Ladies and gentlemen, place your bets. The next 12 months might, or might not bring considerable and tumultuous change to the already reeling HME industry.

The lynchpin for that turmoil: competitive bidding Round Two. If the industry can’t stave off Round Two through the passage of H.R. 6490, the bill that would replace the bid program with the industry’s market pricing program (MPP), then Round Two will undoubtedly redefine the home medical equipment industry — and not for the better. If H.R. 6490 passes, then providers still must revise their business models.

These two factors, Round Two and the MPP, sit at the top of our latest installment of HMEB’s annual Big Ten list. Besides those two pivotal trends, there are a range of challenges, strategies and opportunities that HME business owners must consider:

- Audits
- Mobility/Complex Rehab
- Home Access
- Cash sales
- Software
- Oxygen
- Bariatrics
- Sleep

Some represent new market shifts and others are evolving trends. Read our sixth annual Big Ten list to learn more about how these factors could play out in 2013.
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2013 Big Ten

It’s time once again to look at 10 key factors that will define the next 12 months, and this year couldn’t be tougher. As we compile our sixth annual Big Ten the future of competitive bidding and the MPP are both up in the air. That said, HMEB peered through the veil of uncertainty and examined 10 critical challenges, issues and opportunities facing HMEs.

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Round Two of competitive bidding is poised to radically redefine the industry. How will the current political climate impact providers’ efforts to see H.R. 6490 to replace CMS’s bid program with the Market Pricing Program, and how are providers preparing for the Round Two contracts if the MPP bill doesn’t advance in time?

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Viva the Little Guy

The tiny HME industry faces big changes in 2013, but small guys pack a mighty punch.

I write this in the wee hours of 2012, before the dawn of 2013, and the industry’s situation reminds me of a stirring scene from J.R.R. Tolkien’s “The Return of the King”. The world of Middle Earth sits in early morning darkness right before it is about to launch into a battle that could spell the fate of their world. The wise and powerful wizard Gandalf and the little hobbit Pippin stand on the ramparts of a giant city overlooking a massive battle plain. Pippin remarks, “It’s so quiet,” to which Gandalf replies, “It is the deep breath before the plunge.”

That’s the breath the home medical equipment is inhaling at this very moment. Congress is in its Lame Duck session and providers, state and national associations and even patients are working overtime to convince lawmakers to back H.R. 6490, the bill introduced into the House by Rep. Tom Price (R-Ga.) that would replace the Centers for Medicare and Medicaid Services’ competitive bidding program with the industry’s market pricing program.

The strategy is that the Lame Duck Congress is not going to be able to pass the sorts of sweeping legislation that would turn the country back from the so-called “fiscal cliff,” which would implement substantial spending cuts and tax rate increases if the budget wasn’t balanced by the New Year. There is simply not enough time. But, Congress would most likely be able to pass legislation that would address at least some of the major fixable issues over which it still presides before the New Year.

One of those fixable problems is the physician “Doc Fix” that would adjust physicians’ Medicare reimbursement. As legislative items go, the Doc Fix is almost an absolute must, and that means it could be an excellent piece of legislation to which the industry could attach H.R. 6490. So, the focus has been on getting co-sponsors of the MPP bill. As of press time, the industry has scored 80 backers and is still hustling. But time is running out.

Moreover, a factor that has yet to come into play is CMS to release the Round Two bid amounts. Would these bid amounts throw off any scoring for the currently budget neutral MPP bill? That’s tough to say, but CMS’s timing for release of those figures has to at least be partly political, if not entirely. The Centers were slated to release the figures sometime in fall, but mere days before the Winter Solstice lawmakers and the industry are without bid amounts.

Time is running very tight. I hope the industry is able to make some serious progress on Capitol Hill and wheel a deal that secures the MPP. The alternative is too awful to consider. Already providers are having to make tough decisions about care and product quality in the face of other funding cuts. Already we have seen many provider businesses closed up shop thanks to Round One. How much worse could things get if Round Two is implemented in summer? That’s something I don’t want to even consider.

But Tolkien’s stories did contain a theme that resonates with the HME industry: All throughout his stories the true heroes are not the powerful wizards or mighty warriors. They are truly “the little guys.” Half the height of a human being, these little hobbits, who are typically fixated on creature comforts and living blissfully routine everyday lives, wind up saving the entire world. And they do it not through magical powers or some sort of “just in time” fix; the little hobbits do it simply by struggling and slogging along through tough circumstances, knowing that doing so is their duty and hoping that they can pull it off.

If the industry can’t secure the MPP bill’s passage by the dawn of 2013, the industry will still be smacked in the middle of the battle of its life, but that’s not any place it hasn’t been before. Providers will need to take that deep breath, plunge into the fray, and remember that even the little guys can come out on top.
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Industry’s December Lobbying Push Picks up 21 MPP Bill Backers

Concerted industry advocacy effort during Lame Duck session expands ranks of H.R. 6490’s co-sponsors to 80 lawmakers.

The month of December saw considerable industry effort to increase Congressional support for H.R. 6490, the Medicare DMEPOS Market Pricing Program Act of 2012, a bill that would replace CMS’s current competitive bidding program with the industry’s Market Pricing Program. Coming off November’s Thanksgiving push, which brought the bill’s support to 59 co-sponsors, the December effort had garnered another 21 backers by press time, in mid December.

The first half of December’s industry lobbying efforts included a “virtual fly-in” and in-person visits with lawmakers by the National Association of Medical Equipment Providers, a “Jam the Switchboard” effort by the VGM Group Inc.; visits with lawmakers by representatives of the American Association for Homecare and the Accredited Medical Equipment Providers of America; and visits on the Hill by representatives of state associations, including the New York Medical Equipment Providers Association and the New England Medical Equipment Dealers Association.

The 21 additional co-sponsors brings the total number of backers of the legislation, which was introduced into the House by Rep. Tom Price (R-Ga.), to 80 Congress members. New co-sponsors added to the bill were:
- Rep. Gary Ackerman (D-N.Y.)
- Rep. Gus Bilirakis (R-Fla.)
- Rep. Paul C. Broun (R-Ga.)
- Rep. Charles J. “Chuck” Fleischmann (R-Tenn.)
- Rep. Tom Graves (R-Ga.)
- Rep. Ralph M. Hall (R-Texas)
- Rep. Richard L. Hanna (R-N.Y.)
- Rep. Blaine Luetkemeyer (R-Mo.)
- Rep. Howard P. “Buck” McKeon (R-Calif.)
- Rep. Michael H. Michaud (D-Maine)
- Rep. Shelley Moore Capito (R-W.Va.)
- Rep. Chellie Pingree (D-Maine)
- Rep. Robert Turner (R-N.Y.)
- Rep. Paul C. Broun (R-Ga.)
- Rep. Gus Bilirakis (R-Fla.)
- Rep. Howard P. “Buck” McKeon (R-Calif.)
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- Rep. Tom Graves (R-Ga.)
- Rep. Ralph M. Hall (R-Texas)
- Rep. Richard L. Hanna (R-N.Y.)
- Rep. Blaine Luetkemeyer (R-Mo.)
- Rep. Howard P. “Buck” McKeon (R-Calif.)
- Rep. Michael H. Michaud (D-Maine)
- Rep. Shelley Moore Capito (R-W.Va.)
- Rep. Chellie Pingree (D-Maine)
- Rep. Robert Turner (R-N.Y.)

Starting with the November election, the industry was in a November-July race against time to push the bill’s support during the Lame Duck session of Congress, which ended Jan. 1. The strategy was to leverage the fact Congress will likely be working on the so-called “Doc Fix,” which would adjust physicians’ Medicare reimbursement, and would serve as an ideal piece of legislation to which the industry could attach H.R. 6490, given enough support and a budget neutral score form the Congressional Budget Office.

To this end, industry associations called on providers to advocate on behalf of the industry, and to get their patients and other stakeholders involved in the effort, as well.

“We must make every effort to be heard by our Representatives,” read a statement from the National Association for Independent Medical Equipment Providers. “Ask your employees to call as well as anyone else in your circle that understands the importance of stopping this ‘train wreck.'”

“Everyone must take action,” read a statement from the American Association for Homecare. “Call, email, and meet with your members of Congress. Spread the word. Enlist help from colleagues, patients, family, and friends. If you do nothing, you will get nothing.”

AAHomecare encouraged providers to use its online Take Action Center (action.aaahomecare.org) to get the information they need to contact members of Congress. Moreover, it suggested they follow up to thank their lawmaker when the sign on to H.R. 6490 or to remind them you need their support.

The Accredited Medical Equipment Providers of America also encouraged providers to use HR6490PAL, its newly unveiled H.R. 6490 Patient Advocacy Line. Modeled after the American Medical Association’s Patient Advocacy Line, the HR6490 PAL aims to provide a simple way for patients, caregivers and healthcare providers by press time, in mid December.

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Providers can register for a PDF flyer to distribute that explains the problems of Medicare’s current bidding program, the improvements of H.R. 6490 and a toll free phone number to call to ask their Representative to cosponsor H.R. 6490. In the meantime, providers can get more information about the HR6490PAL by visiting www.hr6490pal.com.

How those efforts were to play out by Jan. 1 was unclear as of this issue’s press time, but scenarios on what would occur based on likely outcomes were discussed by AMEPA President Rob Brant in this issue’s “Industry Newsmaker,” which can be read on page 14.

IRS Releases Final Excise Tax Regulations
HME one sector that could get some relief under the tax rules.

The IRS released final regulations covering the 2.3 percent medical device excise tax that are, overall, little changed from the initially proposed tax regulations, but have enough tweaks to offer solid relief for the HME sector.

The most significant change, the investment firm noted, was a broader definition of retail sales included in the retail exemption, which to AAHomecare’s point, could benefit the HME sector. Mizuho stated that it expects most of the medical devices sold by the companies it covers would be taxed, but that CPAP products, such as those supplied by ResMed, might be exempt.

“In general, we expect our large- and mid-cap companies to see their 2013E EPS growth reduced by an average of 4 percent and our small-cap companies to see their 2013E EPS growth reduced by an average of 12 percent,” a statement from Mizuho read, using publicly traded Resmed as an example of the expanded retail definition’s benefit. “[Resmed’s] CPAP products will probably be exempt from the tax. Based on our read of the final regulations, we now believe that [Resmed] will not have to pay the tax on its CPAP products (excluding Apex sauna and V-Pap TX which are not sold to consumers). We had previously thought that only masks and accessories would be exempt but the retail sales changes in the final regulations now make it clearer that flow generators are also likely to be excluded from the tax.”

MPP Gains Another Nobel Laureate
2012 Nobel Prize Winner in Economics lends his support to replace CMS’s bid program with market pricing program.

Alvin Roth, the newest Nobel Laureate in Economics who co-signed a letter to President Obama, asking to replace Medicare’s flawed bidding program in Durable Medical Equipment with legislation detailed in that bill, Roth also co-signed the September 2010 letter to members of the House Committee on Ways and Means.

Well-known competitive bidding critic and proponent of the Market Pricing Program effort University of Maryland Professor of Economics Peter Cramton remarked that Roth’s award adds significant support for H.R. 6490, the bill introduced into the House by Rep. Tom Price (R-Md.) which calls to replace CMS’s competitive bidding program with the MPP.

“Harvard Professor Alvin Roth is now the fifth Nobel Prize winner in Economics who co-signed the letter to President Obama, asking to replace Medicare’s flawed bidding program in DME with a Market Pricing Program,” Cramton said in a statement to the Accredited Medical Equipment Providers of America. “I think it is fitting that he will be giving his Prize Lecture at Stockholm University this week, while the Home Medical Equipment industry is on Capitol Hill educating Congress on H R 6490, the Medicare Pricing Program Act of 2012.”

The recent letter to President Obama, asking to replace Medicare’s flawed bidding program, was co-signed by a total of 244 economists and other experts in competitive bidding and auction design.

“We are economists, computer scientists and engineers with expertise in the theory and practice of auctions,” the letter reads. “In September 2010, many of us signed a letter to Congressional leaders pointing out the
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COPD Awareness Plummet

National understanding of respiratory condition has sunk to 2008 levels, says NIH survey.

While physicians, respiratory therapists, HME providers, and other healthcare professionals have recognized how under-diagnosed chronic obstructive pulmonary disease is, whatever efforts they have undertaken in recent years to spread awareness of the disease have not taken hold.

In fact, COPD awareness has sunk, according to a survey released by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health. The results of a national survey show current awareness levels have returned to those of 2008.

Sixty-five percent of adults reported that they have heard of COPD, compared to 71 percent in 2011. Among people most at risk for COPD, awareness stood at 78 percent and 76 percent, respectively.

COPD, which in 2010 surprised stroke to become the third leading cause of death in the United States, is a serious and progressive lung disease that makes breathing difficult and can affect quality of life. COPD, includes conditions such as emphysema and chronic bronchitis, and has been diagnosed in an estimated 12 million men and women in the United States, with just as many likely remaining undiagnosed.

“Although these current numbers do not indicate a trend, we are concerned that the awareness level has not continued to increase,” said James P. Kiley, Ph.D., director of the NHLBI Division of Lung Diseases. “We plan to use this as an opportunity to mobilize and re-energize practitioners to be both proactive and reactive in the area of audits, appeals, and compliance.”

Kiley noted that the NHLBI plans to engage more with COPD patients, caregivers, and members of advocacy organizations including the American Lung Association and COPD Foundation, and medical societies like the American Thoracic Society. The NHLBI will also work with partners through the COPD Learn More Breathe Better campaign to expand mobilization of local COPD coalitions and state COPD task forces to enhance message penetration and activation at the community level.

In 2007, the NHLBI along with other professional societies, health organizations, and advocacy groups, launched the COPD Learn More Breathe Better campaign to raise public awareness and understanding of COPD. The campaign encourages people at risk for COPD to get a simple diagnostic breathing test and talk to their health care provider about selection of treatment options; the campaign also encourages those diagnosed with COPD to take personal ownership of and responsibility for their overall care and treatment plans.

“Early diagnosis and treatment can go a long way toward improving quality of life for those with COPD, but the first step to breathing better is reporting symptoms to a health care provider,” Kiley said. “That’s why it is so vital that we do more to not only raise awareness of COPD, but also increase public understanding of how COPD can affect daily life.”

COPD most often occurs in people age 40 and older with a history of smoking. However, as many as one in six people with COPD have never smoked. COPD also can occur in people with a genetic condition known as alpha-1 antitrypsin deficiency or through long-term exposure to substances that can irritate the lungs, such as dust or fumes. COPD can be diagnosed with a simple test called spirometry, which can be conducted in a doctor’s office. The test involves breathing out as hard and fast as possible into a tube connected to a machine that measures lung function.

The NHLBI analyzed the results of the annual HealthStyles and DocStyles surveys of public health attitudes, knowledge, practices, and lifestyle habits of consumers and health care professionals, conducted each year by Porter Novelli, the communications contractor for the NHLBI’s COPD Learn More Breathe Better campaign. The latest survey results represent a sample of 4,703 consumers with a margin of error of 1.4 percentage points and 1,000 physicians with a margin of error of 3.1 percentage points. Both surveys were conducted in summer 2012.

The van Halem Group

Audit consulting firm will help OGPA members in audits, compliance, appeals.

The van Halem Group. Professional, timely, and knowledgeable are qualities every consultant should have. These terms describe Wayne van Halem and his team.

The van Halem Group is an audit and consulting firms that helps providers navigate complex issues related to audits, appeals, and compliance. All consultants and clinicians are former Health and Human Services or Medicare contractor employees, so clients benefit from a collaborative relationship with Medicare as well as a unique perspective and first-hand knowledge of the process which results in significant cost savings. Collectively, the leadership of The van Halem Group has more than 130 years of related experience.

“Never before has the orthotic and prosthetic industry been under such intense scrutiny,” said Wayne van Halem, AHFI, CFE, President of The van Halem Group. “It is so important for practitioners to be both proactive and reactive in the area of audits, appeals, and compliance. This partnership will afford OGPA members the tools and resources they need to succeed and thrive in this strict regulatory environment.”

More information about the campaign can be found at www.nhlbi.nih.gov/health/public/lung/copd.

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Mediware Buys MediServe

Healthcare IT acquisition aims to serve up respiratory software solutions to home medical equipment providers.

Healthcare IT software maker Mediware Information Systems has acquired MediServe, a provider of electronic documentation solutions for inpatient and acute care rehabilitation, outpatient rehabilitation and respiratory care facilities.

A statement from Mediware says the acquiring firm plans to leverage MediServe solutions to expand the current focus of the company’s Alternate Care Solutions product line, which was formed to provide workflow, billing and reimbursement support for home infusion, home medical equipment, and home health agencies.

Founded in 1986, MediServe develops software that aims to improve clinical and business workflow while actively addressing regulatory compliance and revenue cycle improvement. The firm’s software products are used in more than 2,500 facilities ranging from hospital networks to outpatient to private practice providers.

MediServe established a reputation in rehabilitation and respiratory care. MediServe leveraged that expertise along with guidance from its leading customers to build cloud-based (SaaS) solution that addresses the industry’s unique workflow, reimbursement and regulatory requirements. Core offerings include the MediLinks suite of products for inpatient rehabilitation, outpatient rehabilitation and respiratory management. Other key products include the SpectraSoft medical scheduling software.

Mediware’s acquisition history includes the 2008 acquisition of specialty pharmacy provider, Hann’s On Software, the 2009 acquisition of Healthcare Automation, and the 2011 acquisition of CareCentric. Together these acquisitions formed the basis of Mediware’s Alternate Care Solutions product strategy, which provides workflow, billing and reimbursement support for care providers that operate beyond the hospital.

“Most analysts agree that the percentage of care delivered outside traditional hospital rooms will continue to increase over the next twenty years,” said Thomas Mann, Mediware’s president and chief executive officer. “To meet these growing needs Mediware has aggressively pursued technologies that improve the effectiveness of these organizations, looking to improve quality and efficiencies, while lowering costs. Our expansion into home infusion, home medical equipment and home health are examples of this strategy.

“Through the addition of MediServe, we expand our focus to include rehabilitation and respiratory care,” Mann added. “MediServe has strong reputation and a blue chip customer base that is consistent with our other product groups.”

Provider C&C Homecare buys Allcare Medical

New firm to be called AllCare Medical, will serve N.Y., N.J. and Philadelphia patients.

New York durable medical equipment C&C Homecare has acquired New Jersey-based Allcare Medical.

The combined company now services patients in the New York-metro, New Jersey and Philadelphia area markets from five distribution centers and three retail locations. Effective Dec. 1, the company will market itself as AllCare Medical.

“We are thrilled to join C&C Homecare and Allcare Medical together to offer patients throughout our expanded service area a full complement of home medical equipment solutions,” said Win Hayes, the firm’s chief financial officer.

Richard Lerner, Allcare Medical’s former owner, will remain with the company as president of the New Jersey Division. Joseph McGovern will assume the role of president of the New York Division, and Stacey Granat will be president of Corporate Development.

“We are excited to join forces with C&C Homecare, which has the resources to adapt to the evolving market for HME while maintaining a core focus on patient care,” Lerner added.
Industry Newsmaker

People in HME

The Church of DME

How AMEPA’s Rob Brant became a home medical equipment evangelist.

Rob Brant has some serious HME religion. Brant got his start in 1993 while working for a South Florida clinical lab, where he met with HME professionals when traveling to physicians’ offices. This led Brant to get into HME, and after a few years he started his own business, City Medical Services, in 1997. He then grew it to several employees working in a 4,800-square-foot facility, one of the larger providers in South Florida, he says.

When Brant heard about the Polk County, Fla. competitive bidding demonstration in 1999, he paid attention to it. In 2003 he got involved in the industry at state level when he learned that competitive bidding was slated to become a national program.

“My goal as CEO is to make sure ACHC is the preferred choice in every market we serve,” Domingos said.

Ball joins VGM Government Relations

Veteran government analyst and political communicator Ryan Ball has joined the VGM Government Relations department to concentrate on public policy issues that affect VGM Group Members at the state legislative level.

Ball has been involved in different facets of government and politics for more than 10 years including state lobbying efforts, campaign consulting and most recently as director of government relations for Orthotic and Prosthetic Group of America, VGM’s orthotic and prosthetic alliance. For the past two years, Ryan has been active in promoting the influence state legislators across the country have on medical providers.

The increasing importance of state Medicaid programs, and new regulations created by the Patient Protection Affordable Care Act, will accelerate over the next few years and we must ensure independent providers are represented in these discussions,” Ball said.

Ball will be working with John Gallagher, vice president-government relations, who noted, “By working with state associations and VGM regional account managers to help identify members who could potentially join state policy ‘freewalls,’ VGM will be better able to organize the complex rehab, O&P and DME industries to lobby for public policy that will positively affect our membership.”

ACHC Names New CEO

Accrediting organization The Accreditation Commission for Health Care Inc. (ACHC) has appointed José Domingos as its new Chief Executive Officer. Domingos will be responsible for setting the strategic direction of the organization, establishing and maintaining strategic relationships and partnerships, and developing and implementing plans to meet ACHC’s growth objectives.

Domingos takes the helm as ACHC is about to complete its move from leased space in north Raleigh to a purpose-built headquarters in nearby Cary, a development the new CEO said reflects the company’s commitment to growth.

Before the ACHC Board of Commissioners named him CEO, José was the organization’s Vice President of Marketing and Business Development where he redefined corporate branding, improved ACHC’s product and service market awareness and identified market segments of opportunity.

“My goal as CEO is to make sure ACHC is the preferred choice in every market we serve,” Domingos said.

MK Battery Appoints Global Director for Solar Batteries

Power mobility device battery maker MK Battery has appointed Bruce Fairbanks as global director of its Renewable Energy Business for the company’s Deka Solar battery product line.

“Bruce has been the driving force behind the success of the Deka Solar brand and it is most appropriate that he now take a leadership position to direct the company’s team of Renewable Energy battery specialists,” said David Brunelle, vice president of Sales.

Roadnet Appoints Vice President of Global Sales and Marketing

GPS fleet management systems provider Roadnet Technologies, which provides vehicle routing and tracking tools to HMEs, announced the appointment of supply chain and transportation industry veteran Michael Farlekas as vice president of Global Sales and Marketing in support of the transportation management software company’s continued growth.

In his new role, Farlekas will assume responsibility for all sales and marketing strategy and operations for Roadnet Technologies. Farlekas brings more than 25 years of experience in transportation, supply chain management, and enterprise software along with significant expertise in sales strategy, channel expansion and driving company growth. Most recently, Farlekas was senior vice president and general manager for RoadPrizm, where over his 12-year tenure he helped grow the company from $40 million to $450 million in revenues. His career also includes senior sales roles with XATX and STI Transportation.

“Roadnet is committed to growing the company, increasing market share and establishing a solid leadership position as the go-to-platform for transportation routing and fleet management,” Roadnet CEO Ken Kennedy stated. “Michael is an industry veteran who will help Roadnet accelerate achievement of these goals, and his leadership will be a valuable asset to employees, customers, partners and investors.”

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Product Spotlight

A Mobility Misfit

With Round Two looming, Invacare has unveiled a group 2-type chair intended for the retail market.

For a while, Invacare’s Pronto Air Personal Transporter was a power mobility device in search of a home; a sort of mobility misfit. Invacare initially started showing the Pronto Air in select demonstrations in 2011, and talked about the chair coming out in the future, but “didn’t have a definitive time and we didn’t necessarily have a plan around the product,” says Julie Jackson, director of Invacare’s Rehab business unit.

Invacare knew it had a compelling product that represented a unique feature set. “However, when you take a look at your standard Group 2 product offering, this isn’t such a seamless fit,” she explains.

Then Invacare figured out the Pronto Air’s ideal niche, and the DME manufacturer’s strategy for the chair finally took shape this year: release the Pronto Air in the fourth quarter of 2012 in advance of competitive bidding Round Two in order to offer providers a product suited to alternative revenue — in this case, cash sales.

“We realized that where this is going to be positioned is for providers that might not be looking for another group 2 chair, but were in competitive bidding,” Jackson says. “As reimbursement continues to tighten, we’re going to find more providers looking for other avenues to grow their businesses, such as the retail market.” That is where the Pronto Air will exist. While offering group 2-type functionality, the chair is not intended for Medicare reimbursement.

“What makes this product truly different, is that we are not going to be coding it,” Jackson says. “This will strictly be a cash sale product.” And that is why the Pronto Air boasts such a distinctive design and offers unique features.

“This is very different,” Jackson says. “If you were to look at any other product in the group 2 segment, you would not find this type of seating and the amount of features and adjustability that [the Pronto Air] has.”

For starters, the product’s My Body styling offers a very sleek, modern design combined with a metallic silver paint job that truly makes the Pronto Air look unlike other group 2 chairs on the market. It is designed to engage the eye in the same way typical retail products are designed.

But it also offers a number of features that are ideal for a product that the patient will own outright, especially when it comes to adjusting and transporting the chair.

Adjustability and Transportability

The Pronto Air is designed to conform to the user as best as possible, and in that regard the chair offers a number of adjustability features, as well as features that let the chair be easily and completely transportable.

The standard headrest comes with a setscrew that allows for tailored height adjustment. Moving down its 21 in. backrest, the Pronto Air features hooks that can accommodate a standard bag that can hold a charger and accessories, and there are mounting points for accessories as well to allow for better personalization.

The fold-down back can be lifted up and then folded straight down onto the chair, and folded back into place without tools. An adjustment knob allows for up to 25 degrees of recline.

Another adjustability feature to the Pronto Air are its arm rests. The arms can be adjusted in terms of height, width, depth and how far the arms angle inward and outward, as well as up and down and in terms of pitch. Some of these adjustments don’t require tools while other require a tool to adjust set-screws.

In terms of transportability, the Pronto Air can be taken apart and put back together very easily. A latch for the seat allows the user or caregiver to release the seat, which weights about the same as a typical captain’s chair, so that it comes straight off. The base disassembles so that the 30 lb. battery packs that are removed with a trigger. This way, using a conveniently located handle, the base, which weighs 70 lbs. without the batteries, can be moved on its wheels.

Other Features

Looking at other features on the Pronto Air spec sheet, the Pronto Air offers a fair mix of power and performance. The real-wheel drive Pronto Air has a top speed of 4.5 mph, and its 12 in. drive tires give the Pronto Air the ability to better travel over outdoor terrain. Also, the Pronto Air’s inline motors are linked so that both motors can be locked with a single control.

The Pronto Air’s weight capacity is 250 lbs. The base measures 23.5 in. wide, and with seat the chair Pronto Air measures 42 in. to 48 in. high. Seat-to-floor height ranges from 21 in. to 25 in. Seat depth measures 18 in. to 20 in.

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Fastrack Introduces Automated CMS Audit Response System

Plainview, NY... Fastrack Healthcare Systems, Inc. has introduced a new automated system that is an effective, secure and reliable method of responding to a CMS audit request. According to Spencer Key, President/CEO of Fastrack, “We are pleased to offer this new technology that will help providers in responding to audits by streamlining their processes for the capture, storage and submission of medical documentation to CMS. The new system for RAC, MAC and CERT audits will virtually eliminate the labor intensive paper processes in responding to the Center for Medicare & Medicaid Services (CMS).”

Fastrack ARS (Audit Response System) integrates with the Fastrack Enterprise System and works best with Fastrack’s Document Storage Module. Providers simply enter the audit number received from CMS and select the documents that they wish to electronically send to CMS in support of their response. Documents can easily be gathered from the Document Storage Module, the file server or any user’s workstation and includes faxed or emailed or scanned documents.

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Over the past few years, CMS has stepped up its pre- and post-payment audits on Medicare claims for HME providers. And it’s often the providers who take more of a wait-and-see approach or think it’ll never happen to them that have the most difficulty with these audits.

When all of a sudden faced with an audit, unprepared providers realize that they’ve been doing it wrong all along and they’re faced with either a significant amount of claim denials or a large overpayment and they have a harder time getting through it. Some simply don’t survive it.

“Hundreds of millions of dollars of contracts have gone out to private companies to do audits for Medicare in the last couple of years,” says Wayne van Halem, CFE, AHFI, president of The van Halem Group LLC, a firm that helps providers respond to and appeal audits. “There’s a significant return on the investment in many cases for auditing, so if they throw a couple hundred million dollars in the program integrity world they expect to see more than a couple hundred million dollars coming back and that means overpayments on providers.”

So will the pace of audits change for the better or worse in 2013? Van Halem predicts the latter.

“It’s hard to believe that they’d get any worse, but I do think they are,” van Halem explains. “And the only reason I say that is because I know that they have received some additional funding and they hired additional staff for a lot of the prior authorization for power mobility, but they seem to have that under control so they have extra staff.”

With that in mind, here are five key steps that providers can take in 2013 to better prepare their businesses for potential audits.

Implement a comprehensive compliance program

The basic elements of a comprehensive compliance program are as follows:

• Policies and procedures that specifically address risk areas that the government has identified — many providers already have policies and procedures because they are accredited, however they may need to expand on them to make sure they address what the government has identified as risk areas for the medical equipment industry.

• Conduct internal audits on a regular basis — either by assigning the task to internal staff or bringing in an external agency.

• Conduct ongoing training and education, not only on compliance issues, but also regarding Medicare changes and policies.

• Provide a mechanism for employees to report suspected concerns — it could be a lockbox, phone number, a hotline, etc., but there has to be some mechanism for employees to report compliance concerns and they have to be able to do so anonymously if they wish.

• Select a compliance officer and set up effective lines of communication, meaning they not only feel comfortable going to the compliance officer, but they have mechanism which to report. Employees need to see a consistent message of compliance and providers need a process in place to respond promptly to any detected potential offenses.

The comprehensive compliance program is a mandatory requirement as part of the Affordable Care Act, however there hasn’t been a deadline identified for complete implementation, which means providers can set it up at their leisure.

“Since it’s not a mandatory requirement yet, they can certainly at least implement aspects of it and get the process started,” recommends van Halem. “The government has made it pretty clear that they want to only do business with the most compliant of organizations. That’s why they keep coming out with all these programs such as competitive bidding, surety bonds and accreditation and now these intense audits. A compliant company is one that has a comprehensive compliance program.”

Analyze and understand your data

Sometimes providers fail to realize when there are spikes in billing or when there are certain product categories being billing higher level codes at a higher percentage than the lower level codes when Medicare expects to see it the other way around. Conducting regular internal data analysis can help spot red flags like these so if your business becomes the focus of an audit, you’ll be able to quickly respond to it based on your knowledge of the data.

“Ninety-five percent of government audits are done as a direct result of data analysis, and they’re analyzing the data that the suppliers send them, yet most suppliers aren’t being very efficient in analyzing their own data and understanding what it looks like,” van Halem says.

van Halem has noticed that some providers don’t really know when there is an issue with claim denials or when there are issues such as a single physician accounting for an overwhelming majority of referrals.

“I think having a good idea of what your data looks like and having someone that’s responsible for monitoring that on a regular basis, so that they see when something looks different, that’s how Medicare chooses the focus of their audits, so you’ll know that,” he says. “It could be a perfect explanation for it, but you still have to be able to prepare.”

Use technology to help streamline your audit response process

Today’s software and imaging systems often allows providers to pull the images they need easily and send them in to Medicare. Still, some systems make it difficult to find what you need, so having an imaging system that’s able to keep everything in order based on claim is vital.
“If they (Medicare) say we want the documentation to support this claim on this date of service, you know how to get it very easily, and you're only providing information regarding that,” explains van Halem.

Streamlining the process to transmit, such as using ESMD (electronic transmission of medical records) instead of sending medical records hard copy in a box via FedEx, can shave weeks off the response time.

“We transmit them electronically for our clients and what we see in doing that is we get quicker responses,” continues van Halem. “The submissions are more accurate, and normally when you're sending a response back to Medicare for an audit, it's taking them 30 to 40 days to render a decision, but when we send it electronically we're seeing those decisions come back in 10 days.”

“If they (Medicare) say we want the documentation to support this claim on this date of service, you know how to get it very easily, and you're only providing information regarding that,” explains van Halem.

“Ninety-five percent of government audits are done as a direct result of data analysis, and [auditors are] analyzing the data that the suppliers send them, yet most suppliers aren't being very efficient in analyzing their own data and understanding what it looks like.”

— Wayne van Halem
The van Halem Group

**Compliance from the top down**

Also recommended by van Halem is ensuring that management is involved in all of the key aspects of the audit process, as the ownership is directly impacted when an audit comes along.

“If you're going to accept money from the government, you have to play by their rules, whether you like them or not, and making sure that compliance is an absolute commitment from the most senior level management down so that your employees share in that commitment, I think will benefit your company greatly,” he says.

**Be proactive**

For providers, it's much more cost effective to be proactive about audits.

“Most folks, if it's pre-payment, they see a significant number of denials, which has a significant impact on their cash flow,” explains van Halem. “And if it's post-payment review the government is really going after these extrapolated overpayments, meaning they extrapolate the percentage of claims that they denied in the sample to your entire universe of claim, and we've seen $4 million overpayments and, for most companies, that's a significant problem.”

The next option is go to the appeal process and try to correct the problems that were made, get additional documentation and work with someone who has been through the process before to help you through it.

**I’m an EP!**

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Our sixth annual look at 10 key trends, challenges and opportunities that will define the next 12 months for HME providers.

Here we are again, at the start of the New Year, and another difficult-to-divine 12 months of trends that will impact the HME industry. While it’s always a gamble trying to predict how the year will play out and which trends will factor into providers’ businesses, there are some sure bets.

And for 2013, *HME Business* is putting its chips on the following 10 issues owners and management of HME provider business should be monitoring and planning for this year:

- Competitive Bidding
- MPP
- Audits
- Mobility/Complex Rehab
- Home Access
- Cash sales
- Software
- Oxygen
- Bariatrics
- Sleep

So, this being the sixth installment of our annual Big Ten list, let’s dive in and examine why and how providers should be planning for these issues and opportunities.
Competitive Bidding Round Two

Competitive bidding represents the biggest change the industry faces for the coming year, but it also represents the biggest change that might or might not happen. Depending on whether or not the industry can save itself from the Centers for Medicare and Medicaid Services’ bidding program via the Market Pricing Program (MPP; see “Market Pricing Program” to read more about the factors impacting that), competitive bidding Round Two will either recede into fading memory as the industry’s narrowly averted nightmare scenario, or it will be a grim new reality that will radically alter the HME landscape in negative ways.

As it stands, the industry and 240 economic experts including Nobel Laureates have told CMS, Congress and the President that competitive bidding is a bad system that will limit patient access while shuttering businesses. In Round One, which only covered nine competitive bid areas, approximately 400 provider businesses have closed. The Patient Protection and Affordable Care Act expanded Round Two to 91 competitive bid areas, essentially taking the program national for all intents and purposes. As for the timeline, bids closed back in March 2012; CMS was supposed to have released the Round Two bid amounts for Round Two by the time you read this (but as of press time had not done so); the bid winners get announced this spring; and the program is slated for implementation in July.

Of all the sure bets in terms of which factors will affect 2013, Round Two sits at the top. Of course the industry’s hope has been to stop the program, but if providers don’t accomplish that, then they are whistling past the graveyard. The onus is — and has been for some time — to develop and implement the sorts of business plans that will help ensure they can continue to survive and thrive if they lose an entire category of business. If providers can accomplish that, they just might have charted a course to “surthrival,” and if the industry is able to replace the program with the MPP, then they will have additional revenue streams in which to expand their businesses and better serve their patients.

Market Pricing Program

Speaking of bets, the industry is holding a pretty good hand in the fight against competitive bidding: The MPP. Leveraging the input of well-known...
2013: The Year Ahead

Big Ten

cOMPETITIVE BIDDING critic University of Maryland Economics Professor Peter Cramton and his host of 240 auction theory and economic experts, the industry developed a bidding model that addresses multiple issues with competitive bidding, creates a system that is fair and doesn’t shutter businesses. Then the industry developed legislation to advance the MPP.

Rep. Tom Price (R-Ga.) introduced H.R. 6490, the Medicare DMEPOS Market Pricing Program Act of 2012, into the House in September 2012, and the bill would replace CMS’s competitive bidding program with the industry’s MPP. The bill proposes an auction model with some key industry-preserving features:

• Bids are binding for the bidders and cash deposits are required to ensure that only serious homecare providers participate.
• The bid price is based on the clearing price, not the median price of winners.
• The program includes the same equipment and services as the current bidding system and would be implemented across the country during the same timeframe. These categories are oxygen, standard power wheelchairs, manual wheelchairs, enteral nutrition, CPAP, hospital beds, walkers, diabetic supplies, negative pressure wound therapy and Group 2 support surfaces.
• Two product categories per market area would be bid. Eight additional product categories in that same area would have prices reduced based on auctions conducted simultaneously in comparable geographic areas.

Last month saw concentrated industry effort to increase support for H.R. 6490 during the Lame Duck session of Congress, which ended Jan. 1. The strategy was that Congress wouldn’t be able to truly address the “fiscal cliff” in its entirety, but it would work on related legislation that would most likely include the so-called “Doc Fix” to adjust physicians’ Medicare reimbursement. If so a Doc Fix would be the perfect legislation to which the industry could attach H.R. 6490.

How the industry’s strategy will have fared is up in the air at press time. As this is written, 80 lawmakers have co-sponsored the bill (read more in “News, Trends & Analysis,” page 8). If the industry succeeds, providers will all breathe a communal sigh of relief and begin building business strategies to operate under the new program once it is implemented. If not, then they will continue to wage the fight of their lives to somehow get H.R. 6490 passed before competitive bidding implementation, if that is indeed possible. No matter how the dice fall for the H.R. 6490, the MPP will clearly be a factor for the industry over the next 12 months.

Audits

Even if competitive bidding goes away and the MPP is ushered in, providers still have other tough funding hands to play. At their fore is CMS’s ramped-up pre- and post-payment audit program. Audits represent an industry trend where the house seemingly always wins.

In the fiscal year of 2010, CMS invested $311 million in its program integrity, which was a 50 percent increase from 2009’s outlay. In 2011, providers felt the effect of that investment in a bad way. Claims dating back to October 2007 were subject to recoupment, and providers facing pre-payment audit could have 100 percent of their incoming claims reviewed before payment.

There are three main types of audits plaguing providers:

• Recovery Audit Contractor (RAC) audits are post-payment audits, which detect overpayments and underpayments for claims that go back three years from the date the claim was made, stopping at Oct. 1, 2007.
• Comprehensive Error Rate Testing (CERT), which are post-payment audits that randomly select a sample of approximately 120,000 submitted claims, and request medical records from providers who submitted the claims.
• Zone Program Integrity Contractor (ZPIC) audits, which are part of CMS’s Benefit Integrity Audits, are aggressive pre-payment audits that identify and prevent fraud, waste, and abuse of incoming claims. These can even result in the ZPIC auditors referring some cases to law enforcement agencies.

CMS estimated it would recover $10.4 billion in 2012, and crowed that fact to a Congress desperate to save any and all taxpayer dollars. It was a good story to tell until it became clear that the ramped up audit effort was absolutely flooring providers that couldn’t get out from under mounting audit documentation requests. Moreover, it started ringing hollow when providers were seeing as high as 60 percent of their audits being overturned when brought to appeal. This overturn rate points to poor process, and one of the many complaints about the way audit contractors are conducting the audits is their loose interpretations of Medicare rules and regulations.

Industry groups such as the American Association for Homecare have been working with CMS to try to reign in the audits and create a better process that doesn’t paralyze providers. The efforts are ongoing, but in the meantime providers will continue their efforts to improve their documentation processes during 2013, as they have been doing in 2012. From implementing document imaging systems to improving the ways they ensure patient documentation from referral partners will make auditors’ grade, you can bet this will be a “work in progress” over the next 12 months.

Power Mobility & Complex Rehab

The past year saw mobility providers work through the transition to rental when the first month purchase option, but they’re not out of the woods, yet. This year, many factors are poised to impact the category. For starters, power mobility is a key category in competitive bidding. While complex rehab was carved out of the program, the program will affect standard power mobility providers and users. That said, while those users are very vulnerable to the ill effects of the bid program, they are also high visible voices in industry advocacy efforts and could greatly benefit the industry’s efforts behind H.R. 6490.

Another big issue facing mobility providers is the fate of Medicare’s complex rehab benefit. There has always been an effort to break off competitive bidding from the rest of the power mobility benefit altogether, because its patients have extremely complex needs, and the equipment and services that help them are highly specialized. To that end, the industry has legislation, H.R. 4378, the Ensuring Access to Quality Complex

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Rehabilitation Technology Act of 2012, which was introduced in the House by Rep. Joseph Crowley (D-N.Y.). Clearly, complex rehab providers and related stakeholders will be working on that effort during 2013, but the question is how concerted will the industry’s efforts be to back the bill, when it is also working on H.R. 6490, which is a much more far-reaching piece of legislation that protects a larger portion of the industry? How this plays out over 2013 remains to be seen.

Another key issue will be CMS’s prior authorization demonstration project for power wheelchairs and scooters. This is happening in seven states, California, Illinois, Michigan, New York, North Carolina, Florida and Texas, and runs until Sept. 2015. All in all, this is a positive development. The demo aims to put into place the sort of program that providers have wanted; something that outlines specific documentation requirements and instructions for power mobility claims to ensure no documentation snags will hold up the approval and funding for power mobility claims. So far, the results of the project have been generally positive, but there have been hitches. The goal for the industry during 2013 will be to help steer this project to ensure the resulting program works effectively.

Oxygen

Oxygen providers represent the industry’s salty veterans when it comes to dealing with funding cuts. They survived the transition to the 36-month rental cap. They endured the 9.5 percent funding cut due to the Medicare Improvement for Patients and Providers Act. They have also spent the last two years learning how to live under CMS’s onslaught of audits. And currently, they are gearing up for whatever competitive bidding Round Two (or the MPP) will bring. If anything they are the industry’s wizards of reinvention.

To combat their massive funding cuts, oxygen providers leveraged a combination of portable oxygen innovations such as portable oxygen concentrators and home filling systems to convert to a low- to no-delivery business model, along with a massive overhauling of their business models and operational processes and structure to drive out overhead and costly inefficiencies. The result, they were transformed into leaner, meaner survival machines.

But this wasn’t without cost. As oxygen providers approach 2013, they are realizing that they risk losing touch with the clinical care side of their business, which is probably their strong link with patients to ensure optimal outcomes. That’s a concern as outcomes-focused referral partners such as accountable care organizations loom on the horizon. This year will see outcomes-focused referral partners such as accountable care organizations. That’s a concern as outcomes-focused referral partners such as accountable care organizations loom on the horizon. This year will see transitions for 2013 will be home access. For the past two years or so, there has been an effort by organizations such as the VGM Group Inc.’s Accessible Home

Cash Sales

Of course, we can’t talk about diversifying revenue streams without talking about cash sales. For several years, HMEB and other industry resources have been continually banging the retail sales drum as a way to expand incoming cash flow. We’ve discussed why providers need to do it; what they need to do from an operations standpoint; how they need to add retail sales and marketing expertise to their teams; and they need to approach the fine art of merchandising within their stores.

But after five years, providers need to start learning some graduate-level retail sales lessons. As some of the retail sales veterans begin to share their insights with the their provider peers, we will see providers more sharply hone their cash sales games over the next 12 months. In short, 2013 is the time when true retail competition will begin to heat up.

Software

From HMEB’s start, we have pointed to HME software systems as the pivotal tool for making massive changes in their business operations and strategies. Software systems and related technologies such as GPS have given providers operational efficiencies that have helped them radically reduce overhead, while also serving up business intelligence that has helped providers effect massive strategic shifts in their business plans.

And once again, software will serve as a lynchpin in 2013. From new document management tools to better handle auditor requests, to creating systems that will help them automate their patient interactions in nuanced ways that do not spoil the provider-patient relationship, software will remain a key player. The question is how will it adapt to rapid shifts? For instance, if the industry sees success with H.R. 6490, will software makers be able to serve up the tools that help providers succeed in the new system? Time will tell, but given the industry software firms’ track record for quick responding to new shifts in the HME environment, providers needn’t worry.
Bariatrics
While we wished to say otherwise, America continues to wrestle with its obesity epidemic. Adults with a body-mass index of 30 or more are considered to be obese, and in January 2012 the Centers for Disease Control reported that more than one-third of adults (35.7 percent) and almost 17 percent of youth were obese in 2009–2010.

The CDC also found that there while there was no significant difference in prevalence between men and women at any age, adults aged 60 and over were more likely to be obese than younger adults. Among men there was no significant difference in obesity prevalence by age, but among women, 42.3 percent of those aged 60 and over were obese compared with 31.9 percent of women aged 20–39. The upside is that the CDC reports that the rate of obesity appears to be plateauing.

In terms of impact, obesity is accompanied by a number of possible co-morbidities, such as including hypertension, adverse lipid concentrations, and Type Two diabetes. Ultimately, according to at least one study, obesity leads to the deaths of 300,000 Americans each year.

This means providers will continue to serve bariatric patients with a variety of services ranging from bath safety to support surfaces to diabetic products through 2013. One can only hope that the country will someday be able to reduce the rate of obesity.

Sleep
Sleep should see a tumultuous 2013. The last year was challenging for sleep given the audit environment and the consolidation of insurance networks, as well as the frustration providers felt over the implementation of DOT rules regarding mandatory screening for OSA for certain professional drivers, the criteria for which were published and then revoked early in the year. Now, providers are gearing to see Medicare reimbursement rates decline significantly in 2013 due to Round Two competitive bidding.

Because of that, sleep providers will need to continue on reducing their operating costs while trying to maximize their re-supply businesses. Technology, such as HME software, will be critical in these efforts. Also, in working with private payor insurance, home sleep testing will grow increasingly appealing for HME providers. As those payors require pre-authorization for in-lab testing, home sleep testing is becoming an increasingly accepted method for that authorization. Sleep providers must monitor this trend and capitalize on as it gains momentum over the coming months.
With the implementation of competitive bidding Round Two looming, HME providers are left to contemplate the many unresolved issues plaguing this controversial and industry-changing CMS program.

In spring of this year, CMS will announce bid-winning providers and start educating them, referral partners and beneficiaries on how the program will proceed. In July, CMS plans to implement Round Two of the program. In the meantime, providers search for answers regarding what to do if they win or lose bids. And, if needed, whether there is enough time to turn to a contingency plan.

As this issue goes to press, the industry is working overtime to attach H.R. 6490, a bill that would replace competitive bidding with the industry’s Market Pricing Program (MPP), to legislation being passed by the Lame Duck session of Congress, which will have come to a close Jan. 1. The MPP takes into account various recommendations made by the more than 240 economic experts in auction models — including Nobel laureates — who have been led by Prof. Peter Cramton of the University of Maryland. The MPP creates an auction structure that gives CMS the price competitiveness it seeks, while not forcing HME providers to go out of business by awarding contracts to single providers.

How that legislation will progress if it does not make it out of the Lame Duck Congress will remain to be seen, but providers must plan for the worst case in the meantime. With Round Two contracts getting announced in Spring, and the program slated for July implementation, they must have a plan in place.

Provider concerns

What to do next is heavily influenced by the particular concerns competitive bidding has instilled in providers. And on most providers’ minds is the ability to provide patients with a high standard of care.

“I believe that patients are unaware of what is coming,” says Robyn Parrott, RRT, president of Sleep Solutions Inc. “We have been trying to educate them over the last two years but I believe they will be caught blind-sided. Competitive bidding will have ill-effects and I hope this doesn’t impact my staff in regards to having to make employee cut backs. We will have to do more and get paid less.”

Georgie Blackburn, vice president of Government Relations and Legislative Affairs for HME provider business BLACKBURN’S, says that
provider choice has always been a treasured option for patients and that it is what drives excellent service. When patient choice is severely diminished, the patient loses. She also has concerns regarding the expanded areas and expanded list of products for Round Two.

“We’ve had access issues and more than 400 business closings in Round One with only nine MSAs involved,” she says. “We’re adding 91 more to that in Round Two. The expansion is massive in all respects. This will lead to more consolidation, more business closings. With the Medicare demographic greatly expanding over the next decade and beyond, having fewer providers to service more patients will result in continuity of care and access problems for patients.”

As a result of competitive bidding, Parrott has been diversifying Sleep Solutions’ offerings along more non-CMS-involved lines. They have solidified their current accounts so that if they are not awarded the bid their accounts will still use their services.

“The HME community has to face reality,” Parrott says. “Competitive bidding is on the horizon and if by some chance, MPP would pass instead, it still means cut backs. It still means the way we do business will forever change. You will either embrace the change and hopefully be a survivor or possibly end up closing your doors. What’s the saying? ‘When one door closes, another one opens.’ It is your choice whether to walk through it. Companies needed to be proactive some time ago, not reactive now. It’s too late if you haven’t been taking this seriously.”

One of the problems Parrott points out is that it’s hard to tell how Sleep Solutions will be affected if it doesn’t win a bid. She says they might have more referrals but at a much reduced rate. She is unsure if her company can provide the same level of service as it provides today and wonders how all the competitive bidding requirements can be met at a reduced rate. Parrott employs two full-time staff members to monitor compliance and hopes that in a post-Round Two world, her company will be able to afford this.

Blackburn suggests that for providers winning a contract, and with median pricing in place, the first step is to carefully analyze if the bid award is below what was bid. If not, she says to give serious consideration to accepting it. If a provider doesn’t win a bid, Blackburn calls it “a limbo situation.” She believes companies must adopt a pro-active framework with respect to new areas of business, new ways of doing business and reducing dependency on third-party payers. Niche areas should be on the drawing board.

MPP: A glimmer of hope
The industry’s attempt to improve the way that Medicare pays for DMEPOS benefits is called the Market Pricing program (MPP), a bill (H.R. 6490) now in committee.

“The HME community has to face reality. Competitive bidding is on the horizon and if by some chance, MPP would pass instead, it still means cut backs. It still means the way we do business will forever change.”

— Robyn Parrott, RRT, Sleep Solutions Inc.

**Round Two Reactions from VGM Membership**

Mark Higley, vice president of Development for the VGM Group, recently polled VGM members about Round Two of Competitive Bidding. From main concerns to what they’ll do if they get/ don’t get a contract, here are words of advice from industry peers. VGM’s queries generated some thoughtful and thought-provoking replies:

**What concerns you most about Round Two?**

- Competitive bidding will drive some HMEs out of business, significantly impact the ability of others to make debt payments, reduce HME profit margins and thus lower enterprise values of HMEs. Lower profitability of HMEs and increased financial risk will likely reduce capital flow to HMEs by raising their cost of capital. Capital is required to innovate and improve — with less capital attracted to HMEs, HMEs will be slower to innovate and prone to take fewer risks. HMEs will be forced to offset lower pricing by reducing labor costs and lowering wage rates, resulting in lower-trained employees, higher error rates and lower quality of care for patients.
- Competing with providers from outside my market with no overhead or patient commitment.
- Winning a contract at a price point that I can afford to provide appropriate patient care.
- That providers made suicide bids after the Round One rebid and feel that they must bid lower than that amount to get in the bid. This is a result of them witnessing the number of businesses that have sold or closed during Round One.

**What should providers be doing now to compete in a post-Round Two HME industry?**

- Obviously you need to streamline their operations. The art of efficiencies is the key to reducing your costs, and will ultimately allow you to do more with less and for less. Just-in-time inventory is critical to manage your cash flow and your inventory. Determine the needs of your customers or referrals, a product or service out there that they need, and provide it for them. CPM machines have been a great new product line for us, and it was out of the need from one of our referral sources that we decided to add that to our service line. It does not cap out, so you keep your asset and it does not require respiratory therapist to manage the patient, and it did not fall under the competitive bid product lines.
- We are doing some diversification of business and looking at also adding some new features to our business (sleep transportation, sitter service, and online retail store).
“We’ve had access issues and more than 400 business closings in Round One with only nine MSAs involved. We’re adding 91 more to that in Round Two. The expansion is massive in all respects. This will lead to more consolidation, more business closings.”

— Georgie Blackburn, BLACKBURN’S

According to John Shirvinsky, executive director of the Pennsylvania Association of Medical Suppliers, MPP creates a state-of-the-art auction system that addresses concerns that have been raised by economists who say that the existing program is flawed because it creates fundamentally anti-competitive markets. It also addresses concerns of auction experts who say the CMS design is flawed and violates every rule of auction design. Finally, it addresses the concerns of the ultimate experts on the HME industry — patients and industry practitioners — and addresses the problems with markets that are just too large to ensure proper patient care and low-ball bids that result in unsustainable pricing.

Key components of MPP, as described by Jay Witter IV, vice president of Legislative Affairs for the American Association for Homecare, include:

- MPP includes the same DME items as the current bidding program and is implemented across the country in the same timeframe.
- In market areas subject to auctions, two product categories are auctioned per geographic area.
- Eight additional product categories in those same areas would have prices adjusted based on auctions conducted simultaneously in comparable geographic areas.
- In areas not subject to auction, prices will be adjusted for all 10 product categories, and any qualified supplier may provide those items.
- Bid areas are smaller than metropolitan statistical areas (MSAs) and more homogeneous.
- Bids are binding and cash deposits are required to ensure only serious bidders participate.
- The bid price is based on the clearing price, not the median price of winners.
- The same areas that are exempted under the current bidding program will be exempted under MPP.

Reactions continued from page 27

- We are also opening up smaller branches in non-competitive bid areas to help make up some of the loss revenue potential.
- We are reducing our Medicare business and we might walk away from certain Medicare product lines. Medicare is turning into the Kmart of healthcare. Who wants their healthcare from Kmart?
- We have been focusing for over a decade on diversification in our current space: (1) geographic — locations outside of Round One or Two; (2) payor — contracts with third-party payers and our state Medicaid; (3) product niche — maybe retail or other specialty; and (4) products like Homefill and other non-delivery products.
- Get very lean, and develop non-Medicare payers and products, plus geographically expanding away from Round Two CBAs.
- Shore up all and every facet of your business. Nothing is too trivial or unimportant to not analyze.

What should providers do if they get a contract?

- You need to wait until you know what you will be reimbursed before you market the contracts; you may not want that business. However, if the pricing is sustainable you want to market the contract.
- Evaluate if you should walk away or if the loss-leader approach of serving Medicare is worth it.
- Market the contract aggressively to gain more market share. Pray, as well!
- Work with referral sources to program the most efficient way to move patients from facilities to homes.
- If you have any margin at all, look at the incremental gross margin and make the most of it.
- Analyze the bid numbers. If they work then market, market and market.
- Review it carefully and make sure that you are not accepting something that is not profitable. The contract offer will most likely be less than what you bid. After implementation, accept new Medicare patients only after you have adequate documentation of the medical records showing medical necessity.

What should providers do if they don’t get a contract?

- It seems many are waiting and not doing anything until they hear if they won. Is there even time to implement contingencies if they wait until bid winners are announced? They should have been meeting with their referral sources and building that relationship on service and quality and explaining what will happen if they don’t get the bid. They are the same strong, reliable organization with or without the bid and it will not diminish the quality of service that they can continue to provide their patients who have other coverage than Medicare.
- I don’t think you can have a contingency plan unless you plan to purchase a winning company. If you don’t get a contract, I believe you will really have to modify what you are currently doing if you are greater than 20 percent Medicare. And if you haven’t started, then it’s probably too late.
- Because of our 10-year preparation plan, we believe that we are in good shape with or without a contract. With a contract, we will build slowly and make sure that we can deliver products and services profitably. Without a contract we will reduce some of our staff as we focus our services to our ‘winning niche areas.’
- They should be looking to diversify in any direction they can. Time is of the essence but later is better than never.
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“The ability to get [H.R. 6490] passed has little to do with the so-called ‘fiscal cliff,’ the budget, the national debt. It has almost everything to do with the size of our lobby and our lobby efforts.”

— Wayne E. Stanfield, NAIMES

Where the bill sits

“The chances of MPP legislation being passed in the lame-duck session is very low, 10 percent,” says Wayne Stanfield, president and CEO of the National Association of Independent Medical Equipment Suppliers (NAIMES). “The chances of MPP passing next year before the go live date is also slim, 25 percent. Unless we can get 218 co-sponsors.

“The bill is in Committee and will remain there unless we have a ground-swell of co-sponsors. The ability to get it passed has little to do with the so-called ‘fiscal cliff,’ the budget, the national debt. It has almost everything to do with the size of our lobby and our lobby efforts.”

John Gallagher, Vice President of Government Relations, VGM Group, says the chances for MPP to be passed before Round Two is implemented are good, but like Stanfield, Gallagher says it needs providers’ help.

“We need all providers out there contacting their members of Congress to get maximum support of H.R. 6490,” he says. “The best chances for this to happen this year is if the language of H.R. 6490 is included in a larger bill during the lame duck. One of those bills could include the ‘fiscal cliff’ agreement, the ‘doc fix,’ or an omnibus bill. If Congress is bipartisan support and enough noise is created about the MPP, the chances of it passing this year are greater.”

According to Gallagher, the bill currently has 31 co-sponsors. Senate members have indicated that they are watching this bill very closely to see how much support it gains in the House. Gallagher says that Rep. Tom Price, M.D., who introduced the bill, has indicated that the industry needs at least 100 co-sponsors signed on to get any movement of this bill.

“Providers need to persist and urge their representatives to sign on,” says Gallagher. “We especially need to focus on the Congressmen who signed on to H.R. 1041, the bill that would have repealed competitive bidding, to sign on to H.R. 6490. We have heard from several providers that many of the Congressmen who had signed on to H.R. 1041 are waiting to see if other H.R. 1041 co-sponsors will support H.R. 6490. This is an unacceptable answer. Once again, providers need to insist their representatives support this bill.”

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The proliferation of oxygen generating portable equipment (OGPE), such as transfilling cylinder systems and portable oxygen concentrators (POCs), has been advantageous for both providers and patients alike. For patients, POCs greatly expand their ability to get around, even flying on airplanes, without having to wrangle heavy tanks. For providers, non-delivery and retail oxygen sales buoyed by demand for POCs have respectively become ways to slash delivery overhead, and to diversify their payer mix to be less dependent on Medicare in the future. Participating in POC retail sales gives oxygen providers the opportunity to offset Medicare reimbursement changes, improve cash flow and gain experience with the various POCs available today.

On the non-retail side of the industry, oxygen providers serving Medicare patients need to be aware of the industry’s growing frustration with audits, which have oxygen claims firmly fixed in their sites. NHIC Corp.’s recently published results of a widespread prepayment review of claims for oxygen and oxygen equipment (HCPCS E1390, E0431 and E0439) in Jurisdiction A says that out of 818 claims submitted by 357 suppliers, the charge denial rate was 46.7 percent. In another example in Jurisdiction D, Noridian Administrative Services reports that the results of a review of the claims for oxygen concentrators, code E1390, identified 4,783 claims of which 3,501 were denied. This is a denial rate of 74 percent.

**Oxygen Product Solutions**

**By Cindy Horbrook**

**Lightweight Alternative**

**AirSep Focus POC**
- FAA-approved for air travel and provides 25 patients an alternative to heavy oxygen equipment.
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- The POC is packaged with a carry-all case, which enables all accessories for plugging in at home or in an automobile.

**Supplemental Battery**

**XPO2 Portable Concentrator**
- Named for its extreme portability, the device is lightweight, clinically robust and easy to operate.
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- Approved for in-flight use by the FAA, the device encourages mobility, travel and independence.

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**OxySafe Cannula Valve**
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- Features quick installation and helps keep patients safe no matter what method of oxygen delivery they use.

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Medtrade Spring is the first major HME event of 2013 and is moving to the beautiful Mandalay Bay Convention Center. Come surround yourself with products from leading as well as up-and-coming manufacturers and network with thousands of providers who share your same concerns, yet are optimistic about what lies ahead for those ready to tackle the changes and adopt a new way of thinking. Now more than ever it is important to meet with your suppliers and other providers to share ideas, struggles, victories and be inspired.

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Upcoming Industry Events

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California Association of Medical Product Suppliers Annual Convention
http://www.campsone.org/

March 1-2
National Sleep Foundation: Sleep Health & Safety 2013
http://www.sleepfoundation.org/event/sleep-health-safety-2013

March 19-21
Medtrade Spring
http://www.medtrade.com/medtrade-spring/

April 17-19
Midwest Association for Medical Equipment Services Spring Convention & Exhibition
http://mames.site-ym.com/

May 9-10
Pennsylvania Association of Medical Suppliers Annual Convention
http://www.pamsonline.org/

May 22-23
American Association for Homecare Washington Conference
http://www.aahomecare.org/

May 30-June 1
2013 CSRT Educational Conference and Trade Show

June 1-5
SLEEP 2013
http://www.sleepmeeting.org/

June 10-13
VGM Heartland Conference
http://www.vgmheartland.com/

June 19-14
Annual RESNA Conference
http://web.resna.org/conference/index.dot

Oct. 8-10
Medtrade 2010
http://www.medtrade.com/medtrade/
The New Guys in Washington

The 113th Congress now sits on the Hill. How should you work with them?

The election is now over and the first session of the new, 113th Congress will include a large crop of freshmen lawmakers. Just as I wrote after the 2008 election, educating and influencing these newly elected Representatives and Senators is critical to changing public policy for the DME industry. That's where you, the supplier, come in. Regardless of what happened in the last weeks of 2012, DME will continue to be in the crosshairs of Congress and CMS.

As an industry, we must ensure that DME is a part of the future of U.S. healthcare, and that can only be realized if the supplier community gets involved. Not just the stalwart owners and stakeholders must be engaged, but also the rank and file supplier owners and managers who make up the thousands of suppliers that serve millions of patients in their homes. Not a single supplier owner can afford to wait for someone else to be his or her advocate.

Strike While the Metal Is Hot

With the new Congress beginning its work on legislation that will be passed in the first 100 days, some suppliers have one unique opportunity to make a difference: There are 84 new Representatives and 12 new Senators making up the freshman class of 2013. A few of these are veteran lawmakers assuming new roles, but most are fresh faces that have yet to be pulled fully into the Washington establishment.

If one of these newly elected legislators happens to be yours, you can't afford to waste any time. Among these new members of the House and Senate could be several champions for DME and home care. This is an impressionable period for new members as they get settled in and complete their orientation. While it will take a little time and some resources to reach them, the result could be well worth the effort.

Here are some ways to engage freshmen legislators and influence their perception of the DME industry:

- Make friends with staff. As soon as a Chief of Staff, Legislative Director, Health LA, and Scheduler has been put in place, get their names and begin to introduce yourself to them, by phone or email. Although many of a new legislator’s staff hires will be experienced old hands in Washington, they are still new to this new lawmaker and will be guiding his or her political positions. Getting to know them will be a critical part of your advocacy efforts.

- Since the real power of your efforts will be at home, make friends with the district office and find out how they can support your relationship. The local staff has the ability to direct information and documents to the member quickly and this will aid your cause. Get to know the people in the district office, since they will be your path to the lawmaker.

- You must learn all you can about them. Nothing will impress these new legislators more than you doing your homework about their positions, goals, and ambitions. Showing them you are interested in their issues in your first meetings will encourage your relationship. Not only learn about their connections in Washington, but also discover any connection they may have to the industry and other local politicians you may know personally. Visit this site for information on your new lawmaker: http://nationaljournal.com/congress-legacy/see-new-senators-and-house-members-of-the-113th-congress-20121106

- You are the expert in your field so offer them your help. New legislators and their staff are swamped with tasks. They need assistance in understanding the issues. Offer them your insight and expertise. Keep them informed by sending talking points, white papers and studies supporting the issues.

- Become an Asset and Build from There

You must be patient. Building a relationship with a member of Congress is like running a marathon, not a 100-meter sprint. Starting early means you get ahead of the gatekeeper system before it is in place. Being a valuable friend will aid in winning their confidence.

- We must not take our ability to influence public policy lightly. It is certain that we cannot affect change unless we are willing to get involved. Use these techniques to help build a relationship that will allow you to become your own lobbyist and be an effective advocate for your business and the industry.

- Also, if your Representative or Senator won reelection, don’t take that for granted either. You can always use these same techniques with them to improve your relationship.

Wayne Stanfield is president and CEO of the National Association of Independent Medical Equipment Suppliers (NAIMES). Contact NAIMES at (877) 436-4357, or at yourfuture@dmehelp.org.
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