Benchmarking Hospital Performance: Six Months Under MS-DRGs

By J. A. Thomas & Associates
Table of Contents

Executive Summary ........................................... 3
Goals of Benchmarking .......................................... 4
How CMI Impacts Reimbursement ......................... 5
Benchmarking in More Detail ............................... 6
Summary ......................................................... 9
For More Information ......................................... 10
Coding Terms Defined ........................................ 11
In August 2007, the Centers for Medicare and Medicaid Services (CMS) instituted major changes to the nation’s healthcare coding system by which hospitals receive Medicare reimbursement. The intent of the final rule from CMS was to have provider organizations reflect more accurately the severity of patient illness within their Medicare population.

Why does coding for severity of illness matter? The more severe the patient’s condition, the longer the patient stays in the hospital and consumes more resources, which produces a higher case mix index (CMI), which translates into more reimbursement for hospitals. (see graphic at end: How CMI Impacts Reimbursement)

The result of this overhaul was the creation of the Medicare Severity Diagnostic Related Group (MS-DRG) coding system, which became effective October 1, 2007. Since then, the MS-DRG system has raised the bar for physicians to document with more specificity the principal patient diagnosis and comorbidities, or other conditions increasing severity, so that coders can code these diagnoses accurately and hospitals can receive higher payments for more severe cases.

**Executive Summary**

This benchmarking report - *Benchmarking Hospital Performance: Six Months Under MS-DRGs* tracks progress for 188 J. A. Thomas & Associates (JATA) client hospitals using the company’s Compliant Documentation Management Program (CDMP®). Representing 194,620 cases, the report is based on the analysis of six months of data that was reported during the months of October through March of 2007 and compares that data to CMS projections.

CMS issued MEDPAR projections in 2007, from data reported in 2006 from hospitals throughout the United States. These MEDPAR projections were meant to give hospitals a sense of how they would fare under the new coding system, whether or not they had any focus on improved documentation.
While this report looks exclusively at JATA hospital clients, the findings are important for chief financial officers at all hospitals who want to ascertain the impact of MS-DRG on hospital case mix index and profiling. First, this is the only report of its kind showing how hospitals are faring under MS-DRG in real-time (CMS MEDPAR data is a projection based on older data). Second, this report demonstrates that hospitals can not only survive under MS-DRGs, but can also prosper under the Medicare reimbursement system.

Report Results:

• Overall, JATA clients are achieving at least a 5 percent higher overall CMI than projected by CMS.

• Most notably, when one looks at Medical CMI, which indicates the most vigorous improvement in documentation, JATA clients have a 10 percent higher CMI versus CMS’ MEDPAR.

• When looking at Major CCs (MCC) – a method to identify diagnoses that significantly increase expected resource consumption – the overall JATA client Medical MCC rate is 14 percent higher than MEDPAR, and the surgical MCC rate is 19 percent higher than MEDPAR.

Goals of Benchmarking

Performance benchmarks are meant to gauge how well hospitals are executing relative to MEDPAR. For our clients, these performance benchmarks enable them to compare themselves to hospitals with similar bed size and annual discharge numbers. In the future, as we refine our peer group comparisons, you will see how hospitals are performing compared to others, including teaching hospitals or transplant centers.

These benchmarks are not simply meant for bragging rights. Benchmarks are also a useful tool to identify opportunities for documentation improvement or to make necessary changes in the workflow or adjustments in the program that would result in even greater success.

Simply stated, accurate clinical documentation improvement is critical to hospital performance: hospital and physician profiling, quality measures, patient safety, case mix index and reimbursement.

Finally, in each category below, there are top-performers – those hospitals that are in the top 20 percentile in each tracking category and therefore, serve as a “Best Practice” group. Not only are these hospitals outperforming CMS projections, but they are outperforming their peers.
**How CMI Impacts Reimbursement**

Every incremental increase in the case mix index impacts a hospital’s revenue. The blended rate is an assigned rate from CMS for each hospital based on factors such as where hospitals are located and labor costs. Medicare discharges mean number of cases that qualify for Medicare in any given month, or on average. As a hospital CMI improves – primarily through better clinical documentation – hospital reimbursement increases.

CMI x Blended Rate = Revenue Improvement.

### Hospital A

Current CMI: **1.92**

Inpatient Medicare Revenue: **$97,490,774**

Blended Rate: **$9,043**

Medicare Discharges: **5,615**

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Blended Rate supplied by Hospital
Benchmarking in More Detail

The graphic illustrations below show 1) the CMS MEDPAR projections, 2) how our overall clients are doing relative to MEDPAR and 3) how “best practice” hospitals are doing in each category.

CMI Analysis
Overall CMI impact; JATA clients hitting a 1.59 CMI vs. 1.52 for MEDPAR, 5 percent higher than projected. Best practice hospitals have hit a 2.07 CMI.

Medical CMI Analysis
JATA clients hitting a 1.16 CMI vs. 1.05 for MEDPAR, 10 percent higher than projected. Best practice hospitals have hit a 1.25 CMI.
CC Capture Analysis
JATA clients capturing 53 percent of CCs compared to 42 percent for MEDPAR – Best practice hospitals up to 59 percent.

Medical CC Analysis
JATA clients capturing 55 percent of CCs compared to 43 percent for MEDPAR – Best practice hospitals up to 62 percent.

MCC Analysis
JATA clients capturing 40 percent of MCCs compared to 25 percent for MEDPAR – Best practice hospitals up to 50 percent.
Medical MCC Analysis

JATA clients capturing 37 percent of MCCs compared to 23 percent for MEDPAR – Best practice hospitals up to 45 percent.
Summary

Our performance benchmarks show conclusively that a structured, effective clinical documentation program, with trained and cohesive teams and task forces, are achieving outstanding improvement for quality patient care and a hospital’s bottom line.

Hospitals, however, need to manage CMI continually in order to benefit from improved reimbursement. Looking forward, we encourage our clients to continue working to keep documentation language precise, profiling accurate, CMI strong, and increase reimbursement:

• Continually inform and educate physicians, coders, documentation specialists, and nursing staff on evolving clinical documentation requirements and how to support levels of severity under MS-DRG.

• Focus on establishing severity of illness regardless of DRG methodology.

• Institute concurrent intervention at the bedside rather than waiting until the time of coding for clarification. Concurrent intervention improves documentation.

• Analyze data and monitor CMI every month.

• Share results and share best practices. Telling your hospital staff how their efforts are contributing to improved patient care and reimbursement is the best way to ensure continued participation and instill dedication to clinical documentation improvement.
For More Information

Hospitals:
Contact Joanne Webb
joanne.webb@jathomas.com

Media:
Contact Caroline March-Long, Chuck Buck Associates
434-295-5938
cdlong@earthlink.net
**Coding Terms Defined**

**DRG:** Diagnosis-related group (DRG) is a system to classify hospital cases into severity groups, developed for Medicare as part of the prospective payment system. Base DRGs are now subdivided into severity subgroups with two to three different levels of CC severity, with MCCs capturing the highest clinical severity and as a result, the most appropriate case mix.

**Triplet DRGs:** The “triplet” group of DRGs include:

1. DRG with Major CC (MCC)
2. DRG with CC
3. DRG without MCC or CC

Coding with a CC or MCC shows increased severity of illness, increased resource consumption and longer length of stay.

**CC:** Under the old and new DRG system, coders establish the principal diagnosis as documented by the physician and then use “CC” (Complications and Comorbidities) to further support severity of illness.

**MCC:** With MS-DRG, CMS introduced Major CC (MCC) as a way to identify diagnoses present on a case that significantly increase the expected resource consumption beyond that of the same case with a CC. The higher MCC rate means a higher severity of illness and more accurate payments.

**Medical CMI, Medical CC or Medical MCC:** Medical indicates non-surgical cases. This also indicates the most vigorous improvement in documentation, since physicians need to start with a principal diagnosis and then add MCC and CC.

**Surgical CMI, CC or Surgical MCC:** Refers to cases with reimbursable surgical procedures. Severity of illness is easier to establish since coders need to only need to add an MCC or CC in most cases.

**MEDPAR:** The Medicare Provider Analysis and Review (MEDPAR) contains data from claims for services provided to beneficiaries admitted to Medicare certified inpatient hospitals and skilled nursing facilities (SNF).

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*J. A. Thomas and Associates benchmarking only looks at inpatient acute care hospitals – not SNFs.*