Supporting Statement – Part A
Medicaid Managed Care Quality including Supporting Regulations
CMS-10553, OMB 0938-1281

Supporting regulations can be found at: §§438.310, 438.330, 438.332, 438.334, (proposed to be designed at 438 Subpart G), and 438.340.

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 collection of information request 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 August 2023 iteration would establish the MAC Quality Rating System as a one-stop-shop where beneficiaries could access information about Medicaid and CHIP eligibility and managed care; compare plans based on quality and other factors key to beneficiary decision making, such as the plan's drug formulary and provider network; and ultimately select a plan that meets their needs. States would be required to collect data using the framework of a mandatory QRS Measure Set and, based on data collected, calculate and issue an annual quality rating to each managed care plan. States would also build a website display that must: allow users to view tailored information, compare managed care plans, provide information on quality ratings and directs users to resources on how to enroll in a Medicaid or CHIP plan.

This collection of information does not provide respondents with any reporting instruments or instruction/guidance documents other than what is published in our final rules and codified in the CFR.

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.

In this August 2023 iteration beneficiaries are the main users of a state's quality rating system. Beneficiaries will use a state's QRS to compare plans on quality, benefits, and other plan performance indicators. States and other interested parties may also use state QRSs learn information about plans available in a state. CMS would use information reported by states through QRS reporting to conduct oversight on state QRSs.

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.

In this August 2023 iteration states would be required to build a QRS website that uses information technology in a variety of ways to create a user-friendly experience for beneficiaries and other users navigating the website. States would be allowed to phase in more interactive features overtime.

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. We do not expect any impact on small businesses since plans must have 500 members.

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 August 28, 2023 (88 FR 58588). Comments must be received by October 27, 2023.

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. The Quality Ratings System will be posted on state website (all info in QRS)

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

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 44 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 and other indirect costs (calculated at near 100 percent of salary), and our adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operations Specialist	13-1000	38.64	38.64	77.28
Computer Programmer	15-1251	54.68	54.68	109.36
Database Administrator	15-1242	49.25	49.25	98.50
General and Operations Manager	11-1021	55.41	55.41	110.82

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Medical Records Specialist	29-2072	23.23	23.23	46.46
Office Clerk, General	43-9061	18.98	18.98	37.96
Statistician	15-2041	47.81	47.81	95.62
Registered Nurse	29-1141	39.78	39.78	79.56
Web Developer	15-1245	39.09	39.09	78.18

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, or PAHP. In aggregate, we estimate **9,435 hours** (629 MCOs, PIHPs and PAHPs, x 15 hr) and **$729,136.80** (9,435 hr x $77.28/hr) **(Estimate 12.12 (S)).**

Under §438.330€(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 629 MCOs, PIHPs, and PAHPs (467 MCOs, 161 PIHPs, 31 PAHPs). In aggregate, we estimate **629 hr** (629 MCOs, PIHPs, and PAHPs x 1 hr) and **$48,609.12** (629 hr x $77.28/hr) (**Estimate 12.14(S)).**

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 113 MLTSS plans. In aggregate, we estimate **113 hr** (113 MLTSS plans x 1 hr) and **$8,732.64** (113 hr x $77.28/hr) for the assessment (**Estimate 12.16(S)).**

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 629 MCOs,

PIHPs, and PAHPs. In aggregate, we estimate an annual burden of **157.25 hr** (0.25 hr x 629 MCOs, PIHPs, and PAHPs) and **$12,152.28** (157.25 hr x $77.28/hr) (**Estimate 12.17(S)).**

Section 438.334 Medicaid Managed Care Quality Rating System

Medicaid managed care quality rating system methodology

Under § 438.515(a)(1) the State will calculate and issue an annual quality rating to each managed care plan. For Medicaid managed care, we assume 629 MCOs, PIHPs and PAHPs and 44 States would be subject to the mandatory QRS measure set collection and reporting requirement.

We estimate reporting the QRS non-survey measures would take: 680 hours at $109.36/hr for a computer programmer to program and synthesize the data; 212 hours at $77.28/hr for a business operations specialist to manage the data collection process; 232 hours at $37.96/hr for an office clerk to input the data; 300 hours at $79.56/hr for a registered nurse to review medical records for data collection; and 300 hours at $46.46/hr for medical records and health information analyst to compile and process medical records. For Medicaid, for one managed care entity we estimate an annual private sector burden of 1,724 hours (680 hr + 212 hr + 232 hr + 300 hr + 300 hr) at cost of $137,361 ([680 hr x $109.36/hr] + [252 hr x $77.28/hr] + [328 hr x $37.96/hr] + [300 hr x $79.56/hr] + [300 hr x $46.46/hr]).

We estimate that conducting the QRS survey measures comprised of the CAHPS survey would take: 20 hours at $77.28/hr for a business operations specialist to manage the data collection process; 40 hours at $37.96/hr for an office clerk to input the data; and 32 hours at $95.62/hr for a statistician to conduct data sampling. For one Medicaid managed care entity we estimate an annual private sector burden of 92 hours (20 hr + 40 hr + 32 hr) at cost of $6,124 ([20 hr x $77.28/hr] + [40 hr x $37.96/hr] + [32 hr x $95.62]).

For mandatory QRS non-survey and survey measures we estimate an annual private sector burden of 1,816 hours (1,724 hr +92 hr) at a cost of $143,485 ($137,361 + $6,124). In aggregate, for Medicaid, we estimate an annual private sector burden of **1,142,264** hours (629 Medicaid MCOs, PIHPs and PAHPs × 1,816 hours) and **$90,252,065** (629 Medicaid MCOs, PIHPs and PAHPs × $143,485). **(Estimate 12.32 (PS))**

In addition, the CAHPS survey measures a burden on Medicaid beneficiaries. Beneficiaries complete the survey via telephone or mail. Response rates vary slightly by survey population. We estimate it would take 20 minutes (0.33 hr) at $28.01/hr for a Medicaid or CHIP beneficiary to complete the CAHPS Health Plan Survey. For Medicaid, in aggregate, we estimate a new beneficiary burden of **172,346** hours (629 MCOs, PIHPs and PAHPs x 0.33 hr per survey response x 822 beneficiary responses) at a cost of **$4,827,411** (172,346 hr x $28.01/hr). (**Estimate 12.33 (PS))**

Additionally, amendments to § 438.515(a)(1)(i), reporting QRS measures would require States to update existing managed care contracts. We estimate it would take 1 hour at $77.28/hr for a business operations specialist and 30 minutes at $110.82/hr a general operations manager to amend vendor contracts to reflect the new reporting requirements. In aggregate for Medicaid, we

estimate a one-time State burden of **944** hours (629 MCOs, PIHPs, and PAHPs × 1.5 hours) at a cost of $**83,462** (629 contracts x [(1 hr × $77.28/hr) + (0.5 hr x $110.82/hr)]). As this would be a one-time requirement, we annualize our time and cost estimates to 315 hours and $27,821. The annualization divides our estimates by three (3) years to reflect OMB's likely approval period. We are annualizing the one-time burden estimates since we do not anticipate any additional burden after the 3-year approval period expires. (**Estimate 12.34 (S))**

Under § 438.515(a)(1)(ii) require States will collect data from Medicare and the State's fee-for-service providers, if all data necessary to issue an annual quality rating cannot be provided by the managed care plans and the data are available for collection by the State without undue burden. We expect a that subset of States would need to collect Medicare data or State Medicaid fee-for-service data to report the mandatory quality measures. We assume that plans have access to Medicare data for their members and have included this burden in the cost of data collection described above. However, we assume Medicaid fee-for-service data would need to be provided and that this requirement would impact 5 States.

For a State to collect the fee-for-service data needed for QRS reporting, we expect it would take: 120 hours at $109.36/hr for a computer programmer to program and synthesize the data and 20 hours at $77.28/hr for a business operations specialist to manage the data collection process. In aggregate for Medicaid, we estimate an annual State burden of **700** hours (5 States x [120 hr + 20 hr]) at a cost of **$73,344** ([120 hr x $109.36/hr] + [20 hr x $77.28/hr]). (**Estimate 12.35 (S))**

Amendments to §§ 438.515(a)(2) and 457.1240(d) require the QRS measure data to be validated. We estimate it would take 16 hours at $77.28/hr for a business operations specialist to review, analyze and validate measure data. In aggregate for Medicaid, we estimate an annual private sector burden of **10,064** hours (629 MCOs, PIHPs, PAHPs and PCCMs x 16 hr) at a cost of **$777,746** (10,064 hr x $77.28/hr). **(Estimate 12.36 (PS))**

QRS Web site display

Under §§ 438.520(a) the State will post an up-to-date display on its website that provides information on available MCOs, PIHPs and PAHPs. While there would be a phase-in approach to the QRS website display requirements; however, the burden estimate reflects the full implementation of the website. We recognize this may results is an overestimate during the initial phase of the website display but believe the estimate is representative of the longer-term burden associated with the QRS website display requirements.

To develop the initial display, we estimate it would take: 600 hours at $109.36/hr for a computer programmer to create and test code; 600 hours at $78.18/hr for a web developer to create the user interface; 80 hours at $77.28/hr for a business operations specialist to manage the display technical development process; and 450 hours at $98.50/hr for a database administer to establish the data structure and organization. For one State, we estimate a burden of 1,730 hours (600 hr + 600 hr + 80 hr + 450 hr) at a cost of $163,031 ([600 hr x $109.36/hr] + [600 hr x $78.18/hr] + [80 hr x $77.28/hr] + [450 hr x $98.50/hr]). In aggregate for Medicaid, we estimate a one-time State burden of **76,120** hours (44 States x 1,730 hr) at a cost of **$7,173,364** (44 States x $163,031). **(Estimate 12.37 (S))**

To maintain the QRS display annually, we estimate it would take: 384 hours at $109.36/hr for a computer programmer to modify and test code; 256 hours at $78.18/hr to update and maintain the user interface; 120 hours at $77.28/hr for a business operations specialist to manage the daily operations of the display; and 384 hours at $98.50/hr for a database administer to organize data. For one State, we estimate a burden of 1,144 hours (384 hr + 256 hr + 120 hr + 384 hr) at a cost of $109,106 ([384 hr x $92.92/hr] + [256 hr x $78.18/hr] + [120 hr x $77.28/hr] + [384 hr x $98.50/hr]). In aggregate for Medicaid, we estimate an annual State burden of **50,336** hours (1,144 hours x 44 States) at a cost of **$4,800,664** ($109,106 x 44 States). **(Estimate 12.38 (S))**

Under 438.520(a)(2)(iv) the State QRS website must display to include quality ratings for mandatory measures which may be stratified by factors determined by CMS. We estimate it would take 24 hours at $109.36/hr for a computer programmer to develop code to stratify plan data. In aggregate for Medicaid (§ 438.520(a)(2)(iv)), we estimate an annual private sector burden of **15,096** hours (629 MCOs, PIHPs and PAHPs x 24 hr) at a cost of **$1,650,899** (15,096 hr x $109.36/hr). **(Estimate 12.39 (PS))**

Provision 438.520(a)(3)(v) will require the QRS website display to include certain managed care plan performance metrics, as specified by CMS including the results of the secret shopper survey specified in § 438.68(f). The secret shopper survey is currently accounted for by OMB under control number 0938-0920 (CMS-10108). Plans would complete the secret shopper independent of the QRS requirements. To meet QRS requirements, States would enter data collected from the secret shopper survey and display the results of the survey on the QRS. Since the burden for the secret shopper survey is accounted for under a separate control number, for the purposes of MAC QRS, we account for the incremental burden associated with meeting the QRS requirements. We estimate it would take 16 hours at $37.96/hr for an office clerk to enter the results from the secret shopper survey into the QRS. In aggregate for Medicaid § 438.520(a)(3)(v), we estimate an annual private sector burden of **10,064** hours (629 MCOs, PIHPs and PAHPs x 16 hr) at a cost of **$382,029** (10,064 hr x $37.96/hr). **(Estimate 12.40 (PS))**

Annual Reporting

Under§ 438.535(a) the State will submit a Medicaid managed care quality rating system report in a form and manner determined by CMS. We estimate it would take 24 hours at $77.28/hr for a business operations specialist to compile the required documentation to complete this report and attestation that the State is in compliance with QRS standards. In aggregate for Medicaid for § 438.535(a), we estimate an annual State burden of **1,056** hours (44 States x 24 hr) at a cost of **$81,608** (1,056 hr x $77.28/hr). **(Estimate 12.41 (S))**

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 **484 hr** [(44 states x 33 hr) / 3 years] and **$35,673** [(44 states x ((30 hr x $77.28/hr) + (3 hr x $37.96/hr))) / 3 years] (**Estimate 12.25 (S)).**

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 44 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 **586.67 hr** [(44 states x 40 hr) / 3 years] at a cost of **$45,337.86** (586.67 hr x $77.28/hr) (**Estimate 12.28 (S)).**

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 **3.67 hr** [(44 states x 0.25 hr) / 3 years] and **$283.62** (3.67 hr x $77.28/hr) **(Estimate 12.29 (S)).**

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 **3.67 hr** [(44 states x 0.25 hr) / 3 years] and **$283.62** (3.67 hr x $77.28/hr) **(Estimate 12.31 (S)).**

12.3 Summary of Burden Estimates

Summary of Annual Burden Estimates: States

Summary of Annual Burden Estimates: State (S)

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	44	629	15	9,435	77.28	729,137	annual	R	9,435	729,137
12.14	438.330(e)(1)(ii) State Review of Outcomes	44	629	1	629	77.28	48,609	annual	R	629	48,609
12.16	438.330(e)(1)(iii) State Assess LTSS	44	113	1	113	77.28	8,733	annual	R	113	8,733
12.17	438.332(a)	44	629	0.25	157	77.28	12,152	annual	R	157	12,152
12.25	438.340(c)(2) Revise QS	44	44	33	1,452	varies	107,019	triennial	R	484	35,673
12.28	438.340(c)(2) QS Effectiveness Evaluation	44	44	40	1760	77.28	136,013	triennial	R	587	45,338
12.34	438.515(a)(1)(i) Update Existing Managed Care Contracts	44	629	1.5	944	varies	83,462	one-time	R	944	83,462
12.35	438.515(a)(1)(ii) Obtain Data from FFS and Medicare	5	5	140	700	varies	73,344	annual	R	700	73,344
12.37	438.520(a) QRS Website Display Development	44	44	1730	76,120	varies	7,173,364	one time	R	76,120	7,173,364
12.38	438.520(a) QRS Website Display Maintenance	44	44	1144	50,336	varies	4,800,664	annual	R	1144	4,800,664
12.41	438.535(a) QRS Report	44	44	24	1,056	77.28	81,608	annual	R	1056	81,608
Subtotal: Reporting		*44*	*2,854*	*varies*	*142,702*	*varies*	*13,252,105*	*varies*	*R*	*140,561*	*13,092,083*

12.29	438.340(c)(2)(ii) Post QS Effectiveness Evaluation Online	44	44	0.25	11	77.28	850	triennial	TPD	4	284
12.31	438.340(d) Post Final QS Online	44	44	0.25	11	77.28	850	triennial	TPD	4	284
Subtotal: Third-Party Disclosure		*44*	*88*	*varies*	*22*	*varies*	*1,700*	*varies*	*TPD*	*8*	*568*
TOTAL		**44**	**2,942**	**varies**	**142,724**	**varies**	**13,250,909**	**varies**	**varies**	**91,377**	**13,091,020**

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

Summary of New Annual Burden Estimates: Private Sector (PS)

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 ($)
12.32	438.515(a)(1) QRS Survey and Non-Survey Measures	629	629	1816	1,142,264	varies	90,252,065	annual	R	1,142,264	90,252,065
12.33	438.515(a)(1) CAHPS Survey	629	629	.33	172,346	28.01	4,827,411	annual	R	172,346	4,827,411
12.36	438.515(a)(2) 457.1240(d) QRS Validation	629	629	16	10,064	77.28	777,746	annual	R	10,064	777,746
12.39	438.520(a)(2)(iv) QRS Website Stratification	629	629	24	15,096	109.36	1,650,899	annual	R	15,096	1,650,899
12.40	438.520(a)(3)(v) Secret Shopper Survey Data Entry	629	629	16	10,064	37.96	382,029	annual	R	10,064	382,029
TOTAL		**629**	**3,145**	**varies**	**1,349,834**	**varies**	**97,890,150**	**annual**	**varies**	**1,349,834**	**97,890,150**

*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 both private sector (MCOs, PIHPs and PAHPs)and public sector (state government).

Total annualized private sector costs are $97,890,150. Consistent with the assumptionsused for the private sector match rate in 42 CFR part 438, we assume that the private sector will pass along costs to states through their capitation rates and, applying the estimated weighted (for enrollment) Federal match rate of 58.44 percent. Therefore, the Federal share for annualized private sector costs is $57,207,004.

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 $13,092,651 total computable annualized state costs, the Federal share is $6,546,325.

Total annualized Federal share (private and public sector) is **$63,753,329.**

15. Changes to Burden

The burden estimates in this August 2023 iteration have been revised to account for: (1) updated number of state respondents and responses and (2) the addition of state and private section burden estimates related the new MAC Quality Rating System which includes mandatory measure collection and website display.

As demonstrated below, this iteration would increase our active burden estimates by 3,432 responses, 1,456,880 hours, and $108,394,633.

For the states, our currently approved annualized time, cost and responses increased. Our annualized total time increased by 107,046 hours (from 33,523 hours to 140,569). Our annualized total cost increased by $10,504,483 (from $2,588,168 to $13,092,651). Our responses increased by 287 (from 2,655 responses to 2,942 responses)

For the private sector burden, our currently approved time, cost and responses increased as our currently approval does not have private section burden. Our annualized time increased by 1,349,834 hours; our total cost increased by $97,890,150; and our responses increased by 3,145 responses.

State Burden Changes (Adjustments and Removals)

Adjustments and Removals		# 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	46	44	(2)	578	629	51	8,670	9,435	765	670,018	729,137	59,119
12.14	438.330(e)(1)(ii) State Review of Outcomes	40	44	4	568	629	61	568	629	61	43,895	48,609	4,714
12.16	438.330(e)(1)(iii) State Assess LTSS	16	44	28	179	113	(66)	179	113	(66)	13,833	8,733	(5,100)
12.17	438.332(a) Confirmation of Accreditation Status	40	44	4	568	629	61	142	157	15	10,974	12,152	1,178
12.22	438.334(c)(3) Amend alternative QRS	10	0	(10)	10	0	(10)	117	0	(117)	8,361	0	-8,361
12.23	438.334(d) Calculate and Issue Ratings	40	0	(40)	568	0	(568)	22720	0	(22,720)	1,755,802	0	(1,755,802)
12.25	438.340(c)(2) Revise QS	46	44	(2)	46	44	(2)	506	484	-22	37,295	35,673	-1,622
12.28	438.340(c)(2) QS Effectiveness Evaluation	46	44	(2)	46	44	(2)	613	587	(26)	47,398	45,338	(2,060)
12.34	438.515(a)(1)(i) Update Existing Managed Care Contracts	0	44	44	0	629	629	0	944	944	0	83,462	83,462
12.35	438.515(a)(1)(ii), Obtain Data from FFS and Medicare	0	5	5	0	5	5	0	700	700	0	73,344	73,344

12.37	438.520(a), QRS Website Display Development	0	44	44	0	44	44	0	76,120	76,120	0	7,173,364	7,173,364
12.38	438.520(a), QRS Website Display Maintenance	0	44	44	0	44	44	0	50,336	50,336	0	4,800,664	4,800,664
12.41	438.535(a) QRS Report	0	44	44	0	44	44	0	1,056	1,056	0	81,608	81,608
12.29	438.340(c)(2)(ii) Post QS Effectiveness Evaluation Online	46	44	(2)	46	44	(2)	4	4	0	296	284	(12)
12.31	438.340(d) Post Final QS Online	46	44	(2)	46	44	(2)	4	4	0	296	284	(12)
TOTAL		**46**	**44**		**2,655**	**2,942**	**287**	**33,523**	**140,569**	**107,046**	**2,588,168**	**13,092,651**	**10,504,483**

New Private Sector Burden Changes (Additions)

Additions		**#**	**Total #**	**Time per**	**Total Time (hr)**	**Labor Rate ($/hr)**	**Total cost**	**Frequency**	**Response Type***	**Annualized Time (hr)**	**Annualized costs ($)**
Estimate # (PS)	**CFR Section**	**Respondents**	**Responses**	**response (hr)**			**($)**				
12.32	438.515(a)(1) QRS Survey and Non-Survey Measures	629	629	1816	1,142,264	varies	90,252,065	annual	R	1,142,264	90,252,065
12.33	438.515(a)(1) CAHPS Survey	629	629	.33	172,346	28.01	4,827,411	annual	R	172,346	4,827,411
12.36	438.515(a)(2) 457.1240(d) QRS Validation	629	629	16	10,064	77.28	777,746	annual	R	10,064	777,746
12.39	438.520(a)(2)(iv) QRS Website Stratification	629	629	24	15,096	109.36	1,650,899	annual	R	15,096	1,650,899
12.40	438.520(a)(3)(v) Secret Shopper Survey Data Entry	629	629	16	10,064	37.96	382,029	annual	R	10,064	382,029
TOTAL		**629**	**3,145**	**varies**	**1,349,834**	**varies**	**97,890,150**	**annual**	**varies**	**1,349,834**	**97,890,150**

Summary of Burden Changes

Respondent	# Respondents	Total # Responses	Annualized Time (hr)	Annualized Costs ($)
States	(2)	287	107,046	10,504,483
Private Sector	629	3,145	1,349,834	97,890,150
TOTAL	**627**	**3,432**	**1,456,880**	**108,394,633**

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.