

Supporting Statement A:
13th SOW QIN-QIO and AIAN
Advancing Healthcare Quality through Technology (AHQT)
Readiness Assessment.

A. Background

This is a new information collection request. The Quality Innovation Network – Quality Improvement Organization (QIN-QIO) program and American Indian/Alaska Native (AIAN) program assists providers/practices with high-quality, hands-on quality improvement assistance toward meeting their needs, and the healthcare quality and safety goals for beneficiaries. The purpose of this new information collection within these programs is to assess participating nursing homes’, hospitals’, outpatient clinical practices’ and AIAN facilities’ readiness to access, share, and use data electronically for quality improvement and quality reporting. Use of health information technology (HIT) is imperative to assess, monitor, and improve healthcare quality, patient safety, and care coordination.

Many providers/practices continue to lack basic knowledge and capacity to implement HIT to support data exchange between providers/practices, payers, and patients, and to use data for improving quality and outcomes. This “digital divide” creates burden for patients, families, caregivers, providers/practices and increases costs and administrative waste. This burden is disproportionate for small health care organizations and other organizations with limited access to resources. Advancing the use of technology and using interoperable standards can reduce the overall cost and burden associated with data collection and supports communication across the care continuum and is an agency priority.

CMS has developed a 41-item Assessment of Health care Quality Technical Readiness (AHQT) for use with participating providers/practices under the QIN-QIO and AIAN 13th SOW. Provider/practice burden associated with the collection and reporting of quality measurement data has historically been a pain point for the QIN-QIO and AIAN programs, especially in outpatient clinical practices and critical access hospitals; this burden has been a barrier to both the achievement of quality improvement contract goals and proper evaluation of their impact.

The results of the assessment will be used to determine which providers/practices may benefit from participation in a technical assistance pilot specific during the QIN-QIO 13th SOW intended to advance provider/practice capacity for engaging in quality improvement and reporting activities facilitated by HIT.

B. Justification

1. Need and Legal Basis

The statutory authority for the QIO program is found in Part B of Title XI of the Social Security Act (the Act). The statutory provisions originated with the Peer Review Improvement Act of 1982 (P.L.

97-248, §141-143, 96 Stat. 324), which established the Utilization and Quality Control Peer Review Organization program, now known as the QIO program. These provisions were significantly amended by the Trade Adjustment Assistance Extension Act of 2011 (P.L. 112-40, §261, 125 Stat. 401).

The QIO statute, as amended by Section 261 of the Trade Adjustment Assistance Extension Act of 2011, also requires QIOs to perform, subject to the terms of their contracts, activities that the Secretary determines may be necessary for the purposes of improving the quality of care furnished to Medicare beneficiaries. This provision, in addition to several others as applicable, provides specific authority for what is included in the contracts of the QIOs. While the purpose of the QIN-QIO 13th SOW is to carry out the goals listed in Section 1862(g) of the Act, the QIO program requirements will be fulfilled in a manner that supports CMS in its efforts to improve health and healthcare for all Medicare beneficiaries by promoting quality of care.

The purpose of this new data collection activity is to assess the level of technological readiness in participating nursing homes, hospitals, outpatient clinical practices and AIAN facilities for quality improvement in 13th SOW QIN-QIO and AIAN Programs. This assessment requires providers/practices to answer questions about their existing information technology systems/infrastructure as well as their readiness to incorporate enhancements to their systems and infrastructure that facilitate quality improvement and reporting functions. The assessment tool is designed to categorize each provider/practice by its level of Technical Readiness across 4 Tiers (Tiers 0, 1, 2, 3). With some providers/practices entirely lacking technology itself (Tier 0), some lacking the organizational structures, skills, and workflow processes to make use of this technology for quality improvement (Tier 1), and some providers/practices fully ready to use data for quality improvement (Tier 2) or already using it for quality improvement (Tier 3). The AHQT Readiness Assessment can be used to track the progress of each provider/practice in achieving readiness over time and is included as an Attachment to this ICR package.

QIN-QIOs and AIAN program contractors under the 13th SOW, will need this assessment information so that services can be appropriately tailored to providers/practices given their level of technological readiness. CMS and its program evaluators will also need this information to properly contextualize the choice of interventions and evaluate their impact.

QIN-QIOs and AIAN program contractors will identify 3,000 Tier 1 providers/practices in the states included in the pilot to engage them in a targeted technical assistance pilot program (also known as the AHQT pilot) to facilitate movement from Tier 1 to a more advanced stage of readiness. The technical assistance to be provided through the AHQT pilot will focus primarily on approaches to address organizational structures, skills, and resources to ensure that a provider/practice is better equipped to perform quality improvement. An offer to participate will be extended to hospitals, nursing homes, and outpatient clinical practices in the pilot states and all AIAN facilities.

2. Information Users

Data on the current technology level of the providers/practices will be collected by the QIN-QIOs

and AIAN contractors to assign the technology Tier level to the providers/practices. Providers/practices identified as a technology Tier 1 level will be part of the AHQT pilot. As described above, the data collected will be used to achieve 3 main objectives essential to the success and evaluation of the QIN-QIO and AIAN 13th SOWs. These are: (1) to identify facilities within AHQT pilot states that would most benefit from participating in this pilot project intended to improve readiness for quality improvement activities; (2) to inform and improve the general design of the entire 13th SOW by understanding the technological context that will either facilitate or limit the extent of clinical quality improvement across all tasks and providers /practices in the 13th SOW; and (3) to support the evaluation of both the AHQT technical assistance pilot and other QIN-QIO and AIAN quality improvement activities by ensuring that technological readiness is considered when selecting comparison providers/practices to assess impact. According to QIN-QIOs knowledge of their regions, Critical Access Hospitals (CAHs) and Rural facilities and small provider practices are definite areas of focus and need additional support for Electronic Health Record (EHR) adoption. Some of the states with the lowest EHR adoption rates (less than 50%) include: Rhode Island and Vermont (Region 1), Louisiana (Region 5), and Hawaii (Region 7). In addition, there are some states with no health Information Exchange (HIE) support, impacting the ability for QIN-QIOs to access the data for care coordination and to reduce reporting burden for providers including Minnesota (Region 4) and Washington State (Region 6).

Ultimately, as stated in the background, the intent of the pilot is to advance the use of technology and interoperable standards to reduce the overall cost and burden associated with data collection and supports communication across the care continuum and is an agency priority, especially among small health care organizations and other organizations with limited access to resources. The 14-month metric is the percentage of Tier 1 providers who sign participation agreements, at 36 months, metrics include percentage of Tier 1 providers who have achieved Tier 2 status, Tier 1 offices that are now submitting data to the QIN-QIOs electronically, Tier 1 hospitals that have increase safety planning for ED patients at risk for suicide, and Tier 1 nursing homes that are reporting vaccination measures to NHSN.

By 57 months, improvements are expected in Office-based practices: Hypertension control. Diabetes management, and Emergency department (ED) visits for ambulatory care sensitive conditions; Acute care hospitals: 30-day readmissions and follow-up after an ED visit for behavioral health conditions; and Nursing homes: ED Visits Among Short and Long-Stay Residents and Readmissions to Hospitals from skilled nursing facilities.

The QIN-QIOs and AIAN contractors are expected to recruit a maximum of 25,300 providers/practices in the 13th SOW who will complete an AHQT Baseline Readiness Assessment within the first 14 months of the contract (within 3 months of the approval of this data collection tool –whichever is later) and a Final Readiness assessment again by the 57th month of the contract. The estimated breakdown by health care setting of those participating in each time period is: 8,500 nursing homes, 3,500 hospitals, and 13,000 outpatient clinical practices. We note that 300 American Indian/Alaskan Native (AIAN) facilities and providers/practices are included among these numbers. The assessment covers foundational, technical, administrative, and operational aspects of AHQT readiness. In addition to these two data collections, an Interim assessment will be conducted among 3,000 Tier 1 facilities and outpatient practices that are targeted to participate in the AHQT technical

assistance pilot. Although the AHQT technical assistance pilot is designed to last for 5 years, this interim assessment will facilitate any needed mid-course corrections in approach, including a change of direction or discontinuation or expansion of the task as the evidence suggests.

CMS may also use these data to inform the feasibility and timing of future evolution of CMS' quality measurement, reporting and value-based purchasing programs to better support quality improvement. In this regard, quality measurement and value-based purchasing programs are particularly interested in stages of readiness and implementation of FHIR standards.

3. Use of Information Technology

CMS will employ a web-based collection tool for the AHQT after public comment and OMB approval for the information collection. This tool can be ready for use as early as April 1, 2025. The collection of AHQT information will be 100% electronic and does not require a signature from the respondents. Please see the table below for information required by the Government Paperwork Elimination Act (GPEA).

GPEA Question	Response
Is this collection currently available for completion electronically?	No – this is a new information collection.
Does this collection require a signature from the respondent(s)?	No.
If CMS had the capability of accepting electronic signature(s), could this collection be made available electronically?	N/A – no signatures from respondents are needed.
If this collection isn't currently electronic but will be made electronic in the future, please give a date (month & year) as to when this will be available electronically and explain why it can't be done sooner.	This collection can be made available as early as April 1, 2025. However, we cannot finalize the assessment tool and begin collection prior to considering public comment and receiving OMB approval for the information collection.
If this collection cannot be made electronic or if it isn't cost beneficial to make it electronic, please explain.	N/A -- The collection of AHQT information will be 100% electronic.

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

The assessment is designed so that those providers/practices with the least capacity will skip the majority of items allowing for quicker completion, thus minimizing burden to small providers/practices. This information collection will provide CMS with additional insight into the needs of small providers/practices for meeting existing CMS requirements to maintain and report quality data. Therefore, small providers/practices are most likely to benefit from this data collection effort.

6. Less Frequent Collection

The decision to collect these critical data only three times (instead of annually) from AHQT technical assistance pilot participants, and only twice from facilities and practices not participating in the pilot reflects an intentional implementation of the minimum data collection frequency needed to meet the three main purposes described above. Without this data collection, the AHQT pilot could not be implemented or evaluated at all, and the rest of the QIN-QIO and AIAN program implementation and evaluation would lack visibility into the technical capabilities of providers/practices to successfully engage in health care quality improvement and reporting.

We note that although there are 41 questions in the survey but not all the questions will apply to all the providers/practices completing the survey. The questionnaire is designed with skip patterns that are dependent on the responses from previous questions. For example, most Tier 0, will skip all but 7 questions whereas Tier 1-3 will require answers to most of the 41 questions.

7. Special Circumstances

There are no special circumstances associated with this collection.

8. Federal Register/Outside Consultation

The 60-day Federal Register Notice published

We note that in October 2023, the Agency issued a Request for Information (RFI) on SAM.gov seeking public input on features of the 13th SOW QIN-QIO and AIAN programs, including an earlier version of the AHQT instrument. The current assessment tool (included as an Attachment to this ICR package) is a refined version based on the input received during the October 2023 RFI and subsequent internal testing.

9. Payments/Gifts to Respondents

There will be no payment, gift, or other remuneration provided to respondents for completing this assessment.

We note that as part of the AHQT technical assistance pilot under the 13th SOW, the QIN-QIOs and AIAN contractors are expected to provide additional assistance focused on health care technology to 3,000 providers/practices (including AIAN facilities) that are assessed as Tier 1 using the instrument. This assistance will go beyond the general quality improvement assistance the QIN-QIOs and AIAN contractors will deliver for all participating providers/practices under the 13th Statement of Work. This additional technical assistance for Tier 1 providers/practices participating in the AHQT pilot will include education, guidance and support for building the infrastructure and capacity for data exchange that is necessary for providers/practices to access, share, and use data for quality improvement purposes.

10. Confidentiality

The system operates within a cloud-based technology platform which has a CMS Authority to Operate (ATO) to collect, analyze, synthesize and store data including PII. CMS Privacy Impact Assessment (PIA) was approved by the CMS Privacy Officer on 3/28/2024, draft-approved by the HHS Privacy reviewer on 4/23/2024 and currently awaiting HHS final review. The system's System of Records Notice (SORN) number is: 09-70-0536 Medicare Beneficiary Database (MBD). The information collected specific to this effort will be utilized by CMS and its agents to assess the level of technological readiness for quality improvement in 13th SOW QIO Program nursing homes, hospitals, outpatient clinical practices and AIAN facilities. Any identifiable data subject to the Privacy Act is not disclosed after the determination of the Tier.

11. Sensitive Questions

There are no questions of a sensitive nature on the tool.

12. Burden Estimates (Hours & Wages)

QIN-QIOs and AIAN contractors will recruit a maximum of 25,300 13th SOW providers/practices, (including AIAN facilities/practices) to complete an AHQT Baseline Readiness Assessment in the first 14 months of the contract (within 3 months of the approval of this data collection tool – whichever is later) and again by the 57th month of the contract. The estimated breakdown by health care setting of those participating in each of this period is 8,500 nursing homes, 3,500 hospitals, 13,000 outpatient clinical practices and 300 AIAN facilities. In addition to these two data collections, an interim assessment will be conducted only among the 3,000 facilities or outpatient practices targeted to participate in the pilot. We believe that the person who would complete the AHQT assessment tool would be an employee such as a health information technologist. The mean hourly wage for this labor category according to the Bureau of Labor Statistics (BLS)

Occupational Outlook ¹ is \$33.78 per hour. The loaded labor rate² is estimated at \$50.66. The calculations below represent the estimated annualized burden hours among all respondents as well as for each respondent.

Annualized burden hours for the total number of respondents are 10,600 hours per year.

- 3 administrations yielding 53,600 responses total over the 13th SOW.
- 53,600 responses x 60 minutes on average per response = 3,216,000 minutes. total over the 13th SOW.
- Divided by 5-year period of performance for the 13th SOW = 643,200 minutes per year /60 minutes per hour = 10,720 hours.

Annualized cost for total number of respondents is \$536,996.00 per year.

- \$50.66 loaded labor rate x 10,720 hours = \$543,076.00

Annualized burden hours for each respondent is .424 hours per year.

- 10,720 hours divided by 25,300 respondents = .424

Annualized cost for each respondent is \$21.48 per year.

- \$50.66 loaded labor rate x .424 = \$21.48

Table 1: Annualized Cost Burden per Respondent

Total Responses over the 5-year contract period (25,000 responses in years 2 and 5 plus an additional 3,000 interim responses)	Yearly Responses	Response time per respondent in hours	Total Yearly Response time in hours	Labor Rate per Respondent	Annualized cost for Total Respondents	Annualized Burden Hours for each Respondent (10,720 hours x 25,300 respondents)	Annualized Cost for each Respondent (\$50.66 x 0.424)
53,600	10,720	1	10,720	\$50.66	\$ 543,076	0.424	\$21.48

We note that although there are 41 questions in the survey but not all the questions will apply to all the providers/practices completing the survey. The questionnaire is designed with skip patterns that are dependent on the responses from previous questions. For example, most Tier 0, will skip all but 7 questions whereas Tier 1-3 will require answers to most of the 41 questions.

13. Capital Costs

There are no additional costs to respondents associated with recordkeeping, information retention or technology acquisition for this information collection effort.

¹ <https://www.bls.gov/ooh/>

² Loaded labor rate assumptions: 30% fringe, 12% overhead, 3% general & administrative costs.

14. Cost to Federal Government

The estimated Federal costs for 3 collection periods of the AHQT assessment consist of: 1) contractor labor costs for web-design, and collection of the assessment; 2) contractor labor costs for an independent evaluation/analysis contractor to analyze results, generate reports and conduct sensitivity and impact analyses; 3) Federal staff labor costs for the inspection of results, and ad hoc analyses requested by program leadership for ongoing monitoring and planning. The Table below shows the total estimated costs to the Federal government over the 5-year period of administration, as well as the annualized costs. The estimated total cost over the 5 years is \$ 42,558 and annual cost is \$8,512. Unless otherwise noted, hourly labor rates for the labor categories in the Table are from BLS' Occupational Outlook.

Table 2: Cost to the Federal Government for AHQT information collection during the 13th SOW.

Labor Category	Loaded Hourly Labor Rate³	Total 13th SOW Hours	Total 13th SOW Cost	Annualized Cost (Total Cost/5 years)
Database Administrator (Web-survey Contractor)	\$84.67	120	\$10,160	\$2,032
Web Developer/Designer (Web-Survey Contractor)	\$66.87	120	\$8,024	\$1,605
Data Scientist/Analyst (Evaluation Contractor)	\$77.88	120	\$9,346	\$1,869
Statistician (Evaluation Contractor)	\$75.60	80	\$6,048	\$1,210
COR-III (Federal GS-12 Step 5)	\$53.87	24	\$1,293	\$259
Data Scientist/Analyst (Federal GS-13 Step 5)	\$64.06	120	\$7,687	\$1,537
TOTAL		584	\$42,558	\$8,512

15. Changes to Burden

This is a new information collection request..

16. Publication/Tabulation Dates

Three information collections will occur at 14-months (all 25,300 participating providers/practices), 36-months (3,000 providers/practices receiving technical assistance through the AHQT pilot only), and 57-months (all 25,300 participating providers/practices) during the 13th SOW. CMS expects to receive at least 3 tabulations at these points in time of provider tiering results from the assessment that would be aggregated by State and Region. CMS publishes aggregated QIO program information in its annual Report to Congress, which is posted on its public-facing website. and after the conclusion of each Statement of Work (*See: <https://www.cms.gov/medicare/quality/quality-improvement-organizations>*). CMS will receive reports containing metrics regarding assessment completion on an ongoing basis for program monitoring purposes during the three survey administration periods. CMS will provide assessment data to its program evaluation contractor on an annual basis for purposes of conducting independent program impact analyses. Independent evaluation reports for each SOW are published on the QIO program's public facing website on CMS.gov after conclusion of the SOW.

17. Expiration Date

CMS will display the OMB number and expiration date for this ICR on the first page of the web-based tool.

18. Certification Statement

There are no exceptions to this certification statement.