

**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 eQMs 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 _____
December 2022

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

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

Exception or Extension Request Information

*Date ECE relief would end _____

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***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.

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/XXXX)**. 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.**