CITY OF SPRINGFIELD

STATE OF ILLINOIS

LONG-TERM CARE FACILITY ADVISORY SUBCOMMITTEE

METHODOLOGY WORKGROUP MEETING

LONG-TERM CARE FACILITY ADVISORY SUBCOMMITTEE METHODOLOGY WORKGROUP MEETING, held on February 24, 2016, between the hours of 10:00 o'clock in the forenoon and twelve-nineteen o'clock in the afternoon of that day, at the Department of Public Health, 535 West Jefferson Street, Springfield, Illinois 62702, before Ann Marie Hollo, CSR, RDR, CRR.

A P P E A R A N C E S

Mr. Paul Corpstein
Mr. Charles Foley
Mr. Alan Gaffner
Mr. John Kniery
Mr. Nelson Agbodo
Mr. Chavan Aashay

Via video:
Mr. Juan Morado
Ms. Jeannie Mitchell
Ms. Courtney Avery

Via telephone:
Mr. William Bell
Mr. Mike Constantino
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MR. AGBODO: I know people might find this interesting. People who worked with me yesterday, they might find it redundant, but I apologize for that.

MS. AVERY: Nelson, let me interrupt.

Just real quick, the purpose of yesterday, we were getting the three associations on a conference call with Alice's assistance to try and get some feedback. So it wasn't a long-term committee meeting or a work group. It was just to bring those three into the loop and different people -- Kurt Riva. There was another lady that joined us.

MR. MORADO: Meeker.

MS. AVERY: Susan Meeker, Alan, Jerry. And was there someone else?

MR. GAFFNER: Those were all the association members, Courtney.

MS. AVERY: So that was the purpose of yesterday's meeting. There wasn't any decisions, rule voting or anything of that nature. It was just a learning session to bring them up to speed on their reports.

Okay, Nelson. Sorry.

MR. AGBODO: That's fine. Thank you.

So in the first report, we shared, if you recall, it was titled, "An overview of the Illinois Long-Term Care Bed Need Methodology." We presented the step-by-step computation of the long-term care bed need projection and provided a descriptive statistical analysis of bed allocation, projection, and utilization of the state and health planning area levels. In that report, we identified that projected number of beds exceeded the need at the state level from 2005 to 2014. That was the case.

Okay. So we also find that utilization of licensed beds was around 74 percent, but as you know, the target occupancy rate is 90 percent. And the licensed bed utilization have been decreasing. And the decrease averaged 4 percent over the 10-year period went from 2003 to 2013. So our projections allotted patient days that exceeded needs in some areas and fell below the needs in other areas. So from this observation, we hypothesized that bed allocation between Health Planning Areas was not optimal. So that was something that we -- the group asked to investigate. So how can we make the bed allocation to solve the problem, the bedding issue that we have seen in the

Health Planning Areas.

Then we conducted a second study entitled, "Evaluation of Five Methodologies for Projecting Illinois Long-Term Care Bed Need" to evaluate five different methodologies on their likelihood of projecting Health Planning Area number of beds that cover 100 percent to 110 percent of the needs. So for clarification, the goal for this study was to produce -- project the number of beds that cover 100 to 110 percent of health planning area historical bed needs. So the need is not the future needs. Actually, we capped our goal on previous needs that we have seen in those areas.

So this study -- I will say that we are actually making the assumption that the past needs might be carried forward into the future.

So this study shows that the methodology that performed best on this evaluation was the modified version of the current methodology that we call CIM-3, whereby the 30 percent to 150 percent assumption is used for computing the projected use rates.

So how do we do that? Actually, the Health Planning Area projected use rates will equal the base use rates if this rate falls between

30 percent and 150 percent of the Health Service Area's use rates, will equal 0.3 times Health Service Area's use rates if the Health Planning Area based use rate is less than 30 percent of Health Service Area use rates, and 0.6 times Health Service Area use rates if the Health Planning Area base use rate is more than 60 percent of Health Service Area use rate.

The assumption was the occupancy factor. We changed the occupancy factor from 90 percent to 95 percent. Like I explained this before, occupancy factor gives more beds. I mean, if you have a higher occupancy factor, you have a higher number of projected beds, but if you are reducing the occupancy factor, you are decreasing projected -- the projected number of beds. But what we realized is that it only gave a moderate improvement to the projection. So the methodology of projected bed needs with that number, with that respect, the goal of 100 and 110 percent, but just for only 26 Health Planning Area out of 95 that we have in the state. So that's moderate. We think we can improve that.

So this finding led to another hypothesis that we are missing a very important

variable. That's why we cannot improve it so much. So from there, we actually request the group to come up with a consensual definition of the policy purpose for the methodology that can translate into measurable goals.

And on this end, I haven't heard any proposal from the other presenter entities of the group.

Then we did a review to see how people project long-term care beds somewhere in the world. You know, what are they using? We realize that in the United States, all the 36 states that have CON use, you know, similar variables. You know, use rates, population, number. That's the common methodology that they use, but in Europe, I found some study that actually used the disability rates, the factor to do the projection.

Then we conducted a third study called "The Determinant of Long-Term Care in Illinois," and this study was to identify variables that explain the variability of bed allocation among counties. So like I said, the goal we set out for this study was to produce projections that meet the community needs where disabled persons live at the time they need long-term care, while ensuring the

market sustainability. And on this, we found a very interesting definition from New York State. The definition -- the objective of the CON process are to promote delivery of high-quality health care and ensure that services are aligned with community needs. So I think that's what our bed methodology should do here in Illinois. And for that, we made the hypothesis that the bed allocation should normally correlate positively with functional disability rates, and our review of literature supported that hypothesis.

But, surprisingly, our data analysis showed a negative correlation between bed allocation and disability rates. And something very interesting -- that's why that's -- the bed allocation correlates positively with what I will call economical factors or variables such as per capita income. So these results indicated that counties with higher per capita incomes have higher licensed bed numbers, and counties with higher disability rates have lower licensed bed numbers.

The correlation with per capita income is not an issue, but having a negative correlation between disability rates and licensed bed distribution throughout the state, I think,

should be improved. It's something that shows some concern.

And, now, I would like to -- before I continue, I would like to go to the page, the document, the Long-Term Care Bed Needs Report. Go to page -- yes. Go to Page 14. We can look at Page 14 and 15.

So, first off, Page 14, this graph shows the correlation between average licensed beds and the disability rate per a thousand population. And if you look at Cook County up here, so Cook County on this graph can be classified as an outlier. What I mean by that is it's out of the crowd. I mean, you see all the counties in one group, and Cook County, it's out of that group. But you can also see that Cook County has very low disability rates by thousand population, yet has the highest number of licensed beds. On the other end, Hardin down here has the number of disability rates, but has the lowest licensed beds.

THE REPORTER: Did you say Hardin?

MR. AGBODO: Hardin, H-A-R-D-I-N.

So that's the contrast. And if you go to the beds projection -- they say that we already published -- Hardin has needs. There's a

need in Hardin. And Cook County, there's no need, I think.

So I'm trying just to set out using disability rates supports our projection as well. You know, what our projection is showing. You know, the needs, and you know, excess beds. It's actually captured -- this actually captures it in this analysis as well.

So, you know, this is -- I will say, you know, what is not looking good, and if our formula in the future can change this pattern, I think that would be great.

So if you go to Page 15, we have a graph that shows a correlation between per capita income and licensed bed, and the line going upward shows a positive correlation. You'll see that Cook County is also -- stay out of the graph. And, you know, it's one of the counties that have the highest per capita income and also has a number of beds. And DuPage, Lake County, and they are in the same group with Cook County. All those counties are in one group.

And as I was talking about Hardin -- we had to look at Hardin, just a figure, but Hardin would be down. I mean, I'm on the county

with low per capita income and low number of beds.

So those are the two figures that are very interesting in this report, and I just want this group to think about it and see if this can help to come with good proposals for the bed needs methodology.

MR. FOLEY: Very amusing and very confusing.

MR. AGBODO: It's confusing.

MR. FOLEY: Very confusing, but amusing.

MR. AGBODO: I will be very open for questions, but I'll try to finish quickly, my report, and then get ready for questions.

So we actually did the analysis by running a regression model. So for our further investigation of this correlation and the variables that we put in this analysis have to come up with a model that explains 89 percent of bed distribution variability and disability rates, percentage of population aged 65 years and older, percentage of black population, and annual average net migration for both sexes, aged 60 years and older, were not significant predicters of licensed beds' variation. If you recall, this group has the variable migration

in the methodology, but here this study showed that migration is not a factor that will explain the bed variability in the states.

In this study, we have seen that per capita income, urbanization, home ownership rates, educational level -- mainly people with a Bachelor's or higher degrees -- that's what we actually evaluated on education, the educational level. Percentage of married females, age 65 to 74 year-olds, population density are a significant predictor of bed distribution among counties.

So this study shows that where we have low disability rates, that's where we actually have higher number of beds. And at the same time where we have high capita income, that's where we have higher number of beds. Something to think about.

So policy wise, we have seen that there's a strong support of what has been called rebalancing of long-term care from institutional settings to home and community beds -- community service settings. This is just for cost saving reasons. The review of the data shows that policy, Medicare policy, trying to reduce budget deficits so they actually put in more funding into home and

community bed service settings. And some of the cost analysis actually showed that the institutional setting cost more than home-based settings. And on average, I think for -- I can't remember the year, but for a year, the average cost in an institutional setting was 85,000 a year, and home-based setting was just 45,000. I think it's in the reports. If you read the data, you'll find all those figures.

So as a result, long-term care beds, the Medicaid-paid beds in institutional long-term care are expected to decrease. So this conclusion is coming directly from the review of the literature. It's not a recommendation that I'm making, but that's what we can tell from reading the trends of the markets.

So at the end of this study, I recommend that we use the disability rate as a significant criterion in the long-term care bed need determination and the CON process, so we can adjust the CIM-3 projections to the disability rates. So we already have a projection set from all the CIM-3, so we can now adjust that to reflect the disability rates. And that was a suggestion from yesterday's meeting.

And, also, I think our -- the

projection that we are getting from our formula, some people have said that's very conservative. Many have said it's increasing the number of beds that we project for five years, and I think that is in relationship with the trend that we are seeing in the market. So I also recommend that for further research, we may investigate how effective the CON program is at balancing the objectives of both public health and the long-term care markets.

Thank you very much for your attention, and I will now respond to questions now.

MR. FOLEY: I'm still trying to process a lot of this, Nelson. Not being a mathematician or anything, it is somewhat difficult to quite honestly understand. I think I know where you're coming from. Nevertheless, I do want to thank you for the time and effort and work that you did, in fact, put into this. You are to be commended for this.

MR. AGBODO: Thank you.

MR. FOLEY: So we need to continue a planning process at the community levels, but we need to be aware of how the bed need affects other variables, which would include --

MS. AVERY: Hey, Nelson, can you move

your papers from the mike?

MR. AGBODO: Okay. Sorry.

MR. FOLEY: I guess my question is, one of the questions that you made here is the effectiveness of the CON program to balance both the long-term care market and public health interests. What does that mean exactly?

MR. AGBODO: Thank you for that question. I think what I had in mind by saying that --

MR. FOLEY: Page 24.

MR. AGBODO: Yeah, on Page 24.

MR. FOLEY: The last one.

MR. AGBODO: Because that is -- this report shows that what I will call a predominant inference of economic variables on the CON process.

MR. FOLEY: Economic viability of the CON process?

MR. AGBODO: Right. So it would be interesting to see a positive correlation between the licensed bed distribution and the disability rate. And I think, you know, a lawmaker would love to hear something like that, but right now this does not assure that. So what I'm saying is, if we start projecting to what our goals to make both

distribution to go in the same direction, meaning licensed beds and disability rates, then it's like we are really meeting the community needs, which is assessing health care services.

MR. FOLEY: Okay.

MR. AGBODO: What I'm really looking for is a clear purpose for the methodologies so we can evaluate that in the future, because without that, we cannot select a set of projections and say -- among many others. We did five different projections, and what are the criteria to select one of those five? But if we say, "Well, this is what we need the projection to do," it will be easier for everybody to say, "Well, this set looks better." And for me, in order for that to look better -- the one has to meet the community needs as far as access to long-term care services.

At the same time, I understand that -- at the same time, I believe that our projection will not project beds that compromise the markets, or you know, we cannot just put all the beds in the area where the market is not interested in -- I don't know how to phrase that, but what I'm trying to say is we will have to make sure that both have objectives, which is access to health care and

market objectives are met. Both -- you know, both objectives are met.

MR. FOLEY: Okay.

MR. AGBODO: Maybe I'm beyond my expertise, so I just want to maybe come back to this report, if you will allow that.

MS. AVERY: Nelson, I think Bill had a question.

MR. AGBODO: Sorry. I didn't hear the question.

MR. BELL: Nelson, this is Bill Bell.

We talked a little bit yesterday, and you alluded to it today of trying to combine the CIM-3 with the disability rates. Have you got a time frame for how long that would take you to calculate that out and see where that puts us?

MR. AGBODO: Yes, I can get it ready in two weeks.

MR. CORPSTEIN: CIM-3 was the one that you recommended?

MR. AGBODO: Right, in the previous study. So I would add the disability rates factor to that. So I will have another set that will go along with the five that we already have, and send that back to you to see which is what. We'll have

to meet, like I said, the public's objectives and the market's objectives.

MR. BELL: That's great. I appreciate that. Thank you.

MR. AGBODO: You are welcome.

MS. AVERY: Anything else?

MR. LAVENZA: What's the next step?

MR. AGBODO: Well, the next stop for me is to prepare the new projection sets, using the disability rates and CIM-3 methodology. And then once it's ready, I will send the new reports, just on that projection set to everyone on this group. And I will expect feedback as far as, you know, which one of the six sets we should use in the future, and I want Mike to reach out to see how -- as well as Courtney to see how we can implement that.

MR. KNIERY: Nelson, this is John Kniery.

I see a disconnect between the objective of utilizing the community more and keeping people home more versus institution, and I also see a disconnect between payer source, especially because the full continuum of care is not within the purview of this program.

MR. AGBODO: Right.

MR. KNIERY: How do you reconcile those things? And what I have seen in the past, there was a huge push to keep people at home. Let me pick on DDs for instance. Can you put those people in the community where you had -- you could have eight bed ICF DD. That was an institution versus an eight bed CILA that was not, but the only way to fill a CILA is if a person is homeless or if it's an emergency situation. There's no access there, not for the individuals and not for the families. Yes, it keeps people -- it saves the State money because they're not filling a bed, but that's not accessibility.

MR. FOLEY: It's putting the burden back on the families is what it's doing.

MR. AGBODO: Right.

MR. KNIERY: And the fact that we have a CILA program that's closed. I just think that there's a disconnect between the noble objective and the reality of delivery.

MR. AGBODO: Yeah, of the delivery.

Well, what I can tell that the formula can do is to make sure that we continue to project to meet the trends of the markets. And,

actually, the CIM-3 has the data as well as the base user rates. That's what carries forth the trends of the market in the formula and the methodology.

So if we see -- so if we see more demands from the market, the data will show that it will increase, so the user beds will increase. But if the market is trending down, that user bed group will also go down. At the same time, if we adjust the finite set of projections with the disability rates, we are also trying to shift beds toward communities that need that the most.

So the formula cannot do more than that, you know. So if there's a situation on the field, maybe it needs to be investigated to address that. That can be policy, or you know, rules, you know, but outside of the formula -- but what I really want the formula to be able to do now is to follow the market's trends and shift the beds to the community that needs that the most. And I know, you know, we talked migration might play into this, but what I have done shows that migration is not a significant factor for some reason. Now, yeah.

MR. FOLEY: That's interesting.

MR. AGBODO: Right, what we have.

Actually, we use IRS -- yes, IRS

data. They actually publish things like that, and they actually publish migration data. We used -- in this study, we used the data from 1980 to 2010, so it's 30 years of data that we have used, and it doesn't really show that migration is a significant factor.

MR. GAFFNER: This is Alan Gaffner.

In the migration, you're talking about actual relocation of establishing residency, not so much a time of commute pattern?

MR. AGBODO: No. It's location. You see, when people pay taxes, they will report the allocation rates. So between two years, if it's not the same address, then there's the migration, you know, in terms of IRS data. So that's what we have used in this data.

MR. GAFFNER: Thank you.

MR. AGBODO: Yes.

MS. AVERY: Any other questions or feedback?

MR. GAFFNER: Nelson, following our meeting yesterday, I had an opportunity during my drive to think a little bit more about Page 24.

MR. AGBODO: 24, yeah.

MR. GAFFNER: And you did reference

those last three bullets, and I believe those are really critical issues. And I'm not suggesting someone needing to go down another exhaustive research effort initially, but how would you recommend from your data perspective that further research could be done to address the mediation effect influencing the neighboring counties, affecting the CON program balance? Have you thought about how research might be done in those areas, sir?

MR. AGBODO: Yes. The analysis, it's very interesting. I think that it needs to be done, because in the limitations, like I said -- where is that? I said that one may argue that if counties that have a higher number of licensed beds are adjusted to the county with a lower number of beds, the problem of marginal distribution of licensed beds will not be dramatic. It would just mean that if you have two counties, and the one county you don't have the facility, or you don't have long-term care facility, but the next county -- in the next county, you have, you know, facilities. People might think, you know, well, people can just migrate from that county with no beds to the county with many beds, and that should solve the problem, but

the distance needs to be thought about. So that's what this analysis will do to see if the distance, if that's an issue or not. So that would be through all the states.

We have the facility's address, and we can code the address and do that for final analysis, but it won't be -- I haven't really started on that. I don't know what the difficulty that can come with this type of work, but it can be done. It can be done. And what we'll get out of that is, you know, to see distance between residences and long-term care facilities and see if the distance, if it's a problem. So I would say even a 30-minute drive might not be a problem, right? But if we find that on average, on average people will drive one hour, two hours to get to facilities, then that can become a problem.

So the distribution can be a real problem. So that needs to be done, and eventually I'm going to look into that, but I won't say in the short term because I have to make sure that we have all the data, the maps, because we have to use a GIS map to do this type of work, but I can really picture how that can be done, yes.

MR. GAFFNER: And the third area then

that talks about the effectiveness of the CON program to balance, how would you be proposing that type of research be done?

MR. AGBODO: Well, that will be difficult for now. I'll have to -- what I'll think in that is to do a systemic analysis, you know, of -- our thinking is actually to see the overall system of CON, how it will play in the system. You know, define clearly what are the goals, see the whole policy process, and just, you know, see how we can make sure that we increase access.

So the analysis will be done first, and then when we see that problem, we can see how then we can shift the whole process to increase access to long-term care services, and also making sure that the facility will go in an area where they cannot make profits. Because, actually, I have to say that the market's objective is to making profit, right? So that needs to be -- and I don't really see that should come on this table, because I don't think that will help with making the final decision. I don't know, but maybe. It will be interesting. But for the research, just for research, I think it's interesting.

MR. GAFFNER: Thank you. I think

these are three fascinating areas.

MR. AGBODO: They are fascinating.

MR. GAFFNER: But do have direct implications or ramifications to determining bed need.

MR. AGBODO: Right. Yes, of course. Like I said, for research because it's -- yes, we can think that those are -- knowledge is important, but now for the simple task of projecting beds, so, you know, CON can continue working. I don't know if we really need to go that far, but, yes, if we have that knowledge, why not use them?

MR. FOLEY: I may have missed something when I just now left the room, but in order to assure access of care, you're saying that distance plays a very important role here?

MR. AGBODO: I haven't evaluated that yet, but, yes, I can.

MR. FOLEY: What should the distance be? Do we know that? I mean, you said earlier 30 minutes.

MR. AGBODO: Right.

MR. FOLEY: Or it could be an hour?

MR. AGBODO: Right. In this, what planners -- or you know, researchers will do is to

create what they call centroids of population.

So in Springfield where the population is, is the centroid, and they will define that cycle and see where are the facilities. So when you have a county with facilities around, that might be not the problem. I mean, the distance issue might not be a problem. That might not show a problem for distance, but if you took a county like Putnam where we don't have any beds.

MR. FOLEY: Putnam County?

MR. AGBODO: Right, Putnam County. We don't have beds in that county today. If you take that county and you create centroids of population, and then you create a centroid of beds, where the beds are in the other county, then you measure that distance. That can be a problem. But how many -- how much of those -- this problem we have throughout the state, we don't know yet until we do this type of evaluation.

MR. FOLEY: So are we saying that maybe what we do -- see, I always thought in terms of health planning, planning to me means planning for something in the future.

MR. AGBODO: Right.

MR. FOLEY: Not for today, but for

tomorrow, okay? So if we talk about Sangamon County first, for instance, right now in Sangamon County, the methodology shows that there is not a need for additional beds in Sangamon County. I guess where I'm trying to take this is that if we pinpoint the center of Sangamon County and draw that 30-minute circle around and look at the population in it and everything, you know, within that, that might show a need for beds. That might show a need for beds, but when just looking at Sangamon County by itself, it says there's not any need for beds, because you take it 30 minutes, you take it outside of Sangamon County. Am I making sense, what I'm trying to say? So I guess what I'm trying to point out is that -- I guess I don't know what I'm saying. I guess I'm getting myself confused with all this. This is very confusing.

MR. AGBODO: Myself, I can't really expand on this right now, because I need to do some work because I have to review methodologies on this. It's not that easy.

MR. FOLEY: I guess what I'm saying is that we still need planning areas. Planning areas is a set area. It is in most cases in the state. It is by county and in most cases in the

state, okay? So that is a non-factor. So when you plan for the future, we could see that in Sangamon County if you project it out, or any county, that there is a need for beds so we can look at the need for beds in the future, five years down the road. Our planning process seems like it does not look into the future, and it looks at what is going on today because we are looking at what is the occupancy rates of today. We are not looking at what it should be or might be tomorrow.

MR. AGBODO: The population projection actually takes care of that because you are also seeing what will be the population that will need those beds in the future.

MR. FOLEY: We need those beds in the future, that's right, but then at the same time --

MR. AGBODO: He will do that.

MR. FOLEY: You're correct in that the methodology does look at in the future.

MR. AGBODO: Right, with the population projection and actually using the percent factor also adds more beds, which you know, it's something else that is, you know, good for the methodology.

MR. FOLEY: Okay, because your

population projection is seeing -- take any county that there is, in fact, the need for beds, and talk about in the area, okay? But when an application is being reviewed, okay, they're looking at what the population is today and not tomorrow. The staff is saying that there are excess beds in the planning area, even though there may be a need for beds. They're saying that there's excess beds in the planning area; so, therefore, beds are not needed. So on one side, we're saying beds are needed, and the other side we're saying, based on today's figures, beds are not needed.

MR. KNIERY: It's not even today's figures. It's based on right now. It's based on 2014's figures. It's not even --

MR. FOLEY: It's not today's figures. It's two-year-old data.

MS. AVERY: What did you say, John?

MR. KNIERY: I said that Charles' point is that we're -- based on today's figures, we are not even using today's figures. We don't have access to today's figures. We're actually using 2014 figures.

MR. AGBODO: Actually, the projection is for five years, right? So it's taking --

averaging between 2013 to 2018.

MR. KNIERY: '18, right. So today we're --

MR. AGBODO: It's improving that.

MR. KNIERY: Today is included, but we're using --

MR. FOLEY: Two-year-old data.

MR. AGBODO: Today is included. You know, it's like you're budgeting for five years. So every --

MR. FOLEY: The staff is looking at 2014 utilization data. Staff is looking at 2014 utilization data, and that data is already two years old.

MR. CONSTANTINO: I think we're talking about two different things there. What Nelson is talking about is that need population projections that we do. He's talking about what the rules are for unnecessary duplication of service and service access issues. That's two different things. The rule -- this is completely different than what Nelson is providing you with. We have to use that utilization from 2014 because that's what the rules require us to do.

MR. FOLEY: I see. I apologize. I

guess I am confused, Mike. So I do apologize for that.

MR. CONSTANTINO: We have two criteria that requires that information to be used for 2014. One is service access, and that's all facilities within 45 minutes have to meet that 90 percent. And then when you go down unnecessary duplication, that's a 30-minute time frame, and all facilities in that 30-minute time frame need to meet that 90 percent. It doesn't make such sense. No. Those two criteria in the past were used as variants, but that's been changed -- the variances due to the computed bed need that we've talked about here for six years. Now, they're part of the determination whether a new facility is needed or not. That's a completely different thing than what it was in the past.

MR. FOLEY: I guess I still don't follow him.

MR. CONSTANTINO: Nelson is doing something completely different than what we do here as the staff when we get an application, two different things. Nelson is providing you with a bed need.

MR. FOLEY: I understand that. I

understand that. I guess I was just confusing -- okay. I'll leave it alone.

MS. AVERY: Is it clear to you?

MR. FOLEY: No.

MS. AVERY: Does it make sense? What can we do?

MR. FOLEY: Nothing. I just have to let this sink in a little bit and go back and read Nelson's report, you know, yet again, to try and get some of this, you know, to sink in. I mean, Nelson did a superb job, you know, by all means, but obviously it is confusing, and I have to read it over, you know, a few more times, I guess, to try and get more understanding. You know, when we talk about -- well, I'm sorry. I'm off here now. Let me get back in here.

Go ahead. I'll save my questions for later.

MS. AVERY: Okay.

MR. GAFFNER: John, let me go back to what you and Nelson were -- I was trying to write it down. When you're talking about the 2014 figures, you're talking about data that's in the bed need methodology?

MR. KNIERY: 2014 isn't even -- 2013

is the base year for the bed needs.

MR. AGBODO: Bed needs, yes.

MR. KNIERY: Yeah.

MR. AGBODO: Right.

MR. FOLEY: For this bed need? Right.

MR. AGBODO: Right. Do you think it's an issue? Because actually we have to project for five years, and we take --

MR. KNIERY: I think unlike the Constitution, it is a living and breathing document. And it should be -- it should be updated even more regularly than what it is, in my opinion, to be accurate, to continue to be accurate. I think there's always fluctuations and changes in the market. So it should be updated and continued to be -- to use the current, most current data available.

MR. AGBODO: With the current rule we have.

MR. KNIERY: I'm sorry? Mike?

MR. CONSTANTINO: 2014 is the most current data we have.

MR. KNIERY: But that's not reflected in the inventory.

MR. CONSTANTINO: No, no. Do you think these long-term care facilities want us bothering them every quarter?

MS. AVERY: We were having a discussion about that possibility in an overall group, and we never really got a consensus of it, but I'm wondering what -- it probably would be burdensome to do it on a quarterly basis, and what would we do with that?

MR. KNIERY: As a planner --

MR. CONSTANTINO: We can't even get some of the facilities to even do it once a year and not complain and bitch about it.

MR. KNIERY: It doesn't mean it's right, though. I think you and I would agree on that. It doesn't mean that the facilities are correct.

MR. MORADO: John, if I can for a second. This is Juan Morado.

You know, I can appreciate your comments about it needs to be a living document. As state workers, though, we kind of follow the example of the great departed Anthony Scalia, the law is the law. It's written the way it is written. But with that said, I think that what we might need to be

talking about are different -- I don't know if you want to call them variances or different ways in which we can say here is the data. It is what it is, but maybe there's an explanation or reason why a facility needs to go up, and it will allow applicants to kind of make that argument to the Board when they have their application up. I don't know what that will look like, and I'm not sure what the circumstance would be, but I think it would be easier for us to tackle the problem that way versus this entire change to the formula, which seems to be tough right now. It seems to be giving us, you know, data which has been helpful in the past, and there seems to be an argument that maybe it's not as much right now, but maybe some either short-term variances are other options or things we need to look at.

MR. AGBODO: Now, my turn to ask questions.

MR. MORADO: I had a question for the group. I'm going to ask this out of ignorance because I am not as familiar as the other folks are.

There seemed to be an issue with modernization of facilities. We have a lot of facilities in the state that are older, and you

know, because of the way that is bearing out, we're showing access in different parts of the state where, in fact, there are significantly older facilities. And we were having this conversation the other day up here about what are different ways that we could -- I don't want to say incentivize, but other ways we can encourage facilities to modernize their buildings and in the same way, you know, deal with the fact that there is access to some of these areas? And I just want to put it out there to see if you guys have any ideas.

MR. FOLEY: The problem with that, Juan, is the fact that there are existing providers out there who are strapped with a very low reimbursement rate, that it's hard to afford to go out and to modernize a facility. It's like putting, you know, bad money into a bad building, I guess, to phrase it. It's very difficult to modernize an existing facility in order to compete in today's marketplace. You have to really spend a lot of money to do that, and I do mean several million dollars to modernize an existing facility.

I mean, gosh, even today, if somebody says, 'I spent a millions dollars to modernize my facility,' do you know what that tells me right

away? That tells me that, okay, only 50 percent of a million dollars went into the building because the other 50 percent went into labor costs, okay? So not that much money went into modernizing a facility for a millions dollars, so.

MR. KNIERY: I think that's a huge issue though, Juan. I think that is a fantastic question.

MR. FOLEY: Yeah, I agree. Juan, that's a fantastic question. It really is. And, you know, we've really got to -- the facilities are just put into a bind with their low reimbursement rate that they cannot do much unless they are a multi-facility owner, or they have the cash and the wherewithal to do so.

I think we have a couple providers on this call. If they would care to comment, I would like to hear from them.

MR. GAFFNER: This is Alan Gaffner.

I'll begin by saying, Juan, I would encourage those discussions to continue.

MR. FOLEY: Yes.

MR. GAFFNER: Unfortunately, I don't, off the top of mind, have a path for you to go, but I will vow to go back to both the Health Care

Council of Illinois and to my organization to see what they might be able to offer. Obviously --

MR. MORADO: But -- I apologize. Go ahead.

MR. GAFFNER: No, go ahead, Juan. Sorry. I didn't mean to double.

MR. MORADO: All I was going to say is simply we welcome the conversation. We want to try and figure it out. Keep the program healthy and make sure that folks are getting the services they need. We can achieve that, but we're going to have to get creative, but at the same time abide by what the law is, so.

MR. GAFFNER: Absolutely. And I think if we begin to find barriers within statute, that I would urge the full long-term care subcommittee to identify those and then consider how through the legislative process those could be changed. The environment is so different.

One of the things that I'm hearing as I talk to other providers -- and Bill and or Jerry can jump in if they believe this is not the significant factor that at least I'm hearing -- but the whole long-term care delivery structure in Illinois is changing not just because of the

Medicaid reimbursement rate that we've received for a long period of time that's always been anywhere from 49 to 47 lowest, but with each year's further implementation of the Accountable Care Act, there are fewer dollars that are going to the long-term care provider, especially with bundled payments.

And for many years -- we've had quite a discussion within our organization about this. For many years, the Medicare side was used to subsidize the Illinois Medicaid rate. Now, by no means did it cover it all, or it was -- but that was a service line that we knew was important because it needed to help compensate for the low Medicaid Illinois rate. Now, with the federal change, fewer dollars rolling through the Medicare program, that just further narrowed that funnel. And so the challenge to find revenues to renovate buildings that are especially high Medicaid utilization, it's a challenge. It's a challenge.

And, again, I welcome whatever Bill or Jerry could add to that.

MR. FOLEY: I think where everybody's hands is tied is that even coming from the federal government, the trend is to obviously have less institutional care and more home care. And I guess

the biggest question is, during these difficult economic times that we're in right now, is home care really and truly the best answer? I mean, obviously if we lived in an ideal world, the ideal world would be a ratio of one to one, okay? But we don't have that luxury. The main reason why people don't go into nursing homes today is because a lot of them -- not all of them -- we've got some excellent facilities out there that I would go into, but there's also more facilities out there that I would not go into because they're old, dilapidated, because they have been operating with such a low reimbursement rate.

Now, having said that, you know, when the federal government in our state is pushing for more home care as an alternative model, okay, then our hands are tied. So what's happening is that a lot of federal dollars are being funneled into the Illinois Department on Aging to help keep people at home, and when you keep people at home, they're isolated. You know, is that good? Well, some people like to be at home and left alone. And I'm not saying that it's not, you know, the best alternative, but there's also a lot of people out there that likes to be around other people. They

like to socialize. You know, activities.

So when you're at home, you have home health care, an agent comes in maybe half hour, 20 minutes. Maybe physical therapy, maybe Meals on Wheels. You know, you go on and on. So they may have an hour or two hours of people coming into their homes, but yet there's 23 hours of the day where they're left alone and isolated, okay? And it seems like that's what the government is, in fact, encouraging. So when that is happening, then obviously less monies are going into the long-term care industry, and so fewer people are being able to afford to modernize their existing facilities.

So we're in a big dilemma here, and it's nothing, in my opinion, but a legislative issue. Until the legislature comes up and realizes maybe just home health care is not the best option out there for all people -- maybe for some, but not for all, okay, we're going to have and we'll continue to have this dilemma.

MR. CORPSTEIN: And insurance.

MR. FOLEY: And you brought up an excellent point.

MR. CORPSTEIN: Insurance is driving a lot of this, the Affordable Care Act.

MR. FOLEY: I'm sorry?

MR. CORPSTEIN: I said insurance is making the decisions a lot for residents themselves, whether they're -- you know, home health care is cheaper than that.

The anecdote I use is my father-in-law had three rounds of battling cancer over a period of five years. In the middle of that time, he also had a knee replacement. Throughout that whole time -- surgery, recovery, chemo, knee rehab, all that kind of stuff, he never once sat foot in -- including hospice and death, he never once sat foot in a nursing home. It's near town. We have several places here. He did it all at home, all through that for five, six years. You know, take out a piece here, more chemo, take out a piece there, more chemo. A knee replacement. He never once spent any time whatsoever in a nursing home. Now, whether that was his choice or not, I don't know, but insurance and what they're going to pay for and what they're going to give you as options is part of what's driving this.

Baby boomers are a little more affluent. There's more options these days. Nursing homes do have a reputation, deserved or not. So,

you know, I don't think they give them a choice and said, "Well, would you like to go into Springfield Care Center, or would you like to do all this at home?" I'm sure that question was never posed to him whatsoever. If it did, what was going to be his answer? "Well, I want to stay at home," yes.

MR. FOLEY: If you look at Springfield, yes, Springfield does have some excellent facilities here, okay? But those facilities are also -- you'll find as being full, okay? So it might be difficult to get in, you know, for a short-term or long-term stay. And the remaining facilities, I probably wouldn't want to go into either. You know, the alternative is, I'm going to stay home, because there's not enough facilities maybe even in Springfield, okay?

MR. CORPSTEIN: And I would be curious as to what an insurance company pays out for 24/7 care in a skilled facility and what they pay out for, what, they come once a day or a couple of hours? I mean, depending on the condition or whatever, what they're actually paying out for home health care to have the rehab nurse to come in, to have the hospice come in, to have the, you know, rehab guy who works on his knee and stuff, what are

they paying for that? And what are they paying for somebody's 24/7 in a skilled facility?

MR. FOLEY: I'd like to ask the question, if I can.

MR. CORPSTEIN: Follow the money. That's where it is, I would say, in general.

MR. FOLEY: I would like to ask a question, if I can. I guess the simple way of putting it is, are there studies out there that compares apples with apples that basically state that home health care is, in fact, cheaper than long-term care? When you compare apples with apples now, I'm saying.

MR. KNIERY: The latest study that I saw saying that home care was cheaper or facility institutional care was more expensive didn't include a housing component. There were items that were -- you know, you're not comparing apples with apples. That would be very difficult to do.

MS. AVERY: I really don't know if you can. I really don't know if you can compare apples to apples when you look at it from that perspective because some issues may be complicated by other needs. There may be people who require some type of institutional care, but choose to go

home, but are immobile. So how do you factor in walking devices, reconstruction of a bathroom, a hallway, things of that nature? Who comes in to do an assessment and figure out if this is the best care for them?

So in my head, I don't know if you can do strictly apples to apples. You can make some assumptions and conclusions based on several articles. And as Paul pointed out, insurance companies unfortunately are probably more than likely going to take the least expensive way to provide care for that individual.

So I mean, we can do some research and work with the state library with someone and try to figure that out and get back to you.

MR. FOLEY: You know, I would think that -- Courtney, I would think that, you know, the associations, since they have affiliations at the national level, that maybe the associations could come in and help out and maybe jointly do some kind of a study to hire somebody to come in and to do a study. I would think that they would want something like this in order to show the legislature both at this state and federal level to show that there are -- I mean, what you said is absolutely correct.

It would probably be very difficult to really and truly compare, because how do you also compare that what the patient really and truly wants, okay? We are forcing them to stay at home and to be lonely is what we're doing, okay? And maybe that's not what they want. So how do you put a dollar value on that? You can't.

MS. AVERY: It also goes to stigma, the stigma of a person going into a nursing home. That's where people go to die. The family is guilty. "I don't want to put my mom or dad or anyone in the nursing facility because that looks like I'm slacking off in providing care and don't love them." So you also have that component to go with it.

But I'll follow up with Bill, if that's okay with Bill, to see what we can possibly come up with as far as resources to find those kind of studies if they're out there. Bill Bell.

MR. BELL: That's fine, Courtney. I'll check with AHCA to see what they've got on that.

MS. AVERY: Okay. And now --

MR. JENICH: This is Gerry. I just wanted to say that the American Health Care

Association is currently and does currently have data on the differences between nursing home care, home health care. There is actually a tremendous amount of data that is available right now through the American Health Care Association where they're looking at episodes of care, which translates into episodes of payments for CMS. And it can show you the things and differences where, you know -- they can show you the dollar differences between what Medicare pays for that home health versus what they pay for that inpatient stay. And, unfortunately, they're not taking into account some of the factors that have been discussed on the calls. They're looking at it truly in economic terms, and surely it's a complicated mission.

MS. AVERY: Exactly.

MR. JENICH: And they're on a mission. According to The American Health Care Association, in the next eight years, Medicare will transition from a pay per service basis to a managed care profit or to a capitated payment, which is going to -- it's going to alter the health plan, going to alter some of the conditions that have been mentioned on the call.

If I can, I want to go back to, Juan,

to your question about incentives, and maybe by referencing four things. The health planning that -- the current bed methodology and all the work Nelson has been doing and the rules. And, you know, trying to get my arms around everything in the bed methodology that Nelson is doing and trying to understand how these are applied in the real world, there's a couple things.

And, Nelson, I applaud you for looking at other states, and you know, pulling out experiences that they've learned from or benefited from.

And you referenced something out of New York, which very closely resembles what's in the current Health Plan Act. And in the Health Plan Act, the first section or first paragraph, there's four basic purposes for the purpose of the Act, one of which -- and I'm not quoting verbatim. I apologize. I'm in the car, but one of which is provision number three, which talks about basically takes what you said about New York, puts it into the Illinois terminology, and uses the phrase "specifically when a need has been determined," that it's the function of the Act to provide and upgrade health care services specifically when the need has

been determined.

So with the current bed methodology, you know -- and there's a lot of smart people on this call, and there's a lot of smart people that have been involved in this conversation for an extended period of time. I find, you know, there's probably a general consensus, and I'm speaking for myself, not for anybody else, but I'm assuming there's probably a general consensus that the methodology that inflates is probably pretty good. Maybe with some variables, as you put it, or some assumptions that need to be revisited, and we talked about this a little bit on the call yesterday, particularly that licensed versus operating bed capacity. We're making a very big assumption on the current methodology that the licensed is reflective of the beds that are in use. And that may or may not meet needs that either are identified or not identified in the planning.

Mike, your comment about the rules is very interesting with -- when you apply the rules to an area that has identified needs, and we use this 90 percent occupancy number, and you say that -- you know, that goes back about six years, and it initially started out as a variable. I think that

that's something that really needs to be dealt with because that is being used in applications as opportunities to limit innovation and limit compensation.

And as an example, right -- if a decision is made on the process where there's an identified need, and the decision -- the criteria of that is set in the rules -- give a misrepresentation of what the actual utilization is, you're not denying a project; you're denying people the right and access to the latest and greatest health care that's available.

And, Juan, to your comment about incentives, you're going to open up a big pandora's box, and I think we all know that, right? And even on the call -- operators that are in business today that want to continue to compete in the local marketplaces and use that money into their existing operations, they have to do it to survive. They have to do it to be able to draw those patients that are being directed to home-based community services, but need that inpatient stay, into their facilities. Operators that are comfortable with the status quo are not putting that money into their physical plant.

You know, Steve is on the call, and Steve's been my accountant for a number of years in our operating company, and we talked about the capital rate, and we're tapped out at the capital rate. So I mean, we need conversations about incentives are going to keep coming back, and if you put that up to the association, it's going to come back as we need more money. And I don't know if that's the objective of the plan or the Department or the State, but we know that's where it's going to go.

Competition. Allowing competition where there's identified need will also create that incentive for existing providers to upgrade their services. The worst possible outcome or maybe the best possible outcome is operators that oppose projects because they're going to step up their game. They also have the right to be able to go in and develop these projects, but they take an opposing viewpoint when competition comes into the area.

So I know I'm probably preaching to the choir in a lot of respects. I hope what I said, you know, provides some context and makes some sense. I think, you know, the bed methodology, for

the most part, works, and probably needs to go back and be reevaluated. The application of the rules impact that methodology. It cannot be discounted in this whole conversation. And without adding money to the budget, without asking for more money, you know, finding a way to allow competition to drive those improvements to the marketplace is probably the best incentive, and I'm saying that as an operator. I'm saying that as somebody who truly believes that, you know -- and I know there are other operators represented on this call and on these committees that feel the same way, that allow me to compete, and I will provide the quality. I will perform. I will deliver. And that's what the plan of the Board should all be about is to improve the quality of services that we provide.

MS. AVERY: So, Gerry, as -- you know, not you personally, but as a provider, if there was a way to award or provide incentives, for lack of a better term, to someone that's trying to come into an area that's on paper overbedded, but you all have the inside information that it is not, the facility is not up to par, they take beds out, what would be your incentive to make sure that if you're building in an area where there's a high

Medicaid, Medicare population, that you will go into that area and build? After hearing about the low rates, the caps, everything else, I'm not understanding why providers want to go into areas and build? What's the secret that will make that facility a success? And that's probably some of the things that we need to focus on and talk about.

We've got the feedback that the bed methodology is flawed, but no one is coming up with how to un-flaw it. We're not getting any suggestions and recommendations, so maybe we need to go a different route to figure this out, a different conversation. Suspend the criticism of the methodology isn't working.

And what will we need to do if we have to take this into consideration with what John is saying, and you hold your peers accountable, and you submit daily -- I mean, quarterly data? How do we get you all as the industry to buy into this and to participate in calling out who these bad facilities are? They might not be so bad. Are they getting passes from departments for certifications from the State and the federal government? What's making them bad? The food? The ceiling is falling in? What's making them bad? We probably need to go

from that aspect, other than the criticism of the bed methodology is flawed and try to create a false need.

MR. JENICH: You have several questions, there, Courtney.

MS. AVERY: I did.

MR. JENICH: But I understand what you're saying, and I'm not sure there's a single answer to that. It's very complicated as we're all finding out. But I do think there are some real shifts that are occurring, and people have spoken.

So, one, the pressure on providers today is being mandated through the payment sources. So take Medicaid for a second and put it off to the side and just look at those two payer sources that all providers are trying to survive off of by creating, you know, specialized units that cater to a short-term stay patient or what have you.

But there is various rate compression, which is going to continue, and it's going to continue at a very fast pace, that in the next -- what Nelson has already identified in his opening comments yesterday and today is going to continue at a very fast pace, and it's going to change the face of health care delivery for that

payer in that segment and the consumer.

What incentivizes providers today is trying to get ahead of that curve, okay? There's always going to be a place for long-term care. There's always going to be a place for long-term care providers that are providing both short-term services versus long-term services for purely long-term services or purely short-term services, but the strategic location of those may or may not be identified through the current bed methodology. And in some cases, yes, and in other cases, no. So what incentivizes those providers under the current plan is being able to utilize the beds that they have in their inventory and apply that, again, to the kind of comment that Nelson made, right, where you're trying to redistribute that based on where you have identified the need. I think that would be an incentive for existing providers.

As far as the quality -- the quality pressures that providers are under today, there's really two levels. There's one level of pressure if you're purely a long-term care provider. If you're getting into -- and this is what most providers have been forced to do. If you're getting into managed care and if you're getting in the higher

concentration of Medicare, and if you're trying to service the needs and pressures that the hospitals that are under today, you have to specialize. And right now, we're in a gap period where providers are reluctantly moving toward that specialization because it does mean more staff, more cost, higher acuity, shorter length of stay, higher volume. You've got to be a better machine to handle that, than if you're just a purely traditional long-term care provider.

The pressures on those providers are compounded by length-of-stay mandates, where external care managers are coming in and saying, "Okay. This patient is ready to go home today." And that provider then has to say, "Okay. Great. I have got to deal with that. I made a conscious decision to get into this service line, but I've also got to replace that bed, and the only way I can do it is to have relationship with either that payer source or that referral source; in this case, a hospital."

So those pressures are really changing the dynamics, and if we try to put those dynamics on top of an old methodology -- and I'm not faulting the current bed methodology at all. It's a

round peg in a square hole, and it doesn't fit. So, you know, if you look at the methodology that they use, you shorten the projection window a couple of years back from ten years to five years to try and get a more accurate projection, you've got a pretty good confidence in the statistical support for the methodology, but we still have a lot of issues that need to be dealt with.

I don't know if that makes sense or not. I'm going to relinquish the table to anybody else who would like to comment.

MS. AVERY: Thank you. Good response.

So I guess what this group needs to decide, Steve, is do we continue on with this? Has something came out of today's discussion? Do we need to shift focus? I know we're still -- I'm not really satisfied with what we're getting from the associations, but I understand what they're faced with. And I know this probably is not a higher priority, and I respect that, but I'm wondering if we need to kind of suspend this goal and let Nelson keep working on things and find some kind of way to communicate until we can have some really viable input when the associations have time to do so.

Should we start looking at something else?

MR. LAVENZA: How long do we want to give them? I mean, it's like a constant thing with them. That they're fighting the fight, you know, to keep the money flowing.

MS. AVERY: It's probably going to be three years on that fight with the State.

MR. LAVENZA: I don't know if we want to wait that long. I'm not sure waiting for them until they're not as busy is the right answer.

MS. AVERY: You can encourage them.

MR. LAVENDA: I'm sorry?

MS. AVERY: I'm wondering if we can encourage point persons and work with the associations to set up timelines and goals and benchmarks.

MS. MITCHELL: Or if we could just establish them, and then give it to -- tell them that this is what they have to adhere to.

MR. FOLEY: I think the associations' hands are tied now with all these legislator issues before them. It's like they've got more important things to worry about in terms of survivorship.

MS. AVERY: And I get that. I understand that. Totally, totally support it and

appreciate it, but we are kind of on the fence. It's like we have to do something. The subcommittee was charged with making sure that the industry is heard and communicates to the Board, but that communication is missing.

You know, Kathy (sp) is asking me constantly and Waxman (sp) is saying constantly "What's the Board doing?" And the Board is saying, "What is the long-term subcommittee doing?" So we're at a standstill, and I don't know how to move us along because on this part that's really critical of where we're getting the most criticism from is coming from the associations, but we're not getting what we need from the associations because of other priorities. I mean, if they don't get this other stuff resolved, they don't exist. So I totally get that, and it's not a criticism, not a criticism at all. But we need to come up with some kind of game plan, whether that is Alan is our point person, Gerry is our point person, Kurt, and we need to meet more often to figure out if there is a recommendation that needs to happen in order to change the bed formula, or it's okay, or what do we need to do?

MR. FOLEY: Let's back up for a

second. I guess our primary goal and objective when this whole thing started was to, and still is, to identify all the dead beds out there; is that correct?

MS. AVERY: Yeah, that was -- that's one of them.

MR. MORADO: One of the goals.

MR. FOLEY: Go ahead.

MR. MORADO: Go ahead.

MR. FOLEY: I guess we just need to maybe -- I don't know -- take the bull by the horn, and I mean, being respectful of the associations and the dilemmas that they're in, maybe we just need to look at the facilities' utilization over the last, you know, three years, five years, and make some kind of determination as to how many beds that they're actually using and had been using, and maybe create some sort of a process or a step or something whereby we identify a number of excess beds, be it percentage or whatever, to put them at a certain level.

And as we talked about several times in the past, we talked about banking these beds. We're not giving up those beds by any means. They are still those beds, and maybe the bed need

methodology could then be recalculated based on beds in operations versus licensed beds. We just need to think this whole thing through so we have got to bank -- I'm sorry?

MS. AVERY: That makes sense, but, again, we need the support of the associations.

MR. FOLEY: I understand that.

MS. AVERY: To meet the goals, we definitely need the support.

MR. FOLEY: What I'm trying to say is that maybe we go ahead and at least initially initiate this step and take it to the association and say, "Okay. We'll work with you and try to resolve this." I mean, now we've got a goal, we've got an objective. Now we're going to do something. Right now it seems like all we're doing is spinning our wheels, and we're not going anywhere is what you're saying.

MS. AVERY: For a long time.

MR. FOLEY: That's absolutely correct.

MS. AVERY: And we basically know where those beds are that are dead, but, again, we also struggled with getting the support of the associations in the industry of how to define that,

how to not jeopardize the facility or the operators, but have some realistic numbers out there.

MR. FOLEY: Well, again, if we bank -- if we come to some sort of a formula, some sort of -- as to how many beds. If we have a facility that's licensed for 200 beds, and for the last 5 years, you know, he's been averaging, averaging a daily census of a hundred twenty-five beds, you know, that range between 125 and 200, try to figure out, you know, a number there that we could arbitrarily take those beds out and put them over here in this bank. They are not losing them. They are not giving them up. They're still, you know, their beds. But we're recalculating the bed need on a more realistic number, which is based on the number of beds that are in operation versus licensed beds. So here's the process that we could get started and do something. Now, let's get some feedback from the association to see what they think about it.

Do you have any comments?

MS. AVERY: The recommendation has to come from the long-term care subcommittee. I wouldn't force that as a recommendation from the Board, per se, or Board staff, because I think it's

important that there's value from the beginning and that there's some initiative from those that are going to be affected.

MR. LAVENDA: I agree. Maybe, you know, if we have this proposal and present it to the regular group.

MS. AVERY: To the subcommittee?

MR. LAVENDA: I'm sorry?

MS. AVERY: To the subcommittee?

MR. LAVENDA: Correct, correct.

MS. AVERY: Okay. The larger group? Okay.

MR. LAVENDA: And then see what they say about how to get around the associations. And I don't think "get around," but how do we keep it moving? Because we definitely need the associations' input, and to go behind their back or force it out of them, I don't think is the right way at all.

MS. AVERY: Yeah. And I don't know the structure of all of the associations, but, again, if there's someone that they can give us that can be the spokesperson, that can make some decisions, that can give valid input, and I don't mean just, "Okay, let me take that back," and it

takes three months to come back with a response from the entire body, because I know that's kind of complicated. There's the divide between who belongs to what association. How does all three come up with a unified front, if possible? But if we had point people that we can talk to that have some power and authority, I think that would move us along a lot quicker, or a process within their associations that would allow for that to happen quickly.

MR. GAFFNER: This is Alan.

Courtney, before I make my next comment, I just want to offer thanks to you and your staff, because you and I have talked, other staff have talked. You've been very gracious, very patient and very understanding.

As you've echoed this morning about the priority needs that we have been facing relative to budget issues, and the phrase I often use is "just keeping the lights on." One of my goals when Gerry and I were reaching back to our association was to try to look at these different other kinds of concepts that Charles mentioned, not just the bed need methodology, but I think it's clear from the time this group was formed while Steve was chairman,

that we wanted to somehow more accurately identify these categories of beds. How many of the licensed beds were no longer in use, but yet, as we know, they're very critical to mortgage and lending purposes. How many beds could never again be reconstituted because those rooms are now therapy or they are waiting rooms or they've moved from wards to private care.

Yesterday was our effort to try to bring some of the new folks up to speed with this very thorough research that Nelson has done. I will certainly go back to the Health Care Council of Illinois, Courtney, propose to them this idea of either these representatives that can meet in a smaller group with you and your staff, or to determine when they believe they could have a position available, the feedback that you and Nelson have been seeking.

But, again, thank you for being understanding, and I certainly understand that you need some feedback from HCCI, IHCA and Leading Age.

MS. AVERY: Definitely.

MR. FOLEY: I think that this is a positive step forward if we could somehow work the three -- you know, with the three associations. I'm

hoping that we can come to some consensus right away. I guess what I was suggesting, you know, would not affect their licensed capacity, would not affect, you know, their mortgage lender problem or anything like that because we're just -- I'm just suggesting that we get a true and more accurate bed number that we could calculate to give a true picture out there as to what a need may or may not be. I think this is very, very important, and if we could just -- these facilities are not giving up these beds. These beds are not being de-licensed by any means. They're just simply being put over here in limbo for the time being. And I think this requires obviously further study, further conversations, but it is something to move us forward. Otherwise five years from now, we're going to be seeing the same thing.

MR. GAFFNER: Courtney, when you mentioned about knowing where the beds were, with that knowledge or if that has been quantified in any way, has staff run some projections as to how that would make the bed need calculations per county look different?

MS. AVERY: I made that statement based on the utilization rates that we -- you know,

when we see that they're constant, and you know, they're not up and down, they're not peak seasons, they're constant. Then if we only see that you're using 63 percent, then I assume that's in the number of years, those beds are never coming back. Because with some of the conditions that you describe, they became therapy rooms, single room occupancy, doubles, no longer wards, things of that nature. It can be the apparatus that sets that bed up within the 24-hour requirement.

MR. GAFFNER: Has there been some even just basic feeding of that projected number into the bed need? And then I guess if so, has that changed the county --

MS. AVERY: We haven't. We really can't do it that way.

MR. AGBODO: Yes, the formula is not that way. We don't use -- just beds in the formula, no. We have provided that before. I think we provided three years' average of bed utilization user rates, you know, at previous meetings. And my question is, what do we really need to use that for?

MR. GAFFNER: I guess what I meant -- and maybe I didn't describe it accurately or maybe this will not even be a premise that is

meaningful, Nelson.

Let's pick DuPage County. 5,000 beds are identified as that finite group that's available. It's now showing that it's overbedded. For example purposes, there are 1,200 dead beds in DuPage County. 5,000 minus 1,200 takes it to 3,800 actual beds, which may mean there's margin there. There's room there for another facility or other facilities for that type of thing, but it would skew what would show is really available in the marketplace. I guess that's what I was trying to say, yes, it wouldn't fit into the formula, but if we knew the number of dead beds per county, and we took that off the count, would that then change --

MR. AGBODO: If those beds are really dead, yes, we can do that, but if they're not really dead, they can come back. People can --

MR. GAFFNER: You're right. That's where this gets gray.

MR. AGBODO: Right. That would change everything.

MR. GAFFNER: That's what you're saying, but I am talking about for practical purposes. If someone needs a bed and the 5,000 in DuPage are really 3,800, that affects the planning

board's decision and staff work on an application.

MR. AASHAY: If you are wanting to implement a bank system like some states do, so you can kind of do research based off that. So, like, you don't have to start it from scratch. The bank system -- I think Connecticut did that, and it's a small system geographically. Connecticut did that kind of banking. So it's like with the smaller states, it indicates the geographically smaller county. So it would be -- it's like kind of easier there, but like you said, for example, if there's 1,200 beds that are not used in one facility or one county -- like 1,200 is a significant number, so you'd be able to move however many you want to a nearby county as opposed to having like eight beds that are empty. So, like, you'd be able to do that. Like, that research can be done with how you do that.

MR. GAFFNER: Okay.

MR. AASHAY: But that's not always the case. Like 1,200 is an example. Like, you're not going to find that many empty beds.

MR. GAFFNER: I was just trying to do it to create a margin between -- it says 5,000 are needed and --

MR. FOLEY: Juan is trying to say something.

Juan, do you want to say something?

MS. AVERY: Sorry.

MR. MORADO: Sorry. He was trying to explain something to me.

MS. AVERY: Hello? Go ahead. We're doubling.

MR. FOLEY: I'm just -- I'm sorry. You're not finished? Go ahead.

MR. AASHAY: I was finished.

MR. AGBODO: For me, the only way we can use the bed in our formula and for the licensed beds is if the dead beds are really dead. So we can put that back in the service, but if they're doing that, if they can do that, then the -- and we use unused beds in the formula, which is going to happen, and we are going to inflate the projection. And in the future, it will create more dead beds, or you know, unused beds. For example, the example Alan was giving, if you had those 12 beds, okay, minus -- for example, for that area, we have a hundred licensed beds, right? So instead of taking 12 out of the -- so when we do the projection, we would have the bed projection, right? And then we

would take the licensed bed out, and we would figure out the licensed area.

So if we projected, for example, 200 beds for the area, and then instead of taking a hundred out and say that we have a hundred beds that are needed for the area, we only take 88. We only take 88 out, right? And they would say there's 112 beds needed for the area. And if we do that, we increase the need to -- for 12 more beds, right? And if we continue to do that in the future, we will go -- we will see more needs in the area. At the same time, if they already went back and established those 12 beds, in the reality, the need is going to go down, but our projection is going to show a lot of needs for the same area. And if we continue to do that, the CON process is not going to be effective because, you know, people won't even need to come back to the -- to approve anyway because they already fulfilled all the needs, and our formula shows excellent need again for the area. So in the future if people need beds, what they just need to do is to get the beds from their bank and stop using them. I think if we do that, we put in the CON process, and you know, there's a danger because it's not going to be effective in the

moratorium system anymore. That's what I'm thinking, and I think it's easy to understand.

MR. FOLEY: Is there any kind of incentives that we could -- or even the state legislature could give existing providers if they give up beds?

MS. AVERY: Again, I think we have to talk to the associations and other interested parties about that.

MS. MITCHELL: I don't -- I mean, I hear that -- this is Jeanie Mitchell. I hear that the releasing of those beds is financial. It's attached to a loan. So if it is attached to a loan, and we're not really seeing the license to it, we'll just simply take the CON inventory so that you would have to come back before the Board to add more beds, and I don't see what the issue with that would be. There's a disconnect for me if that's truly the reason.

MS. AVERY: Let me do a check really quick. It's 12:03. I think we're scheduled until noon. I think that room is probably still available. I don't know if the people on the call have a couple more minutes.

MR. GAFFNER: Could I just respond to

Jeanie, Courtney?

MS. AVERY: Bill, did you say something?

MR. BELL: No.

MS. AVERY: So I think I have a few more minutes that we can go. Sorry.

MR. GAFFNER: No problem. Thank you for extending.

Jeanie, your point is very well made. Aside from -- let me just reference as recently as two years ago, I guess I would say providers are gun shy. When the governor had an initiative, that had some traction for a while, and the associations responded, and I think Bill may remember this. That he was considering removing somehow what was determined as unused beds from the licenses of the providers, and that's a step beyond what you're saying. I mean, in theory, if my license doesn't change from the 225 that I have, but some unused beds go into a bank, and I don't really, you know, lose them, but what had been proposed within even the last two years was something more aggressive that would have actually altered the license by state decree, and so that's what raised some high concerns among the providers.

MR. KNIERY: I like Jeanie's idea. I always like the idea of baby steps, especially for this industry. Moving forward in smaller increments helps things be more palatable.

MR. CORPSTEIN: And a lot of this, this sounds like this discussion sounds like a false equivalency, because there are -- and in whatever county, there's 1,200 unused beds. They're not artificially unused. Sometimes they are wanting to use this space for an OPT or whatever, and we're going to keep these three beds. Fine. But if the beds are unused, that's because, in general, there's no need. By removing the beds, then Nelson's numbers go up, and then we start reaching that 90 percent. That's not an increasing need. If we bank those beds, that's not an increasing need. It's because they're not, like, holding beds because they don't want occupancy. If they could fill that bed, they would. They're not using it, and they're coming up with other uses for that space because they can't fill that bed. So by taking away those beds, it isn't suddenly now in Cook County there's all this need for beds, no.

Nelson's number will rise from 72, or whatever, to 86, or whatever, still not reaching our

goal. But I would say for the most part, the beds are not being arbitrarily hoarded for whatever reason. I don't know. I can't see any financial reason in that, whatsoever. But taking away those beds, banking them, holding them off to the side, taking them off the books, your numbers will increase, the occupancy rate will go up, but that isn't going to make any more demand, because if there was a demand, then we wouldn't be in this situation, or at least that's --

MR. FOLEY: I'm sorry.

MR. KNIERY: Go ahead.

I would say that I don't entirely agree with your premise. I do think you are correct. I don't think the bed needs should change to -- I think the banking of beds is a separate issue and can be factored in after the fact. So I don't think that we change the bed need. If you do a banking process or identification, but beds -- there are four bedrooms that aren't marketable. It's not -- so that is not a bed -- could they fill it? No, because no one will go into a four bedroom. There are beds. I think there are a substantial number of beds that are turned into PT/OT areas because of the financial

drivers that Medicaid, Medicare and short-term and rehab offer. I do think that there's a lot more of that than what we think.

MR. CORPSTEIN: Sure, absolutely. Maybe I misspoke. There is definitely a percentage, not a huge percentage, maybe a quarter percent or whatever, about exactly what you're talking about: Four-bedroom wards that nobody wants to be in whatsoever. I mean, maybe they'll put Medicaid and have four Medicaids in there or what have you. There is a percentage of those. Absolutely, I would agree.

MR. FOLEY: That's absolutely correct because we still have a lot of facilities out there, and I've been into them here recently where, gosh, I could tell you facilities and you could, too, where a resident still has to go down a hall to go to the bathroom, you know. There are still some of those out there where residents are sharing bathrooms. You have -- you know, even with the two beds when there are two bedrooms side by side with the bathroom in the middle, so there's four people sharing one bathroom. That's what people don't want. Those kinds of beds are not marketable, so they help our providers. You know, what do we do?

I think it goes back to, you know, their hands are tied, the providers are, because they can't do anything about it because of their low Medicaid reimbursement rate. Would they like to fill that bed? Of course they would, by all means, but the reason why people don't -- the reason why we've got empty beds, yes, this is one factor because they're being used for other purposes, but it's also because we have got facilities -- even the physical plant itself is not conducive to a facility that I would want to go into. That's not -- it's a bad facility is what I'm trying to say.

MR. CORPSTEIN: I get that, but I'm not so sure just wiping out those beds -- you know, me and Mike getting in the van and going around and identifying every bed that's not used, and arbitrarily whacking it off -- that would be paid by the associations, by the way -- that is going to drive demand. I would say a tiny bit, a little bit.

MR. FOLEY: You're absolutely correct.

MR. CORPSTEIN: And his numbers, like I said, it would look better on the stats. We're in the 86 margin now.

MR. FOLEY: As Jeanie has said, it

has to start from down here at the bottom and kind of work our way up. So maybe this is one step to get us closer, closer to our end objective.

MR. CORPSTEIN: I need to think on the bank things. There is actually some back-end stuff that would make it rather difficult. I haven't really explored that concept before, so I need to think on it now.

MR. FOLEY: And, again, just an idea until somebody else comes up with something else.

MR. AGBODO: I would suggest that we classify the dead bed in time of -- you know, what other bed can never be used again because of the situations that we're talking about. You know, they are using the room for something else. And some of the beds that needs the license, you know, the license they have for those. I mean, they will never use that again for the situation that they have. And some of them, they come back and maybe reestablish those beds if they have the demand for it.

So we have that kind of classification. We can maybe put that on the question and ask -- maybe we'll have to do that on a small scale, so we understand the issue. And then

we can put that on the -- solve it, so all the facilities can report the dead bed in those categories. So if they want that, we know for sure they're not going to come back, and we can take them out from our calculation.

MR. FOLEY: As well as the associations, they asked to come in and to help us figure out a way, another way as to how we identify those beds. I mean, it's --

MS. AVERY: And we're not -- what I'm thinking is that we will, as staff, come up with some type of outline agenda, not create another subcommittee or anything of that nature or work group, but come up with an agenda to present to, I think, our point person is Gerry and Alan, Kurt Riva and Judy, Bill -- I think Bill is all alone, and Bill. And we can run it by you, and, again, come up with some kind of working document where we can prioritize some things that need to be done to help us out with this situation. And that group can formally make recommendations to this work group. But we would need to move on it quickly because I'm thinking we're not going to be able to figure it out today. We've got a lot of great ideas, and we can go back in the transcript and pull some things out,

present that to you all before we even approach the associations. Does that work?

MR. GAFFNER: Yes.

And Gerry and I spoke yesterday and developed our next steps for reaching, as I say, back to our associations. So I was going to be starting that process as soon as possible, Courtney, you know, following that learning session of yesterday. And I'm not suggesting that what you're offering not take place. I just want to let --

MS. AVERY: I can't -- we still need some input on the bed need. We still need some input on that, but I think it takes us a step further in identifying the unused dead beds, how to handle that without opening up a false need, how to identify the needs in the communities that's going to benefit the residents of those communities, looking at the issues that we've discussed about the moderation part of it, you know, what's holding them back from doing so. Why are -- what's happening?

And at IDPH, Paul can help us with that part to shed some light on, you know, safety codes, and are those a barrier? Are we getting a lot of, I guess, exemptions -- something? Is that the right term, Paul?

MR. CORPSTEIN: You mean like waivers for room size or something?

MS. AVERY: Waivers, waiver issues.

MR. CORPSTEIN: We do for state beds, but for Medicare beds, I could issue a waiver for whatever reason, and the feds will just reject it. So we've pretty much, as far as Medicare goes, there's very few -- at least as far as physical plant, waivers regarding -- especially room size, that they will -- I mean, the State can offer them, but the feds reject it, and then your bed won't be certified. So you'd be right back -- and we have some facilities that are exactly that. They don't want to spend any money on this little end of the hallway on these four rooms, so they just make them licensure only or Medicaid only, or what have you, even though they may be skilled, but because they can't get a waiver, they don't want to spend money on, you know, move all the windows up an inch and the hallway out an inch or that kind of stuff. It can be very expensive to do that. So they'll carry a couple of just unlicensed beds and use them at that time as private pay situations or so, that kind of thing.

MS. AVERY: Okay. That explains a

lot. And to go a step further, what can the Board staff or the Board do to help out facilities and the associations? So we can pull some things from the transcript today would be our next step.

MR. GAFFNER: Pardon me. I didn't mean to step on you while you were speaking, Courtney.

Nelson indicated he's going to run that CIM-3 with the disability rate. That will be helpful to see what that may or may not do. And then I know Gerry and I will start the process with HCCI. And then when you have that document prepared, Courtney, from transcript review, then we'll incorporate that as well. And if I think -- or I'm sure Bill or Gerry or others, if we think of something after today, I think I'm going to have a slow drive home, and I'll sure -- I'll reach out and thank you for that offer.

MS. AVERY: You're welcome.

I'm sorry. Steve?

MR. LAVENDA: Yes, ma'am.

MS. AVERY: Is that okay?

MR. LAVENDA: More than fine.

MS. AVERY: Okay. Anything else?

UNKNOWN SPEAKER: I'd just like to

thank everyone for taking the time to participate, and Courtney and everyone for helping organize this, and we'll go from here. Great. We'll get -- we'll go to work on that.

MS. AVERY: Thanks, everyone. All right. Thank you. Take care. Bye-bye, and be safe.

(Whereupon the meeting ended at 12:19 p.m.)

CERTIFICATE OF REPORTER

I, Ann Marie Hollo, Certified Shorthand Reporter, Registered Diplomatic Reporter and a Certified Realtime Reporter within and for the State of Illinois, do hereby certify that the preceding meeting was taken down by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this hearing was taken, and further that I am not a relative or employee of any entity employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

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