Complexity and Burden of Hospital Reporting

Between May and June 2018, 151 hospital staff and leadership shared their experiences with reporting information to external and regulatory entities. This graphic illustrates the reporting interactions that pull hospitals away from their central focus of patient care and the burden they experience.

REPORTING INTERACTIONS

A - Caring for Patients
Providing patients with coordinated healthcare

B - Accreditation and Certification
Establishing and maintaining compliance with patient health and safety requirements

C - Quality Reporting
Abstracting, submitting, and improving performance on quality measures

D - Utilization and Case Management
Reviewing utilization of benefits and managing patient care across providers

E - Cost Reporting
Gathering financial data, filing annual cost report, and settling accounts payable to or receivable from Medicare

F - Coding, Billing, and Appeals
Coding patient records, billing payers, and appealing denied claims for reimbursement

G - Individual Provider Enrollment
Credentialing, verifying, and enrolling providers to bill to Medicare and Medicaid

BURDEN EXPERIENCED

Varying Standards
Multiple regulators impose varying requirements.

Duplicative Reporting
Multiple entities ask for the same data in slightly different formats.

Pace of Change
Regulatory requirements change rapidly.

Insufficient Dialogue
Hospitals wish their regulators could all get on the same page and write consistent standards.

Lack of Transparency
Regulatory requirements are imposed by CMS, hospitals feel that CMS operates in an inscrutable "black box.

Areas where this burden is felt most:

A - Caring for Patients
B - Accreditation and Certification
C - Quality Reporting
D - Utilization and Case Management
E - Cost Reporting
F - Coding, Billing, and Appeals
G - Individual Provider Enrollment

A1 Sending patient health records, medical orders, and prescriptions to other providers, facilities, and suppliers
A2 Reviewing utilization of benefits and managing patient care across providers
A3 Reviewing CMS coverage rules and guidance
A4 Coordinating care with other providers and exchanging patient health records
A5 Reviewing other payers’ coverage and coordinating benefits
A6 Submitting quality measures as required
A7 Submitting corrective action plans for citations captured on Form CMS-2567 following an accreditation survey
A8 Submitting corrective action plans for citations resulting from other payers
A9 Responding to complaint surveys conducted by the state on behalf of CMS
A10 Submitting core measures, Electronic Clinical Quality Measures (eCQMs), and hospital-acquired infection data
A11 Submitting core measures as required by Accrediting Organization
A12 Submitting quality measures as required by the state
A13 Submitting core measures as required by other payers

B1 Submitting corrective action plans for citations captured on Form CMS-2567 following an accreditation survey
B2 Submitting corrective action plans for citations resulting from other payers
B3 Responding to complaint surveys conducted by the state on behalf of CMS
C1 Submitting core measures, Electronic Clinical Quality Measures (eCQMs), and hospital-acquired infection data
C2 Submitting quality measures as required by Accrediting Organization
C3 Submitting quality measures as required by the state
C4 Submitting quality measures as required by other payers

D1 Submitting corrective action plans for citations captured on Form CMS-2567 following an accreditation survey
D2 Submitting corrective action plans for citations resulting from other payers
D3 Responding to complaint surveys conducted by the state on behalf of CMS

E1 Submitting core measures, Electronic Clinical Quality Measures (eCQMs), and hospital-acquired infection data
E2 Submitting core measures as required by Accrediting Organization
E3 Submitting quality measures as required by the state
E4 Submitting core measures as required by other payers

F1 Submitting claims, appeal letters, and documentation to MAC
F2 Submitting claims, appeal letters, and documentation to other payers
F3 Submitting claims, appeal letters, and documentation to state licensure
F4 Submitting claims, appeal letters, and documentation to commercial payers

G1 Submitting credentials and application for state licensure
G2 Submitting Medicaid provider enrollment application
G3 Submitting provider enrollment application to commercial payers
G4 Submitting Medicare provider enrollment application