Introduction
December 14, 2016
The controversial CMS Pre-Claim Review (PCR) Demonstration Project actually started out as something quite different from what it has become. Originally envisioned as a pre-authorization process, the project morphed into a serious attempt by CMS to prevent Medicare home health fraud and abuse by controlling episode payments before final claims are processed, rather than through the traditional “pay and chase” investigations that generally take years to reach fruition. Pre-Claim Review has been underway in Illinois since August, and it is still tentatively scheduled for a roll-out in four other states (Florida, Texas, Massachusetts, Michigan) on a yet-to-be-determined schedule. [NOTE: On December 19, 2016, CMS announced that PCR will expand into its second state, Florida, on April 1, 2017.] Assuming that PCR is implemented in all five states, the program will affect claim payment decisions for nearly 20 percent of the nation’s home health agencies.

On one side, industry leaders have characterized the project as chaotic, expensive, and a complete mess destined to put medically fragile Medicare patients at risk due to delayed or denied care. CMS and Palmetto (the MAC serving most Illinois providers) have worked to demonstrate why the project is a growing success — largely because agencies are now getting the hang of things — and ostensibly, why it should be allowed to continue for the purpose of assessing whether this approach to reducing fraud does, in fact, produce the hoped-for reduction in program abuse. According to CMS, during week 17 of the project, 83 percent of PCR requests were fully, provisionally affirmed, and four percent were partially provisionally affirmed — leaving only 13 percent that were entirely non-affirmed due to deficiencies in the submitted records.

The reality is that PCR does not impose any new documentation requirements even though it does create the need to submit documentation for review prior to provisional affirmation of payment. And the “provisional” part of the affirmation statement simply confirms that payments are not guaranteed to be insulated from a second review that could be conducted by a CERT contractor, a ZPIC or even the MAC in some situations.

A significant issue for many (if not most) agencies in Illinois has been the paperwork burden associated with obtaining and carefully examining Face-to-Face Clinical Encounter notes and determining if those notes have gaps that require the agency to offer, to the certifying physician, information from their own assessment records to establish the need for skilled home health services, homebound status, or both.
Some agencies also have the challenge of convincing the physician to sign off on those offerings for the purpose of incorporating them into the physician record. However, my experience has been that most physicians are relatively quiescent about why home health agencies are making the requests and willing to make the accommodation to ensure that their patients get the skilled care they need.

Of course, another significant issue for providers obligated to submit PCR requests is simply the extra time that it takes to trudge through the e-Services portal questions and tasks to get the documentation submitted. I can attest to the fact that, even for an experienced end user, the documentation submission through the portal requires at least 15 to 30 minutes to assemble the required documentation that resides in the patient record and formulate advance responses to various questions around the nature of homebound status followed by another 15 minutes or so to actually get the submission reviewed and completed.

For many agencies in Illinois with process gaps that precipitate delays in acquiring signed documentation from physicians, there is increasing concern over protecting cash flow. To put things in perspective, for the even the most efficient provider, every 1,000 Medicare fee-for-service episodes produces an additional work burden in the neighborhood of 1,125 hours. Essentially, that is an added half of an FTE on the cost side of things. For that same provider, the submission of a final claim is likely to be delayed by at least the two weeks (the time it takes to get the initial affirmation decision). And that’s assuming all episodes are completely affirmed the first time through. With a five percent non-affirmation rate, cash flow for the same 1,000 episodes would be reduced by at least $140,000 (assuming an average reimbursement of $2,800 per episode). The reality is that Pre-Claim Review presents a significant cost burden even for the most efficient providers with carefully honed process flows. Others (particularly small agencies without sufficient working capital) could be at risk for failure unless they are able to institute major efficiency improvements.

A wildcard in the mix is the result of the 2016 presidential election and the pledge from a Republican controlled congress and the President-Elect to repeal and replace the Affordable Care Act (PPACA). A looming question is what that would mean to the regulatory framework around delivery of Medicare home health services — particularly since the Face-to-Face Encounter requirements were originally established by PPACA, which also expanded CMS’ ability to accelerate the development and testing of new payment models, one of which is Pre-Claim Review. Notably, the incoming Secretary of HHS has co-sponsored a bill, dubbed the PUSH Act (HR 6226), which would establish a one-year moratorium on the demonstration project “to allow CMS to re-evaluate the full impact of this initiative.”

We are hopeful that Pre-Claim Review will be stopped in IL and prevented from starting in any other state, but until that time comes, we need to face up to the fact that CMS is serious about prevention of improper payments and we, as an industry, need to become equally serious about meeting the documentation requirements for Medicare fee-for-service episodes and doing so as efficiently as possible.

Whether your agency operates in a Pre-Claim Review state or not, it will pay to keep an eye on the progress of this demonstration project.

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Pre-Claim Review Basics

Episodes That Must Be Reviewed
Claims for traditional, fee-for-service (FFS) Medicare episodes that begin on or after the effective date in each PCR State are subject to the demonstration project review rules. Agencies that are located in a PCR state and serving patients in neighboring states (for example, an IL agency serving patients residing in WI) would submit all Medicare FFS episodes for patients from both states for Pre-Claim Review. This is a departure from earlier assurances that episodes for patients residing in the non-PCR state would be exempt from the review requirements.

Prior to submitting the final claim for reimbursement, each agency will be required to submit a limited amount of documentation to its MAC for review. Agencies that do not submit the PCR request prior to submitting the final claim will receive ADRs that will determine whether payment will be made and, following the first 90 days of the project in each PCR state, each such payment will be subject to a 25 percent reduction.

The table below lists the PCR requirements by episode or event type.

<table>
<thead>
<tr>
<th>Episode Type / Event</th>
<th>PCR Required?</th>
</tr>
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<tbody>
<tr>
<td>Start of Care</td>
<td>Yes</td>
</tr>
<tr>
<td>Recertification</td>
<td>Yes</td>
</tr>
<tr>
<td>Resumption of Care</td>
<td>No</td>
</tr>
<tr>
<td>LUPA</td>
<td>No</td>
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<tr>
<td>Transfer from Another Agency</td>
<td>Yes</td>
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Documentation Requirements
Submitted documents will be reviewed in the context of the degree to which the episode fulfills the Medicare Conditions of Payment. For example, the Conditions of Payment require that the documentation associated with each Medicare episode include information that confirms the following:

1. The patient’s homebound status.
2. A timely Face-to-Face Encounter between the patient and the certifying physician or a qualified non-physician practitioner working with the certifying physician,
3. Medical necessity for skilled home health services,
4. A Plan of Care that has been established by the physician following the patient’s home health services, and
5. Reasonableness of services being ordered.

As a result, the documentation that is submitted with each PCR request must lead the reviewer to conclude that the contemplated services are fully compliant with the Conditions of Payment as a prelude to provisionally authorizing payment.

Certain documents are required for every PCR review request. Others may be submitted based on the provider’s determination that they are responsive to the Conditions of Payment and needed to justify care. At a minimum, the following documents are required:

- The physician’s clinical encounter note of even date with the certified encounter date.
- The physician’s certification of the encounter including the encounter date and a statement confirming the patient’s eligibility for care.
- If the episode is a recertification, the initial, SOC Plan of Care.
- The Plan of Care for the episode to be reviewed.

Additionally, the agency is able to submit information accepted by the physician for incorporation into his/her records and corroborative of information already in those records for the purpose of establishing the minimum eligibility requirements relative to the patient’s skilled home health need and homebound status of the patient. However, such information must be signed and dated by the physician in order to be used during the review process.
Homebound Status
With respect to establishing the patient’s homebound status, the agency must also ensure that its documentation confirms homebound status as defined by Medicare including:

1. That the patient, because of illness or injury, needs the aid of supportive devices such as crutches, a cane, a wheelchair or walker, or the use of special transportation, or assistance from another to leave home and,
2. That there is a normal inability to leave home such that leaving is a considerable and taxing effort.

Often this information is contained in another document already in the submission, in which case, the agency can refer to that document for the purpose of confirming eligibility.

If submitting through the Palmetto GBA e-Services portal, the agency may also be asked to confirm the existence of Structural Impairments, Functional Impairments and Activity Limitations.

Structural Impairments include:
1. Structures of the nervous system
2. Eye, ear and related structures
3. Structures involved in voice and speech
4. Structures of the cardiovascular system
5. Structures of the immunological system
6. Structures of the respiratory system
7. Structures related to the digestive system
8. Structures related to the metabolic and endocrine systems
9. Structures related to the genitourinary system
10. Structures related to movement
11. Structures related to skin

Functional Impairments are:
1. Mental functions
2. Sensory functions and pain
3. Voice and speech functions
4. Functions of the cardiovascular system
5. Functions of the hematological and immunological systems
6. Functions of the respiratory system
7. Functions of the digestive system
8. Functions of the metabolic and endocrine systems
9. Genitourinary functions
10. Neuromusculoskeletal and movement related functions
11. Functions of the skin and related structures

Activity Limitations are:
1. Communication
2. Mobility
3. Self-care
4. Domestic life
5. Interpersonal interactions and relationships

Submitting Review Requests
The Pre-Claim Review request can be submitted at any time after the patient has been admitted and services have begun and prior to submission of the final claim for reimbursement. However, the PCR rules require that certain elements of the submission record be signed and dated prior to sending in the request. Notably, the Plan of Care must be signed and dated by the physician who will be supervising home health services. The Face-to-Face Encounter “actual clinical note” must be signed and dated by the certifying physician, and he/she must also provide a signed, dated certification of patient eligibility for service and confirmation of the encounter date as well as a signed, dated copy of any agency supplied information that will be used to augment the physician’s clinical record.

Other documents that fill out the Plan of Care, such as therapy evaluations should also be sent, and as with the Plan of Care, those orders must also be executed by the patient’s physician. If the agency’s comprehensive assessment is being used to defend homebound status, apart from the Face-to-Face Encounter information, it does not need to be signed by the physician. But if the information from the assessment is being used to bring the encounter clinical note into conformity with the requirements, it must be signed and dated.
CMS originally indicated that PCR requests should be sent only after the RAP has been submitted; however, that was changed early on in the project. Even so, Palmetto, the MAC for the first three PCR states has said that RAPs should precede the PCR submission and should be allowed to process in advance of the PCR submission to allow the beneficiary record to open in the Common Working File.

Each PCR request is assigned a Unique Tracking Number (UTN). Each UTN is, in turn, associated with specific HCPCS for which payment is either provisionally affirmed or non-affirmed. It will be possible for an episode to have some visits/services that are provisionally affirmed while others may be non-affirmed. In that case, the HCPCS for the non-affirmed services would be ignored as the final payment is calculated unless a subsequent PCR request yields a provisional affirmation for the services.

PCR requests that yield a non-affirmation decision can be resubmitted an unlimited number of times. The last UTN assigned is the UTN that governs payment of services.

UTNs must be included on each final claim to which they apply. It is also worth noting that each UTN is specific to the agency, not the patient. In the instance of a partial episode between two different agencies, both would need to submit documentation for Pre-Claim Review and issuance of the UTN to facilitate payment.

Initial PCR submissions are generally being handled within a 10-day window, while the MAC has 20 days to consider each resubmission. If the submission or resubmission is sent through the MAC’s e-Services portal, the decision will be sent via that route, as well.

While agencies are not able to appeal non-affirmation decisions, they can resubmit the PCR request with new information intended to cover any identified gaps or shortcomings in a prior submission. If one or more PCR resubmission requests still fail to yield a provisional affirmation, the agency’s final option is to submit the final claim, allow it to be denied for payment, and then commence an appeal.

**When a Review Request is Not Submitted**

The PCR project calls for a temporary grace period that extends for 90 days after the effective date in each of the five states. During that period, any claim received that is subject to PCR (started and ended on or after the effective date) will be subject to an ADR if there is no record of a UTN associated with that episode. Once the agency timely submits the documentation that is responsive to the ADR and the episode is approved for payment, reimbursement will be received by the agency in full. For claims that are submitted after the grace period without benefit of Pre-Claim Review, an ADR will be issued and, if payment is finally approved, there will be a non-appealable 25 percent payment reduction.

**Advance Notice to Patients of Non-Coverage**

CMS has made it very clear that it is unacceptable to issue blanket notices of non-coverage to patients as a means of insulating the agency from non-affirmations and inability to collect for services. In fact, engaging in the practice of issuing Advance Beneficiary Notices (ABNs) or Notices of Medicare Non-Coverage (NOMNCs) to all patients directly controverts established Medicare policy.

The intended use of an advance notification is to provide notice to a patient that a continuation of care may not be covered by Medicare due to lack of eligibility such as a lack of homebound status or medical need. If an agency believes that a patient may not be homebound or may not have a bona fide skilled need at the beginning of an episode, the wiser choice would be to not certify or recertify the patient for Medicare services.

**Exceptions**

Probe and Educate activities will be suspended in the PCR states at the time that Pre-Claim Review becomes effective.
Agencies that are currently under a ZPIC review will not be able to submit PCR requests until they are no longer under review.

**Non-Affirmations**
In Illinois, as the PCR project has progressed, the MAC places a call to each agency for each episode that is non-affirmed in an attempt to clarify the deficiency and offer suggestions for how the record could be improved. These calls are useful, and it is important to note that, during such a call, a pending non-affirmation decision can be reversed if there are no new or corrected documents that need to be submitted; however, if new or additional documentation needs to be sent in, the agency will need to resubmit its request.

**Defensive Documentation: How to Avoid Mistakes That Derail Reviews**
Many ADRs associated with the Probe and Educate process failed due to technical insufficiencies and the PCR demonstration project has highlighted similar problems along with some new ones. It is a reality that, technical elements of the record are reviewed first, and if an error is found the review stops. What does that mean? In many cases, it means that the medical review never gets as far as an evaluation of the clinical content of the record in terms of skilled need. Examples of documentation mistakes that can be potentially fatal usually boil down to only a few simple categories of errors. These are important for every agency — not just those contending with Pre-Claim Review — to look out for and avoid.

**Face-to-Face Encounters**
The Face-to-Face Encounter documentation must address each of the Medicare requirements related to the encounter in terms of who conducted the encounter, the timing of the visit, and the contents of the clinical record.

Since 2015, for purposes of medical review, the Face-to-Face Encounter must have at least two components — the physician’s certification of patient eligibility including the encounter date and the certifying physician’s “actual clinical note” that is demonstrative of the following requirements:

1. That the encounter occurred within the required timeframe,
2. That the encounter was related to the primary reason the patient needs home health services,
3. That the encounter was performed by an allowed provider type,
4. That the patient is homebound and
5. That the patient requires skilled home health services.

If the actual clinical note from the physician does not sufficiently establish all of the requirements noted above, the agency may draw relevant supporting information from its own record (usually the comprehensive assessment) and offer that information to the physician for his/her own record. The physician must sign and date the agency-supplied information in order for it to be useful in fulfilling the Face-to-Face content requirements.

CMS has issued updated guidance in MLN Matters SE1436 as to what types of documents are most likely to be accepted as evidence of the physician/patient encounter, including discharge summaries, a physician progress notes, and problem lists. Occasionally a history and physical (H&P) will suffice as the encounter; but often when an H&P is used, it is an admission (rather than discharge) document that fails to meet the home health parameters related to identification of the patient’s skilled home health need and homebound status. Thus, in our experience, whenever an H&P is used to substantiate the encounter, the agency will almost always need to supplement that documentation with its own information and offer that supplement to the physician for inclusion into his or her record.
Agencies should be cognizant of the types of errors that will cause Face-to-Face Encounter documentation to fail. CMS has issued a set of four errors that could be related to Face-to-Face issues including the following:

1. **HH01A.** The physician certification is invalid since the required Face-to-Face encounter clinical note (for admissions on or after 1/1/15) or the physician narrative (for episodes beginning between 1/1/2011 and 12/31/14) is missing.

2. **HH01B.** The physician certification is invalid because the encounter was not timely and/or the physician did not document the date of the encounter.

3. **HH01C.** The physician certification is invalid because the encounter was not performed by an approved practitioner.

4. **HH01D.** The physician certification is invalid because the encounter was not related to the primary reason for home health services.

**Plans of Care and Orders**

Plans of Care must be complete and aligned with applicable Local Coverage Determinations (LCDs). Palmetto has several LCDs that are being used to determine the adequacy of contemplated interventions and goals. The active LCDs are as follows:

1. **Palmetto. L34546** – Home Based Fall Evaluations and Interventions
2. **Palmetto. L34565** – Home Health Surface Electrical Stimulation in the Treatment of Dysphagia
3. **Palmetto. L34563** – Home Health Speech Language Pathology
4. **Palmetto. L34562** – Home Health Skilled Nursing Care: Teaching and Training - Alzheimer's Disease and Behavioral Disturbances
5. **Palmetto. L35132** – Home Health Plans of Care – Monitoring Glucose Control in the Medicare Home Health Population with Type II Diabetes Mellitus
6. **Palmetto. L34564** – Home Health Physical Therapy
7. **Palmetto. L34561** – Home Health Psychiatric Care
8. **CGS. L33942** – Physical Therapy – Home Health
9. **NGS. L33617** – Erythropoiesis Stimulating Agents (ESA)

Plans of Care need to be structured so that interventions are specifically directed toward the primary and most important secondary diagnoses along with the patient's functional limitations. It is also important to remember that goals should be measurable in terms of the patient's baseline at the Start of Care in order to effectively measure progressive functional capacity. It is also a very good idea, for every Plan of Care, to include specific information as to why the patient is, or remains, homebound with specific information as to why and how the patient meets the two-tiers of the homebound status test.

There are several errors that could be associated with a deficiency in the Plan of Care. They are as follows:

1. **HH02A.** The Plan of Care is missing.
2. **HH02B.** The content in the Plan of Care is insufficient.
3. **HH02C.** The submitted Plan of Care lacks a signature.
4. **HH02D.** The Plan of Care is missing the physician certification or recertification.
5. **HH02E.** The physician certification/recertification does not support skilled need.
6. **HH02F.** The physician certification/recertification does not support homebound status.
7. **HH02G.** The physician statement of how much longer skilled services are required is missing.
8. **HH02H.** The home health agency generated record with information on homebound status was not signed and dated by the physician.
9. **HH02I.** The Plan of Care was not signed timely by a qualified physician or the home
health agency generated record with information on skilled need was not signed and dated by the physician.

10. HH05A. The initial Plan of Care was not submitted with the documentation (for a recertified episode) and the subsequent episode may not be allowed.

11. HH05B. There is no valid initial physician’s certification of patient eligibility; therefore, services on the subsequent episode may not be allowed.

In addition, orders for care must be specific and must address the discipline of the person to provide services, the frequency with which services will be delivered and the reasonableness and necessity of the services.

In the event of a missing order, CMS has created reason codes for each discipline, including HH06A (SN), HH06C (PT), HH06F (SLP), HH06I (OT), HH07A (MSW), and HH07D (HHA). These generally relate to an omission of frequency orders and/or interventions and goals for the particular discipline.

When an order is determined to be invalid due to omission of the type of services to be provided (interventions are missing), the discipline that will provide the services (disciplines for services are not identified), or when services will be delivered (omitted visit frequencies), another set of codes will highlight the order gaps. HH06M indicates an omission with respect to a skilled nursing order. HH06N, HH06O, and HH06P relate to insufficient order details for PT, OT, and SLP respectively. HH07G is suggestive of an issue with an order for MSW services and HH07H related to an invalid order for HHA services.

If the documentation in the Plan of Care or orders does not support skilled need, a third set of errors will be generated, including HH06B (SN), HH06E (PT), HH06H (SLP), HH06L (OT), HH07C (MSW), and HH07F (HHA).

If specific goals are omitted from therapy orders, errors will be returned as HH06D (PT), HH06G (SLP) or HH06K (OT). OT, MSW, and HHA services, in order to be valid must accompany a qualified nursing or therapy service. If there is an order for OT, MSW, or HHA services without a corresponding order for SN, PT, or SLP services an error will also be generated: HH06J (OT), HH07B (MSW), or HH07E (HHA).

Documenting Homebound Status

Homebound status is the linchpin of eligibility and if it isn’t documented thoroughly with details that are specific to the patient, the episode will likely be non-affirmed. And, in the case of a garden-variety ADR, a denial will be the likely result. As we have seen in IL with PCR, the tired phraseology that it is a taxing effort for the patient to leave home just simply isn’t enough. If our documentation doesn’t specify WHY the effort is taxing and WHY the patient is dependent on an assistive device or another person to leave home, our homebound status will be left wanting. There are three reason codes that now identify homebound status problems: HH03A indicates that the first criteria of homebound status has not been met; HH04A tells us that the documentation submitted does not support a normal ability to leave home; and HH04B indicates that the documentation does not support the considerable and taxing effort to leave home as required by CMS. For every description of homebound status, the agency should always try to set forth the homebound status reasons in the context of the patient’s functional and structural impairment as well as activity limitations to ensure that there is no doubt around this very important component of eligibility.

When Additional Documentation Helps

Palmetto in particular has made it clear that its reviewers have been charged with ensuring that all of the contemplated services for an episode are appropriately justified. And sometimes that may mean submission of additional information in the form of visit notes, especially those that set forth
patient health status and skilled service delivery. So
while there is no set listing of required documents
other than the applicable Plans of Care and Face-
to-Face encounter documentation, agencies can
submit any other documentation that they feel will
help justify care. And likewise, reviewers may ask
for additional documentation, such as visit notes if
they are unable to arrive at an affirmation decision
based on what has been submitted. With that said,
agencies need to resist the temptation to bury the
reviewer in documents that do little to advance the
cause.

Process Tips and Tools

Agencies in Illinois have learned valuable lessons
from the PCR project. Agencies in other states will
be wise to take heed and learn from Illinois.

- Save time by ensuring that the agency
  acquires the Face-to-Face Clinical Encounter
documentation at the time of admission
  rather than waiting until later to request it.
  With this information in hand at the SOC,
  the assessing clinician will be able to know
  if there are gaps in the documentation
  that will need to be filled by the agency’s
  information.

- In establishing the reasons each patient is
  homebound during the assessment, use
  language that aligns with CMS’ rules. For
  example, “it is difficult and taxing for the
  patient to leave home because [state the
  reason].” If there is a medical contraindication
  for leaving home, such as the patient being
  prone to infection, associate that medical
  contraindication in the assessment narrative
  with a patient diagnosis.

- Assessments and homebound status
  narratives should be clearly focused on the
  patient’s structural and function impairments
  and activity limitations.

- When sending documentation to Palmetto
  through the e-Services portal, documents
  that are responsive to Tasks 5, 6 and 7 do
  not have to be signed by a physician. All
  other documentation submitted with Tasks
  1 through 4 must be signed and dated.

- For recertifications, the physician estimate
  of how much longer care will be required
  should be stated in terms of days, months
  or even years. Statements such as “lifetime”
  or “whenever the patient has better living
  arrangements” are not responsive to the
  expectation.

- For recertifications make good use of
  the 60-Day Summary to document the
  patient conditions or changes that warrant
  a continuation of care and transfer that
  information to the recertification order. Then
  make sure to include both with your
documentation in support of recertified
episodes.

- For each episode that will be reviewed,
  establish a checklist that agency staff can use
  to get the submission information together.
  This will speed up the document acquisition
  and submission process. For example,
  use the checklist to describe the type of
  facility that the patient was in prior to his/
  her home health admission. If an inpatient
  physician or NPP performed the Face-to-
  Face Encounter, use the checklist to identify
  whether that individual is an NP, clinical
  nurse specialist, certified nurse midwife, or
  physician assistant.

- Track the agency’s Pre-Claim Review
  submissions by Document Control Number,
  initially, and UTN once the tracking number
  is issued to ensure that the UTNs that are
  going on each claim are correct and that
  submissions don’t inadvertently fall through
  the cracks.
• Consider performing an agency assessment of key processes — Intake, Case Management, Documentation Tracking, and QA, for example — to ensure that each is structured to encompass the new requirements imposed by Pre-Claim Review.

• Consider implementing key performance indicators (KPIs) as a means of assessing Pre-Claim success or, alternatively, process weaknesses that need additional work and reinforcement.

The Bottom Line on Pre-Claim Review

Whether the PCR demonstration comes to your state, or not, the guidance and lessons learned in Illinois can be applied to your agency’s continuing efforts to realize improvement in documentation and, with that improvement, greater success in not only billing for the services provided, but also ensuring that your agency will be able to keep the money after payment is received. This is an interesting time for agencies everywhere, not just those in IL or the other four states waiting to hear whether Pre-Claim Review will be rolled out there and when. As with most things, the devil is in the details. Agencies that can effectively master those details will be the winners in the days and months to come.

About the author
Sharon S. Harder has over three decades of executive management experience in the healthcare industry. She has served in financial and operational leadership roles in a variety of healthcare organizations ranging from a major healthcare professional association to large post-acute healthcare providers. As President of C3 Advisors, LLC, Sharon engages with clients to develop and implement the strategic vision required to improve their profitability and competitive position in the rapidly transforming healthcare marketplace. Learn more at C3Advisors.com.