Centers for Medicare & Medicaid Services (CMS) Quality Program
Extraordinary Circumstances Exceptions (ECE) Request Form

A facility can request an exception from CMS quality reporting and payment program requirements due to extraordinary circumstances beyond the control of the facility. Such circumstances may include (but are not limited to) natural disasters (such as a severe hurricane or flood), issues with CMS data-collection systems that directly affected the ability of facilities to submit data, or extreme circumstances preventing facilities from electronic clinical quality measure (eCQM) or electronic health record (EHR)-based reporting. Please refer to the *Federal Register* and *Code of Federal Regulations* for program-specific rules on availability of this exception. To request an exception, please complete and submit this form. This form must be submitted **within 90 calendar days of the extraordinary circumstance for all programs, except the submission of eCQMs under the Hospital IQR Program, which has an ECE Request deadline of April 1** following the end of the reporting period.

An asterisk (*) indicates required fields. All sections must be complete and specific in order for the CMS to consider the request.

***Dates**

*Date of Request _____

*Date of Extraordinary Circumstance _____

***Program(s) for Which Facility is Requesting Exception**

- ☐ Ambulatory Surgical Centers Quality Reporting (ASCQR) Program
- ☐ End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- ☐ Hospital-Acquired Condition (HAC) Reduction Program
- ☐ Hospital Inpatient Quality Reporting (IQR) Program (includes eCQMs)
- ☐ Hospital Outpatient Quality Reporting (OQR) Program
- ☐ Hospital Readmissions Reduction Program (HRRP)
- ☐ Hospital Value-Based Purchasing (VBP) Program
- ☐ Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
- ☐ PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
- ☐ Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

***Facility Contact Information**

*Facility Name _____

*CMS Certification Number (CCN) _____

*National Provider Identifier Number (NPI) (ASC only) _____
(Place additional NPIs in Additional Comments section.)

***CEO/Designee Contact Information**

*Name _____ *Title _____

*Address (must include physical street address) _____

*City _____ *State _____ *Zip Code _____

*Telephone Number _____ *Extension _____

*Email Address _____

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Additional Contact Information

Name _____ Title _____

Address (must include physical street address)_____

City_____ State _____ ZIP Code_____

Telephone Number_____ Extension_____

Email Address_____

Exception or Extension Request Information

*Data Submission Requirement(s) Affected – Please indicate which requirement(s) were affected by the extraordinary circumstance.

- ☐ Chart-abstracted measure(s)
- ☐ Claims-based measure(s)
- ☐ CrownWeb
- ☐ Electronic Clinical Quality Measures (eCQMs)
- ☐ NHSN Healthcare-associated infection (HAI) measure(s)
- ☐ Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data
- ☐ Influenza Vaccination Among Healthcare Personnel (HCP) measure
- ☐ Web-based measure(s)
- ☐ Structural measure(s)
- ☐ Non-measure related requirement(s) (Please specify below)

_____

*Submission quarter(s)/dates affected _____

*Validation quarter(s)/dates affected (State "None" if not applicable) _____

*Date facility will restart data submission _____

***Provide justification for the submission restart date.**

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***Enter specific reasons for requesting an exception. Please include the specific requirements or data for which you are seeking an exception. Please indicate how the extraordinary circumstance negatively impacted performance on the measure(s) for which an exception is being sought (if applicable). Attach supporting documentation when necessary.**

***Provide evidence of the impact of the extraordinary circumstance including (but not limited to) photographs, web links, newspaper, and other media articles. Attach supporting documentation when necessary.**

Additional Comments (Attach additional documentation/comments if necessary.)

*CEO/Designee Signature: _____ *Date: _____

Extraordinary Circumstances Exceptions Request Form Submission Instructions

Complete and submit this form via the Hospital Quality Reporting Secure Portal, Managed File Transfer to QRFormsSubmission@hsag.com. If unable to submit via Managed File Transfer, please submit via email to QRFormsSubmission@hsag.com, secure fax to (877) 789-4443, or mail to 3000 Bayport Drive, Suite 300, Tampa, FL 33607. The Support Contractor will forward, as directed, to CMS.

For ESRD QIP only, please complete and submit this form to the ESRD QIP mailbox at ESRDQIP@cms.hhs.gov.

For SNF VBP only, please complete and submit this form to the SNF VBP mailbox at SNFVBP@rti.org.

Following receipt of the request form, CMS will: (1) Provide a written acknowledgement using the contact information provided in the request, to the CEO and any additional designated facility personnel, notifying them that the facility's request has been received and (2) provide a formal response to the CEO and any additional designated facility personnel using the contact information provided in the request notifying them of our decision. CMS will strive to complete its review of each ECE request within 90 calendar days of receipt of the request.

PRA Disclosure Statement