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

A hospital or healthcare facility that has experienced an extraordinary circumstance(s) that affected the ability of the healthcare facility to comply with one or more applicable quality reporting and value-based purchasing program reporting requirements may submit this form to CMS **within 60 calendar days of the date the extraordinary circumstance occurred** to request an exception for the requirement(s).[1] An extraordinary circumstance is an event beyond the control of a healthcare facility (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing, or issues with CMS-designated information systems that directly affect the ability of the facility to submit data).

CMS may grant either an exception or extension, as appropriate under the circumstances, for one or more reporting requirements indicated. Please refer to the *Federal Register* and *Code of Federal Regulations* for additional information regarding program-specific ECE policies.

> **Note:** An ECE request form may be submitted for multiple programs, requirements, and/or reporting periods. CMS reviews ECE requests on a case-by-case basis. The **submission of an ECE request does not guarantee complete or partial approval.**

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

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**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______________________________

[1] For electronic clinical quality measures (eCQMs), the ECE request submission deadline is April 1st or June 15th following the end of the reporting year in which the extraordinary circumstance occurred for the Hospital Inpatient Quality Reporting Program and Hospital Outpatient Quality Reporting Program, respectively).

## *Dates

*Date of Request: ___________________ *Date of Extraordinary Circumstance: _______________________

## *Program(s) and Program Requirement(s) for Which Facility is Requesting an ECE

Please indicate which program requirement(s) and reporting period(s) for each requirement which you are requesting an exception for an extraordinary circumstance.

| Program | Measure and/or Program Requirement | Reporting Period(s) (Quarter and Year, for example, Q1 2025) |
|---|---|---|
| Ambulatory Surgical Center Quality Reporting Program | ☐ Web-based Measure(s) | |
| | | |
| | ☐ Outpatient and Ambulatory Surgical Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) | |
| | ☐ Other (Please specify): ______________________________ | |
| End-Stage Renal Disease (ESRD) Quality Incentive Program | ☐ In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey | |
| | ☐ National Healthcare Safety Network (NHSN) Measure(s) | |
| | ☐ ESRD Quality Reporting System (EQRS) | |
| | ☐ Data Validation | |
| | ☐ Other (Please specify): ______________________________ | |
| Hospital-Acquired Condition Reduction Program | ☐ National Healthcare Safety Network (NHSN) Measure(s) | |
| | ☐ Data Validation | |
| | ☐ Other (Please specify): ______________________________ | |
| Hospital Inpatient Quality Reporting Program | ☐ Severe Sepsis and Septic Shock Management Bundle (Composite Measure) | |
| | ☐ Electronic Clinical Quality Measures (eCQMs) | |
| | ☐ Hybrid Measure(s) | |
| | ☐ Patient-Reported Outcome-Based Performance Measure(s) | |
| | ☐ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey | |

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| Program | Measure and/or Program Requirement | Reporting Period(s)<br>(Quarter and Year, for example, Q1 2025) |
|---|---|---|
| | National Healthcare Safety Network (NHSN) Measure(s):<br>☐ Influenza Vaccination Coverage Among Healthcare Personnel<br>☐ Patient Safety Structural Measure<br>☐ CAUTI-Onc<br>☐ CLABSI-Onc | |
| | ☐ Web-based Structural Measure(s) | |
| | ☐ Population and Sampling | |
| | Data Validation<br>☐ Chart-abstracted<br>☐ eCQM | |
| | ☐ Other (Please specify):<br>____________________ | |
| Hospital Outpatient Quality Reporting Program | ☐ Chart-abstracted Measure(s) | |
| | ☐ Web-based Measure(s) | |
| | ☐ Electronic Clinical Quality Measures (eCQMs) | |
| | ☐ Patient-Reported Outcome-Based Performance Measure(s) | |
| | ☐ Outpatient and Ambulatory Surgical Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) | |
| | ☐ Data Validation | |
| | ☐ Other (Please specify):<br>____________________ | |
| Hospital Readmissions Reduction Program | ☐ Other (Please specify):<br>____________________ | |
| Hospital Value-Based Purchasing Program | ☐ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey | |
| | ☐ National Healthcare Safety Network (NHSN) Measure(s) | |
| | ☐ Severe Sepsis and Septic Shock Management Bundle (Composite Measure) | |
| | ☐ Other (Please specify):<br>____________________ | |
| Inpatient Psychiatric Facility | ☐ Chart-abstracted Measure(s) | |
| | ☐ Web-based Measure(s) | |

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| Program | Measure and/or Program Requirement | Reporting Period(s) (Quarter and Year, for example, Q1 2025) |
|---|---|---|
| Quality Reporting Program | ☐ Psychiatric Inpatient Experience (PIX) | |
| | ☐ Other (Please specify): ______________________ | |
| Rural Emergency Hospital Quality Reporting Program | ☐ Chart-abstracted Measure(s) | |
| | ☐ eCQM | |
| | ☐ Web-based Measure(s) | |
| | ☐ Other (Please specify): ______________________ | |
| PPS-Exempt Cancer Hospital Quality Reporting Program | ☐ Web-based Measure(s) | |
| | ☐ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey | |
| | ☐ National Healthcare Safety Network (NHSN) Measure(s) | |
| | ☐ Other (Please specify): ______________________ | |

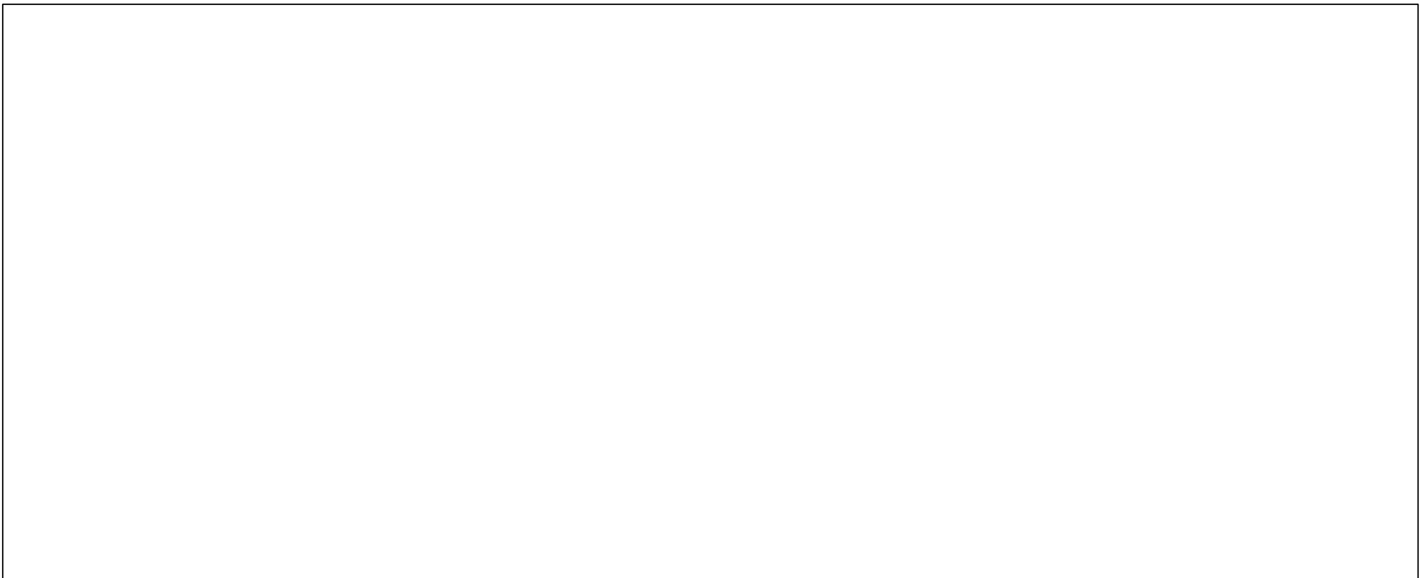
## ECE Request Information

**Please list the quarter(s) and year(s) by which you believe you will be able to meet the requirements identified above and provide an explanation for why those quarter(s) and year(s) were identified. If you are not able to anticipate when the circumstance will end and you will be able to meet the specified requirements, please write “Unknown” and explain why you are not able to anticipate when the requirement can be met.**

*Anticipated Quarter(s) and Year(s) that relief will no longer be needed for each requirement listed above:

Requirement:_____________ Quarter/Year:___________

***For each of the requirement(s) or data for which you are seeking an ECE, provide details as to how the extraordinary circumstance prevented your healthcare facility from complying with the reporting requirement(s) for the program(s) and/or requirement(s) for which this ECE is being sought.**



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

**Provide any additional information you would like CMS to consider when assessing and determining your ECE request.**

*CEO/Designee Signature: ________________________________________*Date: ________________

## Extraordinary Circumstances Exception Request Form Submission Instructions

Complete and submit this form, via the *Hospital Quality Reporting Secure Portal*, Unified File Management/Managed File Transfer to QRFormsSubmission@hsag.com. You may instead submit via email to QRFormsSubmission@hsag.com or secure fax to (877) 789-4443.

**For ESRD Quality Incentive Program only**, please complete and submit this form to the ESRD Quality Incentive Program mailbox at esrdqps-admin@arborresearch.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**

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 **0938-1022 (Expires XX-XX-20XX)**. The time required to complete this information collection is estimated to average 15 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, MD 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 the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor at (844) 472-4477.**