

## 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** (or by April 1<sup>st</sup> or June 15<sup>th</sup> following the end of the reporting year in which the extraordinary circumstance occurred for electronic clinical quality measures (eCQMs) for the Hospital Inpatient Quality Reporting Program and Hospital Outpatient Quality Reporting Program, respectively) to request an exception or extension for the requirement(s). 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, if appropriate under the circumstances, an extension of time to comply with 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.**

### 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 \_\_\_\_\_  
January 2026

\*Date of Extraordinary Circumstance \_\_\_\_\_

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### **\*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 exception or extension for an extraordinary circumstance.

| Program                                                      | Measure and/or Program Requirement                                                                                              | Reporting Periods |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------|
| Ambulatory Surgical Center Quality Reporting (ASCQR) Program | <input type="checkbox"/> National Healthcare Safety Network (NHSN) Measures                                                     |                   |
|                                                              | <input type="checkbox"/> Web-based Measure(s)                                                                                   |                   |
|                                                              | <input type="checkbox"/> Patient-Reported Outcome-Based Performance Measure(s) (PRO-PMs)                                        |                   |
|                                                              | <input type="checkbox"/> Outpatient and Ambulatory Surgical Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) |                   |
|                                                              | <input type="checkbox"/> Other (Please specify):<br>_____                                                                       |                   |
| 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):<br>_____                                                                       |                   |
| Hospital-Acquired Condition (HAC) Reduction Program          | <input type="checkbox"/> National Healthcare Safety Network (NHSN) Measures                                                     |                   |
|                                                              | <input type="checkbox"/> Validation                                                                                             |                   |
|                                                              | <input type="checkbox"/> Other (Please specify):<br>_____                                                                       |                   |
| 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"/> Patient-Reported Outcome-Based Performance Measure(s)                                                  |                   |
|                                                              | <input type="checkbox"/> Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey                       |                   |
|                                                              | National Healthcare Safety Network (NHSN) Measures                                                                              |                   |
|                                                              | <input type="checkbox"/> Influenza Vaccination Coverage Among Healthcare Personnel                                              |                   |
|                                                              | <input type="checkbox"/> Patient Safety Structural Measure                                                                      |                   |
| <input type="checkbox"/> CAUTI-Onc                           |                                                                                                                                 |                   |
| <input type="checkbox"/> CLABSI-Onc                          |                                                                                                                                 |                   |
| <input type="checkbox"/> Web-based Structural Measure(s)     |                                                                                                                                 |                   |

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| Program                                                          | Measure and/or Program Requirement                                                                                              | Reporting Periods |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------|
|                                                                  | <input type="checkbox"/> Population and Sampling                                                                                |                   |
|                                                                  | <input type="checkbox"/> Chart-abstracted Validation                                                                            |                   |
|                                                                  | <input type="checkbox"/> eCQM Validation                                                                                        |                   |
|                                                                  | <input type="checkbox"/> Other (Please specify):<br>_____                                                                       |                   |
| Hospital Outpatient Quality Reporting (OQR) Program              | <input type="checkbox"/> Chart-abstracted Measure(s)                                                                            |                   |
|                                                                  | <input type="checkbox"/> Web-based Measure(s)                                                                                   |                   |
|                                                                  | <input type="checkbox"/> National Healthcare Safety Network (NHSN) Measures                                                     |                   |
|                                                                  | <input type="checkbox"/> Electronic Clinical Quality Measures (eCQMs)                                                           |                   |
|                                                                  | <input type="checkbox"/> Patient-Reported Outcome-Based Performance Measure(s)                                                  |                   |
|                                                                  | <input type="checkbox"/> Outpatient and Ambulatory Surgical Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) |                   |
|                                                                  | <input type="checkbox"/> Validation                                                                                             |                   |
|                                                                  | <input type="checkbox"/> Other (Please specify):<br>_____                                                                       |                   |
| Hospital Readmissions Reduction Program (HRRP)                   | <input type="checkbox"/> Other (Please specify):<br>_____                                                                       |                   |
| 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"/> Severe Sepsis and Septic Shock Management Bundle (Composite Measure)                                   |                   |
|                                                                  | <input type="checkbox"/> Other (Please specify):<br>_____                                                                       |                   |
| Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program | <input type="checkbox"/> Chart-abstracted Measure(s)                                                                            |                   |
|                                                                  | <input type="checkbox"/> Web-based Measure(s)                                                                                   |                   |
|                                                                  | <input type="checkbox"/> National Healthcare Safety Network (NHSN) Measure(s)                                                   |                   |
|                                                                  | <input type="checkbox"/> Chart-abstracted Measure(s)                                                                            |                   |
|                                                                  | <input type="checkbox"/> Other (Please specify):<br>_____                                                                       |                   |
| Rural Emergency Hospital Quality Reporting (REHQR)               | <input type="checkbox"/> Chart-abstracted Measure(s)                                                                            |                   |
|                                                                  | <input type="checkbox"/> Web-based Measure(s)                                                                                   |                   |
|                                                                  | <input type="checkbox"/> Other (Please specify):<br>_____                                                                       |                   |

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| Program                                                                        | Measure and/or Program Requirement                                                                        | Reporting Periods |
|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------|
| Program                                                                        |                                                                                                           |                   |
| PPS-Exempt<br>Cancer<br>Hospital<br>Quality<br>Reporting<br>(PCHQR)<br>Program | <input type="checkbox"/> Web-based Measure(s)                                                             |                   |
|                                                                                | <input type="checkbox"/> Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey |                   |
|                                                                                | <input type="checkbox"/> National Healthcare Safety Network (NHSN) Measure(s)                             |                   |
|                                                                                | <input type="checkbox"/> Other (Please specify):<br>_____                                                 |                   |

**ECE Request Information**

\*Date ECE relief would end \_\_\_\_\_

**\*Provide justification for the ECE end date and provide details if there are any reason(s) your healthcare facility may not be able to fully complete reporting requirements if an extension (versus an exception) is granted.**

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**\*Enter the specific 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.**

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

**For ESRD QIP only**, please complete and submit this form to the ESRD QIP mailbox at [esrdqps-admin@arborresearch.org](mailto: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 12-31-2028)**. 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.