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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.

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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
Mr. Steve Lavenza
Mr. Gerry Jenich

The Court Reporter:

Ann Marie Hollo
Midwest Litigation Services
711 North 11th Street
St. Louis, Missouri 63101
(217)644-2191

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1 MR. AGBODO: I know people might find
2 this interesting. People who worked with me
3 yesterday, they might find it redundant, but I
4 apologize for that.

5 MS. AVERY: Nelson, let me interrupt.

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

14 MR. MORADO: Meeker.

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

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

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

24 Okay, Nelson. Sorry.

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

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

12 Okay. So we also find that
13 utilization of licensed beds was around 74 percent,
14 but as you know, the target occupancy rate is
15 90 percent. And the licensed bed utilization have
16 been decreasing. And the decrease averaged
17 4 percent over the 10-year period went from 2003 to
18 2013. So our projections allotted patient days that
19 exceeded needs in some areas and fell below the
20 needs in other areas. So from this observation, we
21 hypothesized that bed allocation between Health
22 Planning Areas was not optimal. So that was
23 something that we -- the group asked to investigate.
24 So how can we make the bed allocation to solve the
25 problem, the bedding issue that we have seen in the

1 Health Planning Areas.

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

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

17 So this study shows that the
18 methodology that performed best on this evaluation
19 was the modified version of the current methodology
20 that we call CIM-3, whereby the 30 percent to
21 150 percent assumption is used for computing the
22 projected use rates.

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

1 30 percent and 150 percent of the Health Service
2 Area's use rates, will equal 0.3 times Health
3 Service Area's use rates if the Health Planning Area
4 based use rate is less than 30 percent of Health
5 Service Area use rates, and 0.6 times Health Service
6 Area use rates if the Health Planning Area base use
7 rate is more than 60 percent of Health Service Area
8 use rate.

9 The assumption was the occupancy
10 factor. We changed the occupancy factor from
11 90 percent to 95 percent. Like I explained this
12 before, occupancy factor gives more beds. I mean,
13 if you have a higher occupancy factor, you have a
14 higher number of projected beds, but if you are
15 reducing the occupancy factor, you are decreasing
16 projected -- the projected number of beds. But what
17 we realized is that it only gave a moderate
18 improvement to the projection. So the methodology
19 of projected bed needs with that number, with that
20 respect, the goal of 100 and 110 percent, but just
21 for only 26 Health Planning Area out of 95 that we
22 have in the state. So that's moderate. We think we
23 can improve that.

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

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

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

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

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

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

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

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

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

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

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

21 THE REPORTER: Did you say Hardin?

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

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

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

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

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

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

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

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1 with low per capita income and low number of beds.

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

7 MR. FOLEY: Very amusing and very
8 confusing.

9 MR. AGBODO: It's confusing.

10 MR. FOLEY: Very confusing, but
11 amusing.

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

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

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

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

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

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

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

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

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

25 And, also, I think our -- the

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

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

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

20 MR. AGBODO: Thank you.

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

25 MS. AVERY: Hey, Nelson, can you move

1 your papers from the mike?

2 MR. AGBODO: Okay. Sorry.

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

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

11 MR. FOLEY: Page 24.

12 MR. AGBODO: Yeah, on Page 24.

13 MR. FOLEY: The last one.

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

17 MR. FOLEY: Economic viability of the
18 CON process?

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

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

5 MR. FOLEY: Okay.

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

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

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

3 MR. FOLEY: Okay.

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

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

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

11 MR. BELL: Nelson, this is Bill Bell.

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

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

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

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

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

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

5 MR. AGBODO: You are welcome.

6 MS. AVERY: Anything else?

7 MR. LAVENZA: What's the next step?

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

18 MR. KNIERY: Nelson, this is John
19 Kniery.

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

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1 MR. AGBODO: Right.

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

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

17 MR. AGBODO: Right.

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

22 MR. AGBODO: Yeah, of the delivery.

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

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

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

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

23 MR. FOLEY: That's interesting.

24 MR. AGBODO: Right, what we have.

25 Actually, we use IRS -- yes, IRS

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

7 MR. GAFFNER: This is Alan Gaffner.

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

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

17 MR. GAFFNER: Thank you.

18 MR. AGBODO: Yes.

19 MS. AVERY: Any other questions or
20 feedback?

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

24 MR. AGBODO: 24, yeah.

25 MR. GAFFNER: And you did reference

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

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

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

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

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

25 MR. GAFFNER: And the third area then

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

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

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

25 MR. GAFFNER: Thank you. I think

1 these are three fascinating areas.

2 MR. AGBODO: They are fascinating.

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

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

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

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

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

22 MR. AGBODO: Right.

23 MR. FOLEY: Or it could be an hour?

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

1 create what they call centroids of population.

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

10 MR. FOLEY: Putnam County?

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

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

24 MR. AGBODO: Right.

25 MR. FOLEY: Not for today, but for

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

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

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

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

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

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

17 MR. AGBODO: He will do that.

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

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

25 MR. FOLEY: Okay, because your

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

13 MR. KNIERY: It's not even today's
14 figures. It's based on right now. It's based on
15 2014's figures. It's not even --

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

18 MS. AVERY: What did you say, John?

19 MR. KNIERY: I said that Charles'
20 point is that we're -- based on today's figures, we
21 are not even using today's figures. We don't have
22 access to today's figures. We're actually using
23 2014 figures.

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

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1 averaging between 2013 to 2018.

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

4 MR. AGBODO: It's improving that.

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

7 MR. FOLEY: Two-year-old data.

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

11 MR. FOLEY: The staff is looking at
12 2014 utilization data. Staff is looking at 2014
13 utilization data, and that data is already two years
14 old.

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

25 MR. FOLEY: I see. I apologize. I

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

3 MR. CONSTANTINO: We have two
4 criteria that requires that information to be used
5 for 2014. One is service access, and that's all
6 facilities within 45 minutes have to meet that
7 90 percent. And then when you go down unnecessary
8 duplication, that's a 30-minute time frame, and all
9 facilities in that 30-minute time frame need to meet
10 that 90 percent. It doesn't make such sense. No.
11 Those two criteria in the past were used as
12 variants, but that's been changed -- the variances
13 due to the computed bed need that we've talked about
14 here for six years. Now, they're part of the
15 determination whether a new facility is needed or
16 not. That's a completely different thing than what
17 it was in the past.

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

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

25 MR. FOLEY: I understand that. I

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

3 MS. AVERY: Is it clear to you?

4 MR. FOLEY: No.

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

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

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

19 MS. AVERY: Okay.

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

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

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1 is the base year for the bed needs.

2 MR. AGBODO: Bed needs, yes.

3 MR. KNIERY: Yeah.

4 MR. AGBODO: Right.

5 MR. FOLEY: For this bed need?

6 Right.

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

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

19 MR. AGBODO: With the current rule we
20 have.

21 MR. KNIERY: I'm sorry? Mike?

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

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

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

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

10 MR. KNIERY: As a planner --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 MR. GAFFNER: This is Alan Gaffner.

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

22 MR. FOLEY: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 like to socialize. You know, activities.

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

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

21 MR. CORPSTEIN: And insurance.

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

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

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1 MR. FOLEY: I'm sorry?

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

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

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

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

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

17 MR. CORPSTEIN: And I would be
18 curious as to what an insurance company pays out for
19 24/7 care in a skilled facility and what they pay
20 out for, what, they come once a day or a couple of
21 hours? I mean, depending on the condition or
22 whatever, what they're actually paying out for home
23 health care to have the rehab nurse to come in, to
24 have the hospice come in, to have the, you know,
25 rehab guy who works on his knee and stuff, what are

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 MS. AVERY: Okay. And now --

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

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

16 MS. AVERY: Exactly.

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

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

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

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

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

1 been determined.

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

20 Mike, your comment about the rules is
21 very interesting with -- when you apply the rules to
22 an area that has identified needs, and we use this
23 90 percent occupancy number, and you say that -- you
24 know, that goes back about six years, and it
25 initially started out as a variable. I think that

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

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

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

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

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

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

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

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

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

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

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

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

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

6 MS. AVERY: I did.

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

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

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

1 payer in that segment and the consumer.

2 What incentivizes providers today is

3 trying to get ahead of that curve, okay? There's

4 always going to be a place for long-term care.

5 There's always going to be a place for long-term

6 care providers that are providing both short-term

7 services versus long-term services for purely

8 long-term services or purely short-term services,

9 but the strategic location of those may or may not

10 be identified through the current bed methodology.

11 And in some cases, yes, and in other cases, no. So

12 what incentivizes those providers under the current

13 plan is being able to utilize the beds that they

14 have in their inventory and apply that, again, to

15 the kind of comment that Nelson made, right, where

16 you're trying to redistribute that based on where

17 you have identified the need. I think that would be

18 an incentive for existing providers.

19 As far as the quality -- the quality

20 pressures that providers are under today, there's

21 really two levels. There's one level of pressure if

22 you're purely a long-term care provider. If you're

23 getting into -- and this is what most providers have

24 been forced to do. If you're getting into managed

25 care and if you're getting in the higher

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

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

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

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

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

12 MS. AVERY: Thank you. Good
13 response.

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

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1 Should we start looking at something else?

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

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

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

11 MS. AVERY: You can encourage them.

12 MR. LAVENDA: I'm sorry?

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

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

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

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

1 appreciate it, but we are kind of on the fence.

2 It's like we have to do something. The subcommittee
3 was charged with making sure that the industry is
4 heard and communicates to the Board, but that
5 communication is missing.

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

25 MR. FOLEY: Let's back up for a

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

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

7 MR. MORADO: One of the goals.

8 MR. FOLEY: Go ahead.

9 MR. MORADO: Go ahead.

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

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

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

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

7 MR. FOLEY: I understand that.

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

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

19 MS. AVERY: For a long time.

20 MR. FOLEY: That's absolutely
21 correct.

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

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

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

21 Do you have any comments?

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

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

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

7 MS. AVERY: To the subcommittee?

8 MR. LAVENDA: I'm sorry?

9 MS. AVERY: To the subcommittee?

10 MR. LAVENDA: Correct, correct.

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

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

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

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

11 MR. GAFFNER: This is Alan.

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

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

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

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

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

22 MS. AVERY: Definitely.

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

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

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

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

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

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

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

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

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

1 meaningful, Nelson.

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

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

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

20 MR. AGBODO: Right. That would
21 change everything.

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

1 board's decision and staff work on an application.

2 MR. AASHAY: If you are wanting to
3 implement a bank system like some states do, so you
4 can kind of do research based off that. So, like,
5 you don't have to start it from scratch. The bank
6 system -- I think Connecticut did that, and it's a
7 small system geographically. Connecticut did that
8 kind of banking. So it's like with the smaller
9 states, it indicates the geographically smaller
10 county. So it would be -- it's like kind of easier
11 there, but like you said, for example, if there's
12 1,200 beds that are not used in one facility or one
13 county -- like 1,200 is a significant number, so
14 you'd be able to move however many you want to a
15 nearby county as opposed to having like eight beds
16 that are empty. So, like, you'd be able to do that.
17 Like, that research can be done with how you do
18 that.

19 MR. GAFFNER: Okay.

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

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

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1 MR. FOLEY: Juan is trying to say
2 something.

3 Juan, do you want to say something?

4 MS. AVERY: Sorry.

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

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

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

11 MR. AASHAY: I was finished.

12 MR. AGBODO: For me, the only way we
13 can use the bed in our formula and for the licensed
14 beds is if the dead beds are really dead. So we can
15 put that back in the service, but if they're doing
16 that, if they can do that, then the -- and we use
17 unused beds in the formula, which is going to
18 happen, and we are going to inflate the projection.
19 And in the future, it will create more dead beds, or
20 you know, unused beds. For example, the example
21 Alan was giving, if you had those 12 beds, okay,
22 minus -- for example, for that area, we have a
23 hundred licensed beds, right? So instead of taking
24 12 out of the -- so when we do the projection, we
25 would have the bed projection, right? And then we

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

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

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

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

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

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

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

25 MR. GAFFNER: Could I just respond to

1 Jeanie, Courtney?

2 MS. AVERY: Bill, did you say
3 something?

4 MR. BELL: No.

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

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

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

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

5 MR. CORPSTEIN: And a lot of this,
6 this sounds like this discussion sounds like a false
7 equivalency, because there are -- and in whatever
8 county, there's 1,200 unused beds. They're not
9 artificially unused. Sometimes they are wanting to
10 use this space for an OPT or whatever, and we're
11 going to keep these three beds. Fine. But if the
12 beds are unused, that's because, in general, there's
13 no need. By removing the beds, then Nelson's
14 numbers go up, and then we start reaching that
15 90 percent. That's not an increasing need. If we
16 bank those beds, that's not an increasing need.
17 It's because they're not, like, holding beds because
18 they don't want occupancy. If they could fill that
19 bed, they would. They're not using it, and they're
20 coming up with other uses for that space because
21 they can't fill that bed. So by taking away those
22 beds, it isn't suddenly now in Cook County there's
23 all this need for beds, no.

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

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

11 MR. FOLEY: I'm sorry.

12 MR. KNIERY: Go ahead.

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

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

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

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

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

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

20 MR. FOLEY: You're absolutely
21 correct.

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

25 MR. FOLEY: As Jeanie has said, it

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

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

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

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

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

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

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

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

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

3 MR. GAFFNER: Yes.

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

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

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

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

3 MS. AVERY: Waivers, waiver issues.

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

25 MS. AVERY: Okay. That explains a

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

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

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

19 MS. AVERY: You're welcome.

20 I'm sorry. Steve?

21 MR. LAVENDA: Yes, ma'am.

22 MS. AVERY: Is that okay?

23 MR. LAVENDA: More than fine.

24 MS. AVERY: Okay. Anything else?

25 UNKNOWN SPEAKER: I'd just like to

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

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

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

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