

**Supporting Statement A:**  
**13th SOW QIN-QIO and AIAN**  
**Measure Data Collection**

**A. Background**

The Quality Innovation Network – Quality Improvement Organization (QIN-QIO) program and American Indian Alaskan 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 quantify performance and improvement in a broad set of quality measures that are not currently available from other sources. Selected measures are derived from the Merit Based Incentive Payment System (MIPS), the Hospital Inpatient Quality Reporting Program (HIQR), the Hospital Outpatient Quality Reporting Program (HOQR), and the CDC National Healthcare Safety Network (NHSN).

**B. Justification**

1. Need and Legal Basis

The statutory authority for the QIN-QIO and AIAN programs 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 QIO program uses quality measure data to quantify and understand the state of healthcare quality in enrolled hospitals, nursing homes, and outpatient clinical practices. Over the course of the five-year period of performance, quality measures will be constantly monitored and analyzed by CMS and its contractors. Data and analyses will be shared with enrolled providers and practices to provide insight into their own operations and used directly by CMS to assess the impact of specific program activities and guide strategic direction. Finally, quality measure data will be the primary input to the Return on Investment calculations used to assess the overall impact of the program and justify its cost to the taxpayer.

Healthcare quality data is already collected by other CMS programs, such as the Hospital Value Based Purchasing Program (HVBP) and the Merit-based Incentive Payment System (MIPS). Wherever possible, existing sources of data will be utilized to avoid duplication. This new data collection will serve to fill gaps where data is necessary for the operation and management of the QIN-QIO program but is not currently available from existing sources. For example, small providers such as Critical Access Hospitals do not currently report most HVBP measures. Outpatient practices report MIPS measures annually, too infrequently to support the dynamic nature of intensive quality improvement work.

## 2. Information Users

Measure data collection is an integral part of the quality improvement process. It is the primary source of knowledge about quality of care, allowing Quality Improvement (QI) practitioners to understand current state and quantitatively measure progress and effectiveness. There are three primary user categories for this data collection:

- Participants in the QIO program will use measure data from their facilities/practices to implement their own quality improvement efforts, and benefit from the collection and analysis of data from other facilities and practices to contextualize progress towards QI goals.
- QI contractors (both QIOs and the AIAN contractor) will use measure data to direct their efforts and understand the effectiveness of interventions, to measure progress towards their contractual objectives, and to report on progress to CMS.
- CMS will use the collected measure data along with derived analytic products to track the success of the program, to inform strategic decisions and priorities, and to calculate return on investment.

The QIN-QIO contractors are expected to recruit a maximum of 25,000 providers and practices in the 13<sup>th</sup> SOW. The AIAN contractor is expected to recruit 261 providers and practices.

Table 1: QIN-QIO Recruitment

Setting/ Category	Projected number of QIN-QIO Program participants	Projected number of AIAN Program participants	Existing Data Sources	Proposed New Measure Data Collection
Nursing Homes	8,500	26	Multiple programs, extensive frequent collection of measure data	N/A
Critical Access Hospitals	1,361	15	A few major measures, exempt from most requirements	8 QI measures listed in section 12B
IPPS Hospitals	2,139	31	Multiple programs, extensive frequent collection, some critical gaps	2 new measures currently pending implementation by other programs
Outpatient Clinical Practices	13,000	189	Annual collection of 6 measures self-selected from a list of 22 to 63 MIPS measures depending on specialty	Quarterly collection of 6 measures self- selected from a list of 10 MIPS measures

Other CMS quality improvement programs collect extensive data from nursing homes, allowing both the QIN-QIO and AIAN programs to execute their goals in this setting without additional quality measure data collection. Hospital data collection is somewhat unevenly distributed, with extensive data collection from hospitals enrolled in the Inpatient Prospective Payment System (IPPS) and limited data collected from Critical Access Hospitals. Outpatient clinical practices enrolled in MIPS choose several measures to report annually. This provides some information at an aggregate level but is too infrequent or inconsistent to support intensive QI work and inform strategic course corrections. This collection is carefully tailored in each setting to complement existing data collection and fill gaps where necessary without duplication of effort or unnecessary burden on program participants.

### 3. Use of Information Technology

CMS will employ a web-based collection tool for measure data after public comment and OMB approval for the information collection. The collection of this information will be 100% electronic and does not require a signature from the respondents. Initial implementation will use a web-based form with specified fields for each information element.

Providers will be assisted by CMS-funded QIN-QIO contractors who will perform data collection and submission on the provider's behalf wherever possible. In addition, CMS is actively developing alternative collection methods, including bulk upload and application programming interface (API) connections, which will shift burden from respondents to CMS contractors and further reduce burden overall.

#### 4. Duplication of Efforts

Healthcare quality data is already collected by other CMS programs, such as the Hospital Value Based Purchasing Program (HVBP) and the Merit-based Incentive Payment System (MIPS). Wherever possible, existing sources of data will be utilized to avoid duplication. This new data collection will serve to fill gaps where data is necessary for the operation and management of the QIN-QIO program but is not currently available from existing sources. For example, small providers such as Critical Access Hospitals do not currently report most HVBP measures. Outpatient practices report MIPS measures annually, too infrequently to support the dynamic nature of intensive quality improvement work. This new collection is composed of the minimum possible elements that cannot be replicated from other sources.

#### 5. Small Businesses

Many of the providers and practices targeted by the information collection, particularly outpatient clinical practices, qualify as small businesses. This information collection will provide CMS with additional insight into the needs of small providers/practices and enable QIN-QIOs to assist them in improving quality of care. The collection strategy for outpatient practices was designed specifically to minimize burden. Outpatient practices will have substantial flexibility to choose which measures to focus on during their participation. Practices will be encouraged to select measures which are also being reported to MIPS, further reducing the burden introduced by this collection.

#### 6. Less Frequent Collection

Quality improvement activities require health care organizations to review their outcomes routinely, at least monthly if not more frequently. The decision to collect these critical data only quarterly (instead of monthly) reflects an intentional implementation of the minimum data collection frequency needed to meet the three main purposes described above. The annual data collection of measures under the existing MIPS program is insufficient to support effective quality improvement activities, particularly with respect to reassessment and responsiveness to changing needs over the course of the program.

#### 7. Special Circumstances

There are no special circumstances associated with this collection.

#### 8. Federal Register/Outside Consultation

The 60-day Federal Register notice published on XXXXXXXXX (90 FR XXXXX).

The 30-day Federal Register notice published XXXXXXXXX.

#### 9. Payments/Gifts to Respondents

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

#### 10. Confidentiality

The system operates within a cloud-based technology platform which has CMS Authority to Operate (ATO) to collect, analyze, synthesize and store data including Personally Identifiable Information (PII). CMS Privacy Impact Assessment (PIA) was approved by the CMS Privacy Officer on March 28, 2024, draft-approved by the HHS Privacy reviewer on April 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 enable quality improvement activities in 13<sup>th</sup> SOW QIO Program nursing homes, hospitals, outpatient clinical practices and AIAN facilities.

#### 11. Sensitive Questions

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

#### 12. Burden Estimates (Hours & Wages)

QIN-QIOs will recruit a maximum of 25,000 providers and practices, including 3,500 hospitals and 13,000 outpatient clinical practices to engage in quality improvement activities over the course of the five-year period of performance. The AIAN contractor will recruit a maximum of 261 providers and practices, including 46 hospitals and 189 outpatient clinical practices. Data from the nursing home setting is available through other sources and recruited nursing homes are unaffected by this collection. The following burden estimates are computed separately for QIN-QIO and AIAN participants and broken down further by setting of care.

##### A) Outpatient Clinical Practice Measures

The following measures will be collected from enrolled Outpatient Clinical Practices. Additional descriptive information on measures can be found in the CMS Measures Inventory Tool (CMIT) and the MIPS Quality Measures List.

**Table 2: QIN-QIO Outpatient Clinical Practice Measures**

<b>Measure Name</b>	<b>CMIT ID</b>	<b>MIPS Quality Number</b>
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	672	134
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	30	107
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	597	431
Falls: Plan of Care	255	155
Falls: Screening for Future Fall Risk	257	318
Kidney Health Evaluation for Patients with Diabetes (KED)	989	488
Controlling High Blood Pressure	167	236

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	594	128
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	205	1

Burden estimates for MIPS measures are provided by the MIPS Supporting Statement, broken down by data collection type: Claims, Clinical Quality Measure (CQM), or Electronic Clinical Quality Measure (eCQM). Claims-based data collection will not apply during the QIN/QIO period of performance so we consider only CQM or eCQM.

Each MIPS measure may be possible to submit as a CQM, eCQM, or both. Because providers are selected based on need, and are encouraged to engage with the QIN-QIO program in areas where they are currently struggling, these burden estimates will assume the most burdensome data collection category for each measure in the program; e.g. if a measure can be collected as either a CQM or an eCQM, we apply the burden estimate associated with CQM collection.

Under the requirements of the MIPS program itself, measures are submitted annually. To account for the increased burden associated with quarterly data submission, we separate the burden estimates into fixed “startup costs” and non-fixed “submission costs.” Startup costs such as clinical review of measure specifications remain the same, while submission costs are multiplied by 4 to reflect the change from annual to quarterly submission.

Outpatient clinical practices will not be expected to report on all 9 measures; instead, they will choose 6 from the list that are appropriate for their needs and capabilities. We assume that the choice of measures will be relatively evenly distributed, so the average burden across the 9 measures will give a reasonable approximation of the aggregate burden of reporting 6 selected measures.

We believe that tasks related to measure data collection would be performed by clinical staff such as physicians and LPNs, as well as non-clinical staff such as billing clerks and computer systems analysts<sup>12</sup>. Whenever possible, QIN-QIO contractors will assume the burden of reporting on behalf of respondents. In particular, tasks attributed to Computer Systems Analysts to review measure specifications and submit quality data are expected to be substantially performed by QIN-QIO contractors. In addition, this burden estimate does not account for the planned implementation of API and bulk upload submission alternatives. With that in mind, the calculations below represent an overestimate of the burden on respondents.

The calculations below represent the estimated annualized burden hours among all respondents as well as for each respondent.

---

<sup>1</sup> <https://www.bls.gov/ooh/>

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

Table 3: QIN-QIO Outpatient Clinical Practice Burden

<b>Hours</b>	<b>CQM</b>	<b>eCQM</b>
# of Hours Per Respondent to submit (d)	12	8
# of Hours per Medical and Health Services Manager to Review Measure Specifications (e)	2	2
# of Hours for Computer Systems Analyst to Review Measure Specifications (f)	1	1
# of Hours for LPN to Review Measure Specifications (g)	1	1
# of Hours for Billing Clerk to Review Measure Specifications (h)	1	1
# of Hours for Physician to Review Measure Specifications (i)	1	1
# of Hours Per Respondent to Authorize Qualified Registry to Report on Respondent's Behalf (j)	0.083	0
Annual Hours for one measure (k)= (d) + (e) + (f) + (g) + (h) + (i) + (j)	18.083	14
Average Annual Hours for a measure selected from 6 CQM and 3 eCQM	16.722	
Average Annual Hours for a practice reporting 6 measures	100.33	
Annual Hours for 13,000 practices reporting 6 measures	1,304,316	
Total Hours for 4 years of data collection	5,217,264	
<b>Cost</b>	<b>CQM</b>	<b>eCQM</b>
Cost Per Respondent to Submit Quality Data (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (l) = \$106.54/hr × (d)	\$1,278.48	\$852.32
Cost to Review Measure Specifications (at Medical and Health Services Manager's Labor Rate of \$129.28/hr) (m) = \$129.28/hr × (e)	\$258.56	\$258.56
Cost to Review Measure Specifications (at Computer System's Analyst's Labor Rate of \$106.54/hr) (n) = \$106.54/hr × (f)	\$106.54	\$106.54
Cost to Review Measure Specifications (at LPN's Labor Rate of \$58.46/hr) (o) = \$58.46/hr × (g)	\$58.46	\$58.46
Cost to Review Measure Specifications (at Clerk's Labor Rate of \$45.32/hr) (p) = \$45.32/hr × (h)	\$45.32	\$45.32
Cost to Review Measure Specifications (at Physician's Labor Rate of \$291.64/hr) (q) = \$291.64/hr × (i)	\$291.64	\$291.64
Cost for Respondent to Authorize Qualified Registry/QCDR to Report on Respondent's Behalf (at Computer Systems Analyst's Labor Rate of \$106.54/hr) (r) = (j) × \$106.54/hr	\$8.84	\$0.00
Total Annual Cost Per Measure (t) = (m) + (n) + (o) + (p) + (q) + (r)	\$2,047.84	\$1,612.84
Average Annual Cost for a measure selected from 6 CQM and 3 eCQM	\$1,902.84	
Average Annual Cost for a practice reporting 6 measures	\$11,417.05	
Annual Cost for 13,000 practices reporting 6 measures	\$148,421,666.60	
Total cost for 4 years of data collection	\$593,686,666.60	

## B) Hospital Measures

Hospital measures in this collection are derived from the Hospital Inpatient Quality Reporting Program (HIQR), the Hospital Outpatient Quality Reporting Program (HOQR), the CDC National Healthcare Safety Network (NHSN), and the Medicaid Adult Core Set.

Table 4: QIN-QIO Hospital Measures

Measure Name	CMIT ID	Source Program
Safe Use of Opioids - Concurrent Prescribing	669	HIQR
Hospital Harm – Pressure Injury	341	HIQR
Hybrid Hospital-Wide All-Cause Readmission Measure (HWR)	356	HIQR
Median time from ED Arrival to ED Departure for Discharged ED patients	427	HOQR
NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI)	462	NHSN
NHSN Catheter-Associated Urinary Tract Infection (CAUTI)	459	NHSN
Surgical Site Infection (SSI)	1	NHSN
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	264	Medicaid

The first two measures in this collection, Safe Use of Opioids – Concurrent Prescribing and Hospital Harm – Pressure Injury, will be collected from 2139 (projected) hospitals in the Inpatient Prospective Payment System (IPPS). All 8 measures will be collected from 1361 (projected) Critical Access Hospitals (CAHs). Burden estimates are computed separately for IPPS and Critical Access Hospitals.

Each source program provides burden estimates in a different format, and we have endeavored to unify them in a reasonable manner in order to calculate an accurate overall burden estimate for this new collection.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, which is reported at the state level rather than at the facility level as part of the Medicaid Adult Core Set, does not have an associated burden estimate provided by the source program. For the purposes of this burden assessment, we matched this measure with Surgical Site Infection due to the similar nature of the follow-up analysis required for both measures. Hours and costs for data collection activities associated with the matched measure are duplicated accordingly.

Data collection and reporting activities will be performed by various clinical and non-clinical staff, including Medical Records and Health Information Technicians, Information Technologists, Infection Preventionists/Microbiologists, and Occupational Health RNs/Specialists.

Data collection activities are broken down by labor category. Each activity is associated with specific measures, so the table below is aggregated according to the number of measures that require execution of each activity. Some activities are performed annually while others are performed each time a measure is reported, and the number of hours has been modified accordingly to translate the source program burden estimates and accurately reflect the quarterly cadence of reporting that will occur in this new collection.



Whenever possible, QIN-QIO contractors will assume the burden of reporting on behalf of respondents. In particular, tasks attributed to Health Technologists, Medical Records Technicians, and Health Information Technicians for setup and maintenance of measure reporting plans, reporting measures, and validating measures are expected to be substantially performed by QIN-QIO contractors. In addition, this burden estimate does not account for the planned implementation of API and bulk upload submission alternatives. With that in mind, the calculations below represent an overestimate of the burden on respondents.

**Table 5: QIN-QIO IPPS Hospital Burden**

<b>Data Collection Activity</b>	<b>Labor Category</b>	<b>Annual Hours</b>	<b>Wage Rate</b>	<b>Annual Cost</b>
Reporting eCQM	Medical Records and Health Information Technician	1.33	37.66	50.21
eCQM Validation	Medical Records and Health Information Technician	11	37.66	414.26
Other forms used in the data collection process	Medical Records and Health Information Technician	0.25	37.66	9.42
Annual Total per Respondent		12.58		473.89
Annual Total for 2139 IPPS Hospitals		26,909		1,013,647.15
Total for 4 years of data collection		107,636		4,054,588.58

**Table 6: QIN-QIO Critical Access Hospital Burden**

<b>Data Collection Activity</b>	<b>Labor Category</b>	<b>Annual Hours</b>	<b>Wage Rate</b>	<b>Annual Cost</b>
CDI Infection Form	Occupational Health RN/Specialist	6.8	46.60	316.88
Laboratory-identified CDI Event	Occupational Health RN/Specialist	4.8	46.60	223.68
Patient Safety Component Digital Measure Reporting Plan (initial setup)	Information Technologist	5.4	56.50	305.10
Patient Safety Component Digital Measure Reporting Plan (yearly maintenance)	Information Technologist	20	56.50	1,130.00
Patient Safety Component Digital Measure Reporting Plan (infection preventionist)	Infection Preventionist/Microbiologist	0.67	58.60	39.07
Urinary Tract Infection	Infection Preventionist/Microbiologist	4.8	58.60	281.28
Surgical Site Infection	Infection Preventionist/Microbiologist	5.6	58.60	328.16
Reporting eCQM	Medical Records and Health Information Technician	1.33	37.66	150.64
eCQM Validation	Medical Records and Health Information Technician	11	37.66	414.26
Reporting Hybrid HWR Measure	Medical Records and Health Information Technician	0.17	37.66	19.21
Other forms used in the data collection	Medical Records and Health	0.25	37.66	9.42

process	Information Technician			
Chart Abstraction	Health Information Technician	14.2	46.46	659.73
Annual Total per Respondent		75.02		3,764.19
Annual Total for 1361 Critical Access Hospitals		102,102		5,123,062.59
Total for 4 years of data collection		408,408		20,492,250.36

### C) AIAN participants

Participating AIAN hospitals and practices will choose measures to report from an approved list, based on the needs and capacity of their operations. The program does not set a minimum or maximum number of measures for participants. Based on historic participation in the AIAN program, we expect that the average participant will report 10 or fewer measures. Many of the approved measures are designed to be reported by the AIAN QIO contractor and are outside the scope of this package – participants will incur burden only if self-reported measures are selected from the approved list.

Wherever possible, measure specifications are aligned with other programs and the burden estimates from those source programs are used with appropriate adjustments to reflect changes to reporting cadence. For measures that are unique to the AIAN program, a search for similar measures was performed to determine an appropriate burden estimate. For example, “Patients Co-prescribed Naloxone (CoNAL)” is structurally similar to “Safe Use of Opioids – Concurrent Prescribing,” so the latter burden estimate is used for both measures.

Outpatient clinical practices will choose from a list of 37 measures, of which 13 are self-reported. Hospitals will choose from a list of 28 measures, of which 7 are self-reported. Given the wide variety of measures available and the complex needs of the participants, we assume that measure selection will be evenly distributed, meaning that on average each hospital will be responsible for self-reporting data for  $(X * 7 / 28)$  measures and each outpatient clinical practice will be responsible for self-reporting data for  $(X * 13 / 37)$  measures. An average burden estimate per measure is computed for each setting, then multiplied by the appropriate factor to give the average burden per participant.

**Table 7: AIAN Outpatient Clinical Practice Measures**

Measure Name	CMIT ID	Measure Type
Breast Cancer Screening	93	eCQM
Colorectal Cancer Screening	139	CQM
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	204	CQM
Hypertension: Controlling High Blood Pressure	167	CQM
Patients Co-prescribed Naloxone (CoNAL)	N/A	CQM
BMI Screening and Follow-Up	594	CQM
Screening for Depression and Follow-Up Plan	672	CQM

Unhealthy Alcohol Use: Screening & Brief Counseling	597	eCQM
Use of High-Risk Medications	744	eCQM
CDC Antibiotic Stewardship Outpatient Program	N/A	CQM

Some of these measures are also used in the QIN-QIO program and their burden estimates are calculated using the same source material. Due to the differences in reporting cadence and measure selection processes, the calculations for overall burden are performed separately for the AIAN program.

Most of the measures collected from outpatient clinical practices are aligned with measures from the MIPS program. The CDC Antibiotic Stewardship Outpatient Program measure is sourced from CDC's NHSN program, but calculations for this measure will be substantially similar to other MIPS measures related to prescribing behavior such as Patients Co-Prescribed Naloxone and Use of High-Risk Medications, so we will use the burden estimate for a MIPS CQM measure. The overall burden of MIPS measures is averaged across 7 CQM and 3 eCQM measures.

Whenever possible, the AIAN QIO contractor will assume the burden of reporting on behalf of respondents. As in the QIN-QIO Outpatient setting, tasks attributed to Computer Systems Analysts to review measure specifications and submit quality data are expected to be substantially performed by the AIAN QIO contractor. As in the QIN-QIO Hospital setting, tasks attributed to Health Technologists, Medical Records Technicians, and Health Information Technicians for setup and maintenance of measure reporting plans, reporting measures, and validating measures are expected to be substantially performed by the AIAN QIO contractor. In addition, this burden estimate does not account for the planned implementation of API and bulk upload submission alternatives. With that in mind, the calculations below represent an overestimate of the burden on respondents.

**Table 8: AIAN Outpatient Clinical Practice Burden**

Measure Category	Number of measures	Annual Hours	Annual Cost
MIPS CQM measure	7	18.08	\$2,047.84
MIPS eCQM measure	3	14.00	\$1,612.84
Measure collected from other sources	24	0.00	0
Average Annual Hours for a practice that selected ten measures		49.58	\$5,639.24
Annual Total for 189 practices		9,371	\$1,065,815.47
Total for 4 years of data collection		37484	\$4,263,261.88

**Table 9: AIAN Hospital Measures**

Measure Name	CMIT ID	Source
Safe Opioid Use – Concurrent Prescribing	669	IQR
Patients Co-prescribed Naloxone	N/A	IQR
CDC Antibiotic Stewardship: Antibiotic Use and Resistance	N/A	NHSN
COVID-19 Staff Vaccination	180	NHSN
Facility-wide Inpatient Hospital-onset Clostridium Difficile Infection (CDI)	462	NHSN

Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteremia	463	NHSN
--	-----	------

Table 10: AIAN Hospital Burden by Activity

Data Collection Activity	Labor Category	Annual Hours	Wage Rate	Annual Cost
Patient Satisfaction Survey	Survey Respondent	111.99	29.76	\$3332.76
Reporting eCQM	Medical Records and Health Information Technician	4.00	37.66	\$150.64
eCQM Validation	Medical Records and Health Information Technician	11.00	37.66	\$414.26
Other forms used in the data collection process	Medical Records and Health Information Technician	0.25	37.66	\$9.42
CDI Infection Form	Occupational Health RN/Specialist	13.60	46.60	\$633.76
Laboratory-identified CDI Event	Occupational Health RN/Specialist	9.60	46.60	\$447.36
Antimicrobial Use and Resistance (AUR) - Microbiology Data - Initial Set-up	Pharmacist	80.00	69.36	\$5,548.80
Antimicrobial Use and Resistance (AUR) - Microbiology Data - Yearly Maintenance	Pharmacist	4.00	69.36	\$277.44
Antimicrobial Use and Resistance (AUR) - Microbiology Data - Monthly	Pharmacist	1.00	69.36	\$69.36
Antimicrobial Use and Resistance (AUR) - Pharmacy Data - Initial Set-up	Pharmacist	40.00	69.36	\$2,774.40
Antimicrobial Use and Resistance (AUR) - Pharmacy Data - Yearly Maintenance	Pharmacist	2.00	69.36	\$138.72
Antimicrobial Use and Resistance (AUR) - Pharmacy Data - Monthly	Pharmacist	0.08	69.36	\$5.78
Average burden for a self-reported hospital measure		46.25		\$2,300.46

Table 11: AIAN Overall Hospital Burden

Measure Category	Number of measures	Annual Hours	Annual Cost
------------------	--------------------	--------------	-------------

Self-reported hospital measure	6	46.25	\$2,300.46
Measure collected from other sources	21	0	0
Average Annual Hours for a hospital that selected ten measures		10.28	\$511.21
Annual Total for 46 AIAN hospitals		473	\$23,515.66
Total for 4 years of data collection		1,892	\$94,062.64

The total annual burden hours for this information collection request is 1,471,284.

**Table 12: Annual Burden Summary**

<b>Program and Setting</b>	<b>Respondents</b>	<b>Annual Responses</b>	<b>Annual Burden Hours</b>
QIN-QIO Outpatient Clinical Practice	13,000	52,000	1,304,316
QIN-QIO IPPS Hospital	2,139	8,556	26,909
QIN-QIO Critical Access Hospital	1,361	5,444	102,102
AIAN Outpatient Clinical Practice	189	756	37,484
AIAN Overall Hospital	46	184	473
Totals	16,735	66,940	1,471,284

### 13. Capital Costs

There are no capital costs associated with this collection.

### 14. Cost to Federal Government

The estimated Federal costs consist of: 1) contractor labor costs for design, implementation, and maintenance of the collection system; 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 costs over the 5 years is \$23,010,777.60 and annual cost is \$4,602,156. Unless otherwise noted, hourly labor rates for the labor categories in the Table are from BLS' Occupational Outlook.

**Table 13: Cost to the Federal Government**

<b>Labor Category</b>	<b>Loaded Hourly Labor Rate<sup>3</sup></b>	<b>Total 13<sup>th</sup> SOW Hours</b>	<b>Total 13<sup>th</sup> SOW Cost</b>	<b>Annualized Cost (Total Cost/5 years)</b>
-----------------------	---	--	---------------------------------------	---

<sup>3</sup> Unless otherwise noted, hourly labor rates are from the Bureau of Labor Statistics Occupational Outlook.

Business Analyst II	\$94.28	11520	\$1,086,105.60	\$217,221.12
Devops Engineer III	\$161.69	11520	\$1,862,668.80	\$372,533.76
Program Manager III	\$180.84	19200	\$3,472,128.00	\$694,425.60
Scrum Master	\$148.38	13440	\$1,994,227.20	\$398,845.44
Software Engineer I	\$97.35	28800	\$2,803,680.00	\$560,736.00
Software Engineer II	\$114.87	30720	\$3,528,806.40	\$705,761.28
Test Automation Engineer II	\$133.27	13440	\$1,791,148.80	\$358,229.76
Data Scientist/Analyst (Evaluation Contractor)	\$77.88	28800	\$2,242,944.00	\$448,588.80
Statistician (Evaluation Contractor)	\$75.60	28800	\$2,177,280.00	\$435,456.00
COR-III (Federal GS-12 Step 5)	\$53.87	3840	\$206,860.80	\$41,372.16
Data Scientist/Analyst (Federal GS-13 Step 5)	\$64.06	28800	\$1,844,928.00	\$368,985.60
<b>TOTAL</b>		<b>218880</b>	<b>\$23,010,777.60</b>	<b>\$4,602,156</b>

#### 15. Changes to Burden

This is a new information collection request.

#### 16. Publication/Tabulation Dates

Measures will be collected quarterly from each provider/practice over the course of the five year period of performance.

CMS will receive reports containing metrics regarding assessment completion on an ongoing basis for program monitoring purposes during the entire data collection period. CMS will provide the submitters and the QI contractors supporting them with access to their submitted data in dashboards that contain trend and benchmark information. 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' program monitoring and evaluation contractor will produce annual reports reflecting on program progress and to independently assess impact. 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 data submission interface.

#### 18. Certification Statement

There is no exception to the certification statement.