COLUMN

Outselling the Chain Stores

Maintain the upper hand with exceptional customer service and specialty product options

By Jack Evans

If your customers can buy HME products at Wal-Mart, a chain drug-store or online, why would they bother coming into an independent home health care (HHC) store and pay a higher price just to buy from you? The answer is really about positioning.

Mass market retailers and drugstore chains merchandise over-the-counter (OTC) products that sell themselves. They only sell the fastest moving SKUs within a given category. And these products must be self-explanatory so customers are able to pick them up off the shelf (or find them online) and instantly understand how the product works and its benefits.

Unfortunately (or fortunately, depending on your point of view), most HHC products are not OTC products. Home care products and medical supplies are more like boutique items that require specialty retailers to display and sell quality brands; highly trained salespeople to explain and demonstrate these products; increased breadth and depth of inventory to meet customers' diverse needs and products merchandised out-of-the-box for customers to touch and try, then buy.

Chains and online retailers focus on turns and minimum profit margins. Quality is not usually a concern as higher retail price points reduce sales as well as net profits. Educated salespeople are also an unnecessary expense when minimum-wage employees are adequate clerks to work registers. Sales-per-facing, sales-per-square-foot, sales-per-click and one-size-fits-all are the name of the game in mass market sales.

Successful HHC sales are the result of selling a package rather than a single product. This package includes medical-grade product(s), customer education, product demonstration, delivery (if necessary), customer service follow-up, 24/7 support, warranty and recall support and repair service.

Remember that chains only sell a product at a price. In our HHC marketplace, retailers are in the business of educating people about how HHC products and services will maintain or improve the quality of their daily lives. Our knowledgeable salespeople then offer a recommendation, which is usually what the customer buys.

Chains usually sell advertised name brands or their private labels. HHC retailers have learned that selling these same brands is a no-win situation for them. Chains or online retailers sell these name brands for retail price points that are often less than what HHC retailers pay wholesale for the same products.

Successful HHC retailers know their competitors and which brands to sell in respective categories. They carefully decide which of these products to carry so as not to compete head-to-head on price. These HME brands are often what we consider medical-grade products—higher quality than mass market brands and often hospital grade.

HHC brands also offer a complete product selection within their respective categories, such as a basic model offering one or more upgrades. For example, instead of stocking only one inexpensive/basic brand lift chair in a chain, HHC retailers will display three or more options (good/better/best) with different features, benefits and price points.

Today 80 percent of purchasing decisions among baby boomers/family caregivers are made inside a retail store. These customers usually do not know what they are going to buy before they enter. Boomers now represent two-thirds of our retail HHC customers, as the adult children who care for aging parents or loved ones.

When a customer enters a chain or mass merchandiser and requests an item, they are directed to a respective aisle number on which to find the product. If the customer can find the product, they will only find one product option and may not know if it's the best option for their loved one at home.

However, when that same customer enters a HHC retailer, they are greeted by a salesperson who asks how they might help. When the customer asks for a specific product, they are walked to the appropriate department, asked a few qualifying questions about the end user and then shown and educated on the core and related products that will help meet the end user's HHC needs.

Superior customer service combined with a complete product selection and medical-grade products can provide a winning formula for keeping independent HHC retailers successful and profitable in today's competitive marketplace. HC

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It's No Bundle of Joy

Review potential issues concerning facets of CMS's proposed rulemaking

By Cara C. Bachenheimer

The Centers for Medicare and Medicaid Services (CMS) released its Advance Notice of Proposed Rulemaking on Feb. 26, 2014, and it's safe to say that no one anticipated CMS would be proposing to scrap the current Medicare payment methodology and replace it with a bundled payment system for future rounds of competitive bidding. CMS also included what we were expecting—the first step in CMS's implementation of its authority to apply bid rates in areas beyond those included in Rounds 1 and 2, or to conduct bidding programs in these rural areas. Unexpected was CMS's use of the Advance NPRM, an unusual step that federal agencies take prior to issuing a proposed rule. The next stage in the rulemaking process is that CMS will issue a proposed rule, take more public comments and publish a final rule later this year.

On the expansion of the bidding program or application of bid rates to areas beyond Rounds 1 and 2, CMS asked for public comments on "several aspects that it would consider in developing a methodology to adjust DMEPOS fee schedule amounts or other payment amounts in non-competitive areas based on DMEPOS competitive bidding payment information." CMS asked whether costs vary by geography, market size, population or distance covered, and whether there should be a different or interim methodology for items such as transcutaneous electrical nerve stimulation (TENS) that have only been included in the most recent Round 1 recompete. CMS did not identify any particular methodology it might eventually employ.

On the unexpected bundling proposal, CMS provided very little information on how it would develop such a methodology for items in competitive bidding in future bidding rounds. In its press release, CMS states, "CMS is seeking comments on whether it should consider simplifying the payment rules under competitive bidding programs...by making one monthly payment to the supplier for all related items and services needed each month. The monthly payments would continue as long as medical necessity for the covered items continued and the supplier would be responsible for furnishing all items and services needed each month." CMS also asks, "Are lump sum purchases and capped rental payment rules for DME and enteral nutrition equipment still needed? Are there reasons beneficiaries need to own expensive DME or enteral nutrition equipment? Would there be any negative impacts associated with continuous bundled monthly payments for enteral nutrients, supplies and equipment or for certain DME?"

This proposed bundling payment system raises more questions than it answers. It is unclear how many related items would be included in the bundle. Would CMS limit the bundle to a single item and related accessories, such as a particular wheelchair and accessories, or would it bundle a larger bundle of DME items, such as manual and power wheelchairs, into a single payment amount? Regardless of the scope of what would be bundled, the proposal raises questions about coding, coverage and documentation. Would suppliers bill a code bundle or bill codes separately? What data does CMS have for suppliers to understand beneficiary utilization of various items included in a bundle during a period of medical need in order to be able to submit an informed bid? Presumably, CMS will provide further details in its proposed rule.

One of the more interesting aspects of the proposal is that CMS proposes to pay a continuous monthly bundled rate throughout the period of medial need—there would be no rental cap, and the supplier would retain ownership of the item once medical need ends. Another interesting facet of CMS's proposal to bundle payments for DME under competitive bidding is its tacit acknowledgement that the current bidding program has resulted in problems for beneficiaries to access repair services, for wheelchairs and other beneficiary-owned items. One of CMS's stated objectives is that payment for repairs, maintenance and servicing would be included in the bundled payment. CMS states this would eliminate the need for beneficiaries to worry about access to these services. For more than six months, industry representatives have been trying to work with CMS to fix the issue of beneficiary access to repairs, yet CMS has continually denied that there is any problem and hence no need to change current policy. More details will likely unfold in the next few months. HC

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COLUMN

Active Participation

The success or failure of an endeavor is determined by those involved

By Tom Ryan

There are a number of forces at work shaping the HME marketplace, from the exploding numbers of baby boomers reaching qualifying Medicare age to technological advances in the equipment companies sell and the systems they use to manage their employees' time. In the case of companies that receive a significant portion of their revenue from Medicare, the government is by far the most prominent force.

Within the government, Congress and CMS are the market-makers. Congress passes legislation, such as the Medicare Modernization Act and the Affordable Care Act, which contains specific language directed toward HME. CMS interprets legislation, makes rules on how to put it into effect, and devises systems for delivering, monitoring and assessing the results. Every one of these actions impacts the HME marketplace in small and large ways.

Because most markets have at least some degree of volatility, successful businesspeople know that one of the keys to long-term profitability is managing proactively rather than reactively. When a company is running just to keep up, there is no room for error and it is unlikely that the company will ever truly get ahead. In other words, hoping for the best is not a good strategy for a company that wants to stay in business.

For the past few years, the Medicare HME market has experienced high volatility—the start of the bidding program in 2011, the tremendous increase in audits, the power mobility prior authorization demonstration project and the introduction of PECOS are just a few examples.

It stands to reason then, that companies with Medicare revenue should take advantage of every opportunity to be proactive in shaping the marketplace in which they hope to continue doing business. How else will they have real influence over what happens?

One excellent way that AAHomecare members get involved is by actively participating on one of the Association's policy councils. There are four primary councils, each with a unique focus and each staffed entirely by volunteers from among the Association's member companies. These volunteers are experts in their fields, and the expertise they share benefits not only Association members, but also the entire HME industry.

The councils are integral to AAHomecare's legislative and regulatory advocacy. They help shape the Association's responses to the many ways Congress and CMS try to change the HME marketplace. Below are some of the councils' top goals for 2014.

HME/RT (oxygen and respiratory)—1) Protect the Medicare Part B oxygen benefit (outside of competitive bidding) from reductions in the capped rental period or reimbursement rate 2) Make significant progress in working with the Administration and Congress to clarify or change the CPAP policy on refill and adherence. 3) Document the clinical component of the Medicare Part B respiratory benefit.

Medical Supplies—1) Address access to wound care supplies and negative pressure wound therapy in competitive bid areas. 2) Work with the Congressional Diabetes Caucus to address patient access problems for diabetic testing supplies as part of the larger competitive bidding strategy.

Mobility—1) Add cosponsors on the House and Senate separate benefit bills. 2) Work with the Administration to address issues in the ESRD final rule relating to repairs and replacement of component parts. 3)Work with Congress and the Administration to address issues with the prior authorization process.

Regulatory—1) Participate in jurisdictional council meetings to help foster better coordination and address problems facing the home care sector. 2) Work with CMS to create educational material on confusing coverage criteria to educate providers, suppliers and prescribers. 3) Implement an audit survey tool to collect data on the impact of audits and effectively use that data in advocacy efforts. 4) Work with other organizations on the introduction and promotion of audit oversight legislation.

If you are an AAHomecare member without council experience, consider joining. The HME/RT, Medical Supplies and Mobility Councils are currently accepting nominations. If you're not yet a member of the Association, it's time to stop reacting and start finding ways to manage your company from a position of strength. HC

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Avoid an Employee Lawsuit

Follow these points to better protect yourself under the Fair Labor Standards Act

By Edward Vishnevetsky

There has been a recent increase in the number of lawsuits brought by health care workers against employers under the Fair Labor Standards Act (FLSA). This article provides a summary of the FLSA and how DME suppliers can comply with the FLSA "outside exemption" for commission-based marketing employees.

Under a commission-based compensation arrangement, a DME supplier pays its marketing employees (full-time or part-time) a commission to recommend the company's products to referral sources. The amount of compensation varies with the amount of DME sold to Medicare or Medicaid beneficiaries based on referrals. The federal Anti-Kickback Statute (AKS) "bona fide employee" safe harbor allows a DME supplier to engage in this kind of financial arrangement, which is otherwise not allowed for independent contractors.

A commission-based compensation arrangement must comply with the FLSA. The FLSA is a federal statute that establishes minimum wage and overtime pay for the majority of non-exempt employees. According to the FLSA, employers can pay marketing/sales employees commission-based compensation, but the compensation must be equal to, at least, the federal minimum wage. If not, the employer must pay the difference.

The FLSA exempts an employer from paying a commission-based employee minimum wage and overtime if the commission-based employee is deemed a: (a) bona fide executive, (b) administrator, (c) professional or (d) outside salesman.

The outside salesman employee exemption applies if the following are met: 1) The employee's primary duty is making sales or obtaining orders or contracts for services; 2) The employee must be customarily and regularly engaged away from the employer's place or places of business.

In a recent Supreme Court case, Christopher v. SmithKline Beecham Corp. d/b/a GlaxoSmithKline, 132 S. Ct. 2156 (2012), two pharmaceutical sales representatives brought suit against GlaxoSmithKline for failure to pay overtime under the FLSA. The representatives spent approximately 40 hours/week calling on physicians to discuss GlaxoSmithKline's prescription drugs. The representatives' primary duty was to obtain a nonbinding commitment from physicians to prescribe GlaxoSmithKline's drugs. The representatives also spent 10-20 hours attending events and performing other tasks. The representatives did not have to report their hours, and were subject to minimal supervision. The representatives' compensation was based on the number of drugs sold. Ultimately, the Court held that the representatives were exempt outside salesmen because their primary duty was to make sales at a physician's place of business.

Similar to Christopher, marketing employees in a DME setting primarily promote a supplier's products and obtain referral sources' commitment to prescribe products to be provided by the supplier. DME marketing personnel are paid a commission based on the amount of referrals that materialize in sold products.

Based on the foregoing, for DME suppliers to properly invoke the outside sales exemption for their marketing personnel:

- Suppliers must make sure they treat marketing personnel as bona fide employees, and treat them as independent contractors.
- Primary duty of marketing personnel must be to make sales or obtain orders or contracts for services. According to the FLSA, sales include any "sale, exchange, or contract to sell, consignment for sale, shipment for sale, or other disposition."
- Marketing personnel must conduct their primary duties away from the supplier's regular place of business. A commission-based employee is engaged away from the employer's place of business if the employee makes sales "at the customer's place of business, or, if selling door-to-door, at the customer's home." The Department of Labor clarified that outside sales does not include "sales made by mail, telephone or the Internet unless such contact is used merely as an adjunct to personal calls." Any fixed site, including a home or office, used by a salesperson as a headquarters or for telephone solicitations, is considered the employer's place of business, even if the employer is not the owner or tenant of the property.
- Total amount paid to the marketing employee must equal, at least, federal minimum wage multiplied by the number of hours worked. HC

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COLUMN

Benefit From Complaints

Prepare your business to handle negative customer feedback to profit in the end

By Louis Feuer, MA, MSW

The interaction your company has with anyone outside the office can have either a negative or positive impact on the future success of your company. Interactions are a test. Companies work for years to preserve and build their reputation, and often find that one wrong word or failure to act appropriately can destroy what they have worked to develop.

This could happen to your business. Any customer can repeat what you say, and in the process, reinterpret your comments. Sometimes it is not what you say, but what you forgot to say, or the call you forgot to make. You may have forgotten to explain to the customer about the copayment they are responsible for. You may have forgotten to remind the customer that the part they need will be delayed and could take up to one week before it arrives. Customers can simply become irritated with the lack of communication.

Each customer—family member or end-user—comes to us with their own set of stressors and expectations. They often have little experience with insurance issues related to medical equipment, how to use the equipment or the role you can play in the rehabilitation. When they do not get what they expect, the challenge is often determining how that happened. For this reason, all complaints—big or small—require some research. Each complaint requires a minor audit. Valuable responses can come from the questions such as: Who was impacted regarding this complaint? Is this problem related to an existing corporate policy or procedure? Is it related to how we interpreted Federal Guidelines for the patient? Is it related to our patient education program? Is there a form or instruction sheet that could have been provided to avoid this complaint? Is it related to an unfulfilled promise to the customer? Do records indicate that this complaint has been registered before? Could the staff benefit from changes in orientation and training to help address this issue? What can we do as a company to insure this problem is not going to happen again? What have we learned from this complaint?

There is no better consultant than our customers. Unfortunately, when they complain, we are sometimes often too defensive. We are most often responsible for the problem, and it is most distressing is that we fail to learn from our mistakes.

Accreditation requires us to maintain a log book for our complaints and use what we have learned to develop and concentrate on our performance improvement program. While it might sound easy, it is a long road from documenting a problem to then using the data for performance improvement and behavioral change.

Helpful information regarding the nature of the complaint can be gathered by asking questions such as: When was the complaint brought to our attention? Who notified the company of the issue or problem? Are there any names or numbers that should be recorded regarding the problem? Where will information regarding for the complaint be recorded? Who on staff will address the issue? What will be the process for handling the complaint? Were any promises made to the customer regarding getting back to them about the issue? Is there a policy or procedure that is not being followed that causes the problem to occur?

Complaints often fall into two categories which are related to systems or people. Systems do not work well unless the operators are well trained. It is easy to create a new system or a new way to explain the system to the customer, but there is no way to remove the people issue from the equation.

Regardless of the issue, customers are often receptive to negative news when presented by a person with a positive attitude. If we are going to have to pay extra for a service or copayment, at least have the information shared by a polite and understanding employee.

Those who can sense the storm coming are the ones who will best be prepared to react appropriately. Nothing can destroy a business faster that an angry customer, and those who are prepared to handle complaints ahead of time will be less impacted by the potential damage those complaints can create.

Complaints are bits of company education that allow you to maintain your revenues, learn from experience and continue to improve. Of course, they never seem to come at a good time. The problem is, after being the in the industry for a lifetime, there is never a good time, but when handled correctly, you can benefit from a complaint in the long run. HC

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Finding a Software Provider

Your best fit will measure priorities, reduce risk and increase productivity

By Edward Kutt and Robert Katarincic

As an HME supplier, your revenue and profit is dependent on your billing system to accurately process claims, manage rejected submissions and to increase your business cash flow. In the recent months, several billing system software vendors have been bought out by other companies and/or are sun-setting their products. This may cause you to feel abandoned, uncertain of your future and wondering about the best strategy to protect your revenue stream. You're also concerned about maintaining a high level of customer satisfaction.

In this column, we will discuss the elements and implications of migrating your business data to another software provider from an executive, management, operational and technical viewpoint. As a software solutions provider, some of the more common questions we hear regarding data migration include: What happens when companies walk away? How do I select a new software vendor? What technology should I choose? How do I make due with a limited staff? Is the Cloud a good solution for me? How do I get my data from my existing software vendor? How accurate is my data? What are all the risks? What are all the costs? How long will this take? How do I prepare for the ICD10 transition?

The good news for you is that these questions can all be accurately answered by a methodical process. One of the biggest challenges is to understand what needs to be done, what the priorities are, and also to ensure that you do not waste time on unnecessary steps. You are asking, "How do we get our critical business data to a new system as seamlessly and cost effectively as possible?" It's important that you understand how to reduce risk, increase productivity and increase product demand, while receiving the quickest reimbursements possible.

We recently able to help one of our clients migrate over 120,000 patients and over 4,000 products from their antiquated billing system to a modern replacement. The products had more than 50,000 pricing variations for 2,000 payers, and $100,000 in inventory that needed to be meticulously analyzed and migrated. Each patient had associated primary and secondary physicians, ICD-9 diagnostic codes, referrals, sales contact logging information and legal documents such as prescriptions. Additionally, they had a requirement to tie their automated sales lead generations seamlessly into the new billing software.

As you can image, this was quite an effort, but we overcame the challenges by careful planning, prioritization and delegation. To enable a smooth transition, 150 staff needed training on the new system: the sales order takers, logistics, purchasing, billing, support and management. All these pieces had to be carefully put in place to work together.

As the maintenance costs on the old billing system disappeared, the ROI on the new system showed itself relatively quickly. Not only did the internal processes flow more smoothly, but the valuation of the company as a whole increased while increasing EBITDA, which pleased the board of directors as well as the investors.

Each business is unique and has its own set of challenges. Solutions need to be flexible enough to meet rapidly changing requirements. Due to Medicare, Medicaid and other state and federal regulations, the HME business is far too dynamic to create requirements with little or no flexibility. What works for a large company may not work as well for a smaller business. The goal is to find a happy medium that delivers the best results for the size of your organization. Delivery is the key to success. You can be assured that solutions are available and the migration process doesn't have to be daunting or painful.

As you drill down into more specific areas of concern, a business owner can develop confidence that they have made the correct decision in billing software migration and that their revenue stream is protected. Management can gain a clearer understanding of the technical challenges and the steps required to complete the data transition.

Operational staff can further understand the requirements needed to successfully run the business smoothly in the future to secure revenue and increase customer demand and satisfaction. HC

Edward Kutt

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