How Escalating Costs are Giving Rise to Home Care and Telemedicine

Presenters: Kevin Gaffney – Medtrade • Jeremy Malecha – ResMed

Mike Serhan – Drive Medical • Tom Ryan – AAHomecare

Seth Johnson - Pride Mobility

In collaboration with Joe Hage and the LinkedIn Medical Devices Group

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Kevin Gaffney: Good morning everyone. My name is Kevin Gaffney. I'm the Group Show Director for Medtrade which is largest trade show and conference that is exclusively dedicated to the home medical equipment market. And I'm very pleased to have a distinguished panel of guests.

Let me introduce our guests here. First up, Mr. Tom Ryan. Tom's the CEO of AAHomecare which is the national association for that works to preserve and strengthen access to care for millions of Americans who require medical care in their homes.

Tom spent the last 25 years as President and CEO of Homecare Concepts Inc., a respiratory and home medical equipment manufacturing … medical equipment company which was founded in Farmingdale, New York where he also serves as the Village Trustee.

So a lot of responsibility there I'm sure too, right?

Tom Ryan: Very political. Yeah.

Kevin Gaffney: Mr. Ryan is a founding member and former chairman of the New York Medical Equipment Providers Association and past chairman of AAHomecare which as I mentioned he now leads.

Next to Tom, we have Jeremy Malecha who is the Senior Director with ResMed and Jeremy, you're focused on the global Healthcare Informatics for ResMed's Healthcare Informatics offerings globally.

Previously held the role as Senior Director of Product Management Americas which included respiratory care, patient interfaces and flow generations including the recent America's launch of the new AirSolutions platform.

Welcome.

Next to Jeremy, we have Michael Serhan. Michael is Executive Vice President for Drive Medical. He's Executive Principal for Drive Medical. You joined the company in 2004 with the company's merger of Dr. K International, a West Coast manufacturer and distributor of durable medical products where he served as President and principal stockholder.

At Dr. K, Mike Serhan was able to redirect the company's direction and grow annual revenues to approximately $14 million in the industry from 1987. Mike has served as West Coast Division President of approximately $180 million publicly-traded company.

So welcome Mike.

And finally, we have …

Michael Serhan: By the way I just want to clarify. We do find Bedside Commodes sexy in our industry though.

Kevin Gaffney: And finally my end here we have Mr. Seth Johnson who is the Vice President of Government Affairs for Pride Mobility. Seth is based in Washington, DC. The company's headquarter is in Pennsylvania and Seth lobbies and has worked very closely with Tom at AAHomecare and Capitol Hill. Lobbies the Capitol Hill Congress, the White House and a lot of interaction with CMS on major policy issues impacting complex rehab and mobility providers.

He's a former member of CMS DME Program Advisory and Oversight Committee which was charged with providing guidance to CMS on issues related to information of competitive bidding. And we'll touch a little bit on competitive bidding as well.

So what we wanted to talk you all about today was the idea that homecare and specifically home medical equipment does have a place in the overall continuum of care and is definitely a opportunity to help reduce some of the overall healthcare cost that we face.

According to the OECD Health Statistics Survey, the US spent $2.919 trillion on healthcare in 2013. That's $9,255 for every American a year which is more than every other developed country in the world by far.

In fact, the average is about $4,100 for the other developed countries. The closest to us is Switzerland that comes in just a little over $6,000 a year.

Obviously we can get into some of this. There's a lot of reasons why our healthcare costs are so much higher. We have higher expectations in certain things. We pay people more typically and obviously that cost has to be filtered down.

So we're going to touch on that.

Americans expect a certain standard of care and we typically are not patient as patients.

So we want what we want when we want it and obviously that has to be passed along into in some cases, higher costs.

Homecare, home medical equipment offers an opportunity to potentially lower some of those costs.

So Tom, let me start with you. For those in our audience who may not be as familiar with homecare and the HME industry, can you give us some background on how it developed and what role it has traditionally played in the continuum of care?

Tom Ryan: Sure. Homecare actually is a fairly new industry.

In reality, if you think back where it begin to get its roots, it was really in the party supply companies. Back in the 60's, if you were renting tents and tables and chairs, you're probably renting some wheelchairs along the way and maybe some hospital beds along the way.

If you had some needs probably on the oxygen end, the welding companies will provide oxygen to the welding supply companies. Every once in a while you'd get a call for oxygen, then they'll say, "Let me deliver one of these big green tanks into the home."

So that's kind of where it got its roots and actually when the Social Security Act was passed and Medicaid came into law, there was a benefit that was put in there called the Durable Medical Equipment benefit or the DME benefit.

And again, the term that stick with us today when we torture our regulators is that it's the DME industry. Meaning durable medical equipment industry.

I don't find that very sexy at all myself. Home medical equipment sounds a little bit better but I'm still trying to work on a little bit of a nuance of that. So it's a little bit more I don't know, less technical and maybe sexy as a word. But when it comes to the regulators, it's durable medical equipment.

So yeah. It's evolved from the early days and those party companies are sold out and Abbey Rents was a big party company back in the probably 60's, 70's. Became one of the larger DME companies and now it is evolving again.

I started 25 years ago as a respiratory therapist working for a hospital, a large hospital in New York City. Entrepreneurial spirit, decided I wanted to do something in homecare and I actually worked for a homecare company and then I decided to do it on my own.

So the problem was back then, and I'd say that to the regulators. If you wanted to get into this industry and you could fog a mirror, you can get a Medicare provider number.

So it was an evolving industry that had many many derivatives of it and people in our society, they came into it and over the years have become more highly regulated which I think is a good thing.

So that's essentially where the home medical equipment industry evolved from. It's continuing to evolve today as we say and one of the gentlemen talked back there, it's patient-preferred, it's cost-effective and you have better outcomes in the home.

It's amazing what could be done in the home today as compared to many many years ago. Even 20 years ago, you were taking people out of the ICU and putting them on a ventilator in the home.

These things were unheard of before that but now it's commonplace. It happens all the time.

So a lot can be done in the home. It's an evolving industry and again, highly regulated and in my opinion, we are part of the solution. Not part of the problem.

But for too long, there had been issues with fraud and abuse in the industry, overutilization, you still read about it in the paper today.

So there's kind of a punitive effect from Congress and they're changing the industry as we speak and we're now in a competitive bid environment where in the past if you fogged the mirror, you got a Medicare provider number, you could build Medicare.

Now you actually have to bid out on a price and get a contract. They look at one thing only. Price point only. To me that's counterintuitive to the way healthcare should be going.

Kevin Gaffney: So traditionally, right, this equipment was prescribed by doctors and Medicare played a big role in how those doctors got paid, correct?

Tom Ryan: Well, you know. Medicare played a big role in how the doctor got paid. We're paid under the Part B benefit. It's the same benefit that the physician is paid under and yes, if you're going to build a Medicare benefit, you do need a prescription for this.

So it is prescription-driven and it's amazingly complicated from a regulatory front. The fact that to get a morphine drug, you can do a fax prescription and get it within hours – yet we need a face-to-face regulation for a doctor and fill out a lengthy form talking about medical necessity for a quad cane is absolutely ludicrous but some of that comes from the overregulation due to the fact that there was a lot of abuse on the industry early on.

But yes, it is required to have a physician's prescription.

Kevin Gaffney: So Seth, despite the fact that homecare and HME provides a patient-preferred outcome, it definitely tends to be lower cost and is effective in treating some ongoing conditions…

Over the past 5 years, we've seen the industry consolidate and constrict and a large part of this was because of competitive bidding… which is the regulation by the government through the Medicare Program and even though the number of providers continues to shrink in the last five years, the demand for these types of products in the home continues to increase exponentially not only in the United States but globally.

What do you think that this HME industry is going to look like in the next five to ten years?

Seth Johnson: Kevin you're absolutely right. The industry has consolidated significantly on the home medical equipment providers' side. The upside is that the market while you have that consolidation on the providers' side, the baby boomers' now hitting retirement, getting older, aging into the Medicare benefit and needing home medical equipment products. That market is literally exploding.

So the market for these products is growing significantly. Some of the statistics regarding the market specifics have 78.2 million now turning to 65 million at a rate of one every ten seconds.

It's 8,640 people a day. About 263,000 people a month. By age 65, there are 65% of seniors that have at least one chronic disease and 20% of that number have five or more.

So there's clearly a need for home medical equipment for these patients. The industry's evolving. The model's going to continue to evolve due to the regulatory challenges that were

seen both at a federal level coming out of Washington and at the state level through some of the other Medicaid and other payers also. Commercial insurance is a significant payer for the industry.

That wave of baby boomers is going to continue for another 14 years so pretty solid market growth when you look at it through 2029. There's $256 billion, it's the latest statistic being spent out of pocket on home medical equipment to retail products annually and that rate is also expected to grow about 10% a year.

So again, the market for these products is strong and whenever you have a strong market, you're going to have people come in and those business models adapt to meet the needs of that market. Regardless of the regulatory challenges which currently are providing some pretty significant headwinds.

Kevin Gaffney: So a company like Homecare Concepts which Tom had founded was a small regional provider, correct? And that's typically how the HME industry has been set-up for pretty much most of its cycle in history. Small regional providers that are providing the services directly to the patients.

Tom, is that era of standalone HME shops coming to an end or is it going to be shifting even further?

Tom Ryan: I don't think it's coming to an end. It might have come to an end for my business. We're an $8 million company. I found it again in New York and we've bid on 32 contracts and we actually won one.

So it's hard to go overnight from an $8.5 million company to a $2.5 million company. There's something called debt service. You guys remember that, right?

So that was difficult. So we now have a forbearance agreement. Worked with the bank. My partner is in New York trying to figure that out. But that's one market. New York Metro Market was a difficult market.

There's still many standalone HME companies here but as Seth eluded to the fact that the demographics are wonderful.

So what's happening today actually is private equity is coming into this industry. People who just have dollars to spend, seed money to spend, the angels so to say. The angel investors and they're coming into the industry and we're seeing new larger companies coming in every day that they don't have a clue about the industry but they know how to make money. They like the demographics.

And I'm seeing some of those entrepreneurial private equity groups now three years in saying, "This is quite involved from a regulatory standpoint."

So to answer your question, we are seeing consolidation. We are seeing new private equity coming in.

But I do think healthcare is local still and many of these small companies and when I define small, I'm talking less than $10 million, still have a pretty good play in this industry and do a very good job and they've learned to adapt and some won more contracts, some didn't and some to some statistics you know went into the retail end. They went into other payers beyond Medicare.

And again, Medicare was evolving and the payer concept itself with a lot of mandatory manage care. So if you don't win the Medicare contract, you can get manage care contract.

So we'll see a little bit of both. But likely larger companies, more consolidation. But I still think there'll be some standalone DME's out there or HME's.

Kevin Gaffney: Excellent. This next question I'd like to pose to Jeremy and Mike and we'll start with Jeremy. How has the overall rise in cost of healthcare affected the types of products that your company develops?

Jeremy Malecha: Yeah. So from our perspective, obviously Tom eluded to the idea of competitive bidding. So the rising healthcare costs, our customers, HME providers are under tremendous constraints regarding reimbursement that's declining. And so for us, the problem was is there's also pressure to increase the value that they're also delivering.

So they need to be handling more patients, delivering better outcomes with less reimbursement.

So one of the things that we actually did is we actually invested in our product line. We actually put cellular coms onboard for all of our devices.

And the idea there is that, yes there's a cost-constraint environment but there's an opportunity to gain an efficiency and volume that helps our providers actually deliver on those outcomes without actually increasing the costs.

And so I think that's really resonated with this customer base in terms of how do you actually do more with less. And tools like that I think are going to help them be successful in the future.

Kevin Gaffney: Mike, same question.

Michael Serhan: We had a segment a little bit here. One thing with these lower reimbursements, these competitive bidding, one thing we realized, it didn't cure old age, right? And so we have as the demographics that you spoke of, we have this growing population of seniors that actually have about 75% of disposable income.

So we have a large group of people that have money that are having issues with access to care.

So we're really having to hone the industry's skills differently on how we approach our customers.

Our company, we've looked and by the way, we think of now as customers and as patients. There's really two ways you can go into the home DME fill a prescription, deliver a hospital bed and set-up oxygen. Perhaps they're our patient but you have to start thinking of them now as a customer as well.

What other products are they going to need next week that you didn't bring up? Because you know what they're going to do, they're going to call CDS.

So we've had to look at a couple of different segments.

One, educating our customer base which is our providers. We sell to providers that would deliver the product on how to go get more referrals and more dollars. We had to build products really for that competitive bid market that met Medicare standards but were very basic items.

We looked at teaching providers how to enhance revenue streams from retail and other revenue streams within our industry. Perhaps hospice, whatever it may be.

And we're looking now at changing the gold standards. What we think of as an industry, as a gold standard needs to change and we need to redefine ourselves as caregivers and not just delivery service.

And that's really what the government has put us into. So we're really trying to educate on those parts of our industry right now.

Kevin Gaffney: And you touched a little bit on this but where do you see some of the baby boomers' shopping trends and attitudes as they trickle down to HME?

Michael Serhan: So boomers are more savvy than ever. Again it's an issue of wants and needs. Nobody wakes up in the morning and says, "Wow, I want a wheelchair today." Or "I want a hospital bed."

Something happens right? An event has happened and now they need something.

Again with access of care issues, I have to go to my doctor and I have to do a face-to-face steps to do all this. Let me just go buy the thing.

The problem is, they may be buying the wrong thing. An inappropriate thing. What we've tried to do and understanding that is build products that are appropriate as much as possible in those retail environments but also look good.

You've seen these walkers everybody has. That four-legged walkers, nobody wants a four-legged walker and that's what Medicare is going to give you.

Everybody wants those sexy rolators, right? The four-wheel rolators.

So you have to adapt and that's really what we do.

I'm also in charge of product development at Drive. We really try to adapt on the retail side products that people want.

Back to the unsafe issue, as these providers are having difficulty with getting products to patients through Medicare, patients are having to go online.

Now we're trying to figure out and looking at the demographics, who is actually buying these products?

And we really find that it's not … it's actually generally not the person that needs the product. It's the caregiver.

What we see mostly as a sandwich mom. Sandwiched between children at home and a parent that needs assistance. And they want to do everything they can to make sure that they don't come and live with them.

So they buy as much product as they can to really make their parent safe and comfortable in the home environment.

So that's really who we are trying to market to is that sandwich mom.

Kevin Gaffney: So Jeremy, a study that came out recently from one of your competitors in Georgetown which we won't name the competitor. The study basically said that 90% of the baby boomers want to age in place but only about 30% of them actually thought the technology existed for that to actually happen.

So how are you all addressing some of those gaps in technology that we all know exist but communicating that and Seth I'd like for you to jump in on that too after Jeremy.

Jeremy Malecha: Yeah. So from our perspective, we've historically been provider-focused in the old world and delivering value for the providers who are actually delivering the equipment.

Now we recognize we can't only do that. We also have to deliver on education and empowerment for the patient or the caregiver loved ones.

And so a lot of kind of our shift in focus here is not necessarily just investing in the hardware, in the features and benefits associated with that but really thinking about how do we deliver engagement, self-education and things like that to the family so that they know the therapy is on. It's working. They're feeling the benefits. To help kind of drive them to be more self-sufficient.

Again, going back to that idea of dealing with less people actually managing more patients.

Seth Johnson: Thank you, Kevin. Consumers are becoming much more educated. It's through the web. They know what they want. They don't want to have to wait to get it.

Similar to the others at the table on the manufacturing side, we're continuing to innovate, listen to our consumers. We pride ourselves in being a listening organization.

So we have products that are out there, we engage the consumers in a listening group.

So we're actually getting feedback from them on what they like about the product, what they don't like about the product, what they like to see improved with that product.

So then as we're continuing to innovate and redesign our products, we're bringing to market a feature-rich product that addresses the needs of the consumers whether they're a Medicare beneficiary or on the retail side.

Kevin Gaffney: Any questions for the panelists at this point? Anyone? Ken, I'm going to put you on the spot.

Ken and I were talking last night and he was talking about some customers that he works or some clients that he works with. Really cool technology that I don't know that people know exists or they're just beginning to know it exists. Can you touch on that a little bit for the audience Ken?

Ken: Thanks. Yeah actually while I'm out here this week, my former CEO that I worked for at Datascope and then later at Iris is watching his mother age and after he sold and made a bazillion dollars, I lost track of him. I talked to him.

He's making just perhaps the most advanced, I can't say much about it. The most advanced drug dispensing system I've ever seen.

Now there's packages and boxes and boxes and trays and calendars, forget all that. This is amazingly innovative. I went over and spent all of Friday with him. And I asked, why did you do that?

He said, "Because it needed to be done." And he went on to explain the most simple things that we deal with. Watch your parents age and watch the simple little problems. And then that is a tremendous opportunity to innovate for something that you can really have an impact on healthcare.

For 40 years, you always feel like we do something special, I can't imagine anything more special.

I'm working with two other companies Kevin but the same thing that you see this and you say, "Gee, that's amazing. It's going to work."

Information about patient to help them stay out of the hospital. I'm working with another company in relation with Johns Hopkins to bring a product to market. It's directly linking physicians, hospitals and patients and caregivers to keep them out of the hospital.

Again, what do they want to do? That patient's going to be at home.

It's amazing and as I said earlier, the growth in this.

So we need to think about this whole industry differently because I think there's a giant sucking sound of simple little problems that need to be solved by innovative companies.

Simply cost-effectively but think of your parent and then think of me because I'm going to be there in a few years.

Kevin Gaffney: Thanks Ken and having been involved with Medtrade for the last eight years which again, brings a lot of new equipment and folks in the industry together, the thing that has always struck me is what Ken just said. Is that people have their caregivers for parents or grandparents and they just can't find the product that they need to help make their relatives' life more comfortable.

So they create it. They create it. They bring it to the show. Next thing you know somebody comes along and buys it out. Because that's not their business. They didn't want to be in a medical device company.

They just wanted to help their family member. And some of the most incredible unbelievable products I've ever seen and it's simple stuff as Ken said. It's like, wow, I could've made $5 million if I would've thought of that.

Again, it's based on the need.

Joe Hage: We have at least three questions on the queue already. We didn't choreograph ahead of time which is fine. We'll do it on the fly.

I can see that … I very much appreciate, prepared, and you have questions that you want to cover.

Can you give me a sense of how many absolutely you got to give us 10 minutes because these are really critical points that we need to make versus opening it up because I want to make sure that we cover the really solid stuff too?

Kevin Gaffney: Why don't we cover some of our solid stuff in the next 10 minutes and then if we've got a few minutes, we could open it up.

Joe Hage: Sure. Right after my question.

Kevin Gaffney: Yup. After your question. Of course.

Joe Hage: Privilege of the guy with the mic you know?

Kevin Gaffney: That's right.

Joe Hage: Speaking of Mikes, you made a comment that I thought was really really interesting. You said nobody wants a four-legged walker but that's what you're going to get from Medicare. What is the implication to this room and to people in TV-land watching?

Michael Serhan: In relation to what Medicare's willing to provide versus what they want?

Joe Hage: Relative to that and perhaps what we as a medical device and homecare industry can do to better align that which is available to people with less resources, with their reality.

Michael Serhan: Yeah difficult question. Our providers deal with that every day with the reimbursement structure that allows really for you to give the very basic of items that really no one wants.

And in some cases are probably now inappropriate because reimbursements have dropped so much.

We have tried to develop products that people want at lower cost by changing and I'm also doing a lot of the manufacturing end of things. We changed materials if it was aluminum before, we can go to steel and the weight of the item really is not the concern, it's more of the function, we look at how we manufacture products differently at a cost structure that providers can be healthy and give a product to the end-users that can also be healthy and using it.

Tom Ryan: You got to go to outcomes and we've seen success in the industry where you go to the payer because it's counterintuitive the way Medicare operates today.

They've got a value-based purchases where in fact they want to ding the hospital. If the patient has a chronic disease like CHF, COPD gets readmitted within 30 days, yet they want to have the lowest commodity product that are out there in their home.

When we go to the hospital payer and back in my company in New York and say that anybody who comes out and has a diagnosis of CHF, if you put him on our disease management program, we can send a respiratory therapist in their home, we can put him on overnight oximetry. We can see if these patients which typically 35% of them have desaturations where their oxygen levels go down.

It's not typically picked up in the hospital. We can avoid that readmission and we could save you money on having your patients having less of a readmission rate.

But someone's going to have to pay for that. It's just like telemedicine. It's amazing what could be done in the home and I thought years ago when some of the manufacturers came in with these great telehealth products, we'll wake up and we'll know the patient's weights.

So if they're CHF and beginning to retain weight we'll know it. We can act proactively but who's going to pay for it? You got to follow that payer. If we can follow the payer and get them to understand that you have better outcomes and save here where you might pay a little bit here, we'll get out of that silo mentality.

So much silo mentality in DC. It's very frustrating.

Joe Hage: I'm not going to assume that all of you are able to stay with us after lunch but I suspect that you would really find Raymond McCauley's talk interesting. So maybe I'll enlist him to engage you a bit in the question and answer session.

So ten minutes then check in with me, okay?

Kevin Gaffney: Thank you.

Jeremy, so we kind of touched on this idea that people want the products that they want. And retail and e-commerce is becoming more of a player in HME overall. But how do we balance that between having access to the product and also that whole concept that the home medical equipment is more than just a commodity. It's a service industry as well and buying a product on Amazon doesn't necessarily get you the outcomes that the patient may be looking for.

Jeremy Malecha: Yeah I mean so from our perspective obviously with the rising consumer-directed health plans, people are out there shopping, looking for products, trying to find the best value that they could get for their spend. The challenge exactly that we've had is that with the rise of e-commerce, chronic disease is not a transactional issue, right?

You can't just go and go buy something. All of a sudden you're treating your chronic disease. You need education. You need support. Especially early on.

So from our perspective, on the product side and the education side, obviously we invested in that. But then we really look for partners in e-commerce that actually provide that service and support. And that's who we're really focused on in terms of how we manage our relationships with our online dealers and who actually is approved and authorized to sell our products.

Kevin Gaffney: So for our three manufacturers, who … I mean your customers now, you provider customers in this industry, where do you see a majority of them getting paid? How are they getting paid the majority of your customers right now?

Is it still Medicare? Is it moving away from Medicare?

Michael Serhan: Well there are many different channel partners. You have your strict DME guys that really are trying to survive in this competitive world. We do our best to try to teach them of the revenue streams but you have this emerging population of e-commerce and retail providers. CVS's, Rite Aids, Walmarts that are getting into this because as we compress the reimbursements, again these people still need product.

So we see a large growth in those retail segments.

Kevin Gaffney: Seth anything?

Seth Johnson: Yeah. It really depends. Specifically within the homecare sector in the mobility space. So I know we have respiratory. I think it's important as we're talking about payers. It does differ significantly based on the products that you're providing within the home medical equipment industry from a power mobility perspective.

Five years ago, Medicare was the primary payer. Due to the regulatory challenges, Medicare is no longer or is just marginally the primary payer. Medicaid's a significant payer. We're seeing consumers that want standard power wheelchairs going out and actually paying retail for some of the lower cost items because they can't get what they need through Medicare.

So they're looking at other channels. Internet is a channel that is continuing to grow for some of the more retail items. Scooters, when you get down on the very low end of the power mobility side whether it's a three-wheel or a four-wheel scooter, those are largely retail.

Medicare pays for a very small portion of that. Medicaid as well.

So that's largely a retail transaction and that's one of the ways that our customers are continuing to adapt as they're looking at other channels as the Medicare market is shrinking due to the regulatory challenges. They're looking at other revenue streams to make that up. Retail and the internet being one.

Kevin Gaffney: Thank you.

So this is really for any of the panelists and Tom why don't you jump in first. Some are saying that much of the routine primary care that normally takes place currently in a physician's office will one day be done at home, is that even a possibility and how far away do you think we are from that future?

Tom Ryan: We're here today if we can get paid for it. That's again the problem. I go back to telehealth. I go back through the reimbursement of the homecare physician. The doc that's going to actually make the trek to the home. And can it be done via Skype and telehealth and good telemedicine where you can get the results and make changes?

So we too often follow the reimbursement and we don't follow the needs of the patient.

So I do believe it's going to get here sooner rather than later. We've got no choice. It's got to get there.

But somebody's going to get paid for this at the end of the day. And we too often look at traditional payment is Medicare and Medicare again developed in the 60's. They still got a benefit for iron lungs out there.

The Medicare benefit actually is for patients in the home. So if you really wanted to use that wheelchair outside of the home, guess what, according to the Medicare, you're not able to.

It's for in-the-home use. We've been trying for a decade to get the in-the-home use terminology out of the Social Security Act but it's not been successful.

So the frustration and the challenges remain with the payer but the technology is evolving and my concern when I talk up on the Hill is that if you continue to take dollars out of the industry, the first thing that's going to go is going to be R&D and if you start to thwart technology, we're really going to see an issue.

We'd be unfortunate to see the American citizen not seeing what people are getting around the world because we don't have an evolving technology which could really help in the core structure.

Joe Hage: What's the biggest resistance to getting the words "in-the-home" off that legislation? Is it just that it would be …

Tom Ryan: It's opening up the benefit again and it's just the regulatory and process of getting anything passed in this particular government is challenging and at this point, we've worked around it enough that there are more challenging issues out there that it's not been worked on in a couple of years. But I don't know, Seth if you want to comment on that because you were kind of involved in that at one point. The in-the-home rule.

At the end of the day, I'm not quite sure we've got the energy, the time, the dollars to get that changed.

Joe Hage: Seth?

Seth Johnson: Yeah and specific to the in-the-home, from a mobility perspective, that scenario where we have seen some change.

We've had the extensive discussions with Medicare, there's actually a lawsuit back in 2003. The Olmstead Act where State Medicaids are unable to apply that in the home restriction to Medicaid coverage because Medicaid is the last payer. Has to provide for payment in the least restrictive setting and if you have that in the home restriction, the court found that you're not allowing them to transition from an institution back to the home and community where Medicaid recipients, they're not necessarily aging into the benefit, you know?

They're in the benefit because they have an income issue and they're a younger population. They can work. They can go to school and that's what they really should be doing. It should be able to be an active participant. Not only with their family in the home but also in their community.

So we are making progress on that and we're hopeful based on a proposed rule in the home health side back in 2010 that there will be a change to that in-the-home rule potentially later this year.

Jeremy Malecha: And I think just to comment a little bit on the telehealth side, we're actually seeing some of the new codes on discharge coordination codes, some chronic care management codes that's starting to open up the idea around telemonitoring.

The problem I think in the past historically is there's a fear that in a fee-for-service world, if we add more codes to bill to, then our cost just goes up without anything coming out.

I think in this new world of shifting for-fee-for-value, when you start putting some sticks in place in terms of readmission penalties, it's given CMS the opportunity open up some other new codes to help kind of coordinate care to help offset the costs there.

The problem for our customers is those are all physician-based codes. They're not the ones that are actually caring for the patient in the home.

So it's been a real challenge and hoping at some point, right? I mean there is a telemonitoring code, "hick pick" code which is what our customers provide but there's no fees associated with it, right? So they're essentially doing it for free.

What we've found in some of our more advanced providers is they're looking for products that bring things together that allow them to create an offering where they're actually going to health systems or small payer plans and they're actually getting preferred arrangements similar to what Tom was saying which is, "If you give me your COPD patients coming out of the hospital, we'll take care of them. We'll keep them out and if you pay us a per member per month fee, you'll actually get the benefit and the savings on the readmission reduction."

So we're seeing a lot of inventive ways of coming about that but ultimately I think our providers reeling to did benefit from a direct payment model to help really kindle the outcomes that people want to see in terms of what we can deliver on the home from better care.

Tom Ryan: Outcomes are so key. I mean the problem is new technology, very often with a new code and the new DME benefit shows increased utilization. Non-invasive ventilation is a perfect example.

Great new technology, we can non-invasively ventilate somebody at home. You don't have to put a tracheostomy tube into them.

So that spikes an increase in utilization so then the auditors thought to come in and say, "What's going on here?" Again, maybe I'm showing a little bit of my Washington frustration coming out but there's got to be a better solution. And there is.

Kevin Gaffney: Excellent. So let me wrap it up with this.

I think we've sort of touched on the whole idea of the overall continuum of care and where that is now and as it continues to evolve and how all the different sectors of healthcare are involved including HME.

I want to give everybody an opportunity to answer this question. We'll start with Tom and work our way down. Tell us why a strong HME homecare sector is really good for the overall continuum of care.

Tom Ryan: I mean it started out with the early comment. It's patient-preferred. It's cost-effective and if we can get it to be outcome-based, that's where patients want to be. We want to age in place. You want to age in the home.

My Dad had a stroke recently. He lived with me for a year in a half. We just got him out of rehab. He couldn't wait to get out of that rehab facility.

So now he's at home for a week. There are challenges there. I got all the DME that I want or the HME that I want but there's still challenges there.

But this is where the patients want to be. And we've just got to figure out I think again, the reimbursement and it'll work because we are part of the solution. We're not part of the problem and I believe we're going to get there someday.

But it appears to me the only way we'd get there is becoming an advocate in lobbying our government and the legislators are beginning to age in place and change themselves. So they're beginning to get a little bit more empathetic.

So I have hope.

Jeremy Malecha: Yes. So for my perspective, on top of wanting to age in place and being at a place that's comfortable, I mean anybody that follows, the spend $9,000 per American, it's all related to chronic disease, right? And chronic disease is managed outside the four walls of the hospital.

If that patient is admitted to the hospital, it's too late and it's too costly and the homecare industry is really going to be the key if not the "key" to managing patients. Helping patients understand why they need to take their medications, helping them understand why they need to be adherent to their therapy and be engaged. Engaging in caregivers and loved ones within the home to support that patient. To make sure that they're staying adherent to therapy and staying out of the hospital.

Ultimately, that's where we're going to see our cost savings come in.

Michael Serhan: On the technology side, we are trying to focus on products that will give better outcomes. Outcomes are key. Keeping these people that want to be at home out of the hospital.

We're looking at new respiratory devices that can lower COPD readmissions first month by 50% over a year, as much as 80%. So we're trying to rebrand ourselves as an industry as caregivers that are going to reduce cost and bring better outcomes.

So that's really our focus for the future.

Seth Johnson: I think Tom really hit the nail in the head. Ultimately it comes down to cost regardless of the payer whether it's Medicare, Medicaid, private insurance, all payers are looking at the economics and they're saying, "Look, we want more but we want to pay less," and ultimately, homecare is a solution to that. There's a lot of support by public policy-makers recognizing the true value of homecare and the fact that that's where the patient ultimately wants to be treated in their last days of life.

In their home surrounded by their family and friends.

Joe Hage: Nick, tell them who you are and what you do.

Nic Anderson: I'm Nic Anderson. I'm a payer. So I determine what Intermountain Healthcare reimburses and what we don't. And I think the five of you are sitting on a goldmine.

I think I've been really happy to hear the discussion and I think you're all along to it with technology and just as the … you know, 50 years ago, we had a mainframe computer. There're only a few of them in the United States. Now everyone has a supercomputer in their back pocket and your 4-year-old can use it.

We're leaving the hospital and we're going to the home. All healthcare with the exception of surgery is going to the home. Diagnostics and all of that.

But I think the DME and home health company that wins is the DME and home health company that stops talking about billing and coding. It's like talking about the Ferrari Enzo in context to the horse and buggy and saying, "I just invented this new Bugatti Veyron. I just got to get the horse and buggy to catch up."

The point of the automobile is to get rid of the horse and buggy. The point of digital health, telehealth is to get rid of billing and coding and CPT codes. And all home health care, it's not going to be for the Medicare population. It's going to be for all of us.

Newborns on up, we're going to diagnose ourselves at home, we're going to in many respects treat ourselves at home.

Everyone needs to look up a company called ApolloDX and 3PDx, Biomeme, the company I'm associated with that I mentioned the other day, Steffi that you're going to breathe on your own phone and Amazon's going to home deliver you your medications.

And I think that all of us that are in the home health digital health world are sitting on a goldmine. Saying, "We're done with the hospital networks. We're done with billing and CPT. We're done with the Nick Andersons of this world that are the gatekeepers saying, 'I'm not going to reimburse for that that. I'm not going to reimburse for that.'" And instead just saying, "I'm just going to go to the home health and concierge medicine which I think would be a great discussion next year at this conference. Concierge healthcare.

That's where healthcare's going.

Joe Hage: Let's put it on the agenda.

Nic Anderson: You got it.

Joe Hage: You just create the topic, okay?

Comments?

Tom Ryan: Outcomes, I mean you said it well. Unfortunately we're traditionally facing codes, regulations and that's the way healthcare has been. If we can begin to focus on patient outcomes, at the end of the day, better health outcome's going to have a lesser spend I would think.

It seems to be intuitive.

Michael Serhan: Getting ahead of the issue is key and I think what we're going to be seeing at technology and to Tom's point earlier, I'm not sure if it's going to be our industry. Someone else is going to come in and force this down our throats but how many times does a patient go to the refrigerator, that consumer go to the refrigerator a day? How many times they go to the restroom? How many daily activities are they performing a day and at what times?

You start looking at that as feedback into a data point. You can just develop algorithms to see if there's going to be an exacerbation coming up.

We start seeing a decline in how many times someone goes to the refrigerator, how many times they do this.

Now, we do a little bit of that now. We have diabetic monitors that will communicate compliance you have, CPAP that will communicate compliance.

We have a lot of single data points. We need to look at the whole life of that person at home and that will help us get ahead in saying, "Look, based on these algorithms, someone needs to get in there and take a look. It seems like Mrs. Smith is having some issues with X." And that's what's I think really going to change your industry.

Jeremy Malecha: I mean you know, from our perspective, they talk about Clayton Christensen's 'The Innovator's Dilemma,' right? We are in the middle of disruption and there are people who are going to figure it out. There are people that are going to go concierge route, e-commerce, focus on the out-of-pocket-pay.

There are people that are going to go after outcomes, therapy management programs, disease management programs and it's going to be really interesting to see how everything unfolds in the future.

Joe Hage: Our next question is from Rick Gerace.

Rick Gerace: Thank you Joe.

Thank you gentlemen for being here this morning.

My company is Medolutions and we make a product called the BioBack which is a solution for low back pain which affects 25% of the population overall and that percentage grows to about 30% in seniors.

But as a small company, we've really had to focus on what markets we go to and as we all heard last night, trying to sell through doctors is a real challenge.

We have not yet really looked at the homecare segment and so my question is, is it the homecare agencies that we'd be looking to and if so, what percentage of those are setup to bill for DME?

Thank you.

Tom Ryan: You need to get a code and maybe the manufacturers can talk about getting a code and again you have to have a code that's reimbursable. And if your defining market is 30% of the elderly and it's the Medicare population, you got to go get a code through CMS. And I would agree with you.

My Dad's at home and he's got a chronic back issue and if you got something to help, I might probably buy it if it's reasonable because I need to get a better outcome there because I see what that chronic back pain does but I'll let the manufacturer maybe work through that.

Michael Serhan: You said it yourself. There's a huge population of people with back pain. Trying to get a code is pushing a rock up a hill.

So getting it reimbursed, getting it referred, all good stuff but difficult. I don't know how it's packaged. I don't know how it's educated to the user but that retail market right now if it can be packaged as a mass market retail item, is where you can find some real gold.

Running it through hospitals, running it through referral sources, running it through doctor's offices, it's difficult.

Seth Johnson: The other piece of advice that I would give you and I don't know where you are in the process is from a clinical perspective. Showing the clinical efficacy of that, having a university or an independent organization look at that with a small test group to actually provide the data that then you would use to advocate for the need for this product within the payer max.

I think that's very important to have that type of clinical study to speak to the efficacy and the appropriateness of that product.

Joe Hage: I don't know what you guys are doing on May 4th 2016 but if you're able to come back because clearly we have much more to talk about than our time will allow, okay?

So there's an invitation.

Our next question's from Leo.

Leo Eisner: Hi my name's Leo Eisner. I deal actually with home-use products on the standards side. So standards, development. I'm on a brand new committee in IEC. It's a system committee which is a new concept.

So they're getting a whole bunch of committees together and working with Continua which you may know of. It's plug n' play for home use.

So I've worked with several companies that have monitoring products that go to the home. Who controls that product? Is it the hospital or is it you guys?

Tom Ryan: Well the home health agency again, I think is evolving and it hasn't found its niche yet in my opinion but typically I would believe it's going to be more the home health part. I like

to say it's going to be us, hopefully us providing it to the home health agencies but I would think that's probably where it's going to find its most comfortable niche.

I'll let the other gentlemen respond.

Jeremy Malecha: Yeah so on the telemonitoring side like Bay Station with the peripherals, that's typically home health agency that would then be managing that. And then on the DME side, we're seeing a lot more connected devices and that's where the manufacturers selling to the distributor, to the home medical equipment provider and they're actually owning the products until it's actually the benefits' transferred to the patient.

Michael Serhan: Many times, those referral sources do want to see the compliance. They're paying for it. They want to make sure you're also using the product so they tend to stick their nose into it as well.

Tom Ryan: That's where the technology has been wonderful when you're talking about ResMed who and to pay us, we had to send somebody into the home, ask the questions, verify. Are they using the sleep apnea device? Well, you can get a daily real-time read of what's going on and if they average six hours a night, all of a sudden you see a change that they're into two hours a night or they're not using it. You can have an intervention and prevent the readmission.

So it's been terrific.

Joe Hage: Our next question is from Libbe Englander who I became friendly with. I don't completely understand what she does yet but Ken told me, "You don't know it yet, but Libbe is your greatest business accomplishment in *my* life by virtue of the fact that she's here, she met him, she talked to Rob Packard and he said, 30, 60 days from now, this is going to be a huge thing. So no pressure. Congratulations in advance and maybe give them just a snippet of what you're doing and what your question is. Thank you.

Libbe Englander: Thank you so much. That was overwhelmingly nice.

My point is very much to what we do and the interaction of what you guys do. I run a software company that with a push of a button tells you all the adverse events and hopefully with some collaboration, some outcomes research in terms of medical devices.

So if you have a medical device, I can tell you the adverse events, the product problems, we can compare it between class, device and company. It's very cool. It's very interesting information and it's very actionable.

But the point is, in our software system, you can push a button and get all that information. For us to teach our clients how to use our system effectively and understand the impact of the information so that they can take that level of action is not a one-day process.

Right now we work for insurance companies that do product liability analysis.

So they really want to insure the medical industry. They don't want to step in it.

So what they do is they hire us to look at leading trends and indicators. They get a subscription to our service and they can look at any device and say, "Okay, here's the trends of the reports. Here's the real product problems." We can do free tech searches and get all sorts of great stuff.

So that's … the end goal is like so tantalizing and wonderful to have in your hand. The comparison of in-this-device class. Here's the good guys and here's the bad guys or of course you know, the ones that are having challenges at the moment.

But even to obtain that information which is very much of a goal that they're excited about, it's not an easy train. It takes a couple days of working with our underwriters and showing them the system and understanding the risk scores. We color code it so it's red for like danger and green for you're good.

But even then it's a challenge and the reason I'm bringing this up is because to Nic's point where the industry's going in this direction and it absolutely is. The demographics, the economics. But still you have people at home who are elderly, middle aged, often the home healthcare aids are kind and wonderful people. They actually haven't been to Harvard engineering.

You're going to have a challenge of taking that gap of what the technology can do and what the information can present. And making sure that it's really accessible to the people who you're now starting to shift the homecare into their hands and I think that interaction of machine and person which I mean the reason that Steve Jobs is so famous is because he took that head-on.

He said, "Look, the technology is great but what we want to do is make it useable and beautiful and accessible." And I think actually one of your huge challenges is not only the payers and I just thought it was wonderful how Nic Anderson said, "Look, put me out of business please." I think that that was like a noble and true statement.

But to do that, there's a gap not only of creating the technology and the channels but also thinking about who the end-user is and making sure that you understand how they're going to experience your product and making sure that they take away from the diagnostic and the action of their medical care what you really want them to do.

And I'm just saying that that's a whole new area of expertise that actually people should start now doing R&D in. That was … I actually have asked the question. I'm sorry.

I just think what you're doing is so vital. My father-in-law's 95 years old. He's the most amazingly wonderful guy. He's a little frail. He's sharp as a tack. He wants to stay home. You'd have to drug him and kidnap him to get him out of his house. And we want to give him the best care. He's brilliant.

But if you are telling him here's the machinery to use, it's not going to be helpful. You need to do things.

Joe Hage: I have a question for Libbe. Are you excited about what you're doing?

Do you guys have a comment? Feedback?

Michael Serhan: I agree with what you're saying. At Drive, the best thing about Drive is we have three thousand items. The worst thing about Drive is we have three thousand items.

And those items go from the very basic of a walker all the way up to some high technology and other products like respiratory. And we do see that interface issue when you have a person at home that now has some type of occurrence in their life that has taken them off their game and now they have to deal with bathroom safety products, maybe respiratory products, mobility products and to try to understand how to communicate that back to some source whether it's through a homecare provider of the doctor, whomever, is difficult.

We are trying to make products that take that out of the situation or out of the conversation for them. Build respiratory items that are self-adjusting, self-dosing, so they don't have to worry about that. Building products that are easy to use and cognitively easy to adjust, whatever it may be.

So we understand that but it's a difficult question.

Joe Hage: As in life, Mike has a comment on the last statement on this session.

Mike Sperduti: Thank you Joe. So full disclosure, Mr. Gaffney and Mr. Ryan are clients of mine and the reason that I'm really excited about these guys being here and you guys are going to be excited too is because there's so much buzz and there's all these manufacturers that are developing product that we're going to see coming to this space.

And so it's awesome and it's piggybacking what he was saying. The disruption is significant and it's going to be so disruptive that you're not going to need an insurance pay. It's going to be cash pay which is really great.

So my question is this, as a manufacturer who's looking to get into this space or has a developed product, how can MedTrade help them? How can AAHomecare help them?

Kevin Gaffney: Well from a MedTrade …

Tom Ryan: MedTrade. There you go.

Kevin Gaffney: Yeah from a MedTrade standpoint, I would say that as I eluded to earlier, a lot of these products come to the show because they're looking to find the market and learn more about the industry.

So there are a lot of opportunities there. I mean we bring thousands of people together that are interested in buying these products to get them in front of their patients.

We have hundreds of companies that bring standard, tried and true products to something that was invented in their garage two months ago and they brought it to the show.

So there's a lot of opportunities to get in front of this marketplace to better understand it.

And you know, Joe kind of put you out of the spot a little bit. So hopefully we'll see you at MedTrade as well but I would be happy to provide you with information to pass along to all of your audience and have all of you come to MedTrade as my guest to take part in the conference, take part in the trade show if you want to learn more about it and spend more time with these folks and other folks like them. I'd be happy to provide you with some information.

Joe Hage: It's an important conversation. Tom? Did you have something to add?

Tom Ryan: Yeah well I mean obviously MedTrade is a very good partner of ours and I've seen more innovation and new products that were in the new product pavilion that a year later on the main floor and quite well-adapted and used throughout the industry. That's important.

As far as AAHomecare can do, I mean we're evolving ourself. We're finding that we're in town. We're a lobbying advocacy organization and we represent all the HME companies, well most of them in the industry, manufacturers.

And there are regulatory challenges in getting your products out there. There are certainly challenges that you might need to have a legislative strategy for that.

So that's potentially where we could be helpful. I would love to see an innovative council out of AAHomecare where we have a group of entrepreneurs out here who are trying to solve these solutions, who are trying to come up with ideas and medical technology and we could get bright minds together and I can get my regulatory team together who is very focused on

regulation, regulation and we could kind of come to a strategy of where we take that product, that idea from an idea to a product to actually mainstream and we don't have that council yet.

But we're an evolving association so maybe we will. It really just takes innovative bright people who want to have an outcome that we think is important.

Joe Hage: Three closing comments from me. First, profound thanks. Thank you for being here.

Second, when you come back next year, none of this, showing-up-for-my-session, I-wasn't-here-the-day-before. You come for the whole damn thing because people want to talk to you, okay? So stay as late as you can today.

Third, and I mean no offense to the other gentlemen. Michael, would you come to the center here and stand up here with me and I'll tell you why. Because I've been doing this conference for three years and my mother-in-law's like, who would go to your conference that you put on?

Like whatever. Couldn't relate to it. Well, we recently bought her a new Drive medical device which she loves and I said, "There's a guy from Drive Medical coming to my conference."

She was like, "Really?" Like, you … just … let's hug it out.

What you've done is you've legitimized me as a son-in-law. Like the whole thing has come together like, "Wow! Like the guy from Drive."

So Rich where are you? Can you …

Everyone get in the background too.

Michael Serhan: I do have a phone … I have a phone full of customers using our product. I get excited about it as well when I see someone.

Joe Hage: Everyone say, "Hi Janet!"

Janet.

Thank you. Thank you everyone. Let's hear it for them.

Tom Ryan: Thank you.

[Applause]

Joe Hage: Thank you.