt the CMS-developed Medicaid managed care QRS consistent with §438.334(b) or the alternative Medicaid managed care QRS consistent with §438.334(c). In aggregate, we estimate an annual state burden of **22,720 hr** (568 MCOs, PIHPs, and PAHPs x 40 hr) and **$1,755,801.60** (22,720 hr x $77.28/hr) (Estimate 12.23).

Section 438.340 Managed Care State Quality Strategy

In accordance with §438.340(c)(2), states will review and revise their state quality strategies as needed, but no less frequently than once every 3 years. We estimate a burden for the revision of a state quality strategy to be, once every 3 years, 25 hr at $77.28/hr for a business operations analyst to review and revise the state quality strategy, 2 hr at $37.96/hr for an office and administrative support worker to publicize the state quality strategy, 5 hr at $77.28/hr for a business operations specialist to review and incorporate public comments, and 1 hr at $37.96/hr for an office and administrative support worker to submit the revised state quality strategy to CMS. In aggregate, we estimate an ongoing annual state burden of **506 hr** [(46 states x 33 hr) / 3 years] and **$37,294.96** [(46 states x ((30 hr x $77.28/hr) + (3 hr x $37.96/hr))) / 3 years] (Estimate 12.25).

Consistent with §438.340(c)(2), the review of the state quality strategy will include an effectiveness evaluation conducted within the previous 3 years. We estimate the burden of this evaluation at 40 hr at $77.28/hr for a business operations specialist once every 3 years for all 46 states that contract with MCOs, PIHPs, PAHPs, and/or PCCM entities (described in §438.310(c)(2)). In aggregate, we estimate an ongoing burden of **613.3 hr** [(46 states x 40 hr) / 3 years] at a cost of **$47,398.40** (613.3 hr x $77.28/hr) (Estimate 12.28).

Section §438.340(c)(2)(ii) requires states to post the state quality strategy effectiveness evaluation to their Medicaid websites. We estimate that posting the state quality strategy effectiveness evaluation online will require 0.25 hr at $77.28 from a business operations specialist once every three years. In aggregate, we estimate an ongoing annual burden of **3.8 hr** [(46 states x 0.25 hr) / 3 years] and **$296.24** (3.8 hr x $77.28/hr) (Estimate 12.29).

Section 438.340(d) requires states to post the final state quality strategy to their Medicaid websites.

We estimate that posting the final state quality strategy online will require 0.25 hr at $77.28 from a business operations specialist once every three years. In aggregate, we estimate an ongoing annual burden of **3.8 hr** [(46 states x 0.25 hr) / 3 years] and **$296.24** (3.8 hr x $77.28/hr) (Estimate 12.31).

12.3 Summary of Burden Estimates

Summary of Annual Burden Estimates: States

Estimate #	CFR Section	# Respondents	Total # Responses	Time per response (hr)	Total Time (hr)	Labor Rate ($/hr)	Total cost ($)	Frequency	Response Type*	Annualized Time (hr)	Annualized costs ($)
12.12	438.330(e) Assess MCOs, PIHPs, PAHPs, and PCCM entities	46	578	15	8,670	77.28	670,018	annual	R	8,670	670,018
12.14	438.330(e)(1)(ii) State Review of Outcomes	40	568	1	568	77.28	43,895	annual	R	568	43,895
12.16	438.330(e)(1)(iii) State Assess LTSS	16	179	1	179	77.28	13,833	annual	R	179	13,833
12.17	438.332(a) Confirmation of Accreditation Status	40	568	0.25	142	77.28	10,974	annual	R	142	10,974
12.22	438.334(c)(3) Amend Alternative QRS	10	10	35	350	varies	25,082	triennial	R	117	8,361
12.23	438.334(d) Calculate and Issue Ratings	40	568	40	22,720	77.28	1,755,802	annual	R	22,720	1,755,802
12.25	438.340(c)(2) Revise QS	46	46	33	1,518	varies	111,885	triennial	R	506	37,295
12.28	438.340(c)(2) QS Effectiveness Evaluation	46	46	40	1,840	77.28	142,195	triennial	R	613	47,398
Subtotal: Reporting		*46*	*2,563*	*Varies*	*35,987*	*Varies*	*2,773,684*	*varies*	*R*	*33,515*	*2,587,576*
12.29	438.340(c)(2)(ii) Post QS Effectiveness Evaluation Online	46	46	0.25	12	77.28	889	triennial	TPD	4	296
12.31	438.340(d) Post Final QS	46	46	0.25	12	77.28	889	triennial	TPD	*4*	296

	Online										
Subtotal: Third-Party Disclosure		*46*	*92*	*0.5*	*23*	*77.28*	*1,778*	*triennial*	*TPD*	*8*	*592*
TOTAL		**46**	**2,655**	**Varies**	**36,010**	**Varies**	**2,775,462**	**varies**	**varies**	**33,523**	**2,588,168**

*Response Type: R=reporting; TPD=third-party disclosure

12.4 Information Collection Instruments and Guidance/Instruction Documents

None. All of the requirements are in the CFR.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

This collection involves public sector (state government) costs associated with §§438.310, 438.320, 438.330, 438.332, 438.334 and 438.340.

The public sector costs associated with these provisions are considered to be Medicaid administrative costs, and are therefore eligible for the 50 percent federal financial participation (FFP) matching rate. Therefore, of the estimated $2,588,168 total computable annualized costs, the Federal share is **$1,294,084**.

15. Changes to Burden

The burden estimates in this 2022 iteration have been revised to account for: (1) updated BLS wages, (2) updated number of state respondents and responses, (3) the removal of one-time state burden, and (4) the removal of all private sector requirements and burden.

Updated Wages

Occupation Title	Occupation Code	May 2018 Adjusted Hourly Wage ($/hr)	May 2021 Adjusted Hourly Wage ($/hr)	Difference ($/hr)
Business Operations Specialist	13-1000	71.04	77.28	+6.24
Office and Administrative Support Worker	43-9000	34.56	37.96	+3.40

State Burden Adjustments

Burden Estimate Adjustments		# Respondents			# Responses			Total Time (hr)			Total Cost ($)		
Estimate #	CRF Section	Previous	Revised	Difference	Previous	Revised	Difference	Previous	Revised	Difference	Previous	Revised	Difference
12.12	438.330(e) Assess MCOs, PIHPs, PAHPs, and PCCM entities	9	46	37	9	578	569	135	8,670	8,535	9,590	670,018	660,427
12.14	438.330(e)(1)(ii) State Review of Outcomes	40	40	0	552	568	16	552	568	16	39,214	43,895	4,681
12.16	438.330(e)(1)(iii) State Assess LTSS	16	16	0	179	179	0	179	179	0	12,716	13,833	1,117
12.17	438.332(a) Confirmation of Accreditation Status	40	40	0	552	568	16	138	142	4	9,804	10,974	1,170
12.22	438.334(c)(3) Amend Alternative QRS	10	10	0	35	35	0	117	117	0	7,680	8,361	681
12.23	438.334(d) Calculate and Issue Ratings	40	40	0	552	568	16	22,080	22,720	640	1,568,563	1,755,802	187,239
12.25	438.340(c)(2) Revise QS	18	46	28	18	46	28	198	506	308	12,822	37,295	24,473

12.28	438.340(c)(2) QS Effectiveness Evaluation	42	46	4	42	46	4	560	613	53	39,782	47,398	7,616
12.29	438.340(c)(2)(ii) Post QS Effectiveness Evaluation Online	42	46	4	42	46	4	4	4	0	249	296	48
12.31	438.340(d) Post Final QS Online	42	46	4	42	46	4	4	4	0	249	296	48
TOTAL		**42**	**46**	**4**	**2,023**	**2,680**	**657**	**23,966**	**33,523**	**9,557**	**1,700,669**	**2,588,168**	**887,499**

Removal of State Requirements and Burden Estimates

Estimate #	CFR Section	# Respondents	# Responses	Time Per Response (hr)	Total Time (hr)	Labor Rate ($/hr)	Total Cost ($)	Frequency	Response Type	Annualized Time (hr)*	Annualized Costs ($)
12.1	438.310(c)(2)	5	(5)	2	(3)	71.04	(237)	once	TPD	(3)	(237)
12.18	438.332(b)	40	(552)	0.25	(138)	71.04	(9,804)	once	TPD	(46)	(3,268)
12.24	438.340(b)(6)	40	(40)	130	(5,200)	varies	(274,560)	annual	TPD	(5,200)	(274,560)
SUBTOTAL: Third Party Disclosure		*40*	*(597)*	*varies*	*(5,341)*	*varies*	*(284,600)*	*varies*	*TPD*	*(5,249)*	*(278,065)*
12.2	438.330(a)(2)	40	(40)	10	(400)	86.14	(34,456)	annual	R	(133)	(11,485)

12.3	438.330(a)(2)	11	(11)	1	(11)	71.04	(781)	annual	R	(4)	(260)
12.13	438.330(e)(1)(ii)	40	(40)	0.5	(20)	71.04	(1,421)	once	R	(7)	(474)
12.15	438.330(e)(1)(iii)	16	(16)	0.5	(8)	71.04	(568)	once	R	(3)	(189)
12.19	438.334(b)	30	(30)	330	(9,900)	71.04	(791,868)	once	R	(3,300)	(263,956)
12.20	438.334(c)	10	(10)	1,390	(13,900)	varies	(1,098,256)	once	R	(4,633)	(366,085)
12.21	438.334(c)	10	(10)	20	(200)	71.04	(14,208)	once	R	(67)	(4,736)
12.26	438.340(c)(2)	5	(5)	0.5	(3)	71.04	(178)	once	R	(1)	(59)
12.27	438.340(c)(2)	5	(5)	33	(165)	varies	(11,174)	annual	R	(55)	(3,725)
12.30	438.340(c)(3)	5	(5)	0.5	(3)	71.04	(178)	once	R	(1)	(59)
SUBTOTAL: Reporting		*40*	*(172)*	*varies*	*(24,609)*	*varies*	*(1,953,088)*	*n/a*	*R*	*(8,203)*	*(651,029)*
TOTAL		**40**	**(769)**	**Varies**	**(29,950)**	**varies**	**(2,237,688)**	**n/a**	**n/a**	**(13,452)**	**(929,094)**

Removal of Private Sector Requirements and Burden Estimates

Estimate #	CFR Section	# Respondents	# Responses	Time per response (hr)	Total Annual Time (hr)	Labor Rate ($/hr)	Total cost ($)	Frequency	Response Type	Annualized hours*	Annualized costs ($)
12.4	438.330(b)(3)	(9)	(9)	10	(90)	71.04	(6,394)	once	TPD	(30)	(2,131)

12.10	438.330(d)(1)-(3)	(41)	(41)	2	(27)	71.04	(1,942)	once	TPD	(27)	(1,942)
12.5	438.330(b)(3)	(9)	(9)	10	(90)	71.04	(6,394)	annual	R	(90)	(6,394)
12.6	438.330(c)(2)	(511)	(1,533)	0	(153)	71.04	(10,890)	annual	R	(153)	(10,890)
12.7	438.330(c)(2)	(50)	(150)	4	(600)	71.04	(42,624)	annual	R	(600)	(42,624)
12.8	438.330(c)(2)	(179)	(358)	4	(1,432)	71.04	(101,729)	annual	R	(1,432)	(101,729)
12.9	438.330(d)(1)-(3)	(511)	(1,533)	8	(12,264)	71.04	(871,235)	annual	R	(12,264)	(871,235)
12.11	438.330(d)(1)-(3)	(41)	(41)	8	(328)	71.04	(23,301)	annual	R	(328)	(23,301)
TOTAL		**561**	**(3,674)**	**varies**	**(14,925)**	**71.04**	**(1,064,508)**	**varies**	**varies**	**(14,925)**	**(1,060,246)**

Summary of Burden Changes

Change Type	**# Respondents**	**Total # Responses**	**Annualized Time (hr)**	**Annualized Costs ($)**

State Adjustments	4	657	9,557	887,499
State Removals	n/a	(769)	(13,452)	(929,094)
Subtotal (States)	*4*	*(112)*	*(3,895)*	*(41,595)*
Private Sector	(561)	(3,674)	(14,925)	(1,060,246)
TOTAL	**(557)**	**(3,786)**	**(18,820)**	**(1,101,841)**

16. Publication/Tabulation Dates

States must at least annually, make the accreditation status for each contracted MCO, PIHP, and PAHP available on the website required under §438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level.

States must prominently display the annual quality rating given by the State to each MCO, PIHP, or PAHP on the website required under §438.10(c)(3). States must implement a quality rating system within 3 years of the date of a final notice published in the Federal Register.

States must post current state quality strategies, which include all of the elements required in §438.340(b) on their websites. CMS will maintain a list of hyperlinks to current state QS on Medicaid.gov. States are required to review and revise their QS at least once every three years; this process includes an effectiveness evaluation of the QS, the results of which must be published on the state's website. States must make the strategy available for public comment before submitting the strategy to CMS for review CMS will review QS submitted to the agency by states as a part of its normal oversight activities for the Medicaid program.

17. Expiration Date

We display the expiration date.

18. Certification Statement

There are no exceptions to the certification statement.