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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
LONG-TERM CARE ADVISORY SUBCOMMITTEE MEETING

REPORT OF PROCEEDINGS

Bolingbrook Golf Club
2001 Rodeo Drive
Bolingbrook, Illinois

February 21, 2014
9:30 a.m.

Reported by: Jean S. Busse, CSR, RPR
Notary Public, DuPage County, Illinois

1 PRESENT:

2 MR. MICHAEL WAXMAN, Chairman;

3 MS. JUDY AMIANO, Member;

4 MR. BILL CASPER, Member;

5 MR. PAUL CORPSTEIN, Member;

6 MS. CECELIA CREDILE; Member;

7 MS. ANN GUILD, Member;

8 MS. CAROLYN HANDLER, Member;

9 MS. NEYNA JOHNSON, Member;

10 MR. TIMOTHY PHILLIPPE, Member;

11 MR. DAVID RAIKES, Member;

12 MR. CHUCK SHEETS, Proxy Member; and

13 MR. FRANK URSO, General Counsel.

14 STAFF PRESENT:

15 MR. MICHAEL CONSTANTINO;

16 MR. NELSON AGBODO;

17 MS. CLAIRE BURMAN; and

18 MS. CATHERINE CLARKE.

19 ALSO PRESENT:

20 MR. DALE GALASSIE;

21 MR. CHARLES FOLEY;

22 MR. JOHN FLORINA;

23 MR. JASON SPEAKS;

24 MR. COADY WING;

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MS. TAMARA KONETZKA;
MR. TONY LOSASSO;
MR. JOSEPH BENITEZ; and
MR. GREG WILL.

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CHAIRMAN WAXMAN: We have a motion to approve the agenda. I need a second.

MEMBER RAIKES: Second.

CHAIRMAN WAXMAN: All in favor?

(The ayes were thereupon heard.)

CHAIRMAN WAXMAN: Any opposed?

Motion carries.

I need a motion to approve the minutes of January 14th.

MEMBER AMIANO: I'll move.

CHAIRMAN WAXMAN: Judy, thank you.

I need a second.

MEMBER HANDLER: Second.

CHAIRMAN WAXMAN: I have a second from Carolyn.

All in favor?

(The ayes were thereupon heard.)

CHAIRMAN WAXMAN: Any opposed?

Motion carries. Thank you very much.

We are lucky and fortunate to have Dale join us. Dale was just past Chair of the Mother Board. So

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1 he brings that experience to the table. He has been
2 reappointed to the Board, either not as Chair or
3 choosing not to be a Chair, whatever that choice might
4 be, but an opportunity for Dale to represent his group
5 to us.

6 As most of you know, there is a liaison from
7 the Mother Board to our subcommittee. We have not
8 seen that person very often, which is both good and
9 bad. Dale may become that person. I don't know if
10 that's been official yet.

11 MR. GALASSIE: Yes, it is.

12 CHAIRMAN WAXMAN: I just heard in my
13 good ear that it is official. So welcome to our group
14 as the liaison. We're happy to have you, obviously.

15 You do have some moments of speaking time.
16 We have allotted two minutes and 30 seconds for you.
17 Take your time.

18 MR. GALASSIE: Understood.

19 Many of us know one another; some don't.
20 So very briefly -- and certainly no ego intended by
21 any means -- my life was in public health. I was
22 with Lake County for 30 years, 20 as Executive
23 Director, a large public health agency which our
24 economic colleagues might be familiar with.

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1 I lived this life for 20 years. So I
2 understand very well where you are. Lake developed
3 probably 20 years ago a delegation agreement with IDPH
4 to regulate long-term care within its county.

5 So again, this is very familiar to me, and I
6 don't pretend to suggest I'm going to give you content
7 edition. I don't pretend to understand the issues
8 nearly as well as you do, but I am going to give you
9 support in the process in getting some things moved
10 forward in a timely way.

11 I want to say from the outset that part of
12 my career belief has been public and private
13 partnerships, meaning bringing the private sector and
14 government together. That's not always easy to do. I
15 don't pretend to suggest to you that I did it alone in
16 Lake, but we did a very successful marriage between
17 the private sector and the public sector.

18 I think much of that success ultimately
19 ended up in convincing our regulatory folks, the
20 employees, if you will, and at that time long-term
21 care, restaurants, you know, bars, septic systems,
22 which don't sound too intriguing, but in a county like
23 Lake it's huge, huge dollars involved with those kinds
24 of issues.

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1 What we ultimately evolved to was being
2 educators rather than regulators. There's also hidden
3 agendas in rooms like this, even though folks have
4 known one another for a long time.

5 The good news is I think there's a good deal
6 of mutual respect. The friction is there's always
7 self-interest. That's all okay. I mean, that's part
8 of the process.

9 I believe that the Health Facilities Review
10 Board is ready to hear from this group. Now, I also
11 believe there's been somewhat of a disconnect through
12 probably no fault of your own but through a fault of
13 our own.

14 It's got to be over a year since I've been
15 here, and there's probably not been a board presence
16 there. Staff has diligently represented some issues;
17 but if I can just be candid, I think there's a whole
18 bunch of very successful folks in this room that are
19 volunteering their time and driving in this kind of
20 weather. So I have to believe you want to get things
21 done.

22 Staff has more than to enough do, and I have
23 a great deal of respect for them. They want to get
24 some things done.

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1 The message I want to give you, if I may, is
2 I think it's time to get some things done or give it
3 up. There's been a lot of discussion, and it's just
4 been kind of hanging out there. So it's time to
5 really get down to two or three items, and I'm going
6 to suggest what they are. If I'm way off the bat,
7 Constantino will throw something at me.

8 That having been said, there was a very, in
9 my opinion, intriguing conversation yesterday at the
10 Board that had to do with -- and again, some of my
11 acronyms are dated. So feel free to correct me if I'm
12 outdated. There was some very interesting dialogue on
13 a transitional facility --

14 MR. CONSTANTINO: Transitional care,
15 yes.

16 MR. GALASSIE: -- transitional care
17 facility that was looking to establish a new site in
18 Naperville and some very interesting dialogue by Board
19 members, very healthy dialogue.

20 I think at the end of the day, in my
21 opinion, it was fairly clear that the Board and
22 certainly the Chair -- Cathy spoke strongly on this
23 subject -- wants to see us move in a policy direction
24 to some of the -- the word has been used to me

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1 "innovative." I'm not sure -- and you know better
2 than I do as the industry representatives. I'm not
3 sure "innovative" is truly the word today. I tend to
4 see it more as an evolutionary stage, but a desire to
5 have some policy changes occur.

6 So if I'm making some sense to you, the
7 window is open. Having worked for many years, again,
8 in the public sector dealing with policy change, when
9 you see an opportunity to get policy change, that's
10 the time to jump through that window.

11 This is the time for this Committee to get
12 itself heard to the Board, and I think you can do
13 that. I think you've had a lot of dialogue about
14 that; but I also believe if we're going to get down to
15 it, the success that comes out of groups like this is
16 the result of both parties having to give.

17 Nobody gets everything they want. The
18 industry is not going to get everything they want; the
19 government is not going to get everything they want.
20 There's some mutual distrust along the way.

21 But again, as I said before, there's mutual
22 self-respect in trying to get to a better place for
23 our state. I think we can do that. I think we need
24 to do that. I think clearly the message I can give to

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1 you from the Board is the Board feels we need to do
2 that. So the time is right to try and succinctly
3 suggest to the Board what issues they have.

4 That having been said -- and again, I will
5 try to be reasonably succinct -- it's clear to me that
6 we need to have just a five-minute agenda item on the
7 Board agenda from this. Otherwise, there's no real
8 connecti vi ty.

9 You can't spend two years, as some of you
10 have, discussing an issue. Now you come to the Board
11 and want to get the Board to make a decision. Well,
12 you're all in the ninth inning of the game, if you
13 allow the analogy, and the Board is in the first
14 inning of the game. So we have to walk them along.

15 I believe as early as next month I'll be
16 asking Staff to include an agenda item on the
17 Committee, a five-minute issue. The suggestion I'll
18 give you -- and, please, I don't mean to suggest you
19 need to take my suggestion -- is if it's possible for
20 you today to narrow down your three priorities.

21 There's no magic to three, but I'm not a
22 believer of ten priorities. That doesn't sound like a
23 priority to me, but if you've got one or two or three
24 priorities.

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1 What I've heard discussed is buy/sell as an
2 issue. I'll remember two of the three. The issue
3 that we discussed yesterday -- Mike, maybe you
4 could help me a little bit here, but the rules
5 surrounding -- I guess it's part of buy/sell -- the
6 rules surrounding bed numbers and how that impacts
7 this -- what's the word I'm using?

8 MR. FOLEY: Are you talking about a
9 variance?

10 MR. GALASSIE: I'm really talking about
11 what occurred yesterday.

12 PROXY MEMBER SHEETS: The inventory?

13 MR. GALASSIE: Yes, the inventory.
14 Thank you. I'm brain dead here.

15 The inventory and how do we get our rules
16 sufficient -- let me back up.

17 I think what happened yesterday is you saw
18 a presentation by this group who wanted to open up a
19 facility in Naperville. I think generally there
20 were -- am I right -- six members, seven members?

21 MR. CONSTANTINO: Seven members.

22 MR. GALASSIE: There were seven members
23 there.

24 I think for the most part all seven members

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1 were supportive of this concept, believing this
2 concept needs to move forward, knowing many of you
3 probably are already moving forward with that type of
4 concept with your facilities, but our rules really
5 don't support that right now.

6 MR. CONSTANTINO: That's correct.

7 MR. GALASSIE: The Board wants to see
8 those rules reviewed and able to support this type of
9 evolution, if you will, and they're ready for that.
10 You all understand how to get there much better than I
11 do, but they're ready for that.

12 I think at a minimum at next month's meeting
13 the representative -- if you want that to be me, so be
14 it. I guess that can be Mike's decision. It doesn't
15 have to be me. It might be better off not being me.

16 But in any event, it would be healthy if the
17 Board heard, "All right. The Committee has been
18 together this long. Here's our one, two, or three
19 issues. This is what we're working on and hoping to
20 come to you fairly soon with some dialogue, some
21 recommendation."

22 It might not necessarily even have to be,
23 you know, concrete rule change yet, but at least they
24 need to know what it is. They need to hear -- in my

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1 opinion, they need to hear this is where you feel it
2 needs to go.

3 You're the industry representatives, and we
4 might not agree -- when I say "we," the government
5 side of the house might not be able to agree
6 completely on how to get there, but I think ultimately
7 through compromise it can be a much better place for
8 everybody to get there.

9 The good news, if I'm not being redundant,
10 is that the Board clearly wants to get there. In my
11 experience, that's a hell of a lot easier than working
12 your way up the hill when they're all opposed to you.
13 So I think this is a good time and a good period for
14 you.

15 I'm going to stop. If there's questions for
16 me, I'll entertain them. Otherwise, I'll be quiet.

17 CHAIRMAN WAXMAN: Are there questions
18 for Dale?

19 While people are thinking of questions, I
20 have always offered to attend those Board meetings to
21 represent this group. I will put that offer back on
22 the table.

23 I certainly have no problem with you being
24 our representative. It may be good to have one or two

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1 of our Board members there since the two-year history
2 is sitting within this group and you don't have all
3 that history with you.

4 I agree with you. Staff does an incredible
5 job, and the people like Mike and Frank and Claire,
6 you know, do have the history and Courtney; but maybe
7 a Board member or a Committee member of this group can
8 join you. I'm certainly willing to do that. I've
9 said that in the past.

10 Are there any questions for Dale?

11 MR. GALASSIE: I think, if I may --

12 CHAIRMAN WAXMAN: Do you have a
13 question for yourself?

14 MR. GALASSIE: Yeah. It's called
15 "really compulsive."

16 If you can get to your one, two, or three
17 points and then a subset. What are the sticking
18 points? I mean, in other words, if I may, let's cut
19 through the bullshit at this point. What are the
20 sticking points?

21 I understand very well there's hesitancy at
22 times on the government side. These are very smart
23 people who also have certain biases and concerns.
24 It's understandable, but everybody has got to give a

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1 little bit. Everybody has got to grow a little bit.

2 CHAIRMAN WAXMAN: Frank?

3 MR. URSO: I just have a couple
4 comments.

5 First of all, in your bylaws that you
6 approved, you have it designated that you're going to
7 be providing quarterly reports to the Health
8 Facilities and Services Review Board from this
9 Committee. So it ties right into what Dale is saying.

10 Also, your statutory mandate from the Health
11 Facilities Planning Act is that you should be looking
12 at innovative design models in the long-term care
13 industry. So you have essentially the backing and the
14 foundation for a couple of the comments that Dale was
15 making. So I just wanted to bring that to your
16 attention.

17 MR. GALASSIE: At the end of the day,
18 there's also -- let's face it. When we finally get
19 there and it's time to go in front of JCAR and those
20 kinds of things, the partnership is very important.
21 That's a reality. We need to work together to get
22 through what everybody ultimately wants to get
23 through, and I think it's much more potentially
24 successful as a result of that partnership.

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1 CHAIRMAN WAXMAN: Judy?

2 MEMBER AMIANO: Well, first of all, I'm
3 thrilled to hear that we're going to kind of do it or
4 get off the pot.

5 However, I would throw in there that over
6 the last two to three years -- you know, I'm not sure
7 that the question we're trying to answer is the same
8 question today because the external environment has
9 changed so much.

10 So how SNFs are being utilized in our
11 relationship now with ACOs, all these things that
12 weren't present 2 1/2 years ago have really changed
13 some of those dynamics.

14 So while I don't necessarily want to start
15 back at the beginning, I think we need to make sure
16 are we answering the right question here as we move
17 forward, or is there an opportunity to take a step
18 back and say, "Wow, things have changed. Let's
19 rethink a couple of these things as we move forward."
20 So I'd just throw that out.

21 MR. GALASSIE: If I may, just even
22 advising the Board of that is a good thing.

23 MEMBER AMIANO: I mean, it's a
24 completely different world now than it was three years

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1 ago as a provider.

2 CHAIRMAN WAXMAN: I was going to go
3 down that same road.

4 What we talked about 2 1/2 years ago when we
5 started this is much different than where we are at
6 today. I think it is great news to hear that the
7 Mother Board is interested and wants to move forward,
8 and this is the proper time and a good time for us to
9 bring our ideas, too, because we struggle as a
10 Committee because there is such a diversity among this
11 group.

12 Not only are there non-nursing home people
13 in the group, but there's also different types of
14 nursing home people in the group who have kind of
15 different philosophies, for profit, not for profit.

16 So it's been a hard 2 1/2 years for this
17 group to feel like they have accomplished as much as
18 they have accomplished and feel like there should be a
19 lot more accomplishments done already.

20 So there's been some changes to the
21 Committee. I think those are good changes for the
22 most part. We've lost a couple people that I feel bad
23 about. I think some people were originally on the
24 Committee that felt they didn't have the right

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1 background to be part of the Committee, and they've
2 kind of filtered themselves off of the Committee. I
3 think that's okay.

4 I think now we have a core group of people
5 that really do want to look at what's going on in the
6 world of long-term care, and I think Judy is
7 absolutely correct about what was critical when we
8 started is not necessarily the most critical part now.

9 We as a group will have to formulate the
10 three priorities today, or our other choice is to let
11 Staff pull it off of the transcripts of prior meetings
12 and get it to us before your next meeting. That's
13 another option is to let Staff go through transcripts.

14 Claire, do you think it's in the
15 transcripts?

16 MS. BURMAN: I'm sure it is. That's
17 how the subcommittee started out.

18 CHAIRMAN WAXMAN: So that's one option.
19 We can talk about that, whether we want to try to
20 specify them today before we leave or at least broadly
21 identify the three things we're most interested in
22 before we leave and let Staff go back to the
23 transcripts and get it to us for approval before -- do
24 you know the date of your next meeting?

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1 MR. FOLEY: March 23rd.

2 CHAIRMAN WAXMAN: I'm sorry?

3 MR. GALASSIE: March 23rd.

4 MR. URSO: No, March 11th. March 11th
5 of 2014.

6 CHAIRMAN WAXMAN: That's not a lot of
7 time, guys.

8 MR. GALASSIE: Can I give you a
9 suggestion -- offer you a suggestion just for fun?

10 CHAIRMAN WAXMAN: Feel free.

11 MR. GALASSIE: Break up into two groups
12 and give people 20 minutes. What do you think the top
13 priorities are?

14 CHAIRMAN WAXMAN: We could do that.

15 MR. GALASSIE: My guess is it's going
16 to have to move fast.

17 CHAIRMAN WAXMAN: Mr. Foley, you're
18 getting antsy. What's on your mind?

19 MR. FOLEY: Should we hear from our
20 guests first so they can get out of here?

21 CHAIRMAN WAXMAN: Are you on a time
22 commitment?

23 MR. LOSASSO: No.

24 CHAIRMAN WAXMAN: I think they ordered

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1 lunch. I think they're here for the day.

2 PROXY MEMBER SHEETS: Maybe the better
3 question is: Are they billing per hour?

4 CHAIRMAN WAXMAN: I don't know how
5 they're billing.

6 How are you billing?

7 MR. LOSASSO: Not hourly.

8 CHAIRMAN WAXMAN: You raise a whole
9 other issue. I don't think this Committee has even
10 seen what the RFP looks like in terms of the dollars
11 that we're paying for them.

12 Do we know that yet? Can you share that
13 with us, Frank?

14 I think the Committee is entitled to know
15 what the RFPs ended up being and what kind of dollars
16 are involved.

17 So who might know that?

18 MR. URSO: Courtney. She's not here.

19 MR. LOSASSO: We're worth every penny.

20 MEMBER AMIANO: Guys, we're not being
21 fair here. I think we need to stay focused on the
22 task at hand. That was a pretty divergent thing
23 there.

24 CHAIRMAN WAXMAN: It was, Judy, but it

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1 was on my mind from the day that this meeting was
2 taking place. We haven't been informed on any of this
3 stuff, and I think that's wrong. I was going to do it
4 at some point today, but you're right.

5 Okay. We have a suggestion. I don't know
6 that we really need to break into two groups. I bet
7 you we can do this pretty quickly pulling out the
8 three items.

9 I look at Tim and Judy and Cece as maybe --
10 what do you think is one of the three items we need to
11 look at? I raise that because you represent the
12 industry. Bill, you certainly have a piece of this.

13 Tim?

14 MEMBER PHILLIPPE: Probably the bed
15 buying and selling we've been talking about for five
16 years.

17 I remember it suddenly entered on a task
18 force I was leading that we were doing telephonically.
19 Suddenly, we had 15, 20 people showing up for the
20 conference calls. So I think there was a lot of
21 interest, and there has been for a long time.

22 MEMBER CREDILE: Well, the reason there
23 is an interest in buy/sell is because the Committee
24 is -- our task is for innovative facilities.

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1 In Illinois, with the face of limited
2 reimbursements and many aging facilities and the
3 changing environment that Judy is talking about where
4 many facilities have become post-acute providers, not
5 all but some segment has, and the ACO environment, I
6 mean, there's limited dollars available to modernize,
7 upgrade.

8 And now there's been a recent change with
9 limited bed availability with the current bed need
10 formula, and so buy/sell is an option that other
11 states employ to upgrade the industry.

12 What I appreciate hearing is it sounds like
13 the long-term care industry is being -- it feels like
14 reconsidered as an integral part of the health care
15 system in Illinois.

16 But if we don't put dollars in it and you
17 can't modernize facilities and you can't upgrade, we
18 can't accomplish for the consumer what we need to and
19 for the health care continuum.

20 So the buy/sell piece is an outgrowth of
21 very limited reimbursement and limited abilities in
22 the state.

23 CHAIRMAN WAXMAN: Okay. So we have
24 one.

1 Second, Mr. Foley?

2 MR. FOLEY: Obviously, it would be
3 beneficial also to try to identify and get rid of a
4 lot of the dead beds across the state. That's been a
5 main focus, try to accomplish that, one of which falls
6 back onto the bed sale concept as well. So that's
7 another issue that we need to seriously discuss.

8 CHAIRMAN WAXMAN: Can you
9 rephrase?

10 Are you saying a better, accurate inventory
11 count?

12 MR. FOLEY: Exactly. That's what we
13 need.

14 We have all these dead beds out there. We
15 have all this utilization moving across the state,
16 supposedly. There are a lot of dead beds out there,
17 but we need to focus on finding out are they really
18 and truly dead beds? Are they in fact being used? If
19 they're not being used, are they being used for other
20 purposes? That needs to be identified.

21 We talked about the buy/sell concept that
22 maybe if it was done on a ratio basis -- this was
23 discussed a couple years ago where if you're going to
24 buy beds for one location and put them in another

1 location, you're not doing anything to the overall bed
2 count because you're just trading beds from one spot
3 to another. The bottom number stays the same.

4 If you need to buy two beds and only get one
5 bed, then you're going to see a net reduction of beds
6 in the state. So we had talked about that, also. It
7 all goes hand in hand.

8 CHAIRMAN WAXMAN: Bill?

9 MEMBER CASPER: I just would offer a
10 more politically correct term. We call them "beds out
11 of service."

12 It seems to me, having worked in other
13 states, to be an anomaly here that when beds are taken
14 out of service, there's no regulatory mechanism for
15 that to be considered in the bed inventory or in the
16 licensure category.

17 There's no loss of license. Somebody can
18 take beds out of service for ten years and still have
19 the same number of licensed beds.

20 CHAIRMAN WAXMAN: What was the term you
21 used?

22 MR. CASPER: Beds out of service.

23 MR. URSO: So are you saying
24 discontinued beds?

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1 PROXY MEMBER SHEETS: He's saying set
2 up but not actually in the facility.

3 So they're licensed, but they're not set up;
4 correct?

5 MEMBER CASPER: Yes.

6 MR. GALASSIE: I don't know if I'm
7 asking Staff or you guys. Does that dialogue need to
8 proceed, the buy/sell dialogue?

9 MEMBER HANDLER: Yes.

10 PROXY MEMBER SHEETS: It's the same
11 kind of dialogue. I mean, one relates to the other.
12 One of the solutions for getting rid of this excess
13 bed issue is to allow them to sell them.

14 MEMBER AMIANO: Then I think there's a
15 whole category of process with some of these things.
16 I think innovation and what do you do with these
17 excess beds is a process thing.

18 And how is the long-term care industry
19 treated differently than the hospital industry in the
20 process because they mirrored each other for so long.
21 I think some of that has changed over the past few
22 years.

23 When we first started, that was clearly a
24 notion. I mean, why this Committee was even set up is

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1 we need experts who understand long-term care to help
2 drive that process a little differently than
3 hospitals.

4 MR. GALASSIE: Again, just exposing my
5 ignorance, we're not breaking new ground here in
6 Illinois.

7 MEMBER AMIANO: No.

8 MR. GALASSIE: I'm assuming this has
9 been done in other states.

10 MEMBER CREDILE: Correct. That's why
11 we have this group so they can provide some expertise.
12 Claire has done an inordinate amount of work already
13 which she's fed to this group, I'm assuming.

14 CHAIRMAN WAXMAN: To follow up a little
15 bit on what Judy is talking about, we have put
16 together a new application, a new CON application,
17 that does eliminate what we feel are the
18 hospital-related questions and documentation and data
19 that has no bearing on the success or failure of a
20 nursing home.

21 So that has been sitting around in
22 committee. Where it stands right now is that we have
23 some concepts that we want to implement, but there are
24 parts of that that require permission from your group

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1 to move it forward because it does require legislative
2 change.

3 Correct, Frank?

4 MR. URSO: It depends on what the
5 change is.

6 CHAIRMAN WAXMAN: That, I think, is
7 another priority of this group is to get our CON
8 application for long-term care through the system. So
9 I think that would be another priority.

10 MEMBER AMIANO: Then I would just add
11 to that, you know, that whatever we create, that we
12 create some sort of environment that allows for
13 ongoing change at a more fluid pace than this process
14 has been so as that health care continuum continues to
15 change and evolve, that we have mechanisms that we can
16 as a state be responsive to those needs without having
17 to go through, you know, a three- or four- or
18 five-year process to change.

19 MR. GALASSIE: That would go back to
20 the whole statutory -- would that even be -- I hear
21 you. I guess I'm trying to understand in my mind.

22 Where would that dialogue begin with the
23 legislature? Would that come from the Health
24 Facilities Review Board, IDPH?

1 We're talking about a big deal when we want
2 to alter statutory, which should be done, but I'm not
3 sure where that --

4 MR. URSO: Well, I think it would be a
5 communication between IDPH and the Board because you
6 have the licensure piece and then you've got the CON
7 piece.

8 We work very closely together very often.
9 On major statutory legislative changes, we would be
10 communicating with each other. We do on a daily
11 basis, so this would be no different.

12 MR. GALASSIE: And we'd want to pool
13 some legislators who have some interest.

14 MR. URSO: That would support that,
15 sure.

16 MR. GALASSIE: Who would dialogue it.

17 MR. URSO: Right.

18 PROXY MEMBER SHEETS: I think it
19 depends on the type of change, though. If it's
20 something within the discretion of the Board, then
21 it's just a rulemaking process. You can do it a lot
22 quicker sometimes.

23 MR. URSO: It definitely depends on the
24 change.

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1 MEMBER AMIANO: In the future, you
2 know, the payer, being an ACO, or someone takes over
3 the quality standards of the care provision, you know.

4 How does that start to look and what does
5 that change? That's a realistic near-term kind of
6 thing. So how does that fit within our current
7 constraints?

8 It would be terrific if Illinois could be a
9 leader in the nation in thinking through some of these
10 things.

11 CHAIRMAN WAXMAN: You're spending too
12 much time in your car, too.

13 MEMBER AMIANO: It's my desire to
14 change things before I retire out of this industry.

15 CHAIRMAN WAXMAN: Claire?

16 MS. BURMAN: I just wanted to point out
17 that there are a number of suggested changes that the
18 task force is going to bring forth in a presentation
19 in the near future. Many of those are actually rule
20 change and not legislative.

21 MR. GALASSIE: The rule change being
22 within the authority of the Board?

23 MS. BURMAN: That's correct. That's
24 correct.

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1 MR. GALASSIE: Yeah. My comments were
2 more if it was legislative change.

3 MR. URSO: We have much more
4 flexibility with the rules than we do with the
5 statutory changes.

6 MR. GALASSIE: Sure.

7 CHAIRMAN WAXMAN: I think Judy is
8 talking about both, though, aren't you?

9 MEMBER AMIANO: Frank is the expert in
10 this because I've been caught up a number of times
11 over the years of thinking it's an easy thing to
12 change and, oh, no, you have to go down the long path
13 on that one.

14 I would rely on Frank commenting on that but
15 helping us to envision a structure that allows us to
16 make future changes more easily attainable, so
17 whatever structure that is. It's probably not
18 legislative in nature.

19 CHAIRMAN WAXMAN: Tim?

20 MEMBER PHILLIPPE: This is an important
21 issue to some people who are not here. Mike Scavatto,
22 a member of the Committee who is not here today, has
23 been working on this for years now in this group.
24 He's very passionate about some changes, and Claire

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1 has been very clear on the task force, I think, in
2 explaining what can be made and what cannot be made
3 without rule changes.

4 So the first step is really at least to make
5 those changes that can be made with rule changes.

6 CHAIRMAN WAXMAN: Right.

7 MEMBER PHILLIPPE: It does tie into
8 Judy's comment because of, really, the way the
9 application is written, it locks you into what you're
10 allowed to do with the building and how it has to
11 look. So it limits, really, your flexibility to be
12 innovative.

13 I think it is a very important thing that
14 the task force has been working on for a long time.

15 CHAIRMAN WAXMAN: I totally agree.

16 MEMBER PHILLIPPE: The things that most
17 frustrate them, I think, are things that require rule
18 changes; right?

19 MEMBER AMIANO: Yes. That's my
20 assessment.

21 CHAIRMAN WAXMAN: And Cece has been
22 part of that from the beginning, too.

23 MEMBER CREDILE: Correct. That is the
24 number one frustrator.

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1 CHAIRMAN WAXMAN: I think we've got
2 three or four listed.

3 If Staff can pull from this conversation and
4 get the Board members back, you know, an outline of
5 what we just discussed before your meeting, which is
6 March 11th --

7 MR. URSO: Correct.

8 CHAIRMAN WAXMAN: -- that would be
9 greatly appreciated so we can review it and agree to
10 it.

11 MEMBER AMIANO: It would be helpful if
12 that could be mailed out to the members of the
13 committee.

14 CHAIRMAN WAXMAN: Yes, absolutely.

15 MR. GALASSIE: Can I just ask again --
16 I'm exposing my ignorance -- the task force you
17 mentioned, is that a task force of the Health
18 Facilities Review Board?

19 MEMBER PHILLIPPE: It's better called a
20 work group out of this committee.

21 MEMBER CREDILE: Actually, it was Ellie
22 and Mike and myself, and then it became, obviously,
23 Mike and myself. Then, obviously, we had Staff
24 participation, and we were doing conference calls.

1 But our sticking point all the time is the
2 rule change, and can't we just go for language
3 instead? We have simple changes here and then rule
4 changes and then statutory changes, and we get stuck
5 because it's rather monumental.

6 The application for long-term care needs to
7 be changed so that it doesn't mirror the hospital
8 application.

9 MS. BURMAN: Actually, it is a rule
10 change because the application follows the rule. All
11 the application does is it reflects what is in the
12 rule.

13 MR. GALASSIE: So the application
14 change is within the auspice or authority of the
15 Board?

16 MR. URSO: The Board's rulemaking
17 authority, right.

18 MR. GALASSIE: That's good.

19 CHAIRMAN WAXMAN: Does anyone have
20 anything else they want to put on this list before we
21 leave this subject?

22 Mr. Sheets?

23 PROXY MEMBER SHEETS: I just want to
24 clarify the innovation concept.

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1 CHAIRMAN WAXMAN: Please.

2 PROXY MEMBER SHEETS: I think the Board
3 has in the past had a process for, as Charles will
4 call it, a variance.

5 So I think the project that you heard
6 yesterday which was of concern that you wanted to
7 approve but there just seemed to be no mechanism to do
8 that, I think a variance for innovation might be the
9 way to accomplish that in quick order.

10 CHAIRMAN WAXMAN: I feel like I'm at a
11 loss in this discussion since I was not at that
12 meeting.

13 Can somebody fill in the blanks as to what
14 really happened and what the stumbling block was or
15 what the issues were?

16 MR. GALASSIE: I can tell you the
17 meeting started at 10:00 and ended at noon. That was
18 pretty impressive. There's a challenge for you,
19 Mr. Chairman.

20 CHAIRMAN WAXMAN: I'm going to keep
21 them all day because they drove so far to get here.
22 I'm kidding.

23 Again, can you explain to me what the issue
24 was with the presentation?

1 MR. CONSTANTINO: They were proposing a
2 short-stay facility, a facility that provides rehab
3 services.

4 CHAIRMAN WAXMAN: Okay.

5 MR. CONSTANTINO: And our current rules
6 do not lend itself to that type of facility.

7 PROXY MEMBER SHEETS: There's no bed
8 need.

9 MR. CONSTANTINO: There's no bed need;
10 there's excess beds in the planning area; and there's
11 a number of facilities not at target occupancy.

12 So they had a number of criteria that they
13 did not meet, yet the Board -- it was my impression
14 the Board felt that this was a good project, but they
15 couldn't meet the criteria as we've got them set up
16 now.

17 MR. GALASSIE: Yeah. If I may use
18 their term, it was sold as new, different, and
19 innovative. I think we could all discuss whether
20 that's the case, granted; but it was certainly
21 packaged well in that regard, and the Board liked what
22 they heard.

23 Then their discussion went to, well,
24 innovative or not, this is something we do want to

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1 support but we can't currently within our rules.

2 CHAIRMAN WAXMAN: You know, that smacks
3 right out to the next agenda item, which is
4 Mr. Foley's issue that ever since the new bed need
5 IDPH report has been issued, it does seem to be a
6 barrier to any current facility to do any renovation
7 or improvement or add innovative programming.

8 Yet, we've talked here several times that
9 approvals are rendered from the Mother Board based on
10 several criteria, one of which is the bed need count,
11 but innovative ideas or new programming should be
12 looked at as possible exceptions.

13 Yes, sir?

14 MR. FOLEY: I think another serious
15 issue -- and this is what I believe that the task
16 force or the work group on the application form has
17 been trying to deal with -- is the issue of 90 percent
18 occupancy rate.

19 Everybody has got to reach 90 percent -- or
20 all the facilities have got to be at 90 percent. If
21 they're not, that means there's a lot of beds
22 available. That number, 90 percent, I think is what
23 we're saying also needs to be changed drastically
24 because there's not an area in the entire state of

1 Illinois that you're going to find that would exceed
2 90 percent occupancy.

3 So that in itself is basically creating a
4 barrier within itself that nobody can really do
5 anything because automatically when you file an
6 application in any area in the state of Illinois,
7 you're always going to have facilities underutilized.
8 So if that's the case, nobody can do anything in the
9 state.

10 So the biggest question with my
11 conversations with Mike Scavatto is: What is so magic
12 about 90 percent? Why do we need an occupancy rate in
13 the first place? Is it really that important? To
14 some degree it is, and I can understand why. Or
15 should 90 percent be down to 85 or 80 percent? Pick
16 any number that you want.

17 But if you want to allow the existing
18 providers to do something, we have to do something
19 there with the 90 percent.

20 MR. GALASSIE: If I may, I would
21 suggest to you that you're discussing one of the
22 core -- I believe the Board would see that issue as
23 one of its core principles. Occupancy would be
24 relevant to the Board.

1 I mean, the Board, I think, sees its primary
2 mission is trying to ensure that there isn't a
3 complete redundancy within the system in hospitals,
4 long-term care. Whatever that number is, I don't
5 pretend to know the magic number either, but I think
6 it's relevant that there be a number.

7 Can I just suggest what I heard in this
8 dialogue are four items: Buy/sell, beds out of
9 service, inventory count, CON application change, and
10 a variance for innovation.

11 CHAIRMAN WAXMAN: Okay. And a
12 process -- go ahead. I'm sorry.

13 MR. GALASSIE: Please.

14 If those are the four -- and you can decide
15 if they are -- it seems to me as though the
16 low-hanging fruit is the variance for innovation and
17 the CON application. Maybe I'm wrong.

18 Am I wrong, Mike?

19 MR. CONSTANTINO: No.

20 MR. GALASSIE: Those two seem to be,
21 you know, within our rules, within our authority, our
22 ability to do.

23 Variance renovation is yesterday's dialogue.
24 So I'm just throwing that out.

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1 CHAIRMAN WAXMAN: Those are on my list,
2 too.

3 I also want to make sure that we include
4 Judy's thoughts on that. A discussion needs to take
5 place about how to make the structure much easier so
6 we don't have to look at five years to make a change
7 or two years to make a change.

8 So what can we do jointly, the Facilities
9 Planning Board and this Board, to put a structure in
10 place so the communication is better and we can move
11 forward faster?

12 I think that's something that needs to be on
13 that list, also; right, Judy?

14 MEMBER AMIANO: Yes.

15 There was a group -- I mean, Tim, you
16 remember because you and I were on it. It's been a
17 lot of years ago. We started this. We came up with a
18 list of like five recommendations, which were kind
19 of/sort of the foundation of this particular
20 committee, which was an innovation variance, an
21 application, a new application.

22 Do you remember that?

23 MEMBER PHILLIPPE: I do.

24 We're talking about the same things over and

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1 over again. It was started before the subcommittee.

2 MR. GALASSIE: I think, if I might,
3 from a policy perspective --

4 MEMBER AMIANO: I wouldn't put on the
5 top four the beds not in service because to me that's
6 like how do you look at the whole? It's just such a
7 narrow piece of the whole problem. I would hate for
8 that one thing to bubble up as the most important
9 thing to us.

10 MS. BURMAN: It is a very significant
11 one, though.

12 MEMBER AMIANO: It's a significant part
13 of the whole process.

14 MS. BURMAN: Yes, because it's part of
15 the need formula. It skews everything.

16 MEMBER AMIANO: The need formula is the
17 priority.

18 MEMBER CREDILE: The problem is the bed
19 need for me.

20 Let's just suppose that there are a lot of
21 beds out of service out there. So you do an inventory
22 and you find out there's even less beds. Well, then
23 the bed need formula is not going to help us. It's
24 going to make it worse.

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1 MS. BURMAN: You have to decide how
2 you're going to count beds, bed count as used in the
3 formula. That's what we talked about when Tim headed
4 a work group right from the start. That is a big
5 issue.

6 MEMBER AMIANO: So I would just say the
7 bed need formula is the issue, and all these things
8 flow under it.

9 MEMBER CREDILE: Correct.

10 MR. GALASSIE: Is the bed need formula
11 huge? Is that low-hanging fruit?

12 CHAIRMAN WAXMAN: It's an extremely
13 complicated issue.

14 Mr. Constantino, would you like to --

15 MR. GALASSIE: It's not a low-hanging
16 fruit. You answered my question.

17 MS. BURMAN: If I may.

18 CHAIRMAN WAXMAN: Yes.

19 MS. BURMAN: The formula is a very
20 basic need formula.

21 CHAIRMAN WAXMAN: From 1978.

22 MS. BURMAN: It doesn't matter. Truly,
23 the age of it has nothing to do with it. It takes the
24 components you need to look at.

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1 The problem with the formula that we have is
2 the end point where you subtract existing beds. If
3 you don't have the correct number of existing beds,
4 the number is not accurate if you're determining need.

5 MR. GALASSIE: So we're back to
6 inventory.

7 MEMBER CASPER: The inventory is a
8 critical issue.

9 PROXY MEMBER SHEETS: But the inventory
10 is also an asset. So it's very guarded about giving
11 up -- you know, it's security for their mortgages, et
12 cetera.

13 MR. URSO: It's like a double-edged
14 sword.

15 CHAIRMAN WAXMAN: Yeah. It's securing
16 loans all over the country.

17 MR. URSO: Well, isn't it like a
18 double-edged sword? Because every day, according to
19 our data, there's 15,000 to 20,000 excess beds in
20 long-term care. You're never going to reach the
21 90 percent. Okay?

22 CHAIRMAN WAXMAN: Right.

23 MR. URSO: Then again, on the other
24 side of it, the owners want to keep that asset. So

1 you're trying to balance that all out.

2 MR. GALASSIE: But I think the
3 bottleneck that is occurring, that's ultimately going
4 to have to be decided upon. So that part is going to
5 fall to the owners. You get it either way. You don't
6 get it both ways.

7 MR. URSO: If you don't have true
8 numbers to put into your formula, you're not going to
9 get a true, accurate formula. So that's the bottom
10 line.

11 We can say the formula is no good, but isn't
12 it the pieces that go into the formula that perhaps
13 are suspect?

14 MS. BURMAN: It's one piece.

15 CHAIRMAN WAXMAN: And understand that
16 that piece is attested to by owners and
17 administrators. There are no state agencies that go
18 in and count unused beds. Once a year the
19 administrator and the owner sign a document that says,
20 "This is our bed count. These are the unused beds."

21 So again, you have to suspect the process of
22 how that number is coming about.

23 Tim, I saw you and I saw Chuck.

24 MEMBER PHILLIPPE: We're kind of

1 arguing about the pieces that are all part of a bigger
2 issue. I want to make sure I just mention this
3 because we could try to solve one problem by a little
4 change, but the problem is twofold in Illinois. It's
5 going to get worse.

6 First, there are not enough people who need
7 the beds. Okay? Now, there are beds needed in some
8 parts maybe, but in general there are not enough
9 people needing the beds that exist. That goes to the
10 core of why the Board exists, really.

11 The second one is that the payers in our
12 field skew our industry and the issues and make it
13 very different than the hospitals. In our field,
14 people will leave beds open in some locations -- some
15 people do -- because they don't like those payers.

16 It kind of goes to the heart of innovation.
17 So in some sense when you're talking about innovation,
18 it's not always innovation. It's an innovative
19 business model to try to get a new building approved.
20 It's not something that's not already being done in
21 other places. It's a way to try to go into an area
22 and build a building and take the best payer.

23 MR. GALASSIE: Sure.

24 MEMBER PHILLIPPE: So it kind of goes

1 to the heart of the problem we have in the state of
2 Illinois where the Medicaid, which is the majority of
3 people in long-term care. Compared to costs, it's the
4 lowest payment in the country. It's right down near
5 the lowest anyway; but even if you consider costs,
6 it's way below lowest in the country. So you have
7 that issue.

8 The private pay is declining, except in some
9 areas of big city suburbs, well-off areas. So that's
10 become a smaller payer. Medicare is actually the best
11 payer in the state of Illinois. So people want to
12 build new buildings where they will only take Medicare
13 as a payer, and that makes our field very different
14 and it complicates all the issues.

15 MR. GALASSIE: Is private pay declining
16 because of economy?

17 MEMBER PHILLIPPE: It's declining
18 primarily because there's other avenues for care out
19 there that have been created over the last 20 years,
20 and people are dying before they get to long-term care
21 or they're running out of money.

22 So they have home care, home services, they
23 have assisted living, and they often end up in skilled
24 nursing after they run out of money. So it's kind of

1 a combination.

2 All these issues have to do with the results
3 of that dilemma in our state. So something can look
4 simple, but really it's not simple because it involves
5 all the factors competing.

6 MEMBER CASPER: Imbedded in that issue
7 is the definition of "innovative." I think, Tim, you
8 made an important point. Transitional care is not
9 innovative. We're all doing it.

10 CHAIRMAN WAXMAN: It's subacute with a
11 different name.

12 MEMBER CASPER: Subacute has been
13 around for 20 years.

14 So if you were to look at a market, let's
15 say Naperville, the concept of having 120 transitional
16 care beds would probably mean that nobody else in that
17 market would be able to have any transitional care in
18 their building because I can't imagine filling 120
19 transitional care beds in that kind of a market.

20 So to call that kind of a concept a new,
21 innovative concept I think means that this group has
22 to come up with some definition of what would
23 constitute "innovative."

24 MR. GALASSIE: Well, at the risk of

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1 stepping out, I would think this Committee might want
2 to think about giving a five- or ten-minute dialogue
3 to the Mother Board, as the Chair would say, about
4 that exact subject because I think there's an
5 education level there that needs to occur.

6 CHAIRMAN WAXMAN: And we're happy to do
7 that.

8 MR. GALASSIE: Just to bring balance to
9 the subject.

10 CHAIRMAN WAXMAN: We're absolutely
11 happy to do that.

12 MEMBER PHILLIPPE: Good.

13 MR. GALASSIE: Pardon me.

14 The advantage of your doing it is it's not
15 in opposition to an application. You know, you're a
16 third-party objective subcommittee of the Board trying
17 to give an education to the Board. I think they
18 appreciate that.

19 CHAIRMAN WAXMAN: One of the other
20 issues that we deal with at almost every meeting is
21 the concept that market demand is not being considered
22 when we look at bed need numbers only.

23 For example, you can have four homes in a
24 short geographical area, three of which are, as Tim

1 described, mediocre at best with empty beds; and
2 you've got one home that's doing innovative programs,
3 such as cardiac rehab or dialysis or cath, any of the
4 things that people coming out of the hospital much
5 quicker, much sicker are needing, and they don't have
6 any empty beds.

7 So when you look at that area, you say, "Oh,
8 it's overbedded," but there is a home that can use
9 some more beds because consumer demand is asking for
10 them, and that becomes a stumbling block in trying to
11 get that understood by whoever is making some
12 decisions.

13 You create a demand for a very particular
14 strong clinical program, and then you can't fill it
15 because of this formula that says "Within your area
16 there are empty bodes."

17 Well, the empty beds are there because
18 consumers are choosing not to use those beds, and the
19 beds they want to go into are not available. So I
20 think that's part of this whole discussion.

21 Mr. Foley, you look in pain.

22 MR. FOLEY: I don't know.

23 Unfortunately, we have a lot of facilities
24 in this state that are old facilities built back in

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1 the '30s to '40s or what have you, dilapidated --

2 CHAIRMAN WAXMAN: Careful, Chuck. Some
3 of us come back from the '40s, too.

4 MR. FOLEY: I understand that. I
5 understand that.

6 I guess what I'm trying to say is this
7 issue of occupancy, empty beds, I guess one of our
8 main reasons out there that we have empty beds is
9 because, as you just said, a lot of facilities people
10 just wouldn't go into them, period. They would only
11 have two beds, but they still have three beds, they
12 still have four beds. They're still sharing
13 bathrooms.

14 I have a mother-in-law in a nursing home in
15 Springfield. Unfortunately, she's 88, 89 years old.
16 I'm not saying that's unfortunate; but unfortunately,
17 she's occupying a room where she has to share a
18 bathroom with somebody else.

19 That really should not be the case today.
20 The care is excellent. I can't say anything wrong
21 about the care. The care is actually superb. We need
22 to help out these existing providers, either force
23 them to do something or have them get out of the
24 business, one or the other. I don't know what the

1 answer is, but we have to do something.

2 MEMBER PHILLIPPE: As long as you're
3 speaking on kind of the opposite of what Michael said,
4 I'll speak for the advocates because I've heard them
5 make this statement in our room before, and that is
6 there's also just the opposite.

7 There are places where officially there's no
8 bed need, maybe the Chicago area, more the bigger area
9 up here. The people are a Medicaid payer, and they
10 can't get a bed. They don't have a place that will
11 take them. The places have available beds, but they
12 don't want to use them. They have a limit to how many
13 Medicaid they want to take in their building or none
14 or whatever the percentage is.

15 So they have poor access to care because
16 people don't like the payer up here.

17 CHAIRMAN WAXMAN: Absolutely true.
18 Tim, I totally agree with you. That's what I hear
19 from the advocates.

20 MR. GALASSIE: And that should change.

21 PROXY MEMBER SHEETS: Right. With
22 managed care, that should change.

23 MR. FOLEY: Hopefully.

24 CHAIRMAN WAXMAN: Hold on. Hold on.

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1 The court reporter is having trouble keeping up with
2 the conversations.

3 Chuck, explain your statement, would you,
4 please?

5 PROXY MEMBER SHEETS: Well, I think
6 that as we negotiate dual eligible patients, we're
7 going to get a rate; and eventually I think the rates
8 will come together on the Medicare/Medicaid side.

9 CHAIRMAN WAXMAN: What I've heard is
10 that on dual eligibility, people are being offered the
11 Medicaid rate and not the Medicare rate.

12 PROXY MEMBER SHEETS: Well, that is
13 true, but that's sort of an aside. It's all about
14 market and demand and how many buildings you have and
15 what you can negotiate. You know what I mean? So
16 it's changing.

17 I guess what I'm saying is what the Medicaid
18 rate is is going to be less important in the future
19 than what you can negotiate that rate at.

20 CHAIRMAN WAXMAN: Okay. Again, playing
21 devil's advocate, because Tim started it and I like
22 the concept, we had another attorney make a
23 presentation who basically said that if you are a
24 single home, you have no leverage and no ability to

1 negotiate a rate.

2 Now, how do you feel about that?

3 PROXY MEMBER SHEETS: I agree. That's
4 my partner, Matt. Whatever Matt said I agree with.

5 CHAIRMAN WAXMAN: I'm glad I said it
6 politely.

7 So then if I have a home, how can I
8 negotiate a rate higher than the Public Aid rate if my
9 only strength is my own home?

10 PROXY MEMBER SHEETS: I don't think you
11 can.

12 CHAIRMAN WAXMAN: So then reimbursement
13 is not going to improve in the managed care world.

14 PROXY MEMBER SHEETS: For that
15 provider?

16 CHAIRMAN WAXMAN: Yes.

17 PROXY MEMBER SHEETS: That may be true.
18 They're going to have to find another way to make that
19 facility desirous for the managed care provider. It's
20 going to be a difficult road.

21 MR. FOLEY: It was also discussed at a
22 meeting or two ago in terms of are we going to need
23 the CON program when managed care does take place? So
24 there have been a lot of discussions on that, and

1 that's going to be interesting to see how that irons
2 out.

3 MR. URSO: We're set to Sunset in 2019
4 anyway.

5 CHAIRMAN WAXMAN: When?

6 MR. URSO: 2019.

7 PROXY MEMBER SHEETS: I think we need
8 Judy to put us back on track.

9 CHAIRMAN WAXMAN: Have you been
10 successful negotiating managed care rates with your
11 strength with all the homes?

12 MEMBER AMIANO: Yes.

13 CHAIRMAN WAXMAN: At a rate better than
14 the Medicaid rate?

15 MEMBER AMIANO: Yes.

16 CHAIRMAN WAXMAN: So it can work.

17 MEMBER AMIANO: But it's not easy work.

18 MEMBER HANDLER: And then you have to
19 administer all those contracts because there's a lot
20 of payers. So that means being able to generate a
21 bill and getting it through their system and having
22 the approval processes and maintaining those approval
23 progresses.

24 That's a hefty investment in the business

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1 office on the long-term care side, which has not
2 traditionally been a place where people have invested
3 a lot of resources.

4 CHAIRMAN WAXMAN: Chuck, do you know
5 how many managed care organizations there are in the
6 Illinois market now? Anyone?

7 PROXY MEMBER SHEETS: Seven, I think.

8 MEMBER HANDLER: There's going to be
9 more when they finally figure out who the aces are
10 going to be; right?

11 PROXY MEMBER SHEETS: I think right now
12 there's seven major ones, but there could be more.

13 CHAIRMAN WAXMAN: Can we draw this
14 conversation to a conclusion and ask Staff to put
15 together, then, our list of priorities and get it to
16 us in an e-mail format so we can review it before your
17 meeting?

18 Then we can determine who will come and
19 present this at your meeting.

20 MEMBER HANDLER: Michael, just for the
21 record, can I add one thing to the list of things that
22 I don't want us to lose sight of? We haven't talked
23 about it as a group for quite a while.

24 CHAIRMAN WAXMAN: Please.

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1 MEMBER HANDLER: That is there is no
2 feedback loop. Once the CON Board approves a project
3 and that project goes forward, there's no feedback
4 loop back to the Board about the success or failure of
5 that particular project.

6 I think we've talked about that might be
7 something we should, you know, recommend or work on as
8 a team. I know that it's not the first or second or
9 third thing, but I do want to at least --

10 MR. GALASSIE: You mean from the Board
11 back to the Committee?

12 MEMBER HANDLER: From the provider back
13 to the Board.

14 So if the Board approves this transitional
15 care project, they never really know if it
16 accomplished what it set out to accomplish and what
17 the impact in the community is or from an access
18 perspective or whatever, especially when you're
19 talking about variances and new, kind of innovative
20 projects.

21 MR. GALASSIE: It doesn't occur unless
22 the Board includes it in the approval, which
23 oftentimes it will. Frank will suggest to the Board a
24 parameter of --

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1 MR. URSO: Conditions.

2 MR. GALASSIE: -- conditions. Thank
3 you.

4 That's -- I'm not sure how to say it. If
5 there's 25 applications at a meeting, I'd say it
6 happens a couple of times, two or three, just to give
7 you a perspective.

8 CHAIRMAN WAXMAN: Right. And I think
9 Carolyn is right. It probably should happen all the
10 time.

11 PROXY MEMBER SHEETS: Well, there is a
12 project completion that's filed. You know the
13 building is built and up and running and licensed. So
14 I think maybe Carolyn is talking about down the road a
15 little bit.

16 MR. FOLEY: Yeah. Even after it's
17 opened and licensed, if they get approved under the
18 CCRC variance, for instance, five years from now are
19 they restricting admissions to their community or are
20 they actually admitting from the outside? I think
21 that's what she's referring to.

22 MS. BURMAN: In all of the review
23 criteria for every category of service, right at the
24 end of the criteria there's a section called

1 "Assurances." That's related more to meeting the
2 utilization or occupancy target.

3 Now, this has come up in other parts of the
4 health care industry. Do you check on this? Are you
5 sure that everybody is meeting that requirement? And
6 the answer is no, and the main reason is we don't have
7 enough manpower to be able to do that.

8 MEMBER AMIANO: I'm not sure that what
9 Carolyn is saying is additional oversight because none
10 of us would be interested in that, frankly.

11 MEMBER HANDLER: No.

12 MEMBER AMIANO: It is that learning
13 environment of if we granted a variance, did we
14 achieve what we wanted to in the marketplace so that
15 we as a Board might think about these things
16 differently?

17 So it's creating that ongoing learning
18 versus an oversight type of function.

19 MEMBER HANDLER: Yes.

20 MR. GALASSIE: There actually was brief
21 discussion about that exact point at the Board
22 yesterday.

23 There was one Board member who commented
24 that he was not a supporter of more oversight by any

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1 means, and there was another who said, "How do we get
2 feedback if this is approved?" At least they're
3 starting to think in your direction.

4 MR. URSO: If you're crafting rules,
5 you could have that as part of your structure in the
6 rules to follow up. That's doable, in other words.

7 CHAIRMAN WAXMAN: Anything else people
8 want to add? Otherwise, I'm going to ask Staff to put
9 together this document and get it to us.

10 And your meeting is the 11th?

11 MR. URSO: March 11th.

12 What we normally do is wait for the
13 transcript to make sure we have everything.

14 CHAIRMAN WAXMAN: She'll have it this
15 afternoon.

16 MR. URSO: And this fine young lady is
17 getting everything. We have two weeks -- 14 days
18 before the transcript. So we're kind of really tight
19 for time for the March 11th meeting, I think.

20 PROXY MEMBER SHEETS: Can we order an
21 expedited transcript and pay the young lady a little
22 more to have it faster?

23 MR. URSO: We'll have Chuck pay for an
24 expedited transcript.

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1 CHAIRMAN WAXMAN: He's probably got it
2 on his tape recorder anyway.

3 When is the next meeting after the 11th?

4 MR. URSO: The 22nd of April.

5 CHAIRMAN WAXMAN: That's pretty far
6 down the road.

7 Is the March 11th meeting here?

8 MR. URSO: No. It's in
9 Bloomington-Normal.

10 MEMBER PHILLIPPE: Can I just propose
11 something to help us move faster?

12 CHAIRMAN WAXMAN: Okay.

13 MEMBER PHILLIPPE: The work group on
14 the application has been working very hard. Mike
15 Scavatto really would like to birth this baby someday
16 before he retires.

17 You said this is low-hanging fruit. This
18 would be easier to tackle this. I would love to
19 propose that we make this a priority on our floor
20 because this is one that people have feelings about
21 and we can do something about, that we make that a
22 priority -- we've got the four on the list -- instead
23 of just waiting, coming back, talking again. We've
24 been working on this thing ever since we started on,

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1 really, the application.

2 Can we just make that a priority and
3 highlight that and get that one done --

4 CHAIRMAN WAXMAN: Sure.

5 MEMBER PHILLIPPE: -- and then come
6 forward with, really, the proposal that the group came
7 up with that required rule changes so we can kind of
8 expedite that at the next meeting?

9 CHAIRMAN WAXMAN: Absolutely. I'm fine
10 with that.

11 MR. GALASSIE: I think we want to get
12 to some end points.

13 CHAIRMAN WAXMAN: I'm fine with that.

14 Again, I'll put it back on Staff to put that
15 together for us.

16 MR. GALASSIE: I have to leave at
17 11:00; but to make it easier, if you're comfortable, I
18 would try to give a five-minute perspective to the
19 Board on this whole innovation issue.

20 It might be better if one of you could be
21 there, truthfully, because I think you speak to it
22 better and there's a little more connection between
23 the Committee and the Board at that point.

24 The next meeting would be very well timed to

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1 give them five minutes on what this Committee sees as
2 innovative or not. If you want to bring a balance to
3 that subject, it will be fresh in our minds.

4 MEMBER PHILLIPPE: Good.

5 CHAIRMAN WAXMAN: I cannot attend the
6 March 11th meeting.

7 Tim, are you available to attend or Cece?

8 MEMBER PHILLIPPE: What's the date of
9 the meeting?

10 CHAIRMAN WAXMAN: It's Tuesday,
11 March 11th.

12 MR. GALASSIE: In Bloomington-Normal.

13 I suspect Staff could work to get you either
14 early on or late, whichever is better for your
15 schedule.

16 MEMBER PHILLIPPE: Okay. I wouldn't
17 mind some help if somebody else would like to join me.

18 CHAIRMAN WAXMAN: Chuck, you're welcome
19 to be there, but you're not a member of the Committee.

20 MEMBER HANDLER: Maybe Judy would be
21 willing to do it.

22 CHAIRMAN WAXMAN: Maybe. We'll check
23 with Judy.

24 Bill, is that a bad day for you?

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1 MEMBER CASPER: I can't do that, and I
2 don't have enough history, I don't think.

3 CHAIRMAN WAXMAN: Okay. We'll check
4 with Judy.

5 MR. FOLEY: Mr. Sheets is usually at
6 the meetings, also.

7 PROXY MEMBER SHEETS: I'm not a member
8 either.

9 MR. GALASSIE: Tim, I could frame it
10 for you. Again, it's very informal.

11 MEMBER PHILLIPPE: Good. That will be
12 fine.

13 MR. GALASSIE: I'll frame this
14 dialogue.

15 MEMBER PHILLIPPE: I'd be happy to do
16 it.

17 As Judy said, we started through association
18 meeting together a few years ago. What is innovative
19 was part of the discussion.

20 CHAIRMAN WAXMAN: Cece, do you want to
21 check your calendar and see?

22 PROXY MEMBER SHEETS: Well, Judy is
23 pretty close to Bloomington.

24 CHAIRMAN WAXMAN: I know.

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1 MEMBER CREDILE: Can I just clarify?
2 Is that a meeting not to approve CONs, but it's just a
3 meeting --

4 MR. GALASSIE: This is a regularly
5 scheduled meeting of the Health Facilities Review
6 Board where there will be 20 or 30 applicants coming
7 in front of us.

8 MEMBER CREDILE: Oh, it's actually when
9 the applicants are coming?

10 MR. GALASSIE: Right.

11 MEMBER CREDILE: Is the public going to
12 hear this, or is this just for the Board?

13 MR. GALASSIE: Oh, no. It's all open.
14 The public is going to hear it.

15 PROXY MEMBER SHEETS: It would probably
16 be at the end, wouldn't it, with other business or
17 something?

18 MR. URSO: We'll work on that.

19 MR. GALASSIE: Yeah. I think we'll try
20 and respect Mr. Phillippe's schedule and do it at
21 either the beginning or the end, but you never know
22 what the end is.

23 CHAIRMAN WAXMAN: I think we had a good
24 discussion, and we kind of need Staff's help to put it

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1 together for us to move forward.

2 Again, I apologize. The 11th is the date I
3 can't do it. Otherwise, I would do it.

4 Frank, how much time do you need?

5 MR. URSO: Seconds.

6 CHAIRMAN WAXMAN: How much time do you
7 guys need?

8 MR. LOSASSO: Probably an hour.

9 MR. URSO: State your name.

10 MR. LOSASSO: Tony Losasso.

11 MR. URSO: One person at a time,
12 please, or else we're going to really mess up this
13 transcript.

14 CHAIRMAN WAXMAN: You have an hour
15 planned and discussion. Okay.

16 One other housekeeping matter: Do we know
17 what time lunch is coming up?

18 MR. URSO: 12:00, 12:30-ish probably.

19 MR. GALASSIE: She told me noon this
20 morning.

21 CHAIRMAN WAXMAN: Okay. Who is doing
22 Agenda Item 6?

23 MR. URSO: Do you want to do 5?

24 CHAIRMAN WAXMAN: Yeah, I'm doing 5.

1 I'm just trying to get in my head how to lay this out.
2 Is 6 the Staff Report?

3 Discussion of bed need determination, have
4 we covered that already?

5 MS. BURMAN: A little bit, unless Mike
6 wanted to add something.

7 MR. CONSTANTINO: No. We've been over
8 the bed need formula a number of times here. All of
9 us have our opinions about the accuracy of the
10 methodology.

11 I think it's a good formula. We've used it
12 for years. It's been tested in court. If there are
13 areas where it could be changed, we've always looked
14 at the bed number, the licensed bed capacity as a
15 problem area.

16 As Charlie said, the target occupancy of
17 90 percent, we use that in the formula. If you
18 decrease it to 80 or 85 percent, that will increase
19 the need in the area.

20 The population projections I think are good.
21 We do it in-house. We have a demographer on staff at
22 IDPH. Nelson is working with him this year. We went
23 to a five-year projection, which I also think is a
24 very good idea. That's from a ten-year projection. I

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1 think the ten-year projection overstated the number of
2 beds needed in the planning area.

3 I'm proud of the methodology we've used for
4 the last 30 years. I think it's been very good.

5 MR. GALASSIE: Isn't the beds out of
6 service still the issue?

7 MR. CONSTANTINO: Oh, yes, definitely.
8 Yes.

9 CHAIRMAN WAXMAN: Mike, I think the
10 reason this is on the agenda was to kind of go over
11 the broader concept that all decisions for
12 applications presented to the Mother Board, the sole
13 criteria is not the bed formula. Other things are
14 being used in the determination.

15 I think we need to make sure that people in
16 the industry don't have the sense that it's futile to
17 bring an application to the Mother Board in an area
18 where there is no need.

19 If they can prove unique programming or some
20 specific purposes that will show that they can be
21 successful clinically and profitability-wise, that can
22 overcome the fact that in that area there is no bed
23 need shown.

24 MR. CONSTANTINO: If you're talking

1 about existing facilities, historically the Board has
2 approved those types of projects.

3 However, when you modernize the facility and
4 want to add beds and there's an excess of beds in the
5 planning area, they take another look at it.

6 So you're correct. If we're just looking at
7 the modernization, the bed need calculation is not
8 considered in our review, and neither is the other
9 facilities in the planning area.

10 So you have to tell us and show us --
11 demonstrate with documentation that the modernization
12 is warranted based upon surveys conducted by IDPH or
13 the Federal Government, the age of the facility,
14 obsolescence. Yeah, the bed need calculation nor the
15 utilization by the facilities is not considered in
16 modernization projects.

17 Charlie Foley had a project before us, and
18 the applicant wanted to modernize and add beds. Well,
19 the Board rejected the idea of adding beds. They came
20 back and took those additional beds out of service --
21 or did not request those beds. I'm sorry.

22 However, under the 10 percent or 20-bed
23 rule, they can come in at any time within a two-year
24 period and add beds. So there is an avenue to add

1 those beds without Board approval.

2 CHAIRMAN WAXMAN: Thank you, Mike.

3 MR. CONSTANTINO: So the modernization
4 of these older facilities is possible.

5 CHAIRMAN WAXMAN: Thank you, Mike.

6 Mr. Foley?

7 MR. FOLEY: The case that Mike just
8 presented I think was somewhat of a unique situation.

9 One of the biggest problems out there is
10 that to modernize a facility itself, we have a
11 threshold of \$7.9 million. You could do a lot,
12 obviously, for \$7.9 million; but a lot of times if you
13 see that you need to do a lot more and you go over
14 that, you're at a 10, 11, \$12 million project.

15 It's hard to really make the numbers work
16 without adding beds in order to get the additional
17 revenue. So we oftentimes will see projects that they
18 may not -- yes, the 20-bed, 10 percent rule applies if
19 you have a large facility. You can add 20 beds if you
20 have a 200-bed facility.

21 If you just have a 100-bed facility,
22 sometimes to make the project financially viable, you
23 might have to add 15 beds, which is about 8, 10
24 percent. So it makes it extremely difficult.

1 So that's another issue, too, that we're
2 going to discuss under bed need determination, along
3 with the methodology itself.

4 CHAIRMAN WAXMAN: Any other questions?

5 Okay. What I propose -- Frank, do you want
6 to take a few minutes? We'll take a break, and then
7 we'll go into their presentation.

8 MR. URSO: Do you want me to go now?

9 CHAIRMAN WAXMAN: Yes. Would you,
10 please?

11 MR. URSO: I think Cathy handed
12 everybody the ethics training packet. Proxies as well
13 as standing members have to take the ethics training.
14 The packet of material is contained in the
15 paperclipped item.

16 What we're requesting is that you read the
17 document, and then on the last page there's a page
18 that you have to sign off saying you've read it and
19 you understood it basically. That has to be returned
20 back to Cathy or myself.

21 We've set the date of April 1st to give you
22 time to do that. That doesn't mean you have to wait
23 until April 1st. I'm not sure when the next long-term
24 care meeting is. I presume we'll have one before

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1 April 1st, if you wanted to bring it to that meeting.
2 If we're not going to have a meeting, then Cathy can
3 provide an envelope.

4 No, we're not providing envelopes?

5 Okay. I see.

6 MS. CLARKE: Sorry.

7 MR. URSO: No envelopes.

8 You need to get the last signed page back to
9 Cathy or I. So if you want to call us and mail it to
10 us or however you want to make arrangements to do
11 that, but the deadline is April 1st to complete it.

12 PROXY MEMBER SHEETS: Do you want the
13 original?

14 MR. URSO: The original, yes.

15 CHAIRMAN WAXMAN: Any questions of
16 Frank?

17 MR. URSO: This is the annual training
18 that we take every year.

19 MEMBER HANDLER: Did we not do this
20 online last year?

21 MR. URSO: You could have done it for
22 somebody else online, but ours is a paper one because
23 you're all appointees and appointees have a paper
24 copy. Employees of the State have it online.

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1 Any questions? I appreciate your assistance
2 with this.

3 CHAIRMAN WAXMAN: All right. Then I
4 propose we take a break, and we'll reconvene promptly
5 at 11:00 and have their presentation.

6 (Recess taken, 10:47 a.m. to
7 11:01 a.m.)

8 CHAIRMAN WAXMAN: Let's get back to our
9 meeting. We're missing a couple people. I have
10 11:00; right? We said we'd reconvene at 11:00.
11 They're probably on the phone.

12 We have a new member to the group.

13 Do you want to introduce yourself, please?

14 MS. KONETZKA: I'm Tamara Konetzka.
15 I'm a health economist at the University of Chicago.

16 CHAIRMAN WAXMAN: Thank you. Step up,
17 please.

18 MR. GALASSIE: For those of us that
19 have to leave early, is it possible to get a copy of
20 this?

21 MR. LOSASSO: Sure.

22 MS. KONETZKA: Can we just send it to
23 the whole committee?

24 CHAIRMAN WAXMAN: Sure.

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1 Frank has an announcement.

2 MR. URSO: If you want to submit the
3 last page of the ethics training either electronically
4 or by fax, that's permissible. So you don't need to
5 send the original.

6 CHAIRMAN WAXMAN: The other piece of
7 housekeeping, somehow or other in the process of
8 paying for our lunch, Kathleen is \$20 short.

9 So if you got change back, do you want to
10 check and see if you accidentally got more than you
11 should? Or if you accidentally forgot to pay for your
12 lunch, check with Kathleen, if you would. We don't
13 want Kathleen to be short.

14 That being said, we've cleared the whole
15 agenda, except the miscellaneous things. So it's all
16 yours.

17 MR. LOSASSO: All right. Thank you,
18 Mike, and thank you, Members of the Committee.

19 This has been a lot of fun for us and also a
20 lot of work. We've enjoyed it. We've found the
21 question to be a really interesting one, I think,
22 particularly against the backdrop of your conversation
23 just a short while ago, which was very illuminating, I
24 think, for us how you view these issues in the context

1 of a need formula and how we're going to kind of
2 present the issue to you.

3 I think there is actually a fair amount of
4 overlap. You guys obviously have a great deal more
5 detailed know-how on how this industry works because
6 you're in it, many of you, and others have been
7 working with this group for many years.

8 So as I said before, we don't have a dog in
9 this race. I don't in my spare time run a nursing
10 home. Neither do my colleagues, Tamara Konetzka and
11 Coady Wing. I'll also acknowledge we have a graduate
12 research assistant, Joe Benitez, working with us on
13 this project as well.

14 I wanted to first show you the study
15 questions that guided us. These are the Committee's
16 questions as they were provided to us.

17 Can a bed market improve utilization of
18 existing beds? Obviously, we heard a lot of those
19 points echoed just a short while ago.

20 How might a bed market affect long-term care
21 residents and the community, particularly underserved
22 communities?

23 What are the best ways to structure a bed
24 market? We'll be talking about that, offering our

1 insights.

2 Can a bed market infuse capital into
3 long-term care institutions? We'll have some
4 commentary on that.

5 Then lastly, what are the potential
6 unintended consequences?

7 These were, again, the starting points that
8 you provided us. This is what has motivated us. So
9 with that, I'm going to give you just a quick outline
10 of what we're going to do here this morning.

11 First, we're going to give you a short -- we
12 wouldn't be academics if we didn't give you some kind
13 of conceptual framework. I wouldn't be an economist
14 if I didn't draw a supply and demand curve for you
15 guys. So I wouldn't be doing my job, but it is going
16 to be a very important piece of this, of how we
17 conceptualize this issue.

18 Then we're going to -- we're not just going
19 to stay in the esoterica of economic theory. We're
20 going to get down and dirty, as it were, with data,
21 and we're going to tell you what we found and relate
22 that back to this conceptual model that we'll show you
23 in a short while here.

24 So we're going to do a very brief discussion on

1 on scientific literature on the topic. The short
2 answer is there's not a great deal. We're going to
3 talk about Ohio and use Ohio data as an example of a
4 functioning bed market in another state nearby.

5 With this data we're going to create a
6 predictive analytic model of bed buying and selling
7 behavior from Ohio; and in doing so, we're going to
8 bring together 15 years worth of data from multiple
9 data sets. I will show you that here in a bit.

10 Then we're going to apply that model that we
11 build to simulate what could happen in Illinois if bed
12 buying and selling were allowed.

13 Finally, we're going to draw conclusions and
14 recommendations.

15 I also want to invite you to jump in if you
16 find something I say particularly objectionable.
17 We're academics. We can take it. So feel free. We
18 can make this as interactive as you like.

19 The conceptual questions that motivated us
20 here, again, thinking about a framework for this
21 analysis here is how do nursing homes make decisions
22 about how many beds to fill and how many to leave
23 vacant?

24 So right there you're getting a sense kind

1 of where we're coming at this, that there is a choice
2 element on the part of nursing homes. We'll go
3 through some of that thinking here.

4 So we're going to present a highly
5 simplified basic model that tries to help us
6 understand bed occupancy as a concept and how it's
7 affected potentially by Medicaid reimbursement rates,
8 nursing home cost structures, and restrictions on the
9 number of licensed beds for any given facility.

10 So the basic model here is this one. In
11 this case we're only -- we're really simplifying here.
12 Obviously, the market is much more complicated than
13 this. You all know that far better than I do. We're
14 acknowledging that up front.

15 But in this very simple model we just
16 imagine that there is a public payer. Call it
17 Medicaid. In this circumstance the state Medicaid
18 pays a fixed amount, PM in this model here.

19 So for however many patients there are,
20 however many Medicaid patients there are -- we're not
21 even imposing any sort of cap or a licensed bed total
22 or restriction in this yet. Basically no matter how
23 many there are, you'll get PM, the Medicaid
24 reimbursement rate, for however many nursing home

1 patients you have. So it's a very simple model.

2 This MC line, that's what we think of as
3 marginal cost. We typically draw that in an upward
4 kind of direction. You might think that -- and we
5 certainly do acknowledge that usually the full cost
6 function, if you will, in other words, as you add more
7 patients, initially you have some economies of scale.

8 What that means is that the marginal cost
9 would be declining for a period of time. However, at
10 some point the economies of scale run out, and
11 eventually there's what we call "diminishing marginal
12 returns."

13 As you add more labor to a facility to take
14 care of patients, the underlying technology, if you
15 will, of caring for patients is such that there will
16 eventually be an upward-sloping marginal cost. The
17 additional cost of taking care of another patient is
18 incrementally higher.

19 So if we take that here as a given,
20 regardless of the capacity, okay, there will be a
21 tendency in this setting for homes to want to have QM
22 patients in their facility. Okay? Regardless of any
23 other factors, this is where they'd like to be.

24 Why would they like to be here at this point

1 QM? Because if they take care of another patient,
2 given the cost of doing so, they would lose money. If
3 they were taking care of less than QM, they'd like to
4 get more patients into that facility.

5 So that's the tendency. This is sort of a
6 basic kind of -- we think of this as an equilibrium
7 kind of model here, but underlying it is this basic
8 assumption.

9 Now, we can imagine that there is a Q high
10 amount here. This we can think of as the licensed
11 beds for that facility. I drew it up there. I drew
12 it above the QM there.

13 So what we have here is this facility, this
14 hypothetical facility in the simple setting here, has
15 more licensed beds than they currently have patients,
16 QM. Now, they have room to put more patients in; but
17 given their cost structure, given the cost of doing
18 so, given the Medicaid reimbursement rate, they try to
19 avoid that.

20 I mean, again, think back to the
21 conversation that you were just having a short while
22 ago about these -- I forgot the phrase that somebody
23 used -- beds that are out of service or that sort of
24 concept. These are beds that are just taken out of

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1 production, if you will, unused capacity. So that is
2 what we're drawing here. There's unused capacity
3 here.

4 MEMBER CREDILE: Part of the unused
5 capacity -- I don't know if it was very clear today,
6 but with aging facilities in Illinois, there are lots
7 of facilities out there -- somebody said shared
8 bathrooms, but there are also facilities with three-
9 and four-bed wards.

10 The consumer no longer will tolerate a
11 three- or four-bed ward, especially since hospitals
12 are all modernizing. When they construct, they're
13 mandated to do private rooms.

14 MR. LOSASSO: Sure.

15 MEMBER CREDILE: So that's an
16 underlying issue of, A, a need to modernize existing
17 facilities and try to do it, but the consumer won't
18 stand for it anymore.

19 MR. LOSASSO: Sure.

20 PROXY MEMBER SHEETS: Can I follow up
21 with that?

22 CHAIRMAN WAXMAN: Please.

23 PROXY MEMBER SHEETS: I don't
24 understand why the cost per patient would go up as the

1 occupancy goes up.

2 You know, in Medicaid facilities
3 transitionally they try to be 100 percent occupied
4 because their margin is so tight.

5 Can you explain how the cost per unit goes
6 up with the occupancy going up? That's the part I
7 don't understand.

8 MR. WING: Let me try both. My name is
9 Coady Wing.

10 First, I think your point is exactly right.
11 This is obviously a really simple picture here; right?
12 The idea is that a lot of things can determine whether
13 a nursing home will want to expand, have more beds and
14 fill more beds or not.

15 What we're trying to say with the graph here
16 is just that nursing homes are going to look at how
17 much revenue they're going to get by adding a new
18 patient, and they're going to look at how much it's
19 going to cost them to add that next patient.

20 They're going to stop adding new patients or
21 new beds, right, when costs are too high, when costs
22 are higher than the revenue.

23 So revenue could change because of demand
24 conditions; it could change because of the Medicaid

1 program here; and it could change because of the level
2 of the marginal cost curve.

3 The key point is that the decision to fill a
4 bed doesn't just depend on community demand or
5 community characteristics. It depends on the cost
6 structure of the individual nursing home and the
7 revenue and demand prospects that that nursing home
8 faces.

9 MR. LOSASSO: And it doesn't even
10 depend on how many licensed beds they have.

11 MR. WING: That's right.

12 If you give them extra beds but it's
13 unprofitable for them to fill them because of the cost
14 structure and Medicaid reimbursements rates, then they
15 would choose to leave those beds empty; right?

16 They might not always decide to do that.
17 There could be various frictions. They might not be
18 able to aim for that target, but they're going to seek
19 to avoid filling beds where they're losing money on
20 that option. So that's one answer.

21 Do you want to jump in first?

22 MEMBER PHILLIPPE: I'll just tell you I
23 agree. It's because there's three payers.

24 They're taking Medicaid for simplicity, but

1 that's what causes people to believe that. So there
2 are a lot of providers that believe exactly what you
3 say, and there are consultants who tell them that.

4 MR. WING: Yeah. So we've started here
5 with just Medicaid only. The next graph is going to
6 complicate things by having two players.

7 Why does the marginal curve slope upwards?
8 There are, I think, a lot of reasons here. First of
9 all, on some margins, as Tony pointed out, marginal
10 cost curves probably are falling. We're just assuming
11 firms have already expanded past that point because it
12 just makes sense to do so; right?

13 The idea is at some point there's an
14 expansion opportunity that isn't worth it. So if you
15 started by thinking -- the facility can only have so
16 many beds in it. So if you wanted to add a new bed,
17 right, you would need to add a new wing to the
18 building.

19 If you have to do that, the marginal cost of
20 that next patient is very high, right, because the new
21 bed requires actually new capital investment. It's
22 not easy to make; right?

23 But there are other reasons, too. You might
24 be adding more staff, right, or adding a bigger

1 caseload to existing staff. In either case, you might
2 be raising total costs; right? If you add more and
3 more staff, perhaps the managerial burden of managing
4 more staff is growing.

5 So we're just assuming by drawing upward
6 sloping that firms have already reached the point
7 where the cost curve is starting to grow. Now they're
8 at the margin deciding, "Have we crossed the point at
9 which costs are higher than revenues or not?" Once
10 they've crossed, then they think, "We should back off.
11 No need to expand any further."

12 So it's not a function of how many beds are
13 available to them to use. They will only use them if
14 it's worthwhile.

15 MS. KONETZKA: Let me add one point to
16 that. This is Tamara Konetzka.

17 So if you have a facility that really wants
18 to be at 100 percent occupancy and still is trying to
19 fill all those beds, that just means that they
20 probably haven't reached that point.

21 MR. LOSASSO: In fact, I'm going to
22 push the button here because that's this facility
23 here. Okay? Now, this facility has a lower number of
24 licensed beds. This place would actually like to --

1 this place would be at 100 percent occupancy because
2 we're going to just say that Q low here is their
3 hypothetical low level of licensed beds. They will be
4 totally full and would want more.

5 This home in this simple setting would like
6 to have more beds. It would be a potential buyer if
7 there were a market available. The other one that we
8 saw would be a potential seller, but we'll get into
9 that a little bit more as we get into some more of our
10 model slides here.

11 MR. WING: The nursing home that was in
12 this situation, presumably this is the kind of nursing
13 home that under the current policy would show up at
14 the CON Board and ask for more beds or maybe even
15 consider filing an application.

16 Their decision to do that is how difficult
17 and costly is it to make that application? Is that
18 big enough to justify the new revenues I could get by
19 adding the beds?

20 MR. LOSASSO: And it might be right
21 next door to this one or it might be in the same
22 region as this one.

23 So when a need assessment is done, you say,
24 "Well, but there are beds already, you know. So we're

1 going to reject this application because there's beds
2 already." But these might be two different -- and I
3 heard this expressed quite well earlier by Michael.
4 There could be two different facilities.

5 And again, this is a very simple setting;
6 but as Coady said, we're going to add private pay.
7 We're going to complicate it a little bit here.

8 Then the other point is that there is a
9 dynamic nature to this. Maybe at some point --
10 because we're not here to bash anybody. At some point
11 maybe it was spot on with the number of licensed beds
12 a facility had, at some point in the past perhaps, but
13 times change; right?

14 So what can happen is that under very
15 plausible circumstances, costs can increase. So in
16 this case here we have the cost -- and this, of
17 course, is something that you can probably all
18 appreciate, that the cost of providing health care has
19 gone up, not at all implausible.

20 So with that, as I animated it there to show
21 you, the cost of providing care to patients, the whole
22 thing shifted up. That means every patient is more
23 costly to care for. This likely has been happening.
24 It is happening today, and it will happen again

1 tomorrow.

2 So in this case, now you have a situation
3 where this home would like to reduce the number of
4 patients in its facility. So you can get -- was the
5 term "dead beds"? You can get dead beds that are out
6 of production here just out of a setting like this.

7 Then the other thing that can happen --
8 now, this, again, would be very much, I think,
9 appreciated -- is the Medicaid price falling also.

10 That could fall in relative terms, real
11 terms, however you want to think about that, also a
12 very plausible scenario here in Illinois, which I
13 won't say what our ranking is for Medicaid per diem
14 reimbursements nationally, but it's not number one.
15 It's the opposite. So you all know that, though,
16 better than I do.

17 So the key take-away from the model, then,
18 even the simple version of the model is that nursing
19 homes may leave beds vacant if the cost of filling an
20 additional bed exceeds the revenue that you get from
21 filling that bed.

22 And so low occupancy rates, as it says
23 here, don't necessarily indicate low demand for
24 nursing homes. We haven't even introduced demand here

1 in any formal way, but you could imagine that it's out
2 there as well.

3 And cost structures likely vary across
4 individual nursing homes. This point just came up
5 here that some other facilities have particular cost
6 structures and facility arrangements that are costly
7 to maintain, and this might vary.

8 So you could at the same time have nursing
9 homes have too many beds alongside others that have,
10 quote, unquote, "too few" beds.

11 Finally, cost structures, reimbursement
12 rates, and demand can vary over time, but they're the
13 dynamic piece to this. If you were right at one point
14 on nailing the need, it doesn't mean that you're going
15 to be right next year or that that amount will be
16 right in 20 years.

17 So we're just going to take it up a notch
18 and add a little more complexity here. I think it
19 will be worth it because, again, we're going to draw
20 upon this model when we examine the data.

21 So our simple model now is going to add a
22 couple of additional features here. So we're going
23 to add a private-pay market into this arrangement
24 here. So this will give us a few more kind of

1 stylized examples of types of scenarios that might
2 describe different types of facilities at any point in
3 time.

4 Our same underlying model is still here
5 where we have a Medicaid payer. They're still paying
6 PM. We still have this cost structure which I've
7 shown here. It's exactly the same as this increasing
8 incremental cost, but now we have what we typically
9 see as a downward sloping demand curve from private
10 payers.

11 So we can suppose that there will be some
12 private payer rate, P_p there, and that it's going to
13 be higher than the Medicaid reimbursement rate.

14 Now, in this setting -- and this is actually
15 quite an older model of the nursing home market that
16 was actually developed back in the '80s.

17 MR. GALASSIE: Can I ask a question?

18 MR. LOSASSO: Yes, please.

19 MR. GALASSIE: If I understand this
20 correctly, where PM intersects with MC and QT --

21 MR. LOSASSO: Yes.

22 MR. GALASSIE: -- then it's a fully
23 Medicaid occupied facility?

24 MR. LOSASSO: No.

1 What you get here in this setting here,
2 absent any sort of -- we haven't introduced any
3 licensed bed numbers or caps or anything of that sort.
4 In this case, what this home is going to do is it's
5 going to first take private-pay patients, all right,
6 who will pay this Pp amount.

7 Then, however, at some point it will find it
8 more profitable in a sort of revenue minus cost sense,
9 more profitable to take Medicaid. So this facility
10 actually has QP -- or from 0 to QP, those are private
11 patients, and from QP out to QT are Medicaid patients
12 in this situation. So this is a mixed home.

13 MR. WING: What is true about the way
14 the graph is drawn here is that the marginal patient,
15 the next patient that this nursing home would fill a
16 bed with, is going to be a Medicaid patient.

17 This nursing home has exhausted the number
18 of private-pay consumers that it can get its hands on.
19 Now if it wants to add --

20 MR. GALASSIE: Because of the market?

21 MR. WING: There's no takers at this
22 price. It two have to cut its price, but it doesn't
23 want to cut its price because it could do better just
24 by getting another Medicaid patient.

1 MR. GALASSIE: Right.

2 MR. LOSASSO: Again, I've drawn it this
3 way here. I'm going to change it up here a little bit
4 as well. That assumes this particular cost curve or
5 cost structure that we have, and we will change that
6 again.

7 First I want to introduce again, as before,
8 these different cap levels. Again, the same story
9 here applies. We've got a high here, a high cap.
10 This is a situation where there's excess or there's
11 unused occupancy.

12 Again, it's just because of the fact that
13 the next patient that they would take they would lose
14 money on. They tend to lose money on them.

15 So there would be a tendency -- again, I
16 know that these decisions -- we're simplifying here.
17 I know these decisions aren't made quite at this
18 granular level. We're talking about, as Coady said,
19 the tendency to try to hit QT and avoid taking on
20 money-losing patients.

21 Then we could have another -- let's say a
22 low where it's going to be Q mid. This is a situation
23 where if this was the cap, it's going to be fully
24 occupied; but the next patient it would like to take

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1 it could profit from, first of all. Second, it would
2 likely be a Medicaid patient because that would be a
3 higher reimbursement level.

4 Now, you're all thinking, "Well, we only
5 want the private payers," but there is a scenario
6 where homes can prefer a Medicaid patient to a private
7 payer.

8 If we have a very low cap here, Q low, this
9 home, if it was down here, it again would be at full
10 capacity, but it would likely take private-pay
11 patients next given this setup. So it would fill the
12 next bed.

13 MEMBER PHILLIPPE: Did you say that
14 there would be a situation where people would want to
15 take Medicaid and turn down private pay?

16 MS. KONETZKA: I was going to add
17 something.

18 MEMBER PHILLIPPE: I don't believe
19 that.

20 MS. KONETZKA: The general idea is that
21 because private-pay patients -- you have to compete
22 for private-pay patients; right? It's a
23 downward-sloping demand curve, so you have to compete
24 on the basis of price.

1 At some point you've gotten so many
2 private-pay patients or as many as you can get at a
3 good price, and you would have to lower the price so
4 much to get more private-pay that the Medicaid rate is
5 actually more profitable. That's the idea.

6 MR. WING: Right. Your intuition that
7 everybody would always prefer the private-pay, that's
8 probably true.

9 It's just that at prevailing rates, you
10 couldn't get any more private-pay patients; but for a
11 nursing home, not this one but for the previous
12 version, the next patient -- you couldn't get another
13 private-pay patient at the prevailing price.

14 But for you, taking on a Medicaid patient
15 would not be a money-losing proposition. So if you
16 gave that nursing home some more beds, they would fill
17 them with some Medicaid patients and they would
18 consider it a win. It would be profitable.

19 This doesn't mean lots of nursing homes are
20 in this scenario, just that you can draw on versions
21 where nursing homes can be --

22 MEMBER CASPER: What you're saying in
23 that situation is filling a bed with a Medicaid person
24 is better than nothing?

1 MEMBER PHILLIPPE: It's better than
2 nothing.

3 MR. WING: The reason to do this more
4 complicated model is to understand those kinds of
5 questions; right?

6 If you want to know if we allowed more
7 trading or if you changed the supply of beds, would
8 most of the benefits or costs of that decision affect
9 poor people, Medicaid patients, or would they affect
10 rich people, then you need something a little bit more
11 complicated. You need the graph to distinguish
12 between those two groups. That's what we're trying to
13 do here.

14 MR. GALASSIE: Can that facility make
15 money?

16 MEMBER PHILLIPPE: Which one?

17 MR. GALASSIE: All Medicaid.

18 MR. WING: Yeah. It's making money the
19 way we drew it here, or at least at the margin it's
20 breaking even.

21 MR. LOSASSO: This one here, it would
22 want more beds. It would happily fill them with
23 Medicaid patients profitably.

24 Again, we're just trying to conceptualize

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1 here. Are there settings where that's possible?

2 MEMBER PHILLIPPE: Yes.

3 MR. LOSASSO: I think the answer is we
4 can.

5 PROXY MEMBER SHEETS: Can I interrupt?
6 I just want to address that comment you made.

7 That facility could make money; but because
8 the cost of decent health care is above the Medicaid
9 rate in a nursing home, the health care provided is
10 going to have to drop down to afford that cost.

11 So it's not going to be a place you'd want
12 to send your mom.

13 MR. WING: You need another graph to
14 get that point across.

15 MR. LOSASSO: This one here.

16 So that's your rising cost curve here. For
17 most of the patients here, if the cost curve is like
18 this -- and again, this is going to be the situation
19 where you nailed it at some point in time in the past
20 but costs escalated. There's no provision for
21 changing the amount of beds allocated to a facility.

22 This now displays a cost curve that for
23 almost all patients is above the Medicaid
24 reimbursement rate, although there is a bit over

1 there. It would like to fill those with private-pay
2 patients.

3 So this might -- and again, I also joke that
4 if I dropped the Medicaid reimbursement as I did in
5 the previous graph, that would just accentuate the
6 same point where that type of home would really not
7 want any Medicaid patients.

8 So these are all possible scenarios. Again,
9 we do this to tell us something about what we should
10 be looking for and understanding what we find when we
11 do look at the data.

12 So just a few take-aways from this slightly
13 more complex but still very simplistic model is that
14 any change in costs, in demand, or reimbursement rates
15 can result in nursing homes having too many or too few
16 beds.

17 These changes don't affect every home the
18 same way. So you can, again, have situations where
19 neighboring nursing homes simultaneously one has too
20 many, one has too few.

21 So the bottom line is that changes in
22 market conditions can -- the other point is changes in
23 market conditions can affect private-pay and Medicaid
24 patients in different ways. We do acknowledge that

1 there is a Medicare market as well, and it could be
2 added but with more lines and more time.

3 MEMBER PHILLIPPE: Let me ask you so
4 I'm clear. I think I basically understand it, but
5 with your model you're talking about adding beds would
6 be profitable, that people would choose to add new
7 Medicaid.

8 I find it hard to actually believe that
9 looking at new construction. I could see if you
10 already had the building, but I don't know anybody who
11 can afford new construction to add additional Medicaid
12 patients.

13 MR. WING: So what might be the case is
14 that some of those scenarios that we're drawing are
15 like conceptually possible but like never happen in
16 the real world right now. The key point is that even
17 that situation is dependent upon prevailing
18 conditions.

19 MEMBER PHILLIPPE: Yes, right.

20 MR. WING: If you change the Medicare
21 reimbursement rate, you might induce a whole bunch of
22 homes to be in that situation and want to expand.

23 CHAIRMAN WAXMAN: Are you assuming that
24 the cost of caring for a private-pay patient is the

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1 same as the cost for caring for a Medicaid patient?

2 MR. LOSASSO: We are in this model.

3 You could allow for differences across that.

4 MR. WING: If you wanted to see it
5 separately, you just have either a bent marginal cost
6 curve or two marginal cost curves.

7 MR. LOSASSO: You have two marginal
8 costs, basically private pay.

9 MR. WING: It would work the same way
10 but look really ugly.

11 CHAIRMAN WAXMAN: Tim?

12 MR. FOLEY: Yes. A facility I think
13 could in fact be new construction and an all Medicaid
14 facility, but he is not going to be able to build a
15 marketable facility.

16 One factor would be the construction costs
17 would be less -- considerably less in order to make
18 the numbers work. It would be all two-beds. There
19 would be no private room luxuries or anything like
20 that, and it's going to be very, very tight.

21 But can it be done? It is awfully marginal.
22 It would be tough. Our Board has in fact approved
23 such a project probably about a year ago -- I think it
24 was in Pontiac -- and it was an all-Medicaid facility.

1 At least that's what their projection was.

2 I might question that as to whether or not
3 they could do it.

4 MEMBER PHILLIPPE: All I would say is
5 having an all-Medicaid certified facility is what
6 you're talking about.

7 What they're talking about the census you're
8 adding on is all Medicaid. Saying you're going to
9 certify all Medicaid is one thing, but actually
10 growing through Medicaid is what their model shows,
11 and that's more accurate.

12 MR. LOSASSO: Fair enough. I think
13 we're in agreement.

14 MR. WING: Most of what we're doing
15 here I think are pretty consistent with nursing homes
16 that would have a mix of patient types. There are
17 scenarios where you could be one-sided, absolutely.

18 MR. LOSASSO: Why don't we push a
19 little bit on here. So we just wanted to make a few
20 more summary points.

21 MR. AGBODO: All these models show
22 perfect markets where providers, they're making
23 rational decisions.

24 What if we see how they react to

1 competition? For example, I'm not saying that, but
2 that can happen, you know. The competition, people
3 hold their licensed beds just to limit competition.
4 So how that will affect --

5 MR. LOSASSO: That's a great point that
6 we're going to come back to. That's one of our --
7 you've segued very nicely into what will be one of our
8 potential unintended consequences. It's a great
9 point.

10 So again, just some kind of take-aways from
11 the model. We do have a lot more slides. So the
12 simple take-away, cost structures and demand change
13 over time. There's always going to be a need for
14 changes in bed allocations.

15 To maintain this hypothetical allocation of
16 good allocation of beds, the Board is in the very
17 unenviable spot of having to anticipate and respond to
18 all of these changes at least at some level; whereas,
19 a market mechanism basically, you know, provides an
20 automatic kind of correction in terms of adapting to
21 these market changes, and likely that's a very
22 important point.

23 I think it sort of picks up on some of the
24 threads that were being discussed earlier, and it

1 probably is not necessarily a surprise to you if I say
2 that.

3 So I could draw a little bit from the
4 literature on CON regulation in general. There's not
5 a great deal. Well, there's a fair number of studies
6 out there. Here's a summary of a few of them.

7 So it's been demonstrated that CON
8 regulation can prevent entry of competitors, which
9 entry of competitors can exert downward pressure on
10 prices. That's the competition margin that we're
11 talking about.

12 There was an FTC/DOJ report a few years ago
13 that said that anything limiting competition tends to
14 increase prices in markets. This would be really more
15 in a private-pay market setting.

16 Then in another study where CON restrictions
17 were removed, these authors saw no evidence of a surge
18 in acquisitions of facilities or in costs following
19 the removal of CON. As you know, many states have
20 removed their CON regulations.

21 Lastly, then, a bed need formula, as you
22 guys have said here, has no conception of the cost of
23 delivering care and is also likely not the best
24 indicator of the demand for care.

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1 MR. GALASSIE: A bed need formula that
2 would define beds and -- what's the term, unused beds?

3 CHAIRMAN WAXMAN: Dead beds.

4 MR. GALASSIE: That to me would seem to
5 communicate better the reality of the market.

6 MR. LOSASSO: It would be better.

7 MR. GALASSIE: I'm asking that question
8 myself even to Mike.

9 At this point in time, when the Board sees
10 an application and we get statistics from Staff about
11 the available beds in that area, under or over, would
12 it be possible to see the number of those over beds
13 that have been designated by the owners as unused
14 beds?

15 MR. CONSTANTINO: They don't provide us
16 with that data. That's something we've been wanting
17 to get at since the existence of this Committee.

18 MR. LOSASSO: But you also wouldn't
19 necessarily be able to distinguish whether it's cost
20 that is driving it or demand that's driving it in a
21 particular market as well.

22 MR. WING: There's this key idea here
23 that at least -- and again, there are other ways
24 probably to think about this, but if you think back to

1 the very first -- the simplest graph that we showed
2 you, that graph is trying to say what is the ideal
3 number of beds for a given facility? That was that
4 QT. That's how many beds it should have.

5 So if you had the perfect bed need formula,
6 it would tell you that for that facility it's QT.

7 MR. GALASSIE: To be honest with you,
8 that's a world that's not my reality.

9 MR. LOSASSO: We're not arguing that.

10 MR. WING: I'm saying that's what you
11 would want from a bed need formula, and I'm saying --
12 hang on one second.

13 MR. GALASSIE: Sure.

14 MR. WING: I'm saying I don't think
15 there is such a formula that exists at a county or
16 planning area level because inside that same county,
17 right, the global number of beds, which is what the
18 bed need formula is going to tell you, would tell you
19 nothing about whether individual facilities have too
20 many or too few beds.

21 So there's problems with the whole idea of a
22 bed need formula when applied at the level of a
23 geographical area rather than at the level of a single
24 nursing home or nursing home project.

1 MR. GALASSIE: Yes.

2 MR. WING: It's not that you've done it
3 wrong. It's that it can't be accomplished as in the
4 past.

5 MS. KONETZKA: So even if we had the
6 perfect formula for demand within a geographic area,
7 we'd still have some facilities that didn't use some
8 beds and have some overflowing capacity.

9 MR. LOSASSO: There could be different
10 demand for attributes of the facility. There could be
11 different cost structures also in those facilities.

12 MR. FLORINA: Your heading indicates
13 the hospital industry.

14 Is the data or information the same for
15 long-term care?

16 MR. LOSASSO: We're going to draw on
17 data from the long-term care industry. This is
18 information that we're bringing from sort of the
19 parallel sector, hospital sector, and we think there
20 is some at least conceptual overlap in hospital CON
21 regulation and long-term care.

22 So then sort of a take-away here about the
23 role of CON, this just restates, I think, what Coady
24 just said. So I don't need to beat this too hard; but

1 as we say here, evidence from other states and sectors
2 and from our theoretical framework suggests that
3 long-term care markets would function better with
4 relaxed CON constraints; so again, talking about the
5 more flexible dynamic adjustments that the market is
6 capable of.

7 This, though, is all sort of the backdrop
8 about the question that we were asked, which was:
9 What if we allow a market for nursing home beds?

10 So I'm going to pose this slightly
11 differently. Is a market for existing bed licenses a
12 second best?

13 MR. WING: That's a good thing. It
14 gets you almost there.

15 MR. LOSASSO: Yes. How much does it
16 get you there to, again, a more optimal distribution
17 of beds where bed demand and bed supply is better
18 balanced?

19 So again, this only makes sense in a setting
20 where there are CON regulations in place, and there is
21 no literature, at least academic literature, to draw
22 upon. So really, this is going to come down to how
23 the bed market is structured and what we can learn
24 from other situations.

1 So we're going to draw upon experience from
2 Ohio in particular to give you the timeline. Many of
3 you know this already, but in Ohio a bed market was
4 established back in 1991. It was restricted to trade
5 within counties in Ohio. A couple years later there
6 was a moratorium placed on construction of new
7 long-term care beds in Ohio.

8 Then much later, more recently in 2009, the
9 bed market was amended so that beds could flow across
10 county borders within the state.

11 MR. GALASSIE: How long was the
12 moratorium on?

13 MR. LOSASSO: It's still on.

14 MR. GALASSIE: So there's no new bed
15 construction since '93?

16 MR. LOSASSO: If you were going to
17 construct them, you would have to buy beds, and we
18 certainly saw that. That did take place in Ohio.

19 MEMBER CASPER: If you bought beds,
20 there could be construction of new beds with the
21 licenses you purchased?

22 MR. LOSASSO: Yes, and there was.

23 MEMBER CASPER: It's not a total
24 moratorium on construction. It's the construction of

1 new licensed beds.

2 MR. LOSASSO: That's true. I
3 appreciate that clarification, yes.

4 MR. FLORINA: It was a net zero sum.

5 MR. LOSASSO: It was a net zero sum.

6 There was a fixed supply back in '93. That's the Ohio
7 setting.

8 I'll tell you a little bit about what
9 happened in Ohio, first high level. There were, over
10 this time period that we had data, which our data goes
11 through 2012, I believe, 536 bed transactions
12 involving about 14,000 beds and about \$250 million
13 changing hands since the inception.

14 Since the moratorium, the average bed price
15 was about \$17,000. Over the whole time period, there
16 were -- I'm going to show you that it breaks down into
17 two different periods here. So between the moratorium
18 and the change in the bed market, the price was about
19 \$20,000 per bed. After that it was closer to \$10,000
20 per bed.

21 You'll see the pattern here in this figure.
22 So this figure shows two axes. The bars here are
23 transactions, number of transactions. The red line is
24 the price of the bed.

1 So what you see is that after the moratorium
2 is imposed, which happened in '93, you see that bed
3 prices increased. They were increasing, but they
4 spiked, as did transactions here.

5 So now there's a fixed supply of beds. The
6 way we think about this is now homes can no longer go
7 to the CON Board in Ohio and petition for new bed
8 licenses. So now they begin to trade more actively.
9 It started off pretty inactive. The price then is
10 high as opposed to \$25,000 initially. It tends to go
11 down. There are transactions occurring in this
12 intervening period.

13 Then we see that after the statewide --
14 after the market was loosened to allow statewide
15 trading cross-county, what you got then was a large
16 spike in sales in 2010 and a reduction in the price of
17 beds.

18 Why would that happen? Again, it's supply
19 and demand. We've got a lot more beds available. If
20 you're just restricted to the beds -- if you're just
21 restricted to buying the beds in your county, they
22 could come at a high premium.

23 If now you can buy excess beds in
24 neighboring counties, that is represented by a large

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1 increase in the supply of beds available. When that
2 happens, we see the price tends to go down. That's
3 exactly what happened.

4 The largest spike here is this transaction
5 spike happening in 2010 as people reallocated, now
6 taking advantage of the cross-county.

7 That means something important, though. I
8 mean, that tells us something --

9 MR. GALASSIE: I'm sorry. That was
10 good news to owners because I could sell easier but
11 bad news because the prices fell in half; right?

12 MR. WING: Those are both good news,
13 I'd say.

14 MR. GALASSIE: Why was the price going
15 to half to an owner?

16 MR. LOSASSO: To an owner.

17 MR. WING: The buyers are also owners.

18 MR. LOSASSO: The buyers are owners.
19 There's more transactions and certainly more volume of
20 sales here. If we tallied up the amount of money,
21 then we would certainly see greater sales volume.

22 MEMBER PHILLIPPE: The point is well
23 taken.

24 If you're an owner who is primarily

1 interested in selling and leverage, like Charles often
2 talks about ways of raising money to fix up your own
3 buildings, then you want to keep it within a small
4 area because it drives up the price they have to pay
5 you.

6 MR. LOSASSO: Yes, that's right. But
7 if you can sell statewide, that opens up a whole new
8 world of potential buyers.

9 MEMBER PHILLIPPE: That's true, too.

10 MR. LOSASSO: What this tells us is at
11 least in Ohio, the relative number of -- basically the
12 relative increase in the demand and the relative
13 increase in the supply that happened was such that
14 there was more supply than there was demand.

15 So that's what resulted in the price
16 decreasing. It didn't have to decrease, and certainly
17 in a different setting it could have gone another way.

18 MR. GALASSIE: Do we think the result
19 of this in Ohio from a public health perspective was
20 getting more beds to where the need was?

21 MR. LOSASSO: That's a great question.
22 In fact, we have multiple slides to get at that. It's
23 like I'm paying you to prompt me with these excellent
24 questions.

1 So just a few salient facts about what
2 happened in Ohio. You kind of saw this visually.
3 Obviously, there was this large 115 percent spike in
4 2010. It actually did start towards the end of 2009,
5 but the bulk of the activity was in 2010, and then the
6 50 percent drop in the average price.

7 Again, some of these are -- a number of
8 these, particularly after the 2009 change, were within
9 ownership, the common owner -- what do they call
10 them? -- intracorporation relocations, transfers that
11 took place. You own a facility. I think Judy owns
12 lots of facilities; right? They probably cross county
13 lines.

14 So those were generally accomplished with a
15 \$1 nominal price associated with them. Whether we
16 take out those transactions or not, we see the same
17 pattern that I showed you.

18 MEMBER PHILLIPPE: That's worth noting.

19 MR. LOSASSO: Yes.

20 MEMBER PHILLIPPE: There is an
21 advantage in this model to a large chain. We have
22 large chains that own 80 buildings, you know, 50
23 buildings. There is a large advantage because they're
24 not really buying and selling. They are transferring

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1 beds to a larger market --

2 MR. LOSASSO: That's right.

3 MEMBER PHILLIPPE: -- within their own
4 company.

5 MR. WING: Why is that an advantage?

6 They will do that almost certainly, but why
7 is that an advantage over a smaller -- as long as they
8 had the right to go and get a bed from somebody else
9 if they wanted to?

10 MEMBER PHILLIPPE: Good point.

11 MR. WING: Remember that the big chain
12 could sell its beds to somebody else if it wanted to,
13 and it probably would if they thought it was worth it.

14 MEMBER PHILLIPPE: First, you have the
15 competitive issues. So you're bringing in a new
16 competitor. Then you have the financial issue.

17 I just looked at a proposal on a new campus
18 in Ohio. It's \$20,000 a bed. It would come with an
19 option to buy. It's complicated.

20 MR. WING: You're overpaying.

21 MEMBER PHILLIPPE: Well, it depends on
22 the market. In some markets it's 20. In some markets
23 it may be 6. It depends on what part of the state
24 you're in and the --

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1 MR. WING: That's right.

2 THE REPORTER: Excuse me. You have to
3 speak one at a time.

4 MEMBER PHILLIPPE: So it does add
5 cost to the project. As we were saying earlier, you
6 cannot afford to build -- some people would argue you
7 cannot afford to build a new wing just for Medicaid
8 only.

9 Then if I add another \$1 million or
10 \$2 million onto that wing by buying the bed, it makes
11 it that much more expensive; right?

12 MR. LOSASSO: Yes.

13 MEMBER PHILLIPPE: So it's an advantage
14 internally because you're just reallocating your
15 resources in the company in a very efficient way.

16 MR. GALASSIE: Well, from a public
17 policy perspective, how do we know we're not losing
18 75 percent in Medicaid beds?

19 MR. LOSASSO: Again, you ask wonderful
20 questions that we will have answers for. A perfect
21 question. I do want to get to them, noting that we're
22 competing against our growling stomachs.

23 I'm not putting you off there.

24 CHAIRMAN WAXMAN: I have a question.

1 MR. LOSASSO: Yes, sir.

2 CHAIRMAN WAXMAN: In Ohio is there any
3 stipulation of what the seller can do or must do with
4 the proceeds from the sale of a bed?

5 MR. LOSASSO: My understanding is no,
6 there is not any binding stipulation as to what they
7 do.

8 CHAIRMAN WAXMAN: We've had discussions
9 that a seller of beds should have to reinvest that
10 money into his home or liquidate a loan rather than
11 just, you know --

12 MR. LOSASSO: We're going to take a
13 crack at looking at that for some outcomes. We can't
14 get at everything we want to, but we can look to see
15 if there's evidence post sale of a changing service
16 provision at the home in Ohio. It's a great question.

17 For the county-level analysis, you saw --
18 I'm going to turn this over to Coady here in a second,
19 but this is really just focusing on the very large
20 reallocation that took place beginning in 2010 versus
21 the previous within-county trading regime, if you
22 will.

23 Why don't I give it to you? You can take
24 it.

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1 MR. WING: Okay.

2 MR. LOSASSO: I'll give you like five
3 minutes. I'll tap you on the shoulder or kick you.

4 MR. WING: I guess lots of the
5 interesting questions that we wanted to look at are
6 really properly thought of as things happen at the
7 nursing home level. So we're going to talk about that
8 in a minute.

9 Some of the policy questions really have to
10 do with what's going to happen if you suddenly allow
11 this kind of trading to occur; right?

12 Are we going to suddenly have like a mass
13 outflow of beds from poor counties into rich counties?

14 Are they going to all flow from, you know,
15 counties that have a lot of beds right now to counties
16 that have not very many beds right now?

17 What are the gross flows going to look like?

18 So to think about this, we're going to focus
19 on that first, you know, big spike that occurred when
20 statewide trading was allowed in Ohio. The basic idea
21 is that prior to allowing statewide trading, the beds
22 were misallocated, right? It was the case that some
23 nursing homes had too many beds, and some nursing
24 homes had too few beds.

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1 Then when you allow them to trade, a big
2 spike, a sudden flurry of trading is exactly what
3 you'd expect; right? And then it should taper off
4 because they get to a pretty good allocation, and from
5 that point forward it's just marginal trades from year
6 to year. They do little deals here and there.

7 You'd expect to see this big flood of
8 changes, and that's probably the case whenever you
9 suddenly allow trading. Okay?

10 So to think about what the gross flows look
11 like, we're going to take that 2010 period, and we're
12 going to take each county and count up the number of
13 beds that were purchased by nursing homes in that
14 county and the number of beds that were sold by
15 nursing homes in that county. Then we'll calculate
16 net change in beds. All right?

17 So we define a county as a net importer if
18 they bought more beds than they sold at the county
19 level. So again, the decisions get made by individual
20 nursing homes. We add them all up in the geographical
21 scenario. So you're a net importer if you bought more
22 than you sold. You're a net exporter if you sold more
23 than you bought. Okay?

24 This is very descriptive. We're just going

1 to ask simple questions. If we block the counties out
2 by different characteristics, richer counties versus
3 poorer counties, bigger counties versus smaller
4 counties, what percentage of counties in those
5 different groupings were net importers or net
6 exporters?

7 Now, just keep in mind that when we block
8 things like this, the very idea that we're thinking in
9 terms of percentages means that even within a
10 category, some counties will be net importers and some
11 counties will be net exporters. There's always
12 heterogeneity, but we're looking for common trends
13 because one obvious worry is that there will be this
14 sort of ugly-to-look-at flow from rich to poor or
15 something like that. Okay?

16 So what happens when beds are traded across
17 county lines? Do beds systemically move into high,
18 medium, or low poverty counties?

19 Do they flow to counties that already have a
20 lot of beds or the reverse?

21 Do beds flow to counties with larger elderly
22 populations?

23 These are not meant to be the only way to
24 think about it. They're just ways of grouping

1 counties in ways that might appear obvious and might
2 be unseemly if they were too systematic.

3 Notice, too, that the sort of conceptual
4 framework we started with early says it probably
5 shouldn't be that systematic. A lot of this depends
6 on individual nursing home cost structures. They
7 might be located all over the place, and so the flows
8 might not be correlated with these things at the
9 county level even though they might well be at the
10 nursing home level.

11 Okay. This first one is just saying if I
12 take the counties and I block them into, you know,
13 lowest poverty -- these are quintiles of poverty
14 rates, okay, in the counties. I know the poverty rate
15 in the county in 2010. I take all the counties in
16 Ohio. I just sort them into categories, okay, into
17 equal bins, the sort of 20 percent lowest poverty, the
18 20 percent highest poverty, and each quintile is in
19 between there.

20 Then I calculate what fraction of counties
21 in each of those bins were net importers and net
22 exporters. Okay?

23 So what we'd be worried about is that high
24 poverty counties were net exporters in droves, and low

1 poverty counties, rich counties, were net importers in
2 droves. What you see instead is that there is a fair
3 amount of heterogeneity.

4 The richest counties, the lowest poverty
5 counties, they have high rates of both importing and
6 exporting. So even in rich counties, there are a lot
7 of nursing homes that wanted to expand and there are a
8 bunch more that had too many beds.

9 When you move over to the other end, you
10 find a similar story; right? There's a mix of net
11 importing and net exporting counties even among the
12 high poverty areas. Okay?

13 MR. GALASSIE: Tell me what the axis on
14 the left is.

15 MR. WING: The vertical axis?

16 MR. GALASSIE: Yes.

17 MR. WING: That's the percentage of
18 counties that are either net importers or net
19 exporters. The blue line is showing you that, for
20 example, the lowest poverty counties are the -- 18
21 percent of lowest poverty counties were net importers.
22 So that line is the net importing.

23 MR. WILL: I apologize for walking
24 right in and asking questions. Greg Will, SEIU

1 Heal thcare, Indi ana.

2 The fraction of counties, are the counties
3 wei ghted by anything?

4 MR. WING: No. We are counting them
5 all equally.

6 MR. WILL: Thank you.

7 MR. WING: In Ohio. It's not
8 nationwide or anything like that, just Ohio in 2010.

9 MR. WILL: Got you.

10 MR. WING: The key take-away from this
11 graph, there isn't an obvious outflow from poor to
12 rich counties. There's a lot of two-way flows, and
13 that's true across the poverty distribution.

14 A similar situation, if I chop up the
15 counties into counties that have relatively few beds
16 in 2010 versus lots and lots of beds, it is
17 interesting here that -- you know, one intuitive story
18 would be that counties that don't have very many beds
19 would be really constrained and would want more beds.

20 What you see is that lots of those counties
21 that had only 250 beds or less -- so they're
22 relatively small. They're in the bottom tail of the
23 distribution -- they sold a bunch of beds. So even
24 though they're quite small, they're actually too big,

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1 okay, or there were nursing homes there that felt that
2 they were too big and they had too many beds. Okay?

3 A key point, too, is that it doesn't just
4 trend in any totally systematic way. There are
5 two-way flows in all of these counties.

6 MR. GALASSIE: If I may, I think I'm
7 understanding this. My limited awareness of Ohio,
8 Ohio doesn't have a Cook County.

9 MR. WING: A giant, huge county?

10 MR. GALASSIE: Right.

11 With the demographics of collar counties in
12 Illinois and in central and rural Illinois, it would
13 be very interesting

14 MR. WING: To think about what could
15 happen. That is a fair point; right?

16 Remember, the reason why there's this sudden
17 change that we're studying right now in 2010, okay, in
18 theory is that not allowing between-county trades for
19 like 10 or 15 years in a row meant that there was
20 probably a big stockpile of beds in wrong places.
21 Okay?

22 MR. GALASSIE: True.

23 MR. WING: God knows exactly where they
24 were in Ohio.

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1 This data is trying to say after 2010,
2 there's going to be a big flurry of activity as it
3 tries to resolve those problems. So beds should flow
4 from where they shouldn't be to where they should be
5 in terms of what nursing homes would like to expand
6 and could do so without losing their shirt kind of
7 story. Okay?

8 Whether those are going to be systematically
9 located in humongous counties or tiny counties I have
10 no idea, and the same, I think, is true in Illinois.
11 We don't know.

12 Your intuition maybe says, "Rich counties
13 should have more or less," but you really can't tell.
14 I think it has to happen at individual nursing home
15 levels.

16 So the point of this graph is that it's not
17 so obvious at a geographical level. I think it's much
18 clearer, much more predictable at nursing home levels.
19 We're going to see that, I think.

20 MR. GALASSIE: Ohio had some very
21 excellent public policy thought process or they got
22 lucky. I would be very remiss to see Illinois open it
23 up statewide initially.

24 MR. WING: When you don't do it

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1 statewide --

2 MR. LOSASSO: We're going to come back
3 to that.

4 MR. WING: Yeah, we are going to come
5 back to that.

6 When you don't do it statewide, the key
7 thing is that you don't allow some of those
8 advantageous flexibility issues to prevail. You have
9 to think about what you think you're gaining by not
10 allowing statewide, and there may be benefits; right?

11 MEMBER PHILLIPPE: Just a point. I
12 don't think they're statewide. At least I knew when I
13 was working there last, they are contiguous county.
14 That's exactly what the attorneys told me.

15 They did open it up so it's contiguous
16 county, which does have some dynamics because you have
17 the big city, you've got the suburbs around the city,
18 and you've got the rural areas out in the middle.

19 MR. WING: We should double check.

20 MEMBER PHILLIPPE: That's what
21 everybody has told me.

22 MR. WING: If it were contiguous
23 counties, that would just mean you'd have to take
24 three years to move the bed all the way across the

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1 state.

2 MEMBER PHILLIPPE: By the way, they
3 still control the process, though. You get an option
4 on the beds with approval of the Board. So they're
5 not letting you just buy beds and stockpile them and
6 gradually move them across the state. They have a
7 policy issue.

8 MR. WING: That constrains things?

9 MEMBER PHILLIPPE: I think so.

10 CHAIRMAN WAXMAN: Did you have a
11 question?

12 MEMBER JOHNSON: I probably missed
13 something because this is way out of my league.

14 In the poorer areas, did you see an increase
15 in the Medicaid beds? And if so, did you see a lot of
16 mixed populations, mixing MIs or under 60 with
17 geriatric care?

18 MR. WING: The slide coming up after
19 this is going to speak not exactly to your question
20 but more clearly as to what kind of nursing homes were
21 make the buying and selling decisions.

22 Here, this is just gross county flows.
23 Okay? In the end, this is really not the right way to
24 do it. You should think about it at the nursing home

1 level, but this is important because it would be
2 undesirable at a macro level to just have weird
3 unsystematic flows.

4 That's pretty much my -- all right. I sort
5 of skipped this. This last one is my top counties by
6 the size of the elderly population, okay, and just
7 what do the flows look like there. Okay?

8 Here you saw the most activity in counties
9 that were around the 10,000 mark. Okay? But you,
10 again, don't see some kind of systematic flow from one
11 type of county to the other, but the most active
12 trading, right, the highest prevalence of both net
13 importing counties and exporting counties were in this
14 particular size. That kind of thing is probably a
15 feature of Ohio. I'm not sure that that tells you
16 much about Illinois.

17 So that was the county level work.

18 MR. LOSASSO: So just a few take-aways
19 from that, again, supply of beds are fixed. Coady
20 pretty much said this in answer to some of the
21 questions that came up.

22 Bed exchange is happening because of likely
23 changes in demands, in cost; and again, if the bed
24 need was being met, we wouldn't see any trading.

1 It suggests that bed need is not necessarily being
2 met.

3 Now we're going to move into, apparently,
4 lunch and the nursing home level analysis. So we're
5 going to talk about the factors that determine whether
6 a nursing home buys or sells a bed. We're going to
7 first reconcile the results we see with our theory.
8 Do the results we find make sense? Then we're going
9 to take that from Ohio to Illinois.

10 So to do this, like I said, we're going to
11 build a predictive analytic model at the nursing home
12 level.

13 CHAIRMAN WAXMAN: I have a question, a
14 housekeeping question.

15 You can either suggest that we stop your
16 presentation and eat or you can allow people to eat
17 while you're doing your presentation. It's your
18 choice.

19 MR. LOSASSO: I don't want to get in
20 between people and their food. It can be a dangerous
21 proposition.

22 So if you'd like some accompaniment -- some
23 vocal accompaniment here and don't mind asking
24 questions with your mouth full, I don't mind being the

1 recipient. I'm willing to continue and encourage you
2 guys to eat. We won't eat. We'll wait. That would
3 get messy.

4 So I can't think of anything better to talk
5 about than a predictive model while eating lunch.
6 We're going to use Ohio's experience, like I said, to
7 construct a predictive model of bed buying and selling
8 behavior.

9 We're going to then model to Illinois
10 nursing homes, taking care to adjust for the key ways
11 in which Illinois nursing homes and populations differ
12 from Ohio's. We're not grafting Ohio on top of
13 Illinois. We will take care to adjust for the
14 differences between both the homes and the populations
15 of the two states.

16 Then what our model is going to provide us
17 with is basically a probability that a specific
18 facility -- and indeed we'll group them into specific
19 facility types -- whether they want to buy or sell
20 beds on average and how many annually.

21 So we're going to bring together multiple
22 data sources, as you can see, more than 15 years of
23 OSCAR data.

24 We also have the Ohio transaction data, as

1 Claire was very helpful in obtaining for us -- we
2 appreciate that -- and then Area Resource File. It's
3 a resource out there that tells us about county-level
4 characteristics. So that's going to allow us to
5 characterize the county. Coady has already shown you
6 some information that this data includes.

7 So some key descriptive -- you should go.
8 Tamara, why don't you take care of it? I'll hold your
9 food.

10 MS. KONETZKA: Okay. So just to sort
11 of reiterate a little, we built this model. I think
12 you all probably know what the OSCAR data is; right?
13 It's online certification and reporting data. It's
14 what comes out of the survey, the certification
15 inspection process and gets uploaded to the State.
16 It's what CMS uses, and it's a record of their
17 certification process.

18 So that OSCAR data has a lot of information
19 about individual facilities like the payer mix, like
20 whether they're for profit, not for profit. We can
21 get out of OSCAR data also occupancy rates; right? So
22 we have certified beds, total beds, and the total
23 number of residents in there and a bunch of other
24 characteristics.

1 So we took that and merged it with the data
2 that we got from Ohio. So we looked up manually all
3 the provider numbers for those facilities that were
4 involved in the transactions in Ohio and merged it
5 into the OSCAR data.

6 So we have all of that OSCAR data for Ohio,
7 and we know which ones bought and sold facilities, and
8 then we have all of that OSCAR data for Illinois.
9 Then we just added in this census-based, county-level
10 information as well. So that's what we built our
11 model off of.

12 So we first look at Ohio and determine
13 through our predictive model what are the biggest
14 predictors -- the most significant predictors of a
15 facility wanting to buy a bed or be involved in a
16 buying transaction or be involved in a selling
17 transaction. We looked at that a couple different
18 ways, too.

19 So we also combined it into an index much
20 like the index that Coady was talking about where we
21 sort of look at that volume, the number of beds bought
22 and sold as well. Those were all pretty consistent.

23 So I'm basically just going to talk about
24 our predictions for a facility wanting to buy a bed or

1 sell a bed.

2 All the descriptors were in the year
3 before; right? So look at the payer mix of a facility
4 and the occupants of a facility to see whether it
5 predicts whether they buy or sell a bed that following
6 year.

7 The other thing I will note before getting
8 into the details of the model is that we also did it
9 separately for the earlier period when it was only
10 between county and later where it was across county
11 lines as well, and the predictors are really pretty
12 constant. So I'm just going to talk about the
13 predictors in general because it didn't really matter
14 which way we looked at it.

15 So before we even put in this prediction, we
16 just looked at some basics like the occupancy rates;
17 right? If you look at Ohio versus Illinois, there's
18 much greater variation in Illinois in occupancy rates.
19 So just sort of basic descriptive evidence that
20 reallocation really evened out occupancy rates in
21 Ohio.

22 MR. GALASSIE: Which is a good thing.

23 MS. KONETZKA: Which is a good thing.

24 The other thing I'll note just descriptively

1 is that even though, as we saw from these other graphs
2 and from some of the results that Tony was talking
3 about, you know, there was a significant amount of
4 buying and selling going on. In an average year, it's
5 actually only concerning 2 to 4 percent of facilities;
6 right? So the vast majority of facilities are not
7 making these adjustments in any given year.

8 So it's sort of important to remember that
9 as we look at the predictors of which types are buying
10 and selling. It doesn't mean there's this mass exodus
11 from one type to the other.

12 This is basically what I just said. We use
13 the Ohio data to build this predictive models, and
14 then we apply those predictions to the Illinois OSCAR
15 data while adjusting for the ways in which Illinois is
16 different; right?

17 So we look at the relationship between payer
18 mix and the probability of buying or selling in Ohio;
19 and then when we apply it to Illinois, we can adjust
20 for the fact that nursing homes in Illinois might have
21 a different payer mix. That's basically what I'm
22 saying here.

23 So this is a very long list of the kind of
24 things we put in our model. Like I said, we're just

1 presenting the predictors of the probability, a
2 yes/no, did they buy or sell in a given year.

3 The kind of facility characteristics we put
4 in our model were measures of occupancy. So very high
5 occupancy was 95 percent or higher, high occupy was
6 90 to 95, and low was less than 85.

7 The totality bed size. This is total beds,
8 not just certified beds, that we used. For profit,
9 not for profit, whether it was hospital based, whether
10 it was part of a CCRC, part of a chain, urban versus
11 rural. The OSCAR just has a very rough cut of that.
12 That's a little bit of a fuzzy distinction. And then
13 the payer mix variables looking at percent of
14 residents, Medicaid, Medicare, private pay.

15 A total number of deficiencies as a rough
16 proxy for quality, and I think you guys all know about
17 deficiencies. I don't need to explain that. Then we
18 added in some of these sort of common-level
19 characteristics.

20 So basic results on which homes would buy
21 beds, the things that kind of came out consistently in
22 our model even when we kind of tweaked it in different
23 ways is that perhaps, obviously, the homes that were
24 more likely to buy beds were the very high-occupancy

1 homes, those that were already reaching their
2 capacity.

3 It's not a perfect predictor because there
4 are facilities that want to expand for other reasons,
5 but anyway, the very high occupancy ones were more
6 likely to buy beds. The ones that had a sort of
7 profitable payer mix to begin or that had more private
8 pay to begin with are those that were more likely to
9 buy beds.

10 Then we found that for-profits were the most
11 likely to want to buy beds than nonprofits and then
12 the government facilities.

13 One thing I should note about this,
14 personally I was surprised because I was thinking -- I
15 think there was a comment earlier about how Medicare
16 rates are actually higher than present pay rates right
17 now or that the Medicare patients are more attractive
18 to owners now.

19 So we really thought we might see that the
20 high Medicare facilities would be the ones that would
21 be wanting to expand their Medicare beds, and that's
22 not really what we found.

23 It was really sort of the private pay that
24 came out much more consistently in our models. The

1 facilities that managed to have a high private pay
2 population are the ones that wanted to expand.

3 Now, they may be expanding into Medicare
4 beds. We don't know what they were going to do with
5 the new beds, but this was the predictors in terms of
6 their payer mix the year before.

7 MR. GALASSIE: Are you going to show us
8 the same predictor?

9 MS. KONETZKA: Which facilities will
10 sell beds?

11 Again, perhaps obviously those that have low
12 occupancy and those that had a higher percent
13 Medicaid -- percent of residents on Medicaid and
14 hospital-based facilities.

15 There's a lot of other sort of
16 payment-related issues that have gone on with
17 hospital-based facilities. So that may or may not be
18 surprising, and a lot of them have left the market
19 over the last decade or two, but these were the
20 facilities that were most likely to sell.

21 MR. AGBODO: May I ask, what is the
22 level of significance of those results? Are they
23 95 percent or 99 percent?

24 MS. KONETZKA: The level of

1 significance we used in our models?

2 MR. AGBODO: Yes.

3 MS. KONETZKA: These are all
4 significant in at least the 95 percent level.

5 MR. AGBODO: 95 percent?

6 MS. KONETZKA: Right.

7 I'm sorry. There was another one on our
8 list. No, there's two more.

9 Also, we found that facilities that were
10 sort of in the top quartile or had more regulatory
11 deficiencies were those who were more likely to want
12 to sell, so basically sort of high Medicaid, lower
13 occupancy, poorer quality as reflected in
14 deficiencies, and larger facilities were all more
15 likely to sell.

16 Then this graph really sort of captures what
17 those characteristics were. Hopefully, you can see
18 that from here. What's on this piece is the predicted
19 probability of a facility wanting to buy or sell in
20 any given year. Like I said, only 2 to 4 percent are
21 in the buying and selling business in Ohio anyway in
22 each year.

23 When we predicted for Illinois, not
24 surprisingly, only a few percent each year are

1 actually predicted to buy or sell; but I think what's
2 important here is the sort of relative probability;
3 right?

4 And so these are some of the things that I
5 talked about before. So low-occupancy facilities are
6 much more likely to want to sell. There are some
7 low-occupancy facilities that want to buy, going back
8 to our sort of theory graphs before; but on the whole,
9 they're more likely to want to sell. The flip for the
10 high-occupancy facilities, they're much more likely to
11 want to buy beds.

12 On average in Illinois, so if you take the
13 Ohio predictors, the predicted probability of buying
14 and selling in Illinois, one thing that you find is
15 that the probability of selling is much greater than
16 the probability of buying; right?

17 So in Illinois relative to Ohio, more
18 facilities are going to want to sell than buy, right,
19 which probably means -- I have this on another
20 slide -- the price would actually be lower in
21 Illinois than in Ohio. It will be more of a buyer's
22 market.

23 MR. WILL: A quick question because the
24 payer mix piece is pretty striking on there,

1 especially when you get the quantitative pieces up
2 there. I think this is just to confirm. I think I
3 know the answer is yes.

4 The program is just selling licenses, as in
5 the certification. Like if there's a bunch of
6 Medicaid certified beds and they sell somewhere, no
7 requirement that those become certified into Medicaid
8 or made available to Medicaid patient transfers?

9 I just wanted to confirm that.

10 MS. KONETZKA: Yeah. There's no
11 requirement, and we didn't really look at what happens
12 to payer mix afterwards. This is just sort of
13 baseline predictors of who wants to buy and sell.

14 On these top probabilities, what we did is
15 to kind of group them into stylized types of
16 facilities to see what the relative probabilities
17 would be for the types of facilities one might sort of
18 automatically classify or automatically think of.

19 So first of all, we think about for-profit,
20 high-private-pay facilities with high quality. So
21 they're facilities that already have a payer mix that
22 have higher quality. They are much more likely to
23 want to buy than sell. So those are the facilities
24 that you really would see expanding.

1 And interestingly, if you add the area
2 level characteristics, the predictions don't really
3 change; right? And this is just reinforcing Coady's
4 point that it's really at the nursing home level
5 that these imbalances occur; right? You can't
6 really say much about what happens in the county as a
7 whole.

8 MR. GALASSIE: Can you elaborate on
9 that? I don't understand that.

10 MS. KONETZKA: So what I'm saying is
11 it's an individual nursing home level decision based
12 on their cost structure and the demand for the
13 services that they offer because the nursing homes
14 aren't all the same; right?

15 So given that, even neighboring facilities
16 might have different incentives to want to buy or
17 sell; right?

18 MR. GALASSIE: Right.

19 MS. KONETZKA: And so just looking at
20 what happens in an area doesn't account for that
21 difference from facility to facility.

22 MR. GALASSIE: Okay.

23 MR. WING: Another way to try and frame
24 it is that even in a county with a very high poverty

1 rate, there may be facilities that are richer and
2 poorer or higher cost and lower cost.

3 So even in a county that's relatively
4 disadvantaged, there will be nursing homes that want
5 to expand -- or there may well be nursing homes that
6 want to expand and other ones that would like to
7 contract.

8 The decision to buy and sell beds and
9 whether it's feasible to expand or not is something
10 that is determined by nursing home level situations.
11 Okay? The county level situation is a by-product of
12 that is the idea.

13 MR. GALASSIE: Okay.

14 MS. KONETZKA: If we look at another
15 couple of types of facilities, look at small
16 nonprofit, high-Medicare facilities with high quality,
17 many of which might be sort of the hospital-based
18 facilities, let's say, but some that are not, they're
19 more likely to want to sell than buy. There's sort of
20 less action in those facilities overall.

21 Then if you look at sort of the large
22 for-profit, high-Medicaid facilities with lower
23 quality -- sorry. The difference between these two,
24 again, just sort of adding in the area

1 characteristics, again, it doesn't actually matter.
2 The facility type matters, but whether or not they're
3 in a poor area doesn't really change the probability;
4 right?

5 MR. GALASSIE: I'm really having a
6 tough time computing that. I'm having a really hard
7 time. I came from the world of building too many
8 houses and all that.

9 The hospitals aren't building in low-income
10 areas for a reason, and this is telling me all the
11 sellers are coming from low-profit Medicaid
12 facilities, which tend to be in areas of economic
13 need.

14 MS. KONETZKA: Right. I guess another
15 way of saying that is looking at a facility's payer
16 mix tells you all you need to know because most of
17 them are going to be in poor areas.

18 MR. WING: After controlling for that,
19 no county information.

20 MEMBER PHILLIPPE: Comment.

21 So compared to a hospital, nursing
22 facilities are small. So what I'm taking away from
23 this, if you start with a big area like the county and
24 you rate the income, there's still people with money

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1 in that county somewhere. So there's still people
2 buying beds to build, but they're probably building
3 them for the private people in that county. That's
4 what you're saying.

5 MS. KONETZKA: Right.

6 MR. WING: The other thing I think that
7 we're saying, too, is that decisions to trade are sort
8 of determined by whether you happen to have too many
9 beds at the moment.

10 The biggest predictor here -- or one of the
11 biggest predictors is that occupancy rate or the
12 occupancy level. That's just like saying -- it might
13 sound worrisome, and maybe it is a problem. I'm not
14 totally sure, but maybe it's a problem if lots of
15 Medicaid facilities are selling off beds.

16 But if they're selling off beds because they
17 don't fill them anyway, so they have low occupancy
18 rates and they're just leaving them vacant, then you
19 shouldn't think that you're protecting Medicaid
20 patients by keeping those empty beds there. They
21 might as well go somewhere else. You want to get
22 filled Medicaid beds when you have a strategy.

23 MS. KONETZKA: I think that's a really
24 crucial point.

1 This says nothing about whether or not
2 access will be affected for Medicaid. This says
3 nothing about access because these could be empty beds
4 that they're just finally getting rid of. That's a
5 crucial point.

6 MR. AGBODO: One moment. It would be
7 interesting to know how many facilities are in each
8 group. I'm just assuming that this is going to be
9 applied to Illinois.

10 MS. KONETZKA: This is predictions for
11 Illinois.

12 MR. AGBODO: Okay.

13 MS. KONETZKA: This is building
14 predictions for Ohio, and this is what we predict for
15 Illinois.

16 MR. AGBODO: Anyway, I still believe
17 that the number of facilities in each category, we can
18 see how significant is this because if even one
19 category had just like two facilities and another
20 category had like 100 facilities --

21 MR. WING: One percent of a big number
22 is a lot.

23 MR. AGBODO: You're right.

24 MS. KONETZKA: Right. I think that's a

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1 valid point. I don't remember right now. I can look
2 at what they are over lunch even.

3 MR. WING: The other thing to keep in
4 mind is that it is one big model; right?

5 So facilities are not broken into -- you can
6 have combinations of all of these characteristics that
7 add up to things.

8 MS. KONETZKA: Right.

9 MR. WING: What we're presenting here
10 is just a simplification of the overall model.
11 Technically, each nursing home gets their own
12 prediction of what their likely buyers are.

13 MEMBER CASPER: Two questions.

14 One is you basically made an assumption
15 transitioning to the Illinois predictor that the
16 market is statewide; is that correct?

17 MS. KONETZKA: No.

18 What I said earlier is that I based it on
19 all of the years of data in Illinois and Ohio or all
20 the years I have OSCAR data for, which is 1996 through
21 2012.

22 MEMBER CASPER: Some of those years
23 were county restricted?

24 MS. KONETZKA: In some of those years,

1 but the predictors didn't change. We looked at that,
2 and the predictors didn't change.

3 MEMBER CASPER: The second question is
4 regarding all of the discussion that has taken place
5 today about the number of beds in Illinois that are
6 not occupied now because they've been taken out of
7 service by the license holder.

8 Do you think the model -- was there any kind
9 of analogous situation in Ohio? Does the model
10 account for that in any way, or do you think it's not
11 a relevant factor in the model?

12 MS. KONETZKA: I think it could well be
13 relevant; but our data, just like you guys were
14 complaining about, can't account for those beds that
15 are completely out of service; right?

16 We have not only certified beds but the
17 total number of beds in the facility; but if those
18 don't go into the total that go into the OSCAR data,
19 then we don't know what they are either.

20 That's why you might get -- even if we had
21 that data and could figure occupancy based on those
22 sort of more inclusive numbers of beds, including
23 those that are out of service, then you might see even
24 more striking results for the occupancy. We just

1 don't know. Just like you don't have that data, we
2 don't have that data.

3 MEMBER CREDILE: We've had data here --
4 and I can't find it. I was rifling through my bag --
5 where we had beds per thousand. It was just a very
6 simple calculation. Illinois is off the charts in
7 terms of beds per thousand. We're an outlier.

8 Is that maybe what happened in 1993 with
9 Ohio? And they've placed a moratorium on it. I don't
10 know if they used beds per thousand. I don't know
11 what they used to decide. Somebody said, "You know
12 what? Moratorium on beds because."

13 MS. KONETZKA: Yeah. I'm not sure what
14 reasoning went into their moratorium. It may have
15 been a sense that there were too many beds. It may
16 have been a budget crisis. I'm not exactly sure why
17 they put that moratorium in.

18 I think what you're saying about Illinois
19 potentially having more beds than other places, on the
20 whole, you know, I think it's consistent with what
21 we're saying in that if you try to apply what happened
22 in Ohio to Illinois, you're actually going to get many
23 more facilities that want to get rid of beds than that
24 want to acquire beds; right?

1 MEMBER CREDILE: Because if we think
2 there are a lot of beds that are out of service and
3 we put that in the mix, then the bed need -- if you
4 left the bed need formula the same in Illinois, then
5 suddenly you would need more beds, and then our number
6 of beds per thousand would just go up again.

7 MR. WING: Here if you kept the --
8 let's say in Illinois there are lots and lots of beds;
9 right?

10 That's part of the reason why everybody is
11 predicted to sell or it's predicted lots of selling
12 will happen. Lots of people would want to sell.
13 There's so many excess beds basically.

14 In some sense it's sort of like the last
15 problematic thing to worry about; right? If you have
16 lots and lots of beds but the worry is the beds are
17 all in the wrong places, the question is: Where will
18 the beds go if you let people trade them?

19 The qualitative relationships, the people
20 that will on the margin decide that they'd like to buy
21 a bed rather than sell a bed, right, that seems more
22 plausible as a whole between Ohio and -- it's always
23 hard to tell; right? Who knows, really, whether it
24 extends to the Illinois case.

1 But the relationships of why a nursing home
2 might want to sell a bed, that seems to transfer
3 pretty well. The total number of people wanting to
4 sell versus buy is probably a function of how many
5 total beds are available in the market and how out of
6 whack they are; right?

7 MR. GALASSIE: However many buy and
8 sell, to Cecelia's point, wouldn't it be a wash as
9 opposed to increasing?

10 MEMBER CREDILE: If you put a
11 moratorium.

12 MR. WING: If you leave the giant
13 number of beds alone, none of the trading will create
14 new beds. So the total number will stay the same, but
15 shortages and excesses that happen in different
16 nursing homes will be diminished, will be reduced.

17 MS. KONETZKA: You're right. The
18 actual transactions will even out; right? The buyers
19 will equal the sellers.

20 But what we're saying here is if you look at
21 the predictors of buying and selling based on Ohio and
22 apply those predictions to Illinois, you're going to
23 have more homes wanting to sell than buy, which means
24 the price will adjust; right?

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1 So we would expect the price to be lower in
2 Illinois than in Ohio, which is also consistent with
3 the lower Medicaid rate in Illinois than Ohio.

4 MEMBER PHILLIPPE: From the consumer
5 perspective, this model would seem to predict the
6 consumer will get a better product on average.

7 We can assume that some of these have low
8 occupancy because they're not attractive, people don't
9 want to live there, or they're in the wrong location,
10 and the people who are adding are the high-quality
11 places with the better surveys. So it would mean
12 there's more options for people for better quality
13 locations.

14 Is that what you're saying?

15 MS. KONETZKA: I think that's a fair
16 interpretation.

17 We have another slide about the unintended
18 consequence that people expressed worried about the
19 last time we were here, which is: Do you have
20 low-quality facilities wanting to buy beds?

21 Was there another one?

22 MR. GALASSIE: I'm just going to say
23 thank you very much. I have to leave. For what it's
24 worth, I'm about an hour and a half behind schedule.

1 I found this fascinating, and I don't say that easily.

2 See you all. Thank you.

3 MR. LOSASSO: Like I said,

4 Mr. Chairman, two hours was all we needed.

5 MR. WING: Could I just make one

6 comment?

7 One thing worth thinking about in trying to
8 make sense of the results Tamara presented is that if
9 you go back to that graph that showed you prices of
10 beds and numbers of transactions over time, the two
11 really big points to pay attention to are that once
12 you change the trading conditions, there's probably
13 going to be a big sudden spike, a flurry of activity.
14 After that it will be little marginal changes.

15 So these relationships, they include the
16 full time period, but most of the data comes from
17 non-flurry-of-activity periods. It comes from -- we
18 did a big readjustment, and now we tinker around the
19 edges. That's probably true. It's hard to predict
20 exactly what happens in the big flurry of adjustment;
21 but it happens, and then from that year on it's
22 probably much more predictable.

23 MR. LOSASSO: It would follow what
24 you'd expect, cost, demand changes, these sorts of

1 factors that are going to drive homes in particular
2 areas to either have too many or too few beds.

3 MR. WING: If you actually contemplated
4 doing this -- I think this is something to bear in
5 mind; right? -- you would put it in place, and then
6 you've got to be prepared for that first year to be a
7 big crazy year of trading. Then from that point
8 forward, it should get really calm.

9 CHAIRMAN WAXMAN: Does the fact that --
10 when I was involved in the operations side, Ohio used
11 to have a very high Medicaid reimbursement rate,
12 especially compared to Illinois. I don't know if it
13 still does.

14 Does that factor into your analysis in any
15 way, shape, or form?

16 MR. LOSASSO: Certainly by implication,
17 yes.

18 It's a big -- we can't incorporate it
19 directly, but I will have a few points here where I
20 reference the differential Medicaid reimbursement rate
21 and how we predict it will have an impact in an
22 Illinois bed market.

23 MEMBER GUILD: In terms of selling
24 beds, can you sell any number of beds you want?

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1 Were there nursing homes that sold all their
2 beds?

3 MR. WING: I have no idea if there were
4 100. There were some big transactions, like lots of
5 beds got traded. There were a few like multi-way
6 transactions, like one seller and a bunch of buyers.

7 MR. LOSASSO: The other way, one buyer
8 and a bunch of sellers.

9 MR. WING: Yes.
10 I don't know if we can sell -- you're
11 talking about like a closure.

12 MEMBER GUILD: Right.

13 MR. WING: I sold all my beds, got out
14 of the business.

15 MEMBER GUILD: Right.

16 MR. LOSASSO: That's something we could
17 investigate.

18 MR. WING: It doesn't tell you in the
19 trading data set.

20 MR. LOSASSO: Was there another
21 question over here?

22 MR. FOLEY: I guess I am somewhat --
23 let me see if I can explain myself here.

24 We have a lot of rural areas with, quite

1 honestly, a lot of beds but also a lot of beds that
2 are empty. They're empty because there's no bodies.
3 The population growth is just not there anymore. So
4 that's another reason why we have empty beds.

5 This process would allow them, obviously, to
6 sell those beds. They're never going to be used
7 again; but at the same time, I don't know how all this
8 factors in that we are also now seeing this huge jump
9 in the population projections, you know, over 65,
10 which we didn't have yesteryear in Ohio.

11 I'm just trying to figure out in my mind how
12 this is going to fair out in the future when we see
13 this big jump in our aging population. A lot of
14 facilities are going to be needing beds, obviously,
15 but it just depends on how those beds are going to be
16 used in terms of high-skill beds because the ICF beds
17 are gone, in essence.

18 Those things basically are assisted living
19 and supported living facilities are coming in over ICF
20 beds.

21 MR. LOSASSO: I guess I do take the
22 point. It's a good one.

23 I guess the response would be that if you
24 have a bed market and you sell beds now, that doesn't

1 prevent you from buying them back if market conditions
2 change and turn more profitable later. You could
3 potentially buy them back, I guess.

4 So in other words, the beds would move to
5 where the demand is; and that's what a bed market
6 would afford. It would provide an adjustment
7 mechanism for doing that. That would supplement -- in
8 the case of Illinois, that would supplement this
9 Board.

10 MR. FOLEY: When somebody actually
11 sells beds, what do the providers in Ohio do with the
12 money itself? Are they able to keep that money?

13 MR. LOSASSO: That's a great question.
14 We do have a slide for that.

15 This is where I'm going to try to answer the
16 questions that we started with three hours ago, I
17 guess, or an hour and a half ago. Would a bed market
18 improve the utilization of existing beds?

19 We believe the evidence points strongly to
20 yes. We lean on both our theoretical and our
21 empirical results that it would be consistent with
22 improvements in utilization of existing beds.

23 The second question is: How will a bed
24 market affect low-income and underserved?

1 Again, as you've heard I think multiple
2 times now, our evidence is not consistent with beds
3 fleeing low-income areas. We see a lot of
4 transactions, both outflows and inflows, and it very
5 much depends on the differences between.

6 So the really key variation is not so much
7 the differences across counties but really kind of the
8 differences across nursing homes themselves. This is
9 just restating a point that both Coady and Tamara made
10 earlier that the real meaningful variation is across
11 nursing homes.

12 Nursing homes are very -- it's not a widget,
13 to use my economic language, and they're very
14 different products, really.

15 Question?

16 MR. WILL: A real quick question.

17 Again, I think this is just confirming an
18 understanding. In this context, "areas" means
19 counties. It's not using the areas that we use or
20 like a 30- or 45-minute market area or anything like
21 that. It means counties.

22 MR. LOSASSO: Yeah, that's correct.

23 We had to use what Ohio did, which was a
24 county designation. So we did apply it. There are

1 other ways that one could group areas together, as you
2 said, HSAs, a lot of different possibilities.

3 Again, our theory and our empirical
4 evidence does suggest that beds can flow to settings
5 with Medicaid patient demand.

6 So this is a question that just came up and
7 has come up multiple times here. What can we infer
8 about bed prices in Illinois? Our take-away is that
9 by and large, the bulk of the evidence I think points
10 to lower prices for beds in Illinois.

11 The three reasons would be, first of all,
12 there's not a moratorium. People can still come to
13 the Board to petition for more beds, again, if they
14 can demonstrate the need.

15 That really depends on -- that goes back to
16 your conversation and your dialog about the extent to
17 which the need formula represents almost a soft
18 moratorium. I'm going to stay agnostic on that point;
19 but to the extent that new beds can enter the system,
20 that would tend to lower prices because there's
21 another option for beds to come in.

22 Medicaid reimbursement is very low in
23 Illinois. That's going to tend to drive down the
24 price of beds. That will exert downward pressure. No

1 way around that.

2 Then Tamara's point, which was that in our
3 model, we saw that the bulk of the predicted
4 probabilities of buying and selling, the weight of
5 that -- the preponderance of it was on the selling
6 side.

7 So as we said earlier, it does look like,
8 at least at first glance, it's more of a buyer's
9 market. So that means lower prices predicted here in
10 Illinois.

11 It doesn't mean that -- again, there could
12 be regional variation and so on. We just make an
13 average prediction that we'd expect there to be lower
14 prices.

15 CHAIRMAN WAXMAN: I have a question.
16 Chuck, I have to ask you: If the price of beds now
17 becomes established through the process, what does
18 that do to owners that have used those beds as
19 security for a loan?

20 PROXY MEMBER SHEETS: Well, I think
21 they'll have to get permission from their lender to do
22 the deal. Otherwise, they'll be in default on their
23 mortgage. If it's a HUD loan or a regular bank loan,
24 they will still have to get permission from the lender

1 to do the deal.

2 Maybe the lender will want them to catch up
3 on some of their -- if they have like an operating
4 line out or some other liability, they may have to
5 catch up on that.

6 MR. WING: Nursing homes are allowed to
7 borrow against their beds?

8 CHAIRMAN WAXMAN: It's the earning
9 asset for an operator.

10 So a lot of lenders, at least, again, when I
11 was on the other side of this, the operating side,
12 would use the bed count -- licensed bed count as the
13 collateral for the money they put up.

14 So it's brick, mortar, and equipment,
15 "equipment" being a bed. So it had a dollar value at
16 some point in the loan negotiation. If it was \$20,000
17 a bed and now we're saying it could be \$10,000, now
18 that puts their loan in a default situation.

19 MR. WING: Okay. So that's tricky;
20 right?

21 Is it the price of the bed that the lender
22 was holding as collateral or the ability to generate
23 revenue because you have the bed?

24 MR. FOLEY: The ability to generate

1 revenue.

2 MR. WING: Yeah.

3 Now, there's a connection between the two;
4 right?

5 The prevailing price of the market is
6 probably connected to the revenue prospect, but it
7 probably doesn't have a direct relationship as it
8 first seems.

9 PROXY MEMBER SHEETS: It has an effect
10 on the appraisal when there's a purchase. There's an
11 appraisal amount, and that's what they secure.

12 Then when you mess with the bed count, they
13 feel that you're going to change that appraisal; but
14 if you can show them another way that it's operating
15 more efficiently and still making money --

16 MR. LOSASSO: Was there a question over
17 here?

18 MEMBER PHILLIPPE: I was going to say I
19 have all these dialogues, also.

20 Mainly, yes, they consider it because of the
21 stability, but really it's how much money you're
22 making on your asset. If you can show you're going to
23 pay down your debt or you're going to improve the
24 asset by selling unused beds, I haven't met a banker

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1 who turned that down. That's the reason it works in
2 Ohio and other states.

3 MR. FOLEY: I don't think it's that
4 much of a serious problem here because we have
5 facilities all the time that are given lip on their
6 price of beds.

7 If you look at the update that comes out
8 every month, you'll see where this facility gave up 10
9 nursing beds, 12 nursing beds. There aren't a lot,
10 but obviously it does happen.

11 MEMBER PHILLIPPE: I think just
12 practically speaking for our purposes, if it's an
13 opportunity, it doesn't matter for the banks because
14 we're not mandating like we're taking away beds like
15 had been discussed.

16 MR. FOLEY: Correct.

17 MEMBER PHILLIPPE: Here it's just an
18 opportunity, and just market pressures will bring the
19 result.

20 MR. LOSASSO: So another question that
21 came up that Tamara alluded to, will low-quality
22 nursing homes expand?

23 We saw in Ohio that only 1 percent of
24 purchase transactions involved purchase by

1 lower-quality facilities as defined with the
2 deficiency measure. So it looks like probably not.

3 In addition, less than 1 percent of purchase
4 transactions involved purchase by high-Medicaid
5 facilities. I mean, again, I think as we've
6 acknowledged, it's sort of a two-way sword, maybe not
7 a surprising sword. So our answer is on balance, no.

8 Then another question that you are
9 interested in is: What can we learn about what
10 nursing homes do with the funds they raise from a
11 sale?

12 So our data don't allow us to get at this
13 directly, but what we did look at was in Ohio we were
14 able to look at posttransaction at the facility level.
15 Tamara did this. You can jump in with any clarifiers.

16 We did not see evidence of staffing ratios
17 improving after a sale occurred or deficiencies
18 declining after a sale occurred. That's using what we
19 had on hand.

20 Again, if they were reinvesting those funds
21 into the facility, maybe you'd hope to see staffing
22 ratios improve. Maybe you'd hope to see deficiencies
23 decline if the funds are being reinvested. We didn't
24 see evidence of that.

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1 PROXY MEMBER SHEETS: Did you look at
2 the cost reports and determine --

3 MR. LOSASSO: We did not link this to
4 cost report data. That would require a little more
5 energy and time, though we put a lot in, but we'd
6 probably have to get Courtney involved for that
7 conversation.

8 MR. WILL: I was going to ask that same
9 thing like five minutes ago, talking about the effect
10 of the differential Medicaid rates between the two
11 states, just whether you looked at it.

12 So the short, short version of that is it
13 would require a heck of a lot of work to integrate
14 into a model.

15 MR. LOSASSO: Integrating core data
16 into the model would require more work on our part, a
17 fairly substantial amount of work. That's a whole
18 other data set. There's a fair amount of nuance in
19 linking it to the data sets we already have. It's
20 feasible.

21 MEMBER PHILLIPPE: It's a big issue we
22 have to consider. I don't know if it's maybe good or
23 bad, but I operated in Ohio until -- during the last
24 year we stepped out of two buildings that we were

1 managi ng.

2 Ohio is very different. It's so different
3 that up until just a few years ago, people didn't even
4 care about having Medicare, kind of like New York.
5 The Medicaid rate was 180, 190 in some locations that
6 are not real expensive, high-end areas in the state.

7 So there is a difference there. I'm not
8 sure how they've affected the operation here, but
9 clearly the payment issue is very different there.

10 PROXY MEMBER SHEETS: Is it possible
11 this has something to do with the fact that they've
12 had this in place for how many years? It may effect
13 the Medicaid rate.

14 MEMBER PHILLIPPE: It could have to do
15 with the wealth of the state and how they operated the
16 state government.

17 MEMBER CREDILE: They put a moratorium
18 on beds in 1993. So they made a decision a long time
19 ago to operate very differently.

20 MEMBER PHILLIPPE: They have.

21 MR. WING: A lot of these differences,
22 they almost certainly matter in gross terms for
23 exactly how things would play out if you adopted an
24 Ohio-like model in Illinois, but I don't think they

1 matter very much for the general proposition that if
2 you allow nursing homes to trade beds with one
3 another, that you'd get an allocation of beds across
4 the state that lowered variation in occupancy rates
5 and which better satisfied the local demand and cost
6 conditions.

7 I don't think that has anything to do with
8 these clearly very important issues about the Medicaid
9 reimbursement rates, the numbers of rich and poor
10 people in the state.

11 I think the mechanism itself, which is most
12 of what we're talking about here, is mostly about
13 whether places can decide to adapt to changing
14 conditions by selling off some beds that they're not
15 using or by acquiring some beds in a relatively easy
16 manner.

17 Those things don't seem to depend
18 intrinsically on the Medicaid reimbursement payment.

19 MEMBER PHILLIPPE: Related to what you
20 said on the other side, I noticed Ohio's buildings all
21 look nicer than Illinois'. In general, the buildings
22 are much nicer. Let's put it that way, in general.

23 MR. LOSASSO: Present company excluded,
24 I'm sure.

1 MEMBER PHILLIPPE: Not our buildings,
2 but in general across the state. It kind of goes to
3 Charles' comments earlier.

4 What this does is create competition because
5 what we have -- and you talked about it earlier -- the
6 CON process, one advantage is to a current provider it
7 stops competition. It limits competition.

8 So going to the point of where people put
9 the money, it does look like in a model like this,
10 there's more pressure to compete sort of because
11 somebody can come in, buy up excess beds, add on a
12 nice new wing or nice new building. So everybody is
13 under pressure to kind of use their money to upgrade
14 their product.

15 MR. LOSASSO: You're spot on. I think
16 that's exactly right.

17 MR. FLORINA: Two questions.

18 Does Ohio have the same type of system as
19 Illinois where they can add a percentage or a flat
20 number of beds to an existing facility?

21 Secondly, what percentage of the buyers of
22 these beds in Ohio actually create a whole new
23 facility rather than just adding on?

24 MR. LOSASSO: First question -- Tim was

1 shaking his head.

2 MEMBER PHILLIPPE: I don't think you
3 can grow there.

4 MR. LOSASSO: I'm going to defer to him
5 on that.

6 The second one, we can see that in the data,
7 but I don't know it off the top of my head.

8 MS. KONETZKA: In the buy and sell -- I
9 glossed over that quickly -- there are leases.
10 There's not just actual purchases, but one can lease
11 beds in Ohio. Then one can acquire beds for
12 renovation and one can acquire beds for expansion. We
13 have all of those categories in the Ohio data.

14 When we sort of expand our definition of buy
15 and sell, our predictors don't change, right, but all
16 of those possibilities are there and we could look at
17 it separately.

18 MR. FLORINA: That's right.

19 I guess the point I was getting to is that
20 if you can't add on an existing building in Ohio like
21 you can in Illinois, they have more reason to have to
22 buy beds from somewhere else. Here we don't have to.
23 We can still add on without buying.

24 MR. LOSASSO: That's another factor

1 that would tend to decrease the price of the bed here
2 in Illinois.

3 MR. URSO: Tony, can you hang on? The
4 court reporter needs a break.

5 Don't you need a break?

6 THE REPORTER: Yes, but go ahead and
7 finish.

8 MR. LOSASSO: The last point on this
9 slide is just that the bed market seems a
10 particularly -- well, as I noted, the bed sales
11 prices -- for all these reasons and maybe more, bed
12 prices would tend to be lower in Illinois.

13 Our summary judgment on this is that a bed
14 market seems a particularly inefficient way of
15 improving capital stock at a facility. If that is the
16 goal of this, this is not the way. This is not an
17 efficient way to try to achieve that.

18 A few more points here. Structuring a bed
19 market. Our recommendation is that the largest
20 geographic unit, that is, the whole state, is the best
21 way to go.

22 As we observed, when the statewide exchange
23 was allowed in Ohio or adjacent county -- I mean,
24 we'll clarify that, but to the extent it became a

1 larger unit for exchange, we saw that given the
2 evidence, which is right there before us, the number
3 of transactions that we saw, it allowed for better
4 balancing or elimination of regional imbalance.

5 So if you start with the whole state or
6 start with a large geo unit, you'll get rid of more of
7 these imbalances that exist in the state.

8 Siloing, that is to say, however you want
9 to do it, will just create larger units of imbalance.
10 Right now we have imbalance that goes all the way down
11 to the facility level.

12 If you make it the county, you'll get rid of
13 some of it. If you make it the HSA, you'll get rid of
14 more of it. If you make it the whole state, you'll
15 get rid of much of it.

16 Potential unintended consequences. This is
17 my final slide, I promise. So we do have to remember
18 that creating a market for goods whose scarcity is
19 wholly artificial, it's only because there is a cap,
20 however you want to characterize that, a restriction
21 on the number of beds allowed in a state.

22 It does create winners and losers, and
23 that's just simply something to be mindful of. So
24 that's an important statement that I'll put out there

1 to keep in mind, but there's nothing intrinsic here
2 about the nature of a bed market creating value here.
3 You could just as easily say, "Go out there and build
4 what you want."

5 Beds will still have value, as we talked
6 about, but creating a market like this does create
7 winners and losers, which could have come from past
8 long-ago decision made about how many beds to grant an
9 institution.

10 Thin markets, we've hinted at this a few
11 times. We are worried that there is a potential for
12 few buyers in Illinois. We saw a fairly robust market
13 in Ohio. There are all those reasons that we talked
14 about as to why we might expect a less potentially
15 robust market here that I've gone through already. So
16 worry about thin markets.

17 Finally, we do worry -- this point was made
18 earlier -- that facilities might hoard beds just
19 simply out of uncertainty with regard to future
20 regulations, the future regulatory regime. Hoard a
21 bed, you hedge against future unpredictability or
22 uncertainty about the Board's decisions and behavior,
23 maybe bed buying.

24 If you get cold feet and you eliminate it,

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1 it might be safer not to get involved. Keep your
2 beds. You just don't know.

3 MR. WING: You have to convince the
4 potential buyers and sellers that you were serious
5 about this and that you aren't going to let them sell
6 off their beds and then like, you know, screw them by
7 not allowing them to ever do this again.

8 MR. LOSASSO: Right.
9 Exactly two hours on the dot and we're out.
10 So thank you for your attention to this.

11 CHAIRMAN WAXMAN: Can you hold
12 questions? Let's let her take a break, let us take a
13 break, and then come back and deal with questions that
14 are remaining?

15 THE REPORTER: Thank you.

16 CHAIRMAN WAXMAN: We'll take a
17 15-minute break.

18 (Recess taken, 1:03 p.m. to
19 1:15 p.m.)

20 CHAIRMAN WAXMAN: Let's come back.
21 What I'd like to do is if you have any
22 questions for our presenters, please feel free to ask.

23 MR. FOLEY: I'm sorry. Mr. Chairman,
24 what did you say?

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1 CHAIRMAN WAXMAN: I said now that the
2 break is over, if you have any questions for our
3 presenters, who did an excellent job, feel free to
4 ask.

5 Everything I heard in the hallway was either
6 "Great presentation" or "Get out of my way. I have to
7 get to the bathroom." It was one of those two
8 comments.

9 MR. LOSASSO: Both important.

10 CHAIRMAN WAXMAN: Or both.

11 Again, thank you very, very much. We have
12 asked them to stay. So please feel free to ask any
13 questions.

14 If you can send your presentation, whether
15 you want to change it in any way from the questions,
16 but if you get it to Claire, she'll get it to all of
17 us.

18 I saw someone's hand waving.

19 MEMBER PHILLIPPE: This is unrelated to
20 what you were talking about, but it's important in
21 Illinois. I think states always want jobs. Jobs are
22 good for the state. Construction is good.

23 So it would be interesting to know how this
24 changes the number of new buildings. By doing this,

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1 did Ohio have more or less new construction than
2 Illinois? I'd just be curious because it would open
3 up the door and cause development in the state. Some
4 people would see that as valuable.

5 MR. FOLEY: A good economic boon is
6 what we need.

7 MEMBER PHILLIPPE: That's what I
8 thought, too.

9 MR. URSO: Are you running for
10 governor?

11 MEMBER PHILLIPPE: It's different
12 because Illinois was continuing to approve new
13 buildings and expansion throughout that area in that
14 time frame, and they've actually had a freeze. So I'm
15 just curious about the impact it would have on
16 construction.

17 MS. KONETZKA: We can get to that to
18 some extent; right? We know the transactions in Ohio
19 that involved renovations or new construction. So we
20 can specifically talk about how much of that happened
21 and where.

22 MR. WING: Likewise, the flip side,
23 whether some facilities just closed and sold off their
24 beds.

1 MEMBER GUILD: Following up from that,
2 it's not just construction jobs, but for facilities
3 that did add significant construction, was there an
4 increase in health care jobs in the long run?

5 Did they hire?

6 MS. KONETZKA: That we don't really
7 have data on. I think that's a good question. We
8 don't have data on the jobs.

9 MR. LOSASSO: That's something we could
10 look into.

11 MS. KONETZKA: We can look at it at
12 least indirectly.

13 CHAIRMAN WAXMAN: Any other questions?
14 Yes, sir?

15 MEMBER CORPSTEIN: Paul Corpstein.

16 So this market, is this a completely private
17 sector market in which they administer and do, or does
18 the State have some oversight of the pool?

19 Are they watching it?

20 Are they extracting a fee from the selling
21 of beds between facilities, or is this just something
22 that happens outside of state authority and then they
23 come to me like "Oh, I bought these new beds here. I
24 need them licensed"?

1 MR. LOSASSO: I guess I'd characterize
2 that as probably a little more -- a touch more
3 operational than we're -- you could imagine any of the
4 above, really, but I think there's certainly a
5 potential role for an oversight process on the part of
6 this subcommittee. So it's easy to imagine some sort
7 of oversight role.

8 Again, I don't know if you have any plans to
9 institute a moratorium; but given that the bed
10 process, the review process would be parallel with the
11 market hypothetically, I think the Board would at
12 least have to know about where licensed beds are going
13 in order to use the mean formula.

14 MEMBER CORPSTEIN: Sure. The buying
15 and selling doesn't give them the approval to put that
16 bed in their facility.

17 MR. LOSASSO: Sure. So there are some
18 clear oversight interests that are obvious.

19 MEMBER CORPSTEIN: But the market is
20 not like they're setting up now with all the Obama
21 Care stuff. They're setting up those exchanges and
22 stuff like that.

23 Did Ohio set up an exchange in order for
24 that or that's just completely private sector? They

1 deal with it, and they just come to us when they have
2 the beds?

3 MR. LOSASSO: Out understanding --
4 again, maybe people with Ohio-specific knowledge
5 could speak better to this point, but our
6 understanding is that they allowed it and then the
7 market came up.

8 Interested parties will find a way to get
9 together.

10 MR. WING: I think it's clear that if
11 you want to -- there are some states who just
12 completely disbanded their CON boards entirely,
13 and that is a completely free market in beds. You
14 don't need approval. You can do what you please;
15 right?

16 MEMBER CORPSTEIN: Sure.

17 MR. WING: What Ohio has done has got
18 to be somewhere in between; right?

19 The very fact that we were able to get the
20 data on all the transactions and the fact that there's
21 a moratorium on the beds proves that it's a market
22 that is controlled by the state government in some
23 way.

24 You have to register. You have to tell them

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1 that you've transferred the bed in some way. That's
2 how we're able to track it in the first place. So
3 it's controlled.

4 MEMBER PHILLIPPE: My experience is you
5 don't actually buy the bed because I've been involved
6 a couple times. You actually go through somebody like
7 my colleague over here who works as an intermediary,
8 and you have options with the state with the process.
9 Then everything gets approved, and then you buy the
10 bed.

11 MEMBER CASPER: Right.

12 Plus, to transfer a license, you have to
13 obviously include the licensing authority.

14 MR. WING: You're basically buying the
15 license itself.

16 MEMBER CORPSTEIN: The certificate will
17 not travel with the bed. You have to recertify.

18 MR. CONSTANTINO: In Illinois, though,
19 you would have to get approval from the Board. To add
20 beds, they can't do that without the approval of the
21 Board.

22 MEMBER CORPSTEIN: Right. Your rule is
23 still in effect, the 2010. My health and physical
24 plant rules are still there. Buying and selling the

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1 bed doesn't imply anything other than they can now add
2 a bed here, but they still have to have all three
3 approvals.

4 MR. WING: In truth, in Illinois it
5 would be whatever you wanted it to be. These rules
6 that you have right now, those are your own making;
7 right? If you wanted to design a market in a
8 particular way, you could do so.

9 The question is what's the best way? There
10 are a lot of nitty-gritty details.

11 MEMBER CORPSTEIN: So Ohio doesn't have
12 an exchange. They don't have a set up area. This is
13 completely private sector.

14 MEMBER PHILLIPPE: Yes, that's my
15 experience.

16 CHAIRMAN WAXMAN: Chuck, you had a
17 question?

18 MR. FOLEY: I was just going to ask
19 when our next meeting is going to be.

20 CHAIRMAN WAXMAN: We don't know that
21 yet.

22 MR. URSO: I just want to ask a basic
23 question.

24 What about patient satisfaction? What is

1 the impact on patient satisfaction with all these
2 maneuvers going on?

3 You talked about quality improvements in
4 terms of numbers of deficiency, and I think you had
5 some other parameters there. But the person in the
6 bed, does that person benefit at all or not benefit at
7 all from creating this kind of marketplace?

8 MS. KONETZKA: That's always a
9 million-dollar question because we don't have good
10 data on customer satisfaction. We just don't; right?
11 So we're limited to what we can find in the standard
12 data sources.

13 So we looked at staffing ratios. We looked
14 at deficiencies. We could look at some patient level
15 outcomes but not the more subjective ones. We could
16 look at rates of pressure sores and things like that.
17 We don't see anything coming out in the deficiencies.
18 I doubt we'll see something in those very individual,
19 very narrow measures.

20 So the answer is we don't really know the
21 effect on customer satisfaction. We don't really see
22 a subsequent effect on these kind of quality outcomes
23 that you can look at.

24 One thing that we were just talking about

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1 doing that we haven't done is looking at subsequent
2 payer mix; right? So we looked at what kinds of
3 facilities might buy and sell, but one thing we can do
4 before we send you our final report is to look at
5 whether we see changes in payer mix, who is the
6 marginal patient when it's expanded.

7 MEMBER PHILLIPPE: Yes.

8 MR. WING: That is something that we'll
9 add.

10 CHAIRMAN WAXMAN: Any other questions?

11 MR. URSO: I did have another question.
12 Maybe I just missed this one.

13 Do you know how many total beds were
14 involved in these transactions?

15 MR. LOSASSO: In Ohio there were
16 roughly 14,000 beds that changed hands over the whole
17 '91 through 2012.

18 MR. WING: Most of that time period is
19 with a fixed total quantity of beds. Those are the
20 same beds.

21 MR. LOSASSO: Yeah.

22 MR. URSO: Thank you.

23 CHAIRMAN WAXMAN: Tim?

24 MEMBER PHILLIPPE: I know you were

1 asked to do the study, not bring a recommendation or
2 anything. When you talk about it, you seem positive
3 about it. You talk about it in a positive way.

4 So I took away from that somehow going
5 through the analysis, working on all this, you saw it
6 somehow that it helped Ohio. Somehow you saw it as a
7 good thing.

8 Is that fair?

9 MR. LOSASSO: I think, again, we did
10 summarize our points there.

11 Again, I guess it really does depend on the
12 goals of such a program. If the goal is to kind of
13 eliminate imbalances at whatever level you think is
14 important, whether it's the home or the county or the
15 region, it is a more efficient mechanism for achieving
16 that.

17 It's probably not the most efficient because
18 that would still be no ceiling, but it is nevertheless
19 a -- that's why we characterize it as a plausible
20 second best where it can achieve a better balance.

21 MEMBER CASPER: I want to maybe talk a
22 little bit to that point but also to clarify for other
23 people in the room a point that we discussed while we
24 were on a break. That is I was challenging the

1 assumption that this kind of program, because of lower
2 sale prices for beds in Illinois, would create capital
3 infusion into the market.

4 I think it was clear after our discussion
5 that that's on the seller side. So if the intent is
6 that allowing an owner to sell beds in order to
7 improve their current facility would create enough
8 capital, to enable them to do that is questionable.

9 On the other side of that, however, it's not
10 the cost of the bed or the price of the bed that
11 creates the value on the buyer side. It's the
12 business plan and the access to capital that that
13 creates that creates the access to capital for the
14 market in general.

15 CHAIRMAN WAXMAN: Any other questions?

16 MR. WILL: I've been trying to think of
17 a way to frame this one, but I'm going to ask you to
18 talk to kind of some of where it comes from.

19 What do you think would have happened if
20 instead of using Ohio you used Missouri? That is a
21 state that doesn't have a moratorium, has lower
22 Medicaid rates, you know, has a bed buy/sell program.

23 There are reasons for picking Ohio, I guess.
24 I missed the start of the presentation; but as we

1 discussed it, these sort of things came up. I'm
2 wondering if on some of the like inputs into the
3 model, if you had looked into what those looked
4 like for Missouri or some other state that's more
5 like it and maybe on some other things that this group
6 was interested about, looked at them more like
7 Illinois.

8 MR. LOSASSO: I think it's a fair
9 question, but I think it's one that is very difficult
10 to answer.

11 I think the short answer would be I don't
12 know what it would look like if we used Missouri.
13 Ohio offered easily obtainable data. It was in many
14 ways a convenience issue that allowed us to freely --
15 again, Claire got the data for us. I'll be honest.

16 It's readily obtainable, and it was
17 something that we could implement in a time frame we
18 believe that facilitated the process set forth here by
19 the Committee and Subcommittee.

20 I can't really speak to that.

21 MS. KONETZKA: Can I add something to
22 that?

23 One is that we first sat down when presented
24 with this project and kind of thought through the

1 theory and what we would expect from the theory. The
2 fact that our conclusions kind of came out to be
3 really consistent with what we would expect from the
4 way we were conceptualizing it made us confident that
5 these are sort of underlying things that you might
6 find anywhere.

7 There are, I think, in the details some
8 things that might be pretty different. So I doubt
9 that if we looked at Missouri, you would find -- even
10 if the Medicaid rate is higher, I doubt that you would
11 find -- without being able to really know, I doubt
12 that you would find low-quality, high-Medicaid
13 facilities buying up beds right and left.

14 I think the fundamental of the model would
15 probably still hold. What might be different -- and
16 this came up a little bit earlier. I thought it was
17 very interesting -- is that in Ohio, since the
18 Medicaid rate is higher, in our model we found it
19 really wasn't -- Medicare, for example. It wasn't the
20 high Medicare facilities that were really wanting to
21 buy. It was the ones who had more private pay.

22 Once you look at states that have different
23 differentials between Medicaid, Medicare, and private
24 pay, some of those predictions might have come out a

1 little bit differently.

2 I think on the whole we probably still would
3 have found -- and I'm just extrapolating here, but we
4 probably still would have found that it's the
5 facilities that are already doing better that would
6 want to expand.

7 Whether that means a high Medicare census or
8 a high private-pay census may vary from state to
9 state.

10 MR. WILL: It would be like you
11 wouldn't rewire the model. You would maybe correct
12 some of the facts in terms of, say, if you made them
13 into kind of like coefficient numbers, it might be
14 different.

15 MR. WING: Just a slight elaboration
16 that might put things in perspective a little.

17 In statistics and research design, people
18 use these two concepts, internal validity and external
19 validity. Okay? And there's no way we can know.
20 It's questionable to extrapolate from Ohio to any
21 other state as a sort of first principle; right?

22 I think the issue is just that some things
23 are more likely to have external validity and some
24 things aren't. So the things that don't have external

1 validity, i.e., they don't extrapolate well to another
2 state, are the nitty-gritty details of how many
3 different kinds of nursing homes there are in those
4 states, what the prevailing conditions are for those
5 nursing homes.

6 Those vary dramatically across the state. I
7 know Ohio may well be very different from Illinois.
8 What we think probably has very good external validity
9 is the basic model of how a nursing home goes about
10 deciding how many beds it wants to fill and how it
11 goes about making that decision.

12 That kind of thing seems to be -- people are
13 just as capitalist in Missouri as they are in Ohio.
14 We think that's probably true; and so to the extent
15 that that is true, the relationships we see in a
16 market in Ohio probably would extend very well to
17 Illinois or Missouri.

18 CHAIRMAN WAXMAN: Any other questions?

19 MR. AGBODO: I am still interested to
20 know what kind of distortion competition can introduce
21 in this type of market and what will be the impact on
22 the predictions because if competition is one of the
23 reasons that the providers are holding the beds, I
24 think that is a significant factor.

1 You might know better than I know as far as
2 economics. So market and distortion competition, it's
3 also possible to study. I don't know if you guys
4 would want to look into that avenue.

5 MS. KONETZKA: I think the basic point
6 we would start with about competition is that supply
7 constraints are inherently anti competitive.

8 So I think to the extent that this bed
9 buying and selling is allowed, then competition would
10 increase, and we would expect that on the whole to be
11 good.

12 There could be some unintended
13 consequences in terms of change that are worth
14 thinking about. So there might be still some
15 anti competitive results or unintended consequences;
16 but on the whole, the bed buying and selling would
17 promote competition.

18 MR. WING: Usually the way we frame
19 it is that -- at least economists, the way that they
20 frame it is that it's a lack of competition which
21 distorts outcomes in negative way.

22 Typically we think a perfectly competitive
23 process is what we wish could happen, but for various
24 reasons we don't have that. So you're looking for

1 ways to mitigate the damage -- the allocative damage
2 done by lack of competition by making the market more
3 flexible and competitive.

4 MR. AGBODO: Actually, I was looking at
5 what the competition that is right now in the market
6 that is causing the dead beds.

7 MR. WING: We think it's the lack of
8 competition in the market that's causing the dead
9 beds.

10 MR. AGBODO: It's a different
11 hypothesis. We have the same conditions here in
12 Illinois.

13 Have you guys compared the conditions that
14 you have in Ohio to what we have in Illinois to make
15 sure that a prediction would not be affected by --

16 MR. WING: By differences in market
17 structure?

18 MR. AGBODO: Right.

19 MR. WING: We should think about it.

20 MS. KONETZKA: It's actually something
21 we could easily add to a model.

22 MR. LOSASSO: There are standard
23 measures of competitiveness in a market that we have
24 not incorporated that we could define.

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1 MR. AGBODO: Thank you.

2 CHAIRMAN WAXMAN: Any other questions?
3 Cece?

4 MEMBER CREDILE: That's a process
5 issue. They've made a presentation. It sounds like
6 you may be gathering some additional data.

7 What are our next steps? Do we make a
8 recommendation? Do we suggest that they present to
9 the Mother Board?

10 CHAIRMAN WAXMAN: My gut feeling at
11 this particular moment is that I think we need to meet
12 again as a group, decide what we want to do with their
13 recommendations.

14 Does the RFP say to you who gets the final
15 draft? Is it this subcommittee or are you supposed to
16 deliver it to the Health Resource Board or Governor
17 Quinn personally?

18 MEMBER CREDILE: We haven't seen the
19 RFP. We don't know.

20 MR. LOSASSO: That would be a question
21 for Courtney.

22 CHAIRMAN WAXMAN: That's three for her.

23 MR. LOSASSO: I know.

24 My working assumption is that we will -- our

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1 plan from here is to write this up as a report which
2 we would deliver to this subcommittee. Where it goes
3 from there --

4 CHAIRMAN WAXMAN: To answer your
5 question, I think at our next meeting we should all
6 have that report through Claire and then decide what
7 we think should happen to it.

8 MEMBER CREDILE: So whenever we meet
9 again, we will have the PowerPoint that we had today,
10 and you will provide us, hopefully, sooner than 72
11 hours prior to the meeting, I mean, that we get it so
12 we can read the summary of the report to be prepared
13 to discuss it at our next meeting.

14 CHAIRMAN WAXMAN: And you're going to
15 fine tune it a little on some issues that came up.

16 MR. LOSASSO: Yeah.

17 MEMBER HANDLER: So how long will it
18 take before a final report is submitted?

19 MR. LOSASSO: I think our plan would be
20 to have that by the end of March. So I'm not sure
21 when your next meeting is.

22 CHAIRMAN WAXMAN: I don't think we're
23 going to meet until April anyway. This is the end of
24 February. We've been meeting every other month. That

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1 puts us into an April date, which is our next agenda
2 item.

3 MEMBER CREDILE: A lot of our
4 information we get because of the Act is that 72 hours
5 prior or whatever the time frame is, that this report,
6 Mark would give us enough time to read it as opposed
7 to very short window. It would just be very helpful.

8 CHAIRMAN WAXMAN: Point well taken.

9 Any other questions?

10 We've got like two minutes of business to
11 do. So if you want to hang loose, and we can all
12 leave together.

13 Again our gratitude. Thank you.

14 Is there any other business that's floating
15 around that anybody wants put on the agenda?

16 The next meeting, then, I've forgotten if
17 there was a plan, but it seems to me like we should be
18 in April. It seems to me that we should probably be
19 looking at the week of the 21st. We used to meet on
20 Tuesdays. I don't know how we got with Friday.

21 The Tuesday, then, would be the 22nd of
22 April.

23 PROXY MEMBER SHEETS: There's a
24 Planning Board meeting that day.

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1 CHAIRMAN WAXMAN: There is? Okay.
2 The 29th or the 15th? The 15th is tax day.
3 Boo. So the 15th or 29th? Do you want to do the 29th
4 to give us more time?

5 MEMBER CREDILE: The 29th.

6 CHAIRMAN WAXMAN: The 29th works?
7 Staff?

8 MS. BURMAN: It should be all right.

9 CHAIRMAN WAXMAN: We'll meet here,
10 unless otherwise noted.

11 9:00 o'clock? Do you guys like the 9:00
12 o'clock start time or do you want to go back to 10:00?

13 MEMBER CREDILE: It's really the people
14 that drive further than some of us.

15 MEMBER HANDLER: I think today was a
16 little unusual because we had ice.

17 MEMBER CASPER: There's an LSN meeting
18 that day.

19 CHAIRMAN WAXMAN: You might be the only
20 one impacted or the guy next to you --

21 MEMBER CASPER: Jason.

22 CHAIRMAN WAXMAN: -- Jason.

23 What time is your Board meeting?

24 MEMBER CASPER: It's 10:00 to 2:00, the

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1 same time this one was. Whatever. That's fine.

2 CHAIRMAN WAXMAN: Well, if it affects
3 Judy also --

4 MEMBER PHILLIPPE: I think it would be
5 wise to have them here. We may be deciding to make a
6 recommendation on this.

7 CHAIRMAN WAXMAN: Do you want to move
8 it to the 30th?

9 MR. FOLEY: How about the 15th?

10 CHAIRMAN WAXMAN: That's not enough
11 time. We want to get their report, everybody have a
12 chance to read it.

13 MR. FOLEY: That's two weeks.

14 MEMBER CREDILE: I'm not available on
15 the 15th.

16 PROXY MEMBER SHEETS: So the 30th would
17 be at 9:00 o'clock or 10:00?

18 CHAIRMAN WAXMAN: I don't care. I'm
19 open to that.

20 Does the 30th work? And if 9:00 o'clock
21 works, it might -- I think the reason we went to 9:00
22 was hopefully we'd get out at 1:00. People would have
23 enough time to have a real day. I'm fine with the
24 30th at 9:00 o'clock.

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1 MR. FOLEY: Would it help to have it
2 before or after the Board meeting maybe to give the
3 chance for some of these subcommittee members to
4 attend a Board meeting?

5 CHAIRMAN WAXMAN: I don't know what
6 you're talking about.

7 MR. FOLEY: Our Planning Board meeting,
8 the Mother Board meeting.

9 If we had it the day before or after the
10 Mother Board meeting, you might have a chance for some
11 of these subcommittee members to attend a Board
12 meeting if they were back to back.

13 CHAIRMAN WAXMAN: I'm still not
14 following what you're saying.

15 MR. FOLEY: Never mind.

16 CHAIRMAN WAXMAN: You're saying you
17 want us to meet the same day as the Mother Board?

18 MR. FOLEY: No. I said a day before or
19 a day after so that at least -- it's right in the same
20 time frame. It might give some of the subcommittee
21 members an opportunity to attend a Mother Board
22 meeting.

23 CHAIRMAN WAXMAN: Well, I think they're
24 always invited to a Mother Board meeting; but off the

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1 top of my head, I think we may be putting too much
2 stress on Staff to do those two meetings in a row.

3 MR. FOLEY: Okay.

4 PROXY MEMBER SHEETS: Like yesterday
5 and today?

6 CHAIRMAN WAXMAN: Yeah. Okay.

7 We're on the 30th at 9:00 o'clock, and
8 hopefully they can get this room again for us. I
9 don't have anything else.

10 I need a motion to adjourn.

11 MEMBER PHILLIPPE: So move.

12 CHAIRMAN WAXMAN: Second?

13 MEMBER CASPER: Second.

14 CHAIRMAN WAXMAN: In all favor?

15 (The ayes were thereupon
16 heard.)

17 CHAIRMAN WAXMAN: Thank you. Guys,
18 thanks for your presentation. Thank you for coming
19 out on such a bad day.

20 (Which were all of the
21 proceedings had in the
22 above-entitled matter,
23 concluding at 1:53 p.m.)
24

