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HEALTH FACILITIES &
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**STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD**

**LONG-TERM CARE ADVISORY SUBCOMMITTEE
APPLICATION WORKGROUP MEETING**

CONFERENCE CALL

NOVEMBER 19, 2012

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State OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
217.782.3516

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LONG-TERM CARE ADVISORY SUBCOMMITTEE
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AGENDA

CALL TO ORDER: Monday, November 19, 2012

1. Attendance
2. Approval of Agenda
3. Proposed Application Changes Discussion
5. Other Business
6. Next Meeting
7. Adjournment

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LONG-TERM CARE ADVISORY SUBCOMMITTEE
APPLICATION WORKGROUP MEETING
CONFERENCE CALL

Meeting of the Health Facilities and Services
Review Board, Long-Term Care Advisory Subcommittee,
Application Workgroup, was held on the 19th day of
November, 2012, between the hours of 10:00 A.M. and
11:45 A.M. of that day, with the reporter at the
offices of the Health Facilities and Services Review
Board, 525 West Jefferson Street, 2nd Floor,
Springfield, Illinois 62761.

1 MEMBERS PRESENT:

2 Michael Scavotto

3 Eli Pick

4 Cecilia Credille

5 Michael Waxman

6

7 ALSO PRESENT:

8 George Roate

9 Courtney Avery

10 Claire Burman

11 Frank Urso

12 Juan Morado

13 Alexis Kendrick

14 Charles Foley

15 John Kniery

16

17

18

19

REPORTED BY:

20 Robin A. Enstrom, RPR, CSR

Illinois CSR #084-002046

21 Midwest Litigation Services

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24

1 SCHEDULED START TIME: 10:00 A.M.

2

3 MR. SCAVOTTO: Let's go ahead and get
4 started.

5 MR. ROATE: Okay. Do you mind? I'll go
6 ahead and take role then.

7 MS. AVERY: Yes, please.

8 MR. SCAVOTTO: Yeah, let's do that.

9 MR. ROATE: Okay. I have listed Courtney
10 Avery.

11 (No response.)

12 MR. ROATE: Claire Burman.

13 MS. AVERY: Here. Sorry.

14 MR. ROATE: Claire Burman.

15 MS. BURMAN: Yes.

16 MR. ROATE: Frank Urso.

17 MR. URSO: Yes.

18 MR. ROATE: Alexis Kendrick.

19 MS. KENDRICK: Here.

20 MR. ROATE: Cecilia Credille.

21 MS. CREDILLE: Here. Cece Credille.

22 MR. ROATE: Cece Credille. Okay.

23 Eli Pick.

24 MR. PICK: Here.

1 MR. ROATE: Michael Waxman.

2 MR. WAXMAN: Here.

3 MR. ROATE: And Mike Scavotto.

4 MR. SCAVOTTO: Here.

5 MR. ROATE: And then myself, George Roate.

6 Is there anybody else who signed on that I
7 did not name?

8 MR. FOLEY: How about Charles Foley?

9 MR. ROATE: Charles Foley.

10 Okay. Is there anybody else who signed on
11 that I did not call? Okay. I have all the names.

12 MR. SCAVOTTO: All right, everybody. This
13 is Mike Scavotto, and let's dig into this as best we
14 can and get as much accomplished as we can.

15 Claire got me off onto the rules, and I
16 did learn a lot from that process, and there is --
17 there's a fair amount of this application -- a lot, in
18 fact -- that is dictated by the legislative rules that
19 are published through JCAR. So if we -- and there's
20 plenty of stuff that we're going to want to address
21 that may involve changes to the rules, and that's
22 going to be a longer, drawn-out process if we decide
23 to go that way.

24 But that being said, let's go through the

1 application point by point as we have summarized it in
2 our latest memoranda and see what it is that we want
3 to attack, and let's get some input from the staff
4 members.

5 Now, George, you're pinch-hitting for
6 Mike --

7 MR. ROATE: That I am.

8 MR. SCAVOTTO: -- Constantino. Are you
9 going to be in a position to help us out on some of
10 this stuff?

11 MR. ROATE: I will do my best, yes.

12 MR. SCAVOTTO: Okay. Did I hear Claire
13 sign in?

14 MS. BURMAN: Yes.

15 MR. SCAVOTTO: Claire is here. Okay. I
16 didn't have you logged in. All right. So same there.
17 Okay.

18 So we'll do this knowing that this may end
19 up being a much longer, much more drawn-out procedure
20 because we have -- if we want to make changes to the
21 rules, we're going to have to get these things
22 processed through the planning board and through JCAR
23 and maybe even some other legislative processes. But
24 if it's worth fixing and doing right, it's worth

1 taking a shot at it. Fair enough, everybody?

2 UNIDENTIFIED: Yes.

3 UNIDENTIFIED: Yes.

4 MR. SCAVOTTO: Okay. All right.

5 Okay. So the first -- the first comment
6 that we have in the October 25th summary concerned the
7 opening four pages, and I think I'm going to -- I
8 think I'm doing everybody's comment justice in the
9 sense that we thought it might be best to have a brief
10 description of this, and this looks to me like it's a
11 dashboard. The thing that I found awkward about it is
12 that the narrative description comes at the very end.
13 So, you know, the reader is here taking a look at a
14 project, and you have to wait till the end of this
15 thing till you find out what it is you're reviewing
16 and what the scope of it is.

17 And I think, Eli, you picked up on this
18 one, and I'm thinking that perhaps the best thing we
19 can do is just suggest that we relocate that narrative
20 description to an earlier spot in section one.

21 MR. PICK: I agree with you, Mike.

22 COURT REPORTER: Who was that?

23 MR. SCAVOTTO: Say it again. I didn't get
24 that.

1 COURT REPORTER: Who agreed with Mr.
2 Scavotto?

3 MR. PICK: Oh. Sorry. Eli. Eli.

4 MR. SCAVOTTO: Eli agreed.

5 MR. ROATE: If you don't mind, what we'll
6 need to do is, once again, before you speak, as
7 Mr. Scavotto introduced himself, please do the same if
8 anybody has any comments.

9 MR. SCAVOTTO: Okay. That's fair enough.

10 MR. ROATE: Thank you.

11 MR. SCAVOTTO: Cece, where are you on
12 this?

13 MS. CREDILLE: I'm parked where you are.

14 MR. SCAVOTTO: Okay. All right. So
15 relocating the description sounds like a good thing to
16 do.

17 Okay. Now, another item that came up for
18 discussion was in the introductory, small Roman ii in
19 the introductory section to this application, and I
20 think we'd like to get some input from the staff as
21 far as the usability of the utilization data by ZIP
22 code, physician referral letters. And I know it's a
23 requirement. It's in the rules. But we also know
24 from previous discussion and comment, particularly

1 from Mike Constantino, that this doesn't seem to be
2 working out well in practice. And certain providers,
3 in particular the hospitals, don't seem to be too
4 forthcoming with the information.

5 So can we get some comments from the staff
6 on how practical this section really is. Claire, do
7 you want to start off with that?

8 MS. BURMAN: Yes. The use of referrals
9 has been a long-standing way to establish that there
10 is a need in that planning area and, more
11 specifically, a need to provide beds at that
12 particular facility. Okay.

13 Now, some people have suggested performing
14 a market study which will give you information about
15 an approximate number of people who have a certain
16 condition or ailment, whatever you want to call it,
17 within a geographic area. What it does not do is it
18 doesn't tell you, of that group of people, how many
19 are probably going to be going to your facility.
20 Okay.

21 That's why the referrals are much better
22 because they're more specific to the applicant's
23 facility.

24 MR. SCAVOTTO: I think we get that.

1 MR. ROATE: Who just spoke?

2 MR. SCAVOTTO: Mike Scavotto.

3 MS. BURMAN: This is Claire. Claire
4 Burman.

5 MR. ROATE: No, Claire, we got you. But
6 that was Mike who -- you just spoke to that?

7 MR. SCAVOTTO: Yes, it was. That was Mike
8 Scavotto.

9 MR. ROATE: Okay. Thank you.

10 MR. SCAVOTTO: All right. Still Mike
11 Scavotto.

12 So, yes, I think -- I think we know what
13 the intention is but we're -- I keep hearing that that
14 information is just not forthcoming, that it's
15 difficult to get decent information.

16 MS. CREDILLE: This is Cece Credille.

17 The information is very difficult, and
18 from the -- for several reasons. From the point in
19 time at which probably this rule was set, the
20 hospitals were organized very differently. At this
21 point in time many physicians are now employed by
22 hospitals and hospital systems.

23 And so what you find is that physicians,
24 because they are employed by the hospitals, are

1 reticent to provide anything because they're no longer
 2 independent practitioners or in an independent group,
 3 and the hospitals have become more reticent because
 4 they really don't want to put on paper a specific
 5 number of referrals. Folks will say, yes, they will
 6 work with providers is what we're hearing and what has
 7 occurred, but to actually have specific numbers -- and
 8 then the organizational changes that are happening at
 9 the hospital level make it prohibitive.

10 MR. PICK: Mike, this is Eli.

11 If I can jump in, you know, I agree with
 12 Cece. I think the information is subjective and
 13 difficult to get in today's environment. Perhaps we
 14 should consider something more along the line of a
 15 MedPAR report or some data-driven instrument that
 16 tells us how many people have used skilled services in
 17 a specific diagnostic group in the service area rather
 18 than a subjective letter.

19 MR. SCAVOTTO: Mike Scavotto.

20 I know that the American Hospital
 21 Directory is a data source that we use a lot, and it
 22 does give you the number of discharges that are to
 23 skilled nursing facilities.

24 Now, with a little bit extra money, you

1 can get them to drill down and you can -- you can get
2 it by DRG. Those sources are out there.

3 MS. BURMAN: This is Claire.

4 And have you been making use of
5 information from the discharge planners?

6 MR. SCAVOTTO: Claire, who are you asking?

7 MS. BURMAN: Whoever.

8 MR. PICK: Claire, this is Eli.

9 If I can respond, the discharge planning
10 information is not data driven. It's based on their
11 perceptions; so --

12 MS. BURMAN: No, it's all documented. The
13 disposition of patients are always documented.

14 MS. CREDILLE: Claire, this is Cece.

15 They don't provide that information
16 because it goes to a higher level in the hospital. So
17 at the senior management level -- and this is what
18 happens with the physician piece as well -- is that
19 you're not able to get that data; and, as Eli said,
20 it's really more subjective is what they provide.

21 And I would like to say that, on the
22 business side, we use MedPAR data as well. So we know
23 in aggregate in a given service area discharges to a
24 skilled facility, and that's real data.

1 MR. SCAVOTTO: This is Mike Scavotto.

2 Let me go to George for this one.

3 MR. ROATE: Yes.

4 MR. SCAVOTTO: Do you have any experience
5 with this from your end on the staff?

6 MR. ROATE: Yes, I do. I mean, it's -- it
7 is subjective in the sense that how do you -- how do
8 you nail down a specific set of numbers or hold a
9 physician. I was unfamiliar and this -- the whole
10 MedPAR data is -- I mean, this is the first I've heard
11 of it. But to actually -- I mean, to actually nail
12 down a concrete set of numbers that will go to any
13 specific long-term care facility, that would be --
14 that would be a pretty tall task.

15 I'm thinking, based on our conversations
16 here, probably one of the most accurate indicators is,
17 as you said, hospital discharge data to long-term care
18 facilities. Now, where to make the connection in the
19 long-term care, that -- that's where I -- I can't see
20 anything more closer to the pin than these referral
21 letters.

22 Now, as you said -- Cece, as you said
23 about these physicians working for these health care
24 facilities, am I wrong to assume that some of these

1 health care facilities actually -- these doctors on
 2 staff -- or some of these health systems own these
 3 health care facilities or some of them, and if they
 4 make so many referrals to long-term care facilities,
 5 are they not obligated to refer them to one specific
 6 health care facility?

7 I realize that ultimately the customer has
 8 the choice of where they want to go, but is this
 9 something that the doctors would be under some type of
 10 obligation to do is to refer them to some specific
 11 facility?

12 MS. CREDILLE: This is Cece again.

13 That's part of their issue and reticence
 14 to sign at an individual level, and then they defer up
 15 to hospital management because at this point there is
 16 not an obligation nor should there be. It is patient
 17 choice.

18 As we move into the accountable care
 19 organization, I don't know how that is going to impact
 20 referrals and patient choice; but as we move into
 21 accountable care organizations, hospitals are entering
 22 into agreements with specific facilities to refer.
 23 That adds a whole nother dimension to this piece of
 24 trying to get referral letters.

1 MR. SCAVOTTO: Mike Scavotto.

2 I think Cece is on target with her
 3 comment. There's no obligation right now for
 4 physicians to refer to any particular facility. If a
 5 hospital entity employs physicians and it also has a
 6 long-term care facility, you can figure out where
 7 they're going to go. There won't be anything in
 8 writing, but you can figure out where they're going to
 9 go. But absent like that -- absent a deal like that,
 10 Cece's exactly correct.

11 Let me go to Charles Foley on this one.
 12 Charles, you do a lot of CONs, and are you seeing --
 13 what -- are you seeing any difficulties with this
 14 aspect of the referral?

15 MR. FOLEY: I think our specific
 16 difficulty is when you get to the areas of, you know,
 17 ZIP codes, identify patients by ZIP codes. No,
 18 hospitals do not keep that kind of data; and, no, they
 19 will not share that. What this is -- and I think it
 20 was just said -- this exercise is not a justification
 21 of need but just merely an indicator, and it's only
 22 one of many indicators that are out there.

23 What we most certainly do -- and I think
 24 staff has been very, very good -- is, knowing that, we

1 try to -- and really have not had that much
 2 difficulties in just getting a letter from the
 3 hospital saying, yeah, we could refer, you know, two
 4 to four, you know, a month or three to five a month.
 5 I always tell people, so that they don't feel that
 6 they're obligated in sending patients, I feel that
 7 they -- you know, I guess what we used to tell them is
 8 just give us a -- use the word "approximate" and give
 9 us a range -- one to three, two to four, three to
 10 five -- on a monthly basis, and that most generally
 11 does not give us a serious problem.

12 MR. ROATE: Roate here. Oh, I'm sorry.
 13 Roate here.

14 So, basically, until these accountable
 15 care organizations come -- I guess come to fruition,
 16 if that's a correct term here --

17 UNIDENTIFIED: Yeah.

18 MR. ROATE: -- I think we're working --
 19 it's still an inexact science here. So until we get
 20 more, I guess I say, vehicles that produce more
 21 concrete data, perhaps the physician referral letters
 22 are our more -- our most accurate tool. You think?

23 MR. SCAVOTTO: Well -- this is Mike. Mike
 24 Scavotto.

1 I'm still having serious thoughts about
 2 this -- serious considerations about whether or not
 3 it's information that's usable at all. I understand
 4 what it's intended to do. I don't have any -- I don't
 5 have any difficulty with that, but I'm sitting here
 6 thinking why do we continue this if it's not yielding
 7 the results that are desired. And I know it's a rule,
 8 and it will require a longer -- a longer term change,
 9 but if we want to make the application process better,
 10 is there another alternative that we should look at?

11 MR. ROATE: Roate here.

12 Would it be better to, I guess I'd say,
 13 put the hospitals in the, quote/unquote, hot seat then
 14 to provide the data? As Mr. Foley alluded to, just
 15 taking the data -- their discharge data and if they
 16 can estimate, you know, from a three-to-five range per
 17 month or whatever range that they discharge patients
 18 and what they statistically in the past have
 19 discharged to that facility, can they project that
 20 forward? Would that -- do you think that would
 21 provide a more stable number?

22 MR. PICK: If I may, this is Eli.

23 It seems to me we're going at this
 24 backwards. That rather -- I can tell you, from a

1 business planning standpoint, rather than using
 2 projections that's entirely based on subjective
 3 estimates, I like to use historic data as a basis to
 4 project forward, and we're not doing that. We're just
 5 using estimates to determine a projected number, and
 6 estimates are just that, they're estimates. They're
 7 not -- they don't give us any real information other
 8 than an individual's perception of what might be.

9 And I think, from a practical standpoint,
 10 what we're getting are letters that people are
 11 providing because of relationships that exist in the
 12 market area rather than, you know, their real gut feel
 13 on what -- where they think utilization is going to
 14 go.

15 MR. SCAVOTTO: This is Mike Scavotto.

16 Let me back up. I'm going to quote from
 17 the specific instructions on page ii, small Roman
 18 numeral: "For all applications that require physician
 19 referrals, the following must be provided: a summary
 20 of the total number of patients by ZIP code and a
 21 summary" -- meaning number of patients by ZIP code --
 22 "for each facility for physician referred patients in
 23 the past 12 to 24 months, whichever is applicable."

24 So that's not general. That's pretty

1 specific and --

2 MR. FOLEY: This is Charles Foley.

3 Mike, you're absolutely correct. But, you
 4 know, again, I mean, I got to agree with everybody in
 5 terms that, when we get to this, you know, specific by
 6 ZIP code and what have you, yes, that is very
 7 difficult to obtain.

8 But I think just a general letter just
 9 indicating, you know, projected referrals -- and that
 10 is, Eli, most generally -- at least when we talk to
 11 the hospitals, we always ask them, based on the
 12 historical experience, what has it been. And I would
 13 say -- you know, quite honestly, I would say seven out
 14 of ten times, maybe eight out of ten times, they would
 15 actually go back and look at their referral pattern,
 16 and they'll come up with a number of, you know,
 17 whatever it is, one to two a month, three to five a
 18 month, or whatever. And you can ask them that
 19 specifically, and, again, it's nothing, you know, to
 20 get these letters.

21 George, question to you, if I may. Are
 22 you hearing a lot from a lot of other applicants out
 23 there that are having difficulties in getting this
 24 letter? I know there has been some instances, but is

1 it really that many?

2 MR. ROATE: That many -- that many letters
3 or -- I'm sorry.

4 MR. FOLEY: No. I mean, are people -- are
5 applicants really having such great difficulty in
6 getting a letter from a hospital? I mean, again, I
7 know it occurs. I know it happens once in a while.
8 But does it happen all the time?

9 MR. ROATE: Well, I personally haven't got
10 a whole lot of feedback in terms of the applicants
11 having trouble setting up a referral base.

12 Now, also, I mean, as I said earlier, this
13 is -- I think there's an understanding that this is an
14 inexact science.

15 I agree with and I support what, I believe
16 it was, Mr. Pick had said in terms of working with the
17 past data and projecting it forward. Say, for
18 instance, if a doctor has gone on record and can be
19 tracked as his discharge data for discharging 12
20 patients per year or 12 patients per month to
21 long-term care facilities, well, if that doctor writes
22 a referral letter, then their referrals -- perhaps
23 that would be a good base to work from is their -- is
24 their referral base in general in determining what

1 would be a good letter -- what would be a valid
2 referral letter for them in terms of saying, okay,
3 it's --

4 As opposed to, say, for instance, this
5 doctor who made -- who discharged 12 patients per
6 month on an average in the last two years to long-term
7 care facilities, if that doctor came up with a
8 referral letter saying I can send 24 patients a month
9 to this facility, then that would be questionable
10 data; correct? See what I'm getting at?

11 MR. SCAVOTTO: This is Mike Scavotto.

12 Yes, that would be data that's indicative,
13 but it wouldn't be specific because the physician
14 could change the referral habits easily. So it's -- I
15 wouldn't call it completely objective. It's an
16 indication.

17 MR. ROATE: Okay.

18 MR. FOLEY: And that's all it is.

19 This is Charles Foley.

20 That's all it is, Mike. It's just another
21 indicator out there.

22 You know, we like -- you know, I wouldn't
23 mind seeing, like, a detailed market study, and let
24 the state staff determine exactly what should go in

1 that market study even if it includes information from
 2 the MedPAR data report, and that is only if people
 3 have access to that data. Now, when you try to get
 4 data from the hospitals, not everybody has access to
 5 hospital data. Unless you are a member of the
 6 hospital association, you cannot get that data, you
 7 know. So I think it's wide open out there in terms of
 8 what we use. I mean, again, it is an indicator, and
 9 it's not the only indicator of need. There are many
 10 others out there. That's it.

11 MR. SCAVOTTO: Charles, am I --

12 This is Mike.

13 Charles, I'm hearing you say that, from
 14 your perspective, you don't think it's a problem
 15 getting -- getting this type of data. On the other
 16 hand, you're -- I also hear you saying that in your
 17 practice it's not particularly helpful.

18 MR. FOLEY: That is -- that is a safe way
 19 of saying it. Yes, Mike.

20 MR. SCAVOTTO: Okay.

21 Cece, I hear you saying that it's not
 22 helpful to you at all. You don't think it's -- you
 23 don't think it's realistic data.

24 Eli, I hear you saying the same thing, and

1 that's where I am with it. I'm wondering if this
2 isn't -- if this is intended for long-term care in the
3 first place, but long-term care is a physician
4 referral business. That hasn't changed at this point.

5 MR. FOLEY: This is Charles again.

6 Let me just say this: I wouldn't mind
7 leaving it the way it is. The state staff has always
8 been very, very cooperative because there has been,
9 you know, on occasion where it might be a difficult
10 job in getting something, you know, from a hospital.
11 I'm not saying that's never happened because it has
12 happened.

13 You know, I don't mind leaving it the way
14 it is, but I would leave it the way it is on the
15 assumption that we could look at other alternatives.
16 I would not want to take it out altogether. If
17 there's other source data out there that we can, in
18 fact, obtain and that the state would accept,
19 obviously, you know, I would not have a problem with
20 that.

21 So, you know, one, I would just say let's
22 just leave it alone. In the meantime, let's work and
23 see if we can obtain some of this MedPAR data or let's
24 see how easy it is or not easy to get hospital

1 discharge information, and let's just take it from
2 there.

3 MS. CREDILLE: This is Cece again.
4 I'm not supportive of just leaving it
5 in here and looking at other data because it's
6 subjective -- it's very subjective data.

7 MR. FOLEY: Well, the whole application is
8 very subjective.

9 COURT REPORTER: I'm sorry?

10 MR. FOLEY: I said the whole application
11 or at least a lot of it in there is very subjective.

12 MR. SCAVOTTO: Well, Charles --
13 Again, this is Mike.

14 And it's not subjective from the
15 standpoint that this criterion flows from a rule
16 that's published by JCAR. And the question before us
17 is whether or not we can make the application process
18 better, and -- and I think that's -- that's what
19 should -- that's what should be guiding us.

20 And I'm -- if we move on to another topic
21 on this thing, we're going to come back and eventually
22 deal with this because it's not going to get resolved;
23 so -- and I don't think -- I'm not going to let go of
24 it until it gets resolved. Now, maybe we don't

1 resolve it today, and there's no indication that we
2 are going to resolve it today. But what I --

3 MR. FOLEY: Mike, this is Charles again.

4 Why don't we have somebody send to the
5 state staff information from the MedPAR, you know,
6 data report and let the state staff see actually what
7 it does show, or information from hospital discharge,
8 you know, data and see if that's acceptable to them;
9 and, if so, they could always put that in the report
10 or have them include it in a market study. One or the
11 other. I don't have a problem with that.

12 MR. SCAVOTTO: Okay. Good.

13 Eli? Eli, where you on that?

14 MR. PICK: I think Charles is making a
15 good suggestion of at least providing the report to
16 the staff to review.

17 I would also like to add some perspective.
18 I think historically the use of physician referral
19 data as a projection for moving forward was based on,
20 you know, looking at physicians' referral letters. If
21 a new applicant is going to provide an alternative
22 that's closer or provides a more effective program
23 that addresses the specific need of patients, (phone
24 drop) that it was a more specific way to address, you

1 know, some assurances that patients would be flowing
2 to that particular facility.

3 You know, I'm wondering whether that
4 entire basis is still relevant given today's
5 environment as compared to what it was when the
6 original application was formulated.

7 You know, so I'm going back to something
8 like a MedPAR data provides us hard information of
9 what's going on in the market over the last 24-month
10 period, and that's a better -- I think a more -- a
11 firmer way of projecting forward than subjective
12 letters.

13 MR. SCAVOTTO: This is Mike --

14 MR. FOLEY: This is Charles.

15 I have a question. This is Charles.

16 Eli, to you.

17 MS. AVERY: Mr. Foley, one second.

18 MR. FOLEY: -- MedPAR data report and we
19 got historical data. Just because, you know, this
20 report shows, you know, a hundred people referred to
21 nursing homes over the past month, how does one
22 project forward in terms of what that number would be
23 to project for a specific nursing home?

24 MR. SCAVOTTO: Okay. Hang on for a

1 minute. Charles, stop.

2 Courtney, did I hear you in the

3 background?

4 MS. AVERY: Well, I thought you were going
5 to make another comment.

6 MR. SCAVOTTO: You were right.

7 So I was just going to point out that,
8 Eli, your comment lines up pretty much with Cece. We
9 need to have -- we need to have good data that we
10 have, and I don't see -- I don't see where we -- where
11 we do at this point and -- okay.

12 Cece, did I represent your position
13 correctly? You're arguing for good data?

14 MS. CREDILLE: Yes.

15 This is Cece.

16 You did.

17 MR. SCAVOTTO: Okay. All right.

18 MR. URSO: Mike, this is Frank Urso. Can
19 I just ask a question?

20 MR. SCAVOTTO: Sure.

21 MR. URSO: George, do we -- have we ever
22 used this MedPAR data? Are we familiar with it?

23 MR. ROATE: No. As a matter of fact, this
24 is of great interest to me because, if I can pose the

1 question of you professionals in the field, do you
2 feel this MedPAR data would be the most solid data
3 that we could use to solve this problem?

4 MR. PICK: This is Eli.

5 If I can -- can I respond?

6 George, I think what the MedPAR data does
7 is provides us firm information of historic activity.
8 That's -- that's all it's intended to do.

9 MR. ROATE: Okay. Okay.

10 This is Roate here.

11 Once again, getting back to Frank, your
12 question, the MedPAR data, we -- it's my understanding
13 we haven't used it. Yeah.

14 MR. SCAVOTTO: This is Mike Scavotto.

15 It's good historical data and it -- as
16 delivery systems change, your utilization is going to
17 change. There's no way to forecast that, and so you
18 have to go back and you have to base it on a firm
19 historical basis in order for your projections to be
20 any good. So it's -- the devil is in the details.
21 Yes, it's helpful. It's the best information you're
22 going to get, and it probably should be used.

23 What I would like to suggest is that
24 George and Claire and Courtney get together -- and

1 include Mike Constantino in the discussion if you seem
 2 so inclined -- and let us know how this is actually --
 3 how this provision is working in practice. Because
 4 from what you're hearing from the three members on the
 5 task force, we don't like it. We don't think it's
 6 very helpful to the process. And if there's a way to
 7 make it better, it would be very helpful to hear from
 8 the staff what you think you'd like to see. Does that
 9 sound fair enough?

10 MS. AVERY: Yeah, we can look at that.

11 MR. SCAVOTTO: Okay. Because I think, you
 12 know, at this point it's going to involve a rule
 13 change. So we ought to put -- we ought to put things
 14 on the table and see if we can -- we can make it
 15 better.

16 I mean, your utilization rates are going
 17 to continue to go down. Your utilization per thousand
 18 isn't likely to change much. Even as ACOs shake out,
 19 utilization rates per thousand might go up a little
 20 bit, but then they'll come down in the subsequent
 21 years.

22 So I think we ought to -- we have an
 23 opportunity here to try to identify what looks to me
 24 to be a significant improvement in things, and it's

1 going to lead to different methodologies as well.

2 So I appreciate your willingness to do
3 that, Courtney.

4 Okay. Can we move on for the time we
5 have, in the knowledge that we have solved nothing,
6 but we've at least had a good discussion, and we will
7 try to -- try to get something else done here in a
8 minute.

9 Let's move on to the idea of definitions,
10 which was something that was in my summary memo of
11 October 25th.

12 Eli, you were okay with the idea of
13 getting a definition of substantive and
14 non-substantive in the proposal.

15 Cece, I didn't see anything from you. So
16 I interpreted that to mean you were okay with it.

17 MS. CREDILLE: I did not receive specific
18 feedback from Illinois Health Care Association folks
19 on this.

20 MR. SCAVOTTO: Okay. What do you think?

21 MS. CREDILLE: Oh, a definition would be
22 better than --

23 MR. SCAVOTTO: Yeah. Okay.

24 MS. CREDILLE: -- not or, you know,

1 questionable; so --

2 MR. SCAVOTTO: Yeah. I found myself going
3 through it, and I said, okay, this is a -- this is an
4 idiotic question, but what's substantive and what's
5 non-substantive? Sometimes the devil is in the
6 details.

7 Claire, I'm not -- I'm not aware that
8 that's involving a rule change.

9 MS. BURMAN: It isn't. The definitions
10 for both are in our rules.

11 MR. SCAVOTTO: Oh, I'm sure they are, but
12 I think the idea would be whether or not we can
13 incorporate that definition in the instructions or on
14 the application process --

15 MS. BURMAN: We can provide a link.

16 MR. SCAVOTTO: -- in some way, shape, or
17 form and -- okay.

18 MS. AVERY: Okay. We'll do that.

19 MR. SCAVOTTO: Okay. Thanks.

20 Moving on on my memoranda, the -- go to
21 page 6, 1125.330, under Alternatives. This was a
22 question that was originally addressed to Mike
23 Constantino, and I asked his perspective on this.

24 Eli, you had the same comment: What has

1 been the experience with the section on Alternatives?
2 And there was a specific reference to 1125.330,
3 number 3, where empirical evidence or quantifiable
4 outcome data is requested. How is this actually
5 working out in practice?

6 So since Mike Constantino is not here
7 today, let's go to the next likely suspects.

8 Claire.

9 MS. BURMAN: Yes.

10 MR. SCAVOTTO: Are you going to take the
11 Fifth on this? Or do you have any experience on it?

12 MS. BURMAN: On your page 8 comment?

13 MS. AVERY: Page 6.

14 MS. BURMAN: Page 6.

15 MR. SCAVOTTO: Page 6 is where I am.

16 1125.330.

17 MS. BURMAN: Yeah. I think -- I think
18 it's always better if you have some kind of
19 quantifiable outcome data. That's easier to review,
20 it's not ambiguous, and it's not subjective. I think
21 that's why the -- when the template was put together
22 for review criteria, that's why empirical evidence was
23 used, okay, because it's just -- it's a better way to
24 evaluate something if you can put it in those terms.

1 MR. SCAVOTTO: So, in practice, are you
2 seeing any improvements that can be made in this
3 section, or are there any problems in carrying out
4 this section?

5 MR. FOLEY: This is Charles.

6 If I may insert a comment, I guess the
7 problem here is that a lot of people have -- at least
8 the questions that I get -- and that is what is really
9 meant by empirical evidence? What do you really want
10 to see? And quantified outcome data, specifically
11 what are you looking for? I think
12 that's -- you know, I think that's the problem.

13 MR. SCAVOTTO: Well, I agree with you on
14 that one.

15 But let me -- George, let me go to you on
16 this one. Are you seeing any difficulty in
17 implementing this section?

18 MR. ROATE: No. Well, technically the
19 Alternatives section is not one where there can be a
20 negative or where a negative finding can exist. The
21 only time a negative can -- a negative finding would
22 exist is if it's not addressed at all.

23 Now, with many projects in the planning
24 phase, I mean, are there not alternatives considered?

1 And the empirical evidence used may be being the
 2 number of beds planned, may be being --

3 UNIDENTIFIED: The occupancy rates.

4 MR. ROATE: Exactly. And that's where --
 5 and that's where these alternatives -- we don't ask
 6 for a specific number of alternatives. We don't ask a
 7 whole lot from these alternatives other than if there
 8 is a cost associated with this alternative. Other
 9 than that, I mean, it was -- it's up to the applicant
 10 to -- because that -- that would be part of the
 11 planning process is, okay, what other alternatives did
 12 you consider? If you only had one or two
 13 alternatives, then that's all you can list.

14 I've handled applications before that had
 15 two alternatives, and one of them was the proverbial
 16 do nothing and proceed status quo, which, once again,
 17 the applicant -- that's a pretty easy one to address
 18 because, if there's a need for them to add beds or a
 19 need to discontinue and reestablish their facility
 20 somewhere, that's pretty cut and dried.

21 But for a project, I mean, it's -- the
 22 empirical evidence, like I said, other than the
 23 project cost, maybe the bed need and the need for so
 24 many beds in any particular area, that should be --

1 that would be sufficient data and that has been
 2 sufficient data in terms of identifying viable
 3 alternatives.

4 Now, some projects, like I said, they've
 5 had four or five alternatives; some have only had two.
 6 Once again, this is kind of an area where it's -- it's
 7 up to the applicant in terms of what alternatives
 8 they've looked into. But, once again, it's also based
 9 on what the -- I mean, it's all part of the
 10 decision-making process as to why they arrived with
 11 this application: What other alternatives did they
 12 look at? What didn't work? And why are they bringing
 13 this one?

14 MR. SCAVOTTO: This is Mike.

15 One of the things that bothers me about
 16 this section is not -- is not the fact that planning
 17 process should involve the evaluation of alternatives.
 18 Of course it should. It just -- what bothers me is
 19 that I submit the application and the mere fact that
 20 I'm submitting the application means that I've ruled
 21 out every other type of alternative.

22 And let's just say that I'm an operator of
 23 skilled nursing facilities. That's what I do. I know
 24 for a fact that a number of my residents can be taken

1 care of in a home care setting -- not all of them, but
 2 a number of them -- but I'm going to go ahead and
 3 submit the skilled application anyway because that's
 4 my business and that's what I do and I know I can
 5 support it and make it work.

6 And it makes -- it makes me wonder
 7 realistically what alternatives are out there and is
 8 anybody realistically going to implement any of those
 9 alternatives to the extent that they take the CON
 10 application off the table. I don't think that's going
 11 to happen.

12 MR. FOLEY: Mr. Scavotto, this is Charles
 13 Foley.

14 You and I had discussion before, and I
 15 guess I need to go back and just say that the
 16 alternatives -- all it is, basically, is a thinking
 17 process. This whole (phone drop) on the planning
 18 process is hopefully makes an applicant think about
 19 what it is that he really and truly wants to do. Did
 20 he, in fact, really consider other alternatives other
 21 than just let's go ahead and submit an application for
 22 skilled nursing beds even though half your patients
 23 will qualify for home care. Now, there, he thought
 24 about it. So that is an answer right within itself,

1 and that is home care. But home care was ruled out
 2 because of the cost of home care maybe is a lot more
 3 expensive than the cost of skilled nursing care when
 4 you compare apples with apples. I don't know, but at
 5 least you just thought about that, and that is another
 6 alternative.

7 Other alternatives maybe would be, instead
 8 of building a 120-bed facility -- which is the magic
 9 number out there, it seems like -- have you really
 10 considered 150? Have you really considered a smaller
 11 facility such as a 70-bed or a 60-bed facility, which
 12 is another alternative. Have you considered, instead
 13 of having that extra wing of skilled, maybe convert
 14 that to assisted living so you have, you know, both
 15 levels of service there to offer a resident
 16 alternative choices.

17 So there are -- I guess all this is
 18 doing -- the alternatives here -- is just forcing
 19 somebody to sit down and to think a project through
 20 rather than just haphazardly submitting the
 21 application, hope it gets approved, that's it, bam,
 22 I'm done.

23 MR. SCAVOTTO: Yes. And there remain some
 24 of us old-timers who think that the process is a

1 serious one, and you would think through the
2 alternatives anyway.

3 But it also goes to what -- your comment
4 ties in very nicely with what George just pointed out
5 a minute ago, that, you know, you can submit your
6 application and the staff reviews this section on
7 alternatives and they don't use it for much of
8 anything. They don't ding you on it. They don't
9 grade you up; they don't grade you down.

10 Did I understand you correctly, George?

11 MR. ROATE: Yes, other than the fact that
12 if you don't address them at all.

13 MR. SCAVOTTO: Yeah. If you just leave it
14 blank, nothing, you get dinged.

15 MR. ROATE: And, Mike, I'm in agreement
16 with you also in the sense that, if -- as you had said
17 earlier, I mean, by the time the application is
18 sitting on the desk here at the state agency, these
19 alternatives that -- these four or five alternatives
20 maybe that an applicant put in their application,
21 these are not going to have any bearing because this
22 is -- you've already chosen your path. You've already
23 gone down that path and to alter it and move back on
24 any one of these other options would be -- I mean,

1 that would be basically dismantling the application.

2 Now, however, I also agree where Charles
3 had said it just shows that you've given it some
4 thought in terms of, okay, these were some other
5 options we looked at.

6 Now, granted, you don't have to have four
7 or five but if -- but I've seen applications, like I
8 said before, two, sometimes three. I've seen an
9 application with one alternative. That was their only
10 alternative was to -- and this was for a change of
11 ownership. I mean --

12 MR. SCAVOTTO: Might have been the best
13 thing to do. You don't know. That's the problem.

14 MR. ROATE: Exactly. And sometimes if
15 that alternative is discussed -- if the merits are
16 discussed of the alternative chosen over the other
17 alternatives or alternative -- say you only have two
18 alternatives -- that kind of gives some insight into
19 that there was some consideration of other angles,
20 i.e., more beds, another wing, you know, as Charles
21 stated.

22 MR. SCAVOTTO: Eli, let me go to you on
23 this. What's your perspective?

24 MR. PICK: Well, I -- you know, my sense

1 is this is a very soft -- it's a very soft section. I
 2 think if we asked our friends, you know, from the
 3 community advocates, they would speak very strongly to
 4 the fact that they would like to see community
 5 services as a more integral part of this analysis.

6 You know, I think it's too early in our
 7 evolution to take it any further than where it is
 8 right now, that, you know, applicants should use this
 9 for consideration. And I think, as the process
 10 evolves, we can tighten this up further; but I'm
 11 afraid, if we try to do any more than that right now,
 12 we would just complicate this much more than it
 13 already is.

14 MR. SCAVOTTO: Cece, where are you?

15 MS. CREDILLE: I think Eli's comments are
 16 well said in terms of the representatives on our
 17 larger committee from the community. So if we -- if
 18 we wanted to do something -- you couldn't eliminate it
 19 because then you're not looking at community
 20 resources.

21 MR. FOLEY: This is Charles.

22 I think the (unintelligible) specifically
 23 states that we should also consider the other
 24 alternatives such as home health care and what have

1 you. Sometimes that's very -- we find, at least,
2 that's very difficult to ascertain in a particular
3 community in terms of what is and is not available.
4 Sure, home health care is always available, I guess,
5 to some degree, but to quantify that, that makes it
6 very, very difficult.

7 MR. SCAVOTTO: This is Mike.

8 Charles, let me start with you, but I want
9 to get around to Eli and Cece on this one as well.

10 On the home care -- home- and
11 community-based services, how much of this is related
12 to Medicaid funding availability?

13 MR. FOLEY: Medicaid funding?

14 MR. SCAVOTTO: Yeah.

15 MR. FOLEY: Obviously it is out there, you
16 know, because obviously the state has several, several
17 different programs at different levels. That's what
18 I'm saying -- it's very difficult to really define all
19 those different areas, especially talking about
20 bringing in, you know, home health care as relates to
21 therapy, as relates to meals on wheels, as relates to,
22 you know, RN services. I mean, all that is available
23 and is paid for by Medicaid and, to some extent, is
24 also paid for by Medicare. Yeah, but that's not

1 always the best choice. I mean, I do believe that if
 2 a person can stay at home, fine, good, well, and
 3 great; but I think we're always missing the point that
 4 a facility provides other alternatives for a resident,
 5 especially in terms of having company around. They're
 6 not feeling so isolated as they are at home. But to
 7 ascertain and define and to quantify all these
 8 programs, that's what's difficult to do.

9 MR. SCAVOTTO: Cece, what's your
 10 perspective on the Medicaid issue?

11 MS. CREDILLE: It's going to become more
 12 difficult over time, given some of the changes and
 13 limited resources for Medicaid. I'm sure that's part
 14 of the portion --

15 MR. SCAVOTTO: But I guess --

16 MS. CREDILLE: -- that's very challenged
 17 in Illinois. Our reimbursement is so low.

18 MR. SCAVOTTO: Yeah. Yes.

19 Eli.

20 MR. PICK: Yeah. My only addition would
 21 be the Department on Aging programs, the waiver
 22 programs. You know, I think clearly the Medicaid
 23 funding is -- you know, has been stated is a problem,
 24 but I think, you know, when we look at Medicaid as a

1 funder for long-term care, we have to consider the
2 waiver programs and how they're used as alternatives
3 to providing nursing home services for long-term
4 clients who are being covered under Medicaid.

5 MR. SCAVOTTO: Okay. All right. I would
6 just conclude the discussion on this point by saying
7 that we want -- if we want more demand, we'll add the
8 Medicaid funding, and that may -- that's a problem in
9 and of itself.

10 The next thing that I had on my list
11 was --

12 MR. PICK: Mike, I'm going to need to sign
13 off. I got to go to my next meeting. So I apologize
14 but look forward to seeing the minutes and pick it up
15 from there.

16 MR. SCAVOTTO: And we will have many more
17 sessions like this. Thanks for joining us, Eli.

18 MR. PICK: Thank you. Bye.

19 MR. SCAVOTTO: All right. Cece, you and I
20 are carrying the water from here on out.

21 MR. FOLEY: This is Charles.

22 I mean, I think another added comment
23 would be that's why maybe, maybe, just maybe, we
24 should consider having, you know, SLP and assisted

1 living under CON review because obviously a lot of
 2 those patient days into those facilities are eaten up
 3 are skilled patients days. And it's hard to -- to --
 4 I mean, it is somewhat, in a round about way, already
 5 figured out in our formula just by looking at the
 6 occupancy rates obviously are down. So these patients
 7 are, in fact, going somewhere. So they are, you know,
 8 staying at home. We're seeing them in home health
 9 care. Are they going to assisted living? Are they
 10 going to, you know, a SLP?

11 MR. WAXMAN: This is Mike Waxman.

12 I agree. I think assisted living should
 13 be part of the CON process and under, you know, kind
 14 of -- at some point under our review because, again,
 15 there are so many patients who I believe from my
 16 experience who are in assisted living that really need
 17 skilled services but are there for other reasons.

18 MR. SCAVOTTO: This is Mike Scavotto.

19 Your comments are appreciated and well
 20 taken, but are beyond the scope of this conference
 21 call.

22 MR. FOLEY: Mike, this is Charles.

23 I guess what we're saying here -- and
 24 still addressing, I'm assuming, the alternatives. I

1 mean, this is -- again, all this does is to, once
 2 again, force somebody to sit down and think and maybe,
 3 instead of building a 120-, 150-bed skilled nursing
 4 facility, maybe one of the alternatives to consider --
 5 and even at a lesser cost, okay -- would be to include
 6 a wing or a floor that's assisted living or supportive
 7 living, you know, something of that nature.

8 MR. SCAVOTTO: That's true. That's true.
 9 But we're not -- Charles, we're not going to solve the
 10 assisted living issue today.

11 MR. FOLEY: No, we're not because
 12 obviously our act -- our act specifically excludes
 13 assisted living and supportive living, you know, from
 14 CON review so that would obviously have to be changed.
 15 But it would give us more control in terms of a
 16 planning perspective if we had those programs under
 17 CON review. That's all I'm trying to say.

18 MR. SCAVOTTO: And I think you take that
 19 up with Courtney and Frank --

20 MR. FOLEY: I think she'll agree. Right,
 21 Courtney?

22 MR. SCAVOTTO: -- see how we do.

23 MR. URSO: Mike?

24 MR. SCAVOTTO: Yes, sir.

1 MR. URSO: This is Frank Urso.

2 MR. SCAVOTTO: Yes.

3 MR. URSO: In regards to your discussion
4 about alternatives, I just wanted to say a couple
5 things.

6 First of all, the statute -- underpinning
7 statute for what we're doing here is very clear when
8 it says that this board is tasked with the charge of
9 looking at the -- at cost containment of health care.

10 And when you take a look at the rules, it
11 talks specifically in the Alternatives section that
12 the applicant must or shall document that they've --
13 the proposed project is the most effective and least
14 costly and that -- and that language is directly
15 linked to the purposes of the board and the enabling
16 statute. So I think that's why you see this here, and
17 that's why it needs to be addressed. Good or bad, I
18 think it really has its underpinnings in the statute,
19 and not that the board or the statute is saying that
20 whomever comes with an application hasn't thought this
21 through. I think what we're saying is they want to
22 see that documentation to assure the board that
23 they're complying with the statute in terms of taking
24 a look at the most cost effective alternative in the

1 proposed project. So that's all I basically wanted to
 2 say in that regard.

3 MR. SCAVOTTO: Okay. And I -- and I think
 4 that's fine.

5 I did take a look at the rules and -- good
 6 suggestion from Claire -- and many of them appear
 7 verbatim in the current application, and the
 8 Alternatives section, if I recall correctly, is one.
 9 And so I -- I understand what's going on there, but it
 10 seems to me that there's a disconnect. If it's
 11 required in the rule and -- it doesn't sound like it's
 12 being used to the -- to its greatest extent. And if
 13 it doesn't appear, it's a negative; if it does appear,
 14 fine. And it makes me want -- I'm just asking the
 15 question is it as effective as it could be? I
 16 understand why it's there.

17 So I guess, Frank, what I'm questioning is
 18 does the rule make sense, and, you know, in the time
 19 that we're in today, should we be thinking of a
 20 different way to approach this. And I'm asking a
 21 question. I don't have the answer.

22 MR. URSO: I think -- I think that's
 23 entirely up to the great minds that we have on this
 24 subcommittee --

1 MR. SCAVOTTO: Okay. Good. All right.

2 MR. URSO: -- to determine if there's a
3 better way of meeting the purposes of the statute and
4 one that perhaps, in their eyes, makes more sense and
5 is more reasonable and more easy to reach that
6 purpose, and that's entirely possible.

7 MR. SCAVOTTO: Okay. All right. I think
8 that's -- that's what we're trying to get at.

9 Let's move on to 1125.510. I thought we
10 had -- I thought we had some unanimity of opinion on
11 this one. I think my comment on this one was that --
12 I need -- you know, I need to take a minute to compose
13 my thoughts on this, but I was looking for some
14 different column headings to make the application --
15 to make the columns easier to figure out.

16 Cece, did you have any issues on this? I
17 think you did.

18 MS. CREDILLE: Yeah. I'm looking at my --
19 looking at the app because I have the application up
20 on my computer and our comments here.

21 MR. SCAVOTTO: 90 percent occupancy by
22 year two was one.

23 MS. CREDILLE: Yeah. I'm looking at that
24 comment. That actually is very difficult to

1 operationalize, from personal experience. That
2 achieving 90 percent occupancy -- first of all, in our
3 current world, I'm not -- many of our buildings are
4 not 90 percent occupied, period; but to push a
5 facility to that occupancy is very difficult to manage
6 because if you fill too quickly, you have all kind of
7 service delivery issues, potentially, staff, et
8 cetera, et cetera.

9 So I don't -- and I'm sorry to Claire and
10 Avery and Frank. I don't know the rule part. If it's
11 a rule, it's a rule, but it's very difficult to
12 operationalize. 90 percent in today's world, just as
13 an aside, is not a realistic occupancy for most
14 providers.

15 MR. SCAVOTTO: Okay. Okay. That would
16 apply to the second part of this section, utilization.

17 We had something on bed capacity as well.
18 Proposed beds can be either for existing or
19 replacement beds and -- oh, okay. Okay. I'm reading
20 my comments, and I'm picking up on what I was trying
21 to get at.

22 Claire, this is -- to me it was difficult
23 to understand what we were getting at with the
24 different columns. A proposed bed could be an

1 expanded bed, an existing bed could be modernized, but
2 a proposed bed -- a proposed bed could also be an
3 expanded bed, and by definition it would be
4 modernized.

5 So I think one of the things that would be
6 very helpful here would be a formula like this:
7 Proposed beds equals existing plus new and/or
8 modernized beds. So does that make sense?

9 MS. BURMAN: What are modernized beds?

10 MR. SCAVOTTO: What are modernized beds?

11 MS. BURMAN: Yeah. Proposed beds are new
12 beds. Beds that you don't have in your facility yet.

13 MR. SCAVOTTO: Yeah. But modernized could
14 apply to existing beds.

15 MS. BURMAN: It only applies to existing.

16 MS. AVERY: Maybe it's --

17 COURT REPORTER: I'm sorry. Courtney,
18 could you repeat, please.

19 MS. AVERY: Oh, I was asking maybe it
20 means to expand under the 2010 or 1020 rule, but go
21 ahead, Mr. Scavotto. Sorry.

22 MR. SCAVOTTO: Well, if you -- if you --
23 you could modernize an existing bed.

24 MS. BURMAN: You can only modernize an

1 existing bed.

2 MR. SCAVOTTO: Yeah. By def -- but almost
3 by definition, if you had a new bed, it would be
4 modern when it was finished. It would be already
5 modern.

6 MR. ROATE: But that would be under
7 expansion if you put a new bed in -- into an existing
8 facility.

9 This is Roate.

10 MR. SCAVOTTO: Yeah. You could have a
11 proposed bed, and it would be an ex -- and it could be
12 an expanded bed as well.

13 MS. AVERY: But the proposed bed is if you
14 have 10 beds existing and you want to add 10 more.
15 Now you have 20.

16 So modernization of the beds are that
17 you're coming from 20 beds in two rooms to 20 beds in
18 single rooms.

19 And I'm not sure about -- expanding and
20 proposed are probably one and the same, according to
21 our definitions.

22 MR. SCAVOTTO: Okay. Well, let me just
23 come back at you with this observation: In going
24 through this table, we've had just as many

1 interpretations as we've had people reviewing it, and
2 it might -- and I think it would be a good idea to get
3 some definitions of what's what and almost come up
4 with a formula. And I don't particularly care what it
5 is as long as it's clear.

6 MS. CREDILLE: Yeah, Mike, I see exactly
7 what you're saying here. Listening to this and then
8 rereading what your comments are, I would agree that
9 if -- if we have two columns here that looked to be
10 one and the same, we don't need it.

11 MR. SCAVOTTO: Right.

12 MS. CREDILLE: We're not the sure the
13 definition of.

14 MR. SCAVOTTO: Yeah. And listening to
15 Charles talk -- and I think Charles talked -- but I
16 know Courtney talked and Claire were talking, you
17 know, we're not in agreement amongst ourselves as to
18 what these columns mean.

19 MR. SCAVOTTO: Mike, this is Frank Urso.
20 Established or establishment is defined in
21 the 1125 rules under 140. So established has a
22 current definition.

23 MR. SCAVOTTO: Okay.

24 MR. URSO: What was the other term?

1 Expanded?

2 MS. BURMAN: Expand.

3 MR. SCAVOTTO: Expand and modernized.

4 MR. URSO: I don't see expand.

5 MS. CREDILLE: This is Cece.

6 Again, if part of our -- of our charge
7 here is to make the application process simpler or
8 easier for the persons who are either completing it or
9 reviewing, if we're not clear on the definitions --

10 MR. URSO: One thing that I don't --

11 This is Frank.

12 -- I don't see an expansion definition in
13 the 140 rules. I mean, that's easy to fix.

14 MS. BURMAN: Well, there is one proposed
15 in 1130 amendment.

16 COURT REPORTER: Who was that? Was that
17 Claire?

18 MS. BURMAN: I'm sorry. Yeah. This is
19 Claire.

20 COURT REPORTER: Thank you.

21 MS. BURMAN: In the definition section in
22 1130, you have definitions for establishment,
23 expansion, and modernization.

24 MR. SCAVOTTO: Can those --

1 This is Mike.

2 Can they be reflected in this section of
3 the application?

4 MS. BURMAN: Yes. Do you want it by link?

5 MR. SCAVOTTO: I think it would be --
6 myself, I'd prefer not to have it by link. I'd prefer
7 to have it written out so you can see it.

8 MR. WAXMAN: This is Mike Waxman.

9 I agree with you, Mike. I think, in
10 filling out an application or any kind of document,
11 when you have to keep hitting a link, it just confuses
12 you and slows it down. I think definitions should be
13 part of the application itself.

14 MR. SCAVOTTO: Thank you. I agree with
15 you. It makes you -- when you have to keep linking
16 back and forth, it makes you mad at the application.

17 MR. WAXMAN: Yeah. I was going to say, I
18 get ready to throw my computer at points like that.

19 MR. SCAVOTTO: Yeah.

20 MS. AVERY: It would work if we were
21 e-based -- but we're not -- with our application.

22 MR. URSO: If we were what?

23 MS. AVERY: If we had our applications on
24 electronic completion and submission.

1 MR. SCAVOTTO: Oh, I think you're right.

2 Yeah. Yeah. That makes sense. Yeah.

3 All right. Courtney, you cool with this?

4 MS. AVERY: Yes, I am.

5 MR. SCAVOTTO: All right.

6 Frank, you all right with it?

7 MR. URSO: Yeah, I'm okay with it.

8 MR. SCAVOTTO: All right.

9 MR. URSO: Whatever makes it clearer.

10 MR. SCAVOTTO: Well, that's what we're
11 striving for. All right.

12 Cece, did we miss anything else on this
13 one?

14 MS. CREDILLE: No.

15 MR. SCAVOTTO: Okay. Next thing on my
16 list was page 13. That would be 1125.530, item 2.

17 And what did I have here? Indicates that the primary
18 service area should be 50 percent of planned
19 admissions. Can someone shed light on how this figure
20 was derived? Was there a deal cut somewhere along the
21 line? And I'm not being presumptuous there. Most of
22 us in the business would say that the primary service
23 area should represent 70 to 75 percent of admissions.

24 Eli agreed with that comment.

1 Cece, we didn't hear anything from you on
2 that particular one.

3 So, George, let me ask you the question.
4 Is there any -- what's the -- what's the basis behind
5 the primary service area comprising 50 percent of
6 planned admissions?

7 MR. ROATE: Other than the fact that the
8 facility is going to serve its immediate area, I
9 personally don't see anything else behind it.

10 Now, Mike, you just said that on an
11 average these facilities serve upwards of 70 to 75
12 percent of the immediate service area?

13 MR. SCAVOTTO: Service area analysis is 70
14 to 75 percent, yeah. 70 to 75 percent of your
15 admissions should be coming from the primary service
16 area.

17 MR. ROATE: Okay. Unless there's some
18 objection to it, then I -- would it -- would it be
19 of -- would it be a better idea to go that high on the
20 percentage from the service area?

21 MR. SCAVOTTO: That's what we're asking.
22 We probably won't get this one solved today either.

23 Cece --

24 MR. ROATE: I don't see any reason why it

1 wouldn't.

2 MR. SCAVOTTO: Cece, what are your
3 comments on that?

4 MS. CREDILLE: Well, yeah. I actually am
5 looking. I have comments here that if we -- providers
6 meet number one, then you meet number two and three.
7 That's really kind of that simple.

8 MS. AVERY: Cece --

9 This is Courtney.

10 -- I can't -- I'm not following you. Can
11 you state that again?

12 MS. CREDILLE: Yeah. If you -- if you
13 meet the bed need and that determines the need, then
14 we could conceivably eliminate -- eliminate these
15 others.

16 MS. AVERY: Eliminate the planned
17 admissions?

18 MS. CREDILLE: And we're going to get
19 stuck back in the same place because number three is
20 what we already talked about.

21 MR. SCAVOTTO: Well --

22 MS. CREDILLE: If this is referring to is
23 there a need in the planning area, the beds -- the bed
24 need formula says that there is, taking the simplest

1 of views.

2 MR. SCAVOTTO: Let's back up a minute.

3 MS. CREDILLE: I'm on the right page,
4 aren't I, Mike?

5 MR. SCAVOTTO: 1125.530, planning area
6 need.

7 MS. CREDILLE: Yeah, I'm here. I'm on the
8 right --

9 MR. SCAVOTTO: Number one, identify the
10 calculated number of beds needed or excess in the
11 planning area. Okay. There's a bed need formula for
12 that.

13 Number two, a test of the primary purpose
14 of the project is to serve residents in the planning
15 area and that at least 50 percent of the patients will
16 come from within the planning area. And some of us
17 are questioning whether that 50 percent should be a
18 higher amount. 70 to 75 percent is what I'm
19 suggesting.

20 Number three is providing letters. And if
21 I did my homework correctly, that's -- that's a
22 criteria under 530, but it's not in a rule.

23 But, anyway, that's -- at this point
24 that's neither here nor there. The operative question

1 is should the -- is 50 percent too low.

2 MR. FOLEY: Mike, this is Charles.

3 Two things: Number one, I don't have a
4 problem in changing -- you know, in seeing this
5 committee changing the 50 percent rule because, yes,
6 you do have a primary service area which most
7 generally you are correct in saying that it is between
8 70 to 75 percent.

9 You also have, in a lot of market studies,
10 where it's identified as the secondary area which
11 could include, you know, 50 percent or more, between
12 the 50 and the 70 percent.

13 The thing here that bothers me is the word
14 "planning area" because technically we have two
15 planning areas. We have the identified planning area
16 which is -- which is where the bed need is derived
17 from, but we also have the 30-minute, you know, area.
18 And so that 30 minute could obviously extend beyond a
19 planning area.

20 So you are not really -- you're really
21 talking about two things here. So I think we should
22 have a clarification on that.

23 MR. SCAVOTTO: I think that you're right,
24 Charles, and the -- the fact that it's 50 percent

1 means that you can make the project fly on the -- on
 2 the strength of the secondary service area, and, in my
 3 experience, that's just promoting sloppy demand work.
 4 You're making people -- you're allowing people the
 5 chance to become dependent upon a 30-minute drive time
 6 in downtown Chicago, which is just unrealistic. In
 7 the rural areas, it's not that much of a problem.

8 So I think that -- from my perspective,
 9 the 50 percent ought to be raised to a higher number.

10 Cece, what's your perspective on this one?

11 MS. CREDILLE: I'm actually chuckling
 12 because the drive time issue is rather subjective
 13 because I affectionately call it windshield time
 14 because you are correct. So I get stuck on that, that
 15 I don't know why we have drive time because 30 minutes
 16 in Chicago is two miles and 30 minutes in rural is --
 17 could be 40 or 50 miles.

18 MR. SCAVOTTO: Yeah. I was just up in
 19 Chicago on Thursday. 30 minutes was a block.

20 MS. CREDILLE: Correct. I mean, it is --
 21 you can't -- talk about subjective. So I get stuck on
 22 drive time. I don't --

23 MR. SCAVOTTO: I think you should. Yeah.

24 MS. CREDILLE: -- it's realistic at all.

1 MR. SCAVOTTO: Okay. All right.

2 MR. WAXMAN: Mike, this is Mike Waxman.

3 I'm looking at the comments on your paper,
4 and Eli raises the point, you know, what about
5 somebody who is on the border of two planning areas?

6 MR. FOLEY: That's what I was saying.

7 MR. SCAVOTTO: Well, you have to decide
8 what your primary area is going to be. So you're on
9 the bord -- it's an interesting question, and we've
10 had many discussions about this, and there's really --
11 there's really not one way that you can do it.

12 But if you're on the border of a planning
13 area -- let's say you're right close to the border of
14 a county because, if I remember correctly, each --
15 each county represents a planning area. And so you
16 could be close to a county line, and you could be
17 pulling in a fair number of patients from another
18 county. Technically, that's in another planning area.
19 So it gets into whether or not your primary service
20 area would be -- you would be allowed to overlap your
21 primary service area from one planning area to
22 another.

23 MR. FOLEY: Mike, this is Charles.

24 MR. SCAVOTTO: I would think we would want

1 to do that.

2 Go ahead, Charles.

3 MR. FOLEY: I'm sorry.

4 This is why we look at -- you know, I like
5 to look at market studies because most generally a
6 market study -- and let's talk about the Chicago metro
7 area. Most generally they would look at their primary
8 service area as being a 10-, 15-minute drive for that
9 specific, you know, site, and whether it overlaps into
10 another planning area or not, it really doesn't
11 matter. That's reality. That's the facility primary
12 service area.

13 I don't know how we solve the issue of
14 limiting any of this to the planning area because,
15 obviously, you can't do that. It just doesn't work
16 that way. I mean, we are mandated by -- by the act
17 itself is the one that tells us to look at the
18 30-minute drive time. So unless we change the act, we
19 cannot do anything about that.

20 So realistically, as a planning tool --
21 and as a planning tool, if you have a market study
22 that identifies your, quote, primary market area and
23 if it's a 10- to 15-minute drive time, so be it.
24 That's it. I would not -- I would not labor beyond

1 that, to be quite honest. It is what it is.

2 MR. WAXMAN: Mike Waxman --

3 MR. FOLEY: John Kniery from out office
4 just walked in. John, did you want to make a comment
5 on this?

6 That's John Kniery, K-n-i-e-r-y, for the
7 court reporter.

8 MR. KNIERY: My only comment would be why
9 can't we apply the bed need methodology to the
10 applicant's identified market area. In my
11 perspective, if the information -- if the bed need
12 information is up to date, that's the best tool that
13 we have out there, the only forward-looking indicator.
14 I don't know why --

15 MR. SCAVOTTO: John. John. This is Mike.

16 Number one of that criterion is identify
17 the calculated number of beds needed in the planning
18 area, which would invoke the bed need methodology you
19 just mentioned. Unless I'm reading that wrong.

20 So we were responding to Wax's question of
21 which -- actually Eli's. What do you do when you're
22 on the border of one -- of two planning areas, and I
23 think there -- Wax, I think there has to be some
24 overlap on the PSA. I don't know how you get around

1 it.

2 MR. WAXMAN: I agree. I mean, I just --
3 it just needs to be considered.

4 MR. KNIERY: I mean, I think there is a
5 definite issue because there's been several projects
6 like that, and the beds all go to the planning area
7 that it gets approved under regardless of, you know,
8 where their draw is from. I do think that's a
9 significant issue.

10 COURT REPORTER: Who was that, please?

11 MR. ROATE: John Kniery.

12 MR. SCAVOTTO: John Kniery.

13 COURT REPORTER: Thank you.

14 MR. SCAVOTTO: Okay. All right.

15 Okay. So, Courtney, can we -- can we
16 consider getting that 50 percent increased?

17 MS. AVERY: Sure. We'll put it in the
18 proposal.

19 MR. SCAVOTTO: Okay. All right.

20 Let's move on to 1125.530 -- there was
21 something else on that one. Page -- no. Wait a
22 second. Maybe we talked about that already.

23 Oh, on point number 1, identify the
24 calculated number of beds needed in the planning area.

1 One of us suggested -- maybe it was me --
2 that we identify the bed need formula there via link,
3 and that ought to be possible to do; right?

4 MS. BURMAN: Yes. That was Claire. Yes.

5 MR. SCAVOTTO: Okay. Good.

6 And, Frank --

7 MS. BURMAN: Little shy today.

8 MR. SCAVOTTO: Okay. No, that's not the
9 Claire that I know.

10 MR. SCAVOTTO: Frank, would you check on
11 number 3 there? Because I'm not sure that's in the
12 rule.

13 MR. URSO: What do you mean by number 3?

14 MR. SCAVOTTO: It says, under 5 --
15 1125.530, provide letters from referral sources.

16 MR. URSO: 1125.530 talks about planning
17 area need, review criteria.

18 MR. SCAVOTTO: Right.

19 MR. URSO: And the applicant shall
20 document the number of beds to be established or added
21 as necessary to serve planning area's population based
22 on the following: bed need determination, service
23 planning area residents, and then it has some
24 subtopics under that.

1 MR. SCAVOTTO: Okay.

2 MR. URSO: It says the applicant proposing
3 to expand an existing general long-term care service
4 shall submit patient/resident origin information by
5 ZIP code based upon the resident's/patient's legal
6 address.

7 MR. SCAVOTTO: Okay.

8 MR. URSO: And that --

9 MR. SCAVOTTO: To me there's a difference
10 between referral sources and patient origin.

11 MR. URSO: The referral sources that -- if
12 I understand your question, the referral sources come
13 out 1125.540, service demand for establishment of a
14 general long-term care, and that's where they get into
15 historical referrals and projected referrals. Is that
16 what you're referring to?

17 MR. SCAVOTTO: Exactly. So we've got
18 referral sources that says, "I, Dr. Smith, am going to
19 send you 50," but patient origin says 50 came from
20 60652 ZIP code. To me it's quite a bit of difference.

21 I'll also grant you, you know, that if I
22 hadn't been reading that with a specific interest in
23 mind, I would have skipped right over it.

24 It's an issue to take a look at it. I

1 don't think we need to do anything with it right now,
2 but it just seems to me that we got referral sources
3 being quite a bit different from patient origin.

4 MS. CREDILLE: Mike, this is Cece.
5 I agree with you.

6 MR. SCAVOTTO: Okay. Thank you.

7 MS. CREDILLE: Sorry. I was writing
8 and -- sorry.

9 MR. SCAVOTTO: I can tell we have Frank
10 stumped, for the moment, anyway.

11 MR. URSO: We got Claire and Courtney are
12 talking; so --

13 MS. BURMAN: We have some technical
14 problems. So we only have one copy of the rules with
15 us right now. Juan went to get the application for
16 us.

17 MR. SCAVOTTO: All right. I mean, I can
18 read it to you. Frank's got it right there.
19 Applicants proposing to expand shall submit
20 resident/patient origin information by ZIP code.

21 MS. BURMAN: That's because it's about
22 expansion. That's why you want the historical -- you
23 can look at that part of it to see what you've already
24 got in place.

1 MR. SCAVOTTO: Well, now, that's -- that's
 2 a -- I didn't catch that, Claire. That's an existing
 3 point because -- and maybe it wouldn't apply to
 4 renovation.

5 MS. BURMAN: 540 is about if you're
 6 establishing either a new section of beds or you're
 7 establishing a new facility. That's why you need the
 8 referral letters. So it's the criteria that specifies
 9 what you're doing. You can't lump them all together.

10 MR. URSO: Well, 530, what I read --
 11 Claire, you're absolutely right -- it's about
 12 expanding an existing long-term care service, and 540,
 13 which deals with referral sources, is establishing a
 14 new long-term care service.

15 So there's the distinction, Mike. The
 16 patient origin information is being requested for an
 17 expansion of an existing long-term care service, and
 18 the referral sources are needed for establishment of a
 19 new long-term care service.

20 MR. SCAVOTTO: Correct. So item 3 in
 21 1125.530 sounds to me like it belongs in 540, and what
 22 should be in 530 is requests for information regarding
 23 patient origin rather than patient referral.

24 MS. AVERY: Okay. So we'll look at it

1 closer.

2 MR. SCAVOTTO: Good. Good.

3 MS. AVERY: And make revisions as
4 required.

5 MR. SCAVOTTO: That's all we're asking.

6 MS. AVERY: Okay.

7 MR. SCAVOTTO: Now, could I make another
8 request?

9 MS. AVERY: Uh-huh.

10 MR. SCAVOTTO: That we adjourn.

11 MS. AVERY: Oh. Really?

12 MR. SCAVOTTO: We've lost Eli, and we're
13 going to lose Cece in about half an hour.

14 MS. AVERY: Oh, okay. Do you have
15 anything else you want to point out that's critical?

16 MR. SCAVOTTO: Not -- let me take a quick
17 look. Well, all of this stuff would be in my -- in
18 the memo that I sent out.

19 MS. AVERY: Okay. So we'll --

20 MR. SCAVOTTO: And that's basically --
21 we're going to keep -- we made it to number five,
22 which is more progress than I thought we'd make today,
23 and I would -- I just don't want to ruin everybody's
24 day by staying on this until 2:00 o'clock.

1 UNIDENTIFIED: We're having such a good
2 time, Mike.

3 Mr. WAXMAN: This is Mike Waxman, again.

4 Mike, I think you did a great job in doing
5 this document, by the way.

6 MR. SCAVOTTO: Thank you, sir, but I had a
7 lot of help. Eli and Cece were right in there with
8 me, and you can tell from their comments today that
9 they're very active in this effort, which is -- which
10 is good. One person can't do it.

11 So, anyway, Courtney, why don't I -- I
12 will get with the committee members, and we will
13 suggest another time for another call after the
14 Thanksgiving holiday.

15 MS. AVERY: Okay.

16 MR. SCAVOTTO: And we can meet up again.
17 All right?

18 MS. AVERY: Do you want -- are you
19 thinking -- oh, no, it wouldn't be before -- before
20 the full meeting?

21 MR. SCAVOTTO: It could be, but let me ask
22 you a much more direct question. Do you want us to
23 have this work done by a certain time?

24 MS. AVERY: When is our next --

1 MS. CREDILLE: December 3rd.

2 MS. AVERY: No, I was going to say our
3 next proposed date to have rules going through full
4 changes. No, no certain time.

5 MR. SCAVOTTO: Okay. All right. Okay.

6 MS. CREDILLE: This is Cece.

7 Can I clarify then? We will not be
8 presenting anything, though, to our larger
9 subcommittee until we get through this?

10 MS. AVERY: Oh.

11 (Several speaking at once.)

12 MR. SCAVOTTO: Go ahead. Mike Waxman, go
13 ahead.

14 MR. WAXMAN: I would like to see a
15 presentation at the larger committee just to let
16 everybody know how hard you guys have been working and
17 that you have made progress because every once in a
18 while you get the sense that someone on the big
19 committee is feeling that nothing is happening. I
20 think it would be wise to share the progress that you
21 have made and the amount of work that you have
22 accomplished and how difficult these changes are to
23 get agreement on. So, no, I would like to -- I would
24 like to see a small presentation or a presentation at

1 the big meeting about what you've accomplished because
2 you have done a lot.

3 MR. SCAVOTTO: Okay. I'm okay with that,
4 a progress report. So let me write something up, and
5 I will get it to -- Mike, I'll send you a copy of what
6 I submit to Courtney, and I know Courtney will --
7 well, I'll copy you on that too, Frank, just because I
8 know all three of you guys will be the loop.

9 MS. AVERY: Okay.

10 MR. WAXMAN: The other thing --

11 Again, this is Mike Waxman.

12 You know, we also have the ability to make
13 recommendations to the motherboard on those items
14 where rule changes are needed. So someplace along the
15 line you should be drafting a list of those things
16 that you would like the committee to send up to the
17 motherboard for proposed rule changes.

18 Frank; is that correct?

19 MR. URSO: Yes.

20 MS. CREDILLE: This is Cece.

21 Do we want to send piecemeal rule --

22 MS. AVERY: No.

23 MS. CREDILLE: -- changes or --

24 MR. WAXMAN: No, no, I said -- what I said

1 is continue to keep a list so that, as you go through
2 these discussions and the work that we're
3 accomplishing, you are building on to your list of
4 rule changes.

5 MS. AVERY: This is Courtney.

6 Our next meeting after the December
7 meeting is February 5th.

8 MR. SCAVOTTO: I'd like to be done by
9 then.

10 MS. AVERY: So if we have a list to go to
11 them by February the 5th and then go through our
12 process, we can possibly get some things out there by
13 the spring.

14 MR. SCAVOTTO: Okay. Good. All right.

15 Cece, where my notes are deficient, I
16 reserve the right to call you.

17 MS. CREDILLE: Yes, sir, you can. Just,
18 you know, call me after a glass of wine and turkey.
19 You don't have to put that in the minutes but --

20 UNIDENTIFIED: Too late.

21 MR. SCAVOTTO: All right. All right.
22 Everybody, good luck on Thanksgiving, enjoy the
23 holiday, and we'll see you later. Appreciate your
24 participation in today's call.

1 UNIDENTIFIED: Thanks, everybody, for
2 your time.

3

4 MEETING ADJOURNED: 11:45 A.M

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