Another year has arrived, and once again it’s time for our annual Big Ten list to discuss what the next 12 months have in store for the home medical equipment industry. Where 2015 is concerned, providers can expect a number of industry-wide challenges, especially when it comes to Medicare reimbursement. We also identify key opportunities that will help them reinforce their revenues.

In this year’s installment of the annual Big Ten list, HMEB examines the Round Two re-compete; expansion of bidding; bundling; audits; face-to-face; retail sales; private payor; patient management; marketing; and developing new business models.

When it comes to Medicare, every year feels challenging, but in 2015 providers will contend with several reimbursement issues both from a business and a legislative standpoint. Top among those issues is the re-compete of Round Two, which is slated to begin bidding on Jan. 22.

That said, there are new revenue opportunities and new business models that can help clever providers boost their bottom lines while helping them sidestep many of Medicare reimbursement’s pitfalls. Read this year’s Big Ten to learn more about the ways providers can drive new revenue while mitigating the reimbursement challenges they will face in 2015.

Cueing up 2015’s Top Trends to Help Providers Shoot Straight
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Entering Home Access

Home access represents a considerable opportunity for providers to drive new, Medicare-free revenue, but it also represents a new learning curve. However, getting a foothold in the home access arena doesn’t have to be as hard as some providers might think.

2015 Preview

2015 Big Ten

Our eighth annual look at the 10 key trends that will impact the home medical equipment industry in the New Year. This installment includes key challenges facing providers, as well as opportunities. We summarize what 2015 has in store, and provide a springboard to start strategizing.

Business Solutions

Head-on Bidding Collision

The industry enters 2015 in a tricky position where competitive bidding is concerned. It made solid legislative progress at the end of 2014, but can it reform the program before the Round Two re-compete starts? And if it can’t, how do providers prepare for the re-compete?

Columns & Departments

News, Trends & Analysis

CMS announces Round Two re-compete timeline; Industry bills poised to lapse; U.S. health spending growth continues to slow; CMS expands PMD prior authorization demo; NPWT device market poised for growth; MED Group, Omnisys strike a deal; Philips conducting COPD survey; Sunovion joins AAHomecare corporate partner program; Noble House celebrating 25th anniversary; Exhibitors gear up for Medtrade Spring; Mixon retires from Invacare; People in HME.

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Legislation Is a Process

A bill represents much more than a one-time piece of legislation – it’s an investment.

Like a lot of people my age, I can belt out the lyrics to “I’m Just a Bill” from ABC television’s Schoolhouse Rock series with the best of them. Sure, I’ll be off-key and people will cringe, but at least I’ll know the lyrics.

Those impossible-to-forget musical interludes that were dropped in between marathon bouts of Saturday morning cartoon watching were usually far more memorable than the cartoons themselves. And I have to give Schoolhouse Rock’s creators a considerable amount of credit for effectively educating my animation-addled brain.

Probably to my elementary school teachers’ shared chagrin, the three-minute “I’m Just a Bill” short did a solid job of giving me a basic understanding of the U.S. legislative process. It outlined how a bill got proposed, how it moved through Congress, and how it ultimately became a law. Boy did I think I knew it all.

However, witnessing first hand the industry’s fight to first stop, then replace, and now reform competitive bidding has been a massive reeducation in that regard. If anything, what I have truly learned is that legislation is a long-term process. I’m glad I learned that lesson, because it keeps me from pulling my hair out when things don’t go the industry’s way on Capitol Hill.

While “I’m Just a Bill” portrays a single bill as he cheerfully works his way through the process in a very linear, optimistic fashion, the reality is totally different. A bill might start as a standalone piece of legislation, but it actually represents two larger concepts: a political agenda and political capital.

When lawmakers and involved citizens work to launch a bill, they are generating legislative language that can live a life beyond just trying to advance that standalone legislation. That language can get attached to a much larger piece of legislation, or it could be boiled into subsequent legislation. In other words it has flexibility to be advanced in multiple ways.

Likewise, the co-sponsors that sign on to back that bill aren’t just offering a one-time signature, they are offering advocacy that can assist the bill in larger ways. They can help attract other lawmakers, speak to the press about the bill, or help advance the bill by attaching it to other legislation.

And most importantly, the ideas presented in a bill and the advocacy it earns can last long beyond the life of that bill. We’ve certainly seen that with competitive bidding legislation. The industry started out trying to stop the program. Then the industry tried to replace bidding with the Market Pricing Program. And now, the industry is working to reform competitive bidding by creating new requirements that ensure bids are binding, which will help bring an end to the low-ball “suicide bidding” that has plagued the program through Rounds One and Two, so far.

And all the while our legislative allies and advocates have worked with the industry to advance that evolving agenda and help re-shape it to the political and legislative realities of the day. Lawmakers understand that bills aren’t one-time shots — they are efforts that require commitment, and often long-term commitment that can last more than one, two-year Congress. Often an enterprise can stretch over multiple Congresses.

That has certainly been the case in the fight against competitive bidding. And that’s why I’m writing the column. I know that some providers might be feeling either a little burned out, frustrated or simply resigned when it comes to this fight. Well don’t feel that way. If you read “Head-on Competitive Bidding Collision” (page 25), Seth Johnson, vice president of government affairs for Pride Mobility Products Corp., makes an important point, “We’ve never been in a better position, based on what we’re hearing from our champions on the Hill.” He’s right. The industry’s Binding Bids legislation could still get passed before the Round Two re-compete starts bidding, and if not, it will ultimate get advanced. We just need to keep working through the process.
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CMS Announces its Timeline for the Round Two Re-Compete

Bidder registration is already open and closes Feb. 17; the 63-day bidding window for the re-compete opens Jan. 22 and ends on March 25. Implementation starts July 1, 2016.

The Centers for Medicare & Medicaid has announced its timeline for the re-compete of Round Two of its competitive bidding program.

As already seen in Round One, CMS is required by law to re-compete contracts under the DMEPOS Competitive Bidding Program at least once every three years. Contracts for Round Two expire on June 30, 2016.

CMS initially released its rough plans for the re-compete of supplier contracts awarded in Round Two of competitive bidding on July 15, 2014. CMS’s more detailed timeline:

- **Dec. 18, 2014** — Registration for user IDs and passwords begins.
- **Jan. 6** — Authorized Officials are strongly encouraged to register no later than this date.
- **Jan. 20** — Backup Authorized Officials are strongly encouraged to register no later than this date.
- **Jan. 22** — CMS opens 63-day bid window for Round Two re-compete and the national mail-order re-compete.
- **Feb. 17** — Registration closes.
- **Feb. 23** — Covered document review date for bidders to submit financial documents.
- **March 25** — 63-day bid window closes.
- **Winter 2016** — CMS announces single payment amounts, begins contracting process.
- **Spring 2016** — CMS announces contract suppliers, begins contract supplier education campaign.
- **Spring 2016** — CMS begins supplier, referral agent, and beneficiary education campaign.
- **July 1, 2016** — Implementation of Round Two re-compete and the national mail-order re-compete contracts and prices.

The agency took care in its announcement to stipulate that the dates in its timeline are target date. Actual dates will be announced through listserv notice. Providers can register for those announcements at http://dmecompetitivebid.com/cbic/cbicregistration.nsf/Home.

CMS said it is conducting the Round Two re-compete in the same geographic areas that were covered by Round Two’s 91 competitive bidding areas. However, per another CMS announcement the Office of Management and Budget updated the original 91 Round Two metropolitan statistical areas (MSAs), so that there are now 90 MSAs for the Round Two re-compete. The Round Two re-compete’s CBAs have nearly the same ZIP codes as Round Two’s original CBAs, but certain ZIP codes have changed and CMS has updated the CBAs to reflect the changes. Also, CBAs that were located in multi-state MSAs have been re-defined so that no CBA is included in more than one state. A list of the ZIP codes included in each CBA is also available on the CBIC website.

Where categories are concerned, the Round Two re-compete will cover:
- Enteral nutrients, equipment and supplies.
- General home equipment and related supplies and accessories, which was presented by a variety of speakers from the American Association of Homecare and Brightree. Also “No Weak Links: How providers can forge an unbreakable supply chain,” showed providers how to implement new supply chains. This was presented by Ryan McDevitt of Brighttree LLC, and sponsored by McKesson.
- Safety Considerations For Transporting Clients With Special Needs,” a special presentation by occupational therapist Dee Dee Freney, OTR/L, ATP. To register so that you can listen to an archive, visit mobilitymgmt.com. On Nov. 4, HMEB hosted “Increasing Retail Sales While Avoiding Legal Pitfalls,” a special presentation by industry legal expert Jeffrey S. Baird, Esq., chairman of the Health Care Group at law firm Brown & Fortunato, P.C. To pay for an archive access, visit HME-business.com.

More industry intelligence is available at hme-business.com.
includes hospital beds and related accessories, group 1 and 2 support surfaces, commode chairs, patient lifts, and seat lifts.

- Nebulizers and related supplies.
- Negative pressure wound therapy (NPWT) pumps and related supplies and accessories.
- Respiratory equipment and related supplies and accessories, which includes oxygen, oxygen equipment, and supplies; continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories.
- Standard mobility equipment and related accessories, which includes walkers, standard power and manual wheelchairs, scooters, and related accessories.
- Transcutaneous electrical nerve stimulation (TENS) devices and supplies.

CMS said its re-compete of its national mail-order contracts for diabetic testing supplies will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

Industry Bills Poised To Lapse

Just as companion legislation for binding bids bill is launched in the Senate, the 113th Congress begins drawing to its close.

Just as the industry was seeing some steady progress in both its legislative efforts to reform competitive bidding and CMS’s audit program, the 113th Congress was rapidly drawing to a close as of press time, and it looked likely that the industry would have to pick up where it left off at the start of a new year and a new Congress.

Where audits were concerned, H.R. 5083, known as the Audit Improvement and Reform Act (aka, the AIR Act), continued to pick up co-sponsors in the House, bringing the total number of lawmakers officially supporting the legislation to 45. The AIR Act was introduced into the House by Renee Ellmers (R-N.C.) and John Barrow (D-Ga.) in order to address key problems with Medicare’s unchecked audit system by boosting transparency within the program; providing better education and outreach; and rewarding suppliers that have low error rates on audited claims.

On the competitive bidding front, H.R. 4920, otherwise known as the Binding Bids Bill, continued to push forward up until the final moments of 2014, advancing to a total at 68 co-sponsors. Introduced by Reps. Pat Tiberi (R-Ohio) and John Larson (D-Conn.), the Binding Bids Bill would require bidders to have special surety bonds forcing them to hold to their bid amounts. This addresses the major flaw of competitive bidding’s non-binding bids: that it lets companies engage in the sort of low-ball bidding at prices that some bidders have no intention of honoring. The surety bond forces them to live up to their obligation.

The latest triumph for the industry was much needed support in the Senate. Sens. Rob Portman (R-Ohio) and Ben Cardin (D-Md.) have launched S. 2975, the Medicare Competitive Bidding Improvement Act, Senate companion legislation to the House’s Binding Bids Bill. However, the industry’s triumph in launching bidding reform legislation was short-lived given the pending lapse of the 113th Congress. At press time there remained some chance of advancing bid reform before the Round Two re-compete began bidding on Jan. 22.

This was an important move forward for the industry, which had been fighting hard to gain a foothold in the upper chamber.

“Because of loopholes in the Medicare bidding process, speculative bidders were allowed to game the system,” said Tom Ryan, president and CEO of AAHomecare, at the time. “This bill will help restore accountability, alleviate artificially low prices and deter unlicensed providers. AAHomecare is proud to support Senators Portman and Cardin as they fight to bring common sense to the Medicare bidding program.”

“Providing strong financial incentives for bidders to honor their bids, and having an outside third party financially vet bidders will significantly strengthen the Medicare bidding program,” said Cara Bachenheimer, senior vice president of government relations at Invacare Corp. “We are grateful to both Senators for their hard work on this important measure.”

In the waning days of 2014, the industry’s efforts were focused on adding the legislative language of funding bills being pushed through congress in December in order to prevent a government shutdown. At press time, the House spending bill passed without industry legislative language attached, but it did contain language recognizing that the two-year-plus delay of assigning administrative law judges to Medicare audit appeals was a problem that needed to be addressed. To learn more about where the industry’s fight to reform competitive bidding stands, turn to “Competitive Bidding’s Head-on Collision,” page 24.
Pace of U.S. Health Spending Growth Slows

Americans spent 3.6 percent more on health in 2013, reaching $2.9 trillion.

Health spending in the United States continued to grow in 2013, but at a slower pace, according to the latest annual health spending report from CMS’s Office of the Actuary.

Last year, U.S. health spending grew at 3.6 percent, with total national health expenditures hitting $2.9 trillion, or $9,255 per person. The annual OACT report showed health spending continued a pattern of low growth — between 3.6 percent and 4.1 percent — for five consecutive years.

The slowing growth rate in health spending coincides with modest growth in gross domestic product, which averaged 3.9 percent per year since the end of 2010. As a result, the share of the economy devoted to health remained unchanged over this period at 17.4 percent.

Total national health spending slowed from 4.1 percent growth in 2012 to 3.6 percent in 2013. The report attributes the 0.5 percentage point slowdown in health care spending growth to slower growth in private health insurance, Medicare, and investment in medical structures and equipment spending. However, faster growth in Medicaid spending, due to Medicaid expansion, partially offset the slowdown.

Other findings from the paper:
- Medicare spending, which represented 20 percent of national health spending in 2013, grew 3.4 percent to $585.7 billion, a slowdown from growth of 4.0 percent in 2012. This slowdown was primarily caused by a deceleration in Medicare enrollment growth, as well as net impacts from the Affordable Care Act and sequestration. Per-enrollee Medicare spending grew at about the same rate as 2012, increasing just 0.2 percent in 2013.
- Spending on private health insurance premiums (a 33 percent share of total health care spending) reached $967.7 billion in 2013, and increased 2.8 percent, slower than the 4.0 percent growth in 2012. The slower rate of growth reflected low enrollment growth in private health insurance plans, the continued shift of enrollees to high-deductible health plans and other benefit design changes, low underlying medical benefit trends, and the impacts of the Affordable Care Act.
- Medicaid spending grew 6.1 percent in 2013 to $449.4 billion, an acceleration from 4.0 percent growth in 2012. Faster Medicaid growth in 2013 was driven in part by increases in provider reimbursement rates and some states’ expanding benefits.
- Out-of-pocket spending (which includes direct consumer payments such as copayments, deductibles, spending by the insured on services not covered by insurance, and spending by those without health insurance) grew 3.2 percent in 2013 to $339.4 billion, slightly slower than annual growth of 3.6 percent in both 2011 and 2012.

CMS Expands PMD Prior Auth. Demo

Prior authorization project for scooters and most power wheelchairs expanded to a total of 19 states.

The Centers for Medicare and Medicaid Services has expanded the Medicare power mobility device (PMD) demonstration project to incorporate an additional 12 states, bringing the total number of participating states to 19.

The expansion of the demonstration project, which requires prior authorization and accompanying medical justification for scooters and most power wheelchairs, began on Oct. 1. The demonstration project will end for all 19 states on Aug. 31, 2015.

States joining the in-progress demonstration are Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee and Washington. California, Florida, Illinois, Michigan, New York, North Carolina and Texas were the first states to participate in the demonstration project.

In the July 29, edition of the Federal Register, the Centers for Medicare & Medicaid Services (CMS) said the states were chosen “based upon their history of having high levels of improper payments and incidents of fraud related to PMDs. The objective of the demonstration is to develop improved methods for the investigation and prosecution of fraud in order to protect the Medicare Trust Fund from fraudulent actions and any resulting improper payments.”

(To read the article in the Federal Register, visit http://bit.ly/priorautharticle.)

PMDs involved in the demonstration project are Group 1 power-operated vehicles (aka, scooters); all Group 1 and Group 2 standard power wheelchairs (HCPCS codes K0813-K0829), Group 2 power wheelchairs coded K0835-K0843; Group 3 power wheelchairs without power options (K0848-K0855); pediatric power wheelchairs (K0890-K0891), and miscellaneous power wheelchairs (K0898).

Upon receiving the documentation, CMS said in the Federal Register, the organization “will make every effort to conduct a complex medical review and postmark the notification of their decision with the prior authorization number within 10 business days.” CMS’s decision is sent to the physician who wrote the prescription for the PMD, the PMD provider, and the Medicare beneficiary.

 Expedited reviews of documentation may be requested if that 10-business-day waiting period “could seriously jeopardize the beneficiary’s life or health,” CMS added. CMS tries to provide decisions on expedited reviews within 48 hours of receiving them.

— Laurie Watanabe

NPWT Device Market Poised for Growth

Global market for negative pressure wound therapy devices to reach $4.2 billion by 2019.

The global negative pressure wound therapy devices market was valued at $2.1 billion in 2012, but is expected to grow at a compound annual growth rate of 10.2 percent from 2013 to 2019, to reach an estimated value of $4.2 billion in 2019, according to a new study from Transparency Market Research.

The study, “Negative Pressure Wound Therapy Market (Conventional and Single Use NPWT Systems) - Global Industry Analysis, Size, Share, Growth, Trends and Forecast, 2013 - 2019,” attributes growth of the negative pressure wound therapy (NPWT) market to the increase in the number of chronic diseases such as diabetes, cardiovascular diseases, and peripheral vascular diseases. The increasing incidence of cancer and neurological diseases has led to long-term bed occupancy of the affected patients, which has increased the incidence rate of decubitus ulcers, as well.

Also, the survey notes that this growing patient need will likely be served in the home. The global growth of the geriatric population has caused a significant financial burden on the healthcare authorities. To manage this situation patients prefer using portable, easy-to-use NPWT devices that may be used as home healthcare devices, which also minimizes the overall cost of hospital stays.

Another key demographic is diabetic patients. According to the American Diabetes Association nearly 26 million children and adults are currently suffering from diabetes, and 15 percent of diabetes patients experi-
COPD Day aims to improve awareness and care of COPD around the world. The 2014 event is focusing on a critical issue for healthcare providers. Readmission rates for COPD are higher than expected – making proactive management of patients with COPD a critical issue for healthcare providers. According to the World Health Organization, worldwide, chronic diseases such as heart attacks and strokes, cancer, diabetes and COPD account for more than 63 percent of deaths annually. The World Economic Forum is working to raise awareness of COPD among both patients and physicians and is committed to developing its next-generation of disease management solutions.

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Philips Conducting COPD Survey

Respiratory equipment maker begins international survey.

Respiratory and sleep equipment maker Philips has embarked on a survey that will evaluate key issues affecting those living with chronic obstructive pulmonary disease (COPD). The survey, which was launched in its first phase in a number of countries, including the United States, United Kingdom and Germany, aims to uncover some of the day-to-day physical, emotional and psychological challenges that people living with COPD face. The manufacturer will use this information to help develop a next-generation of disease management solutions.

Philips reports that it expects findings to be available in early 2015.

“COPD is highly prevalent, but few people know how serious the condition is or have information at their fingertips to make decisions about when they should talk to their doctor,” said Eli Diacopoulos, general manager of respiratory care for Philips Respironics. “Today, on World COPD Day, and every day, Philips is working to raise awareness of COPD and the challenges of living with this disease.”

“Breathe Easy” is the theme of COPD Day 2015 and the message of the survey.

The survey will focus on patients’ experiences with COPD. It will assess how well patients have access to health care services and medications, how difficult it is to work with their physicians, and the impact COPD has on their physical health, finances and daily lives.

The survey will be conducted online. Participants will be invited to participate via email, and those who complete the survey will be eligible to enter a sweepstakes to win a trip to Philips headquarters in Amsterdam, and an opportunity to participate in a focus group study.

Exhibitors Gearing Up For Medtrade Spring

More than 150 companies have signed on for March 30-April 1 event in Las Vegas.

At press time, more than 150 vendors have signed on to exhibit at Medtrade Spring, slated scheduled for March 30-April 1, 2015, at the Mandalay Bay Convention Center. Medtrade Spring is one of the largest home medical equipment expos in the U.S.

“After the holiday season, many more manufacturers start to gear up and make plans for their trade show season,” says Kevin Gaffney, group show director, Medtrade. “At this point, the more than 150 companies already signed up is a good start.”

Early Medtrade Spring 2015 registration for HME providers opened last week with people choosing to sign up to attend at a savings.

And, where attendees are concerned, the show has been working to tailor their event to attendees’ needs. In response to attendee surveys, organizers have made some alterations to reduce the overlap between conference sessions and expo floor time.

A majority of sessions have been moved to the first day, Monday. With most sessions occurring on day one, attendees will have most of the day Tuesday and all day Wednesday to browse the Expo floor at the Mandalay Bay Convention Center in Las Vegas.

Sunovion Joins AAhomecare Corporate Partner Program

Pharmaceuticals firm signs-on as Silver Level partner to help ensure Americans’ access to home health.

Sunovion Pharmaceuticals Inc., which makes respiratory treatments, has joined the American Association for Homecare as a Silver Level Corporate Partner, to help strengthen Americans’ access to care at home.

“This is a significant addition to our Corporate Partner Program,” said Robert Stedley, chairman of the AAhomecare Board of Directors. “Sunovion brings a depth of experience in patient care, and we value the support that leading companies bring to the homecare community.”

“Our corporate partners are long-standing champions of the industry and advocates for patients,” said Tom Ryan, AAhomecare president and CEO. “We welcome Sunovion’s strong commitment to our shared objectives of improving home health care access and outcomes for patients – and encourage more companies to follow this lead and recognize the importance of engagement.”

The AAhomecare Corporate Partner Program, now in its second year, has grown to 11 companies: Apriva HealthCare, Brighter, Byram Healthcare, Drive Medical, Invacare, Medtronic, Philips Respironics, Pride Mobility, ResMed, Shield Healthcare, and now Sunovion Pharmaceuticals.

Noble House Celebrating 25th Anniversary

HME software maker marks its silver anniversary by emphasizing continued enhancements.

HME billing and claims software company Noble House is celebrating its silver anniversary.

In 1989 Noble House founder and president Richard Mehans developed Noble Direct, which has been in a state of continual improvement and innovation in order to give providers billing and operational software designed to help providers maximize productivity, cash flow and profits, while contending with increased governmental regulations and competitive pressures.

In addition to providing features such as approved HIPAA electronic claims, EHR posting, custom physician orders, CMRs, billing, document imaging scanning, real-time patient eligibility, and patient scheduling, Noble House has developed Noble*Direct ANSI X12 275 capabilities, which allow supplemental health information to accompany electronic claims. This eliminates the need to manually fax or mail required documentation for a claim, thus decreasing human error and increasing the potential administrative cost savings associated with Electronic Data Interchange (EDI).

“We believe that this is and should be standard practice and exactly where it needs to go,” Mehana said. “The vision behind this approach dovetails exactly with ours – helping the industry create a standardized, efficient, cost effective and consistent approach.”

Noble House will release an expanded version of its software in the early part of 2015, to address the changing needs of HME providers, as well as delve into the pharmaceutical industry.
PEOPLE IN HME

Mixon Retires from Invacare Corp.

Founder of DME manufacturing giant Invacare Corp., A. Malachi ‘Mal’ Mixon, III, 74, has retired as the executive chairman of the company’s board of directors, effective Dec. 21, 2014.

Nearly synonymous with his company, Mixon will continue his responsibilities as a non-employee member of the company’s board until the 2015 annual meeting when the company will nominate him for one additional term after which he will reach the board’s mandatory retirement age of 75.

“Over the past 35 years, I have had the privilege of leading and guiding Invacare’s evolution into a global manufacturer and distributor of medical devices that promote recovery and active lifestyles,” Mixon said. “At this important transition point in the company’s history, I feel that now is the appropriate time for me to retire and let the next generation of leadership guide the company into the future. I have full confidence in our management team as they work to restore profitability in the North America and Asia/Pacific businesses and exit the injunctive phase of the company’s consent decree with the United States Food and Drug Administration.”

In 1979, Mixon led a leveraged buy-out of Invacare Corp. with the support of his business partner, Joseph B. Bickley, II, and a small group of investors. During his tenure, the company grew from a domestic manufacturer of lifestyle products with annual net sales of $19 million into a global home medical device company with a broad product portfolio and annual net sales of $1.4 billion in 2013. During his leadership of the company, Mixon also was a staunch advocate for the home medical equipment industry in Washington, D.C., and throughout the United States.

“It has been a pleasure working with the very talented associates at Invacare,” he stated. “They have been integral in fulfilling our brand promise to customers and people who use Invacare products — ‘Making Life’s Experiences Possible.’ I also want to thank the many customers and shareholders who have supported Invacare over the years.”

“Looking ahead, I am confident that the company will be well-positioned for a strong future, as the home and long-term care markets continue to become an increasingly important component of the world’s continuum of care,” he added. “I still have a passion for this incredible channel of healthcare and look forward to continuing to work with the management team and other members of the Board.”

Van Halem Group Adds More Medicare Know-How

Audit and compliance consulting firm The Van Halem Group, a division of VGM Group Inc., has added six full-time employees, expanding its Medicare expertise, which already boasts more than 130 years’ combined Medicare experience at the leadership level.

Joining the van Halem Group are Lucretia LaFavor, a former operations manager with CGS Administrators, who will be a project manager. Also coming on board are three new clinical consultants: Karen Greco and Cheryl Wilkerson, who are both former RAC Clinical Auditors, as well as Donna Youngblood, a former Reconsideration Specialist.

There is no team in the industry that has more Medicare experience than ours,” said Wayne van Halem, president of The van Halem Group. “That knowledge and expertise is invaluable to our clients as we navigate complex issues related to audits, appeals, and compliance.”

Pride Names New CFO

Pride Mobility Products Corp., has named Mario Patone as its new Chief Financial Officer. In his new role, Patone is responsible for all areas of finance and accounting, as well as asset management of the Pride family of companies.

“We are excited about the experience, skill set and vision that Mario Patone brings to our organization as Chief Financial Officer,” said Scott Meuser, chairman and CEO of Pride. “His vast depth of experience in accounting, finance, tax, treasury, and acquisition management are key assets toward the continued growth of our business within the evolving mobility and complex rehab markets.”

Patone brings more than 20 years’ accounting and finance experience, with an emphasis on internal control, financial reporting and acquisition management for public and privately-held companies, according to Pride.

As a Certified Public Accountant in both Pennsylvania and Delaware, Patone has worked in management and executive roles for such prestigious accounting firms as Pricewaterhousecoopers and Baker Tilly. Patone was notably the principal contributor and co-author of Pricewaterhousecoopers’ guide, Internal Control Over Financial Reporting – Guidance for Smaller Public Companies written for COSO.

Jeremy Kauten promoted to president of VGM Forbin

VGM Group Inc. has promoted Jeremy Kauten to president of VGM Forbin, the member service organization’s Web development and Web marketing division.

Kauten started with VGM in 1999 when Forbin was acquired, and has worked in a variety of positions ranging from support desk to general manager. He has presided over the growth and development of Forbin as it evolved from a local Internet service provider to a full-service firm that helps clients with all things Web-related.

Emmett joins Golden as VP of Operations

DME manufacturer Golden Technologies has hired Ralph Emmett, as its new vice president of operations. Emmett comes to Golden with more than 30 years’ experience as an executive in operations management and engineering.

Most recently, Emmett served as the Vice President of Reilly Finishing Technologies for seven years. Prior to that, Emmett was the General Manager of Trion Industries for more than 20 years. Additional employers included Air Devices, Anemostat Products Division and Signetis Corp. In these roles, Emmett directed executive management teams along with hundreds of employees working in various departments including manufacturing, engineering and sales.

“Ralph brings a tremendous amount of leadership, management experience and talent to the Golden team that will benefit many areas of the company, not only in manufacturing,” Richard Golden, CEO of Golden Technologies. “In the few short weeks he has been with the Golden team, Ralph has already made significant improvements to our manufacturing processes to increase production while maintaining our highest quality standards.”

“Ralph is a true leader and a team player who has already earned the respect of his colleagues here at Golden,” Golden continued. “We look forward to following Ralph’s direction to take our manufacturing and operational processes to a new level.”

Emmett holds a degree in chemical engineering from the Pennsylvania State University, an MBA from the University of Scranton, and has credits from the American Management Association in Boston and New York City.

Jaye Liptak, who will work as administrative coordinators. Joining the van Halem Group are Lucretia LaFavor, a former operations manager with CGS Administrators, who will be a project manager. Also coming on board are three new clinical consultants: Karen Greco and Cheryl Wilkerson, who are both former RAC Clinical Auditors, as well as Donna Youngblood, a former Reconsideration Specialist.

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At a recent meeting of HME Industry executives, one noted, ‘Audits are just a part of doing business now.’ It is certainly a sign of the times when companies are now considering outsourcing their audit and appeal workload. That, however, is the reality facing many suppliers in this environment of strict regulatory oversight. Recent reports from CMS revealed that Medicare contractors were sending out approximately 15,000 audits per week. Meanwhile the appeal backlog is quickly approaching 1 million claims at the Office of Medicare Hearings and Appeals. Dealing with this high audit volume, in addition to normal daily activities, creates quite a challenge for all suppliers — whether you’re a small “mom and pop” or a large national.

Just as many suppliers have elected to outsource their billing to experts, many others have begun or are considering the idea of outsourcing their audit and appeal workload to entities that provide those types of services. And while The van Halem Group provides audit and appeal services on behalf of our clients, from simple tracking and reporting to additional documentation requests (ADR) response and appeal representation to name a few, the purpose of this column is not to encourage suppliers to outsource this work if they have control over it, but rather to advise suppliers what they should consider when choosing an entity to submit your audit responses and appeals.

Just like billing, ADR responses and appeals are an integral part of a supplier’s operational activities. Submitting ADRs or appeals incorrectly could lead to denied claims, additional overpayments, or increased scrutiny of a supplier’s claims. For that reason, a supplier considering outsourcing this work should practice due diligence in doing so, and with the same care it would apply when choosing a billing company. Due to the increase in audits, there is no shortage of options available to you when choosing the individual or entity that will assist in your audit and appeal workload. Companies that did not offer these services in the past are now doing so. The reality is, the process is complex and requires that the individual or entity possess the appropriate knowledge and expertise in which to navigate the process, as well the ability to handle all different types of situations that may arise. What follows are some tips we suggest a supplier take when attempting to outsource this workload.

First and foremost, do your due diligence. Because of the number of individuals and entities that are now available to provide audit and appeal support services, the quality of those services will vary, as this is true in any industry. So you want to do your research. Ask for references of other customers or clients that are utilizing them for same or similar services that you intend to subcontract. Contact those references and discuss the quality of the services, the success rate, and the knowledge base of the individual or employees of the entity you are considering. Ask them to discuss their successes and provide some examples as well as what they feel are their challenges and strengths.

We strongly urge you to test them on their knowledge, not only of the audit and appeal process, but also of the Local Coverage Determinations, claim denials, and the wide range of Medicare policies. We would even suggest providing some examples of situations that can sometimes occur and ask how they would handle that situation, as we have personally seen suppliers run into unnecessary problems because the entity handling their appeals did not submit them properly. Ask them to describe for you their process when submitting appeals. Do they specifically address the denials? Do they provide a documentation summary? In some cases, we’ve seen entities just submit the same documentation with a note that says, “Please review for payment.” Using a blanket statement would not be helpful, due to the fact that in most cases, the denial reasons are accurate and should be directly addressed in the appeal process. They should, instead, have knowledgeable and experienced staff that can get “down in the weeds” and summarize the documentation as to how it supports the need for the services provided.

While the past process may have been to abstractly appeal the denials, hoping to have them overturned and the claim paid upon ALJ Hearing, the truth is that this is no longer the environment we are in. Today, suppliers wait nearly three years to go before an Administrative Law Judge, and even then the overturn rate is not as positive as years past. The reality of the situation is that is imperative that issues are corrected and addressed at the earlier levels of appeal.

Another relevant item to consider when making the determination to outsource your audit and appeals workload is whether or not there is an educational component in the services they provide. By that I mean that these entities should be providing consistent feedback and education to your staff so that when they see a pattern of problems or issues, they are reporting back and providing the necessary support to avoid them in the future.

It’s also important to discuss their processes and the tools they utilize to manage the workload. Do they provide reporting and tracking and, if so, how? The ability to accurately report and track audits and appeals is of utmost importance since there are deadlines and requirements that must be met and often no wiggle room when they are not. Ask them how can they assure that this does not happen and in the instance that it does, what would they do about it? This can also help you determine how successful they are in the process. Also find out what, if any, technology they have implemented to automate the process.

The last suggestion I would make would be in regards to their capacity to manage the workload. Provide them with an accurate volume and the number of employees you have currently handling this workload and discuss the capacity in which they would be able to handle it. Most entities will be able to manage the workload more efficiently than a supplier, as they are likely more focused on those tasks alone, wherein the supplier is managing those along with several others.

If you are having difficulties with audits or the workload associated with responding and appealing them successfully, it is very reasonable to consider outsourcing this workload to an expert. However, as with any important decision you make, consider your options dutifully, as the decision you make is one with a goal to improve your operations and make your business run more efficiently. The right decision will allow you to manage the audit and appeals process more effectively, thereby allowing you the time and resources to better focus on patient care.

Wayne H. van Halem, CFE, AHFI is an author, consultant and President of The van Halem Group LLC (Atlanta, Ga.), a firm that helps HME providers navigate complex issues related to Medicare and Medicaid audits, appeals, and compliance. He can be reached at wayne@vanhalemgroup.com.
Despite an unknown enforcement, how should providers prepare?

For several years, providers have been rapidly pushing into retail sales. As competitive bidding has become increasingly “real” as Round Two is approaching a re-compete and CMS has announced it would take bid prices national by 2016, providers have paid similarly increasing attention to retail sales. Many providers are now seeing retail sales not as a bonus, but as a business imperative. Simply put, it drives new, desperately needed revenues that can help compensate for the cash flow cuts caused by constantly dwindling Medicare reimbursement.

In the wake of the face-to-face rule, which states that for certain specified DME items an in-person, face-to-face examination documenting the need for the item must have occurred sometime during the six months prior to the order for the item, providers cannot forget that enforcement of the rule can come any day. And for those who are unprepared, this can be a big enough burden to affect your business.

The ACA 6407 face-to-face ruling was placed into law and implemented July 1, 2013. The DME MACs — responsible for processing Medicare Durable Medical Equipment, Orthotics, and Prosthetics claims for a defined geographic area or jurisdiction — started auditing on the written order prior to delivery (WOPD) requirement for dates of service effective January 1, 2014. The DME MACs are not auditing on the face-to-face encounter requirement; however, other auditing entities are able to enforce this requirement.

“What this means to providers is that the DME MAC won’t audit on the face to face but others may audit the requirement to have a face to face within six months from the date of the WOPD,” said Dan Fedor, compliance specialist for VGM/US Rehab. “Originally the DME MAC stated that the CERT was the only entity that could audit even though an official start date has not been published by CMS other than that it will be some time in 2014. If not already doing so, providers should begin to obtain a face to face within six months from the date of the WOPD for all specified products listed on the ACA immediately.”

CMS has indicated that the face-to-face requirement will not be applied retroactively once the delay is removed.

“The risk today is with the CERT contractor who would deem an audit to fail if the face-to-face requirement is not met,” said Kim Brummett, vice president of regulatory affairs for the American Association for Homecare. “However, as the MACs are not enforcing the requirement, a supplier could appeal a CERT denial through redetermination and assuming the only issue is the face-to-face requirement, the denial should be overturned. However, other auditing entities are able to enforce this requirement.

“If not already doing so, providers should begin to obtain a face to face within six months from the date of the WOPD for all specified products listed on the ACA immediately.”

— Dan Fedor, VGM/US Rehab

Experts agree that to avoid the consequences of enforcement, providers should have procedures in place today to meet the impending enforcement of the face-to-face requirement. They must implement a protocol within their company requiring a copy of a face-to-face encounter and WOPD for specified items listed on the ACA. They should continue educating ordering physicians that this is a requirement and that the product ordered cannot be delivered without meeting these requirements. It all comes down to having procedures in place, which Fedor outlines below.

Step 1: Know the specific products/codes of face-to-face items.

Some of the products on this list include manual wheelchairs, various manual wheelchair accessories, hospital beds, TENS, nebulizer and many more. For a complete list please go to go.cms.gov/1uK082s.

Step 2: Continue to educate physicians about this requirement.

Inform physicians of the requirement and provide them with a copy of the Dear Physician letter from the DME MAC Medical Directors. You can obtain a copy at bit.ly/1swCBrM.

Inform physicians that no DME provider can provide any of the products on the ACA list unless all requirements have been met with copies received by the DME provider PRIOR to delivery.

Step 3: Confirm that all requirements have been met prior to delivering one of the specified DME products

- The face-to-face examination must document that the beneficiary was evaluated or treated for a condition that supports the need for the DME ordered.
- The in-person visit occurred within six months from the date of the order for the item.
- The face-to-face examination was co-signed and dated by a physician (MD or DO) if a PA, NP, or CNS performed the face-to-face encounter.
- The date on the order wasn’t written prior to the face-to-face encounter date.
- The order contains all required elements:
  - The beneficiary’s name
  - The physician’s name
  - The date of the order and start date if the start date is different than the date of the order
  - Detailed description of the item
  - Ordering physician’s NPI
  - The signature of the ordering practitioner
  - The signature date of the order
- For specific items provided on a periodic basis please refer to the Dear Physician letter for additional details: bit.ly/1swCBrM.

- Obtain a valid face to face and WOPD prior to delivering the product.
- Ensure all documents are date stamped to prove receipt date.

If a provider has not obtained all required documents or one of the documents is not valid, it should not deliver the product; otherwise, it will be at risk for recoupment in an audit. Visit cms.gov for more information.

Joseph Duffy is a freelance writer and marketing consultant, and a regular contributor to HME Business magazine and Respiratory & Sleep Management. He can be reached via e-mail at jduffy@hmemediagroup.com, or joe@prooferati.com.
As providers search their markets for new revenue sources beyond Medicare, one key opportunity that is looking increasingly attractive is home access. Providing home access lets providers leverage many of their existing patient and referral partner relationships, while providing a much-needed service.

Home access also offers providers a migration path for ramping up this new line of business. HME providers can start off by offering simple items related to their expertise, and then build from there. For instance, a provider serving senior patients could start by offering bath safety products, and then move into other areas of the home, such as the kitchen or stairs to provide additional solutions.

Market Potential
There is considerable market potential for home access services. Multiple patient groups benefit from home access, such as mobility patients, bariatric patients and seniors. Clearly, patients in wheelchairs and other mobility devices have distinct and clearly recognizable home access needs that can differ greatly from the home access need. If anything, mobility patients represent the “obvious” home access market need.

Also, there are patient demographics that are expanding the home access market, specifically, an aging United States, and our nation’s obesity epidemic. Both senior and bariatric patients need home access solutions, and their numbers are considerable. There were 40.3 million people age 65 and older in the United States in 2010, and the 77 million-person-strong Baby Boom is well into retirement. Also, depending on the study, the population of patients either weighing 300 pounds or more, or with a body mass index of 40 or more, is high as 9 million people.

Getting Educated
The first step in establishing a business in home access is to gain expertise. Providers must competently understand patient needs, the products that address those needs and the various complexities, business relationships and legal requirements that become involved in more in-depth home access jobs.

The VGM Group’s Accessible Home Improvement of America (AHIA), which is a special network of providers and contractors that offer home access services and products, has outlined various levels of home access service capability for holders of its Certified Environmental Access Consultant (CEAC) credential.

CEAC providers can work up from one level to the next while ensuring they cover the minimum standards for safety, competence and capability. Moreover, other home access businesses that might want to work with them will be able to get a clear picture as to the extent of the provider’s home access skill and knowledge. Let’s take a look at them:

Level 1 — The provider understands and can competently offer threshold and suitcase ramps, basic assistive transfer devices, bath safety, and multiple aids to daily living.

Level 2 — The provider can offer products requiring simple installation, such as portable ramps with handrails, standing poles, bedrails, portable patient lifts, trapezes, and bath and tub lifts. This also covers all products that require operational training and simple technical instructions.

Level 3 — The provider understands light remodeling and has the necessary knowledge to comply with applicable local building codes and license requirements. These providers can assess needs and provision of products and equipment, accordingly. They are manufacturer trained for more
Getting a Foothold in Home Access

Bath Safety
Bath safety represents the easiest access point into the home access business, and one that can truly help patients. Simply put, patients of all sorts need to use the bathroom throughout the day. But for bariatric, geriatric and mobility patients, bathing can pose both frustration and safety hazards.

For instance, stepping into a shower stall or tub poses the risk of falls for senior and bariatric patients, and for mobility patients, bathing comes with even more complications due to their mobility limitations. And if bathing complications result in reduced frequency of bathing, this can mean that a patient might, for various reasons, live in a two story home even though the patient might not be able to easily negotiate the stairs. As a result, a common bath safety remodeling projects is to covert a downstairs room into a bedroom, and to have a downstairs half bathroom converted into a full bath.

Entry Ways
Another key access opportunity starts with the front door. Patients with mobility limitations must have a method for entering a home, and when the front door is off the ground — as most front doors are — that means home access providers need to look at installing one of two solutions: a ramp, or a vertical platform lift.

Where ramp installations are concerned, there must be a ramp for every inch of rise between the ground and the 5-foot-by-5-foot platform that is placed in front of the entryway the platform provides a level spot for the patient to open and close the door. That said, the landscape where the ramp will go needs to be assessed as well. If the ground slopes away from the house, then the ramp will actually need to be longer.

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The first thing is to consider the patient’s needs, and that varies in terms of disability. For geriatric and bariatric patients, a primary concern is falls. Older and overweight patients can suffer severe injuries from a fall, bariatric patients because of their weight and geriatric patients because of their age.

So strategically placed grab bars and rails are important, as well as bathing benches or chairs and non-skid surfaces for the shower or tub.

Moreover, bariatric patients run additional risks from average bathroom fixtures catastrophically failing on them, since those fixtures cannot support the patient’s weight. Fixtures such as sinks and toilets must be built to support bariatric patients’ weight.

For patients with mobility limitations, providing ample room for maneuvering and performing bathroom tasks is important, but can be difficult to accommodate given the cramped size of most average bathrooms. Patients might be fully capable of performing all their bathroom tasks on their own, as long as they have freedom of movement. When it comes to bathing, patients might require special shower chairs or transfer chairs that let them transition from their regular wheelchair into the shower.

A safety remodel can range from adding some key pieces of DME to completely enlarging the room, and everything in between. A complete bathroom remodel can range between $15,000 and $30,000 on average. However, it might not be necessary. Simple fixes that increase maneuvering space as well as safety might include removing cupboards or installing pedestal or hanging sinks. That said, if the bathroom is too cramped, it will need expansion. Other modifications include moving the toilet and removing the tub and installing a roll-in shower, which requires a change in drainage system and other plumbing modifications.

A central question is which bathroom will be upgraded to accommodate the patient’s needs. This requires a look the entire household's needs and daily activities, not just the patient’s, to see which room is best. Often a patient might, for various reasons, live in a two story home even though the patient might not be able to easily negotiate the stairs. As a result, a common bath safety remodeling projects is to covert a downstairs room into a bedroom, and to have a downstairs half bathroom converted into a full bath.

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A patient’s mobility capabilities might be more compatible with one device or another. For instance, a manual wheelchair user might find having to roll up a gradually inclining 50-foot ramp a challenge. And, if the patient is a manual wheelchair user, regular landings must be factored into the ramp’s design so that the patient have the ability to rest if he or she gets tired going up the ramp. This is also a safety factor, as well, as landings help prevent the possibility of gravity taking over and a manual wheelchair user accidentally rolling down the ramp with no control.

Additionally aesthetics are an important consideration, as well. We are talking about a patient’s home, and he or she might not like how a large, aluminum ramp might look in the front yard. Similarly, a homeowners association might have rules governing the look and placement of home access devices, and obtaining approval for a ramp or VPL might be required. And, if the patient is renting, then the landlord will need to approve, as well.

In situations where a ramp is not possible, installing a platform lift is the right option. These devices can travel vertical or along an inclined path, but the key is that the patient stays in the mobility device and is carried by the platform. All that’s needed is a four foot-by-four foot concrete pad for the foundation of the lift. This saves considerable space.

Stairs
Once inside the home, patients often still need to get from one floor to the next. Here stair lifts and sometimes platform lifts come into play. A key question that needs to be answered is whether the patient can transfer in and out of a stairlift. Presuming her or she can’t, then it gets back to a question of an incline lift or a vertical lift. Incline lifts not only require the use of the stair but need room for a landing for the platform, both upstairs and down. That can be a space consideration.

In that case the strategy then becomes looking for a way to install a vertical platform lift within the home. That could be made possible via closets or corridors that line up between floors, or what is called a three-wall bump out. This is where an addition is made to the house to accommodate the stairlift; it’s almost like an elevator shaft.
As HME businesses continue to drive new revenue in 2015, the New Year also brings some serious challenges. We explore the solutions and opportunities in this year’s list.

Each January, *HME Business* explores 10 key trends that will impact home medical equipment providers in the coming year. In the case of 2015, providers face several continued challenges in the Medicare arena, but they also have some clear opportunities to drive new revenues over the next 12 months. This year’s Big Ten trends are:

1. The Round Two Re-compete
2. Expansion of bidding
3. Bundling
4. Audits
5. Face-to-Face
6. Retail Sales
7. Private Payor
8. Patient Management & Outcomes
9. Marketing
10. New Business Models

Our goal with the Big 10 list is to give you a starting point for the next 12 months. The following summaries should help you line up how you want to approach each trend, and then take your best shot. Let’s explore:

*By David Kopf*
The next competitive bidding issue that the industry must contend with in 2015 is the expansion of competitive bidding. CMS is required by the Affordable Care Act to expand competitive bidding nationally by 2016. In November, CMS released its final rule that formalizes that expansion.

To begin with, there will be a phase-in process over six months, with allowables to be reduced by 50 percent of reduced amounts on Jan. 1, 2016, and 100 percent on July 1, 2016. But the big issue has been rural providers. CMS’s original argument was that rural provider might see price cuts, but they won’t miss out on categories or geography. That might seem good in theory, until one considers that rural providers don’t have any kind of volume to make up for the reimbursement cuts that they will suffer.

Regardless of that concern, CMS will define rural areas as a postal zip code that has more than 50 percent of its geographic area outside of a metropolitan statistical area (MSA) or a zip code that has a low population density that was excluded from a competitive bidding area. The payment amount for those rural areas will be 110 percent of the average of the single payment amounts of all the areas where competitive bid prices are implemented. Many rural providers will be asking themselves if an extra 10 percent of a pricing model that most providers consider extremely flawed in the first place will be enough to carry their businesses. And if it can’t, then what happens to their rural patients?

Like any competitive bidding-related challenge, this means providers need to approach bidding expansion from both a business and an advocacy perspective. Is there anything the industry can do in 2015 to either work with CMS to reform how it will implement bidding expansion (and especially its reimbursement calculations for rural providers), or work legislatively to reform the expansion if CMS is not game to work with the industry, and, concurrently those providers impacted by the program must plan from a business perspective.

### Bundling

Also, CMS will proceed with a limited version of its proposed bundling plan to phase-in the program. CMS will start with bundling for power wheelchairs and CPAP in up to 12 markets. The bundled rate will include payment for all items and service, including maintenance of the equipment, and replacement of supplies. Comparative markets will be established to compare outcomes. For now, CMS will not move forward with bundling for oxygen, standard...
manual wheelchairs, enteral nutrition, respiratory assist devices, and hospital beds, per the industry’s recommendation.

But what does “move forward” mean? CMS hasn’t yet released the 12 markets to the industry, and how will CMS exactly bundle items. Moreover, when will CMS implement this “test” of bundling? It will likely begin with the Round Two re-compete, but how long will it last? There appears to be now hard timeline, at least not publicly. If CMS begins bundling for the 12 areas, will it start that bundling with the beginning of bidding or later in the process? How will bidders in those areas be alerted that they will be subject to bundling? Will they have enough time to calculate their bids based on that information? And for companies that operating across multiple CBAs, what will be the pricing structure across areas that are bundled and not? All these factors play into how HME businesses will bid in the re-compete, as well as conduct day-to-day businesses, but they have very little information to go on.

Ultimately, CMS’s plans for bundling represent a big box of unknowns that many in the industry would rather the agency simply not open.

**Audits**

If there is one factor in the Medicare funding environment that has nearly eclipsed the threat of competitive bidding, it is CMS’s audit program. Several years ago, CMS unleashed a tsunami of RAC, CERT and ZPIC audits on providers. After shaking off the initial shock, providers realized that audits weren’t going away, and that they would have to learn how to cope with those audits have learned how to educate their referral partners and work with them to ensure that claims have unimpeachable documentation. To respond to auditor questions and request, providers put into place tools and processes that let them respond quickly with the right documentation.

Providers learned their lessons well. So much so that they began appealing Medicare audits when it became clear that auditing contractors were trying to recoup claims based on technicalities and seemingly spurious grounds. In some cases, depending on the type of audit, providers were seeing as good as a 60 percent overturn rate when those appeals were elevated to the administrative law judge (ALJ) level.

But as providers grew increasingly adept at responding to and appealing audits, CMS increased the scope of its program. Over the past three years, the agency’s radically revved up audits have resulted in appeals growing by 184 percent. While CMS’s Office of Medicare Hearings and Appeals (OMHA) received 1,250 appeals a week in January 2012, it received more than 15,000 appeals a week by November 2013. This resulted in a backlog of 357,000 audit appeals by mid 2014. As a result Nancy Griswold, OMHA’s chief judge delayed assigning an Administrative Law Judge to any new audit appeals for more than two years.

This represents a huge problem for the industry. The problem with the ALJ delay is that the impact goes far beyond a simple delay. A recouped reimbursement does not sit in limbo sitting out the ALJ delay. Auditors and CMS continue to pursue the provider for overpayments, or principle and interest via CMS’s Extended Repayment Schedule. And delinquency can involve the U.S. treasury.

The industry worked to try to reform the audit program to reduce the out-of-control system created for audit contractors, but it did not end well. Rep. Renee Ellmers (R-N.C.) and John Barrow (D-Ga.) introduced H.R. 5083, known as the Audit Improvement and Reform Act (aka, the AIR Act), into the House in order to address key problems with Medicare’s unchecked audit system. The bill aimed to boost transparency within the program; provide better education and outreach; and reward suppliers that have low error rates on audited claims with decreased audit exposure.

The bill did well, picking up 45 co-sponsors, but at press time looked poised to lapse with the 113th Congress. This means the industry will need to either attach that legislative language to other legislation moving through the House, or launch a new bill into the 114th Congress. In the meantime, providers will need to contend with a continued audit program and ALJ delay, while working to support the industry’s legislative efforts to bring the runaway program under control.

**Face-to-Face**

If there is one “known unknown” for 2015, it is Medicare’s face-to-face requirement. CMS implemented a requirement that a face-to-face evaluation with a physician must happen within six months prior to ordering frequently ordered DME items.

However, while the requirement was implemented, CMS has kept delaying the enforcement. In late 2013, CMS delayed enforcement of the face-to-face requirement until “some-time” in 2014, but recently CMS delayed enforcement indefinitely.

That open-ended delay happened in part because the volume of conflicting information and instruction from CMS and other sources resulted in pushback from other healthcare professionals, such as nurse practitioners, which resisted the face-to-face requirement,
2015 Preview

Big Ten

because it flew in the face of preexisting Medicare policy that governed their ability to order durable medical equipment items, such as wheelchairs and oxygen equipment as long as they have their own NPI. Even the sizable lobbying entity that is the American Medical Association has fought against the face-to-face requirement.

So the industry is left to wonder, is this a delay of the inevitable, and is CMS going to find a way to enforce face-to-face, or is CMS realizing what many healthcare organizations have been saying all along: the requirement is untenable? What is known the Affordable Care Act requires CMS to pursue the face-to-face requirement, but implementing requirement is looking not only unfeasible, but at least in the case of nurse practitioners flies in the face of law that governs nurse practitioners.

The frustrating part is that while the face-to-face requirement represents a massive unknown for 2015, if the requirement is enforced, then providers need to be ready. Fortunately, CMS has indicated that the face-to-face requirement will not be applied retroactively once the delay is removed, but claims can still be audited. This means that providers must have procedures in place to comply with the requirement. They must implement a protocol within their company requiring a copy of a face-to-face encounter and written order prior to delivery WOPD for specified items listed in the face-to-face rule. (For more detail on this, read “Face-to-Face: Are you Ready?” on page 14.)

Ultimately, the best strategy for dealing with face-to-face in 2015 is to comply with a policy that might not see enforcement over the next 12 months — or at all. That’s a frustrating proposition, but as already seen providers fare better with Medicare if they err on the side of caution.

Retail

Retail remains king

when it comes to new revenue for HME providers. At a time when Medicare programs such as competitive bidding are engaged in slash-and-burn reimbursement cuts, providers have sought new ways to reinforce their cash flow. That’s where retail sales have come into the picture. Retail sales offer an excellent way to accomplish that, because they are simple cash transactions that don’t involve Medicare, private payor insurance carriers or anyone else. The provider and the patient are engaged in a simple retail exchange.

Retail sales items appeal to a wide variety of patients with an equally wide variety of needs. For instance, bath safety items, home access products and aids to daily living offer a wide variety of appeals to patients ranging from seniors to bariatric patients to mobility patients. These opportunities leverage both the provider’s product knowledge and patient relationships.

And this lets providers reach out to their patients in new and creative ways. Throughout 2015, we can expect to see providers ramp up their marketing efforts with more effective, targeted appeals. They will need to consider the appeals that resonate with the different segments of their customers and patients, and determine which venues — print, social media, email, web, print, and even TV and radio — will spread awareness and drive interest and traffic to the store. (See “Marketing” for more on this.)

Once those patients get to the store, providers must be able to create a “retail experience” for customers and patients. When clients come to the providers’ retail location with cash sales in mind, they are expecting an experience that differs from that of a funded patient. A funded patient comes to the provider with a prescription and set expectations. A cash sales customer is looking for options, information and a range of solutions that can help make an informed purchase.

So, providers will increasingly need to display product in ways that attract and engage; use point-of-purchase displays to drive increased transactions; use solid signage to attract buyers to new offering, direct clients to items they are looking for; and maybe get them to consider goods they might not have had on their shopping list. Fortunately, vendors are already helping providers with resources and expertise that help them ramp up their retail game. But it doesn’t stop on the show floor. Providers might even need to consider all new retail locations. As a result, the coming 12 months could see site selection become an increasingly important issue, as well.

Private Payor

Another key to driving new revenue is private payor insurance. Providers are already tapping into this increasingly important alternative revenue source given that CMS has continued to reduce Medicare reimbursement in every way possible. And, private payor is an arena where many providers have already done business. Now they are simply ramping up their game in a known arena. Where several years ago, providers might have not paid much attention to private payor insurance revenue, now they are giving it the time it deserves.

But as familiar as private payor insurance is to providers, it is no a slam-dunk. Let’s not forget that private payor insurance carriers tend to set their rates based on Medicare reimbursement, and increasingly are auditing claims and demanding repayments. And in a move similar to Medicare’s efforts to reduce the number of DMEPOS providers via competitive bidding, there are some private payor carriers that have attempted to enter into single-provider relationships with large national HME providers, as they try to drive down their cost structures which makes the landscape that much
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more difficult. That said, it is also likely that those larger national providers will look to subcontract services for certain categories and geographic areas. However, these single-provider deals have produced mixed results, and the practice could be on the wane. (If only CMS would pay attention to such trends…)

Regardless of whatever challenges the private payor insurance market presents, it is an undeniable source of alternative revenue that providers must continue to pursue. So providers must ensure that their billings and claims, referral sales, delivery and support departments are all up to the task. Moreover, providers must ensure that they have the right accreditation for each of the private payor plans they wish to serve so that they adhere to the right billing protocols, policies and procedures.

And from a sales perspective, establishing solid relationships with private payor insurance carriers will require providers to do some higher level deal-making that they might have previously conducted in referral partner sales efforts. Now the management and ownership level will need to participate in the practice. They will also need to involve a larger sales team for such deals, that involves care and product experts. Likewise, their marketing efforts will need to be more highly targeted to their potential partners as well. Suffice it to say, 2015 will see a much higher-level and higher-touch effort on the part of the home medical equipment industry’s efforts to make broader, more strategic deals with private payors.

**Patient Management**

An undeniable U.S. healthcare trend is the increasing focus on driving optimal patient outcomes. Medicare’s effort to foster Accountable care organizations (ACOs), which are groups of healthcare providers that provide end-to-end health-care solutions that focus on optimizing patient outcomes for the lowest price, is case in point of this trend.

Medicare established guidelines establishing ACOs in the 2010 Patient Protection and Affordable Care Act. The Act lets CMS set up the Medicare Shared Savings program, which lets it extend contracts to ACOs to provide services to Medicare Part A and Part B beneficiaries. In terms of number, Medicare has reported that there were 32 ACOs in December 2011;

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27 ACOs in April 2012; 88 ACOs in July 2012; and 106 in January 2013. All told, there are nearly 350 ACOs across the country.

This speaks to a larger trend: If Medicare continues to set the state for the rest of healthcare, it is likely that healthcare professionals throughout the healthcare continuum will look for partners who can help them ensure the best outcomes for the best price. And this provides HME businesses with a key opportunity: if they can create services that help better manage the care patients receive, then they will position themselves as a key player in the healthcare process.

This is where patient monitoring and management fits in. Using a variety of communications methods and remote monitoring innovations, providers serve as an information conduit to the physicians and other sleep professionals involved in the patients’ care. In this regard, the sleep market has gained considerable ground in patient monitoring and management are sleep providers. There has been an imperative among sleep providers to provide systems that let physicians and other health professionals involved in the patient’s care remotely monitor the patient’s progress, and tweak the therapy as needed. These systems started out as data cards that would be reviewed later, after submission, but now, thanks to technology, sleep providers can offer systems that let doctors monitor patients that day.

This idea can be extrapolated beyond sleep. Physicians are busy people who want results from their partners. By working with the physician, the provider can set thresholds within the monitoring system. This means that the doctor can go about his or her business and be alerted by the provider when there is an event. Through a blend of automated and live communications methods, physicians can consult with patients and even ensure they are complying correctly.

So, by implementing monitoring and management systems, providers can leverage these strategies and technologies to position themselves as lynch pins in ensuring optimal outcomes and cost models for patients and partners, alike. That can translate into entirely new services in which the provider is delivering vital management information for other patient groups to physicians. For example, providers of therapeutic support surfaces and wound care could drive all new business models by regularly checking with patients to ensure wounds are healing and that therapeutic support surfaces are doing their job. Or diabetic supply providers could handle the busy work physicians spend on collecting and monitoring blood-glucose data.

And this makes good business sense. Besides helping ensure outcomes, patient management can help providers maximize the business they are getting from each client. Each time a patient experiences an event, the provider can contact the patient to find out what happened, reported information back to the physician as quickly as possible, and leverage that dialog an opportunity for the
provider to drive new business through resupply and related-item sales. For strategic thinking providers, patient management could mean increased revenue from multiple angles.

**Marketing**

As retail sales rise in importance when it comes to the bottom line at many HME businesses, providers will need to greatly sharpen their marketing game. They will need to infuse their patient-directed marketing efforts with clever, compelling marketing messages that get those patients to come into the retail location. But it doesn’t stop at bricks and mortar. Prompting customers to visit their online storefronts will be just as important. Patients are increasingly checking out DME items online before they even walk into the store. This means that providers need to ramp up their marketing skillset and start thinking both creatively and strategically, when it comes to retail marketing.

A key component of that strategy will be value marketing. Value marketing is a technique in which a business provides usable content and information to its existing and prospective customers on a regular basis. It can come in the form of emails, blog posts, print newsletters and similar delivery methods. But the key is to provide regular benefit so that the recipient will equate your business with that value.

This is a prime opportunity for providers, who have developed considerable expert product, healthcare and clinical expertise and information over the years. So, they simply need to share bits and pieces of this knowledge in order to drive that value marketing. During 2015, providers must develop marketing communications campaigns that provide customers useful health information while highlighting your branding and contact information. This way, every time providers make a marketing impression with these campaigns, customers will associate that value with their brand.

Clearly, social media will be critical in expanding the audience for that value marketing. Social media has almost redefined the way people communicate and interact with each other and businesses. In terms of marketing, it offers providers a unique opportunity to not only communicate to clients, but engage with them. If they haven’t already, providers will need to become masters of social media in the New Year in order to drive not only your value marketing, but also special sales events, or simply share interesting links and third party information they might enjoy or find useful. This makes them more engaged members of a home medical “community” that includes their patients, caregivers, referral partners and others.

Connecting online is only one part of the marketing equation for 2015. Providers will need to strive to make in-person connections, as well. Direct, public outreach will be just as important. In the same way providers offer their referral partners in-services, providers should host special seminars on their areas of expertise at various locations through the month. Their events could hit local senior living centers, libraries or hotel meeting rooms. Moreover, providers should target public community fairs, health conferences or similar public events throughout 2015 that would attract the consumers they want to reach, and try to get involved in each.

**New Business Models**

But cash sales can’t carry it all. While retail sales will be critical in maintaining provider cash flow, it is not a panacea for all Medicare-related funding setbacks and other trends impacting the home medical equipment space.

Looking at these factors, it is clear that providers will need to radically reshape their businesses in 2015 so that they can reach new markets.

What the declining Medicare market and increased effort to pursue avenues such as cash sales and private payor has taught us is that provider will continue to evolve into more unique businesses with business models that tap into varied revenue sources. Providers are taking their strong suits — patient knowledge, product knowledge and care knowledge — and look at their local patients, care providers and health plans to find the customers that will appreciate their expertise. And those customers might not fit the traditional home medical equipment mold.

These models will make matches between patient knowledge and product knowledge to serve customers that HME providers might not have considered before. For instance, working to supply residential care and other facilities-based providers with a variety of durable medical equipment is a perfect example of how a provider could bring that varied expertise to bear in an entirely new venue beyond the home.

Other new business models could greatly hinge on a specific product expertise. For instance, providers specializing in wound care and therapeutic support surfaces could expand into that would help them build off of existing business relationships with physicians, as well as tap into new business relationships with facilities such as wound centers. This would let them extend not only their core offerings in those categories, but special and related offerings, such as NPWT, enteral nutrition, compression, support surfaces, and of course dressings.

And, of course, new models could take place in the home. For instance providing home care services for seniors and other patient groups could be a perfect way to expand on providers’ existing patient relationships. And if there is already a group of established players delivering those kinds of services in a provider’s market, then that provider should consider creating a business relationship between the two.
As the Round Two re-compete thunders down the tracks, HME providers scramble both in terms of their legislative response and in preparing their bids.

Hear that sound? It's the rumble and roar of the Round Two re-compete, which is hurtling straight toward the industry's efforts to reform competitive bidding. We'll call CMS's train the Round Two Express and the industry's the Legislative Locomotive, and neither looks like it will jump on an alternate track before the big collision.

Just like in an old black-and-white serial film, the industry is racing against the clock to respond legislatively, but unlike the cinema cliffhangers of yesteryear, we're not sure the industry can pull it off. In fact, it doesn't look likely. Bidding starts on Jan. 20 (see “Round Two Re-Compete Timeline” for the full slate of pertinent dates), which doesn't give the industry much time...
Head-on Competitive Bidding Collision

“Our goal is to get binding bids passed prior to the opening of the bid window ... We’re working every angle we have to get these bills through.”
— Cara Bachenheimer, Invacare Corp.

“We've never been in a better legislative position, based on what we're hearing from our champions on the Hill.”
— Seth Johnson, Pride Mobility Products Corp.

Round Two Re-Compete Timeline

- Dec. 18, 2014 — Registration for user IDs and passwords began.
- Jan. 6 — Authorized Officials are strongly encouraged to register no later than this date.
- Jan. 20 — Backup Authorized Officials are strongly encouraged to register no later than this date.
- Jan. 22 — CMS opens 63-day bid window for Round Two re-compete and the national mail-order re-compete.
- Feb. 17 — Registration closes.
- Feb. 23 — Covered document review date for bidders to submit financial documents.
- March 25 — 63-day bid window closes.
- Winter 2016 — CMS announces single payment amounts, begins contracting process.
- Spring 2016 — CMS announces contract suppliers, begins contract supplier education campaign.
- Spring 2016 — CMS begins supplier, referral agent, and beneficiary education campaign.
- July 1, 2016 — Implementation of Round Two re-compete and the national mail-order re-compete contracts and prices.

Note: CMS notes that these dates are "target dates" and subject to change.
hands if suicide bidding is allowed to occur once again. Jobs and patient access to care hang in the balance.

One thing helping the industry in terms of the Senate is the changing of the guards the 114th Congress is bringing.

"With the Republicans taking over the Senate, we will be working with a Republican leadership versus a Democrat leadership, and that is helpful to us," Bachenheimer explains.

"The message that voters sent, and that I think both parties understand is that they are fed up with nothing being done," Gallagher said. "From that standpoint I think you are going to see a change in the Senate, and you're already hearing it from the standpoint of [incoming majority leader] Sen. Mitch McConnell … who's going to want to show people that they can legislate."

That means that if there is going to be resolve on Republican-majority House and Senate to drive legislation, and shake the moniker of the do-nothing Congress, then there will be multiple opportunities to advance the industry's binding bids legislation, Gallagher says. If the industry can't secure a win as standalone legislation for binding bids before the re-compete bid window opens, at least there will be opportunities to advance the industry's legislative language as an attachment.

And for providers that are feeling frustrated that the industry can't seem to put its legislation over the top, Johnson reminds that they must keep fighting. Legislation is a process that take time, and isn't as nearly a linear process as the "how a bill becomes a law" segment on Saturday morning television's "Schoolhouse Rock" might have led us to believe. If anything, the industry has built up considerable political capital, he points out.

"Start getting your data together for what you feel your bids can be as far as what price you can offer and live with it and still succeed — and that's been the dilemma all along."

— Georgie Blackburn, BLACKBURN'S

"We've never been in a better position, based on what we're hearing from our champions on the Hill, for the first time we were able to get a Senate binding bids bill introduced, and there is a limited opportunity to get that very necessary reform incorporated into the program [before Jan. 22]."

Johnson explains. "But the only way we'll be successful in doing that is if we continue to engage our legislators and let them know this is a high priority."

The Round Two Express
But the fight to try and reform competitive bidding before the Round Two re-compete starts tells only half the story. While the industry tries to save the Legislative Locomotive, it must also try and purchase a ticket on the Round Two Express. To put it more clearly, providers need to bid in this second round, because despite all its headaches and frustrations, Medicare
reimbursement is still business that providers can’t afford to ignore. Even if a business didn’t secure a contract the first time that Round Two was bid in 2012, they likely have not diversified their businesses and found enough new revenue sources to make them so successful that they can forget about Medicare. They must bid.

“You fight against competitive bidding; you build different revenue streams to combat it,” says Georgie Blackburn, vice president of government relations and legislative affairs for BLACKBURN’S. “At the same time — and I can only speak for my business — every time bidding opens up, there are certain lines that we feel we would love to have. Because one piece of business leads to another, and then to another and another.” This is particularly important, because discharge planners and other key referral sources seek simplicity. When they work with an HME provider for one item for a patient, they ultimately want to use that provider for all sorts of items, related and otherwise. In short, a contract means a provider becomes more of a “one-stop shop” for partners that can bring a lot of business.

“We saw that happen in Round One and Round Two,” Blackburn said. “Your marketing changes to illustrate what you can still do well. Then you’re reaching the discharge planning mindset that says, ‘I don’t have time to call everybody anymore.’”

Besides marketing, Blackburn says that providers bidding in the re-compete need to go back and ensure their financials are in order like they were the first time Round Two got bid.

“That’s the first thing,” she says. “Start getting your financial documents in order and make sure they are failsafe to ensure there is no misunderstanding. … Then of course start getting your data together for what you feel your bids can be as far as what price you can offer and live with it and still succeed — and that’s been the dilemma all along.”

And when we get to the actual bidding, what will be interesting is how some of the Round Two contract holders bid in the re-compete. They might turn the system around, according to Clint Geffert, president of VGM & Associates at VGM Group Inc. It could be that market dynamics might start overturning the crazy-low standards set by previous iterations of CMS’s bid program.

“Those that have won, are looking at the re-compete and quite frankly the previous winners are contemplating what they want to bid on,” Geffert says. “What we’re hearing is that some of them won in multiple categories, and there are certain categories where the bid rates don’t make sense for them to continue. So they’re claiming that they are going to bid reasonably and at rates that will allow them to make money.”

Another dynamic is that the providers that only won one contract are suffering from the fickle nature of referral sources’ need for one-stop providers that Blackburn previously pointed out. Those providers have struggled and might be eager to pick up more contracts. That also could change things up.

“The one thing we’re telling the winners is, you need to prepare for not winning,” Geffert says. “What’s your plan in case you don’t win in the next round? It’s somewhat of an ‘aha moment’ because they have not necessarily had to go through some of the same extremes that non bid winners did to make their businesses more lean and more efficient and pursue new revenue streams.”

The reality of the head-on collision between the Round Two re-compete and the industry’s efforts to stop it is that providers must ride on both trains: They must work to reform the bidding program, while also preparing their businesses to perhaps live under the frustration of flawed program for another three years. But throughout, they must leverage the legislative progress the industry has made to stop CMS’s runaway train before it ultimately derails their businesses.
As providers hunt for ways to expand their revenues, compression garments represent a key opportunity for HME businesses to serve new patients and drive new revenue. Compression can be used to treat a variety of conditions, including foot swelling, mild edema, varicose veins, thrombosis, varicocities of varying severities, and diabetes. This is where providers can help, by offering a range of compression solutions and ensuring staff can knowledgeably assist a wide range of patients.

Better yet, the revenue from compression products is usually cash and free from Medicare. There are only a few Medicare scenarios in which Medicare reimburses compression, so for the most part, compression transactions are done a retail basis. And given the large number of diabetic patients, seniors and other major patient populations that need compression, the number of transactions can get very large. Providers that specialize in compression can often derive as much as a quarter of their revenues from compression garments alone.

That means that providers can concentrate on all the sales and marketing appeals that can drive increased sales. And sales and marketing is an important consideration because, at the end of the day, compression garments are clothing, and that means that fashion can play a role. Compression or no, people want to feel what they’re wearing makes them look good. That opens a wealth of marketing opportunities for providers. Let’s look at some of the latest offerings on the market:

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Touch-free hydrophilic intermittent catheter
The VaPro Plus intermittent catheter is an extension of the innovative VaPro catheter, launched in the U.S. earlier this year. VaPro hydrophilic intermittent catheters use pure catheter hydration technology to minimize the amount of water in the package while still providing a pre-hydrated catheter that is ready to use as soon as the package is opened. VaPro catheters are designed with smooth hydrophilic coating for easier insertion and withdrawal, and a protective tip and sleeve to help avoid contaminating the catheter during use.

Hollister Inc.
(888) 740-8999
www.hollisterpeoplefirst.com

Portable, fold-up ramp for bariatric users
The Bariatric Multifold Ramp is a patented center joint hinge that eliminates a pinch point; adds strength; and lets the ramp fold and be carried like a suitcase. The ramp supports a maximum ramp capacity of 400 lbs. for one axle and 800 lbs. for two axles, and accommodates wheelchairs and scooters with various wheel configurations. A safety guide indicates if ramp is on a safe slope; a high-traction surface prevents slipping; and a closure strap locks ramp panels together.

Prairie View Industries Inc.
(800) 554-7267
www.pviramps.com

Reliable style and durability
The Trident HD front-wheel drive power chair aims to offer style, durability, and reliable performance all in one chair. The Trident HD has a 450 lbs. weight capacity, available in 22 in. or 24 in. captain seats with a semi-reclining back and adjustable height headrest for maximum comfort and support. The chair comes with adjustable height, width, and angle, padded armrests, and the seat has the option of being adjusted forward or back for proper comfort positioning. The front wheel drive provides 4 mph top speed and 15 mile maximum cruising range, as well as a smooth ride.

Drive Medical
(877) 224-0946
www.drivemedical.com

FAA-approved, lightweight portable oxygen therapy
The ActiVox 4L is a 4.8-lb., FAA-approved device that provides up to 4 LPM eq. using Inova’s PULSE-WAVE Delivery, with an oxygen Sensor standard on every unit, and up to 10.25 hours of internal battery runtime. Controls include a transflective display; clear alarm and charging notifications; simplified hour meter and purity readings; tailored compliance tracking. Standard accessories include a four-way carry case; adjustable straps; AC power supply; DC power supply; accessory bag; nasal cannula; and an external battery is available.

Inova Labs
(512) 617-1700
www.inovalabs.com
Easy mobility solution with distinctive design
The I-Walker rollator features an eye-catching design and unique style, while helping patients improve daily mobility. The I-Walker’s caster fork design allows for an enhanced turning radius while the 7 in front casters allow optimal steering and rolling comfort. In addition, the I-Walker offers quick and easy tool-free adjustment to the handle height and back support. Plus, the unit folds to a compact size for storage.
Drive Medical
(877) 224-0946
www.drivemedical.com

Bariatric rehab mobility designed for active users
The Q6 Edge HD features high-torque, four-pole motors, Quantum’s Mid-Wheel 6 Drive Design ATX Suspension, and Group-24 batteries. The chair is engineered to meet the performance needs of active users weighing up to 450 lbs. The Q6 Edge HD accepts a complete range of seating, including TRU-Balance Power Positioning, and supports electronics options such as Q-Logic 2 to deliver exceptional rehab capability at an excellent value.
Quantum Rehab
(866) 800-2002
www.quantumrehab.com

A POC designed both for in-home use and on the go
The Oxlife Independence can be used for both in-home stationary and portable continuous flow. The POC offers up to 3LPM continuous 6 pulse settings, ESA Technology for long battery life, and dual battery bays so patients can swap while the device is running. The Oxlife Independence is FAA approved for air travel, and comes with a five-year warranty.
O2 Concepts LLC
(877) 867-4008
www.o2-concepts.com

Stairlift offers smooth operation, easy installation
The SL400 Vantage Stairlift was designed to provide smooth operation, constant speed, and comfortable seat design that folds to a slender 13.6 in. when not in use to allow others to pass comfortably. Additionally, stairlift’s design facilitates quick installation and delivery, using 20 percent fewer parts. It can be installed on the left or right hand of a stairway without reconfiguration and can adapt to a variety of staircases with provisions for a zero-overrun landing. The rack and pinion drive system can carry 300 lbs., and travels 18 feet per minute with smooth starts and stops and simple controls.
Harmar
(800) 833-0478
www.harmar.com

Tank Tote Features
(1) Improves delivery times to patients.
(2) Eliminates the missing cylinder problem with a convenient cylinder management system.
(3) Provides a convenient low budget storage container to the patient as a value added service.
(4) Stores flat and ships flat.
(5) Available for M-6, C, D, and E size cylinders.
(6) Meets Compressed Gas Association guidelines for cylinder storage.

For More Information Or To Place Your Order
Call 1-800-659-9110

Mountain Aire
Three Sizes

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Call for FREE SAMPLE

HME Inventory
**HME Inventory**

**Quiet PAP therapy with a focus on comfort**
The PillowFit Deluxe Nasal CPAP System was created for quiet PAP therapy while maximizing comfort through a lightweight, minimal facial contact design with three different size nasal pillows for superb user fit. Two breathable, moisture wicking foam straps, make the PillowFit simple to fit to nearly any user. The PillowFit Deluxe includes three pillow sizes, and has been developed with a 360-degree rotating elbow connection with silicon tubing and a simple strap design. By providing a system with two configurations, the full PillowFit system or the PillowFit system without headgear, providers may choose the appropriate configuration to minimize costs and/or maximize reimbursement.

*Drive Medical*
(877) 224-0946
www.drivemedical.com

**Catheter that offers affordable quality**
Apogee HC hydrophilic intermittent catheter is the newest member of the Apogee Essentials line, which offers quality at an affordable price. The Apogee HC hydrophilic catheter is simple to use. It is designed to be well lubricated and offers added control with a sliding sleeve to help avoid touching the catheter.

*Hollister Inc.*
(888) 740-8999
www.hollisterpeoplefirst.com

**Chair offers all-day use, lightweight tilt-in-space**
The Convaid Trekker provides all-day use with the flexibility of 180-degree reversible seating that lets occupants face forward or face their caregivers with a simple adjustment. This opens up a world of possibility for long and varied treks. The chair features variable positioning of tilt and recline, and accepts after-market seating options. The Trekker is designed for early intervention through early teens, and can be used as an all-day chair.

*Convaid Inc.*
(888) 266-8243
www.convaid.com

**Heavy-duty, full-electric bed frame**
The BAR750 Bariatric Bed is capable of supporting up to 750 lbs., and bed expands from 39 in. to 48 in. in width, and from 80 in. to 88 in. in length. Four quiet DC actuators easily reposition the head and foot sections, as well as the bed height. For safety, the bed comes standard with a battery backup, and bed ends and half rails standard, as well.

*Invacare Corp.*
(800) 333-6900
www.invacare.com

**Antimicrobial and anti-fungal protection for larger patients**
Tranquility AIR-Plus Bariatric Disposable Briefs are 100 percent breathable with microscopic pores that allow moisture vapor to escape for complete air circulation and comfort. TQ-A/P (Tranquility’s antimicrobial and antifungal protection) treatment is bonded to the inner and outer surfaces to inhibit bacterial and fungal growth. Stretchy, side panels extend to a circumference of 106 in. and a patented Peach Mat absorbent core minimizes odor and holds over a quart of liquid for maximum protection.

*Principle Business Enterprises*
(800) 467-3224
www.tranquilityproducts.com

**Portable oxygen device with verbal feedback and control in multiple languages**
The SeQual equinox provides continuous flow options from 0.5 LPM to 3.0 LPM and 9 pulse-dose settings from 16mL to 192mL. The multi-language voice interface offers a layer of comfort to users by providing verbal confirmation of changed flow rate settings, battery times, and any alarms. The POC weighs 14 lbs, and a newly designed, easy-to-maneuver frame makes the SeQual eQuinox easy to bring along.

*CAIRE Inc.*
(800) 482-2473
www.cairemedical.com

Management Solutions | Technology | Products
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### Upcoming Industry Events

#### January

- **Jan 28 - 31**
  - Assitive Technology Industry Association (ATIA) Annual Conference
    - [website](http://www.atia.org)

#### February

- **Feb 11**
  - GAMES / GRTC 2015 Winter Meeting
    - [website](http://www.gamedme.org)

- **Feb 20 - 24**
  - American Academy of Allergy, Asthma and Immunology (AAAAI) Annual Meeting
    - [website](http://www.aaaai.org)

- **Feb 24 - 25**
  - National Mobility Equipment Dealers Association (NMEDA) Conference
    - [website](http://www.nmeda.com/annual-conference)

#### March

- **Mar 24-26**
  - GlobalShop
    - [website](http://www.globalshop.org)

- **Mar 27 - 29**
  - LAMposium
    - [website](http://www.thelamfoundation.org/patients/lamposium)
The Changing Nature of ‘Seniors’

HME providers and manufacturers alike are learning how to reach Baby Boomers.

The nature of “senior” DME users and purchasers is changing. That’s a reality that is being felt not only by HME providers, but manufacturers, as well. For instance, since Harmar was founded in 1998, we have focused throughout our brief but active history on helping seniors and others who are facing mobility challenges. We started with a mobility lift designed to carry scooters and wheelchairs inside or onto vehicles for people with limited physical mobility. Since then, we’ve come to manufacture and offer more than 400 products and accessories.

And, while many of Harmar’s products are sought by seniors, it is quite self-evident to many of us Boomers (those of us who were born between 1946 and 1964) that as we approach that category, we’re aging differently than our parents. Sure, the gray hair and reading glasses haven’t changed, yet we’re more committed to, and expect a healthy middle and senior aging experience. Also, we’re more comfortable with technology and more pointedly the Internet. While my 80-year-old mother wouldn’t think of perusing the ‘Net for her health needs, send my Mom a catalog, and you’re “in the game!”

Personally, I regularly employ the Internet as a resource with a few apps that I use daily. However, when it comes to a significant purchase, such as a stair lift or platform lift for my home, I want to see it, touch it, ride it and talk to a dealer. The only tool belt in my house is if a Bob Vila ‘This Old Home’ rerun is on. Yet, similarly, the Amazon Prime constituency among us (my wife) may not want to go into the local dealership and will take installation claims at face value. For her, the Internet is less about price shopping than the means to look for pictures, features and reviews, plus a desire to understand the array of quality alternatives available.

Supporting the Customer

And we cannot forget that these products still have a long way to go to reach general awareness status. They even face a little resistance from potential users who are holding on to their pride that needs to be overcome. Stair lifts, vehicle lifts, and pool lifts are starting to appear in pop-culture on mainstream television shows, in non-related commercials and even some focused product placement.

Thus, in my family unit, we have an array of buying patterns. Of interest is that in the cash-pay (non third-party reimbursement) side of the market where Harmar operates, each of these channels (dealer, mail-order, internet, mass-market direct) has seen a rise in revenue as the demographics of America continue to support the burgeoning mobility and accessibility segment. Though each channel eyes the alternative warily, Harmar has chosen to support the consumer in the fashion they want to buy.

In recognition of the consumer’s interest in quality, service and technology, Harmar is investing in capabilities to help the consumer view which independent dealer has a Harmar products in stock. We’re providing the consumer instant installation verification, allowing our dealer and installer partners (as well as Harmar) to get paid more rapidly; plus systems that also allow us to assure the consumer that our installation partners are en-route, with a picture of the installer such that our Moms and Dads know when and who will be at their door with a valued product and service.

It’s about providing an “easy-to-do-business: customer experience for both the distribution channel and the end-user. We think so strongly about this responsibility that we’ve repurposed several key managers and executives with the implementation of this mission.

Driven by the dual impetus of rising demand and demographics favoring seniors, Harmar will double capacity between today and the end of 2016. Our dealers are less interested in buying ten lifts for a meaningful discount and carrying them in inventory than Harmar shipping lifts the day of order (Mobility) or next day (Access). Though we’re close on Mobility and expect same day shipments to be the norm in 2015, Access will require additional capacity, which is underway shortly.

The Price of Entry

Harmar’s dealers install more than 2,500 lifts a month for seniors and veterans, and we work diligently to improve our products’ installability. We get reports all the time related to this. My favorite was the gentlemen, a one-man dealership, who had three hours until his wife arrived at the airport when he received an urgent request for an immediate install. He was able to pick up a lift from his shop, install it at the customer’s location and still make it to the airport to pick up his wife. Quick and easy installation, personal attention and short lead times at affordable prices is the customer charter for Harmar.

At our facility in Sarasota, our training center educates more than 300 dealers annually who are intent upon staying up with industry standards and credentialing. Our course is an investment in their knowledge and helps them propose the right product for the right scenario; helps them learn how to install and troubleshoot efficiently and effectively, and gives them confidence with Harmar products. Many of our employees, including inside and outside salespeople are Certified Aging in Place Specialist. With our sales teams deployed in the market, coupled with our in-house training, we learn from our dealers as much as they learn from us.

None of this is cutting edge, yet is now the “price of entry” for a company seeking to meet the needs of Boomers, the wealthiest generation in the history of mankind, 10,000 of whom are retiring every day, a trend that will persist every day for the next 17 years! Today there are 12 million seniors between the ages of 74 and 85, that number is projected to double to 24 million by 2030.

As Steve Jobs stated, “People don’t know what they want until you show them.” We see our mandate at Harmar to partner with our dealers to educate the consumer, allowing them to make informed and appropriate decisions around products that will enrich their lives.
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Visit our site daily for HME business strategies, efficiencies, and new revenue opportunities—all in one place!

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