

**Instructions: The following Attestation Statement must be completed by the CAHPS for MIPS Project Director or other authorized representative for each organization conditionally re-approved to administer the CAHPS for MIPS Survey.**

**CAHPS FOR MIPS SURVEY ATTESTATION STATEMENT**

All of the data collected and submitted to the Centers for Medicare & Medicaid Services (CMS) for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for Merit-Based Incentive Payment System (MIPS) by **[name of survey vendor]** and all subcontractors engaged in survey activities are accurate and complete. This includes the following:

1. Meet and comply with the Minimum Business Requirements specified in the current *CAHPS for MIPS Quality Assurance Guidelines (QAG)*
2. Review and adhere to the CAHPS for MIPS QAG and policy updates
3. Provide complete, comprehensive and accurate updates to annual Quality Assurance Plan (QAP)
4. Attest to the accuracy of data collection activities
5. Comply with all requirements of the HIPAA Security and Privacy Rules in conducting all survey administration and data collection activities
6. Maintain confidentiality and security of all CAHPS for MIPS patient-related and survey-related data
7. Comply with the requirement that mail survey administration and telephone interviews are conducted from a physical place of business, not from a residence or virtual office
8. Meet all CAHPS for MIPS due dates (including interim and final data submissions)
9. Report any problems or discrepancies to CMS in a timely manner
10. Participate and cooperate (including subcontractors) in all oversight activities conducted by the CAHPS for MIPS Survey Project Team

The statements herein are true, complete and accurate to the best of my knowledge.

Organization Name: \_\_\_\_\_

Authorized Representative Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1222 (Expiration date: XX/XX/XXXX). The time required to complete this information collection is estimated to average 12.9 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*\*CMS Disclosure\*\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov)