

**PPS-Exempt Cancer Quality Reporting (PCHQR) Program
Notice of Participation**

The hospital agrees to follow procedures for participating in the PCHQR Program as outlined in the federal regulations found in the Federal Register, or is indicating its decision to decline participation.

Each hospital must complete this "PCHQR Notice of Participation" as outlined in the federal regulations found in the Federal Register. In an effort to alleviate the burden associated with submitting this form annually, effective with the PCHQR Notice submitted for participation in FY 2014 or later, a hospital that indicated its intent to participate will be considered an active PCHQR participant until CMS determines a need to pledge again, or the hospital submits a withdrawal to CMS.

This information is in compliance with the CMS guidelines for hospitals submitting their quality performance data in accordance with Section 3005 of the Affordable Care Act. Hospitals must also continue to display quality information for public viewing as required by section 1866(k)(4) of the Social Security Act. Before this information is displayed, hospitals will be permitted to review their information as it is recorded. Eligible hospitals must follow the regulations as outlined in the federal regulations.

(*) indicates required for providers participating in the PPS-Exempt Cancer Hospital Quality Reporting Program

We entities operating under the submitted Provider ID*: _____

___ *Agree to participate*

___ *Do not agree to participate*

___ *Request to be withdrawn from participation*

By entering this pledge, I agree to:

- (1) Transmit or have data transmitted to CMS and/or the QIO Clinical Warehouse; and
- (2) Permit my hospital's performance information to be publicly reported.

This acknowledgement (to participate or not to participate or to withdraw) remains in effect until an electronically signed acknowledgement applying changes has been entered.

*Facility Name: _____

*CEO Signature: _____ *Date: _____

*CEO Email Address: _____

Complete and submit the Notice of Participation Agreement form via email to: PCHQualityReporting@hcqis.org. Following receipt of the request form, an email acknowledgement will be sent confirming the form has been received.

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 0938-1175 and expires XX/XX/XXXX. The time required to complete this information collection is estimated to average 10 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 Disclaimer*****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 James Poyer at (410) 786-2261.
