

Supporting Statement – Part A

Provider Experience of the Centers for Medicare & Medicaid Services (CMS) Quality Innovation Network - Quality Improvement Organization (QIN-QIO) Program

Background

This is a new information collection request. The purpose of this information collection request (ICR) is to gather data to inform the program evaluation of the Centers for Medicare & Medicaid Services' (CMS) Quality Innovation Network-Quality Improvement Organization (QIN-QIO) efforts under the 13th QIN-QIO Statement of Work (SOW). Through this SOW, CMS tasked six QIN-QIO contractors, serving seven regions, with improving the quality of health care for Medicare beneficiaries. This package supports evaluation of the technical assistance (TA) provided by the QIN-QIO program to nursing homes, hospitals, and outpatient clinical practices. This ICR is part of a larger evaluation of the overall impact through the Program Monitoring and Evaluation (PME) Contract.

The QIN-QIO initiative is one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries.¹ As part of this effort, the QIN-QIOs provide CMS-identified healthcare providers (nursing homes, hospitals, and outpatient clinician practices) with high-quality, hands-on quality improvement (QI) assistance to meet foundational, clinical quality, and safety goals. For nursing home setting, CMS selected providers based on the following criteria: (1) poor performance on selected health care quality metrics; (2) CMS enforcement data (e.g., quality management infrastructure related emergency preparedness, inspection deficiencies, quality assurance and performance improvement, etc.); (3) entities not submitting quality reporting data; (4) recommendations received from QIO contractors. For the hospital setting, the selected providers are Medicare-registered hospitals, specialty hospitals — including children's hospitals, psychiatric hospitals, long-term care hospitals, and acute care hospitals operated by the Veterans Affairs and Department of Defense — are excluded. Hospitals covered under the American Indian and Alaska Native (AIAN) Task Order are also excluded. For outpatient clinical practice setting, the QIN-QIO program opens to all outpatient clinicians who expressed interest to partner with QIOs to improve their quality of care.

The QIN-QIOs also collaborate with clinical and non-clinical organizations at the federal, state, local, and community levels on data-driven quality initiatives to achieve measurable change. Through this collective support, the QIN-QIO program strengthens the Medicare system by promoting efficient, effective, and accessible healthcare, to maximize the impact of healthcare services to beneficiaries and the value to taxpayers in a manner that aligns with CMS and the U.S. Department of Health and Human Services (HHS) priorities.

The priority focus areas established by CMS for the 13th SOW QIN-QIO program include the following foundational and clinical aims, and sub-aims:

- Foundational Aim
 - Improve Quality Management Infrastructure (to ensure resilience in the healthcare system, including establishing quality management systems, emergency

¹ Centers for Medicare & Medicaid Services. (2024). *Quality Improvement Organizations*. Retrieved December 10, 2025 from <https://www.cms.gov/medicare/quality/quality-improvement-organizations>

preparedness plans, workforce planning strategies, supply chain management, drug shortage prevention, and cybersecurity readiness)

- Clinical Aims
 - Increase Prevention and Chronic Disease Management (through vaccinations, type 2 diabetes screening, hypertension management, and chronic kidney disease evaluation)
 - Increase Patient Safety (related to infection control and prevention, adverse drug events, and safety events)
 - Improve Behavioral Health Outcomes (focusing on decreased drug and alcohol misuse, chronic pain management, and depression and suicide prevention)
 - Improve Care Coordination (through care delivery to reduce hospital readmissions and emergency department utilization)

To hold the QIN-QIOs accountable for measurable outcomes, each aim and sub-aim has a set of quality measures. Examples of provider-specific improvements that QIN-QIOs are expected to support in each care setting by 2029 include:

- In nursing homes, increase the rate of residents with a flu vaccination (or had medical contraindication) to 80% (absolute rate);
- In acute care hospitals, reduce catheter-associated urinary tract infections (CAUTI) by 50% (relative improvement rate [RIR]);
- In outpatient clinical practices, increase screening for depression (including a follow-up plan) by 20% (RIR).

Outside of the priority focus areas, the QIN-QIO program also supports ad-hoc quality improvement projects to address emerging and unanticipated quality and safety concerns across any setting through Focused QIO Service (FQS).

CMS evaluates the quality and effectiveness of the QIN-QIO program, as authorized in Part B of Title XI of the Social Security Act,² and has hired Booz Allen Hamilton (Booz Allen) as the PME Contractor for the QIN-QIO program.

This ICR will conduct data collection using surveys with administrators or managers of nursing homes and hospitals, and from clinicians working in outpatient community-based settings.

Table 1 provides an overview of proposed data collection methods, including survey topics and respondent groups. The Nursing Home Survey instrument can be found in Appendix A, the Hospital Survey Instrument in Appendix B, and the Outpatient Clinician Survey Instrument in Appendix C.

² Social Security Administration. *Contracts with Quality Improvement Organizations*. Retrieved December 10, 2025 from https://www.ssa.gov/OP_Home/ssact/title11/1153.htm

Table 1. Overview of Data Collection

Surveys	Mode	Survey Topics	Respondents
Nursing Home	Telephone survey of Nursing Home Administrators, Directors of Nursing, or staff member most responsible for QI activities	• Engagement with the CMS QIN-QIO program • Level of Providers' satisfaction with QIN-QIOs • Overall QI Priorities • Perception of QIN-QIO Helpfulness • TA and QI Support • Data Usage and Reporting	• 400 Nursing Home Administrators of enrolled facilities who received program QIN-QIO program support • 100 Nursing Home Administrators of eligible facilities, but either did not enroll or enrolled and did not receive QIN-QIO program support
Hospital	Telephone survey of Hospital Administrators, Directors of Nursing, or staff members most responsible for QI activities	• Quality Improvement Attributed to CMS QIN-QIO program Intervention	• 400 Hospital Administrators of enrolled facilities who received program QIN-QIO program support • 100 Hospital Administrators of eligible facilities, but either did not enroll or enrolled and did not receive QIN-QIO program support
Outpatient Clinician	Online survey of Outpatient Clinicians in clinical practices		• 250 Outpatient Clinicians received QIN-QIO program support (e.g., associated with Tax Identification Numbers - TINs enrolled with QIN-QIO program) • 250 Outpatient Clinicians that did not receive QIN-QIO program support

A. Justification

1. Need and Legal Basis

The statutory authority for the QIN-QIO program is found in Part B of Title XI of the Social Security 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 statutory mission of the QIO program, as set forth in Section 1862(g) of the Act, requires the HHS Secretary to enter into contracts with QIOs for purposes of making determinations about whether items and services provided to Medicare beneficiaries are reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, and are not for custodial care; this function is achieved through the Beneficiary and Family Centered Care (BFCC) QIO program. In addition, the Secretary must enter into contracts to improve the effectiveness, efficiency, economy, and quality of

services delivered to Medicare beneficiaries. Toward those goals, Section 1154(a)³ of the Act requires QIO contractors to perform one or more functions listed in that section.

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 QIO contracts. While the purpose of this QIN-QIO SOW is to carry out the goals listed in Section 1862(g) of the Act, the QIO program requirement shall be fulfilled in a manner that supports CMS in its efforts to improve health and healthcare for all Medicare beneficiaries and promote quality of care.

The Social Security Section 1153 [42 U.S.C. 1320c–2] (c)(2) includes language authorizing evaluation of the QIN-QIO program, “the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract.”⁴

The data collection proposed in this ICR is necessary for CMS to evaluate the QIN-QIO program and provide reports on QIO performance. Sections 1152-1154 of Part B of Title XI of the Social Security Act requires CMS to “regularly furnish each QI organization with a contract under this section with a report that documents the performance of the organization in relation to the performance of other such organizations.”⁴

Additionally, the SOWs for QIN-QIO contractors both specify engagement with the PME Team to aid data collection for program monitoring and impact evaluation, including information to be gathered as a result of this ICR.

2. Information Users

The primary use of this data collection is to provide information to enhance QIN-QIO program evaluation. The PME Team will use survey findings to support program monitoring and impact evaluation on the level of engagement and satisfaction with QIN-QIOs and test these factors for possible associations with fundamental and clinical outcomes. QIN-QIO program leads may use perceived satisfaction responses to inform QIN-QIO contract management; CMS Contract Officer Representatives may share the findings with contractors as part of the contractors’ continual improvement. The findings will also be used to inform CMS’ annual reports to Congress, and its reports and briefings to the Office of Management and Budget (OMB) and other stakeholder groups. The results from this data collection may be published in annual program reports, conferences, and peer-reviewed journal publications per CMS approval.

3. Use of Information Technology

The PME Team will conduct telephone surveys (for Nursing Homes and Hospitals) and online surveys (for Outpatient Clinicians) to effectively balance the need for program

³ Functions of Quality Improvement Organizations. Retrieved December 10, 2025
https://www.ssa.gov/OP_Home/ssact/title11/1154.htm

⁴ Social Security Administration. *Contracts with Quality Improvement Organizations*. Retrieved December 10, 2025
from https://www.ssa.gov/OP_Home/ssact/title11/1153.htm

information with the costs of data collection and potential burden on program staff and stakeholders. Upon completion of survey data collection, completed responses will be extracted to the CMS Central Data Repository (CDR), quantitative data analysis will be conducted within the CMS Data Bricks analytical environment, for qualitative analysis, de-identified free text responses from open-ended questions will be downloaded to local Booz Allen laptop and analyzed using NVivo (local version), then the analytical findings will be included in the PME annual survey report.

The PME Team will conduct telephone surveys using Computer-Assisted Telephone Interviews (CATI) technology. The interviewer will be guided by the survey questionnaire displayed on the computer screen. The CATI program will reflect survey logic and skip patterns. Responses will be entered directly into the survey database in a structured format, eliminating the need for additional data processing (e.g., transcription, data entry, and coding), thus reducing cost and enhancing data accuracy. With interviewee permission, technology will also be used to audio record and transcribe answers to questions with open-ended responses (or the whole interview depending on the NiCE Telephone Survey programmed in the CMS QIO Platform), ensuring accuracy and reducing the time needed to complete these questions.

Another key advantage of conducting the surveys using CATI technology is to ensure that the data are collected from the right person. The survey questionnaire includes a series of screening questions; only facility administrators, directors of nursing, or staff members most responsible for QI activities will be selected to participate in the survey. The interviewer will terminate the interview with individuals who do not meet participation eligibility criteria and continue to reach the right person at the selected facility. Participant screening by a trained interviewer—as opposed to by an electronic survey—will reduce the waste of healthcare providers’ time, who may attempt to take the survey but are not the right individual to provide required contract evaluation information. It also ensures response validity.

The brief online survey is designed to minimize burden on participants and reduce dropout rates. Given outpatient clinicians’ tightly scheduled patient care responsibilities, an online format allows respondents to complete the survey at a time most convenient to them without requiring scheduled calls that may disrupt clinical workflow. In addition, clinicians are highly accustomed to secure, digital platforms in their daily practice, making online administration an efficient and appropriate modality for this population. Finally, given anticipated low response rates within this busy professional group, the study may require outreach to a larger sample; an online survey allows for broader distribution at substantially lower cost than telephone administration, making it a more cost-effective and scalable data collection approach. The link to the online survey will be prominently featured in the email announcing the survey launch and in follow-up emails to non-respondents.

All three surveys will be pre-tested with selected respondents to improve clarity and understandability of the survey questions, reduce participant burden, and verify the expected completion time.

For all three surveys, to further increase response validity, the PME Team will randomize the response list for a group of selected questions depending on the AWS Salesforce Survey functionality within the CMS QIO Platform (CQP) system. These data collection activities do not require signatures from participants. Consent for survey participation will be implied

by continuation after a page displaying the Paperwork Reduction Act statement, verifying the OMB control number, and displaying contact information for questions or concerns about the time required to complete the collection of information.

4. Duplication of Efforts

The PME Team has carefully tracked all sources of data collected or reported by the QIN-QIOs for nursing homes, hospitals, and outpatient clinicians, including QIN-QIO self-reported data collected through the CQP, Medicare Fee-for Service (FFS) and Medicare Advantage (MA) claims, and other HHS data. We are proposing only additional collection of data necessary to inform the contract evaluation questions that are not currently available in existing data sets, program reports, or other sources. The PME Team is collaborating with other CMS contractors to exchange information and data to avoid any duplication of data collection from QIN-QIOs and the facilities they serve.

5. Small Businesses

Survey participants may be employed by small businesses based on the definition of the Small Business Paperwork Relief Task Force as having 500 or fewer employees or \$6M or less in receipts.⁵ For example, approximately 54% of physicians work in practices owned by ten or fewer physicians.⁶ Further, an estimated 150 nursing homes and 275 hospitals to be surveyed are considered small businesses.⁷

To reduce the impact on these small businesses and entities, data collection will be streamlined and focused, limited to only the data collection required to answer the evaluation questions. Surveys will be no longer in duration than 20 minutes for each of the three surveys (nursing homes, hospitals, and outpatient clinicians). Pre-notification mailing letters/postcards and/or emails (for respondents with email information available) will be sent out to respondents prior to data collection to inform them about the purpose of the data collection, expected time required, and to provide other elements of informed consent (see Appendices D.1 for nursing homes, D.3 for hospitals, and D.5 for outpatient clinicians).

6. Less Frequent Collection

Program evaluation tasks require early and frequent inputs to make appropriate changes in time for QI initiatives planned for the near future. If data collection occurs less frequently, QIN-QIOs will not receive timely feedback from an independent source in order to improve their services to meet program goals, which represent HHS and CMS priorities and goals. Data collected less than once per year affects CMS' ability to evaluate provider experience feedback with the QIN-QIOs, assess the extent to which providers perceive the QIN-QIO program to have contributed to QI progress, gather important information for program

⁵ Final Report of the Small Business Paperwork Relief Task Force. (2003). Retrieved December 10, 2025 from <https://www.sba.gov/document/policy-guidance--small-business-paperwork-relief-act-2002>

⁶ American Medical Association. (2022). AMA 2020 Physician Practice Benchmark Survey. Accessed December 10, 2025 from <https://www.ama-assn.org/about/research/physician-practice-benchmark-survey>

⁷ References used for estimating the proportion of small businesses include: https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf ; https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf; and <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrd/r/chartbooks/qdr-ruralhealthchartbook-update.pdf>

monitoring, estimate attributable program impact, assess return on investment, and make any necessary adjustments to increase program effectiveness and efficiency.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice published on XXXXXXXX (XX FR XXXXX) will provide an opportunity for public comment. Simultaneously, during the 60-day public notice, the PME Team will pre-test all three surveys (nursing home, hospital, and outpatient clinician) with no more than nine eligible respondents using cognitive interviews. The pretests will provide substantive input from the targeted respondents to ensure that questions are clearly stated and understood as intended.

CMS also consulted the PME Team, including the survey partner, The Henne Group (THG), on the availability of secondary data, method and frequency of primary data collection, clarity of respondent instructions, data collection database, disclosure and confidentiality statements, and anticipated survey reporting format. THG is a market research company with over 30 years of experience collecting information for federal, state, and local government agencies, as well as with private sector companies and major U.S. academic institutions. THG, which qualifies as a small business, is known for its ability to obtain higher than anticipated response rates, success in recruiting hard-to-reach populations, and ability to navigate gatekeepers and reach target respondents.

9. Payments/Gifts to Respondents

There will be no payments/gifts provided to respondents.

10. Confidentiality

The information collection will use programs inside the CMS Quality Improvement Organization (QIO) Platform (CQP), which is covered under the System of Records Notice (SORN) 09-70-0538 “Individuals Authorized Access to Centers for Medicare & Medicaid Services (CMS) Computer Services” published in [72 FR 63902](#) (11/13/07) and updated in [83 FR 6591](#) (2/14/18). The Privacy Impact Assessment for the CMS QIO Platform was signed on June 27, 2025.

Each survey respondent will be de-identified and given a unique identification (ID) number. This ID number will be the only information that is recorded on data collection instruments, and the data collection instruments will be stored separately from other data collected within this project. Contact information (names, telephone numbers, and email addresses) of participants will be stored separately from data files and will only be accessed by authorized team members for logistical reasons (e.g., scheduling, follow-ups, avoiding recruitment for survey participation with the same individuals in subsequent years, etc.). Likewise, individuals involved in survey instrument pre-testing will not be identified in the transcripts or audio recordings.

11. Sensitive Question

The surveys do not include any sensitive questions.

12. Burden Estimates (Hours & Wages)

The category of respondents for each data collection and estimated annual burden (number of burden hours per year) for the specific information collection are outlined in Table 2.

Table 2. Estimated Burden Hours and Cost

Data Collection Activity	Estimated Number of Respondents (1)	Number of Responses per Respondent (2)	Hours per Response (3)	Estimated Burden Hours (4=1*2*3)	Hourly Wage Rate ⁸ (5)	Estimated Total Respondent Cost (6=4*5)
Nursing Home Survey	500	1	1/3	167	\$102.42	17,104
Hospital Survey	500	1	1/3	167	\$148.54	24,806
Outpatient Clinician Survey	500	1	1/3	167	\$270.98	45,254
Total	1,500	1	--	501	--	87,164

The estimated number of respondents reflects the annual sample of 500 per year for each Nursing Home, Hospital, and Outpatient Clinician Survey. The burden hour estimates for completing the survey screening and questions are based on findings from previous surveys done in 12th SOW. Surveys are expected to take no longer than 20 minutes to complete for all surveys if participating in the QIN-QIO initiative, and less time if they are not participating.

Hourly wage rates were estimated using the most recent U.S. Bureau of Labor Statistics tables available in each respondent setting and responses to similar surveys fielded between 2022 to 2024. Specifically, in nursing homes, those identified as Medical and Health Services Managers (occupation code 11-9111) on average earned \$51.21 in 2023; in [hospitals](#), Medical and Health Services Managers [on average earned \\$74.27 in 2025](#); and in [outpatient](#) care centers, Physicians (29-1210) averaged \$135.49 in 2025. The wages were doubled to account for overhead. The total cost is calculated by multiplying the number of responses by the average time per response by the hourly wage. The PME Team then summed the costs to derive the total cost of \$87,164 for all respondents.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

The cost of this information collection effort to the federal government consists of the costs for government (CMS) activity and CMS' contractor activity (Table 3). The costs to CMS involve labor costs for overseeing the contractor's work and reviewing and providing guidance on data collection instruments, the OMB clearance package, and other materials. Labor costs were estimated using average salaries representative of the professional levels and steps for CMS personnel. CMS contractor costs represent labor for survey development and testing; sample recruitment, screening, and scheduling; survey administration and

⁸ Hourly wage rate is doubled to account for overhead.

management; data cleaning and analysis; and report development. Operational expenses include overhead, survey scripting, data processing, and coding.

For purposes of OMB review and approval, the PME Team has annualized the number. As shown in Table 3, the estimated annual cost to the federal government over a standard three-year OMB approval period will be \$1,024,932.

Table 3. Annual Cost to the Federal Government

Activity	Cost
Government Activity Review and provide guidance on instruments, OMB clearance, and data collection approach	\$25,000.00
Contractor Activity Instrument development, testing, administration, management; sample recruitment and scheduling; Data coding/transcribing; Analysis and reporting	\$999,932.39
Total	\$1,024,932

15. Changes to Burden

This is a new information collection.

16. Publication/Tabulation Dates

The PME Contract period of performance is effective from April 1, 2025, through September 30, 2031. Our plans and timeline for reports and publications using survey findings are outlined in Table 4. Included in this table are program management reports that provide ongoing performance data that can guide CMS' program decisions regarding continuation or modification of contract recruitment and performance targets, measurement strategies, and recommended evidence-based interventions. Table 4 also identifies documents and reports suitable for presentation to various audiences, national stakeholders, and policymakers, including presentations at professional meetings and publications in peer-reviewed journals.

Table 4. Deliverable Schedule for Data Collection and Reporting Activities

Deliverables	Timeline
Survey Reports	Annual Reports 2026-2031
Evaluation Progress Reports (includes survey findings)	Annually (2026-2031)
Presentations	2026-2031
Publications (including peer-reviewed manuscripts)	2026-2031
Final Technical Report	2031

Supporting Statement B provides an overview of the statistical techniques PME Team will use to analyze survey data.

17. Expiration Date

For telephone surveys, the expiration date will be mentioned by the interviewer before survey administration. For online surveys, the expiration date will be displayed on the collection instrument.

18. Certification Statement

There are no exceptions to the certification statement.