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.

For events adversely impacting performance, for the Hospital Value-Based Purchasing, Hospital Acquired-Condition Reduction, and Hospital Readmission Reduction Programs, this form must be submitted **no later than 90 calendar days of the extraordinary circumstance.**

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 _____

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

***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 and if you are requesting the requirement to be excepted from public reporting.

Program	Measure and/or Program Requirement	Quarter(s)
Ambulatory Surgical Center Quality Reporting (ASCQR) Program	☐ Web-based measure(s)	
	☐ Claims-based measure(s)	
	☐ COVID-19 Vaccination Among Healthcare Personnel (HCP) measure	
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	☐ Clinical Depression Screening and Follow-up Plan	
	☐ Clinical Measure(s)	
	☐ In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey	
	☐ ICH CAHPS Attestation	
	☐ National Healthcare Safety Network (NHSN)	
	☐ ESRD Quality Reporting System (EQRS)	
	☐ Claims-based measure(s)	
	☐ Validation	
Hospital-Acquired Condition (HAC) Reduction Program	☐ Claims-based measure(s)	
	☐ NHSN Healthcare-associated infection (HAI) measure(s) data use	
	☐ NHSN HAI measure(s) data submission requirements	
	☐ Validation	
Hospital Inpatient Quality Reporting (IQR) Program	☐ Chart-abstracted measure(s)	
	☐ Claims-based measure(s)	
	☐ Electronic Clinical Quality Measures (eCQMs)	
	☐ 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	
	☐ Non-measure related requirement(s) (Please specify)_____ _____	

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

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

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 negatively impacted performance or how the extraordinary circumstance prevented your facility from meeting the program requirement for 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 or secure fax to (877) 789-4443.

For SNF VBP Program only requests, complete and submit this form to the SNF VBP Program Help Desk 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.