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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

April 30, 2014

9:00 a.m.

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

## 1 PRESENT:

2 MR. WILLIAM BELL, Co-Chairman;  
3 MR. DALE GALASSIE; Board Member;  
4 MR. BILL CASPER, Member;  
5 MR. PAUL CORPSTEIN, Member;  
6 MS. CECELIA CREDILE; Member;  
7 MS. CAROLYN HANDLER, Member;  
8 MS. NEYNA JOHNSON, Member;  
9 MR. TIMOTHY PHILLIPPE, Member;  
10 MR. DAVID RAIKES, Member;  
11 MR. MICHAEL SCAVOTTO, Member;  
12 MR. TERRY SULLIVAN, Member;  
13 MR. GREG WILL, Member; and  
14 MR. FRANK URSO, General Counsel.

## 15 STAFF PRESENT:

16 MS. COURTNEY AVERY;  
17 MR. WILLIAM DART;  
18 MS. ANN GUILD;  
19 MS. CLAIRE BURMAN; and  
20 MS. CATHERINE CLARKE.

## 21 ALSO PRESENT:

22 MR. CHARLES FOLEY;  
23 MR. JOHN FLORINA;  
24 MR. JOHN KNIERY;

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MR. COADY WING;  
MS. TAMARA KONETZKA; and  
MR. TONY LOSASSO.

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1 CO-CHAIRMAN BELL: Good morning.

2 After arriving at the appointed hour of 9:00  
3 o'clock, we will go ahead and convene the meeting of  
4 the Subcommittee of the Health Facilities and Services  
5 Review Board.

6 I'm Bill Bell. I'm, I guess, probably one  
7 of the newest members. I guess it must be an  
8 initiation that the new member has to chair the  
9 meeting. So we'll work through this. I've done a few  
10 of these in the past for the Department of Public  
11 Health when I worked there. So I will do my best to  
12 try to make sure that the meeting goes along in an  
13 efficient and effective manner.

14 A couple of housekeeping things: Please  
15 make sure that you are mindful of our reporter and  
16 that she's able to identify you if there's a comment  
17 made. Please, which I'll have to watch also, talk  
18 distinctly and clearly.

19 At this point I think we'll just, if it's  
20 acceptable, go around the room and do our  
21 introductions, probably first the Board members and  
22 then any guests that we have.

23 MR. GALASSIE: Dale Galassie, Board  
24 member.

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1 MEMBER SULLIVAN: Terry Sullivan,  
2 Alliance for Living and Illinois Nursing Home  
3 Administrators Association.

4 MR. FLORINA: John Florina, Nursing  
5 Home Administrator. I'm a visitor.

6 MEMBER SCAVOTTO: Michael Scavotto,  
7 Committee member.

8 MR. KNIERY: John Kniery, Health  
9 Planner, Health Consultants, visitor.

10 MR. FOLEY: Charles Foley, visitor.

11 MEMBER JOHNSON: Neyna Johnson,  
12 Committee member.

13 MEMBER HANDLER: Carolyn Handler,  
14 Committee member.

15 MEMBER CREDILE: Cece Credile,  
16 Committee member.

17 MEMBER RAIKES: David Raike, Committee  
18 member.

19 MEMBER CORPSTEIN: Paul Corpstein,  
20 Long-Term Care Licensure, Committee member.

21 MEMBER PHILLIPPE: Tim Phillippe,  
22 Committee member.

23 MEMBER CASPER: Bill Casper, Committee  
24 member.

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1 MR. DART: Bill Dart with the  
2 Department of Public Health.

3 MS. AVERY: Courtney Avery, Health  
4 Facilities and Services Review Board.

5 MR. WING: Coady Wing. I'm with the  
6 University of Illinois at Chicago.

7 MR. LOSASSO: Tony Losasso, professor  
8 at University of Illinois-Chicago, visitor.

9 MR. URSO: Frank Urso, Counsel to the  
10 Board.

11 MS. BURMAN: Claire Burman, Staff to  
12 the Board.

13 CO-CHAIRMAN BELL: Very good. Welcome  
14 everyone.

15 I guess our first item of business is the  
16 approval of the agenda. I hope you all received that  
17 in your mailing and have had a chance to look at it.  
18 At this point I'll entertain a motion to approve the  
19 agenda.

20 MEMBER PHILLIPPE: So move.

21 MEMBER SCAVOTTO: Second.

22 CO-CHAIRMAN BELL: Is there any  
23 discussion? If not, all in favor, aye.

24 (The ayes were thereupon

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8

1 heard.)

2 CO-CHAIRMAN BELL: Opposed? Thank you.

3 Next item, approval of the February 21,  
4 2014, meeting transcript. Again, I hope that you all  
5 received that and had a chance to look over that and  
6 review it.

7 At this point I'll take a motion.

8 MEMBER SULLIVAN: So moved.

9 CO-CHAIRMAN BELL: Second?

10 MEMBER CASPER: Second.

11 CO-CHAIRMAN BELL: Any discussion on  
12 the transcript minutes from the last meeting?

13 MEMBER SULLIVAN: The brief discretion  
14 is the transcript summary is a delightful two-page  
15 summary as opposed to reading through the 87 pages of  
16 minutes. Whoever did the transcript, I'm very  
17 grateful, not that I didn't read through the 87 pages.

18 MR. URSO: But now you have two things  
19 to read.

20 MEMBER SULLIVAN: Yes, but this is a  
21 summary. So thank you, whoever did it.

22 MR. URSO: Claire did it.

23 MEMBER SULLIVAN: Thank you, Claire.

24 MS. BURMAN: You're very welcome.

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1 CO-CHAIRMAN BELL: So now that somebody  
2 liked it, you're probably stuck doing that from here  
3 on in.

4 All in favor?

5 MS. BURMAN: The next one will be  
6 illustrative.

7 CO-CHAIRMAN BELL: Is there any  
8 discussion? Any questions, comments, corrections?

9 Go ahead, Ann. Introduce yourself.

10 MS. GUILD: I'm Ann Guild. I'm doing  
11 some contract work for the Health Facilities and  
12 Services Review Board.

13 CO-CHAIRMAN BELL: Good to see you,  
14 Ann. Very good.

15 Not hearing any issues or concerns, all in  
16 favor of approval of the transcript from our last  
17 meeting?

18 (The ayes were thereupon  
19 heard.)

20 CO-CHAIRMAN BELL: Opposed? Very good.  
21 We are going to have a slight change in our  
22 agenda. The UIC folks asked if they could go forward.  
23 At this point in time they have other commitments.

24 So if it's acceptable to the Board, we're

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1 going to go ahead and move No. 6 up to No. 4. Unless  
2 anyone has any problem with that, we'll go ahead and  
3 turn it over to our U of I Staff and see what they  
4 have to tell us today concerning the report that  
5 they've published.

6 MR. LOSASSO: Thank you, Chairman Bell  
7 and members of the Subcommittee. We appreciate this  
8 opportunity to come back and meet with you and get  
9 your reactions.

10 Of course, we sent a couple weeks ago the  
11 report that we wrote. In the prior meeting we gave  
12 you a nice, long two-hour presentation of our results,  
13 which did include at no extra charge an introduction  
14 to economics from the economics professors that are  
15 here before you.

16 I'll also apologize. My other colleague,  
17 Tamara Konetzka, is caught in traffic. She'll be here  
18 shortly.

19 Really, the purpose I see of us coming back  
20 here is to get any reactions or questions or comments  
21 or talk through any of the aspects of our report that  
22 you want to. I mean, I'm happy to give you just a  
23 brief overview, but I don't want to go back into  
24 professorial mode. Nobody wants that, I don't think,

1 I suspect, but it's always lurking there as a risk.

2 So if that's okay, I'll give you a brief  
3 kind of guided tour, I guess, of the report. Of  
4 course, the study questions that guided our work were:

5 Can a bed market improve the utilization of  
6 existing long-term care beds?

7 How might a bed market affect the current  
8 long-term residents and the community, with particular  
9 emphasis on underserved communities?

10 What are the best ways to structure a bed  
11 market?

12 And can a bed market infuse capital into  
13 long-term care institutions?

14 Then lastly, our thoughts on what are  
15 potential unintended consequences of such an approach.

16 So you've read our report. You've seen  
17 that we provided a review of the literature. I won't  
18 rehash that now. It's in the document. We do have  
19 some recommendations there about the role of  
20 Certificate of Need generally and as it relates to bed  
21 market and thinking about the questions that I just  
22 enumerated.

23 Again, I'm happy to talk through any  
24 elements of that. We spent a fair bit of time in the

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1 report talking about the specifics of a bed market, a  
2 buy and sell program for existing licensed beds in the  
3 State.

4 To aid our work, we learned much from  
5 another state that has had a bed market up and running  
6 for more than 20 years. That's Ohio. They actually  
7 have two different flavors of a bed market, one where  
8 beds are allowed to be sold within county, and then  
9 that's then broadened to a cross-county later. So  
10 that gives us two different variations on the same  
11 theme to explore.

12 MR. GALASSIE: Anthony, can I  
13 interrupt?

14 MR. LOSASSO: Yes, sure.

15 MR. GALASSIE: When you both did the  
16 presentation discussing that specific item -- and that  
17 was Ohio, again? --

18 MR. LOSASSO: Ohio.

19 MR. GALASSIE: -- that was initially  
20 done by design because they wanted to see how it  
21 worked?

22 MR. LOSASSO: Yes, I believe that's  
23 correct.

24 MR. GALASSIE: Do you know about how

1 long a period of time it was restricted to within  
2 county?

3 MR. LOSASSO: So the bed market began  
4 in 1991 in Ohio. In 1993, a statewide moratorium was  
5 imposed on the construction of new long-term care  
6 beds, and then by 2009 the laws around the market were  
7 broadened to allow for cross-county trading.

8 MR. WING: I don't think it's true that  
9 it was done by design as an experimental idea, like  
10 "Let's try within county first and then expand."

11 I think they started there because it  
12 actually lasted for a long time within county level,  
13 and then eventually they expanded it. I don't think  
14 they did it preplanned in that way.

15 MEMBER SULLIVAN: I think when we had  
16 our discussions with Ohio, the reason they switched  
17 off the county thing is that it was becoming a  
18 tremendous imbalance in the cost of facilities from  
19 urban and suburban areas where it was, you know,  
20 \$3,000 in an urban area and \$25,000 in a suburban  
21 area.

22 So they wanted to flatten it out a little  
23 bit, expand it.

24 MR. WING: That makes a lot of sense.

1 MR. LOSASSO: For us, really, the most  
2 telling figure, at least with respect to Ohio, is  
3 Figure 5 in the report. I don't know if you have that  
4 here, but Figure 5 does show the -- it shows both the  
5 number of trades, number of beds, that is, bought and  
6 sold over time along with the price of the bed.

7 So what happens, then, is this enormous  
8 spike in 2010, which is the first year in which  
9 cross-county trading is allowed.

10 So you see more than a 100 percent increase  
11 in the number of beds transacted concurrent with a  
12 drop in the price, which is pretty much exactly what  
13 you'd expect to have happen if suddenly the market was  
14 in effect opened up and more beds were available.  
15 You'd expect more transactions and a lower price.

16 So that was very revealing, I think, for us  
17 and informative as well. In fact, I'll get to sort of  
18 the summary recommendations and the lessons learned, I  
19 think, in terms of the report.

20 Before I do, I'll mention the role of Ohio  
21 in all this, which I know there were questions about  
22 both at the meeting last time and in a subsequent  
23 e-mail to us, the idea being that once you've seen one  
24 state, you've seen one state, as the expression goes,

1 that each state is different and has its own  
2 particular idiosyncratic predictions, institutions,  
3 regulatory environment, and all that.

4           However, it's important to keep in mind that  
5 when you talk about what can be learned from one  
6 state, it's not really in our view sufficient just to  
7 say it's a different state and, therefore, we can't  
8 learn anything from it.

9           I mean, I think one needs to have a  
10 different behavioral model in your mind to be able to  
11 then say that it's a different state, so we can't  
12 learn anything from it.

13           In other words, you have to be able to tell  
14 me and convince everyone here that, "Oh, those  
15 Buckeyes, they don't maximize profits in their nursing  
16 home industry" or "We in Illinois don't maximize  
17 profits to the extent we can."

18           So in other words, the underlying behavioral  
19 model of how nursing homes and patients behave needs  
20 to be different between the two states in order for us  
21 to really, I think, cast a great deal of suspicion on  
22 learning from Ohio in this instance.

23           So we didn't have any prior beliefs or come  
24 across any evidence that Ohio is somehow a

1 fundamentally different place where up is down and  
2 black is white and profits are to be minimized instead  
3 of maximized. So that's why we did focus our analysis  
4 on the Ohio experience.

5 We built a predictive analytic model at the  
6 nursing home level that informed us about the  
7 predictors of buying and selling a bed when you have  
8 the ability to do that, both a within-county model and  
9 then a cross-county model of buying and selling  
10 behavior.

11 We then took that model which we built from  
12 Ohio data and then applied it to Illinois nursing  
13 homes to generate specific estimated probability of  
14 buying and selling behavior here or hypothetical  
15 buying and selling behavior in Illinois. So that was  
16 the main thrust of the analytic approach, and all of  
17 that is detailed, of course, in the report.

18 So that then led to a number of predictions  
19 that we discuss in the report about which homes we  
20 predict will buy beds and which homes we predict will  
21 sell beds.

22 I mean, it's back to the questions we were  
23 asked to answer, you know. Would a bed market improve  
24 the utilization of existing beds? I think our answer

1 is that the evidence points to yes, it would.

2 I do point out that it would be a  
3 second-best approach to simply -- maybe it's not  
4 simple but to eliminating the CON process in the first  
5 place, in which case nursing homes would be free to  
6 install new beds or take away beds as they see fit.

7 The imposition of a market whereby nursing  
8 homes would have to buy beds imposes a friction on  
9 that process. Nevertheless, it can lead to  
10 incremental improvements in utilization of beds  
11 throughout the State.

12 So both our theory and our empirical results  
13 are consistent with that finding.

14 MR. GALASSIE: Tony, let's stay with  
15 that for a minute. Share with us a little more your  
16 thoughts about freeing the buy/sell process from the  
17 CON process.

18 MR. LOSASSO: Sure.

19 As some 14 or so states have done over the  
20 last 20-odd years, eliminate the CON process, then in  
21 essence nursing homes are free to -- if they want  
22 another bed, they go to the bed store and buy another  
23 bed and install it. Now, I'm simplifying, obviously,  
24 but that's essentially the process. So that's a

1 market of sorts there, and they're allowed to do that  
2 as they see fit.

3 If they don't want a bed, they simply --  
4 they have that option available to them now, though,  
5 which is to not use a licensed bed, which is why we  
6 have so many reports, anecdotal and otherwise, that  
7 there is this unused occupancy currently in Illinois.

8 So they're doing that part, but what they  
9 can't do is they can't right now add more beds. A bed  
10 market, you know, is one way to allow them to do that.

11 MR. DART: So they can't add beds with  
12 the 10 percent, 20-bed rule?

13 MR. LOSASSO: Right. There is limited  
14 ability.

15 MR. DART: There is also the regulatory  
16 process that would be involved. They can't just open  
17 a bed. They have to go through Public Health  
18 licensure.

19 MR. LOSASSO: Always.

20 MR. WING: Can I add one thing?

21 If you're looking for a way to just sort of  
22 conceptualize the difference between, you know, a  
23 managed -- a CON Board managed bed-trading scheme,  
24 which is what they have done in Ohio, and a market

1 that has a much smaller or nonexistent role for the  
2 CON Board, the analogy might be something like this:

3 If you think in the environmental context,  
4 oftentimes people pose a policy of cap and trade or  
5 carbon images, and what that says is that some  
6 governmental agency is going to fix the total quantity  
7 of carbon permits that are available and from there  
8 will let firms and individuals buy and sell those  
9 permits as they see fit.

10 That's the Ohio model more or less, okay,  
11 that there's a capped number of beds. There's a  
12 moratorium which they can change at any time, and  
13 that's what the CON Board here could do under that  
14 model as well, set the quantity of beds but then step  
15 back from the allocation of beds and let the firms  
16 themselves figure out, you know, where the beds should  
17 be, where they should go based on market mechanisms.  
18 So that's one model.

19 The other model where there's a much smaller  
20 role for the CON Board is just that there's the same  
21 training mechanism but there's no cap, that the firms  
22 themselves can decide how many beds that they want to  
23 have, too.

24 So the difference between the two models in

1 my mind is really about whether we impose a cap on the  
2 total number of beds and then let trading do the  
3 allocation or whether we let trading do the allocation  
4 and we let trading determine the appropriate total  
5 number of beds.

6 To me that seems like the key feature.  
7 It's not whether we should abolish the Board or not.  
8 It's really about, you know, what we're trying to  
9 achieve, whether you want to cap the number of beds  
10 and deal with allocation or whether you want both  
11 mechanisms to work.

12 MEMBER SCAVOTTO: So I'm confused about  
13 what you just said.

14 It seems to me that we're dealing with a  
15 finite number of beds. Is that a correct assumption  
16 or not?

17 MR. WING: It's a choice, I think.

18 MEMBER SCAVOTTO: But in both of your  
19 examples, are we dealing with a finite number of beds?

20 MR. WING: No.

21 So in one example, the Ohio case, for  
22 example, we are dealing with a finite number of beds,  
23 but that's because Ohio decided to only allow there to  
24 be a finite number of beds.

1           If you think of any other market for things,  
2 think of the market for beds in your house, you know,  
3 privately consumed beds in bedrooms, there's no cap  
4 nationwide on the number of beds. You can simply go  
5 and buy a mattress if you want to and put it in your  
6 house.

7           So in that sort of non-long-term care  
8 context, the market for regular beds, there's no  
9 finite number of beds. We can produce as many as we  
10 want and buy them from wherever.

11           MEMBER SCAVOTTO: All right. I get it.  
12           That is really more apropos to the 14 states  
13 that have abolished CON.

14           MR. WING: Precisely correct.  
15           In those places they have a market in beds  
16 that is uncapped, and basically "uncapped" means the  
17 CON Board is not involved -- or not involved in that  
18 aspect.

19           MEMBER GALASSIE: That cap right now --  
20 pardon me. I guess I'm asking Bill.

21           That cap right now is set by IDPH, not the  
22 CON Board?

23           MR. DART: Well, there is no cap at  
24 all.

1                   MEMBER GALASSIE: That's kind of the  
2 question. So we talk about the Ohio model; and with a  
3 moratorium, in Illinois there is no moratorium.

4                   MR. WING: But there is a restraint on  
5 how many beds can be produced. You still control  
6 that. You have a rule; right?

7                   MEMBER SULLIVAN: The bed need formula.

8                   MR. DART: Well, there's a bed need  
9 formula, but then there's the approval of new  
10 applicants, and then there's the 10 percent, 20-bed  
11 rule.

12                   MEMBER SULLIVAN: The interesting thing  
13 with the current system is there is incentive to  
14 putting in more beds. There's no incentive for any  
15 existing provider to reduce beds; whereas, the  
16 buy/sell system would allow at least the transfer of  
17 beds within the system but for a provider to reduce  
18 unused beds.

19                   MR. LOSASSO: Correct.

20                   MR. WING: I'd say both systems have  
21 that feature.

22                   Even now what happens is if an individual  
23 provider doesn't see any value in filling a particular  
24 bed, they can just let that bed not be filled.

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1                   MEMBER SULLIVAN: But they don't give  
2 up the license.

3                   MR. WING: That's right, because  
4 there's no way for them to do so.

5                   MEMBER SULLIVAN: Right, other than to  
6 write a letter and say, "We're cutting our beds by  
7 10 percent," but nobody is going to do that.

8                   MR. WING: Yeah, there's really no  
9 reason. That would be foolish.

10                  MR. FOLEY: It does happen once in a  
11 while. We see providers where they do in fact cut  
12 back on their license capacity by 10 beds, 20 beds.  
13 That does in fact show up in the inventory  
14 periodically. So it does occur. How often I really  
15 don't know.

16                  Sometimes they realize that all these beds,  
17 we're not going to use them, and so they obviously do  
18 give them up, period.

19                  MEMBER PHILLIPPE: I have two  
20 questions.

21                  One is it looks like, reading the report,  
22 you're basically recommending the least control of the  
23 process as possible. So you start with no CON, and  
24 then you kind of move through the different options.

1 Kind of what I got from the report is the least sort  
2 of control of the movement of the beds works for the  
3 best.

4 Is that accurate?

5 MR. LOSASSO: Yes, I think that is a  
6 fair statement.

7 When we think about the questions that we  
8 propose, you know, in terms of utilizing existing  
9 beds, meeting consumer demand for beds, yes, the least  
10 control would allow for the best and most efficient  
11 response to the demand for long-term care services in  
12 the State.

13 MEMBER PHILLIPPE: And the second  
14 question is -- I didn't see it in here, so maybe it  
15 was assumed, but mostly we're talking about buying  
16 beds and adding to an existing facility.

17 In other states, including Ohio, those beds  
18 can actually be used to build something new. I've  
19 looked at, actually, developments in Ohio, and I've  
20 looked at how I put the beds together and the price of  
21 each bed and all that.

22 In Ohio, you build new facilities by buying  
23 beds, and some other states have done that, too. I  
24 just want to point that out because I think the impact

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1 is very different from adding onto an existing  
2 facility versus building something new, partly because  
3 we already have the 10 percent, 20-bed rule. So we  
4 can already expand a little bit.

5 So that difference, is that in the report or  
6 do you have any thoughts about how the impact would be  
7 different from just expanding existing to building  
8 something new?

9 MR. LOSASSO: I think it's a great  
10 point. We certainly do observe instances in the Ohio  
11 data where a facility is putting together beds from  
12 multiple sources in order to open a whole new  
13 long-term care facility.

14 We did not specifically look at that as an  
15 outcome. It wasn't really one of the questions we had  
16 in our mind or were posed going into this, but it is  
17 an interesting point and an interesting thing to think  
18 about, whether that's something that the State would  
19 want to allow.

20 MS. KONETZKA: And in our definitions  
21 in the report of "buying," it means they were  
22 combined.

23 MEMBER SULLIVAN: I'm still confused  
24 about your uncapped system.

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1           Are you saying in an uncapped system I would  
2 have to buy beds or could I just make up beds?

3           MR. WING: You can make up beds.

4           MEMBER SULLIVAN: I can make up beds.  
5 So I wouldn't have to buy the beds.

6           So basically why have a buy/sell program?  
7 If I want to build a 200-bed facility, I'll build a  
8 200-bed facility if there's no CON.

9           MR. LOSASSO: That's a great point.

10           I just want to clarify some of what Coady  
11 said a little while ago, that there are two buy/sell  
12 kind of options. There's a capped one, which is Ohio,  
13 not Illinois. There is a buy/sell under CON, under a  
14 CON restricted environment.

15           Then there is no CON. In that case, there's  
16 no need for buy/sell. You go to the bed store, you  
17 open, you put in -- subject, of course, to all the  
18 regulatory and safety requirements that the State  
19 imposes on such a facility.

20           MR. WING: Of course, there will still  
21 be buying and selling of beds. When we say "make up a  
22 bed," we don't mean build a factory and literally  
23 build a bed. You still go purchase the materials you  
24 would need to build the facility.

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1                   MEMBER SULLIVAN: Right, but you  
2 wouldn't have to buy a bed from another facility.

3                   MR. WING: From an existing facility, no,  
4 not necessarily -- or not at all, actually; right?

5                   MEMBER CASPER: It would be a true free  
6 market.

7                   MR. LOSASSO: That's right.

8                   MEMBER CREDILE: I represent Illinois  
9 Health Care. If the Committee would oblige me, I  
10 actually have a report, if you will, or statement and  
11 comment on behalf of Illinois Health Care that goes  
12 along with this discussion.

13                   Is it okay?

14                   CO-CHAIRMAN BELL: Yes.

15                   MEMBER CREDILE: Illinois Health Care  
16 is a supporter of the strategy in the long-term  
17 industry to include bed market buy/sell as a component  
18 of improving access to nursing home and post-acute  
19 beds, as discussed in this study.

20                   The Ohio study, as summarized on Page 28, is  
21 that, quote, "There is a more efficient matching of  
22 supply and demand such that allocation of beds is  
23 improved, which may improve overall quality by  
24 allowing expansion of high-quality facilities."

1           This strategy would allow for modernization  
2 with new facilities, potential modernization of  
3 existing facilities if parameters were set in Illinois  
4 to require, for example, a reinvestment back into the  
5 seller's facility, for example, an increase in private  
6 rooms from the seller, and all of that is a mission of  
7 our Committee here.

8           IHCA is further supportive of a revised or  
9 modified CON process in Illinois with buy/sell, as  
10 discussed in this study. The UIC study reveals that a  
11 moratorium of beds exists in Ohio, which is a  
12 necessary component of a successful strategy to  
13 equalize access and is required for buy/sell.

14           The existing process of the CON process for  
15 new beds would need to be eliminated for new beds,  
16 but, rather, IHCA would support a moratorium on  
17 existing beds and a new CON process with oversight  
18 under a moratorium.

19           As in Ohio, then the construction of a new  
20 facility would be predicated on a CON process whereby  
21 beds could be moved from a planning area or a county  
22 with limited access from a county with excess  
23 capacity.

24           Ohio has had a moratorium on beds for years.

1 New facilities have been built. Facilities have had  
2 additions, et cetera, under that moratorium.

3 IHCA would suggest there are some  
4 additional components of the Ohio program that  
5 illustrate success and very thoughtful implementation.

6 IHCA would like to offer a resource -- and I  
7 don't know if you have had this resource -- of Chris  
8 Kenny. She's a former CON director in Ohio in a  
9 position very similar to Mike Constantino.  
10 Unfortunately, he's not here for those accolades. She  
11 could provide further confirming information on some  
12 items I'm going to discuss.

13 Then I have a contact for her, if anyone is  
14 interested. Her phone is (614) 580-8046, and her  
15 e-mail is ckenney, K-e-n-n-e-y, @bricker.com.

16 The reason that we are suggesting that  
17 perhaps she'd be a resource to us or I can be in touch  
18 with her, however we might want to proceed, is that  
19 there are additional Ohio components included, as we  
20 understand it as IHCA, that would be included in this  
21 discussion that might help us.

22 This certainly is not inclusive of all the  
23 details of the Ohio program but may be critical  
24 program components for consideration in Illinois. In

1 fact, what Tim has just suggested I think is one of  
2 the components.

3 Number 1 is that statewide changes require  
4 application for buy/sell in Ohio in a finite period of  
5 specified months, and that was 2010, 2012, and every  
6 four years thereafter. So they can't do any  
7 transactions until 2016.

8 It was actually in my understanding moved to  
9 four years because those of us that are in the  
10 industry know that it takes minimally two years to  
11 have approval and construction of a new facility.

12 So what happened was they said 2010 you can  
13 move, 2012 you can move facilities; but the 2010 folks  
14 still weren't finished really in 2012, and even some  
15 of the 2010 folks had backed out. They couldn't get  
16 financing or whatever.

17 So now the next period of time is 2016 that  
18 they can actually move beds. This specified time  
19 period is a critical component of the program and  
20 allows for a CON process as well as market  
21 equalization.

22 Secondly, the state of Ohio allows for  
23 transfer of beds within a county for an owner, but  
24 they cannot transfer more than 30 beds to an existing

1 facility. They can't build a new building. They can  
2 transfer beds but no more than 30.

3 Thirdly, to Tim's point, in the years  
4 allowing statewide access changes, owners can also  
5 move beds within a planning area. So for example, an  
6 owner could pool a bed from counties with excess beds  
7 to a county with need and build a new building, but it  
8 was all predicated on need and access in Ohio.

9 This was exemplified, as we understand it,  
10 in Cincinnati and Cleveland where there was a  
11 population drop and excess beds. Columbus was an  
12 underbedded market. So beds were pooled from an  
13 overbedded market and moved to an underbedded market.  
14 This was all part of the CON process in Ohio to ensure  
15 movement of beds to an underserved population area.

16 This process of pooling may in part explain  
17 some of the yearly variation in average sale price, as  
18 illustrated on Page 18, and IHCA would like to request  
19 confirmation of the sales price as it may be higher  
20 than what is recorded.

21 We think perhaps -- but we're not sure -- it  
22 is because beds were pooled by owners, which would  
23 then lower the price. I don't know. I'm not sure,  
24 but we remain concerned.

1           I had sent original comments that it looks  
2 like the bed price is lower than perhaps it would have  
3 been, but also the spikes are because you could only  
4 move beds in 2010, 2012, and again in 2016.

5           No. 4, Ohio required owners in 2012 to give  
6 10 percent of excess beds back to the State so that  
7 the State could create a pool of beds to serve  
8 underserved areas where there might not be movement of  
9 beds, again, all trying to address access.

10           So for example, if an owner bought 132  
11 beds, they can only build 120. They gave 12 back to  
12 the State. There's a moratorium, don't forget. So  
13 then you have to create a way to be able to move beds  
14 to underserved and for appropriate access, which is  
15 all of our concern. So the moratorium then allowed  
16 for overall beds not to be increased but accessed.

17           Number 5, there is no moratorium on  
18 transactions, and the transactions are reviewed  
19 through a CON process.

20           Finally, Ohio utilizes a different bed need  
21 formula than Illinois, and they use beds per thousand.

22           So ultimately, we'd like to thank UIC for  
23 your thoughtful and insightful review of the bed  
24 market buy/sell. We support the bed market buy/sell.

1 We would appreciate consideration of these items as it  
2 relates to the impact in Illinois, some of which has  
3 already been brought up.

4 MR. LOSASSO: Can I make a couple of  
5 quick reactions? This is the first time I'm hearing  
6 of this response. I appreciate the interest on the  
7 part of Illinois Health Care.

8 I would say that it's a little bit of a  
9 selective interpretation of our report and our  
10 recommendations. We don't have a position. We don't  
11 mention a position on a moratorium in the State on  
12 beds, and I think we could probably be clearer about  
13 that, which I can do now.

14 I will just say that a moratorium limits  
15 flexibility of the response to need in the State. It  
16 artificially raises prices of beds that would happen  
17 in a bed buy/sell or a bed market program. It tends  
18 to benefit insiders, that is to say people who already  
19 have licenses for beds and are operating already in  
20 the State.

21 So again, to that backdrop I would just ask  
22 the Committee to keep in mind that in the order of  
23 most efficient, the first best, as we say in the  
24 report, with all due respect to the Members here, no

1 CON process other than for safety. That has the  
2 maximum flexibility, maximum response to demand and  
3 need in the state.

4 Second best, bed market, preferably  
5 statewide, no moratorium. Then after that, bed  
6 market with a moratorium. Then only after that is the  
7 status quo.

8 Now, there probably are some gradations  
9 within there. As we talk about in the report,  
10 anything that restricts the geography of trading only  
11 serves to limit the effectiveness of the program and  
12 the ultimate ability to respond to the needs of the  
13 patients in the State.

14 So I would just like to have that out there  
15 in response to what we just heard.

16 MEMBER SCAVOTTO: While you're going,  
17 I'll just keep responding.

18 I think, Cece, you pointed out that in Ohio  
19 they were maxed at a block of 30? Did I hear that  
20 right?

21 MEMBER CREDILE: That's for transfer of  
22 beds, correct.

23 So if an owner had excess beds in one  
24 building and they wanted to move them to another

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1 building, they could only do a max of 30.

2 MEMBER SCAVOTTO: They could do 30.

3 MEMBER CREDILE: And they have to do it  
4 within a county. So you can't run around and move  
5 them wherever you want.

6 MEMBER SCAVOTTO: Did I hear you  
7 correctly when you said there were only certain  
8 periods of time where beds could be moved? I thought  
9 I heard that.

10 MEMBER CREDILE: Yes.

11 MEMBER SCAVOTTO: So did you respond to  
12 that in context of your report?

13 MR. LOSASSO: We drew insight from  
14 Ohio. We didn't want to get overly bogged down in the  
15 particulars of how they implemented it and the  
16 particular institutions that they invoked to require  
17 or restrict the trade.

18 I mean, all of those types of behaviors that  
19 you're mentioning, you know, those tend to impose  
20 frictions or costs on the reallocation process that  
21 allows beds to go from where they are to where there  
22 is need for them.

23 Again, the overall thrust of our report is  
24 to try to in effect liberate these beds so that they

1 can go to where the need is. Those types of rules and  
2 restrictions and regulations only serve to impede that  
3 process.

4 MEMBER SCAVOTTO: Let me follow that.

5 So if Ohio had some restrictions and your  
6 conclusion is that those restrictions were not  
7 significant enough to affect your conclusions, you  
8 still feel that an open market is the way to go?

9 That's what I'm hearing. I don't want to  
10 misstate.

11 MR. LOSASSO: No. I think that's  
12 exactly right.

13 MEMBER SULLIVAN: Missouri has a less  
14 restricted buy/sell program than Ohio, and it's  
15 statewide and there's almost no restrictions on it.

16 I know the three associations did have  
17 discussion with Courtney's equivalent in Missouri who  
18 initially was very hesitant about the program because  
19 he wasn't sure where things were going.

20 He said, "You know, after five years,  
21 basically the marketplace did allocate according to  
22 need, and basically beds just by marketplace moved  
23 from overbedded areas to underbedded areas because  
24 that's where in fact the marketplace need was."

1           So it seems like in many ways Missouri kind  
2 of backs up your perception of the fewer touches in  
3 the system, that the marketplace does tend to equalize  
4 it out.

5           MR. LOSASSO: I'll just comment quickly  
6 on that. That's a great point. We would honestly  
7 love to study Missouri as well, but time and resources  
8 did not permit that for this work.

9           I think your broader point, though, is  
10 exactly right. To the extent there are other  
11 frictions, other factors, regulations, it just slows  
12 the process. It did happen and it continues to happen  
13 in Ohio, that is to say reallocation to meet the  
14 needs. It just happens slower when there are more  
15 restrictions and regulations to the process.

16           MEMBER CASPER: So I have kind of three  
17 points to make.

18           One is, I think, just to state a fact.  
19 Maybe you can validate this. One of the principles of  
20 the regulatory process is that in addition to all of  
21 its intended goals of promoting safety and efficiency  
22 and effectiveness, regulations protect those with an  
23 existing franchise.

24           So for example -- I think you implied this.

1 Maybe you didn't state it directly -- if Illinois were  
2 to go forward and impose a moratorium as a component  
3 of the buy/sell program, that would probably cause the  
4 price to go up, correct, because it would then create  
5 a limited supply?

6 MR. LOSASSO: Relative to there not  
7 being a moratorium.

8 MEMBER CASPER: Correct. So again, the  
9 principle of protecting those with the existing  
10 franchise.

11 The second point and/or question is your  
12 comment of if you've seen one state, you've seen one  
13 state. I think some of the nuances and details that  
14 have just been discussed between Missouri and Ohio  
15 illustrate some of that.

16 I guess my question is: In terms of a  
17 recommendation to this Committee and to the Board  
18 ultimately, would it make sense to do a broader review  
19 of alternative models to assess the impact of what  
20 some of the nuances and differences in regulatory  
21 structure have had on how -- what the outcomes have  
22 been in the process?

23 MR. GALASSIE: I'm sure the U of I  
24 thinks so.

1 MEMBER CASPER: Yeah.

2 I guess thirdly is sort of a related  
3 question, and that is: Do you draw any conclusions or  
4 can you make any comments about what's been discussed  
5 here in terms of the number of licensed beds that are  
6 not currently in service in this State that would  
7 really impact what would happen if a buy/sell program  
8 were implemented? Because my guess is that kind of  
9 sort of inventory did not exist in the Ohio model.

10 MR. LOSASSO: Thank you for the  
11 questions. I think I have responded already to the  
12 first one. I'll take the second one regarding what  
13 can be learned from more states.

14 Clearly, as academic economists and  
15 academics generally, we have a baseline response that  
16 is more study is always good.

17 (Laughter.)

18 MR. LOSASSO: We can pass our hat  
19 around in order to acquire the resources to do that.

20 Now, jokingly I will add that -- I tried to  
21 head this off a little bit with my earlier  
22 introductory remarks, just to say that while there are  
23 differences between states along many dimensions -- we  
24 are fully cognizant of that -- we think that the

1 fundamental behavioral responses that we're studying,  
2 which is to say the behaviors that long-term care  
3 facilities have in terms of their motivation for --  
4 let's call it profits, that those are more universal,  
5 unless you tell me otherwise. I mean, you've been to  
6 Ohio. They have their people, too, with human  
7 motivations.

8 So I think there needs to be sort of a  
9 stronger argument, I guess, that we would need to hear  
10 or uncover as part of our research as to why the  
11 conclusions that we draw from Ohio would not be valid  
12 for Illinois.

13 We did not come across such information, and  
14 we think that there is -- with the broad framework  
15 that we took in terms of profit-maximizing  
16 institutions behaving in that manner, we think there's  
17 a lot to learn.

18 I'm going to continue to say, though, that  
19 we could learn more with more states, but it would be  
20 mostly incremental. Like I said, reallocation of beds  
21 happens faster or slower when you have these other  
22 features.

23 I feel comfortable saying that the less  
24 touches -- as you said, Mr. Sullivan, the less

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1 restrictions, the less friction, which is the word I  
2 use, will speed the process of reallocation.

3 MS. KONETZKA: If I may add two small  
4 things to that.

5 One is that just looking within Ohio, over  
6 time they had some changes like the 2010 change. Our  
7 fundamental conclusions as to which facilities would  
8 want to expand and which would not didn't change under  
9 those either.

10 So that gives us more confidence that under  
11 a slightly different structure, those fundamental  
12 conclusions we had probably would not change.

13 The other thing I would add is that we  
14 picked Ohio for one very good reason, and that is they  
15 did have detailed data collected. There is a  
16 practical issue that if you try to look at other  
17 states, you may not have the same kinds of data.

18 MEMBER PHILLIPPE: Actually, I  
19 appreciate the study because we're talking about the  
20 practical stuff of comparing states, but really your  
21 study is based on the economics. It's really not  
22 about comparing states and seeing the practical. I  
23 mean, it's based on the economic themes, which are  
24 relevant in any state.

1           So I appreciate that because it does  
2 eliminate the issues of -- just like you said, the  
3 more control is put on it, like the more you limit the  
4 ability to move beds, the higher the price goes.  
5 Those kinds of things would be true anywhere. So I  
6 like that.

7           Related to that, because you did mention the  
8 idea of the advantage of current providers, it does  
9 seem like the more it's limited, the more it goes to  
10 the advantage of current providers.

11           MR. LOSASSO: Absolutely. I think  
12 there's not too much controversy on that point, at  
13 least in our minds, that a well-functioning, efficient  
14 market can only benefit from entry of competitors into  
15 that market.

16           That will keep prices, not the price of a  
17 bed but the price of the ultimate service being sold,  
18 which is long-term care as a service to people in  
19 need, people who need that health care service, keep  
20 that price down. Clearly, that's something that we  
21 all care about, at least from a policy standpoint. So  
22 that is certainly true.

23           I don't want to lose track of your third  
24 question, though. Would you mind if I moved into

1 that?

2 So the third question you had was about the  
3 number of licensed beds, and the sense here in  
4 Illinois is that, as I think you put it, we might be  
5 as a state overbedded.

6 So we do talk about that issue in our  
7 recommendation and the caveats, I suppose, as well.  
8 We think that the more beds that there are licensed in  
9 the State, that will tend to drive down -- if there is  
10 a bed marketplace, that will tend to drive down the  
11 price that they would be sold at.

12 That's on the one hand not necessarily a bad  
13 thing if you were looking to add more beds to your  
14 facility. So we should not think of that as  
15 necessarily bad.

16 What we worry about is that there won't be  
17 enough buyers for beds. There again, I think the  
18 important thing is to cast a broad market, allow  
19 regions that might be differentially overbedded to  
20 trade with other parts of the state that are  
21 relatively underbedded and allow that process to  
22 happen.

23 Again, to the extent that the bed sale price  
24 is low, that's a good thing because it does allow

1 facilities to more cheaply and at less cost open new  
2 beds to meet the needs of residents in their area.

3 MEMBER CREDILE: Ohio has a CON  
4 process. It just doesn't look at all like Illinois'.

5 So what we're trying to say here is that if  
6 you're trying to look at access, there's still  
7 oversight to make sure that beds are going to  
8 underserved areas where there's excess beds. So it's  
9 not at all in the same context of how we are today but  
10 that there is access for that -- I mean, a way to look  
11 at that.

12 MR. WING: This is sort of in response  
13 to this but maybe in a roundabout way; right?

14 Tony said earlier that we'd all be delighted  
15 to -- it's resource dependent, but we would all be  
16 delighted to do more research on this topic, and then  
17 he said, "But the additions might be marginal from  
18 studying additional states"; right?

19 I think that's sort of true. I think the  
20 kind of additional thinking that you all should be  
21 involved in doing or other people as well, it's not  
22 necessarily so much trying to go to a whole bunch of  
23 other states and seeing how markets work in all those  
24 other states.

1 I think the real question is if you're going  
2 to engage in something like this, the things you want  
3 to think about are exactly what are we trying to  
4 achieve with each deviation from complete free market?

5 So if you begin by just saying, "Let's not  
6 do anything and the nursing homes can just figure all  
7 this stuff out themselves," that sounds pretty good to  
8 me, but there can be problems. Of course, there can  
9 be problems; right?

10 So you should think of each possible  
11 deviation from that model, right, of no intervention  
12 at all as being designed to sum up a particular issue.

13 If you're going to contemplate something  
14 like a moratorium, you should think, "What am I trying  
15 to achieve by imposing a moratorium?" I don't know  
16 what you would be trying to do. There are probably  
17 many good arguments that people make up.

18 If the only thing you can come up with is  
19 current nursing homes would prefer to not have to  
20 compete with new entrants, then maybe that's not a  
21 good reason to do a moratorium, but there could be  
22 other reasons. You can think that way for each kind  
23 of deviation from the model.

24 If you want to impose some kind of rule that

1 they'll only be able to trade beds every three years,  
2 you should think, "Why would we want to do that? What  
3 is wrong with letting them trade every year? What  
4 would we be solving by intervening and saying, 'Only  
5 every three years you can trade beds'?"

6 If you go down that road, I think you can  
7 slowly define a policy that works for Illinois and  
8 perhaps solves the problems that Illinois is  
9 particularly concerned with, but you should think of  
10 those deviations from the market as things that you  
11 are trying to achieve, not as things you should do  
12 because Ohio did or things that you do reflexively.

13 MEMBER CREDILE: Well, the moratorium  
14 is just a component of Ohio's program, but in Illinois  
15 there's sort of a self-imposed moratorium with  
16 reimbursement considerations where it may be part of  
17 why there are so many beds off-line.

18 Secondly, when you look at Illinois' beds  
19 per thousand compared to other states, it is an  
20 overbedded state. We've had concerns surrounding that  
21 and discussions for 2 1/2 years on Illinois and the  
22 number of beds.

23 So to me the moratorium is in that context,  
24 in looking at the number of beds in the State. Claire

1 is shaking her head. We've been discussing that for  
2 quite some time. So the moratorium piece addresses  
3 the fact that there are excess beds in the State  
4 compared to other states.

5 MR. FLORINA: I don't know if this  
6 follows up on your end.

7 The primary comparison is Ohio and Illinois.  
8 In looking through one of the graphs or tables here,  
9 you're showing about a 5 percent difference in  
10 occupancy between the two states with Ohio being  
11 higher but, also, Ohio having more facilities than  
12 Illinois.

13 Is there some underlying demographic factors  
14 or type of service alternatives that also drives these  
15 conclusions that do make this difference between the  
16 two states that we're not incorporating in these  
17 decisions? That's my first question.

18 The second is a comment that we've all  
19 operated for years under a very highly regulated  
20 system, whether it's for beds or operations, and it  
21 somewhat skews how you decide to operate because  
22 you're not operating historically in a free enterprise  
23 system.

24 Yes, it's built that way, but all the

1 programs we have to work within don't allow that to  
2 happen.

3 So existing providers already have made  
4 their investments to providing care. Many of them are  
5 the anchors of the community. To turn around and just  
6 strictly eliminate, you know, the current structure we  
7 have and go to a free enterprise capitalistic system  
8 makes it somewhat difficult on existing providers.

9 I'm somewhat limited in the workings of the  
10 group over the years, but I recall one of the primary  
11 concerns when this whole buy/sell idea came up was to  
12 also allow existing providers the opportunity to  
13 improve what they're doing, to have some capital to  
14 put back into their facilities, to be more modern, to  
15 be able to compete with larger organizations because  
16 the way I see it -- and maybe it's too simplistic --  
17 we're going down a road where unless you're a large  
18 provider with many facilities, if you're just a single  
19 stand-alone provider -- you can call them mom and pop  
20 if you want -- they're going to be at a disadvantage  
21 whether it's through managed care programs, whether  
22 it's through buying and selling beds, whether it's  
23 moving beds from one of your facilities to another,  
24 which an individual facility wouldn't have that

1 opportunity.

2 I'm just saying getting rid of the whole  
3 system and going to free enterprise, I see many other  
4 problems developing for existing providers. That's  
5 one of the things I think the group was trying to  
6 address from the beginning. How do we help existing  
7 providers so they can meet the needs of their  
8 community?

9 So if you can take something out of that, I  
10 would appreciate any comments.

11 MS. KONETZKA: If I could just respond  
12 to the first part of that, I think your question about  
13 why occupancy rates are higher in Ohio than in  
14 Illinois speaks directly to the bluntness of this  
15 beds-per-thousand measure.

16 There may be other reasons why the demand  
17 for nursing home care is very different in Ohio or in  
18 Illinois or maybe different within regions of Illinois  
19 or Ohio; right?

20 We don't know exactly what those are. It  
21 may be that income is different. It may be that  
22 actual severity and health needs are different. It  
23 may be that the alternatives in terms of assisted  
24 living and mental health facilities are different in

1 Ohio such that it affects the demand for nursing home  
2 care.

3           There could be a long list of reasons why  
4 demand may be higher relative to the number of beds in  
5 Ohio than Illinois; but like I said, I feel like it  
6 just underscores this idea that if we have a sort of  
7 blunt measure of beds per thousand, it doesn't mean  
8 all that much unless you consider all of those other  
9 aspects of demand.

10           MR. FLORINA: And that should be taken  
11 into consideration before any decision is made to get  
12 rid of the system, modify the system. You have to  
13 understand the people you're trying to serve.

14           MS. KONETZKA: Well, I think it's  
15 impossible for any group of people to sit in a room  
16 and figure out what all of those pieces of demand are.

17           MR. LOSASSO: So that's why I think our  
18 overall thrust is that if you remove the people in the  
19 room from making the decisions for the industry  
20 regarding how to respond to consumer demand, the  
21 better the likely allocations will be.

22           A lot of the factors that you brought up,  
23 again, with all due respect, those are, I think, quite  
24 plainly to protect incumbents, those existing

1 facilities.

2 Taking a public policy standpoint here, I'm  
3 not entirely convinced that the mission of a public  
4 entity such as this Subcommittee should really be  
5 engaged in protecting the fortunes of incumbents  
6 versus the potential benefits that we're talking about  
7 when competition is introduced to a market, benefits  
8 to the ultimate consumers.

9 MR. GALASSIE: Can anyone give me a  
10 sense -- I'm sorry.

11 MEMBER PHILLIPPE: I just have an  
12 economics question kind of involving what we're  
13 talking about here.

14 It also has to do with knowing Ohio because  
15 I operated buildings there until about this time last  
16 year. Your model, you do talk about the variations  
17 with Medicare versus Medicaid/Medicare and adding  
18 additional beds and that impact.

19 It's an economic issue, though, in Illinois  
20 that my Medicaid rate in Illinois is 40 percent lower  
21 than my Ohio rate. Okay? It's a huge difference.

22 In Illinois, people in my personal  
23 experience -- it may not match everybody's. In my own  
24 personal experience here, people billed for Medicare

1 payment and private pay. Okay? Sometimes they only  
2 billed for Medicare because Medicaid pushes the  
3 private pay rate down, also. It brings it down enough  
4 they can't even afford a smaller new building with  
5 many private pay.

6 Ohio was very different when I operated  
7 there because the rate differences were very  
8 different. So that kind of goes to the impact on the  
9 buildings he was talking about.

10 It's not so much always protecting the  
11 provider because in Illinois what happens is the  
12 Medicare census and to some extent the private pay  
13 census allows for better care for the Medicaid  
14 resident because they are funding care for Medicaid.  
15 I think most of us who operate know this.

16 With an open system -- and I've seen this in  
17 Indiana because I operate in Indiana, also -- what  
18 happens is that people come into a town with four  
19 buildings that are kind of sharing those three, four,  
20 five buildings that are sharing those three payers,  
21 and they build one building and they only take  
22 Medicare and a handful of private pay because those  
23 are the best payers.

24 What happens to the buildings around them is

1 then the care to all those other consumers is lower.  
2 So in a sense it puts pressure on the buildings you  
3 try to improve, but it also affects the consumers.

4 I agree with you. Our job is not to protect  
5 us, really. That's just not our job. This is an  
6 issue to be taking care of the citizens of the State,  
7 really. You can answer it however you think, but  
8 there is a difference in the model because it's not an  
9 open system.

10 I've heard people even in Ohio say they're  
11 building something new for Medicaid, and they don't  
12 take Medicaid people once they open because they can't  
13 afford to make payments. We all know this who  
14 operate.

15 So that's kind of the issue for us is it  
16 won't be kind of a fair system. Our concern for some  
17 of us is if it can be fair. I would be fine if it  
18 protects the consumer, not the provider. Does that  
19 make sense?

20 MR. LOSASSO: Yes.

21 MEMBER PHILLIPPE: I don't know how you  
22 answer it.

23 I like the idea of an open system because  
24 the payment structure is so skewed in Illinois, more

1 than anywhere, really, in the country.

2 MR. WING: On some level we did try to  
3 provide some way of thinking about that kind of issue.

4 So if you look at -- probably the  
5 theoretical section was probably the slowest going,  
6 okay, but it's worth thinking about that carefully;  
7 right?

8 So the more complicated version of the  
9 conceptual framework we offered was a setting where  
10 there's two kinds of providers; right? That's there  
11 to emphasize the fact that Medicaid reimbursement  
12 rates may be different from private pay or Medicare  
13 reimbursements.

14 There are going to be in theory, right, some  
15 facilities that are comprised of a mix of different  
16 kinds of patients, but it's also very plausible that  
17 some facilities will simply specialize, right, will,  
18 like you said, build facilities and then only take on  
19 patients that are paying favorable reimbursement  
20 rates.

21 It's not obvious that by itself is actually  
22 a bad thing from a perspective of the population of  
23 the State. Maybe it is if you prefer like mixed  
24 facilities or something like that, but either way,

1 there's more space available.

2 MEMBER PHILLIPPE: It has an impact if  
3 70 percent of the people in buildings are on Medicaid,  
4 which I think is about our number, and most people in  
5 the field would say it's very difficult to have a  
6 Medicaid-only facility and operate adequately. So it  
7 means without a mix, those 70 percent are really --  
8 those citizens are being hurt.

9 The profits are really -- it ends up being  
10 profit, really. The profit all goes to a small number  
11 of buildings that have the high payers. That's what  
12 it feels like. I mean, I could be wrong. That's the  
13 reason I'm asking.

14 MS. KONETZKA: I think that's true.

15 Going back to the theory and free market  
16 versus imposing some other restrictions, it's not  
17 clear that not having a free market actually helps  
18 that situation, first of all.

19 So the facilities that want to expand -- and  
20 I think that's consistent with our results -- are not  
21 trying to expand their Medicaid. The rates are low.

22 Even if you declare high Medicaid areas, you  
23 know, to be sort of areas where access is restricted,  
24 if those Medicaid rates are not profitable, then sort

1 of restricting expansion elsewhere is not going to  
2 help that access in those high Medicaid areas, right,  
3 because it's still not going to be profitable even if  
4 that's the only place you can't expand.

5 Other places just won't be able to expand  
6 where there is actually more demand in a way that's  
7 profitable and where facilities do want to expand.

8 The other thing is introducing more of a  
9 buy/sell or a free market may actually help the  
10 Medicaid in the sense that when you have  
11 administratively set prices, facilities don't really  
12 compete on the basis of price; right?

13 The only thing they can compete with, then,  
14 is on the basis of quality. So if you have more of  
15 a free market, it's very possible that the new  
16 entrants -- if they want to serve the Medicaid  
17 population, the new entrants are going to find a way.

18 If there are new entrants, it's going to be  
19 because they can provide a better service at that  
20 Medicaid rate, right, or be more profitable at that  
21 Medicaid rate.

22 MR. GALASSIE: If I may, I am sure  
23 you're correct that that makes economic sense, but I  
24 fear the reality of an open market in the State of

1 Illinois is going to be -- lower economic areas are  
2 going to lose beds. They're certainly not going to  
3 gain beds.

4 I don't think -- a public health perspective  
5 is it's not going to increase access to the needy.

6 MS. KONETZKA: I think that may be  
7 exactly right in that expanding Medicaid, given  
8 current Medicaid rates, is not really in the interest  
9 of most providers right now.

10 So whether or not you open the market and  
11 allow beds to be bought and sold, that's not going to  
12 change because those beds that will be sold in those  
13 markets aren't being used anyway.

14 Switching to a buy/sell program wouldn't  
15 probably affect that. It's not really going to help  
16 access in low-income areas.

17 MR. WING: This is a key point.  
18 Neither is the current system.

19 The key thing to keep in mind here is if you  
20 think in Illinois a key problem is that Medicaid  
21 reimbursement rates are so low that, you know, there  
22 are real problems in that segment of the market, then  
23 the right response to me, right, doesn't have anything  
24 to do with moratoriums or restricting the number of

1 available beds for rich people versus poor people.

2 That's all to one side.

3 If that's the real issue, you should be  
4 thinking of ways to raise Medicaid rates or otherwise  
5 subsidize --

6 (Many voices speaking at once.)

7 MR. WING: These conversations about  
8 restrictions on the market don't speak to that issue,  
9 which is an important one.

10 We shouldn't convince ourselves that any of  
11 these conversations about a regulated marketplace or a  
12 CON restriction can help with that problem. They're  
13 just beside the point.

14 MR. GALASSIE: No. I fully agree with  
15 you, but I think we have to work within the context of  
16 believing Medicaid rates are not going to increase  
17 very much, unfortunately.

18 MR. WING: Absolutely.

19 That doesn't mean these other things can  
20 help with that problem or that we should exacerbate  
21 them by restricting the supply of beds. This is key;  
22 right? Keep that in mind.

23 MR. GALASSIE: I keep coming back to  
24 the last point of the RFP that you were addressing.

1 My fear is that it could very well  
2 exacerbate the problem for the needy. It could very  
3 well exacerbate the problem, that the beds are going  
4 to go from East St. Louis to Hinsdale.

5 MEMBER SCAVOTTO: They are rearranging  
6 the deck chairs on the Titanic.

7 MR. GALASSIE: Absolutely. A lot of  
8 chairs are going from the sublevel to the top level.

9 MEMBER PHILLIPPE: The concern I have  
10 is not about more building in the Medicaid areas or  
11 whatever you said because that is not the issue.

12 The issue is really that you can have  
13 something new, especially if you have a new facility.  
14 I'm less worried about expanding capacity. That's a  
15 more limited issue than a new facility. Okay?

16 But this happened in Indiana, and it was not  
17 as extreme because I operate in Indiana. I saw the  
18 same thing because they had no CON.

19 It will be more extreme in Illinois because  
20 you will have an area, say, that has five facilities,  
21 four, five facilities. Okay? And none of them are  
22 perfect. They're not beautiful. They don't have  
23 single rooms, private baths, all the things Charles  
24 wants for his family.

1           So what happens? The new facility builds in  
2 that market. It's an economic issue. Okay? The pool  
3 of revenue doesn't change. You've got the same amount  
4 of revenue available, the same payers, the same  
5 percentages.

6           The only thing that happens is that new  
7 100-bed facility takes virtually all the private pay  
8 and Medicare residents out of all the other buildings.  
9 So what happens is they have less revenue to operate  
10 to take care of the Medicaid people. Probably their  
11 census goes down a little bit, too, which is not  
12 helpful.

13           MEMBER SULLIVAN: Because more beds  
14 doesn't mean more residents suddenly appear.

15           MEMBER PHILLIPPE: No, there's not  
16 going to be more residents typically or very little  
17 new.

18           So what will happen, then, is there's less  
19 revenue for each one of those buildings. So in a  
20 sense we're hurting those people.

21           Now, I'm a person who actually likes the  
22 buy/sell program, but I worry about this issue because  
23 it is an economic issue, and it's all because of the  
24 skewed rates. They're dramatically more than Ohio,

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1 even more than Indiana.

2 MEMBER CREDILE: But that's why I would  
3 suggest that you have some kind of -- back to a CON  
4 kind of process or plan.

5 I understand we have very differing opinions  
6 in the room, but if there were controls where all the  
7 beds couldn't go from East St. Louis to -- it was  
8 somewhere in Chicago -- Hinsdale, you couldn't go from  
9 East St. Louis to Hinsdale because you'd have to have  
10 bed need.

11 It goes back to having some oversight, and I  
12 do think it is in part because our reimbursement is  
13 the lowest in the United States. So we're impacted on  
14 that.

15 MEMBER SCAVOTTO: Let me ask a  
16 question, and I think this is a question that you  
17 would ask. So I'm putting words in your mouth, and I  
18 want you to know that.

19 MR. LOSASSO: I'll take them out, if  
20 necessary.

21 MEMBER SCAVOTTO: If I'm incorrect,  
22 maybe we can study it some more.

23 What difference does it make if they go from  
24 East St. Louis to Hinsdale if they're empty in East

1 St. Louis and they've been empty for a long time?

2 MR. LOSASSO: I'm going to leave them  
3 in my mouth, yes.

4 If they're not being used, yes. That is the  
5 issue. There is no doubt that the Medicaid  
6 reimbursement rate casts a pall over all of the  
7 Illinois long-term care industry. No disputing that.  
8 That is also not a variable or a lever that any of us  
9 apparently can adjust here.

10 So the main thing that we're trying to say  
11 here is if you allow for flexibility in the allocation  
12 of beds, you at least have -- and again, the more the  
13 better because that will allow the industry to respond  
14 to need.

15 It also at least holds out the possibility  
16 for, if you allow it, entry of potential low-cost  
17 operators that might find an ability to profitably  
18 serve the Medicaid market. That's an "if."

19 MEMBER CASPER: Can I make one point?

20 That is that -- which I think illustrates  
21 the fact that these are really two separate issues,  
22 the issue Tim is raising, because there is really  
23 nothing in the current environment that prevents  
24 exactly what Tim has talked about from happening.

1           The four nursing homes in that market that  
2 are already there, one of them can reposition, create  
3 all private rooms, and pull all the Medicaid and  
4 private business from all the other homes. There's  
5 nothing that prevents that from happening in the  
6 market today.

7           Therefore, I think it really illustrates  
8 that they're both issues, but they're not the same  
9 issue.

10           MEMBER SCAVOTTO: Let me challenge that  
11 a little bit because I think there is something in the  
12 application process that prevents that from happening.  
13 It goes to your earlier comment about franchise  
14 protection.

15           The current standard is that you can't add  
16 beds or make major renovations unless occupancies of  
17 all competitors in that service area are at 90  
18 percent, which is essentially franchise protection.  
19 So it prevents me from modernizing. I want to  
20 modernize, but I want to add an additional 25 beds,  
21 and I'm going to fill those 25 beds by taking it out  
22 of your hide.

23           MR. CASPER: Suppose you take a 120-bed  
24 building that you can renovate into 80 private rooms

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1 or 70 private rooms under the threshold.

2 MEMBER SCAVOTTO: You could if you did  
3 it under the threshold.

4 MEMBER CASPER: And it's been done  
5 around the corner from our building.

6 MEMBER SCAVOTTO: Sure.

7 MEMBER PHILLIPPE: But it's still not  
8 the same. I've done both.

9 Because our product is so old, most of us,  
10 something new is dramatically different. I've done  
11 new wings, I've done new buildings, I've renovated  
12 older buildings, and I can tell you it's not the same.

13 There is a sense where that's true and  
14 there's some flexibility there, but it's not the same  
15 as building a new 50-bed building with private rooms,  
16 private baths in a modern-looking building. It's a  
17 whole different world.

18 CO-CHAIRMAN BELL: I think Greg had a  
19 comment. I want to introduce him. He joined our  
20 meeting late. Greg joined us, and then another  
21 gentleman in the corner.

22 MEMBER SULLIVAN: Well, Neyna has been  
23 raising her hand for about 15 minutes.

24 CO-CHAIRMAN BELL: We'll get Greg and

1 then do Neyna.

2 MEMBER WILL: Well, I had kind of two  
3 questions or responses on reading this thing, which I  
4 appreciate as a piece of economic analysis. I'm still  
5 in the process of absorbing --

6 CO-CHAIRMAN BELL: Greg, can you speak  
7 up a little bit?

8 MEMBER WILL: Yes.

9 I had this question a little bit ago, and I  
10 think we're getting into the thick of discussing it,  
11 which is I think under kind of the statute for the  
12 (inaudible) required to think about affordability of  
13 the Health Service Act, especially to the lower-income  
14 population of our State, and we're getting into that.

15 I'd frame both these questions in terms of,  
16 you know, hoping to get you all to talk about how you  
17 thought through some questions in doing the economic  
18 model.

19 This one, I was thinking about the Medicaid  
20 side of the market and how those kinds of access  
21 questions relate to the notion of efficiency because  
22 efficiency seems like one frame on nursing home beds.

23 Sometimes I think -- and if that was like  
24 one thing and wasn't so segmented by different payment

1 rates that we're discussing, then efficiency would  
2 work for a lot of people, talking about the population  
3 that's looking for services.

4 I just wonder if -- and I feel like there's  
5 some parts of the Board that addressed this. Maybe  
6 this is an opportunity for you to kind of phrase this  
7 up, whether nursing home efficiency works for the  
8 Medicaid-eligible folks in our State and the extent to  
9 which it doesn't. This is something that's required,  
10 and it sort of would define an outer bound on the work  
11 you all did.

12 The second question I have is simpler to  
13 say, and I want to make sure we do get to it at some  
14 point, maybe not necessarily now because it would take  
15 the conversation in another direction at your  
16 discretion, which is in terms of kind of defining the  
17 market here.

18 Really, the basic question is: Is the  
19 market defined by licensed nursing home beds or is the  
20 market defined by people need this certain range of  
21 long-term care services which could also be met, you  
22 know, in assisted living, independent living, home  
23 care and home health and the extent to which -- you  
24 know, recognition of that or sort of like, yes, it's

1 actually about the nursing home bed licenses that are  
2 built into -- you know, starting with your analysis.

3 MR. LOSASSO: I'll take the second one  
4 first. I might ask for some clarification on the  
5 first question, though.

6 I guess the question about how we view the  
7 market -- and we can kind of walk through a little bit  
8 of the logic here. The short answer is it's not  
9 defined -- and I'm talking about the market for the  
10 ultimate service, which is long-term care. It's not  
11 defined by licensed beds per se.

12 It should be thought of as being defined by  
13 the demand for that service among consumers and the  
14 costs of providing the service in question, so the  
15 technology of long-term care provision, broadly  
16 speaking, and those two together make the supply and  
17 demand.

18 Now, of course, the market is more  
19 complicated than that. We do go through several very  
20 stylized features of that in our conceptual framework.  
21 We talked a little bit about that, about how licensed  
22 beds can skew decision-making and the role of the  
23 aforementioned Medicaid reimbursement rate and how  
24 that changes and alters decision-making, particularly

1 when it becomes very disconnected from the underlying  
2 cost of providing care.

3 I'm not going to rehash the whole  
4 conversation we just had. That disconnect is hugely  
5 significant, okay, for the market. We've all said  
6 that in various ways here just about over the last  
7 20 minutes or so. So I don't want to rehash that, but  
8 that's a very significant factor.

9 So maybe moving more towards your first  
10 question, then, in thinking about how best to allow  
11 for access and efficiency, by which we mean  
12 cost-minimizing approaches to provide quality care for  
13 patients, which is ultimately what we all want, we  
14 believe that's best served by allowing beds to move  
15 freely subject to quality constraints, as we talked  
16 about, by allowing entry in the market of competitors  
17 who can help drive down the price of care through  
18 competition.

19 Ultimately that process, you know, prevents  
20 the sort of franchise, which was the word used  
21 earlier, nature of these different areas. That  
22 process can only, we think, lead to improvement in the  
23 type of care and access.

24 It's not a home run. It's not an easy road

1 down here. We get that. We also defer to your  
2 expertise on the industry. I don't know if my  
3 colleagues want to add to that.

4 MR. GALASSIE: Can I comment on that?

5 CO-CHAIRMAN BELL: Yes.

6 MR. GALASSIE: Because I think it's  
7 been an excellent discussion that's gotten us there.

8 I feel as though if we could try to drill  
9 down on that -- again, I'm hearing what many people  
10 have said -- less regulation, freer markets, buy and  
11 sell could work. Who cares if they're virtual beds?  
12 I agree, but ultimately the virtual beds are gone.  
13 That's what I'm concerned with.

14 Drill down further. It's feeling to me --  
15 and this is where Cecelia was coming from -- that some  
16 level of regulation or deviation may be necessary to  
17 better ensure access to the uninsured or lower  
18 economic. At least I'd like dialogue on that because  
19 I hear where you're coming from.

20 Less regulation ultimately is better in a  
21 perfect world and maybe in Ohio's reimbursement rate,  
22 but in Illinois I'm not so sure. You folks are much  
23 more knowledgeable than I am on that. From my public  
24 health perspective, that's where I'm at right now.

1 MR. WING: Can I just make one  
2 suggestion?

3 I think it's probably true, and everybody  
4 seems to say this. The rates are a real problem, and  
5 you're worried about what to do about the Medicaid  
6 population or the lower-income population.

7 I don't think we have a specific answer,  
8 obviously, right, but the way to think about it, at  
9 least from my perspective, is not that you should be  
10 thinking -- suppose we had the free market.

11 What are some trades that we could prohibit  
12 which would somehow help the Medicaid population?

13 I think that's the wrong way to think about  
14 it because it's very unlikely you're going to come up  
15 with anything that will really work. You might say it  
16 and think it, if it makes you feel better, but most of  
17 the data will show that you can't just prohibit some  
18 trades and expect poor people to be taken care of. I  
19 don't think that's how it usually works.

20 Instead, what you should be thinking of are  
21 what are some things we can put in place? What are  
22 some nudges or incentives that we can put in place  
23 that might induce some people to take on more Medicaid  
24 patients than they would otherwise do?

1           That's still regulatory. That's still  
2 interventionist. That's still a role for the CON  
3 Board; but by framing the issue as, "What can we do to  
4 nudge people in the direction we'd like them to go  
5 that might be a little different than they would  
6 otherwise pursue?" to me this gets your head in the  
7 right space rather than, "What can we make illegal  
8 that will somehow help?"

9           Because it's rarely going to be the case  
10 that you can prohibit your way out of the  
11 conversation.

12                   CO-CHAIRMAN BELL: Neyna?

13                   MEMBER JOHNSON: I think I forgot what  
14 I was going to ask.

15                                   (Laughter.)

16                   MEMBER JOHNSON: I just wanted to  
17 respond to what Mike said about what difference does  
18 it make if you move beds from East St. Louis to  
19 Hinsdale?

20                   My comment would be I think it would make a  
21 great deal of difference if the quality of care didn't  
22 improve, the staffing didn't increase, resident  
23 satisfaction didn't improve from the profit made of  
24 selling those beds and moving them to Hinsdale because

1 I would bet my paycheck that the kind of care, the  
2 staffing, the type of facility in East St. Louis is  
3 not the same kind of care, quality care, and facility  
4 improvements are not there that would be in Hinsdale.

5 So I would think that there would need to  
6 be some kind of -- I don't want to use the word  
7 "sanction" but some kind of recommendation or  
8 assurance that if a facility in East St. Louis did  
9 send beds to Hinsdale, that they're going to use that  
10 money to make quality of life and quality of care  
11 better for the residents in East St. Louis.

12 MR. GALASSIE: Absolutely. That was  
13 said much earlier.

14 MR. FOLEY: That was said months ago.

15 MEMBER JOHNSON: Okay.

16 MR. FOLEY: And moneys will be used  
17 either for improvement of the facility or to reduce  
18 the debt service of the facility.

19 MEMBER SCAVOTTO: I'm still sticking to  
20 my guns here.

21 If these beds have been empty for a long  
22 time, you know, to me they're qualifying as dead beds.  
23 They're not helping anybody in East St. Louis sitting  
24 empty. They're not doing anybody any good.

1 I agree the people in Hinsdale ought to get  
2 just as good care as they do in East St. Louis.

3 MEMBER JOHNSON: Realistically, that's  
4 not happening.

5 MEMBER SCAVOTTO: That's right. It  
6 doesn't happen, realistically.

7 MR. FOLEY: The problem with using beds  
8 from a contiguous planning area, whatever, is just  
9 maybe that facility may really think twice about  
10 selling his beds because that's going to have a direct  
11 impact on his operations if it's that close within 30  
12 minutes, even outside of the 30-minute drive time.

13 So by going from Marion, Illinois, to  
14 Hinsdale or where ever, obviously that's not going to  
15 have a direct impact.

16 I think our issue here is one of our  
17 problems. Our goal originally was to figure out a way  
18 as to how we were going to, number one, identify the  
19 dead beds in the State, and how can we reduce our  
20 overall occupancy rate?

21 Obviously, this bed sell concept came into  
22 play. The only way that's going to work, if you're  
23 just going to buy/sell beds on a one-to-one basis,  
24 just move them from one area to another, the State

1 total is not going to change.

2 So we have to use some sort of a ratio,  
3 a two-for-one -- I think that was talked about  
4 earlier -- a two-for-one ratio or whatever ratio you  
5 want so that the net result in terms of that  
6 transaction will be a net number of beds in the State.  
7 I think we have to stay focused on that as well.

8 MR. LOSASSO: I want to respond to  
9 Ms. Johnson's point there about using beds to -- using  
10 the proceeds, I guess, of bed sales to perhaps improve  
11 them.

12 We did do some work in the report on looking  
13 at the consequences in Ohio, again, after sales  
14 occurred. I don't know. Maybe Tamara can mention  
15 some of the results here, but basically we did not see  
16 improvements.

17 We come out somewhat skeptical, I think,  
18 about the efficacy of such a program mainly just  
19 because of the simple fact that money is fungible.

20 Again, you can regulate and mandate that the  
21 funds get reinvested some way, but it won't work.  
22 Coady whispered in my ear "It won't work," and I spit  
23 it right out. It probably won't work is how I would  
24 modify that because, again, the funds are fungible and

1 the institutions and their accountants are craftier  
2 than a Board can observe here.

3 MS. KONETZKA: A couple other things  
4 about those funds.

5 One, as we said, we would expect the price  
6 to be lower in Illinois than in Ohio; and if you look  
7 at the average number of beds sold, it may not  
8 actually turn out to be that much money; right?

9 Secondly, it's not sort of an ongoing  
10 funding stream that would affect a facility's  
11 operating costs. It's a onetime windfall basically.

12 So there is really no reason to expect that  
13 that would go into, let's say, staffing or something  
14 that would require an ongoing funding stream; right?  
15 It could perhaps be put into capital or something like  
16 that, but it might not be that much money and the  
17 funds are fungible. So I guess we have pretty low  
18 expectations about whether that would actually improve  
19 quality.

20 The things we could look at in the Ohio data  
21 were things like future staffing ratios and  
22 deficiencies, and we also looked at future payer mix.  
23 We found no significant results for any of those, but  
24 those are all sort of ongoing operational kinds of

1 outcomes where we wouldn't actually expect that to be  
2 affected.

3 MR. WING: One other point, too, is  
4 that although it's true that the monetary gain to the  
5 facility, right, will be probably not huge and onetime  
6 only, in contrast, the gain to consumers who are  
7 living in an area where there is not enough beds will  
8 be ongoing and large; right?

9 So we shouldn't forget that. Just because  
10 it's going to be sort of -- not quite but sort of  
11 pocket change from the perspective of a facility  
12 doesn't mean that in terms of welfare people living in  
13 the State it won't be much, much larger than that.  
14 That's part of the real gain here; right?

15 The other thing, too, this idea of about  
16 fungibility and having rules that say that the  
17 facility has to show that it spent the money on  
18 something else, we aren't suggesting here that  
19 fungibility implies some sort of corruption. Okay?

20 The facilities will be nominally perfectly  
21 compliant, I'm sure, with the rules. They'll spend  
22 the money on something like that. The argument is  
23 that they will spend less of their other money on that  
24 activity than they otherwise would have, and that's

1 how you can get to no net change in quality; right?

2 There's no way you can make a rule that's  
3 going to solve that part of the problem.

4 MR. GALASSIE: If it results in a  
5 physical plant enhancement to the facility, that's a  
6 winner for everybody. If profits are diverted another  
7 way, so be it. That's part of the system.

8 If the people living in that facility end up  
9 with a nicer facility, I think at the end of the day,  
10 that onetime infusion was well worth it.

11 MR. WING: That would be great. I  
12 don't think that will happen.

13 MR. GALASSIE: I think it would happen  
14 with some level of regulation.

15 MR. URSO: What if there were safety  
16 code violations that need to be corrected? I mean,  
17 that's a good example.

18 MR. GALASSIE: Sure.

19 MR. WING: That would work, I agree,  
20 but that's different from the sale of the beds.

21 MR. GALASSIE: I mean, allowing 100  
22 percent of the money to offset your debt, no, that  
23 isn't going to do much more for the community, but  
24 certainly a combo, a formula in there. If nothing

1 else is gained other than enhancing the physical  
2 plant, I think it's a winner.

3 MS. KONETZKA: I want to add one other  
4 sort of tangent on the issue of access, and that is I  
5 think we shouldn't discount -- we keep talking about  
6 Medicaid access in poor areas, but we shouldn't  
7 discount the benefits to access for the parts that  
8 will expand; right?

9 What we all expect is because post-acute  
10 rates are so much higher, profit margins are so much  
11 higher, that we might see sort of more private pay and  
12 post-acute expansion.

13 That's not a bad thing, right, in that  
14 post-acute care is huge right now. It's a huge part  
15 of reducing rehospitalization rates. There's a lot of  
16 focus on post-acute care, and there's a lot of  
17 evidence that also low-income populations, racial and  
18 ethnic minorities, don't have access to high-quality  
19 post-acute care.

20 So the idea that we could expand these more  
21 profitable parts of the industry and potentially  
22 expand access to those kinds of services is also a  
23 great benefit.

24 CO-CHAIRMAN BELL: Do you need a break?

1 THE REPORTER: I could use a break,  
2 yes.

3 CO-CHAIRMAN BELL: We can pause for  
4 five, ten minutes so the reporter can take a break.  
5 We'll get back together.

6 (Recess taken, 10:40 a.m. to  
7 10:50 a.m.)

8 CO-CHAIRMAN BELL: The University of  
9 Illinois folks need to be leaving here shortly. So if  
10 you've got any other questions or issues that you'd  
11 like to ask them, they only have a few minutes left.  
12 They need to be out in about ten minutes.

13 If you've got anything else for them, we  
14 could entertain that at this point. If not, we can  
15 let them go and then carry on with, I guess, our next  
16 plan or our next step.

17 MR. URSO: I do have a question.

18 As the experts in public health economics,  
19 do you have any thoughts on how the Affordable Care  
20 Act is going to impact long-term care?

21 MS. KONETZKA: I can say a few things.  
22 Obviously, one could list off a long list of factors  
23 that might be affected -- or ways in which long-term  
24 care might be affected.

1           One thing is that because of ACOs and  
2 bundling and an increasing focus on post-acute care,  
3 it's kind of carving out post-acute care, and literal  
4 vertical integration between post-acute care providers  
5 and hospitals I think will inevitably increase; right?

6           So I feel like this whole idea that  
7 post-acute care is really bundled with long-term  
8 care and that we see so many of the same providers  
9 doing the same thing, I think inevitably because of  
10 the ACA those are going to get more and more separated  
11 in a sense in that more and more providers are going  
12 to care about post-acute care.

13           So that's one thing.

14           MEMBER SULLIVAN: Just a comment, Bill.

15           This study exceeded my expectations -- or  
16 the results, I should say. I think we get bogged down  
17 in discussing regulatory systems and get blinders on  
18 in terms of just looking at regulations and structures  
19 and things like that.

20           Bringing in the whole economic analysis and  
21 economic model to this process I thought was very  
22 helpful. It was a refreshing change from the way our  
23 discussions usually go. So I thank you for that.

24           MR. GALASSIE: I second that.

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1 CO-CHAIRMAN BELL: Yes, Carolyn?

2 MEMBER HANDLER: I have a follow-up to  
3 Frank's question.

4 Not just the Affordable Care Act, but what  
5 about the impact of the State's incentive to move so  
6 many Medicaid recipients to managed care?

7 What do you predict or what do you think  
8 that will do to the traditional long-term care sector?  
9 Because I think pricing pressures are going to get  
10 more significant. I don't think it's going to get  
11 better.

12 MEMBER CREDILE: Well, they are charged  
13 with improving the cost of care.

14 MEMBER HANDLER: To the State.

15 MEMBER CREDILE: To the State.

16 So it seems to me our rates will be  
17 compressed even further because the managed care  
18 companies have come in here to make money. Well, how  
19 are they going to make money? That way, compressing  
20 rates.

21 MS. KONETZKA: With managed care, I  
22 think there is always sort of the pros and cons.  
23 There's a pressure on the rate, certainly, which  
24 policymakers may see as a good thing, providers may

1 not see as a good thing. There's a pressure on the  
2 rate.

3 There is also this idea that they will have  
4 a different incentive structure as well. So there  
5 might be perhaps more communication, more integration  
6 of care that could actually improve the quality of  
7 care as well relative to a much more fragmented system  
8 that people face right now.

9 MR. LOSASSO: And pressure on forcing  
10 institutions to drive down costs even when it hurts.

11 MS. KONETZKA: Another major way in  
12 which long-term care might be affected is that if you  
13 look at all the provisions which directly address  
14 long-term care in the ACA -- and, of course, the CLASS  
15 Act is gone, but then the things that remain are  
16 really sort of increased pressure to expand home and  
17 community-based care.

18 Putting more Medicaid funding into home and  
19 community-based care affects the spectrum of care  
20 available. I think most people think more home and  
21 community-based care is generally a good thing for  
22 people to have more options and less constraints on  
23 their options. I think there could be a lot of  
24 unintended consequences there as well.

1 I could go on that for a long time, but I  
2 probably shouldn't start. There could be a lot of  
3 intended consequences in terms of we don't really know  
4 what the outcomes of a lot of those alternatives are.

5 People may be sort of receiving more home  
6 and community-based care because of sort of these  
7 policy pressures who really are in need of a higher  
8 level or institutional care, for example.

9 So I think there could be a lot of  
10 interesting unintended consequences of some of those  
11 policies but some good ones as well.

12 CO-CHAIRMAN BELL: Okay. Unless there  
13 are any further questions, we'll go ahead and allow  
14 the --

15 MEMBER CREDILE: Bill, I'm sorry. One  
16 question.

17 CO-CHAIRMAN BELL: Yes.

18 MEMBER CREDILE: Is this our last  
19 access or presentation by this group? What is the  
20 next step? We have great info, great recommendations.

21 MS. BURMAN: Most of the people on the  
22 Subcommittee will recall that we were working on  
23 looking at requirements for the buyers and the  
24 sellers. We had a list that Terry had a lot of input

1 on; and we were working on that, and then the idea of  
2 the RFP got introduced. So I would imagine the  
3 Committee would return to trying to look at ideas for  
4 that.

5 Also, if you recall, we have to think  
6 statutorily. Right now the statute allows for us  
7 investigating the idea of the buy/sell program; but in  
8 order to actually put a program together, we would  
9 need something in the statute that allows for the  
10 development of that.

11 MR. GALASSIE: I'll speak as an  
12 individual Board member.

13 I think the intention of this committee is  
14 to bring forth, if it so chooses, recommendations to  
15 the Board. If you'll allow an analogy, I think it  
16 feels as though we're in about the eighth inning of  
17 the game on at least this issue.

18 So I think the next dialogue is whether we  
19 need our economic colleagues' assistance. I'm not  
20 sure. But it is furthering the dialogue of, A, is  
21 there a consensus that you want to move to buy and  
22 sell? And if you do, how do we do it? Is there going  
23 to be no regulation or is there going to be some  
24 regulation?

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1 MR. WING: Can I make one comment?

2 CO-CHAIRMAN BELL: Yes.

3 MR. WING: If you do plan to go this  
4 way, you should plan to evaluate it, too.

5 MEMBER SULLIVAN: A study?

6 MR. LOSASSO: We always said from the  
7 very start we don't have a dog in this race. That  
8 might be the only dog in this race.

9 We'd be happy to look at the effects of  
10 whatever you do decide to do. Of course, we're  
11 available. It's been fun working with you.

12 CO-CHAIRMAN BELL: Thank you very much.

13 (Applause.)

14 CO-CHAIRMAN BELL: Since I'm new on the  
15 Board and have not been involved in the previous  
16 discussions, in listening to Ms. Burman and  
17 Mr. Galassie talk, is the plan that we would pull the  
18 material that was worked on before and possibly get  
19 that out to everyone and then set up some type of a  
20 time frame for everyone to give their concepts back  
21 and have them accumulated for the next Board meeting,  
22 that we could then go through the different concepts  
23 and have some discussion and maybe make some decisions  
24 on what we could agree with and move forward to the

1 Mother Board, I guess it's called?

2 Would that be an appropriate process to go  
3 with?

4 Again, I'm new coming on here. So I'm not  
5 sure exactly where you were and where you've come  
6 from. I think we need to probably somehow pull all of  
7 this together, have everyone maybe put in what their  
8 concepts or ideas are, get them to someone who could  
9 accumulate them, kind of pull out the ones that are  
10 duplicative and so forth, and then bring them to the  
11 Board as a group to discuss?

12 Is that an option?

13 MR. GALASSIE: I'm just going to give  
14 you my opinion. This Committee has been meeting a  
15 long time. There's been a fair amount of dialogue.  
16 I've heard a fair amount of frustration about when do  
17 we get the ball through the hoop?

18 Again, I think we're close. So to reiterate  
19 the discussion that took place today perhaps, I think  
20 at the next meeting, you know, you get into the real  
21 dialogue.

22 Is there interest in doing this? And if  
23 there is, how would we do it? What kind of  
24 requirements would we have?

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1            Claire, maybe you would be able to come up  
2 with some recommendations of requirements.

3            MS. BURMAN: I think it makes sense to  
4 revisit the ideas that we already talked about, the  
5 points of consideration and putting that together. We  
6 do need statutory authority to go much further with  
7 it.

8            MS. AVERY: I think we need to step  
9 back, as was said, get the recommendations from here,  
10 send them to the Board.

11            MR. GALASSIE: That determines whether  
12 you need statutory authority.

13            MS. AVERY: Right.

14            MR. GALASSIE: Because we don't know  
15 whether this committee is going to recommend it. If  
16 they don't, it's moot. If it comes to the Board and  
17 the Board doesn't approve it, it's moot.

18            MEMBER CREDILE: Is it feasible or  
19 plausible -- and you're the best one to answer this --  
20 for that group to present to the Board or is that a  
21 crazy idea?

22            MR. GALASSIE: No.

23            MS. AVERY: I think the schedule for  
24 June, we're looking to see what that agenda looks

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1 like. Mr. Waxman is aware of that. So he's also  
2 looking at his schedule because he started a new job.  
3 So it will be sometime this summer, within the next  
4 two meetings.

5 MR. GALASSIE: I think when we schedule  
6 that meeting, any members of the Subcommittee can  
7 attend.

8 MS. AVERY: Oh, yes, definitely.

9 MEMBER CREDILE: Is that a separate  
10 meeting?

11 MS. AVERY: No. It's on our regular  
12 meeting agenda, on our Board meeting dates.

13 MEMBER CREDILE: The same day that you  
14 approve CONs?

15 MR. GALASSIE: Yes, we're trying to do  
16 that. We're trying to incorporate like a one-hour  
17 educational session on the normal agenda.

18 MEMBER CREDILE: Okay.

19 MS. AVERY: And you'll get materials  
20 ahead of time. It's not like they'll be sitting there  
21 reading the materials. Whatever goes out will go out  
22 to both the Subcommittee and the Board and be posted  
23 on the Web site.

24 MR. GALASSIE: If I may, the challenge

1 of this process is now you have all spent 2 1/2 years  
2 on this subject. We're going to come in front of the  
3 Board. Now they're first in the game.

4 So do we expect them to make a decision on  
5 that day? No, but we need to start educating them on  
6 the subject, and it's going to take some time to  
7 educate them further on the subject, to have our  
8 dialogue like this. That's certainly months.

9 MR. FOLEY: Mr. Galassie, don't you  
10 think that the Board would like to know possibly where  
11 the Subcommittee is coming from and what do they  
12 think?

13 MR. GALASSIE: Absolutely.

14 MS. AVERY: And that's been updated.  
15 They receive minutes. I keep them updated on what's  
16 going on. So everything that happens here, they have  
17 access to it.

18 MR. GALASSIE: Absolutely, both in  
19 agreement and disagreement.

20 They're going to want to know where the  
21 Subcommittee is coming from, they're going to ask for  
22 a staff perspective, and then they're going to want  
23 this third-party input and validation. That's what we  
24 paid for, and that's what they should hear. I think

1 they will want to know where, generally, did the  
2 Committee agree or not.

3 MEMBER PHILLIPPE: Two points. I like  
4 all of this.

5 One is they said something that was very  
6 pertinent in the beginning that we didn't discuss.  
7 They said our issue is to decide what we're trying to  
8 accomplish. That might be difficult in this group.

9 However, if we're going to do a bed buy and  
10 sell program, it would be helpful to measure if we  
11 knew what we were trying to accomplish from the plan,  
12 the program. I think one of the reasons we get into  
13 debate is because there's probably mixed goals.  
14 Everybody doesn't have the same goal. That's an  
15 important issue.

16 The second one is, because you said we  
17 talked about it, would it be useful just to take a  
18 vote of the Subcommittee today and say, "In general,  
19 we support the concept of a bed transfer buy and sell  
20 program"?

21 Now, we can leave defining how restricted or  
22 unrestricted it is to later discussion, but in general  
23 the Subcommittee supports the idea?

24 MEMBER SCAVOTTO: I would second that

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1 motion.

2 MEMBER SULLIVAN: Do you have a motion,  
3 Tim?

4 MEMBER PHILLIPPE: That is my motion,  
5 just to get the sense of the Committee. We're not  
6 defining the type of the program, just to get the  
7 sense of the Committee about some type of program.

8 MEMBER SULLIVAN: Should we recommend a  
9 buy/sell program to the Mother Board?

10 MEMBER PHILLIPPE: Yes.

11 CO-CHAIRMAN BELL: That's the motion.  
12 Do we have a second?

13 MEMBER SCAVOTTO: We do have a second.

14 CO-CHAIRMAN BELL: So I guess by a show  
15 of hands, all in favor of the motion?

16 MEMBER WILL: Can we have a little bit  
17 of discussion first --

18 CO-CHAIRMAN BELL: Okay. Sure.

19 MEMBER WILL: -- just in the sense of  
20 are we talking -- you know, because we've talked about  
21 a number of different models. We've talked about  
22 pilots. We've talked some about geographic  
23 restrictions. We've talked a little bit about  
24 transparency restrictions. We've talked a lot about

1 the access issues, especially from the Medicaid  
2 population, but I don't think we've talked in terms of  
3 how that would be incorporated in a proposal.

4 I'm trying to think of a way to kind of  
5 scope. Is it like we could agree to some form of bed  
6 buy/sell or is it unfairly -- I'm just kind of  
7 thinking --

8 MEMBER PHILLIPPE: The sense of the  
9 motion, I would say just move it along, we're not  
10 defining the limits.

11 It could be the most open or it could be the  
12 most restricted possible, but the sense of the  
13 Subcommittee is we are all interested in some kind of  
14 program. We'll hash that out at a later meeting.

15 MEMBER WILL: Okay.

16 MR. GALASSIE: Or you might think about  
17 your motion even being tighter. Ask for a strong poll  
18 on today's dialogue, which I think left us with more  
19 of a free market system with some regulation.

20 MEMBER PHILLIPPE: I would recommend  
21 that.

22 CO-CHAIRMAN BELL: Okay. We have an  
23 amended motion.

24 And a second?

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1 MR. GALASSIE: That was just my  
2 suggestion. I'm not voting.

3 CO-CHAIRMAN BELL: Okay.

4 MEMBER PHILLIPPE: But that would be my  
5 motion. I'm okay with that.

6 MEMBER SULLIVAN: I second the  
7 amendment.

8 CO-CHAIRMAN BELL: By a show of hands,  
9 all in favor?

10 (Show of hands.)

11 MS. AVERY: Nine. Do you have nine?

12 MR. GALASSIE: You need to define who  
13 is capable of voting.

14 CO-CHAIRMAN BELL: Just the Board  
15 members.

16 MR. URSO: It looks like nine voted.

17 CO-CHAIRMAN BELL: Any opposed?

18 MEMBER WILL: Yes. On the original  
19 motion, I believe I would have voted yes. On the  
20 amended, I feel I have to vote no.

21 MR. URSO: So how many "nos" were  
22 there, so we're clear on the record?

23 CO-CHAIRMAN BELL: Two.

24 MEMBER CORPSTEIN: I don't really know

1 which way to vote. I have some comments to make about  
2 what was going on. I don't know that I have any  
3 official vote. It's been explained to me I have no  
4 opinions.

5 MS. AVERY: Not from the Board staff.  
6 Not from us; right? You can vote or you can abstain.

7 MEMBER CORPSTEIN: It's been explained  
8 to me by my superiors that I have no opinion. So I  
9 can make some comments.

10 CO-CHAIRMAN BELL: I came from there.

11 MR. GALASSIE: I've been there, too.  
12 Mum's the word.

13 (Laughter.)

14 MS. AVERY: We welcome your opinion.

15 MEMBER CORPSTEIN: I would like to say  
16 a couple things.

17 They used the term "windfall" a couple  
18 times. Maybe that will be the case at some point, but  
19 it was my understanding that the purpose of the  
20 buy/sell was to alleviate or to increase occupancy.  
21 All right?

22 The Board's round-about figure is 72, 75  
23 percent. Looking at my stats from April 1st, that's  
24 about 100,000 skilled and intermediate care beds. So

1 25 percent empty is around 20,000 beds, and in their  
2 stats here it says only 2 to 4 percent of nursing  
3 homes in Ohio engaged in trading beds.

4 So if you have 20,000-plus beds for sale and  
5 you have three buyers, what is the value of that bed?  
6 Very little, I would imagine, because you have  
7 thousands and thousands of beds for sale and you have  
8 two or three people buying them.

9 I think it would exacerbate your fear that  
10 opening a new facility would be considerably cheaper.  
11 If the CON was eliminated and the fees associated with  
12 that, it can be in the millions of dollars for a  
13 100-bed facility or whatever.

14 If they didn't have to pay that and just had  
15 to buy beds, why have 20,000 beds for sale if they're  
16 \$1,000, maybe even less, based on the number  
17 available?

18 Opening a new facility right next to yours,  
19 brand-spanking new and pretty and all that kind of  
20 stuff, it would actually probably be cheaper for  
21 somebody to open a brand-new facility because they're  
22 not paying the millions of dollars to the CON, their  
23 buy-in is only the building and grounds, and then  
24 buying the beds from an oversaturated market.

1           Now, will that increase some occupancy?  
2     Maybe, but likely it's going to steal from yours  
3     because they are not going to be opening Medicaid  
4     beds.

5           I've done every change of ownership, initial  
6     and bed change in the last five years personally, and  
7     I can tell you nobody is asking for intermediate care  
8     beds. Nobody is asking for Medicaid certification  
9     other than a few token beds in order to achieve  
10    Medicare certification.

11           What I spend most of my time doing is  
12    upgrading intermediate care beds to skilled so that  
13    they are available for Medicare certification. Then  
14    usually when they do that, they drop their Medicaid.

15           None of this is going to solve Medicaid.  
16    That is mostly Senate 326 Bill that totally slashed  
17    everything. So there's a mass exodus right now of  
18    Medicaid, first being ICFBDs which are leaving  
19    en masse to DHS under the CILA program.

20           MR. URSO: Paul, this is after  
21    licensure and after CON review, right, that this is  
22    occurring?

23           MEMBER CORPSTEIN: Correct. Right.  
24           When Senate Bill 326 came down, my phone was

1 ringing off the hook from facilities with 100 beds of  
2 intermediate care. Maybe they have 50 skilled care.  
3 They want them all upgraded because they can't  
4 operate.

5 Now, the ICFBDs for the most part are  
6 not-for-profits, and not-for-profits cannot stay  
7 afloat with the Medicaid reimbursement rate.

8 So they are leaving our program and  
9 converting to CILAs, Community Integrated Living  
10 Arrangements, because I guess the reimbursement rate  
11 is better or it's more profitable for them to do that.

12 So the State is trying to get out of the  
13 institution business. They slashed the Medicaid rate.  
14 They can't operate as Medicaid, especially Medicaid  
15 only. So they're either converting to Medicare with a  
16 few token Medicaid beds or they're just leaving the  
17 program altogether.

18 So you have 25,000 beds for sale for 1,000  
19 bucks apiece or maybe less, depending. Their numbers  
20 were high at first and then lowered out. I would  
21 suspect ours are going to be rock-bottom low; and then  
22 until the number of available beds decreases, that  
23 price isn't going to go up.

24 So if you have 50 extra beds, you know,

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1 \$50,000, is that going to be a windfall for your  
2 facility to make improvements, add buildings and wings  
3 and all that kind of stuff?

4 I have no opinion, but --

5 MR. GALASSIE: Is it going to spread  
6 fictitious beds to areas that need beds?

7 MEMBER CORPSTEIN: I don't see why that  
8 is. Like I said, all facilities are sitting at 70, 80  
9 percent occupancy.

10 MEMBER SCAVOTTO: No. That's an  
11 average.

12 MEMBER SULLIVAN: You're talking an  
13 average.

14 MEMBER CORPSTEIN: An average. So  
15 there's a huge number of beds.

16 MEMBER SCAVOTTO: That's right.

17 MEMBER CORPSTEIN: Now, somebody said  
18 maybe two to one. Really, all of this is predicated  
19 on the fact that the Board has to eliminate the CON or  
20 put a moratorium on that.

21 It doesn't sound like anything to do -- I  
22 would imagine that is a significant hurdle for this to  
23 even come into play, but say, okay, the Board gets rid  
24 of it. The beds are for sale and we have a broker or

1 what have you. Here's your 25,000 beds.

2 Where is the windfall in that? Where is the  
3 gain for the facility to make improvements to compete  
4 with the new facility that's going to plop down right  
5 next to Tim's place more cheaply through that than it  
6 is now?

7 Because now they have to go through the CON  
8 process. There's a significant financial fee involved  
9 with all of that, plus the whole building and grounds  
10 and staff and training and all that kind of stuff.

11 So I'm not sure, at least not at the  
12 beginning. It's only after time when the backlog is  
13 eliminated that those beds are going to be of any  
14 value.

15 MEMBER PHILLIPPE: You're right.  
16 Actually, it depends on if it's wide open.

17 We have to remember the economics, and we  
18 have to decide at some point what we would recommend  
19 because if we recommend it statewide, which is what  
20 they're talking about, it would be just like you said,  
21 I think, because there's so many places downstate that  
22 have empty beds that they could sell to people in the  
23 growing suburbs. You're right. So there would be a  
24 huge market.

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1           Now, if you limit it within county, then  
2 it's very different. The price will go up, like I  
3 said, depending on how we structure it. We have to  
4 think through those issues, I think. Your points are  
5 very good.

6           MEMBER CORPSTEIN: If the State was  
7 wide open, then all the beds are going to move above  
8 I-80, generally. The people that are operating  
9 Medicaid facilities are generally county-run homes  
10 that can run at a deficit.

11           They do; right? And that's the only way  
12 they can support that. So Medicaid is leaving.  
13 There's going to be lots of beds available. If it  
14 was statewide, they're mostly going to flow up here.  
15 There will be less access in the southern -- or less  
16 access in the last three quarters of the State;  
17 right?

18           MEMBER CASPER: But those are  
19 unoccupied beds anyway; right?

20           MEMBER CORPSTEIN: They are unoccupied  
21 beds, but there is no value in that bed because  
22 everybody has unoccupied beds.

23           MEMBER CASPER: That was the intent of  
24 my question.

1                   MEMBER CORPSTEIN:  Somebody mentioned  
2 something like two to one you buy the beds, but one  
3 bed is eliminated or somebody said it was put into a  
4 pool that the State can manage or what have you.

5                   That might help eliminate the beds and make  
6 it so that it is profitable, that selling these beds  
7 is -- you know, if they're \$4,000, \$5,000 apiece, then  
8 maybe.

9                   The other thing is everybody is carrying --  
10 or lots of these facilities are carrying all these  
11 beds, but they are also paying bed tax on every single  
12 one of those beds.  They are taking money out of their  
13 own pocket by maintaining these beds that are empty  
14 because they feel that part of the value of their  
15 facility is that "I have 100 licensed beds."

16                   If I want to sell beds, that is part of the  
17 price of that bed, that that facility is licensed and  
18 they have access to 100 beds; right?

19                   So that's part of the reason why nobody  
20 wants to get rid of any of their beds because maybe  
21 baby-boomers are coming.  I suspect everybody's  
22 occupancy will be bumping up in the years to come, but  
23 there are also many more alternative ways than just  
24 nursing homes.  There's assisted living and home

1 health and everything else under the sun.

2 So where Was I going with this? I want  
3 everybody to be aware that I don't think it's going to  
4 be the windfall nature that they're reporting.

5 Then again, of course, they're saying here  
6 in their report that only 2 to 4 percent of nursing  
7 homes are engaged in trading beds.

8 Is it the State's responsibility to make  
9 rules for 2 to 4 percent of the population? I mean,  
10 are we going through all of this for this minuscule  
11 amount of beds to be moved?

12 Sure, at the very beginning there's going to  
13 be a huge rush for not much money. Then we'll have  
14 more unoccupied beds in other places. Maybe the  
15 facilities that are actually full will be able to fill  
16 some, but 20,000, 25,000, that's not going to be  
17 eliminated anytime soon.

18 I don't suspect it's going to generate much  
19 cash for the facilities, for infrastructure, or  
20 improvements or what have you. It will probably make  
21 it easier for new facilities to plop down next to old  
22 facilities and outstrip them in nice appointments and  
23 private baths and all this kind of stuff.

24 It's not going to help Medicaid at all or

1 Medicaid access because everybody is trying to get out  
2 of that. There might be less available Medicaid beds  
3 overall, but that doesn't mean that somebody in East  
4 St. Louis isn't going to be able to put grandma there.  
5 They're going to have to send her all the way to  
6 Hinsdale because there aren't any beds there because  
7 the facility sold them. They took what money they  
8 could get.

9           Everybody that's carrying empty beds, you're  
10 paying bed tax on that. I think the bed tax is the  
11 max allowable in our state. So you have the Medicaid  
12 rate slashed to the lowest in the nation. You have  
13 the bed tax as high as it can possibly be.

14           So facilities with -- I think that was kind  
15 of the point was to try through economics to help  
16 migrate the beds. As I understand it, the purpose of  
17 this was not just to get money to the industry but to  
18 eliminate or reduce the very high unoccupancy rate in  
19 Illinois.

20           I don't necessarily think -- I don't have an  
21 opinion on this, but --

22           MEMBER SULLIVAN: We're not going to  
23 solve global problems with this program. No one is  
24 pretending that.

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1                   MEMBER CORPSTEIN: Those are just my  
2 comments. I wanted you guys to be aware of it.

3                   I do the stats every month. I'd be happy to  
4 provide anybody with actual numbers on the exact  
5 number of beds every month broken down by category, by  
6 region. I don't know if regions mean anything to you  
7 guys.

8                   MEMBER PHILLIPPE: They do, yes.

9                   CO-CHAIRMAN BELL: Yes, Mr. Foley?

10                  MR. FOLEY: I think what Paul just  
11 said, I agree with probably 90 percent of that, and I  
12 thank you for your comments.

13                  One of the misleading items out there is  
14 that when one -- please help me, providers -- that  
15 when one buys/sells a facility, yesteryear, yes, it  
16 used to be a cost facility was based on a per-bed  
17 basis.

18                  Today it seems like it's really not cost out  
19 that way. Today it's all about bottom line, cash  
20 flow. It really doesn't matter how many licensed beds  
21 you have. We have a lot of old-timers out there that  
22 still believe that a bed is going to be worth a dollar  
23 someday.

24                  I think to the bed sell program, that was

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1 possibly going to be some relief. At one of these  
2 meetings, at one point somebody said we could get as  
3 much as \$50,000 a bed, and I think that was thrown out  
4 real fast.

5 What you're going to get for a bed is what  
6 somebody is going to be willing to pay for a bed.

7 MEMBER SCAVOTTO: The discussions we've  
8 had about this is "windfall" has been pretty much  
9 discredited.

10 MR. FOLEY: Yeah, exactly.

11 There's a lot of merits to a buy/sell  
12 program. I'm not going to say there isn't, but I  
13 think this community still has a lot of work to do in  
14 thinking this whole thing through to see how it's  
15 going to benefit.

16 MEMBER CORPSTEIN: What was the actual  
17 point?

18 Is the point of this buy/sell to get money  
19 to the facilities?

20 Is it to change the way occupancy is in the  
21 State?

22 What is the goal of selling the beds other  
23 than free market and this kind of stuff?

24 Is it to get money to the facilities?

1 MR. FOLEY: The original concept, to my  
2 understanding, is it was going help reduce the  
3 occupancy rate because they are sitting there with a  
4 75 average, whatever it is, occupancy rate in the  
5 State. Hopefully, it would help reduce that somewhat.

6 Secondly, obviously, there was talk that any  
7 money realized, okay, would pour back into the  
8 facility, giving them an opportunity, obviously, to  
9 upgrade somewhat, somehow.

10 But if they get \$5,000, \$10,000, \$150,000,  
11 \$300,000 through a bed sell program, they're not going  
12 to be able to do that much other than a lot of  
13 painting, okay, and ongoing maintenance, which is what  
14 you're doing right now anyway.

15 But to do enough, to really go in and rehab  
16 a facility where you can convert double rooms with a  
17 single bath, you know, sharing with two rooms into  
18 private accommodations, private bath, that kind of  
19 renovation is going to be very, very costly.

20 Because of the Medicaid reimbursement rate,  
21 most facilities cannot afford to do that.

22 MEMBER SCAVOTTO: I always heard it as  
23 a redistribution of unused beds.

24 MEMBER SULLIVAN: More flexibility in

1 the system, correct.

2 MEMBER CORPSTEIN: The need is above  
3 I-80.

4 MEMBER SCAVOTTO: That may be true,  
5 yes.

6 As you recall -- it's a shame Mike is not  
7 here, but according to the bed need calculation, there  
8 are pockets around the State.

9 MR. GALASSIE: Sure, Springfield,  
10 Champaign.

11 MR. FOLEY: There's actually six areas  
12 in the State of Illinois where there is a bed need and  
13 a number that somebody could actually do with.

14 I think there's a total of 13 planning areas  
15 in the State where there is a bed need of one bed,  
16 three beds, five beds, but a bed need of 60 or more,  
17 which is a number which you could almost do something  
18 with, I think that just numbers about six.

19 Am I right, John?

20 MR. FLORINA: That's about right.

21 In essence, there's your moratorium right  
22 now, unofficial moratorium.

23 MS. AVERY: Let me clarify. We never  
24 really understood the initiative other than it

1 probably came from the associations with the original  
2 legislation, and in a compromise we've asked the  
3 association's legislative gear to make an evaluation  
4 of a bed sell and exchange program other than  
5 instituting a bed sell and exchange program. That's  
6 how it came to this Subcommittee.

7 CO-CHAIRMAN BELL: I guess we're going  
8 to move forward.

9 Just plan on the next meeting that you bring  
10 any concepts or ideas, or I guess we'll probably have  
11 some further discussion and, hopefully, some --  
12 Mr. Galassie said maybe we can move into the ninth  
13 inning.

14 MR. GALASSIE: If ultimately this  
15 dialogue comes full circle and buy/sell isn't  
16 supported, so be it.

17 MEMBER SULLIVAN: Is Claire bringing  
18 something to the next meeting?

19 MS. AVERY: We'll figure it out.

20 MS. BURMAN: Yeah. That's not an  
21 issue.

22 MEMBER SULLIVAN: Something to work at.

23 MEMBER PHILLIPPE: To kind of move the  
24 discussion along, whether we do it or not, instead of

1 having Claire do all the work, could we like have a  
2 small task force and they could put up a straw dummy  
3 or whatever?

4 It's not to say this would be the plan, but  
5 at least it gives you something to start with and talk  
6 about, if that's something you're going to do.  
7 Otherwise, I'm afraid -- we have to do something so we  
8 make decisions on each point.

9 MS. AVERY: Right.

10 MR. GALASSIE: Right.

11 MR. PHILLIPPE: If you eliminate those,  
12 that would be fine, too. We have to get into the  
13 detail of the major decision points.

14 MR. GALASSIE: Open market, CON, no  
15 CON.

16 MEMBER PHILLIPPE: Right.

17 MR. GALASSIE: I think that's where  
18 you're at.

19 MEMBER SULLIVAN: Right.

20 MS. AVERY: We'll structure it in that  
21 sense --

22 MEMBER PHILLIPPE: Okay. Thank you.

23 MS. AVERY: -- and work with the Chair  
24 and Co-chair on it.

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1 CO-CHAIRMAN BELL: Very good.

2 After that short discussion, our next item  
3 is -- and I hope it's quick -- an update on the State  
4 ethics training.

5 MR. URSO: I just want to thank  
6 everybody. We had 100 percent participation in the  
7 ethics training. Everybody passed, I think.

8 Did you get yours in?

9 CO-CHAIRMAN BELL: I don't know.

10 MR. URSO: I've been told we're at  
11 100 percent. I want to thank everybody for that, and  
12 this is a very ethical subcommittee. Thank you.

13 MEMBER SULLIVAN: I think today's  
14 discussion was evidence of that.

15 CO-CHAIRMAN BELL: That's perfect.

16 MR. URSO: Is that short enough?

17 CO-CHAIRMAN BELL: I don't know. How  
18 do you normally work the lunch hour? Do you eat and  
19 work or how do you do it?

20 MS. AVERY: Yeah, and it will be  
21 delivered probably in the next ten minutes or so.

22 CO-CHAIRMAN BELL: Okay. The next item  
23 on the agenda is an update on the revisions to the  
24 long-term CON application.

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1 Mike, I've got your name on there.

2 MEMBER SCAVOTTO: That's too bad.

3 Cece and I are the surviving members,  
4 literally and figuratively. Ellie, bless his soul,  
5 made it through the fourth conference call. This is  
6 droll stuff. It is detail slogging.

7 What I would like to do so you can get it in  
8 the record is just run through our recommendations and  
9 then open it up for discussion. There are some things  
10 that are going to be worthwhile discussion.

11 The report was provided to Claire and  
12 Courtney. I think it made its way to some of the  
13 older members on the Committee. If you are new to the  
14 Committee and you haven't seen it, do not worry. It  
15 is something that will solve your insomnia.

16 We'll try to keep this on a high level. So  
17 I'm going to go pretty quickly. Then if you want to  
18 come back and ask questions, fine. I do have the  
19 application here. With a little bit of luck, I will  
20 not have to refer to it. That depends a lot upon the  
21 quality of your questions.

22 So the recommendations from the Committee  
23 concern the following: Number one, in the opening  
24 instructions there was an indication that physician

1 referral letters needed to be provided. There's  
2 general agreement among the staff, although not  
3 universal agreement, that that information was hard to  
4 get.

5 We're not talking about physicians saying,  
6 "We will support your facility if you build it."  
7 We're talking about information that's pretty  
8 detailed.

9 In the last three years, I had six cases of  
10 CHF from Zip code 60115. They don't have that  
11 information, and the Staff has reported that it's  
12 difficult getting that information.

13 As a result, we're saying that that should  
14 be dropped. The result of dropping it from the  
15 instructions would be to drop it from Section  
16 1125.540, Nos. 1 through 4.

17 The second recommendation concerns Service  
18 Demand, which is Section 1125.540, and there is an  
19 Item No. 5 on rapid population growth.

20 It turns out that that is very seldom used  
21 in the application, and it didn't take much discussion  
22 for everybody to agree that rapid population growth  
23 ought to be eliminated.

24 Let me back up. What we're going through

1 now on these recommendations are only items that  
2 require a rule change. There have been half a dozen  
3 small items that did not require a rule change that  
4 have already been affected. So I'm not going to  
5 bother with those.

6 So back on the main thing, No. 3, the  
7 planning area needs Section 1125.530 recommending that  
8 you include a link to the bed need formula.

9 The second item that we're recommending is  
10 that you clarify the primary service area from 50  
11 percent to what we believe the industry standard is of  
12 70 to 75 percent. I think that makes sense. If  
13 you've got a primary service area that's 50 percent  
14 and a second area that's also 50 percent, which one is  
15 which?

16 Normally, if you're talking PSA, you're  
17 talking 70 to 75 percent. We don't care which one it  
18 is, but it should be at least 70.

19 The rule also requires patient origin  
20 information in this section. The rule requires  
21 patient origin information. The application requires  
22 patient referrals. It's two different things.

23 So I don't think that's going to require a  
24 rule change. That's a technical correction to the

1 application. We're recommending that that be done.

2 The fourth item concerns Alternatives,  
3 Section 1125.330, and there's some considerable debate  
4 on where alternatives should be discussed.

5 Now, from the work group's point of view, we  
6 don't really care where alternatives get discussed. I  
7 think it ought to be in the project description. As a  
8 practical matter, no one is going to miss it if it's  
9 someplace else.

10 The fact of the matter is that there is a  
11 disconnect between the rule and the application. I  
12 think this is a technical correction that doesn't need  
13 a rule change. It's just a difference in the rule  
14 suggesting that alternatives be discussed.  
15 Alternatives need to be discussed, but they are not  
16 prescribed. Some examples are given.

17 In the application it is prescribed what you  
18 have to discuss. You have to discuss a project of  
19 lesser scope and cost. You have to discuss a joint  
20 venture or similar arrangement. You have to discuss  
21 utilization of other health care resources. That is  
22 not what the rule says. To be correct, we should  
23 bring it in line with the rule.

24 Item No. 5, Service Demand, 1125.550, we

1 were to drop Item 5 above, which referred to the  
2 patient referrals, and also Item 2 calling for the  
3 documentation of patient referrals. That is one item  
4 where I think we've had pretty universal agreement.

5 No. 6, Service Accessibility, 1125.570, and  
6 in this one the fourth bullet was a reference to acute  
7 care and wasn't applicable to long-term care. I wish  
8 they were all that easy to resolve. We're  
9 recommending a rule change to make that specific to  
10 long-term care.

11 No. 7, Duplication of Services, 1125.580,  
12 there are standards in this rule such as a 30-minute  
13 drive and 90 percent occupancy, and they strike us as  
14 being out of step with today's industry environment.

15 If, for example, you're in Chicago, a  
16 30-minute drive doesn't mean anything to you because  
17 you're going up. You're looking more vertical. It  
18 means a lot.

19 But anyway, in terms of demographics, you've  
20 got the vertical consideration, just the price of  
21 land. We have a specific recommendation on that, and  
22 that is to look at your market area in terms of your  
23 population and your service area rather than a  
24 prescribed 30-minute drive.

1           Now, this has been vetted in the Springwood  
2 decision and commented upon by Frank as well. We have  
3 the opportunity to do flexible things here if we  
4 choose. We're not being flexible when we say 30  
5 minutes. It may be totally inappropriate. In rural  
6 areas that is not a big deal.

7           We are also recommending that on --

8           MEMBER SULLIVAN: What is your  
9 recommendation about that?

10          MEMBER SCAVOTTO: The recommendation is  
11 use market feasibility studies.

12          The second recommendation in this section  
13 concerns the 90 percent occupancy, and the rule  
14 requires -- the application states that for  
15 replacement beds, new beds, all providers in that  
16 service area have to be at 90 percent occupancy.

17          It also requires that for significant  
18 modernization, renovation, all providers in that  
19 service area need to be at 90 percent occupancy. It  
20 is on this latter point, the 90 percent for  
21 modernization, that we are recommending that the  
22 90 percent occupancy be dropped.

23          When you look at the statistics in the  
24 State, we're not doing 90 percent average occupancy.

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1 Admittedly, some are at 90 percent or higher.

2 Our belief is that if you can finance it,  
3 you should be able to do it, and that's the  
4 recommendation that we're making. Drop the 90 percent  
5 on renovation and not on adding beds. Drop it on  
6 renovation. If you can finance it, you can do it.

7 MEMBER CREDILE: We didn't necessarily  
8 agree on the new beds -- I mean, on the new facility  
9 either.

10 MEMBER SCAVOTTO: No, we didn't.

11 MEMBER CREDILE: We had quite an  
12 ongoing discussion, 90 percent.

13 MEMBER SCAVOTTO: Right.

14 Item No. 8 was Staffing Availability,  
15 1125.590, and the consensus was to eliminate that.

16 No. 9, Bed Capacity, 1125.600, there is  
17 mention of a 250-bed figure in the current  
18 application, and there's no evidence at all that we  
19 could find supporting the inclusion of 250 beds. It  
20 doesn't seem to be used in the review of the  
21 applications, and the Committee's recommendation is to  
22 drop that.

23 No. 10, Community Related Functions,  
24 1125.610, we note that many states have dropped that

1 requirement, and there may be some importance of  
2 maintaining community linkages. We're in agreement  
3 with that.

4 Courtney was going to give us some draft  
5 language on that, which could be submitted in an  
6 amendment to the rule.

7 Item No. 11 was Project Size, 1125.620. On  
8 this one there are prescriptions for square feet. The  
9 number of square feet drives the project cost, but  
10 that has little impact on the State's per diem, also.  
11 Also, IDPH requires minimums in its surveys. The  
12 conclusion was we figure we ought to eliminate the  
13 upper end of the range on square footage.

14 MEMBER SULLIVAN: Then why have a range  
15 at all?

16 MEMBER SCAVOTTO: Well, you're going to  
17 have a minimum just because IDPH has one. You're  
18 going to have a minimum, and it ties into the 90  
19 percent. If you can build it and you can afford it,  
20 go ahead and do it.

21 I know I've done some projects where there's  
22 been maximum square footages and you would like to  
23 have had some more flexibility.

24 MEMBER SULLIVAN: Oh, absolutely.

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1                   MEMBER SCAVOTTO: So we're saying take  
2 off the upper end.

3                   MEMBER SULLIVAN: You have to have a  
4 minimum based on licensure anyway.

5                   MEMBER SCAVOTTO: That's what I'm  
6 saying, take out the upper end.

7                   No. 12, Estimated Total Project Cost,  
8 1125.800, we had a recommendation on this one, and the  
9 concern on this one was the ability of some applicants  
10 to obtain financing.

11                   On this one we felt that there were two  
12 phases that should be considered. Number 1, provide a  
13 schematic, a market analysis indicating the bed need  
14 in a financial feasibility study. You can get your  
15 Certificate of Need on that basis.

16                   Phase 2, if you couldn't get financing after  
17 a certain number of months, your Certificate of Need  
18 was forfeited.

19                   Now, there's some tweaking that goes on.  
20 Some people are going to get HUD financing, which may  
21 take longer. There are some details that go behind  
22 it, but generally you provide a schematic, not a  
23 complete detailed workup of plans, a feasibility  
24 study, financing. You get the CON. No financing

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1 after X number of months, you lose your CON.

2           Lastly, under Assurances -- that was  
3 1125.640 -- was the representation that 90 percent  
4 occupancy would be achieved within a certain amount of  
5 time. We think that ought to be dropped just because  
6 the statistics that we're operating under indicate  
7 we're not going to get that.

8           So that is the summary of the  
9 recommendations that we made, and we're ready for  
10 discussion.

11           MEMBER SULLIVAN: Far out. The two of  
12 you have done an amazing job.

13           MEMBER CREDILE: He did far more than I  
14 did.

15           MEMBER SULLIVAN: This is not just a  
16 revision to the application, honestly, because the  
17 application is based on the rules. You basically went  
18 through all the rules and said what works and what  
19 doesn't work.

20           MEMBER SCAVOTTO: It was a team effort,  
21 but we had good input from the Staff.

22           MEMBER CREDILE: We initially kind of  
23 got stuck on what we could change, what needs  
24 legislative change. So Claire was very helpful with

1 that.

2 MEMBER SULLIVAN: Okay. And I think,  
3 you know, certainly your recommendations are very  
4 good. As you go through the rules, there's some stuff  
5 that definitely was a hangover from the days where we  
6 mimicked the hospital regs. It's good to get rid of  
7 some of that stuff.

8 Probably my only question would be for a new  
9 project, we want them to be at 90 percent; and to say,  
10 you know, "Sure, I can open a new project, and it  
11 really doesn't matter what my census will be in a year  
12 or two or three," one would hope that a new project is  
13 going to be able to achieve some minimum.

14 We certainly want people building and  
15 saying, "Well, I'm going to be 50 percent full in five  
16 years." To what end is that kind of project?

17 MEMBER SCAVOTTO: I think that's a  
18 policy issue, and it almost gets beyond reviewing the  
19 application. But we've reviewed the application. We  
20 have significant policy issues that we really should  
21 address.

22 So in regard to the new facilities and the  
23 90 percent rule, yes, the rule says that you can't  
24 have any more unless everybody in your area is

1 operating at 90 percent.

2 It goes back to the conversation we were  
3 having earlier and your comment. That's franchise  
4 protection. I'm not pointing that out as news because  
5 most CON programs are set up for that anyway.

6 So it's not really a surprise, but I see the  
7 dilemma coming with people proposing applications for  
8 renovation and then adding a few new beds, maybe 25  
9 new beds. "I'm going to add 25 more beds to the  
10 service area, and I'm going to take them out of your  
11 hide."

12 At that point it becomes predatory. Once  
13 you do that, it is a slippery slope. So I think there  
14 is franchise protection built into it now. We're  
15 suggesting we take a look at it and make it more risky  
16 on the renovation side and the modernization.

17 Just use the figures. "I'm at 70 percent  
18 occupancy, and I want to renovate. I want to  
19 modernize," which is one of the charges that we've  
20 been given. That's the thing that really drove us on  
21 this one.

22 If we don't allow modernization, where is  
23 the innovation that you are seeking?

24 MEMBER SULLIVAN: I agree with that.

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1                   MEMBER SCAVOTTO: That one, we said  
2 eliminate the 90 percent.

3                   MEMBER SULLIVAN: I agree.

4                   MEMBER SCAVOTTO: Now, it opens up some  
5 very interesting discussions because it does mean that  
6 only the people that can finance it are going to be  
7 able to do it.

8                   When you stop to think about it, if you  
9 can't finance it, you don't have any business doing it  
10 anyway.

11                   MEMBER SULLIVAN: Bingo.

12                   MEMBER SCAVOTTO: It's not a game for  
13 the faint of heart.

14                   I don't think I've really answered your  
15 question. We just kind of circled the wagon a few  
16 times.

17                   MEMBER SULLIVAN: I don't disagree  
18 about the modernization.

19                   My question was if you're going to be  
20 building a brand-new facility from scratch, there  
21 should be some census expectations, occupancy  
22 expectations.

23                   MEMBER SCAVOTTO: You wouldn't do it  
24 otherwise.

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1           It goes to Charles' point. Where in the  
2 State are you going to do a new facility? There's  
3 only like six areas, you said? Only a few. As a  
4 practical matter, where were you going to do it?

5           MEMBER SULLIVAN: Unless you come under  
6 variances or innovation.

7           MR. FOLEY: And you didn't discuss  
8 variances.

9           MEMBER SCAVOTTO: I didn't discuss  
10 variances or renovation. That was not in the  
11 application. That's more of a policy point, but it's  
12 a good one. It's a good policy point.

13           MR. FLORINA: I just have a quick  
14 question about consistency back on the 90 percent  
15 rule.

16           You want to continue it for new projects.  
17 You not suggesting that we change. But you want to  
18 eliminate the assurance that you have to meet 90  
19 percent?

20           MEMBER SCAVOTTO: Yes.

21           MR. FLORINA: Then why were we  
22 requiring it if you didn't have to assure it?

23           MEMBER SCAVOTTO: I have no idea.

24           If you eliminate the 90 percent on the

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1 Duplication of Demand, you ought to eliminate it under  
2 Assurances just to be consistent.

3 MEMBER SCAVOTTO: But you only want to  
4 eliminate it for modernization, not for new beds.

5 MEMBER SCAVOTTO: Right, but the  
6 Assurances section that we're suggesting be eliminated  
7 would have applied to both, renovation and  
8 replacement.

9 If you stop to think about it, if you fill  
10 out an application today and say, "We're going to  
11 assure you that we're going to meet 90 percent  
12 occupancy projections," Staff will tell you, "Okay.  
13 You're making the assurance, but it's not happening."

14 MR. FLORINA: You still have to say  
15 you're going to comply when you submit your  
16 application, but you don't have to assure that you're  
17 doing it.

18 MS. AVERY: John, we can't hear you.

19 MR. FLORINA: I'm just trying to see  
20 the consistency.

21 MEMBER SCAVOTTO: There isn't any.

22 MR. FLORINA: That explains it all,  
23 then.

24 MEMBER SCAVOTTO: Courtney, you were

1 saying?

2 MS. AVERY: I couldn't hear John.

3 MR. FLORINA: I'm sorry. Do you want  
4 me to repeat it?

5 MR. FOLEY: So if I hear it correctly,  
6 if you say that you want to add a new facility, the  
7 90 percent does apply. Even if there's a need for  
8 beds and you want to build a new facility under the  
9 bed need, the 90 percent still applies?

10 MEMBER SCAVOTTO: We can always come  
11 back as a Subcommittee and change that policy. We're  
12 not changing it -- we can't change that policy by  
13 chewing up the application.

14 MR. FOLEY: I'm just concerned about  
15 anybody wanting to come in and build a new facility  
16 and spend all this money that it requires to get to  
17 the CON level; and then because of the fact there's so  
18 many facilities under 90 percent, then they're going  
19 to get turned down.

20 Why file an application?

21 MEMBER SCAVOTTO: I don't know why you  
22 would do that.

23 MR. FOLEY: There's a bed need.

24 MEMBER SCAVOTTO: Well, I'm not

1 following you. If there is a bed need and if the  
2 facilities in the area are at 90 percent, I read that  
3 as a green light.

4 MR. FOLEY: That's correct.

5 MEMBER SCAVOTTO: So what is your  
6 point?

7 MR. KNIERY: There are areas in the  
8 State where there is a bed need where all the  
9 facilities within 30 minutes or whatever service area  
10 you're at are not at 90 percent because of population  
11 growth or several others factors.

12 MEMBER CREDILE: But that's separate  
13 from the application. That issue exists all over the  
14 place.

15 MEMBER SCAVOTTO: You have other  
16 facilities that are not at 90 percent.

17 MEMBER CREDILE: Correct, but there is  
18 a bed need.

19 MR. KNIERY: I just wondered if that  
20 90 percent for new facilities is using it twice.  
21 They're already using the 90 percent in the need  
22 methodology, if you follow that through, but then you  
23 have to use it again, the 90 percent, to worry about  
24 all your facilities.

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1           It's already used on an area to determine  
2 need. If there is a need, now you're asking to do it  
3 again to look at every single facility, not just an  
4 average.

5           MEMBER SCAVOTTO: That is the way it's  
6 set up now. That is correct. That is correct.

7           MR. KNIERY: So it's just saying the  
8 same.

9           MEMBER PHILLIPPE: It's also a very  
10 difficult process because I've done it before.

11           So I'm in the position of trying to explain  
12 why the other buildings in the area are below 90  
13 percent, and it's difficult because you can't even say  
14 why they are.

15           First, you don't know; or if you do know,  
16 it's not something you should really be talking about.  
17 So any way you look at it, it's a difficult  
18 discussion. So I understand why we wouldn't want to  
19 be doing that.

20           MEMBER SCAVOTTO: Thank you.

21           MR. FOLEY: Mike, you did a great job.

22           MEMBER PHILLIPPE: Yes, You guys did a  
23 good job.

24           MEMBER SCAVOTTO: Good. We'll accept a

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1 motion to approve all of this without any further  
2 discussion, particularly from Mr. Sullivan here.

3 MEMBER SULLIVAN: I so move.

4 MEMBER SCAVOTTO: Thank you. It dies  
5 for lack of a second.

6 MS. AVERY: So the summary of changes  
7 that Mr. Scavotto just discussed are on the Web site  
8 under the long-term care category on the right side.  
9 The title is Summary of Changes, and it's dated  
10 October 2013.

11 MEMBER SCAVOTTO: What happens from  
12 here?

13 MS. AVERY: Well, I think you went over  
14 the changes to the application that you wanted; right?  
15 Those were simple ones, adding the links, and you have  
16 a summary of those.

17 Were there any questions about those? So we  
18 would make those changes and post it on the Web site  
19 with the new revised application. It's not substance.  
20 It's just adding things for links and other  
21 information that would make it easier to complete it.

22 The next steps, we'll look at what we need  
23 for the rule changes. You all approved those. There  
24 were no questions about that. So we can make those

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1 recommendations to the Board and then possibly start  
2 the JCAR process.

3 We'll have to look at it again. It still  
4 has to get approved through the Board and JCAR.

5 MEMBER SCAVOTTO: I'm still waiting for  
6 a second. The Subcommittee hasn't approved it yet.  
7 I'm going to die for lack of a second.

8 MEMBER PHILLIPPE: Oh, I'll second it  
9 if you want to approve it.

10 MEMBER PHILLIPPE: I thought it was  
11 already unanimous.

12 MR. URSO: You have a clear motion and  
13 a second for the record?

14 Who made the motion, so we're clear,  
15 Terry?

16 MEMBER SULLIVAN: Terry.

17 MEMBER PHILLIPPE: Tim seconded it.

18 MS. AVERY: So we're okay.

19 CO-CHAIRMAN BELL: All in favor say  
20 aye.

21 (The ayes were thereupon  
22 heard.)

23 CO-CHAIRMAN BELL: Opposed?

24 Thank you very much.

1 MEMBER SULLIVAN: So Courtney, the rule  
2 change will be on the Web site or do we get a copy, I  
3 mean, with the proposed rule changes underlined, what  
4 is being submitted to the Board?

5 MS. AVERY: Oh, yes.

6 MEMBER SULLIVAN: "Oh, yes," it will be  
7 on the Web site?

8 MS. AVERY: Well, we usually send them  
9 out to the Subcommittee members as an attachment to an  
10 e-mail, and then we also post it. So it's posted for  
11 the general public, and it will work its way through  
12 that process.

13 CO-CHAIRMAN BELL: Very good. Thank  
14 you, Mike. Thank you, Cece, for your hard work on  
15 this. It sounds like there are some good changes that  
16 need to be done. Awesome.

17 The next item on the agenda is Other  
18 Business. Are there any issues?

19 MEMBER SULLIVAN: I think this  
20 Committee needs a good Co-Chair, and I would like to  
21 nominate Mr. Bill Bell for his experience in the  
22 entire field, despite his newness to the Committee.

23 Do I have a second?

24 MEMBER SCAVOTTO: Yes. I'm not going

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1 to ever let anybody die for lack of a second.

2 CO-CHAIRMAN BELL: Reluctantly, all in  
3 favor?

4 (The ayes were thereupon  
5 heard.)

6 CO-CHAIRMAN BELL: Opposed?

7 MEMBER PHILLIPPE: There we go.

8 MEMBER SULLIVAN: Now you're official.

9 CO-CHAIRMAN BELL: I will do my best.

10 MEMBER PHILLIPPE: I have one brief  
11 thing.

12 CO-CHAIRMAN BELL: Yes, sir.

13 MEMBER PHILLIPPE: At the last meeting  
14 I was asked to talk about innovations at the next  
15 Board meeting. It was an especially busy Board  
16 meeting. They were nice enough to tell me before I  
17 got there they didn't have time for me. That was  
18 helpful. I appreciate the planning.

19 So I'm scheduled to go to the June meeting,  
20 but I wanted to remind people if there's anybody else  
21 that wants to be involved, or do you want to change  
22 that?

23 MEMBER CREDILE: Now you're going to  
24 compete, though, with the UIC guys.

1           MEMBER PHILLIPPE: Well, so maybe we  
2 shouldn't talk about it. It's true. If they are  
3 doing that already at that meeting, there wouldn't be  
4 time for anything else.

5           MS. AVERY: It's still on there.

6           Once we get all of everything that's going  
7 to be on the agenda, we look at it, try to assume the  
8 time, and I think we'll have time. I don't think  
9 there will be any kind of conflict or competition with  
10 it.

11           One of the things that we've heard from  
12 other people in the industry is that there needs to be  
13 a discussion with the Board about the changes in the  
14 landscape and the way health care is being delivered  
15 in accordance with the waivers, transformation,  
16 innovative ways to long-term care. So we have a long  
17 laundry list.

18           One of the other options was to have a  
19 little bit over half a day of those types of  
20 discussions, but the Board hasn't given the Staff  
21 direction on which way to go at this point. So for  
22 now it's June.

23           MEMBER PHILLIPPE: My message really is  
24 fairly simple based on our communication, the

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1 discussion last time, and that is a new building with  
2 private rooms and private baths by itself is not  
3 innovative. There are many buildings already  
4 providing innovative clinical services without having  
5 a new building.

6 I think maybe it came up that people were  
7 thinking private rooms was an innovation. We have  
8 many places like that now.

9 MEMBER CREDILE: Courtney, what are the  
10 dates of those things?

11 MR. URSO: June 3rd is the next Board  
12 meeting. That's in Springfield.

13 MS. AVERY: I'm getting him one after  
14 that.

15 MR. URSO: That's at the conference  
16 center on Northfield.

17 MR. KNIERY: Correct.

18 MS. AVERY: My computer is so slow over  
19 here, but they are posted on the old agenda, all the  
20 meeting dates. The other one I think is on July 15th  
21 here in Bolingbrook. June 3rd, Springfield at the  
22 Northfield Inn; July 15th, here in Bolingbrook at the  
23 Bolingbrook Golf Club.

24 MEMBER HANDLER: What time are the

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1 meetings?

2 MS. AVERY: 9:00 a.m.

3 CO-CHAIRMAN BELL: Any other? Yes,

4 Mr. Foley?

5 MR. FOLEY: Do you recognize me now?

6 CO-CHAIRMAN BELL: I'll recognize you,

7 sir.

8 MR. FOLEY: I thought several months  
9 past we had discussed the issue of variances as it  
10 relates to innovation. That was a hot topic at one  
11 point in time. What was innovation back then, as you  
12 said, is not innovation today.

13 Skilled and rehab beds, everybody is doing  
14 that. Short-term rehab, everybody is doing that. I  
15 thought we were going to have further discussion on  
16 the variances because I do know that there was a  
17 discussion of creating for even existing providers,  
18 again, trying to help them out.

19 If they're there sitting with a 90  
20 percent-plus occupancy, you know, for the last three  
21 years and they got a -- I don't care what the star  
22 rating is, but if they have a four- or five-rated  
23 facility and you want to add beds and you can't  
24 because there's not a bed need, we're talking about

1 creating some sort of a variance that will allow those  
2 existing providers to do so, trying, once again, to  
3 help out our existing providers.

4 MEMBER PHILLIPPE: We've had that  
5 discussion. We just haven't had it lately. It takes  
6 some time to define what real "variance" means.

7 What do we mean by "variance"? Something  
8 innovative.

9 MR. FOLEY: I think another issue along  
10 that also is the issue of accessibility, especially  
11 for Medicaid, because it looks like it could get to  
12 the point someday where areas could be curtailed in a  
13 lot of ways in terms of not having access to Medicaid  
14 beds because everybody is going private-pay Medicare,  
15 period.

16 So down the road I could see some issues  
17 with access. I think we should be at least looking at  
18 a variance of some sort to ensure that accessibility  
19 is in fact out there.

20 MS. AVERY: I'm pretty sure -- remember  
21 early on years ago we did that ranking? We did a  
22 ranking of priorities for the Subcommittee, which is  
23 on the Web site, also. That was one of the issues.  
24 We just haven't gotten to it yet.

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1 MR. FOLEY: Yes, it was.

2 MEMBER HANDLER: Maybe we should  
3 recirculate that ranking, now that we're starting to  
4 move further down the path, to kind of revisit what  
5 some of those topics were because we have new members  
6 and we have had some distance between the last time we  
7 spoke about them.

8 MS. BURMAN: Those rankings were sent  
9 to the Committee.

10 MS. AVERY: And they're on the Web  
11 site, and we'll send them out again.

12 MEMBER HANDLER: Just to recirculate  
13 again.

14 MEMBER SULLIVAN: I agree with Carolyn.  
15 After I looked at them, it's sort of like,  
16 "My goodness, we have come a long way in three years."  
17 I would raise the question with the new members and  
18 experienced members -- I mean, we all have a good  
19 amount under our belts at this point -- of whether  
20 those are the same ranking of priorities of where we  
21 want to go in the future.

22 MS. AVERY: Okay.

23 CO-CHAIRMAN BELL: Any other new  
24 business? Yes, Frank?

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1 MR. URSO: I just wanted to clarify  
2 because there was some confusion earlier today about  
3 the addition of the bylaws that we are now, the  
4 Committee and Subcommittee, operating under.

5 It should be the bylaws that were approved  
6 at the December 3, 2012, meeting. So you need to find  
7 that date at the end of your bylaws, and that's the  
8 correct bylaws that this Subcommittee is operating  
9 under because there were several versions, you'll  
10 recall.

11 So I just wanted to point that out.

12 MEMBER HANDLER: December 2012?

13 MR. URSO: December 2012, correct.

14 MEMBER SULLIVAN: What is our current  
15 need for a quorum?

16 MR. URSO: Eight.

17 MEMBER SULLIVAN: And we have managed  
18 to meet our quorums.

19 MR. URSO: Admirably, today.

20 MEMBER SULLIVAN: But in the past year?

21 MR. URSO: I think the Subcommittee has  
22 been successful.

23 MEMBER SULLIVAN: Since the bylaw  
24 change.

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1 MR. URSO: Yes, where the number for a  
2 quorum has been reduced.

3 CO-CHAIRMAN BELL: Anything else under  
4 Other or New Business? If not, the next issue is the  
5 next meeting.

6 Does the group as a whole decide or do you  
7 have set times?

8 MR. URSO: Just when you're available  
9 because you've been elected.

10 MS. AVERY: I don't know why we had a  
11 Wednesday this time. They're usually held on  
12 Tuesdays. It was maybe the third Tuesday or so.

13 CO-CHAIRMAN BELL: Every two, three  
14 months?

15 MS. AVERY: We've been doing them as we  
16 were going, and it's been every other month recently.

17 The consensus of the body? Next month?  
18 July is heavy vacation time. We usually don't get a  
19 lot of attendance in July. August is kind of hit or  
20 miss. The Chair usually asks for an in-person meeting  
21 as opposed to a conference call.

22 CO-CHAIRMAN BELL: Are there any  
23 recommended dates? Any requests?

24 MS. AVERY: If we met in June, it could

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1 be the 17th or the 24th. If we went into July, it  
2 could be the 21st or the 28th.

3 MR. URSO: It's the 22nd or the 29th.

4 MS. AVERY: I'm sorry. Yes, the 22nd  
5 or the 29th.

6 MEMBER SULLIVAN: How about June 24th?

7 MEMBER CREDILE: I'm good. June 24th.

8 CO-CHAIRMAN BELL: June 24th?

9 MS. AVERY: Next meeting date,  
10 June 24th.

11 CO-CHAIRMAN BELL: Is that acceptable?  
12 Same time? Same place?

13 MEMBER WILL: I don't think I can make  
14 it.

15 MS. AVERY: Is there an alternative or  
16 is it okay to meet without you?

17 MEMBER WILL: Later that week? It's a  
18 long weekend. Wednesday, Thursday?

19 MEMBER HANDLER: I have a Board meeting  
20 on that Friday. I wouldn't be able to do it.

21 MEMBER CREDILE: So you're asking for  
22 the 25th or 26th?

23 MEMBER PHILLIPPE: The 25th?

24 MS. AVERY: 25th.

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1 CO-CHAIRMAN BELL: 25th? That's a  
2 Wednesday, then.

3 MEMBER HANDLER: The 25th doesn't work  
4 for me.

5 MEMBER CREDILE: Does the 26th work?

6 CO-CHAIRMAN BELL: What is the 26th?

7 MEMBER CREDILE: Thursday. The 17th  
8 does not work for me.

9 MEMBER JOHNSON: Me either.

10 CO-CHAIRMAN BELL: Do we move into  
11 July, then, or do we pick a date that we hope is the  
12 best?

13 MEMBER SCAVOTTO: Pick a date and hope  
14 for the best.

15 CO-CHAIRMAN BELL: Was there only one  
16 conflict on the 24th?

17 MS. AVERY: There was one on each day.

18 CO-CHAIRMAN BELL: One on each day.

19 You'd normally have them on Tuesdays?

20 MS. AVERY: Yes.

21 CO-CHAIRMAN BELL: Unless someone is  
22 vehemently opposed, can we just shoot for June 24th,  
23 which is a Tuesday, same time?

24 So do you always use the same place?

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1 MS. AVERY: Yes, but I'll check  
2 availability before we leave.

3 CO-CHAIRMAN BELL: Is 9:00 too early  
4 for some? We could meet at 10:00.

5 MS. AVERY: I won't speak for  
6 Springfield Staff; but coming from Springfield with  
7 him this morning, it was torture.

8 MR. DART: It's rough.

9 MS. AVERY: There's summer construction  
10 that we encountered last year. I think it was one  
11 member that was asking for 9:00.

12 MEMBER HANDLER: Judy Amiano. Judy  
13 wanted 9:00 or later.

14 CO-CHAIRMAN BELL: She's not here.

15 MS. AVERY: I would recommend that  
16 during the summer we look at 10:00, if possible,  
17 10:00 to 2:00.

18 MEMBER SULLIVAN: 10:00 is fine. Even  
19 for those of us coming from Chicago, it eliminates the  
20 rush hour.

21 MS. AVERY: 10:00 a.m.

22 CO-CHAIRMAN BELL: So we're set for  
23 June 24th, and we'll begin at 10:00 o'clock.

24 MS. AVERY: Okay.

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1 MEMBER HANDLER: They will send out  
2 confirmation?

3 MS. AVERY: Yes, definitely.

4 CO-CHAIRMAN BELL: Anything else today?  
5 Very good. Thank you.

6 Can I have a motion to adjourn?

7 MEMBER HANDLER: So move.

8 MEMBER RAIKES: Second.

9 CO-CHAIRMAN BELL: Motion accepted.  
10 All in favor?

11 (The ayes were thereupon  
12 heard.)

13 CO-CHAIRMAN BELL: Opposed?  
14 Thank you.

15 (Which were all of the  
16 proceedings had in the  
17 above-entitled matter,  
18 concluding at 12:09 p.m.)  
19  
20  
21  
22  
23  
24

1 STATE OF ILLINOIS )  
2 ) SS.  
3 COUNTY OF DU PAGE )

4 I, Jean S. Busse, Certified Shorthand  
5 Reporter No. 84-1860, Registered Professional  
6 Reporter, a Notary Public in and for the County  
7 of DuPage, State of Illinois, do hereby certify  
8 that I reported in shorthand the proceedings  
9 had in the above-entitled matter and that the  
10 foregoing is a true, correct and complete  
11 transcript of my shorthand notes so taken as  
12 aforesaid.

13 IN TESTIMONY WHEREOF I have hereunto set  
14 my hand and affixed my notarial seal this 6th  
15 day of May 2014.

16  
17  
18  
19 Jean S. Busse



20 Notary Public

21  
22 My Commission Expires  
23 July 25, 2017.  
24