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IN THIS ISSUE

June 1, 2015 | Vol. 40, Issue 22

Top MAC denial switches from face to face to therapy documentation.....1

Slide in agency, hospice sales could be short-term, M&A consultants believe.....1

MedPAC finds flaws in CMS' 5-star rating system for agencies' care quality 2

Elder care start-ups new source of competition for private duty agencies 2

Warning: Hospice claims are being returned; change coding processes now 4

The Joint Commission will remain an accrediting organization for hospices 5

Benchmark of the Week

Four of Palmetto GBA's top home health denial reasons involve therapy issues..... 6

CMS to conduct "probe-and-educate" reviews in wake of face to face changes..... 8

Research firm: MedPAC and CMS ignore true home health costs..... 8

Denials management

Top MAC denial switches from face to face to therapy documentation

The growing number of denials Medicare administrative contractor (MAC) Palmetto GBA issued last quarter involving episodes with 20 or more therapy visits illustrates the need for agencies to educate quality managers about proper therapy documentation and standards.

5CHG3 — medical review HIPPS code change due to partial denial of therapy — was the top denial reason Palmetto issued agencies from January through March 2015.

(see *Therapy*, p. 5)

Mergers & acquisitions

Slide in agency, hospice sales could be short-term, M&A consultants believe

The number of home health agencies and hospices sold in the final quarter of 2014 dipped to 27 from 40 in the same quarter the previous year. And the slide continued in the first three months of 2015 — 21 home health and hospice providers were sold, down from 35 a year earlier

But those figures — developed by the Braff Group — don't necessarily represent a declining interest in purchases by prospective buyers, says Dexter Braff, president of the Pittsburgh-based mergers and acquisitions advisory firm.

(see *M&A*, p. 7)

11th Annual National Quality Outcomes & OASIS-C1 Conference



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*Quality improvement***MedPAC finds flaws in CMS' 5-star rating system for agencies' care quality**

The Medicare Payment Advisory Commission (MedPAC) is seeking to alter the method CMS intends to use in rating home health agency quality of care.

MedPAC's recent comments point out its perceived shortcomings of CMS' five-star ratings system.

The odds appear against MedPAC's desire to shut down CMS' rating plans. After CMS received the advisory panel's comments, it confirmed its plans to begin posting quality-of-care star ratings in "mid-July" 2015 and to add patient satisfaction star ratings in January 2016.

But CMS also said its methodology for calculating the home health care star ratings "will continue to evolve over time and we welcome additional stakeholder comments and suggestions."

One issue MedPAC had with the new star ratings is CMS' intention to base them partly on timely start of care, influenza and pneumonia immunization and drug education. A substantial body of research has found little or no association between providers' performance on process measures and performance on mortality and readmission rates for the same conditions, the commission's letter notes.

CMS recently has, in fact, decided to remove the process measure "Pneumococcal Vaccine Ever Received" from the rating system (*HHL 3/30/15*).

Another negative MedPAC sees is CMS' intention to determine annually the benchmark for each star value.

As a result, "agencies would not know in advance what performance is necessary to attain a given star ranking," MedPAC says.

In addition, it says, CMS needs to consider the many agencies that have too few patients to be included on the rating system. — *Burt Schorr* (burt.schorr@verizon.net)

Related link: View MedPAC's comments at <http://1.usa.gov/1AaYbFQ>.

*Private duty***Elder care start-ups new source of competition for private duty agencies**

The predicted expansion of the private duty market has caught the attention of the technology sector. And several new online options will likely become a source of competition for traditional private duty agencies.

Honor, a California-based start-up that's being referred to as the "Uber" of elder care, recently launched east of San Francisco, providing senior clients in Contra Costa County, Calif., with in-home devices and an online list of screened caregivers.

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Honor intends to provide clients with its “Honor Frame” technology that will notify seniors and their loved ones when their screened and matched caregiver will arrive, and monitor their activities. The company’s media representative says Honor will employ its caregivers and has pledged to pay a starting wage of \$15 per hour. Families will pay about \$30 per hour for the private duty service.

Amazon, which recently launched its Home Services group, isn’t offering personal care, say, to comply with activities of daily living (ADLs) in its array of services performed by bonded and insured individuals. The service already offers house cleaning, as does private duty. But experts don’t believe it would be a stretch for the online giant to expand in that arena at some point.

Neal Kursban, president of private duty agency Legacy Home Care in Silver Spring, Md., and Family & Nursing Care, a registry, believes that as private duty expands, competition will increase.

“I believe we will continue to see more online vendors enter the marketplace,” he says.

Many of these new companies are “responding to the steep, anticipated growth in demand for services” based on the aging Baby Boomer demographic, says Harry Nelson, partner at Los Angeles-based health care law firm Nelson Hardiman. “Traditional private duty elder care companies and home health agencies are already feeling competition, and that’s going to continue.”

However, Nelson sees several big challenges facing these new online companies hoping to corner the private duty market.

“I think the biggest issue here is going to be the challenge of finding skilled, trained caregivers for all of these new entrants, particularly fast-growing companies,” Nelson says. “It’s a challenge we’ve already heard anecdotally from some of our clients.”

Another concern for these new market entrants is regulatory.

Fewer than 20 states have regulations requiring training for private duty caregivers, Nelson says.

But he believes the onslaught of online options could lead to increased state licensure requirements to prevent elder abuse and neglect. Such requirements would mean many of these new applicants would need to provide training and safeguards similar to what is already being provided by most well-run traditional private duty agencies.

“I’ll be surprised if all 50 states haven’t adopted [private duty care] regulations in the next 15 years,” he says.

Attorney Robert Markette, of the Indianapolis office of Hall, Render, Killian, Heath & Lyman, agrees that many of these ventures, particularly those attempting to “reinvent” the registry model, could encounter difficulties in many states. However, this increased state scrutiny could be positive for many in the private duty market.

“I think for traditional agency models, this is a good thing, because they are only competing with other agencies, not registries,” he says. “If you are a registry model, it is, obviously, not a great development. Some states are very favorable to registries, but some have worked very hard to eliminate registries.”

Don’t automatically assume the worst

Joseph Ebberwein, the former chief financial officer of home health agency THA Group, and currently of consulting firm Longitudinal Health in Savannah, Ga., says private duty agencies must be aware of these private duty entrants but also look for potential opportunities to partner or compete, or possibly lose market share.

“Private duty really needs to take advantage of some of these technologies and solutions, and not get left behind, so to speak,” he says. “A lot of the older Baby Boomers are taking care of their parents, and they’re looking for easy access and Internet solutions for just about anything and everything. It makes sense to utilize these kinds of services for matching up home care providers for their loved ones.”

Nelson sees opportunities for traditional agencies to offer training, or their own skilled personnel at a cost to some of these new online ventures.

Ebberwein agrees, noting that some agencies may be able to form arrangements with registry-type online models in their markets by offering up their “own staff as part of this new solution,” he says. “They’re probably going to have to give up a piece of the pie, or margin, but at least it would guarantee that they’re still in the game.”

Compete with new online ventures

- **Consider stepping up your online presence.**

Ebberwein suggests that agencies take steps to compete with these new media-savvy online companies by focusing on lead generation in social media so that they can really capture the demographics they want in their target regions. “I think agencies that really want to thrive

need to be at the top of their game when looking at some of these potentially disruptive solutions.”

- **Keep your website fresh.** “Collect testimonials from existing clients” and keep those fresh on the website to help drive potential clients to your agency, Ebberwein says.

- **Don’t automatically view new technologies as competition.** Some of these start-ups could present an opportunity for collaboration. However, Nelson says agencies should tread cautiously before locking into a relationship with a new venture until they know who they’re dealing with, he says. “Successful players with well-established brands need to be careful not to dilute their brand or risk damage to their brand through a partnership.” — *Angela Childers (angela.childers@gmail.com)*

Hospice

Warning: Hospice claims are being returned; change coding processes now

Almost 40% of hospices have had records returned for incorrect coding since Oct. 1, 2014, according to the results of a recent DecisionHealth Hospice Coding Survey of 131 hospice coders.

Of those who’ve had claims returned for correction, nearly 30% report having between one and five claims returned, while 8% have had six to 10 records returned, survey results show.

Hospice coders and clinicians are having to make drastic changes to their coding practices, requiring far more frequent collaboration to determine patients’ terminal diagnoses since Medicare started returning to provider (RTP) claims with primary terminal diagnoses of debility (799.3), adult failure to thrive (783.7) and unspecified or manifestation dementia conditions (such as 294.21, Dementia, unspecified, with behavioral disturbance).

Consider that while 37% of survey respondents reported they frequently assigned unspecified dementia codes as the primary terminal diagnosis because the record lacked further diagnostic detail prior to Oct. 1, 2014, 84% of them stopped doing so completely after the RTP edit went into effect.

The hospice industry is undergoing a transition similar to the one that home health went through in 2000 when the PPS system was first introduced, says Judy

Adams, president of Adams Home Care Consulting in Asheville, N.C.

For an industry that historically hasn’t placed a lot of emphasis on coding and that’s been used to assigning a single terminal diagnosis, which was often a vague condition that didn’t fully explain why the patient was nearing death, this new RTP edit is creating a significant learning curve, she says.

Dementia is the biggest challenge

That primary hospice diagnoses of unspecified dementia or vascular dementia just aren’t acceptable anymore is what independent coding consultant Toni Beasley, who is based in Chelsea, Ala., is telling her hospice clients, many of whom she says were not aware of the coding restriction.

One of Beasley’s hospice clients had eight hospice records returned without payment in the first billing cycle after Oct. 1, 2014. They were all hospice patients who were continuing on service and had unallowable diagnoses as their primary reason for hospice care that hadn’t been changed to account for the edit.

Now she’s stressing that “we’re going to have to build a bigger picture of what’s going on with this patient,” Beasley says.

Those eight records, though they weren’t outright denied but rather just needed to be re-coded and resubmitted, caused a cash flow interruption and significant panic to the agency.

Dementia diagnoses are giving hospices the most trouble — either finding an etiology or obtaining physician confirmation of a more specific form of the disease that’s acceptable as a primary reason for hospice care, says Brandi Whitemyer, product specialist for DecisionHealth in Gaithersburg, Md.

And while records are being returned, not every hospice has completely stopped assigning the unacceptable dementia codes in the primary position, according to survey results.

Consider that 15% of survey respondents are still assigning unspecified dementia codes (like 294.21, Dementia, unspecified, with behavioral disturbance) and 10% are still assigning dementia manifestation codes (like 294.11, Dementia in conditions classified elsewhere with behavioral disturbance) as primary when they’re unable to get an etiology.

Comparatively, a smaller number of survey respondents (8%) are still assigning adult failure to thrive and debility as a patient's primary hospice diagnoses when they're unable to get more detail about the patient's health status, according to survey results.

Hospices that aren't changing their coding practices will ultimately have to or face going out of business, Adams says.

Edit slows coding processes

The inability to assign adult failure to thrive, debility and especially unspecified dementia is forcing hospice coders to become detectives, scouring through patient records and consulting with clinicians and physicians to find a diagnosis that won't result in a returned claim, which has slowed coding efficiency and created more work for everyone.

Gone are the days when Beasley received a hospice record, coded it and sent it back to the client. Now, she's being asked to consult with clinicians to find an appropriate terminal diagnosis.

She recently had a case involving a patient with vascular dementia and had to inform the hospice that the condition couldn't be the patient's terminal diagnosis. She advised it to consult the patient's primary care physician and family to see if there was another diagnosis to consider.

Beasley recommend that issues such as whether the patient has shown a recent decline in appetite, has lost weight, is bedbound, has bedsores or is having trouble swallowing be considered in arriving at a suitable terminal diagnosis. — *Megan Gustafson* (mgustafson@decisionhealth.com)

Hospice

The Joint Commission will remain an accrediting organization for hospices

CMS has decided to continue recognizing The Joint Commission as a national accrediting organization for hospices.

A final notice was posted on the Federal Register May 21.

The notice is effective June 18 and runs through June 18, 2021.

Related link: View the notice at <http://1.usa.gov/1Hud57d>.

Therapy

(continued from p. 1)

With 5CHG3, agencies provided at least 20 therapy visits but Palmetto, the MAC in 16 mostly southern states, examined documentation and determined some of those visits should not have been allowed and adjusted reimbursement accordingly.

Depending upon diagnoses and the amount of therapy reduced, agencies could lose in the "high hundreds to at least thousands of dollars," notes Brandi Whitemyer, AHIMA-approved ICD-10 trainer and product specialist for DecisionHealth in Gaithersburg, Md.

Palmetto's quarterly release of denials data, posted May 11, shows that while the number of denials overall significantly decreased, the number of denials issued for 5CHG3 more than doubled from the prior quarter. (*See benchmark, p. 6.*)

Of 2,145 home health claims Palmetto denied from January through March 2015, 5CHG3 yielded 570 denials. By comparison, Palmetto denied 5,285 claims from October through December 2014. 5CHG3 was the third-most common reason, yielding 256 denials.

"This denial code is not limited to a specific medical review," a Palmetto spokesman tells *HHL*. But the fact that so many denials are coming due to the issue could potentially lead MACs to conduct targeted reviews, Whitemyer believes.

With 5CHG3, sometimes auditors determine patients met their goals and therapy should not have continued, Whitemyer says. In other situations, auditors determine the therapy should not have been provided because it would not have helped patients improve.

Much of the issue involves documentation not being clear or supportive enough, she says.

Sometimes partial denials occur because reassessments were missed, adds Dr. Kenneth Miller, clinical educator at Catholic Home Care in Farmingdale, N.Y.

That issue may decrease due to a change within the 2015 PPS final rule that Miller believes relaxes therapy requirements. Qualified therapists — not assistants — from each discipline now only are required to provide the needed therapy service and functionally reassess the patient at least once every 30 calendar days (*HHL 11/10/14*).

All records Palmetto reviewed in the first quarter of 2015 had dates of service prior to 2015. As a result, the

BENCHMARK of the Week**Four of Palmetto GBA's top home health denial reasons involve therapy issues**

Among the 2,145 home health claims Medicare administrative contractor Palmetto GBA denied from January through March 2015, the top denial reason involves 5CHG3 — medical review HIPPS code change due to partial denial of therapy. (See story, p. 1.)

Three other therapy issues are also a significant source of Palmetto's denials.

Information provided does not support the medical necessity for therapy services (5A301 and 5F301) yielded 3.9% and 2.3% of denials last quarter, respectively. In those instances, at least one therapy visit wasn't covered because documentation submitted didn't support the medical necessity of the services.

Meanwhile, absence of short- and/or long-term goals within the initial (PT/OT/ST as appropriate) therapy evaluation documentation (5T080) yielded 3.8% of denials.

Evaluations should state short- and long-term goals in objective measurable terms, as well as the goals' expected date of accomplishment, Palmetto says.

Denial code	Denial description	% of claims denied
5CHG3	Medical review HIPPS code change due to partial denial of therapy	26.6%
56900	Auto deny — requested records not submitted	22.3%
5F041	Information provided does not support the medical necessity for this service	12.6%
5FF2F	Face-to-face encounter requirements not met	12.1%
5A041	Information provided does not support the medical necessity for this service	10.1%
5A301	Information provided does not support the medical necessity for therapy services	3.9%
5T080	Absence of short- and/or long-term goals within the initial (PT/OT/ST as appropriate) therapy evaluation documentation	3.8%
5FNOA	Unable to determine medical necessity of HIPPS code billed as appropriate — OASIS not submitted	3.4%
5F012	Physician's plan of care and/or certification present — signed but not dated	2.9%
5F301	Information provided does not support the medical necessity for therapy services	2.3%

Source: Palmetto GBA

therapy rule change would not have affected the most recent denials data.

How to avoid denials for 5CHG3

- **Conduct quarterly reviews of therapy charts as part of your quality assurance performance improvement (QAPI) program.** Review 10% to 15% of your charts each quarter, including a good cross-section of therapy charts, Whitemyer advises.

Also, run quarterly reports on therapy utilization agencywide. This will identify, for instance, if your agency conducts 700 PT visits but only 22 occupational therapy visits in a quarter.

Although therapy utilization should vary depending upon several factors including patient populations, agencies should be concerned if data show “wide discrepancies,” Whitemyer says. Such discrepancies

might indicate too much — or little — therapy being performed by a particular specialty.

- **Have a therapist who truly understands documentation educate your QA staff.** The therapist should explain how therapy notes, plans of care and orders should look.

She should teach QA employees about clinical terminology used by various therapies, appropriate utilization patterns and what the minimal documentation requirements are for therapists according to home health conditions of participation, Whitemyer says.

- **Alert QA employees about red flags that draw auditor scrutiny.** One such issue: Has the patient reached a level where he can safely ambulate in the community?

A QA employee should be able to identify how many visits appear out of the norm for a patient with a particular health issue. For instance, a typical post-operative hip replacement patient wouldn't need 26 visits from a therapist, Whitemyer says. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

M&A

(continued from p. 1)

Despite quarterly fluctuations, Braff believes the final agency transactions figure will be the same 70 to 80 experienced over the past eight years. Hospice sales, meanwhile, will total roughly the 35 deals they've averaged over the past five years, he predicts.

The major reason for late completions is that potential purchasers typically have to wait three to six months for CMS to OK the ownership change they have in mind, says Jack Eskenazi, senior VP for the M&A advisory firm American Healthcare Capital in Marina Del Ray, Calif.

Eskenazi's firm has been assisting about 100 sales a year of large and small agencies, hospices and other healthcare companies owned by his firm's clients. He expects a similar number in 2015, though more than 60% of those transactions won't close until the final quarter, he says.

A market factor that continues unchanged this year is the increased percentage of larger agencies on

the market — including one for \$55 million, Eskenazi points out.

Another is the low cost of borrowing to finance agency purchases. Even at a relatively high 10% interest rate, such borrowers can still make money, Eskenazi believes.

The readiness of deep-pocket investors to put their money into larger home health providers hasn't diminished either, Kulik finds.

He cites last year's purchase by Wellspring Capital Management of a majority interest in Great Lakes Caring, a 20-office agency based in Jackson, Mich.

William Deary, who founded Great Lakes 17 years ago and will continue to manage the big agency as a minority partner, sees the deal as evidence that the home health and hospice industries "are poised for consolidation."

A good guide to what investors are seeking is the comment by Wellspring managing partner Alexander Carles that his private equity firm found Great Lakes Caring "well-positioned in an attractive market where we expect demographic trends to result in continued growth."

Growth factors cited by Carles include the agency's "longstanding relationships with physicians, facilities and health systems . . . its next-generation technology and considerable experience integrating businesses."

An even more spectacular consolidation occurred in February when Kindred Healthcare, headquartered

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PAS 2015

in Louisville, Ky., acquired Gentiva Health Services in a transaction valued at \$1.8 billion, including the assumption of net debt. According to Kindred, the acquisition makes it the nation's largest provider of home health and rehab services, with operations in 47 states.

That deal followed HealthSouth Corp.'s \$750 million acquisition of Encompass Home Health and Hospice.

On a smaller scale, Almost Family, also headquartered in Louisville, acquired WillCare Healthcare for \$50 million immediately after its \$75.5 million purchase of SunCrest HealthCare. With the acquisitions, Almost Family now has 230 offices in 15 states.

Want to sell? Heed this advice

With the appetite for larger home health providers growing, owners of small agencies who are hoping to find buyers need to be meticulous in their preparations, says Beth DaSilva, president of Fleetridge Pacific, a San Diego-based mergers and acquisitions consulting firm.

A first step, DaSilva advises, is to keep monthly, or at least quarterly, accrual financial statements. Often buyers decide what they're willing to pay based on those statements. Annual financial statements for tax purposes may not show seasonal profitability as well as more frequent statements, she notes.

Other DaSilva tips:

- **Consider the advantages of having non-compete agreements with key employees.** The agreements can influence key employees to stay on after a sale — something that is extremely important to most buyers. But because the enforceability of such agreements can vary from state to state, seek an attorney's advice on how to prepare them.

- **Review real estate and equipment leases.** Can they be transferred to the buyer, if that would be part of the deal? Another consideration: The buyer may want to change locations, so generally avoid signing any long-term leases before selling.

- **Clean up accounts receivable by collecting or writing off old balances.** Also, have a plan to remove and destroy old records and another to codify procedures that have been followed as unwritten rules. — *Burt Schorr* (burt.schorr@verizon.net)

Face-to-face documentation

CMS to conduct “probe-and-educate” reviews in wake of face to face changes

To ensure agencies understand the new patient certification requirements outlined in the 2015 PPS final rule, CMS has decided to conduct pre-payment reviews of claims for episodes beginning on or after Aug. 1, 2015.

Contractors will conduct these pre-payment reviews using a “probe-and-educate” strategy. CMS expects that documentation requests will be sent beginning on or about Oct 1.

The announcement was posted May 21 on CMS' website.

“Home health agencies should obtain as much documentation from the certifying physician and/or the certifying acute/post-acute care facility as they deem necessary to substantiate that the home health patient eligibility criteria have been met,” CMS says. “Home health agencies are required to provide this documentation to CMS upon request.”

Medicare reimbursement

Research firm: MedPAC and CMS ignore true home health costs

If SEC-required financial statements of four publicly held home health companies are an accurate guide, overall industry profit margins shrank dramatically between 2010 and 2014.

As reported by the health care research firm Avalere, the four companies — Almost Family, Amedisys, LHC Group and Gentiva (acquired by Kindred Healthcare in February) — saw their net margins drop from an average 7.1% to 2.4% over the five-year period, partly reflecting the first of the 3.5% annual Medicare reimbursement cuts required by the Affordable Care Act.

The four companies are or were members of the Partnership for Quality Home Healthcare, which requested the Avalere analysis.

By comparison, the Medicare Payment Advisory Commission (MedPAC), an advocate of reduced home health reimbursement, estimated that Medicare profits of free-standing agencies averaged 12.6% in 2014.

But Avalere notes that profit calculations by both MedPAC and CMS exclude corporate income taxes and costs of telehealth and other services agencies routinely provide to patients. — *Burt Schorr* (burt.schorr@verizon.net)

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