NAVIGANT

DIGNITY HEALTH MEDICAL FOUNDATION ACCELERATES CASH FLOW, EBITDA THROUGH REVENUE CYCLE INITIATIVE

CHALLENGE

Headquartered in San Francisco, Dignity Health operates 39 hospitals and 250 ancillary clinics, and employs more than 60,000 caregivers and staff, across California, Arizona, and Nevada. The fifth-largest health system in the nation and the largest not-for-profit hospital provider in California, Dignity Health reported $12.6 billion in net operating revenue for 2016.

In California, there are 14 medical groups that are affiliated with Dignity Health Medical Foundation (DHMF), the largest medical group within Dignity Health. Through its organizational model, DHMF employs clinic staff and contracts with physician groups on an exclusive basis to provide healthcare services to Dignity Health patients.

In January 2017, midway through the fiscal year, DHMF found its performance trending downward in such major leading performance indicators as days in accounts receivable (AR); cash; and earnings before interest, tax, depreciation, and amortization (EBITDA). This resulted in an immediate imperative for DHMF to improve performance in these key areas, as well as provider documentation — specifically, how DHMF's performance compares to Medicare's "bell curve" for specialties.

SOLUTION

DHMF engaged Navigant to help improve revenue-cycle operations, to include accelerating cash flow and EBITDA growth. DHMF and Navigant staff collaborated to deploy a series of steps, including:

AR Management

- Conducted weekly analyses of existing AR at payer, aging, and account balance levels to identify opportunities for cash acceleration, isolate accounts, and implement corrective action. Successful strategies included:
  - Voluntary staff overtime to compensate for unfilled collection staff positions.
  - Identification of accounts for group appeal of denial from payer, needing "documentation only" to appeal denial, and/or that were assigned to a vendor but had no collection activity.
  - Identification of claims paid in error as "out of network".
  - Identification of work queues that had no assigned collector.

"Navigant's onsite staff collaborated well with DHMF staff, partnering to mine the data and develop a plan of attack, which they quickly implemented. We began to see wins almost immediately."

CHRISTOPHER MCGOLDRICK, CHIEF FINANCIAL OFFICER
DIGNITY HEALTH MEDICAL FOUNDATION

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Charge Integrity

- Conducted an analysis of the charge-capture processes and charge lag to address concerns among physicians and medical groups about a perceived loss of productivity due to charge capture, both in clinic and non-clinic environments. Findings and recommendations resulted in the following new processes:
  - Development of a management report of "missing, pending charges" to quickly notify clinic leadership of delays in time from service to bill
  - Decrease in coder review of charges, from all charges to only those with potential high risk
  - Decreased time for finalization of charge and provider signoff

Vendor Management

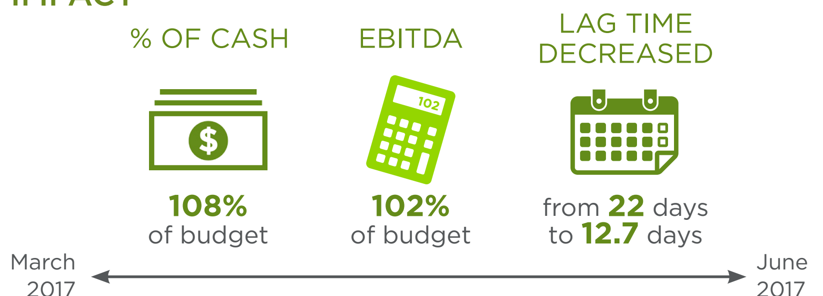
- Created a vendor strategy to optimize DHMF's back-end cash collections through investing, divesting, or altering existing revenue-cycle vendor use. The goal was to reach the optimal use of internal resource knowledge/experience, with specialized knowledge available through vendors in such areas as workers' compensation, veterans' administration, early-out and primary bad debt, and accounts with balances exceeding $200. Navigant also recommended a revision of the parameters for aged accounts being sent to an existing vendor, from 120 days from date of service to 120 days from bill date.

Coding Audit/Physician Documentation

- Conducted an audit of physician records to evaluate existing coding performance and the level of physician documentation. The results of the audit included:
  - Twenty percent of records reviewed had documentation that supported a higher level of service than what was billed. The decision-making exhibited throughout the encounter would have supported a higher level of service, but the history and/or exam was not documented to the appropriate degree, based on Medicare criteria.
- Fourteen percent of records reviewed did not have documentation to support the level billed.

Navigant recommended focused training and education for those providers that fell into either side of the norm, and repeated audits to track change in behavior.

IMPACT



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