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

A facility may request an exception, as specified by CMS, for quality reporting and value-based purchasing programs 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 that prevent 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.

For events affecting the submission of data, this form must be submitted **within 90 calendar days of the extraordinary circumstance, except the submission of eCQMs under the Hospital Inpatient Quality Reporting Program, which has an ECE Request deadline of April 1** following the end of the reporting period. At the latest, you should submit your ECE no later than 90 days from the submission deadline for the quarter requested.

For events affecting the Hospital Value-Based Purchasing, Hospital Acquired-Condition Reduction, and Hospital Readmissions Reduction Programs, this form must be submitted **no later than 90 calendar days of the extraordinary circumstance.** At the latest, you should submit your ECE no later than 90 days from the last date of the quarter requested.

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

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 _____

Additional Contact Information

Name _____ Title _____

Address (must include physical street address)_____

City_____ State _____ ZIP Code_____

Telephone Number_____ Extension_____

Email Address_____

***Dates**

*Date of Request _____ *Date of Extraordinary Circumstance _____

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

Please indicate which program requirement(s) and quarter(s) were affected by the extraordinary circumstance.

Program	Measure and/or Program Requirement	Quarter(s)
Ambulatory Surgical Center Quality Reporting (ASCQR) Program	☐ Web-based measure(s)	
	☐ COVID-19 Vaccination Among Healthcare Personnel (HCP) measure via National Healthcare Safety Network (NHSN)	
	☐ Other (Please specify): _____	
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	☐ In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey	
	☐ National Healthcare Safety Network (NHSN)	
	☐ ESRD Quality Reporting System (EQRS)	
	☐ Validation	
	☐ Other (Please specify): _____	
Hospital-Acquired Condition (HAC) Reduction Program	☐ NHSN Healthcare-associated infection (HAI) measure(s)	
	☐ Validation	
	☐ Other (Please specify): _____	
Hospital Inpatient Quality Reporting (IQR) Program	☐ Chart-abstracted measure(s)	
	☐ Electronic Clinical Quality Measures (eCQMs)	
	☐ Hybrid measure(s)	
	☐ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey	
	☐ Influenza Vaccination Among Healthcare Personnel (HCP) measure	
	☐ COVID-19 Vaccination Among Healthcare Personnel (HCP) measure	
	☐ Web-based measure(s)	
	☐ Structural measure(s)	
	☐ Population and Sampling	
	☐ Validation	
	☐ Other (Please specify): _____	
Hospital	☐ Chart-abstracted measure(s)	

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Program	Measure and/or Program Requirement	Quarter(s)
Outpatient Quality Reporting (OQR) Program	☐ Web-based measure(s)	
	☐ COVID-19 Vaccination Among Healthcare Personnel (HCP) measure National Healthcare Safety Network (NHSN)	
	☐ Validation	
	☐ Other (Please specify): _____	
Hospital Readmissions Reduction Program (HRRP)	☐ Other (Please specify): _____	
Hospital Value-Based Purchasing (VBP) Program	☐ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey	
	☐ NHSN Healthcare-associated infection (HAI) measure(s)	
	☐ Other (Please specify): _____	
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program	☐ Chart-abstracted measure(s)	
	☐ COVID-19 Vaccination Among Healthcare Personnel (HCP) measure	
	☐ Other (Please specify): _____	
PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	☐ Web-based measure(s)	
	☐ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey	
	☐ Influenza Vaccination Among Healthcare Personnel (HCP) measure	
	☐ COVID-19 Vaccination Among Healthcare Personnel (HCP) measure	
	☐ NHSN Healthcare-associated infection (HAI) measure(s)	
	☐ Other (Please specify): _____	

Exception or Extension Request Information

*Date ECE relief would end _____

***Provide justification for the ECE end date.**

***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 prevented your facility from submitting accurate data for the measure(s) for which an exception is being sought (if applicable). Attach supporting documentation when necessary.**

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***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. You may instead submit via email to QRFormsSubmission@hsag.com or secure fax to (877) 789-4443.

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.