HOME OXYGEN PROGRAM
NEW PROCUREMENT PROCESS
MINISTRY OF HEALTH AND LONG-TERM CARE

VENDOR CONSULTATION MEETING #2
JULY 30, 2009

APPEARANCES: Carol Jones
Maureen Williams
Brenda Kritzer - via teleconference
Sara Dobner - via teleconference
Kathleen Powell - via teleconference
Roger Bridges - via teleconference

VENDORS: Doug Fines - Huronia Med-Ox
Mike Pohanka - ProResp
Brian Marshal - ProResp
John Hunter - Vitalaire
Jan Forrest - Medigas
Terry O'Farrell - Medigas
Kerry Dyjack - R.T. Respiratory
Rick Travale - R.T. Respiratory

THURSDAY, JULY 30, 2009

SPEAKER: CAROL JONES:

CAROL JONES (Ministry of Health): Okay, so thank you everybody for attending the session. I note that today is the second meeting of covering the survey responses. Okay, so I'd like to thank all 22 interested parties that took the time to complete the surveys and we acknowledge that you're input is very valuable and appreciated.

The results have been reviewed and analyzed by PricewaterhouseCoopers and key highlights will be shared with you today. As we discussed in previous meetings, the Ministry is moving to a new procurement process for the Home Oxygen program, and we want to ensure that all vendors have full access to all the public documents related to the process. All the documents will continue to be posted on MERX and on the ADP program's site, including all the records of the meetings that we've had. So we will also continue to share the information with OHRSA.

I think you probably all know who is here, but I'll just go right – my name is Carol Jones I'm the Program Manager. There is Maureen Williams. She is the Senior Program Coordinator for the Assistive Devices Program. This is Vanessa our transcriber today and on the line we have Brenda Kritzer who is the Director of the Exceptional Access Program. Sara Dobner I think will be joining us. Kathleen Powell is our Senior Procurement Advisor and is advising as we go through this process and Roger Bridges is the Fairness Commissioner who is joining us today. Okay, so we would also like to engage you in some dialogue and I think anybody - did anybody - was anybody able to print off the site?

MIKE POHANKA (ProResp): Yes.

CAROL JONES (Ministry of Health): Yes, okay. Okay, so the purpose - our agenda today is to re-iterate the purpose of this session as part of the pricing schedule development process; to provide a bit of background to set the context for the Ministry's approach to Home Oxygen services; to highlight some constraints and limitations of the data prior to discussing the preliminary findings and to report on the summary findings of specific components of the survey responses. There we go.

So the Ministry of Health and Long-Term Care is undertaking a pricing review of the Assistive Devices Home Oxygen Program. The Ministry has retained PricewaterhouseCoopers to conduct the Home Oxygen services Pricing Review and as part of the review, PwC developed the Financial Survey for Home Oxygen Program Vendors to collect data from the Home Oxygen vendors to inform the development of the Home Oxygen pricing model.

PwC received feedback from interested parties as of June 12, 2009 on a draft version of the survey.

This feedback has influenced modifications which were incorporated into the final version of the survey posted on-line a week later. Two interactive help sessions were held early in July, during which clarification to the survey questions and minor modifications to the survey itself were made. The survey closed on July 16, and while data validation and analysis is ongoing, the purpose of this consultation is to provide a high level summary of the results of the survey and to obtain feedback where responses to the survey varied greatly.

We have included a slide entitled Discussion Points with each section of the presentation to obtain feedback from yourself. This feedback has been sparked either by our preliminary analysis or from feedback obtained from the vendors throughout the process.

Okay, so the Ministry has determined that issuing a Request for Proposals for the establishment of a public Vendor of Record List for qualified vendors will ensure the necessary transparency and fairness while also ensuring continuity of care to the very vulnerable population served by this program. At the same time, the Ministry will comply with the Procurement Directive of July 2009.

All vendors who qualify will be listed as a Vendor of Record and be eligible to provide home oxygen services to our clients.

Okay, this slide actually is used to construct, to illustrate the main features of our new approach to the procurement of Home Oxygen Services in comparison to the model of procurement which is currently in place.

So the current model we have a pricing agreement with representatives of the vendors. The Ministry negotiates prices in the past with representatives of Vendors. The current term of the agreement is three years and we have actually utilized two-year extensions on that agreement. For the new VOR the vendors who registered will be required to use it from time to time and at the moment a vendor can register with our program at any time. The reimbursement rate for the new model will be a scaled reimbursement rate. Currently the rates that we have are based on American sites and we feel - the Ministry feels that using the new VOR model will be transparent to all.

Okay, before we go on I have to read this exactly. This is the disclaimer.

Information presented in the following slides is intended for presentation purposes only, and is not legally binding.

In the event of inconsistent information between the information in this presentation and the information contained in the future Vendor of Record, the information in the future Vendor of Record will prevail. And that is from PwC.

Okay, so the data presented in these slides today are based on data analyzed as of July 22nd at 5:00 p.m. and that was - the surveys were submitted on July 16th, the final date. Adjustments have been made where advised to PwC by the vendors themselves as identified in validation discussions held on or before July 22nd.

PwC is continuing to conduct its due diligence on the data and many of your organizations have already been contacted.

Changes are not expected to be material. PwC is primarily dealing with outliers.

Because this survey included over 150 specific questions, it is not feasible and would not be productive to review each of them during the course of this meeting. Instead, we will be presenting a high level summary of the findings from the survey.
The findings will be grouped based on the cost components that were reflected in the survey. Where there was a general agreement by most respondents, we will provide a short description

of the findings. Where there was significant variation in the responses or there were gaps in information collected, we will focus our dialogue with you to better understand the context of this variation and what could be the implications in the development of the pricing model.

Okay. All right, so there were 22 vendor responses. The survey was designed to accept responses from HOP vendors and non-HOP vendors. Vendors who are currently providing services to HOP were required to provide information on their current cost structure with respect to the provision of HOP services. For the vendor who identified him or herself as a non-HOP vendor, they provided information solely on key cost drivers and the anticipated impact on these cost drivers in future years.

The classification between large and small vendors was based on home oxygen revenues. A vendor with HOP revenues greater than 10 million dollars in 2008 was considered to be a large vendor and a vendor with home oxygen revenues less than 10 million dollars in 2008 was considered small. If a hospital was registered as a vendor, they were asked to self identify as a hospital vendor. Upon initial review of the data, there were four records which were excluded from the preliminary analysis. One record out of the four was a duplicate response.

Three responses were obtained with incomplete information. PwC excluded these records from the preliminary analysis on the basis that incomplete information would misrepresent total actual cost. PwC is continuing to perform data validation checks with vendors and these records may be incorporated with the final analysis if appropriate. Accordingly, as at July 22, 18 responses were analyzed and the summarized data is presented here.

So as you can see the data collected from the 18 vendors whose responses were included in this preliminary analysis represent 14,855 clients and approximately 87% of total ADP HOP expenditure.

Okay, so this chart represents the composition of the cost structure to deliver for Home Oxygen Program incurred by a vendor for a typical client. A typical client was defined as one that represents the majority of clients a vendor serves, based on a representative sample of existing cases.

The cost components are consistent with those for which data was collected in the survey. The methodology supporting the calculations for the Financial Cost component mirror that of the Deloitte & Touche Report.

The top bar represents the costs, as determined in the Deloitte & Touche Home Oxygen Program Final Report issued in 1998 which included an independent audit and cost analysis of a sample of HOP vendors.

The bottom bar represents the costs, as determined through the preliminary analysis conducted by PwC, on data collected from your 2008 results.

Understanding changes in cost composition through the past ten years will help us establish a fair pricing model for the future, and the trigger points from the Ministry to re-open the VOR and refresh the price over the five to seven year term of the contract.

These changes we're going to look at in more detail in the next slide.

Okay, so the percentages reflect averages weighted by the number of clients served by each vendor. Rather than taking a simple average across all vendors, PwC weighted the costs by the number of clients.

The key findings were that the share of staffing costs has increased from 33% in 1998 to 44% in 2008, an increase of 11%. A small increase in the share of modality equipment costs of 1%. As a percentage of total costs, Oxygen and Bulk

Handling 8%, Vehicle 12% and Premises costs 5% have remained the same. Some cost categories have decreased. These include other equipment costs, care and support costs and general and admin costs.

This is part of where we are asking you, do you think that those responses make intuitive sense. So the response do you feel that makes sense to you?

DOUG FINES (Huronia Medi-Ox): Carol.

CAROL JONES (Ministry of Health): Yes.

DOUG FINES (Huronia Medi-Ox): I was thinking about this last night with some staff and healthcare, pension, unemployment insurance, all those things are part of that staffing costs and all those have increased with a percentage of the cost of payroll far more. And I know in my particular case my respiratory therapist was probably doing 50% more than the average of my staff and now I would say they're getting 100% more than the average of my staff because I can't hire someone for that lower level. I have to hire people and pay them or else they'll leave and go to the hospital sector, or somewhere. So it makes perfect sense to me with all these extra costs plus I'm a small vendor with you know, two RT's and they work part-time.

CAROL JONES (Ministry of Health): Okay, do the rest of you feel the same. Okay.

MIKE POHANKA (ProResp): I think the overall percentages would mirror what we've experienced. And we - I know there's another slide on what's driving the staffing costs so I'll hold off until then on that, but I think in general this is in line with what we're experiencing.

DOUG FINES (Huronia Medi-Ox): I have a question though. I think you were talking - you talked about the weighting. So it was one of the large companies there and they represented say 15% of - then when you're looking at the costs theirs, as being totaled as 15% not 5% you know, which is 1 out of the 18.

CAROL JONES (Ministry of Health): Okay.

MIKE POHANKA (ProResp): Yes, they've been waged based on a number of ….

DOUG FINES (Huronia Medi-Ox): It is wage based on the volume of clients and adjustments.

CAROL JONES (Ministry of Health): Fine. All right.

DOUG FINES (Huronia Medi-Ox): Right.

JOHN HUNTER (Vitalaire): Carol, just to clarify you said that everyone else agrees. I'm here just to listen and learn so I will respond separately to the question, so I don't agree or disagree to these standards that are ….

CAROL JONES (Ministry of Health): Okay. Yes. No, I'm not trying to - and all of you can respond that way as well. We can have these discussion points, but if you feel you want to put more - they're actually on the MERX.

MIKE POHANKA (ProResp): And I think Brendan Aldorsis [ph] is going to send in a response on behalf of its membership as well.

CAROL JONES (Ministry of Health): Okay.

MIKE POHANKA (ProResp): A written response. And again, we'll be commenting today for ProResp.

CAROL JONES (Ministry of Health): Okay, thank you.

DOUG FINES (Huronia Medi-Ox): And just to recap, Doug Fines here, the 87% you talked about it earlier, so 18 acceptable responses represent 87% of the ….

CAROL JONES (Ministry of Health): Total responses.

DOUG FINES (Huronia Medi-Ox): Yes.

MIKE POHANKA (ProResp): We probably have about that in the room.

CAROL JONES (Ministry of Health): Okay. The survey collected data which distributed that the time required to service a typical client over the identified activities for the initial set-up and the maintenance period for a long-term client and for palliative care client.

We wanted to know if there was any difference in the length of time, and thereby costs, it took to service a typical long-term client in the first 90 days compared to a palliative care client.

Interestingly, total weighted mean number of minutes required to complete activities which take place within the first 90 days for a typical long-term client is 1193. Whereas this same number for a palliative care client is 1179. Analysis suggests that the activity time is similar across both types of clients.

However, the weighted average duration, the number of months of a client covered by palliative care funding on the HOP is only 1.36 months while the average duration of a long-term client would be more than the first 3 months.

This information suggests that palliative clients are more intensely serviced for one month than a long-term funding client over three months. Does this make sense?

MIKE POHANKA (ProResp): So it’s Mike Pohanka from ProResp. I think it does make sense because palliative clients are receiving essentially the same services as the long-term client and even in our long-term clients I would think a lot of that in the first 90 days would be front end loaded in the first 45 days. And you’re looking about a 40 or 45 day average length of stay for a palliative client, but we’re going to do the initial set-up, the plan of care, the teaching of the family, all of that is kind of front end loaded into the first 45 days in either type of client. And I think in the case of palliative clients there’s more interface with other caregivers in the home because you’re trying to have a comprehensive service of which the home respiratory is one piece, but you're usually working with brass hospice workers or a nursing staff and you're trying to take that burden off the family as much as you can. So there's probably more interface with other caregivers required for palliative clients. I don't know if anybody has anything else to add to that, but I wasn't that surprised to see that.

DOUG FINES (Huronia Medi-Ox): We have a client we were visiting almost daily and the plan care is changing daily. There were more and more concerns near the end and we were very stressed and very concerned that the equipment was working properly and in working form so we wanted to change the next kind of thing that's going on, so my therapist was going out and pleading on our homes day to day.

CAROL JONES (Ministry of Health): Do you agree?

MAUREEN WILLIAMS (Ministry of Health): The normal patient – a routine palliative patient you mean?

DOUG FINES (Huronia Medi-Ox): At least 50% of the time. Some people are being better and calmer and either your friends are coming and your family is coming, and that's not happening with ….

MIKE POHANKA (ProResp): I think Doug has kind of hit the nail on the head. In the palliative there's kind of two groups. There's the one that you know, put the equipment in and leave us alone to die in peace, and that's one group. And then there's the other group where they really want you in with a high level of service intensity like he's talking about, and you're interfacing with everybody else and there's a high anxiety level and the family really wants to keep them out of the hospital, and it's almost like a hospital in the home situation. And you get both groups, and so it's really hard Maureen to say the typical palliative client because we do see both types.

DOUG FINES (Huronia Medi-Ox): Doug here. I agree with Mike. The number one thing is they don't want to go back into the hospital and if it meant passing away a day earlier that would be the response. They want to stay with their spouse and stay at home.

CAROL JONES (Ministry of Health): Okay, thank you. So we have discussion point one. The shares of Staffing costs have increased from 33% in 1998 to 43% in 2008, an increase of 10%. The question here is, why have staffing costs increased so dramatically?

MIKE POHANKA (ProResp): Okay, thanks Carol. It's Mike Pohanka again. Really what I think when we look at it is we're in an industry where the rate is set based on our agreement and the competition is on the level of care provided. So what we've seen here is, and Doug has talked to it, our staff get an increase every year. We need to recruit respiratory therapists against hospitals. You know, we get most of them out of the hospital sector and so we have to pay competitively with that. And I think since the Deloitte Touche was done 10 years ago RT’s got wage settlements in hospital where they got parody with our end and in general their contracts go up you know, every year by 3% or so. So we’ve had to at least match that to continue to recruit and retain. I think what – so in addition to the increasing base salary costs we’ve also, and Doug mentioned it, we’ve had significant increases on our benefits costs. I think we all know health insurance costs have gone up by far more than the rate of inflation. And in our particular company we’ve increased our benefits coverage percentages. We used to have the staff share the cost of that and now the company pays all of that. So that’s been one of the cost drivers we’ve had on our health insurance. I think the second driver is the higher acuity of care that we’re seeing in our client base. It’s again, 10 years ago when Deloitte was here there was no 90 day requalification. So we had some of our patient based were post-acute clients who got better after 90 days, but they stayed on oxygen for a year and now we take those folks off at 90 days. So that group which required very little care in the past isn’t there anymore. And so the ones that we do have are after 90 days are all fairly end stage COPD clients and they can be – some of them are stable and some of them aren’t. You know as they reach the end they become more unstable. And sometimes they go back into hospital and then when they come out we have to do essentially a re-start or a new set up for them, or we have to change equipment modality because their needs change. So those are drivers and then on the other hand what you're talking about here is wage cost going up in relation to other costs and I would suggest that what we try to do is minimize all of our other costs. As you know we haven't had a rate increase in years, so we've had to deal with increasing wage costs and no increase to our per patient revenue. So what we've tried to do is on things like general administrative costs we've become much more efficient there. We've invested in information technology. We've done things like process mapping to make sure that we're doing only value added activities and so I'm not surprised when I see general admin costs come way down as a percentage. Another one that reduces financing costs and we all know that interest rates are at probably the low we'll ever see in our lifetime right now, so wages would go up just because those other costs are coming down. So I think those are some of the things we see as driving the reasons why our staffing costs have gone up. I think that the message that we would put forward is we think we've cut our costs in other areas. We've tried to hold back on cutting our staffing costs in the direct care area because that's where we're competing right now and you know, so that's where we've tried to maintain the service at a higher level if possible.

CAROL JONES (Ministry of Health): Any other comments? No?

DOUG FINES (Huronia Medi-Ox): I said this the other day as well, once you pass this 90 day period and those clients, maybe they want to start travelling, or going to their family cottage, or getting back to work so they – and if they're not happy with their current vendor then they start to go shopping and comparing. So if you want to hang onto your base clients you have to make sure that when their asking for something you get it ordered, you put them on a regular schedule for RT visits, they're on regular schedules for delivery of supplies and a quart of oxygen or whatever. So you can't ignore that post 90 day client or your competitive advantages in the marketplace will disappear.

CAROL JONES (Ministry of Health): Okay, thank you. Okay, second point responses. Responses varied greatly among vendors in response to the question: In 2008, approximately what percentage of your clients, for which you conducted an initial assessment, were not approved for HOP funding? The responses ranged from 1% to 80%. So the question here to you is what support would the vendors require from the Ministry to help them reduce the number of initial assessments for ineligible clients? Is there anything that we can do at our end that would prevent these applications coming in and obviously that means that we're not meeting the medical criteria?

MIKE POHANKA (ProResp): Well, I think, it's Mike again, I think when we do assessments they tend to be like overnight oximetries or something that are asked for by physicians. So in a physicians view there is a thought that the client may require oxygen and so somebody needs to assess that client and in some cases we'll find they don't need oxygen. I would say if was 80% of the time we probably wouldn't be in business, but my - I thought about this question and you know, I think on the earlier in the consultation process on the quality piece there was the issue brought up about should we have independent assessment centers and I think, yeah, if the Ministry assessed all these clients themselves we wouldn't need to do it, but I would still think that the present system is the most efficient because we're out there, we're used to doing this, it's already built into the rate and we're already on record as saying we don't think it makes a lot of sense to set up independent assessment centers all over the province where clients need to go in. So we're pulling frail elderly people out of their home or out of the long-term care facility into an independent assessment centre when our staff are already out in the community anyways. We can assess them in the home. So it's - so if the question is could the Ministry do the assessments we don't think that makes a lot of sense compared to the current system. If - I'm not a - I don't have the answer for the, whoever the respondent was who's getting 80%. I - you know, maybe they need to have a chat with their physician about you know, what the criteria are, but you know, I - we you know, we do, do some that don't qualify, but they would be in the minority for sure.

CAROL JONES (Ministry of Health): Okay.

DOUG FINES (Huronia Medi-Ox): Yeah, I don't know if this person is working in the mall or something. The thought occurs to me though if there are independent oxygen assessments left the CPAC system - this is particularly fast at getting people in and tested and improved. So if you tried to drag it out like that you know, a lot of our referrals come on a Friday afternoon at three o'clock. And I'm sure it's common right across the industry, across the services. So I wouldn't want to see the same thing.

CAROL JONES (Ministry of Health): Yes.

MIKE POHANKA (ProResp): The other advantage I think for the Ministry on that point is if we do the oximetery at home and we say they don't need it then we're not clogging the hospital system in getting the AVG's done to make sure that they qualify. I mean we're only going to send that client in if the oximetery would indicate that they're going to need oxygen. So again, I think the current system is fairly efficient.

CAROL JONES (Ministry of Health): Okay, any other comments? Onto the third point then. Does the staffing and or service requirements change from the first 90 days to those on maintenance after the 90 days and after 1 year? If not, why?

MIKE POHANKA (ProResp): Well, I think again, and I mentioned earlier compared to 10 years ago now the post acute clients who've recovered are off after 90 days. We know that 40% of our clients are taken off at 90 days roughly. So the ones that are left are the chronic clients who are in stage COPD and we do find that while they may have a stable period their needs do ramp up as they approach end and they become unstable and they require more respiratory intervention. All of the costs that we have in the first 90 days are there beyond 90 days. Like we still have the equipment in the home, we still have the 24/7 on call, we still have the customer service reps to man the phones, and I would think that there is some reduction in the respiratory therapists while that client is stable compared to the first 90 days. Because the first 90 days has the initial set-up and a lot of the training in it, but as Doug pointed out we still have to provide service to that client and we're still doing respiratory assessments, although if the client is stable we don't do them as often. I would think that, and it's been our experience that we actually see an increase beyond the first 90 days in our service tech component because they're going out weekly to replenish oxygen cylinders to check the - they don't check concentrators weekly, but they tend to do it monthly and they're also, we've kind of trained them, or delegated assessing the client's condition. So if they see a change in that client they'll let the respiratory therapist know. So we actually have seen – we have some savings on the therapist side beyond the first 90 days, but that is partially offset by an increase in our service tech and all the other costs are pretty much the same. So I know that we thought the data had reflected our experience which was a – someone of a drop off, but perhaps not as much as the Ministry was anticipating, but I think that that's reflective of what we see.

CAROL JONES (Ministry of Health): Any other comments? No?

DOUG FINES (Huronia Medi-Ox): I've already given you my ….

CAROL JONES (Ministry of Health): Yes. Okay, so moving onto Care and Support Costs. So Care and Support Costs include costs of disposables, client education materials, communications, parking associated with service delivery, uniforms, maintaining individual professional certification, accreditation and other care and support costs as identified by the vendors themselves. The significant portion of those costs reported as other include those which relate to the pandemic planning.

This chart represents how care and support costs are distributed, weighted by the number of clients, for all vendors.

So the key findings were disposables, client education materials, and cost of communications together account for approximately 75% of total care and support costs. Components of care and support costs, other than disposables, client education materials, and communications, are having a greater impact on the total share of care and support costs. Ten years ago disposables, client education materials and communications accounted for one hundred percent of the total care and support costs. It is significant to note that total care and support costs incurred per client, are approximately 1.7 times higher for a small vendor and approximately 1.1 times higher for a hospital vendor, than they are for a large vendor.

Large companies experience cost savings. Well, the implication is obviously large companies experience cost savings in care and support costs.

As disposables continue to represent a large component of Care and Support Costs at approximately 30% of the total weighted for the number of clients the frequency to which disposables are issued was examined. Vehicle costs will also be impacted by the frequency in which disposables are issued.

The majority of vendors are issuing disposables at a frequency of no less than once a month.

The other response includes vendors who distribute weekly and monthly depending on the disposable to be distributed, or distribute based on the client situation.

MIKE POHANKA (ProResp): Do you want any feedback on that?

CAROL JONES (Ministry of Health): Go ahead.

MIKE POHANKA (ProResp): Well, the one observation I'd have on the accreditation piece is it's probably not 6% as the pie graph shows because in the 22 responses you probably had a number of responses from vendors who aren't accredited, so they would have showed zero there. So I think the ones that are accredited it would be a little bit higher. That's one observation. I can't comment on why the smaller vendor, other than you know, we can bulk purchase and deal directly with the manufacturers it may be that we're getting better pricing, but no comment.

BRIAN MARSHALL (ProResp): I would – it's Brian speaking now. I would comment on things like communication costs, professional certification. Those are fixed costs that as the client base – as you have a higher client base you can spread those over more clients, so the overall cost then will end up being less on a per client basis, but there's a certain level of fixed costs that everybody has to incur. We're going to have cell phones and communication equipment.

CAROL JONES (Ministry of Health): Okay, any other comments? All right, moving onto to percentage of clients by modality. Okay, vendors were asked to report the number of clients supported on each type of modality equipment. This chart illustrates the percentage of the client population that is served with each type of equipment and is weighted by the number of clients.

The majority of clients served by the vendors that were surveyed use stationary concentrators. The majority of stationary concentrator users had cylinder backup while a smaller percentage had liquid backup or portable systems. Few clients were using both stationary and portable concentrators, or other devices which include home transfill, portable concentrators only, or dual systems.

Since 1998, several changes in technology had influenced cost and client use of modalities. Over the past 10 years, technology in stationary concentrators has improved, and more vendors are using them now than 10 years ago. Portable concentrator and home transfill systems have emerged, oxygen conserving devices have increased in use and the use of liquid oxygen as a primary mode of delivery has decreased. As compared to 1998, an increase in the use of stationary concentrators and a decrease in the use of liquid systems is reported.

On a per client basis, modality equipment costs have increased slightly.

Okay, so this chart represents how modality costs are distributed, weighted by the number of clients for all vendors.

Modality equipment costs include cost of owned and leased modality equipment and cost of modality equipment repairs and maintenance.

The key findings were that the majority of the equipment is owned, few vendors reported equipment which was leased. Liquid reservoir, portable and stationary, and stationary concentrators account for approximately two thirds of total modality equipment costs. It is significant to note that total modality equipment costs incurred per client, are approximately 1.2 times higher for a small vendor than they are for a large vendor.

While technology has advanced, so the total costs incurred for the modality equipment have increased and the small vendors face challenges as large vendors experience economies of scale.

Home transfill systems which is something that we submit that we see people using more. Several vendors reported that more than 10% of the modality is attributed to home transfill.

The preliminary analysis indicates that these same vendors report fuel costs that are nearly 35% lower than the average.

Okay, home transfill systems have been identified as a viable modality for northern areas in Ontario. What are the strengths and weaknesses of the home transfill systems? Are there opportunities to increase the usage of home transfill while ensuring the same or a greater level of care to the client?

MIKE POHANKA (ProResp): Well, first of all we, it's Mike again, we don't use home transfill systems. We have evaluated them and we've found the technology still to be wanting to a certain degree. I think tomorrow on the conference call we're going to have some of the northern folks on and they'll be able to speak better to this issue, but just in our observation I think you're making an inference here that because they have home fill systems you can really drive down the cost of gas or commuting and I think the reality is that in the north right now there's a $25 differential per month and that's not enough to be able to visit these clients where the distances are formidable. And I'm talking about you know, real northern areas where there's quite a distance between clients and so for the reimbursement that they get they're providing the best service they can, but that wouldn't apply in the south because people would demand better service which would include visits by respiratory therapists on a more frequent basis. I think in the north there is less competition and I'm again, I'm not speaking as one who operates there, but I think expectations of clients are lower there in terms of what service levels there are. One of the models up there is to run the home oxygen service out of a pharmacy. So they may be delivering prescriptions at the same time, but I think that in the south the economies aren't as pronounced. This equipment costs us more than three times what we would invest in a normal client. So we'd have to offset that equipment cost and we can visit that client because we have another client down the same street we can visit them more frequently at less cost than you could in the north. So I think that you may see that the service levels are lower in the north because there's less competition and they can kind of get away with this technology up there. I'm totally open to what other people would say because I'm just saying this based on our understanding of how things run in the south.

RICK TRAVALE (R.T. Respiratory): I'm Rick from R.T. Respiratory and I agree with what Mike is saying on a big percentage. It really sounds like the newest slice of bread out there. You put a machine in, they fill their own cylinders and they go to the mall and do whatever they want to do. And we delved into it ourselves and we've tried it. Now one of those cylinders gets out of date because they need to be hydrostatically you know, tested. Now you got to go out there and get that cylinder, give them another $500 cylinder to replace that one, bring that back, put it into the system. Now your costs have been eaten and you thought you were saving. And sometimes with every transfill, like we experienced they come with two new cylinders, well, could mom have an extra one because she wants to go longer. So now you've got another investment three times the cost of the investment. In Southern Ontario like Mike said it doesn't work in a small town like Tillsonburg where you're on that street anyways and you're dropping off. We've looked at, seriously looked at and we backed away from it.

DOUG FINES (Huronia Medi-Ox): Doug here. We've invested in two or three units and they're out there being used, but it's the clients that have the ability to fill their own cylinders and similar comments though about getting them retested when the time is due. Sometimes the valves don't fit right or the o-rings are missing you know, and then we're out there making service calls. Sometimes there are other equipment issues with the units. You have liquid or portable cylinders the conserving devices if there is power failure most of them last between 24 hours. Well, they have their own set of reserves of six cylinders or whatever it is and concerned that they can go through that 24 hours. With this unit we're out of oxygen in three hours and you're heading for the local hospital. Failing that you know you're looking for a generator.

CAROL JONES (Ministry of Health): Okay, any other points? No. Okay, the second point.

MIKE POHANKA (ProResp): And that's a good question. I wonder if the clients in the north have generators for the most part you know, where you live in a remote area. Maybe they do. I mean we can ask that tomorrow on the call.

CAROL JONES (Ministry of Health): Okay, the analysis shows that large vendors benefit from economies of scale. Are group purchasing opportunities an avenue to explore for smaller vendors or, for all vendors acting as a purchasing consortium?

DOUG FINES (Huronia Medi-Ox): You said consortium now you're eliminating three or four other competitors in the supply chain that supply product to our essential hospitals. And all the sudden the engineering, or the entrepreneurship, or whenever they come out with a better oxygen mask disappears because it's a buying problem you can see wholesale. So if you try something like that - we had this discussion with CCAC six months ago. The cost of delivering medical equipment to a patient, the cost of it is 10%. The rest of it is maintenance, the history of it, the cleaning, the delivery vehicle and the person who's doing the delivery. So the actual capital costs of the disposables or the equipment is a very small part of our costs and you can see that from the chart.

RICK TRAVALE (R.T. Respiratory): If I could comment on that. It's Rick. We've also looked at repurchasing. Over the years, some of us have been around longer than others we had to stay away from that. We have over the years formed relationships with our suppliers as well. And all of the sudden on a Friday afternoon when you need something they're going to have that new part for you. So we sort of stay away from that. They know, most of the suppliers know, what we're being paid. For most suppliers it's competitive as well.

MIKE POHANKA (ProResp): I think Doug did mention it, but some of the smaller vendors have a business model where they do other things for ADP like mobility and they can in effect negotiate some decent pricing with suppliers like Infacare because they're buying their wheelchairs so they can - Doug probably gets a better price on home fills than I would because you know, we don't buy anything else from them. So I think they kind of have their own little group purchasing in that way. I don't know if you want to ….

DOUG FINES (Huronia Medi-Ox): Yeah, that's why I say we've made our own deals and we're happy with them and we don't want to be told this is the new program.

CAROL JONES (Ministry of Health): Okay. All right, other equipment costs. Okay, so this chart represents how other equipment costs are distributed, weighted by the number of clients for all vendors.

Other equipment costs include costs of carts, oximeters, carrying bags, regulators, storage equipment, measuring equipment, portable analyzers, other and the repairs and maintenance cost which relate to this equipment.

The key findings here are that the share of other equipment costs has decreased over the past 10 years a decrease from 2% to 1% of the total cost to provide home oxygen service. This is despite the fact that the Deloitte report did not include repairs and maintenance as a component of other equipment costs which today accounts for 21% of the total costs. Costs of oximeters, regulators and repair and maintenance on the other equipment account for nearly two thirds of the total share of other equipment costs. The implications is you're going to have small vendors face challenges as large vendors experience economies of scale.

Okay, so oxygen and bulk handling costs. Vendors can purchase oxygen in one of the following ways: The oxygen producing or distribution company refills empty cylinders and liquid units. Oxygen is purchased in bulk and the vendor refills the individual unit themselves or a combination of the two. Accordingly oxygen and bulk handling costs components vary according to the means in which the vendor purchases the oxygen.

So approximately 13% of clients represented in the preliminary analysis, are serviced by vendors who do not participate in bulk purchasing. This represents 12 vendors. Examining vendors who do not purchase oxygen in bulk, their costs are comprised of oxygen refills and the costs related to demurrage and rental expense for the gas cylinder. For 2008 this represented approximately 94% and 6% respectively. Oxygen costs for vendors who do not purchase in bulk are approximately 1.3 times higher than the costs for a vendor who purchases oxygen in bulk.

DOUG FINES (Huronia Medi-Ox): Carol, can I just comment?

CAROL JONES (Ministry of Health): Yes, go ahead.

DOUG FINES (Huronia Medi-Ox): Doug here. One of the advantages for a home fill is that you're not required to track and trace every cylinder of oxygen because the client filled it in his own home.

CAROL JONES (Ministry of Health): Right.

DOUG FINES (Huronia Medi-Ox): And there's no requirement by Health Canada or anyone else to track what happened to the cylinders. In our particular case the tracking can be more expensive than the actual oxygen that's going in the south. It's a much bigger administration.

CAROL JONES (Ministry of Health): Okay.

BRIAN MARSHALL (ProResp): Can I just make a comment as well? Brian from ProResp. I'm disturbed when I see something like 13% of the respondents don't have both oxygen capabilities. One of the requirements of being a vendor, if the requirements are staying the same and currently we obviously have vendors that don't provide all the modalities and I'm wondering how the Ministry is going to take that into account. Are we suggesting that liquid is not a viable modality, or contemplating removing that? I just wondered if you have a comment about that?

CAROL JONES (Ministry of Health): I don't think there's any particular scenarios at all. I mean, there are certain – your clients who have to have liquid.

BRIAN MARSHALL (ProResp): I just wondered ….

CAROL JONES (Ministry of Health): But it is a comment that we'll take back, okay.

MIKE POHANKA (ProResp): I guess the other – go ahead.

DOUG FINES (Huronia Medi-Ox): Thirteen percent of clients representative of preliminaries now are served by vendors who do not participate in bulk purchasing. I don't buy bulk oxygen you know, in a bulk tank.

CAROL JONES (Ministry of Health): Yes.

DOUG FINES (Huronia Medi-Ox): And that's how I read the survey question, so I don't have a bulk tank, but I do buy what we call LG3's that are this big and this high. So I think the survey is maybe misunderstood by the smaller vendors who don’t have bulk and they represent this 13% of the customers. If those numbers make some sense than that’s the best question not saying that 13% of the clients don’t have access to it.

CAROL JONES (Ministry of Health): Okay, I’ll make sure that that point gets back. Okay, so this chart represents how oxygen and bulk handling costs are distributed, weighted by the number of clients for vendors who participate in bulk purchasing.

Five vendors reported that they purchase oxygen in bulk, and may also purchase oxygen refills. These 5 vendors service approximately 87% of the clients represented in the preliminary analysis. The costs associated with the bulk oxygen, tanks and site licensing account for approximately 94% of the total costs.

So the implication here is that vendors who do not purchase in bulk are at a disadvantage from a cost perspective.

Is there a question about this?

MIKE POHANKA (ProResp): I don’t have one. We do purchase bulk and I think certainly we’re paying market rates because we don’t make the stuff. So I know in our case our bulk costs go up annually pretty much by CPI so I wasn’t surprised when I saw that was one of the costs that hadn’t changed as a percentage of the total cost over time.

That’s probably been about our experience. It’s gone up with the general read and this other costs.

CAROL JONES (Ministry of Health): So we have a question. Have your costs of meeting municipal guidelines permitting oxygen gas storage increased in the past two years? Is there any indication of continuing changes in municipal guidelines?

BRIAN MARSHALL (ProResp): Brian again. The – I’m not sure how the questions are around municipal guidelines because that depends on the different municipalities as far as how they set their zoning bylaws, but the one thing that does impact bulk handling is the site licensing costs of having a bulk tank located within the province. And in the last year Health Canada went through a cost analysis in their division and determined that they weren’t recovering the whole cost of the site licensing. So the implication was that the medi-gas guy have their guys in their budget. It looks to us like they were talking about quadrupling or even five times the cost of the existing site licenses to recoup their costs. And I know that in fact the Gas Association was involved with working with Health Canada and some other associations to reduce that cost. And my understanding was there was a moratorium on it that was going to last a couple of years and that the cost implications are still there.

MIKE POHANKA (ProResp): Basically we argued to them that this was medical oxygen that was you know, medically necessary to sustain life and that we were under contract with the Ministry of Health where we couldn’t recoup these increased costs. So I think we signed our survey, one of the questions was you know, where do you see costs going in the future and what would perhaps be a reason to reopen the contract pricing and this is certainly one that if they quadrupled or quintupled the cost of site licensing then we’d have to be able to recoup that somehow. And as Brian says they’ve deferred it right now for our sector, but you know, deferred doesn’t mean it’s gone forever. So I think that’s – we couldn’t figure out what municipal guidelines would be. I think the question maybe relates with the federal, with Health Canada.

DOUG FINES (Huronia Medi-Ox): I think Mike this site licensing isn’t the license for a particular tank, bulk tank on your properties it’s your DIM license for filling and distributing the nitrogen, or liquid oxygen and it was that costs ….

BRIAN MARSHALL (ProResp): Well, it includes the packaging of the licensing.

DOUG FINES (Huronia Medi-Ox): Yes, so the packaging of the oxygen.

BRIAN MARSHALL (ProResp): So if you were doing transfilling or if you were doing fills directly from a bulk tank the implication is you need a site license there.

DOUG FINES (Huronia Medi-Ox): Right.

BRIAN MARSHALL (ProResp): And that cost would probably go up significantly.

DOUG FINES (Huronia Medi-Ox): I think the question maybe is coming from this propane industry after the unfortunate incident in the summer. Now they're going through this company that's pulling out dispensers all across the province because of the engineering costs and the licensing costs and they're trying to make them meet the new requirements. And the municipality they're not worth what they're doing so they're taking about those kinds of things, but that's not happening in the medical industry other than this licensing requirement by the federal government to help with the packaging of medical oxygen. And again, the home fills eliminates that because the client is doing it themselves. So we feel – I feel and I think some of the others that you know, an individual who's ill and requires home oxygen is not the person you put in charge of filling their own ….

CAROL JONES (Ministry of Health): Okay, thank you. So we're moving onto vehicle costs. So we have a chart here that represents how vehicle costs are distributed, weighted by the number of clients for all vendors.

Vehicle costs include the cost of purchased or leased vehicles, vehicle licensing, vehicle insurance, fuel, cost of reimbursements to staff for use of personal vehicles and cost of vehicle maintenance.

So the cost of the purchased or leased vehicles accounts for nearly half of the total vehicle costs, while licensing, insurance, fuel and maintenance account for the balance. Per unit monthly lease costs and per unit purchase prices varied greatly between vendors. Vast majority of vehicles utilized by vendors for the Home Oxygen Program are either leased or owned by the vendor. An immaterial portion of the total cost is attributed to vehicles which are personally owned. Vehicle costs for small northern vendors are significantly less than other vendor groups. Northern vendors also utilize the highest percentage of home transfill.

So 1/3 of the total vehicle costs are dependent upon market swings in the cost of fuel.

Premise costs. Premise costs include those costs related to lease and or depreciation on owned buildings. The vast majority of vendors lease their space and the annual lease costs per square foot range from $7.34 to $35.71.

The cost of premise varies greatly among vendors. Just a note that property taxes related to leased space are recorded in this preliminary analysis as a general and administrative cost to maintain comparability with the cost structure reported by Deloitte in their 1998 report.

Okay, we'll move onto to general and administrative costs. This chart shows how the G&A costs are distributed, weighted by the number of clients for all vendors.

So the general finance and corporate expenses represents 30%, office supplies at 13%, bad debt expenses 7%, computer systems and software 5%, donations to individuals or organizations 5%, internal training 4%, utilities 4%, amortization of intangible expenses or goodwill 4%, legal counseling 3%, property taxes 3%, liability insurance 2%, commercial insurance 2%, indirect taxes 2%, bonuses, gifts and honoraria 0, and the rest of them are 0 and I'll just go through them. So fundraising costs, incorporation or reorganization costs, loans to clients or staff, provisions for accruals, and retainer fees are all 0 and other is 14%.

So the finance and corporate, office supplies and other G&A costs account for just over ½ of total G&A costs. Vendors reported no costs associated with fundraising or loans to staff, and the contribution of total costs reported for incorporation and reorganization, provisions for accruals, retainer fees, gifts and honoraria were less than 0%. Accordingly, these components are not listed on the chart.

Okay, and last but not least ….

DOUG FINES (Huronia Medi-Ox): Can I just comment?

CAROL JONES (Ministry of Health): Yes, now you can ask questions.

DOUG FINES (Huronia Medi-Ox): My insurance went up 60% this year from last year. It's going to cost me $30,000 and in the company I do a number of business things, but the company is most concerned about the care portion of my business. It went from 55,000 to $85,000.

CAROL JONES (Ministry of Health): Any other comments? Any other questions? Okay. Well, thank you for coming and paying attention to me. As you know we've captured all of your comments by the reporter and we have one more session by teleconference and we will - once all of the transcripts have been reviewed they'll be posted on the site.

MIKE POHANKA (ProResp): I just want to say Carol, express our appreciation to the Ministry for holding these meetings on a reasonable basis and coming to London. Thank you.

CAROL JONES (Ministry of Health): Thank you. For you on the teleconference this session is completed.

THIS IS TO CERTIFY that this is the transcript of the Vendor Consultation Meeting #2 held July 30, 2009 by a digital recording device.

CERTIFIED CORRECT

August 13, 2009 ________________________

Vanessa Breakwell
Certified Court Reporter