S63053

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

LONG-TERM CARE FACILITY ADVISORY SUBCOMMITTEE

REPORT OF PROCEEDINGS had at the hearing of the above-entitled matter before the Long-Term Care Facility Advisory Subcommittee at the Bolingbrook Golf Club, 2001 Rodeo Drive, Bolingbrook, Illinois, on September 17th, 2013, at the hour of 10:14 a.m.

PRESENT:

MR. MICHAEL WAXMAN, Chairman;
MS. JUDY AMIANO, Member;
MS. CECILIA CREDILLE, Member;
MS. NEYNA JOHNSON, Member;
MR. DAVID RAIKES, Member;
MR. MICHAEL SCAVOTTO, Member; and
MR. GREG WILL, Member.

ALSO PRESENT:

MR. FRANK URSO, Board Staff Counsel;
MS. CLAIRE BURMAN, Board Staff;
MR. NELSON AGBODO, Health Systems Data Manager;
MS. COURTNEY AVERY, Administrator; and
MS. CATHY CLARKE, Assistant Administrator.

CHAIRMAN WAXMAN: We can call roll, which simply means that we'll start with -- Courtney left the room.

Nelson, do you want to introduce yourself? And we'll go around and just introduce ourselves, and that will be our roll call process.

MR. AGBODO: Nelson Agbodo, health systems data manager.

MEMBER RAIKES: David Raikes, Laborers' Local 393.

MEMBER WILL: Greg Will, CIU.

MEMBER JOHNSON: Neyna Johnson, Long-Term Care Ombudsman Program.

MEMBER CREDILLE: Cece Credille, Illinois Health Care Association.

MR. FLORINA: John Florina, visitor.

MR. KNIERY: John Kniery, visitor.

MR. LO SASSO: Tony LoSasso, University of Illinois Chicago.

MR. WING: Coady Wing, University of Illinois Chicago.

MS. KONETZKA: Tamara Konetzka, University of Chicago.

MEMBER SCAVOTTO: Mike Scavotto,

committee member.

MR. SHEETS: Chuck Sheets, Posimeli. I'm here for Terry Sullivan.

MR. URSO: Frank Urso, counsel to the Board.

CHAIRMAN WAXMAN: Mike Waxman, chair of the board.

MS. BURMAN: Claire Burman. I'm board staff.

CHAIRMAN WAXMAN: Courtney Avery is somewhere in the wings, and she is executive director of the Board.

MR. URSO: Administrator. It used to be executive secretary.

CHAIRMAN WAXMAN: Life changes.

We are one short of a quorum. We have two members who when polled said they would be here, so I'm hoping we will get to a quorum. If not, we've been there before. We'll just move on.

So we can't approve the agenda nor can we approve the minutes.

Frank, do you want to talk about subcommittee terms?

MEMBER JOHNSON: I have some minor

corrections. Do you need to hear them verbally, or can I just give them to the Court Reporter?

CHAIRMAN WAXMAN: I'm fine if you just want to turn them in.

MEMBER JOHNSON: Okay. I will do that.

CHAIRMAN WAXMAN: If we get to a quorum and we're going to approve the minutes, then we'll have to read them. Okay?

MEMBER JOHNSON: That's fine.

MR. URSO: Good morning, everybody.

You may recall that we've been talking about establishing staggered terms on the subcommittee, and we set by bylaws how that was all going to unfold.

Basically, everybody's term is going to expire October 1st, it should be of this year, and we're establishing one-, two-, and three-year terms, and what Mr. Waxman has suggested is that people could volunteer essentially for the term that they would like.

So essentially the way it's been designed, since there's 19 board members there are six slots for a one-year term that would start October 1st, 2013, through October 1st, 2014. Then there are

two-year terms which would go until October 1st, 2015, and then a three-year term which would end October 1st, 2016.

I have sign-in sheets. I don't know if you want me to ask people and I could write their names in, or we could send these sheets through.

CHAIRMAN WAXMAN: I don't think this is extremely confidential. So if you just want to respond if you have a thought in mind.

If you don't have a thought, we will then fill out the remainder of the terms as needed. Probably Frank, Courtney, and I will do that. If we have a vice chair, that person will be invited to join us.

So unless someone has some feelings about, you know, voicing their term, I will just allow Frank to go around the room and ask.

Anyone opposed to that method?

(No response.)

CHAIRMAN WAXMAN: Okay. Frank, please.

MR. URSO: David, do you have a choice for a term?

MEMBER RAIKES: Yes. I'm going to start out with a one-year.

And let me ask you something. If like in the middle of the year there's an opening for -- where you can upgrade to the second year, is that open? With my schedule right now is the only reason I'm asking.

MR. URSO: Can you repeat your question, Dave?

MEMBER RAIKES: I was just thinking to myself if you say you want to commit to a one-year term -- the only reason being right now is with my schedule. But say it changed in the middle of the year. Could I upgrade and come back and say if there's an opening for a two- or three-year term, could I do that? Is that possible are you thinking? Before the -- you know, just --

MR. URSO: I guess what I would say, there's always an opportunity to renew your terms. If you're thinking about changing in the middle, I think if you get to that point, we should talk about it and see how that works in terms of administratively how do we make sure people are all on track.

But I think if that comes up, we can talk

about it.

MEMBER RAIKES: Talk about it.

All right.

MR. URSO: So I have you down for one year.

MEMBER RAIKES: Yes, sir. Thank you.

MR. URSO: Craig?

MEMBER WILL: So I don't have a strongly held preference, but I would be amenable to -- depending on what it looked like with everyone else to take one of the three-year terms, that is committing to the subcommittee and its work for that period of time.

MR. URSO: Three-year term, Greg?

MEMBER WILL: If it works out, yeah.

CHAIRMAN WAXMAN: You did six, six, and seven?

MR. URSO: There are six openings for the one-year, six openings for the two-year.

CHAIRMAN WAXMAN: And seven for the three-year?

MR. URSO: Right.

CHAIRMAN WAXMAN: Neyna?

MEMBER JOHNSON: One year, please.

CHAIRMAN WAXMAN: Cece?

MEMBER CREDILLE: Two years, please, if that works.

MR. URSO: Okay.

CHAIRMAN WAXMAN: Mike?

MEMBER SCAVOTTO: One and in all probability less than one.

MR. URSO: We don't have that option.

MEMBER SCAVOTTO: But I do.

MR. URSO: We have your address and we know where you live.

And what -- we should probably give Terry three years. Right?

MR. SHEETS: I think if he's not here, he gets three years.

MR. URSO: Terry is not here. Then seriously --

MR. SHEETS: I don't know. I can e-mail him and see what he says.

MEMBER SCAVOTTO: Give him three years.

MR. URSO: Terrence P. Sullivan is on the three-year term.

Mr. Waxman?

CHAIRMAN WAXMAN: You know what?

I'll take a two-year term.

MR. URSO: And I think that's everybody that we have here today.

CHAIRMAN WAXMAN: All right. Which is still seven.

MR. URSO: That number hasn't changed.

CHAIRMAN WAXMAN: The number hasn't changed. We just verified it.

MR. URSO: Okay.

CHAIRMAN WAXMAN: Thank you.

Mr. Scavotto?

MEMBER SCAVOTTO: Mr. Waxman?

CHAIRMAN WAXMAN: Any application updates?

MEMBER SCAVOTTO: We are making progress at light speed.

We have been through the application and submitted a draft report to Claire and Courtney, and we've got a pretty clear understanding of what can be accomplished without a rule change, and there's six items. There are at least as many that need to be accomplished with the rule change.

There are two areas that we need to resolve.

MS. AVERY: Mr. Scavotto, do you want people to refer to this?

MEMBER SCAVOTTO: Do I want what?

MS. AVERY: We had passed out the response. So do you want people to refer to that in your discussion?

MEMBER SCAVOTTO: Yeah, sure.

There are two areas where we need to make recommendations, and we need to get another meeting in order to do that. We should do that soon.

Those two areas are Section 580 which involves duplication of services. And, Frank, I'm going to need some help on this because this standard involves what staff told us was the Springwood decision, and there's some -- there's a different way to interpret the Springwood decision. Essentially what we're talking about is 30-minute drive time and 90 percent occupancy.

In the opinion of the work group, that's out of step with today's industry environment. Those standards are hanging around in the application because they were required by the Springwood decision.

And I think, Frank, if my memory is correct,

the Springwood decision emanated from a case that came out of Madison County a number of years ago.

When Frank took a look at the Springwood decision, his determination was that it had no precedential value --

MR. URSO: Limited precedential value.

MEMBER SCAVOTTO: So limited precedential value -- and we were free to put flexible criteria under this duplication of services standard if we so wanted.

So, in other words, 580 can be whatever we want it to be, and we haven't discussed yet how we want to go in that respect.

The second open item is the assurances section, additional assurances at 640. And that is where the applicant finally signs off on the application that says, "We're going to get 90 percent occupancy after" -- I think it's after two years.

The staff, namely Mike Constantino, can't find any documentation supporting the 90 percent requirement, and when you look at the data that's out there, very few facilities are getting 90 percent. There are some but statewide when

you look at your occupancy, it's nowhere near 90 percent, so you need to wonder.

The work group is on record as saying that 90 percent standard is just not realistic, out of step with today's industry. So I'm pretty confident that when we get back into this thing, the work group is going to recommend that we just drop the 90 percent standard, and there may be some -- the 90 percent is referenced several other times in this application, as well.

MS. BURMAN: Yes.

MEMBER SCAVOTTO: So those are the two open items that are out there. So that's a status of where we are.

CHAIRMAN WAXMAN: Okay.

MEMBER SCAVOTTO: We're almost done with this thing.

CHAIRMAN WAXMAN: The first issue was the miles issue?

MEMBER SCAVOTTO: Yeah.

MR. SHEETS: Drive time.

MEMBER SCAVOTTO: Drive time. 30-minute drive.

So it's pretty easy if you're like at Quincy,

Illinois, I mean, 30-minute drive time you can easily be in Missouri, but you're out there in a rural area.

CHAIRMAN WAXMAN: Right.

MEMBER SCAVOTTO: But in Chicago a 30-minute drive time --

CHAIRMAN WAXMAN: Gets you two blocks.

MEMBER SCAVOTTO: You've got enough population density in Chicago, it goes up rather than out; it's a vertical issue rather than horizontal.

So the whole discussion tends to focus on a good market study rather than on a fixed standard like a drive time. And that kills several birds with one stone because you have -- the planning areas are contiguous with the county geographical unit, but you can have a provider that's in a border area of a county, and that can cross over into multiple planning areas.

So the market study would be, I think much more sensitive to understanding what the real demand issues were even if it went over into different planning areas.

And it's going to overlap. I don't know

how you deal with that now, but you have to because you've got somebody that beyond -- the Cook County line and the Will County line, there's going to be overlap like that.

So there should be a way to deal with that. A 30-minute -- just having a fixed standard like a 30-minute drive because of the Springwood decision to me doesn't give you the flexibility that you need to manage the parameters.

When Frank said limited precedential value for the Springwood decision, that opens up the flood gates here. We can be much more flexible in how we want to deal with the standard.

CHAIRMAN WAXMAN: Our average is still about 78 percent in the state occupancy?

MR. AGBODO: 75.

MS. AVERY: 75.

CHAIRMAN WAXMAN: 75 percent?

MEMBER SCAVOTTO: 75, 78, that's close enough.

CHAIRMAN WAXMAN: So that really shoots 90 out of the box.

MEMBER SCAVOTTO: I don't see how you can justify it. I guess everybody would like to

be operating at 90 but we're not.

CHAIRMAN WAXMAN: Cece, do you have any homes at 90?

MR. SHEETS: All of them.

MEMBER CREDILLE: Some. But the state averages 75. And the industry, I don't know that. The industry average overall is between 75 and 80, I think. So nationwide we're in the same situation, not just Illinois.

MEMBER SCAVOTTO: When you look at the stats and data, it's coming down.

MR. SHEETS: Well, you get a lot more short-term stays now, so it fluctuates a lot. You may be at 95 for a month, but the rest of the time you're in the 70s.

MS. KONETZKA: I think nationally it's about low 80s.

CHAIRMAN WAXMAN: Really the 90 becomes a dream.

MEMBER SCAVOTTO: I think so. And even -- you can measure peak periods if you want, but if you just measure the total available days versus the total days that were used, you're going to be down. There's no way of getting

around that.

CHAIRMAN WAXMAN: Hypothetically, if the 90 disappeared, do you think it would cause an increase in applications?

MEMBER SCAVOTTO: I don't.

MR. SHEETS: I do.

MEMBER SCAVOTTO: You do? Why do you say yes?

MR. SHEETS: Well, because I think that's one of the big -- the 90 percent occupancy is the big stumbling block in utilization on most applications. Would you agree with that?

MR. URSO: Yeah. I think that's a factor.

CHAIRMAN WAXMAN: I agree with Mike. I don't think it would.

MEMBER SCAVOTTO: I don't think it would. I think the big issue is going to be financing.

CHAIRMAN WAXMAN: I agree with Mike. I mean, it's got pay off in money. It's got to pay off in the bottom line.

MEMBER SCAVOTTO: John, what do you say? Don't say the Cubs are going to win the

World Series.

MR. FLORINA: There's a number of variables, obviously, but if you can't keep your beds occupied, it makes it difficult to make a decision to move forward, whether it's your own operations or your funding source.

CHAIRMAN WAXMAN: If Mr. Foley was here, what would he say?

MR. KNIERY: That it would -- it would increase the number of applications, but you'd have offsetting issues such as a market study. You still have to justify the need for a project, and you still have to finance it.

MEMBER CREDILLE: I don't know that changing one variable of 90 percent the applications would go through the roof. It's a whole combination. The fact of the matter is that facilities aren't funding yet.

MR. SHEETS: I don't think it would make it go through the roof, but I think it might increase them only because there are a lot of areas where there's older buildings and utilization is low, and that's the big stumbling block for putting in a new building because the

competitors are all running at 78 percent or 75 percent.

MEMBER SCAVOTTO: That's true. I think that's --

CHAIRMAN WAXMAN: I mean, if I was an owner and it went -- the 90 disappeared, I would still make my decision based upon the bottom line, which is payor mix more than anything else.

MR. SHEETS: Yeah, you've got to have a market. But even if you have a market, sometimes you can't do it because of the overutilization issue.

MEMBER SCAVOTTO: That's correct. So I don't think it's just one thing.

CHAIRMAN WAXMAN: Very interesting. Yes, John?

MR. FLORINA: I think just in design if you remove that requirement, you'll get more applications. You have one less standard to meet. So whether it makes sense financially or not, you'll still have the opportunity for more to come before you because you don't have to meet the 90 percent rule. You might have more issues between competitors as to who has the better

application than the other facilities.

MEMBER CREDILLE: But if you -- going along with that, if you eliminate the 90 percent and then it encouraged more -- I mean, we have to keep coming back to the purpose of this committee.

The purpose of this committee is to move the industry forward and look at how we can modernize facilities and have the industry keep up with the times, and if the 90 percent becomes a piece of that puzzle so that there then may be more applications or whatever occurs, it's a consideration.

CHAIRMAN WAXMAN: I think the other thing -- and, again, my gut is that the applications will be for fewer beds than in the past. They'll build smaller buildings; correct?

MR. SHEETS: Still have to have a market study to show that it will work; right? It's the accounting.

MEMBER SCAVOTTO: I know where he's going. There's a standard in here in the current application that calls for 250-bed max, and we're saying that's out of step with the times. That needs to come out. That would require a rule

change, but still, I don't think there should be any max on that. If someone wants to build a 400-unit facility in Chicago, let them do it.

CHAIRMAN WAXMAN: God bless them.

MEMBER CREDILLE: Good luck to them.

MEMBER SCAVOTTO: I mean, the current difficulties in accessing capital are a great wanner, and it's a market discipline that really does limit this thing.

So I think if I were looking at it, I'd much rather see a well-developed application that's got financing and a good understanding of its market, good feasibility analysis so you know that the project has a chance of success.

CHAIRMAN WAXMAN: I think it's fun to say you can get money at 3 percent or 4 percent but no one qualifies. So, I mean, it's like --

MR. SHEETS: Well, right now there's a requirement that you have funding when you come in for a renewal, permit renewal. Courtney's pretty familiar with that requirement. I mean, you have to have financing lined up when you have a CON. You have to have a hard commitment.

CHAIRMAN WAXMAN: Well, that's right.

It's no longer just "I can get it."

MR. SHEETS: A letter from your banker saying what a wonderful risk you'd be if you sign the loan.

CHAIRMAN WAXMAN: And when I sign the letter they're required -- it's a bizarre economic world we're living in.

Okay. Anybody else want to jump in on CON workshop?

(No response.)

CHAIRMAN WAXMAN: Mike, thanks for all the work you and Cece are doing.

MEMBER SCAVOTTO: We're almost home.

CHAIRMAN WAXMAN: So are you going to do a conference call? Is that your next step?

MEMBER SCAVOTTO: Soon.

CHAIRMAN WAXMAN: What's your next step?

MEMBER SCAVOTTO: Another conference call soon, please.

MS. AVERY: You just send us the dates, and we'll post it as an open meeting and set it up.

MEMBER SCAVOTTO: Then we can submit

a final reporting on this thing.

CHAIRMAN WAXMAN: Do you need some interpretation from Frank?

MEMBER SCAVOTTO: I don't think so. I've got what I need, but I do need to talk to Courtney and maybe Mike about this duplication of services issue. Where are we going to go with that? That's something that we really weren't prepared for.

MEMBER CREDILLE: Well, and we discussed if that wasn't going to be the criteria then what would be the criteria, and we sort of got stuck there.

We're not saying abandon duplication of services because certainly we don't want to duplicate services, but are those two criteria, 90 percent and 30-minute drive, are those the right -- we're not thinking so. Those are not the two.

MEMBER SCAVOTTO: In that respect we were leaning towards the market study as a way to solve that.

MR. URSO: And you couldn't get rid of the duplication of services because that's

statutory.

MEMBER CREDILLE: We agree that we have to address it. I mean, that's responsible health planning.

CHAIRMAN WAXMAN: Okay. Anybody else want to jump in on that subject before we move on to the next?

(No response.)

CHAIRMAN WAXMAN: All right. Mike, thanks.

Courtney, before you start, should we announce that we did have a recent --

MS. AVERY: Oh, yeah. I was going to do it under new business.

CHAIRMAN WAXMAN: Oh, okay.

MS. AVERY: If you want.

CHAIRMAN WAXMAN: I just don't want to leave today without people being aware.

MS. AVERY: Yesterday Phyllis Mitzen submitted her resignation from the subcommittee, so that leaves us with three openings, I think, at this point. So if you know of anyone or want to make recommendations for filling those seats, you just have to send a letter to the board

chair, Ms. Kathy Olson.

So I thank Phyllis for her service and ask that maybe her group -- she and Margie will make a recommendation for someone to be represented on the subcommittee from that industry.

CHAIRMAN WAXMAN: And we had a brief conversation with John and asked him to consider applying.

Do you want to introduce John?

MS. AVERY: Yes.

In our discussions, as you remember, long ago we came up with RFP criteria for the state colleges and universities to respond to the RFP, and in that process we had a response from Tony and his group.

So we talked with the chair and thought it would be a good idea for them to come here and meet with the entire subcommittee. So we have them here today -- I didn't meet you, Tamara.

They are here today to answer questions, give some feedback on the process which they intend the follow if you select them as the choice for the RFP. Then we'll go forward with getting the paperwork and everything done through

the State of Illinois and Department of Public Health.

CHAIRMAN WAXMAN: So maybe before you begin, if you have a formal presentation, you can introduce each other or yourselves and your background.

MR. LO SASSO: I'm happy to introduce ourselves here.

I'm Tony LoSasso. I'm a professor at the University of Illinois at Chicago in the school of public health, division of public policy and administration.

My training is in economics. I received a Ph.D. in economics from Indiana University, and at least a portion of my dissertation research had to do with the long-term care utilization, and I've also done work on the relation between informal care and formal care use, long-term care use. Most of my research has more recently been around health insurance design and -- benefit design that is.

And I'm really happy to be here and meet with you all and learn about what -- learn about what you're proposing, and we are happy to help

in any way we can.

I'm going to introduce my colleagues here briefly.

To my left is Coady Wing. He's an assistant professor in health policy and administration. He has a Ph.D. from Syracuse University, and he's an expert on program evaluation and public policy more generally.

Tamara Konetzka is at University of Chicago in the health studies division, and she's a nationally known expert on long-term care issues, long-term care policy. She has a Ph.D. from University of North Carolina.

So, again, we're delighted -- did I get all that right, you guys?

So we're delighted to be here and learn about -- have a conversation with you about the policy of buying and selling beds.

I think you know -- I'll just say -- and I do want this to be a dialogue here. I'll just say in terms of helping us think through the scope of work, we do have your RFP, and as an economist I commend you for really coming up with the right sort of economic set of questions in

terms of the objectives of your study. I think with these, as you probably know, the devil really is in the details on how you're going to specify a buy-and-sell bed program.

There are many different models around the country that you can look at, and I think the main thing that I guess we're hoping to hear is kind of what's your -- we've read the seven goals that you have, the seven bullet points or the objectives, I think, for the research. But the main question I think from our vantage point is kind of what's your overall kind of public policy goal here in proposing this.

I mean, you could have a number of different objectives, and I think it would help us to hear a little bit more about your interest in this. I mean, improving access is an obvious one. Also, though, affecting state long-term care spending and utilization more broadly, improving the geographic allocation of a fixed supply of beds, if that's kind of the way -- as a first approximation you want to think about this. I mean, that could be a goal, as well.

I think where the hard part of these types

of arrangements come into play -- and I think that is an area that we can help at least to sort of quantify and think through -- is to what extent is it the goal of this to essentially reward, as it would be, underutilized incumbents in the industry. Because if you allow them to sell their extra capacity, for example, you could then -- that's monetizing their lack of -- their underutilization, for example. There are other ways to go about doing that if that's one of the goals.

So I think Tamara has a few other points she wanted to make, as well, and I can let my colleagues talk about some other questions and issues that they've been thinking about.

Tamara, the points you were going to make about --

MS. KONETZKA: About a plan?

MR. LO SASSO: Yes. Well, about a plan. So the question would be data analysis and some of those -- what are you looking for, I guess.

MS. KONETZKA: Before we hear more about what your goals really are, it was hard to kind of figure out exactly how we should go about

it, so we still need more input from you.

One of the main questions was really about your goals and subgoals. Another question was sort of the practical aspect of the data.

There's a lot of things we can imagine doing. For example, thinking about a potential buy-and-sell policy and looking across the state, determining in the data, also using historical data who would be the likely buyers and sellers, thinking about what the determinates of that are, thinking about if that actually happens, then what might be some of the intended and unintended consequences in terms of access and quality, and perhaps as a next step sort of thinking about how the policies could be tweaked or set up doing some simulations to think about how you might sort of maximize the good intended consequences and minimize those unintended ones.

To do all of that there are some data sources that we're very familiar with, but we would need to know from you what else is available, what data from Illinois, do you have any data, evaluations from other states that have done this. So those are sort of practical aspects in

addition to sort of the broader goals of what you'd like us to do.

CHAIRMAN WAXMAN: The answer to your question rests in that gentleman. He represents the data collection part of the State of Illinois.

The problem -- one of the problems that we talked about and dealt with is Illinois is overbedded, and we're now the 49th reimbursed state, 50th reimbursed state.

MEMBER SCAVOTTO: 49th or 50th. Hard to get any lower.

CHAIRMAN WAXMAN: So not only are we reimbursed at an extremely low rate, the money doesn't flow regularly or timely.

So given those two issues, then, the data that is collected is on a volunteer basis that says, "I swear this is true," but there is no follow up to really go in and count how many beds are being used.

The point is that I don't think anybody really knows how many beds there are, how many beds are in use, how many beds are being in reserve, and how many beds have been turned into offices but the beds are still somewhere that if

our census were to go higher that people would pull beds out.

So there is data. I mean, Illinois collects a lot of data, and Nelson is the state recipient of all that.

Also, there is a gentleman, Mike Constantino, who is recovering from surgery that works together -- but has done this for 150 years, so he has --

MEMBER CREDILLE: He's not going to like that comment.

CHAIRMAN WAXMAN: I know. But he's in surgery, so he won't know what I said.

MR. URSO: He looks good for his age.

CHAIRMAN WAXMAN: So my answer to you is yes, there is data available. We've argued or we've discussed that we don't know how good it is because people protect -- as you again probably know, people are paying bed tax on beds that may or may not be in use, but they don't want to give them up because the bus may show up at any given day with all those people that need those beds.

So there is data. Nelson would be a contact for you to get specifics on the data that's

available. We've questioned many times how good that data is.

Chuck, what do you think?

MR. SHEETS: How good the data is? I wouldn't even know where to begin to comment on that. I don't know.

CHAIRMAN WAXMAN: Chuck is an attorney so that's his answer.

MS. KONETZKA: And the data that you're talking about is mostly about number of beds, licensed beds, occupancy, those types of things?

MR. SHEETS: The number of beds is clear, but the number that are occupied, that's it.

MS. KONETZKA: And are there other parts to that data? Would it be linkable with data that we would use to look at quality?

MS. AVERY: Not so much quality but we can get quality reports from the Department of Public Health.

And the data that we have is self-reported and is very much in line with the data that HFS has in collecting on the bed tax.

The reality of it is we don't know exactly

how many of the beds are actually in use. As Mr. Waxman said, some have converted from double occupancy to single and they keep the bed. We have a definition in there that says how -- it is within 72 hours or 24 hours that you can have a bed set up, reserve bed. So we have these different categories on our questionnaire, hospital questionnaires that are on the Web site, also.

MEMBER CREDILLE: There's multiple reasons why beds may be in and out of service, but many of the facilities in Illinois are antiquated with three-bed rooms and four-bed wards that for many years back that was a standard, there was square footage requirements in the applications. In today's world in many marketplaces, three-bed wards and for sure four-bed wards, the consumer does not want to be in the three-bed or four-bed ward.

And then you have the clinical issues that are increasing related to infection control, and now I'm really leaping, but hospitals have -- all the new hospitals mandated to go with private rooms from infection control. So you now have consumers who have an expectation from the

hospital setting.

And then there are so many patients transitioning to the long-term care setting. Because of the shortened length of stay we're doing the postacute care, which ties to the occupancy, and we can't keep the occupancy up because there's so much acute business that's -- in pockets. Not the entire industry but it's a segment of the industry, and that's really mandating a change in the long-term care industry.

In a state with limited reimbursement and no way out, buy/sell, in the opinion of this committee, is an option to help us in the industry when we are limited on all fronts.

So if you had a buy/sell concept for the provider who has no ability for influx of capital, you could mandate that money that they receive from selling the beds would be put back into the facility, not so they can play on a beach in the Bahamas -- we've talked about this a lot -- and it would force an upgrade to that facility, which in turn would potentially help access and would modernize the facilities and

cause services to be then delivered.

You can modernize for -- I'm making this up. You could modernize and put in piped-in oxygen where you don't have it, or you can modernize and put in private rooms where you had four-bed wards and you can't do it. You cannot do it where there's no money.

MR. LO SASSO: I guess a primary interest or a goal with such a policy is mostly around maybe getting around capital market limitations in the long-term care industry.

MEMBER CREDILLE: It's a piece of that.

CHAIRMAN WAXMAN: I have a few housekeeping things. Would you note that we do have a quorum now, that Judy has arrived. Welcome, Judy.

There are a lot of people that look at us and say, "Why are you even talking about this" because we're overbedded and homes can't fill. But the piece they're missing is that the consumers in some cases are choosing not to go to certain homes because of reputation or because of location, and, therefore, where they want to go may be 100 percent occupied. So in that case,

even though that area, that region may be overbedded in the aggregate, there are homes that are providing great quality or unique programs that have a waiting list.

So in our minds, people who are providing quality care are being restricted from expanding for a variety of reasons, one of which is their neighborhood may be counted as being overbedded.

So we're trying to come up with some ideas so that the consumer -- and we all believe that the consumer votes by where they place their dollars if they're in charge of their dollars -- is being restricted in some cases.

So it's hard when, you know -- because, again, I was at one of the conventions where nursing home people were in the thousands, and we just started talking about the whole concept of buying and selling, and they were all over me about, "How can you do this? We're opposed." Well, you've got to listen to the whole reason of why.

So there are some people both in the state groupings and homeowners that are not understanding why this is a potential solution to problems that

is being recommended.

So, you know, you're really treading on some dangerous waters -- dangerous is probably a bad word, but on some waters that people don't totally understand.

We spent a lot of time talking about it, and we are very concerned about improving the quality of care and access in an area that people deem to be overbedded. So that's what we're doing.

We've tried to come up with ways that people -- if I get money for beds I sell, I can't put it in my pocket or go gambling or buy an airplane or something, but that has to be used to fix my building up in some way.

Yes, sir?

MR. WING: Suppose you implement some strategy like this where you're doing buying and selling. If I'm one of the -- let's say I run a nursing home that has a waiting list, it's one of the good ones that people want to go to, and I would like to expand. What stops me currently? I'd like to add some beds. I could come to you guys and ask if I could do that, and you'd tell me yes or no?

CHAIRMAN WAXMAN: You're allowed to add 10 percent up to 20 beds based upon writing the letter currently. If you want to add more than that, then you have to put an application for the CON.

MR. WING: So that's how it works now, and under the new plan I could either do that or call around to other nursing homes and see if I could buy some of their capacity? So I could go around you?

CHAIRMAN WAXMAN: We're still in discussion as to whether or not that would come before a board approval.

Again, you've got to separate two things. If I can use, Cece -- you know, Manor Care has many, many homes. So there's a possibility that Manor Care in a geographical area could put beds in an area where they're needed. That's the same corporate structure but two different homes versus unrelated homes doing transactions.

So you've got to be aware that you've got -- Illinois does have some very, very large groups of nursing homes. There's the Aldens and the Heritage and Petersens and all those groups that

have many, many homes, some of which are struggling, some of which can use some beds. And then there's the relationship between a home down there and a home up here. So you've got to put a policy together for both.

Michael?

MEMBER SCAVOTTO: There's some fuzzy logic, I think here.

At some point if I go out and I assemble -- if I buy -- say I do more than one bed buying. At some point if -- dependent on how pricey those beds are, I might be better off just filing a CON.

Some of the folks in the debate presume that they're going to get a lot of money, 100,000 a bed, 80,000 a bed, and that's not at all assured that they're going to be that.

MR. WING: Unless you guys make it hard to get it through the board.

MR. SHEETS: Well, that's kind of the situation we're in. If there's a bed need in the area, you're right, I don't think anybody is going to be buying beds.

MEMBER SCAVOTTO: Right. There wouldn't be.

CHAIRMAN WAXMAN: And the other piece that I think Chuck talked about in one of his other visits is that a lot of the financing is based upon licensed beds. So lenders are geared to a facility with 100 licensed beds or 200 licensed beds. Now, if we allow them to reduce that number, what happens to the security on that mortgage?

MR. WING: I think one thing you -- just if you want to look at it purely as a sort of microeconomics question, two things to keep separate are what a market-based solution would produce as the total number of beds that are out there -- right? -- which currently is unknown because we have the board here. And then the other one is for a fixed number of beds which you guys allow to be out there, where should all the beds go.

So a bed buy-and-sell plan with a capped number of beds or a number of beds that you control probably does help allocate the beds -- probably does help allocate the beds geographically a bit better.

MR. SHEETS: In a more efficient manner. Right.

MR. WING: But it doesn't do much to affect the total supply of nursing home beds because you still retain control over it. And maybe that is the part of it that causes the most problems with lineups -- or waiting lists and things like that.

MEMBER CREDILLE: Well, and it was recommended that we go through an RFP process, quite frankly, to legitimize what we've -- I haven't been doing this for very long, I think two years, but there are folks on this committee that have been here for how long?

CHAIRMAN WAXMAN: The committee is only two years old.

MEMBER AMIANO: Since the stone ages.

CHAIRMAN WAXMAN: The conversation has been talked about probably in 18 different forums. This committee has only been around for two years.

MEMBER CREDILLE: And this committee was mandated -- I don't know the legal term, Frank.

MR. URSO: That's good.

MEMBER CREDILLE: -- mandated by the governor to look at and make recommendations to

the Health Facilities Planning Board for what we need to do in the long-term care industry, quite frankly, to look at access, modernize, et cetera.

So we need a group to look at what -- other states are doing buy/sell. So how can buy/sell be part of Illinois and we legitimize it by using an outside source?

And Claire has done exhaustive work of collecting information on what other states are doing, which obviously you would have access to, for buy/sell. But we're looking for an outside group to legitimize the discussions that we have had over and over again over the situation in the long-term care industry that we need to be doing something different given all the dynamics in the industry.

And, my goodness, our last meeting -- it continues to change with managed public aid, and it's just going to continue to evolve and our buildings aren't.

MR. LO SASSO: We don't have a pony in this race, and we are happy to give you an unbiased evaluation and set of recommendations as part of our work if that's what you want.

MS. AVERY: And there was legislation that was introduced in the last general assembly that said that we had to evaluate a bid, sell, and exchange group in addition to what Cece described.

MR. LO SASSO: Evaluate if it's implemented or should it be implemented?

MS. AVERY: Should it be implemented.

MR. WING: So evaluation means come up with some ideas and not do a pilot project and see how it goes?

MR. LO SASSO: Because that's another option.

CHAIRMAN WAXMAN: Well, we talked about doing a pilot project as a means of testing, whether it's done by county or by planning region. We in this group have said that.

MR. WING: But this requirement to evaluate doesn't necessarily mean actually test out?

MR. LO SASSO: It could.

MR. WING: It could. But it could also mean just do a little bit of analysis.

MR. LO SASSO: Some simulations.

CHAIRMAN WAXMAN: But be aware that

there's strong resistance at certain levels just to the fact we're talking about it. So your evaluation has to be pretty strong for or against because there's preconceived ideas already.

MS. AVERY: Within the long-term care industry.

CHAIRMAN WAXMAN: Within the long-term care industry and the legislators and people within IDPH, I think.

MS. AVERY: Not so much.

CHAIRMAN WAXMAN: Okay. Take that out. John?

MR. FLORINA: I just want to make a comment looking from the outside not having been involved in the discussions in the past at least within this group. It doesn't sound like we're talking about reevaluating the whole bed methodology, bed need methodology for the state. If we are, that's a whole bigger issue.

It sounds like we're just talking about, as Dr. Wing pointed out, is how we're taking the existing supply of beds and redistributing them based upon the need. So it doesn't affect the overall bed need methodology.

That's just the observation I'm making. If I'm wrong, tell us, but the first question was what's the big scope here of what we're trying to address, and that's the way I perceived it.

MR. LO SASSO: That's an important -- that's a big distinction, I think, and it would be helpful to have some clarity on that. That has a lot of important implications for how a program will actually function.

CHAIRMAN WAXMAN: We have had years of conversation about the bed need formula in Illinois that I don't think anyone in this room really thinks it's a viable formula at this point in time.

MEMBER AMIANO: If I could just underscore, as an operator, when we started talking about this -- literally, it feels like about 10 years ago, and it may very well have been -- the universe in which we operated was completely different than it is today. So I think as we're even thinking about the bed need formula, as operators how we function is 180 degrees different than how we did just six years ago, and that is going to continue to evolve with the MMAI

coming out in a couple of months.

There are all these external factors that are driving our business models in a very different way than they did when this conversation started. So I'm not even sure that a bed need formula is even a way to start, frankly.

I think we have to ask ourselves what problem are we trying to solve and then work from there because it's a very different question and answer today than it was when we were charged with the work of this committee two years ago.

So I don't know -- I didn't hear your intro so . . .

MR. LO SASSO: It was that exact question, your question, what problem are we trying to solve.

MEMBER AMIANO: So I think to go back through all these things that we've rehashed 12 times over -- we almost need to start with a blank slate and say what is it we're trying to accomplish, and what are the various paths to get us to that outcome that is proper.

MR. WING: That kind of conversation would certainly help us think about how the --

how the -- if you think of the buying and selling of beds as a tool to solve some kind of problem, I think the first step is talking about what the problem is you're trying solve.

This may be an oversimplification, but my first step is they're either problems of overbedding -- too many beds or not enough beds, but questions about whether we have the right number of beds for the population. And then there are questions about where those beds are located and who has access to them.

And if you are interested in solving questions about overbedding, then you would lean towards probably quite different manifestations of bed buying and selling than if you were interested in problems of misallocation, or if you're interested in both problems, but the solution isn't the same for each of those things separately.

MEMBER AMIANO: I would add one more layer of complexity, and that's the emerging models of care that are out there that have impacted the original SNF level of care as we know it. So whether that's assisted living or

SLFs or care at home in the explosion of home care, whatever it may be, there's all kinds of external factors that have impacted our marketplace.

So I think you need a pretty heavy dose of working with providers to really understand what is the marketplace today.

CHAIRMAN WAXMAN: And I think just to make life a little more complicated for you, our role as this committee is, A, there are some things that we can make recommendations to the mother board, and hopefully they will approve it, and, B, there are those things that need legislative rule changes that we can only ask the mother board to propose.

So we're also caught in that bind in terms of how far we can go as a subcommittee in terms of enacting change. So in your analysis, then, you have to distinguish, I would think, between those suggestions that the mother board can enact versus those that require legislative changes, and that all falls into Frank and Courtney's roles to make that determination. And that's driven us crazy over -- at least one topic at every meeting comes up about, "Can we make that

change," or "Does that require legislative changes and writing new laws" and all that good stuff, and that's Claire's expertise and Frank's expertise.

So you've got to be aware of that mix, also. Sorry.

MR. LO SASSO: I have Frank's business card in my pocket.

CHAIRMAN WAXMAN: Mike?

MEMBER SCAVOTTO: You mentioned rationalizing the beds, the number of beds in the market. What are your thoughts on that? Is there a methodology?

MR. WING: So if the goal was, let's get the number of beds right, well, there's a number of possibilities, so you should not like take this as a real answer.

MEMBER SCAVOTTO: Then I'll take it as an unreal answer.

MR. WING: As a wild guess.

It's quite possible that a lot of the reasons why you would get the wrong number of beds, too many beds, or not enough beds has to do with constraints on the way the Board allows

people to get new beds or get rid of old beds. Places might hang onto beds that they don't need anymore because they think "Maybe I'll want it in the future, and it's such a hassle to get a new bed approved that I'm never going to get rid of this one."

Or new entrants to the market, somebody that wants to open or expand may be discharged from doing so because the organizational and even fiscal costs of succeeding in an application process might be so high that you have too few beds in some places.

And those effects could be different in different areas of the state. So a lot of that could stem from the fact that the procedures of the Board itself are a problem.

So bed buying and selling, you know -- I mean, if you start in the extreme, you could just say forget it with the buying and selling, just open a bed if you want; it has to meet various safety requirements -- okay? -- and that will probably lead to a new number of beds.

MS. KONETZKA: Which could be higher or lower.

MR. WING: Could be higher or lower, but you would remove some of those problems of people not getting rid of beds or getting beds because they don't know what they want in the future.

Another possibility could just be that you would promise to always provide a bed to people for some fixed amount of money so they can always come to you and buy a new bed if they want to. So that's more like a tax on the bed or the creation of a bed.

All of those would be versions of buying and selling beds. It's about who is buying and who is selling and what are the ongoing terms. That's very different from you controlling a fixed supply of beds and allowing the existing marketplace to sell them amongst each other in a secondary market. That would be interesting, as well, but it would serve a very different purpose.

MR. SHEETS: Can I try and restate the problem that we want them to solve?

CHAIRMAN WAXMAN: Sure.

MR. SHEETS: I want to go back to

what Cece said earlier. What we have now, we have very successful facilities that are modernized or newer, and we have some antiquated older buildings that are running low occupancy and don't have enough capital to reinvest that have extra beds.

They had four-bed units, as Cece was talking about. There used to be -- the standard model had one bathroom between two rooms, so there were four people sharing one bathroom, and obviously the market doesn't support that. Now they all have a private bathroom; it's just the market conditions.

So what we thought is the concept of buying and selling might allow some of those poorer facilities that aren't occupied and haven't been for 5 or 10 years more than 70 or 60 percent to sell some of their excess beds, reinvest that money into their physical plant and modernize so that they could be more successful in the market now and get money where they normally couldn't.

In other words, they have an asset and that's the beds. And we were hoping that that would help with the bankers because they would reinvest the money into the building so their

collateral allegedly goes up in value.

So we're trying to figure out a way for that to happen, for facilities that want to come into an area to be able to buy those beds from those poorer facilities so those buildings could reinvest and become more successful.

Make sense?

MR. WING: Well, that's certainly a different kind of goal. So now the goal of bed buying and selling is to prop up and help struggling nursing homes.

MR. SHEETS: Certainly one of the goals.

MEMBER CREDILLE: I don't know that that was accepted by everyone, that approach. Because one would ask themselves why haven't they done what they needed to do to prolong --

MR. WING: Or why don't you just let them close and let the new entrant come in and open a new facility.

MEMBER CREDILLE: So there are factions that would not agree necessarily with that particular stance.

MR. WING: In any case, this is good

because it's very hard to evaluate different options if we don't know what it is we're trying to solve. So like my story line there doesn't help with that problem at all. It's not about that but --

MR. SHEETS: We're not trying to replace the whole CON process here. This is just one sliver of how you would be able to go in and add beds or whatever in a nursing home. The regular CON process is still there.

MR. WING: One concern about the approach where you just allow existing facilities to sell their access capacity is you basically endow those incumbents with a bunch of money that they didn't previously have, and they have not done anything necessarily to deserve that other than be underperforming in the marketplace. So maybe you don't want to do that; it encourages them to perform poorly.

MR. SHEETS: A lot of them are little mom and pops.

MR. WING: They may be credit constrained, yes.

MR. SHEETS: The other part of that

that you probably should know is if they reinvest a certain amount of money, their Medicaid capital rate will go up. So they can actually increase their reimbursement to support them.

MS. KONETZKA: I would throw one more wrench in this which sort of gets back to the quality and access goals.

There's sometimes an underlying assumption in these conversations that quality and occupancy are really highly correlated and they're not, actually, in the data. So there are very high quality facilities nationwide that are near capacity, but there are also a lot of very well-performing facilities that because they're sort of in a neighborhood where there aren't options that are sort of low-quality, very high-occupancy facilities.

So one of the questions that this Board would need to deal with is if buying and selling is allowed, the assumption, of course, is that the high-quality facilities would buy beds, and people would have more access to high-quality facilities. But it may actually be sort of low-quality capacity-strained facilities that

want to expand. So is that a good thing that we're expanding access to low-quality facilities?

CHAIRMAN WAXMAN: Well, we've talked about having some set of quality standards in terms of who can buy. So, in other words, someone who has received, let's say adverse State surveys would not be allowed to buy or have some plan of correction in place that solves that issue.

So we have, again, among ourselves talked about the fact that we do not want poor-quality providers, however we define poor quality, to gain additional beds so they can have more poor-quality beds in a marketplace.

Also, you need to be aware that this committee has representation from for-profit homes, not-for-profit homes, and sole proprietors, and chain of homes. So as Judy pointed out, there are a variety of opinions, and, also, some members of this committee more geared to treating people at home rather than nursing homes at all.

So you are looking at a committee when it's full of 19 people with a variety of backgrounds with a variety of opinions. So trust me when I say to get a consensus is sometimes difficult.

MR. WING: That compositional issue is probably something worth keeping in mind, as well, if you were to introduce this sort of plan.

Let's say you went the route of saying, "We don't change the way that we approve the beds, but we let all the people buy and sell beds amongst themselves." In the long run that sounds like a situation where some of the people on this board are going to lobby very hard to not put anymore beds on the market because they're protecting their existing assets. Right? So the more beds that are freely available in the market, the price of beds in the marketplace will go down.

So if you own a bunch of beds, you're opposed to expanding the number of beds probably.

MR. LO SASSO: I think we recognize maybe what I'm also hearing is whatever we say won't make everybody happy.

MEMBER SCAVOTTO: Just like a faculty.

CHAIRMAN WAXMAN: It only took an hour for you to get to that conclusion.

MEMBER CREDILLE: Other states have adopted this as an -- I don't want to say option

because maybe it's more of a methodology. Some of them have moratorium on beds; some of them have CON process and some of them don't.

Illinois is not the first state to stand up and say, "We need another option in the long-term care arena." And it has to do with access across all -- home health, SLF, AL, SNF. It really does because it's just part of the continuum and what the consumer is looking for, what are the access issues in rural versus urban versus really urban in downtown Chicago.

We're not the first people to be asking this question. So we're asking, what have other states done; what do we need to consider if we're going to enter into some kind of --

MR. LO SASSO: I think a thorough review of what the experience has been in other states and how those -- I know Claire has done a lot of work already on this.

MEMBER CREDILLE: And intended and unintended consequences. And we've actually really wrestled with that. Okay. We think we know what might -- but what are the unintended consequences. And folks that are not in the

long-term care, skilled business are very concerned, as am I, on the unintended at the other service levels.

So do you have enough?

MR. LO SASSO: Possibly too much -- no, that's extremely helpful. I appreciate it.

CHAIRMAN WAXMAN: So I guess -- I mean, I think the last hour or whatever has been extremely beneficial to all of us. Although it was a start-off for you, it helped us come back to some of the issues we've dealt with over the last two years.

Now I'm wondering if maybe the RFP needs to be adjusted in terms of what you think needs to happen before you respond to what we ask you to do, if that makes sense.

MR. LO SASSO: In terms of -- specifically what do you mean? I mean, there are a number of -- I think this has been a helpful conversation for us to kind of get a --

CHAIRMAN WAXMAN: Are you now in a position to say there's some prework that needs to be done before you can go into the analysis or the investigation of what the RFP actually would

do, or do you have enough information to now proceed with the RFP?

MR. LO SASSO: My sense is as long as we have an open line of communication to you and your staff, I feel like we do have enough.

CHAIRMAN WAXMAN: Okay.

MR. SHEETS: So how long do you plan on this process taking in terms of the RFP?

CHAIRMAN WAXMAN: Me or them?

MR. SHEETS: There's a contractual --

CHAIRMAN WAXMAN: I think a week's long enough. I mean, they seem like three very bright people.

MR. LO SASSO: Why not tomorrow really?

CHAIRMAN WAXMAN: Well, that's unrealistic.

MR. LO SASSO: I think with Claire and Courtney we've been envisioning -- I mean, this is maybe subject to some further conversation, but we've been envisioning the end of the calendar year to have a preliminary report.

CHAIRMAN WAXMAN: Our next meeting would be -- we meet every two months, so our next meeting would be a November meeting, which we may

or may not do because of the holiday season.

MS. AVERY: Right.

CHAIRMAN WAXMAN: So does that mean a January meeting or November or December?

MS. AVERY: Going back to what Chuck just said, we still have to work it through the system, which shouldn't be too complicated. According to Bill that's the reason that we chose this route to work with a state entity as opposed to an outsider because it would kind of cut down on the process. There's always some contracts in the works that we can add onto but still have it separate and distinct that we wouldn't have to go through all of the other processes as a new vendor. And I think that probably would be about a month or so.

CHAIRMAN WAXMAN: I guess I was thinking in terms of a document back to this committee, and I'm thinking our next meeting won't occur until January.

MS. AVERY: The 1st of the year probably.

CHAIRMAN WAXMAN: So if you could gear to a draft by sometime in January, I think

that would meet our needs.

MS. AVERY: But we also have an RFP committee that will probably have to meet before January.

CHAIRMAN WAXMAN: Refresh my memory. Who is on that committee?

MS. AVERY: Cece, Terry.

MEMBER CREDILLE: Terry.

CHAIRMAN WAXMAN: I think Eli was on it.

MS. AVERY: I think Eli was the other person.

CHAIRMAN WAXMAN: We lost a member last month to cancer who was pretty prominent in the industry, so we have to reconfigure that committee.

MS. AVERY: I mean, so once we get the go-ahead from you all and the Board meets on the 4th, I'll present it to the Board.

CHAIRMAN WAXMAN: The mother board.

MEMBER CREDILLE: Of September?

MS. AVERY: Of September. I'll get the approval -- which they're aware this is occurring. So we'll get the approval and start

the other processes and just start meeting with the RFP committee, which would be an open meeting, conference call, things of that sort.

CHAIRMAN WAXMAN: Does anybody in this group wish to become a member of that group?

MEMBER WILL: I would volunteer to be on that committee.

MEMBER AMIANO: I will.

CHAIRMAN WAXMAN: So it's now Judy, Greg, Cece.

MR. SHEETS: Terry.

MS. AVERY: Terry. I think it was Terry.

CHAIRMAN WAXMAN: And, of course, I'll be there just because.

Great. Okay.

MS. AVERY: I know before --

CHAIRMAN WAXMAN: What does that do to our Open Meetings Act if there's five members?

MR. URSO: You have to a have --

CHAIRMAN WAXMAN: No secret phone calls?

MR. URSO: No secret phone calls.

MS. AVERY: No secret phone calls.

It's -- one of the other things we talked about before, and you slightly talked about it, was the pilot.

I'm not sure. Are we clear we want to use that as the second phase, or was there an intention to have a report on how that should look in the initial?

CHAIRMAN WAXMAN: Again, part of our discussion was that it may make sense to do a pilot to test it out. And then, again, how do you -- if the pilot was anything less than statewide, would you be getting realistic results? Question. So if you said it's only going to be this planning area or these contiguous counties --

MR. URSO: Contiguous.

CHAIRMAN WAXMAN: -- would that be a good result? So I don't know that we know the answer to that question. That's probably something to put back in your basket.

MS. KONETZKA: I think with caveats it could be certainly helpful, if not completely generalizable. I think the first thing to do is see if any of these other states have actually

evaluated theirs a little more rigorously because then we have pilot results of a form that we could look at, but I think it could make sense to do it in a limited region of Illinois.

CHAIRMAN WAXMAN: Just out of curiosity, Chicago or Cook County being such a unique area, would you have to include Cook, or would you not include Cook because it's so large and unique? How would you theoretically deal with that?

MS. KONETZKA: In a pilot or in the overall analysis?

CHAIRMAN WAXMAN: In a pilot.

MR. WING: We had a conversation this morning with someone in our department who suggested that the actual market area for nursing homes is usually much smaller than people realize. So I think he was implying Cook County would not be a cohesive market.

So one strategy would be that parts of Cook County could be part of the intervention, and the rest of it might not be. I think there are limits to this because there's still movement across the markets.

MEMBER CREDILLE: Just the State of Illinois defines Cook and the collar counties really interestingly because that's where we're piloting all the managed care business. So we're on round two. They've decided that Cook County and the collar counties are where we should pilot everything they're trying to do in the public aid world.

CHAIRMAN WAXMAN: I didn't know that.

MEMBER CREDILLE: So for the under 65 public aid, that's the first part, and now the rollout of the dual eligibles January 1 is Cook and the collar counties.

MR. WING: It does change things a little bit depending on kind of -- again, a lot of this is hard to plan for without better specification of what it is you're trying to achieve, but some of the questions would do poorly in a limited pilot project than others.

So if you think one of the big problems is that there are huge amounts of excess capacity in some parts of the state and way over on the other side of the state there's undercapacity, and you're hoping a buy-and-sell program would help

aleviate that problem, and if you put a pilot project that just has half the state that's --

MEMBER CREDILLE: Would you do a pilot that was maybe time bound? Two years -- it's a time frame as opposed to X counties or half of the state or whatever.

MR. WING: So, again, it depends on what it is you're trying to learn from it. There the problem would be your willingness to pay for a bed that you can only have for a couple of years and then give back would be very different than one where you could buy it sort of in perpetuity.

MEMBER CREDILLE: I wasn't thinking -- I thought if it happened in that two years it happens, and then at two years you put the brakes on and you evaluate. I don't have experience in this. I am just . . .

MR. LO SASSO: All possibilities.

MR. WING: It all depends what you're trying to learn.

MEMBER CREDILLE: It would not be successful if you set a time period and, "Just kidding, in two years you've got to give it

all back."

MR. LO SASSO: That probably wouldn't be a very realistic setting.

MR. WING: Like the beds -- it's not a physical bed; it's the license to use a bed. Right? So one of the reasons why someone wants to have excess capacity is that they might have an influx of patients briefly. Maybe all they want to do is rent a bed for couple months and give it back. Sounds not so bad. I don't know.

MEMBER CREDILLE: An underlying issue in Illinois that we grapple with and we can't do anything about is the reimbursement is atrocious, and whoever brought up initially that we're 49 out of 50, that is an underlying -- it's different than other states. That is what sets us apart is the reimbursement system is atrocious.

MR. LO SASSO: There are boundaries we'll have to set. That one will probably be outside the boundaries of where -- we're going to have to take it as a given.

MEMBER CREDILLE: It's what's causing buildings not to be able to modernize.

MR. WING: But it won't --

MS. KONETZKA: It's something to keep in mind when we look at what other states have done and whether it works.

MR. WING: And whether it works because of their better Medicaid system or something.

MS. AVERY: The other component that we discussed before was the solicitation of people or providers, owners outside of the subcommittees. I don't know how we want to --

CHAIRMAN WAXMAN: I'm not -- it's not clicking. Say it again.

MS. AVERY: Well, we discussed how -- and you alluded to it in the beginning that not everyone within the industry is in favor of seeing a buy-and-sell program in the state of Illinois.

And unless I'm imagining it, I thought that we tried to discuss or figure out a mechanism with town hall meetings around the state or conference calls or something to solicit feedback from those outside of this table of what they felt about the buy/sell program.

MR. WING: Do you have a sense of what the biggest concerns are among the people

who are not in favor?

CHAIRMAN WAXMAN: Let me go back. I honestly don't remember that conversation.

MS. AVERY: Remember we talked about where we do something like a town hall meeting? How would we get this message outside of this subcommittee?

MR. SHEETS: I think you have to use the three associations.

CHAIRMAN WAXMAN: Right. I agree.

MR. SHEETS: I think I can tell you what the opposition probably would be just from my experience. I don't share that view, but there are people I think that don't believe there should be a CON process at all, that it should be a free market system, and those would be the people who would be opposed to this.

CHAIRMAN WAXMAN: Judy, what's your sense?

MEMBER AMIANO: I would absolutely agree with your statement, Charles. I agree you have to use the associations, and I think people were handpicked for this committee originally because there was representation from those major

associations. So that's eroded a little bit over time, but I think that's an easy way to relay that information back. But we could easily use the associations as a touch point, if you will, at points in time as the process evolves to see how it's tracking with folks.

I think, unfortunately, this has been going on so long -- in the beginning people were kind of nervous and interested in it. Interested because they were nervous about what was going to happen. And it's been going on for so long that people are like, "Oh, it's just another one of these state things that's not really going to happen."

So there's been a disinterest, if you will, over a period of time. So I think there's some work to be done, actually, to reinvigorate the conversation around what some of the opportunities might be.

CHAIRMAN WAXMAN: I think one of the -- there's a segment of people who don't recognize that the buying and selling is really -- has a consumer aspect to it, has an advantage to the consumer. They simply view it as -- or simply

have a very shortsighted viewpoint that it's just going to help the nursing home owners, and the consumer has no benefit out of it when, in fact, we see that the consumer does have a major advantage in that they could get into a home or into a quality home that they can't get into now.

That's one of the things I heard from some regulators and some owners is that they totally missed the demand side of the equation. They only saw it as a benefit to those nursing home owners that are out to gouge the public. So they missed that one of the things that we were hoping to accomplish in this process is to provide more access to those homes that are providing quality by making sure that only quality providers, however we define quality, are allowed to acquire new beds, and also that it's in those areas where there is a need for those kinds of beds.

Again, one of the things that keeps coming up is that the movement in the industry is toward more specialized programs in nursing homes. It be cardiac, or rehab, or dialysis, or whatever it is, and those are the homes that I think would be looking for being able to expand those very

specific programs and getting away from the kind of facilities that kind of -- forgive me for lack of better analysis, but that warehouse elderly people.

Because, again, if you look at what the hospitals are doing, they're releasing people much sicker, much quicker, so the nursing homes have to pick up much sicker people than they did in the past. So nursing homes have to increase their quality of care and quality of programs, and we think that -- some of us believe that those nursing homes that have recognized that already would be able to expand through this process to either implement newer programs or add to the programs they have or their capacity in some of those programs.

That's part of what we envisioned.

MS. KONETZKA: Can I ask a clarifying question?

The bed approval process in general, does it distinguish between postacute beds and chronic care beds?

CHAIRMAN WAXMAN: No. Also, understand that our subcommittee can only look at

skilled beds and intermediate beds, that we have no jurisdiction over assisted-living beds or independent living. And some of us think that that's wrong, also, that somebody should be looking at the whole industry of long-term care beds, meaning skilled, intermediate and assisted living.

MEMBER AMIANO: Just as another -- clarifying, not only is it not by payor, so to speak, but it's also not by clinical diagnosis. So you might have facilities that are just MI licensed under the same license.

MR. WING: So thinking back again to imagine we did some kind of pilot and figured out that thorny issue of how to split up the state or whatever, are these the kinds of outcomes you'd want to study? The number of people on waiting lists, does that go down because of the bed buying and selling; does the number of specialized facilities or programs available go up; and I guess like what happens to this ancillary market of assisted-living beds, if that's sort of somehow exempt from that?

CHAIRMAN WAXMAN: One of the scary

things for me and I think for a lot of people in the room is to walk through an assisted-living building and see people that really need skilled care. I mean, I've heard the story over and over as long as I've been a part of long-term care, "I promised my mother I would never put her in a nursing home." So they put her in an assisted-living building because it's beautiful and then she strokes out.

I personally know of someone whose father stroked out and laid there for eight hours before they found him, you know, because "I promised I would not put that person in a nursing home."

I'm not opposed to assisted living, but I do believe that there has to be some definition of who really needs skilled care and that it's appropriate.

MS. KONETZKA: And there's certainly a lot of overlap in the market that sort of feeds into this. The problem is there's not always enough data on assisted living. It's really hard to get it.

MEMBER SCAVOTTO: That's a good question and gets back to Judy's point. We're

dealing with the rollout of the MMAI initiative. I believe that's going to be a game changer, and just not knowing is the hard part. So what's the demand for beds going to be? Pick a number. You don't know.

MEMBER AMIANO: Well, it's totally going to change the dynamics because not all facilities are going to sign up. It's an unknown variable right now. We have ideas of what's going to happen here as marketplaces, but it's not tested and known.

CHAIRMAN WAXMAN: So I guess your analysis or your study has to take into account the impact of whatever changes may be coming. I don't know how you do that. Of course, I don't know how you're going to do any of this. But that's okay. That's why you're here. Because we've dealt with it for two years and haven't reached a consensus of how to write our suggestions concrete enough.

We all recognize that things have to change. We all recognize that -- I think we can probably define easier what we don't want to have happen than it is to say what we want to see happen, if

that makes sense to you.

For example, we all agree that we don't want the nonquality providers to get more beds. I don't think there's anybody in the room that doesn't buy into that concept. How you make it happen is one of the issues. I think everybody agrees that the market is changing and the environment is changing, and how do we set into place the right set of circumstances to meet the changing demand?

As I think Chuck has alluded to and we all have at one time or another is that how do you let the marketplace make some decisions when the bed count is controlled? A lot of us do believe in free marketplace and let the consumer vote, but you've got restrictions for that happening. So how do you overcome that?

MEMBER AMIANO: I think the study is a great way to ask that question. Because I loved what you said, everyone around the room has been with the one notion of the buy/sell is between who has the beds and who has not, and you totally change the frame when you said buying and selling could be you just pay a fee to the State

and that's where the buy/sell is; it's not necessarily between the buyers.

So ideas like that have not been fully explored, so I think it's a fantastic thing to kind of go back to scratch and have people who have not been involved in this raise those questions. It forces us to think a little differently.

CHAIRMAN WAXMAN: I think the last hour and a half discussion or whatever it is has been incredibly useful. Absolutely.

You know, it's interesting that when I first got in the business, where were the nursing homes? Well, the nursing homes were where the elderly people were for the most part.

Where are they now? They're where their kids live because the kids don't have enough time to go visit their parents in the old neighborhood, so they bring them out to their neighborhood.

You know, the dynamics are changing as to where the demand is.

It's also interesting to see -- and, again, it's my observation that things that are important to the consumer is not necessarily important to

the resident to be. So the kids will look at, because they're used to health clubs, if a nursing home has exercise equipment or a health club environment. That's important to the kids, but to the mother and father who are going to be the residents, it doesn't mean anything.

It's an incredible change in marketing and demand. That's what I think.

Judy, are you seeing the same kinds of things where kids are making decisions?

MEMBER AMIANO: Well, I think kids have always made decisions. It just depends on what level of care. In the free marketplace you amend your programs over time. That's why I was saying things have changed so dramatically in the space in the last few years.

Six or seven years ago you probably had a higher propensity of true what we used to call long-term care people. You look today and most facilities are really gearing towards that Medicaid not only for financial but it's what the marketplace needs because of changes in the acute care which have flowed down into the postacute care environment.

It's just an interesting time in our space. It's an interesting time to ask these questions and figure out the path moving forward.

I think we would all agree that the current system we have is antiquated. It doesn't work and we need reform. We need change, whatever that may be.

I also would throw out there that I don't think there's been anyone who has been super -- I haven't looked lately, but I think the CON board actually has been doing a good job that even places that are overbedded are getting some approvals through for the right projects. So one might ask the question, is it really broken?

So, again, I haven't looked recently but it used to be that even if you were overbedded in the market, you could still be successful in getting beds if you had the right new offering for that market.

So I think one of the questions should be, is it broken?

MR. WING: When you don't approve a bed, what's the typical reason? Why don't you approve a bed?

MS. AVERY: The application or the applicant does not demonstrate need.

MR. WING: And how do they demonstrate --

MR. SHEETS: It's usually utilization of current facilities. You want to go into a new area and all the competitors may be running at --

MS. AVERY: It goes back to that 30 mile, 30-minute drive radius.

MR. LO SASSO: Do you maintain data on applications that have not been approved as well as those that have been approved?

MS. AVERY: I'm sorry?

MR. SHEETS: They're all available but there's no data, I don't think, on --

MR. LO SASSO: It's not in the electronic data set?

MS. AVERY: The actual applications?

MR. SHEETS: That are not approved.

MS. AVERY: They're all there. They're under the category "Applications acted on by the Board" on the Web site. So whether they receive a positive or a negative.

MR. WING: So if we were crazy people,

we could look --

MR. LO SASSO: Which we're not.

MR. WING: Right. But we could make like a five-year period, and we could go and find every application made and know whether that was approved or denied?

MR. LO SASSO: Because this would tell us about the market. We talked about demand for beds. This would give us a sense.

MS. AVERY: Any data that you need we have. If you want to see those applications from a period back, we could retrieve those because the State Web site would probably take you so long. We still have access to them.

MR. LO SASSO: That's helpful.

MEMBER AMIANO: Just so you know, they go off and then they come back on.

MR. LO SASSO: We would want to know just the up or down and the reason it was denied, and this sort of thing.

MS. AVERY: Included in the application, like Chuck just said -- it's like 300 pages but there's a State agency report, there's letters of opposition, support, feedback,

and the minutes are exactly -- in some instances is exactly why the application wasn't approved. Board members really clarify their votes on some of them.

MR. LO SASSO: And, Judy, you were saying that they come back.

MEMBER AMIANO: As a provider, you'll go on, you get a negative or whatever, then you're going to pull it off, and then you're going to put it back on. So it's really the same provider, so you don't want to count the no vote twice. You want to make sure you go by the provider number.

MS. AVERY: It's very clear if they -- what Judy is describing is an intent to deny.

MR. SHEETS: They get two shots at it. So the first one is only an intent to deny. Then they come back and it's a final denial.

MR. URSO: Or approval.

MR. SHEETS: Or approval.

CHAIRMAN WAXMAN: In your research you might want to get his phone number because his firm probably does 75 percent of all the applications.

MEMBER AMIANO: Are you getting the sense this is a complicated situation?

MR. URSO: Coady, let me see -- I don't know if I misunderstood you, but I wanted to clarify something I think.

This is not the forum that approves or denies permits or certificates of need. This is a subcommittee.

MR. WING: This one. But the Board --

MR. URSO: The Board itself. As Mr. Waxman said, we call it the mother board. That is the nine-member board that really makes the decisions, and anything that's decided here has to go out back to the mother board and comes by virtue of recommendations and motions.

MR. LO SASSO: And do they typically follow your recommendations?

MR. WING: With respect to specifically to the RFP.

CHAIRMAN WAXMAN: They typically have.

MR. URSO: It's not been tested that often.

MS. AVERY: But the Board does understand the importance of it and the

legislation that was passed to evaluate this activity, the bid, sell, and exchange.

CHAIRMAN WAXMAN: The advantage is Frank is part of both boards; Claire is part of both boards; Courtney is part of both boards. So they get to carry the feelings that we have presented and talked about. So it helps to have that kind of connection to the Board.

MS. AVERY: And there's also a board liaison, a board member that sits in these meetings that's not here today.

CHAIRMAN WAXMAN: You need a break? We'll stop in like five more minutes because lunch will be here at noon.

MR. URSO: Can I just make one more?

CHAIRMAN WAXMAN: Of course. You're the attorney. You can do everything.

MR. URSO: You made me forget what I was going to say.

Oh, there has never been a formal motion on the table at this subcommittee to go forward with a buy and sell or not go forward. I just wanted to make that clarifying point with you.

We've been talking about it. The committee

has been talking about it and talking about it but there's been no formal --

MR. WING: -- plan to do anything other than think about what it would mean and what could happen.

MR. URSO: Evaluating it and presenting recommendations.

MR. WING: Sure.

MR. URSO: And maybe you already knew that, and I apologize if you did.

MR. WING: You don't have to apologize but I was aware.

MR. URSO: Coady, you're pretty sharp.

MR. LO SASSO: That's why I brought him.

CHAIRMAN WAXMAN: It seems like this is a good spot to stop. So lunch should be here in about five minutes or so if I have any sense of what's going on. So why don't we stop. We'll reconvene as soon as we get most of lunch down.

(Whereupon, a recess was had at 11:55 a.m., after which the proceedings were resumed at 12:52 p.m. as follows:)

CHAIRMAN WAXMAN: A couple housekeeping things. I need a motion to approve the agenda.

MEMBER SCAVOTTO: So moved.

MEMBER RAIKES: Second.

CHAIRMAN WAXMAN: All in favor?

(The ayes were thereupon heard.)

CHAIRMAN WAXMAN: Motion carries. I need the motion to approve.

MEMBER RAIKES: I'll make a motion to accept it.

MEMBER AMIANO: Second.

CHAIRMAN WAXMAN: There were some corrections made from Neyna. Do you have the corrections?

THE COURT REPORTER: She did not give them to me.

CHAIRMAN WAXMAN: All right. We'll come back to that, then.

Judy, did you come up with an answer to the question of what term you want, one year, two-year, or three-year?

MR. URSO: I put it in the three-year.

MEMBER RAIKES: May as well, she's been here for --

MEMBER AMIANO: Since the stone age.

I'll do the three if we can all agree we'll move this thing forward. How is that? That's the qualifier.

MR. URSO: Three years?

CHAIRMAN WAXMAN: Three years.

MR. URSO: Okay. We've got that on the record, Judy.

CHAIRMAN WAXMAN: There's always options, Judy. Maybe you'll go for five.

Neyna, now that we have a quorum, would you like to address your changes to the minutes, please?

MEMBER JOHNSON: Sure. Nothing major.

On page 128, line 19, it should be "Colbert," C-o-l-b-e-r-t, and "Ligas," L-i-g-a-s, "members who are all part of state lawsuits."

And then page 131, line 23 should be "adult protective," t-i-v-e, "services."

And, lastly, on page 132, line 1, "They would not only be dealing with abuse in the community but also the abuse of" -- the change is "the 18 to 59 population in the community -- or "the age 18 to 59 population in the community."

That's it.

CHAIRMAN WAXMAN: Thank you very much. Does anyone else have any changes?

(No response.)

CHAIRMAN WAXMAN: Then I need a motion to approve the minutes with the changes just made.

MEMBER WILL: So moved.

MEMBER SCAVOTTO: Second.

CHAIRMAN WAXMAN: In all favor?

(The ayes were thereupon heard.)

CHAIRMAN WAXMAN: Opposed?

(No response.)

CHAIRMAN WAXMAN: Then upon discussion with counsel suggesting that we make a motion to -- not approve -- to move forward with the group that just presented so that it's on the record that we've met with that group and that we're in favor of moving forward with them.

So I don't know how you want to -- it's not a commitment other than just an agreement that they did present and we want to move forward with them.

Do you have a suggestion as to what the

motion should look like?

MR. URSO: Well, based upon what you said, it's clear to everybody, then, I think you've done your job. I mean, does everybody understand the motion?

MEMBER SCAVOTTO: Well, can I make --

CHAIRMAN WAXMAN: Please.

MEMBER SCAVOTTO: Were there other groups?

CHAIRMAN WAXMAN: They were the only ones that responded to the RFP.

MS. AVERY: I sent it out to all major state universities and followed it up with a phone call.

MEMBER SCAVOTTO: Okay.

MEMBER AMIANO: Do we have any fiduciary role here, Frank?

MR. URSO: In what regard, Judy?

MEMBER AMIANO: Are we approving any expenditure for this?

MS. AVERY: When test -- after this goes to the Board for approval, then I think there are some guidelines with CMS that we would have to follow. But as long as we follow those

guidelines, we would be fine, but all moneys will come from the planning fund to support it.

MR. SHEETS: The Board will approve the expenditure.

MEMBER AMIANO: Thank you. I wasn't sure what our capacity was here.

CHAIRMAN WAXMAN: We're just agreeing that we all are in agreement we're going to move forward with the group just to get it on the record that we are in agreement that that's the group we want to pursue or work with at this point in time.

MR. URSO: And then whatever that decision is is going to be shared with the Board, and they ultimately will have to decide, you know, to move forward and go along with the expenditure and so on.

CHAIRMAN WAXMAN: So can I get a motion or I already --

MEMBER RAIKES: I'll second it.

CHAIRMAN WAXMAN: All in favor?

(The ayes were thereupon heard.)

CHAIRMAN WAXMAN: Any opposed?

(No response.)

CHAIRMAN WAXMAN: Okay. Judy, it's such a good thing you showed up. I'm teasing. All of us are important but it's the last one that makes the difference that gets us to the quorum.

MEMBER AMIANO: Got it.

CHAIRMAN WAXMAN: Item 9 is what, Courtney?

MS. AVERY: That is the meeting that we've been trying to coordinate with IDPH to kind of look at some of the overlapping regulations as far as the accountability for change of ownership and what that process would look like and to kind of streamline it for facilities to notify the Board and Public Health of how the change of ownerships are taking place and who is changing where and the licenses and all that.

CHAIRMAN WAXMAN: I know Toni has agreed to it. But it hasn't taken place?

MS. AVERY: No. There's been a lot of turnover, so some key people are leaving. And we've discussed some possible dates but haven't got to the point where we confirmed anything.

CHAIRMAN WAXMAN: What's the status

of Mike?

MS. AVERY: He had an operation on his shoulder but he's home recovering.

CHAIRMAN WAXMAN: And how long has he been out and will be out?

MS. AVERY: Probably through the end of the month.

MR. SHEETS: Probably shouldn't be on the record here.

MS. AVERY: I forget. I'm sorry. I'll tell you later but he's doing fine -- good thing we have all these attorneys -- and he did say if anybody asked I can share that he's doing okay.

CHAIRMAN WAXMAN: We didn't say anything bad about him. Thank you, Mr. Sheets.

MS. AVERY: Those attorneys.

CHAIRMAN WAXMAN: Mr. Scavotto?

MEMBER SCAVOTTO: Yes, sir.

CHAIRMAN WAXMAN: You are up.

MEMBER SCAVOTTO: Okay, great.

CHAIRMAN WAXMAN: You're going to learn us some stuff.

MEMBER SCAVOTTO: That remains to

be seen.

Claire extended an invitation to me which I couldn't turn down, "Would you talk about managed care or managed delivery?" And the last several months I've spoken to Life Services Network three times on this subject, and I'm continuing to get calls.

I got out of grad school in '73. I've been in this game a long time. Most of my career has been in acute care, and 14 of those years were as a CEO of a California hospital, and I was there between 1982 and '97, which was the go-go days of managed care.

So the market we were in was Southern California even though -- which extended up to Santa Barbara County where we were. It was a very difficult market, probably the most competitive managed care market in the country. The bay area was competitive. San Jose -- that's part of the bay area -- was also competitive. But the southern California market was the defining experience in terms of managed care in my opinion and I think that's true.

Now, Chicago has had some managed care --

St. Louis where I'm from has managed delivery. There's not much capitation in those markets. Boston, my hometown, has a bunch of capitation. Managed delivery capitation isn't that big a force.

What defined everything, in my opinion, in California was the overriding presence of capitation. And, basically, if you want to look at it -- we have an HMO, health maintenance organization, and a PPO, preferred provider organization where they're contracting for services. The difference between those two is a four letter word named "risk." And under the HMO model, the health plan is completely at risk for the welfare of the beneficiaries and for the financial performance of the plan.

I'm not going to offer any prognostications about certificate of need. What's going to happen to certificate of need under managed delivery? I don't know the answer to that. I filed one of the last applications for CON in California. CON went out in '84 or '85. California was characterized by a wide-open market environment, and that was in name only.

At another level California was highly

regulated. If you were a health care provider and wanted to make any changes at all to your facility -- for example, if you wanted to move that picture and that picture weighed more than 30 pounds, you had to submit seismic drawings by a certified engineer to move it, and sometimes you could get that done in as early as eight months. If you were building a facility, plan check would take upwards of 18 months, more often 24 months. So while you didn't have the certificate-of-need regulation to slow you down, you did have other bureaucracies that you had to contend with.

Missouri has certificate of need, has managed delivery. Florida, big managed care market, they've got certificate of need. Same with Ohio; same with Massachusetts. So the fact that you have certificate of need or not to me is not a defining characteristic of a strategy. The reason I say that is the health plans don't care. They don't care about certificate of need. They care about growing out their own business plan.

It's not a bad business plan. It's just different from what we're used to as a provider.

If I were to define managed care, I would say it's a combination of administrative, financial, and clinical assistance where the incentives are all aligned.

That works great for the health plan, and it works great for providers that are at risk. If you are not a provider at risk, which is most likely the case with all of us in Illinois, then incentives are not aligned, and they never were intended to be, and they probably won't be.

The lesson that I took away from California was that managed delivery can be a very powerful force. It is not just price; it's more utilization. And more often utilization translates to profits for the plan. That's why they hammer it so much.

So let's just say, for example, that you've got days per thousand at say -- pick a long-term care number. Say you've got 18,000 days per thousand in a particular marketplace. Just like the statistics that I've seen in Illinois, 18,000 is at the bottom. It started higher and it's been coming down, which is what your data shows at the health facilities planning board.

If you take a look at the days per thousand, it's coming down. And whether it's 18 or not doesn't matter but it's coming down.

So if I'm a health plan and I'm looking at 18,000 days per thousand population, the one question I'm going to ask is what do I have to do to get that utilization lower. So I don't want to have a day in a skilled nursing facility that I don't need.

Why? Because in a long-term care continuum we are the most expensive at the nursing home, skilled facility. I want people someplace else. I want them in supportive care; I home them in home care; I want them in the garage, wherever, but I don't want them in skilled.

That gets to your point you brought up earlier. That model is going to change. What's it going to change to? We don't know yet but there's a lot of creativity that will be released under this because the financial pressures can be extreme. I'm not going to say that they will be extreme in Illinois because we don't know how this is going to roll out.

In California the financial pressures were

horrendous. You lived with this every day, and it was always strategy, never bothered to think about operation. It was all strategy from my perspective as a chief executive: How do I keep the Board on the reservation; what can I do to get market share into my facility.

If my objective as a health plan is to drop utilization, that's not good for providers. It's good for me because I'm working off the premium dollar. You are working off patient days and you need volume. Obviously, I've got a different agenda. You want volume in your facilities, and I'm saying you can't have it. So it's just a different way of looking at it.

I guarantee you if your occupancies get down to 55 or 60 percent, you're going to be scheming, and that's the way they think about it. So it's not -- are we bad? Maybe. Some of us might be bad. But are we a bad business? No. But just a business with too much utilization in the minds of the health plan.

Is that going to roll out in Illinois? And the answer to that is I'm not sure. I would say the probability of it happening is pretty strong.

If the managed care organizations can develop their panels, build out their networks, then they've got the providers where they want them. But right now I would say that's not at all clear that those networks are going to develop right away. You just can't snap your fingers and get a network. It takes a while.

So do we have enough skilled nursing facilities that are willing to sign on when we're 49th or 50th on the reimbursement scale? Are there enough physicians?

There's indication that the physicians might be coming but probably still not enough.

The MMAI, the dual eligible initiative in Illinois is using the medical home as its primary care physician. Now, there aren't enough medical homes, but in the RFP they've provided for a path for primary care physicians to become certified as medical homes.

So clearly the Department of HFS is indicating that the medical home works for them. That's the model that they want to use. So they're indicating that over time we want to get to an acceptable number of providers.

Are there enough supportive living beds? No, there aren't. We know from conversations that State HFS is expecting a major -- a major departure of ICF out of skilled. They can't do it all, but that's what they've got in mind. And for those ICF that can get shipped downstream, where are they going to go? There's got to be a network that can handle that.

So do they go to assisted living? Only if assisted living takes Medicaid reimbursement. That's not to be ruled out; 44 states have that sort of provision. Where do they go if there's not enough SLF capacity to take them? Do they go to community-based services and in what capacity and how are they supervised?

There's a lot of network development that hasn't happened yet. But when I look at the dual eligible program, I see very strong parallels to what I saw in California. It's capitated. All of the plans in this thing are capitated from the get-go. There is no other method of reimbursement for the plans. They're going to be at risk for utilization experience, and that tells me that I know what their strategy is going to be. I know

what it has to be in order for them to hit their numbers.

One of the things working against the plans right now is the fact that they don't know what they're going to get paid still, and until they do, we providers are going to have a difficult time with rates.

I did see one contract which will -- you can call me later if you want to know. I won't name it now, but there was a Medicaid rate proffered at $100, which is absurd and it makes me wonder. It was a typo? No, it wasn't a typo but that's a rate that's unsustainable and unrealistic.

It makes me wonder about the veracity of that plan. The plan needs providers to deliver the service. It gains nothing by putting all providers out of business. You have to have some providers in order to get the services delivered, which ones remains to be seen.

In the Illinois initiative providers can be tossed by the plan after a year. So if you sign a contract and you say, "I'm in," you can be out after a year for quality determination, which is

completely the responsibility of the plan.

That is -- on the surface that's a real hammer for providers. When I read it, I said that's nice that the State put it out there like that, but the fact of the matter is the plan can do it to you any way they want. Whether you can be a provider on the plan, I have no obligation as the plan to give you any business.

It's a case-managed system. So, Cece, I'm sending cases to your group right now, and now I start getting reports from my case managers that you're not receptive to our needs; you're not as responsive. All I've got to do is say to my case managers, "Start sending them to John" and you're done.

The plan can do it. They did it in California multiple times; they have done it in any other state I've been in working on this stuff. They really don't need the hammer to throw you out. They can just redirect cases to you, which they will use through their case managers.

The health plans, in my opinion, are not to be trifled with. They're holding all the cards

in this deal. I've said many times in speeches that you will get the contract that reflects your strategic importance to the plan. And in my opinion, if you are a single provider, you can answer the question yourself.

Managed care in California forced consolidation, forced consolidation in St. Louis, and I would suspect it probably forced consolidation in Chicago among the acute care facilities. I don't know the answer to that, but I think it probably fostered the development of health care systems.

If you stop and think about it, years ago -- not that many years ago because I don't want you to know how truly old I am, but you'd say, "I have a hospital system. I've got six in Arizona; I've got four in Texas; I've got three in Illinois; I've got four hospitals in Arkansas; and I've got six someplace else in Pennsylvania." I'm a system but I'm really not geographically sensitive to coordinating care in a marketplace.

So what's happened with these systems? I say to Chuck, "You take the ones in Arizona, and I'll take your Pennsylvania facilities." Now

I've got 15 in Pennsylvania, and I'm a little bit more of a market presence there. And then I can go to Frank and I can say, "I'll trade you my facilities in Texas. I want your eight facilities in Philadelphia." So the idea is you want to concentrate your geography. If you've got multiple facilities in a market area, you represent more of a force to the plan than just a plethora of single facilities.

And I think that makes sense, and that's what you see with system development. You see that with Advocate; you see that with BJC; you see that with Dignity, which is Catholic Healthcare West in California. You see it all over the country in the acute care side, and I think that is the direction that will be forced upon long-term care.

The issue with the dual eligible program for providers is, in my opinion, one that is going to be difficult for them to ignore. There are many providers in long-term care that limit their Medicaid involvement, and it's almost the reverse under this dual eligible.

If you limit your Medicaid involvement, you

run the risk of having the plan limit your Medicare referrals, and most of those people that limit their Medicaid involvement thrive on Medicare referrals. You can't blame them. It's good business.

But now what's good business for the plan? It's good business for the plan to be able to refer a Medicare case and have that case seamlessly transition to Medicaid, not have the provider say to them, "Oh, grandma is at the end of her benefit period. Now you, plan, have to transfer grandma to another facility."

The plan might say "We'll take that" a couple of times, but sooner or later the plan is going to say, "Huh-uh. We're just not going to give you any more business because you're creating extra cost for us, and we don't want the coordination of the care to be disrupted that way.

So that I think is going to be a major stumbling block for a number of providers. Am I absolutely certain it's going to develop that way? No. Would I be surprised if it developed that way? No.

But you start to look at your business from

the standpoint of someone referring to it with the responsibility of controlling utilization, and you can get your head wrapped around the concept pretty quickly.

My experience in California -- and that's all that it is; I can just tell you what my experience was -- is that medical staff relations changed for the better under managed care. The normal life of any hospital executive ascends and descends on the whim of the medical staff. You can be trash one day, and you can be the white knight the next. It just depends on how they're feeling.

Once they get the message, which takes about five minutes, that they could lose their practice volumes because of managed delivery, they all of a sudden are your new best friends. And that's important and that gets people that really are responsible for the delivery of medical care on board. That should not be a lesson that is ignored in long-term care.

I think that the -- one of the real weaknesses in long-term care is the -- is really we have an inability to coordinate the care the

way we should. If we do consolidate the medical management in long-term care settings, we'd be much stronger in our quality measures and our ability to coordinate the care among different providers.

Getting that message across is going to take some time, but I do not believe that the physicians will be the barrier. I believe that they will be proponents of change if it's approached well. They will get the message. They know -- physicians are trained to deal with an individual case. I know when I go to the doctor, I want her to be interested in me. I don't want her to be interested in Chuck or Mike, and I know she's not going to be interested in you, Frank. But the fact of the matter is, I want her to be focused on that my condition is.

And physicians react badly -- but it's a natural reaction -- when you put them into a system where at any particular time -- so many transactions are in the system, but at any particular time something is going to be wrong. Most physicians I know can't handle that, but they can learn to get into it in a very short

period of time.

They can learn to function as the system functions. They can learn to work with others. They can play well with others. Believe it or not, they really can. And they can become your closest and your strongest adversaries because the plan gains nothing if it alienates physicians.

For managed to work it needs a surplus of providers. Do we have a surplus of providers in Illinois? Sure, we do. If I were in southern Illinois, we wouldn't be worrying about managed care. Central Illinois won't be that big a force. Up here, Chicago could be a major force, and I think that you have to expect it to be a game changer. I don't see any way around it.

The other aspect of the provider surplus is that they need that provider surplus to create demand for their product. They want you to come after them, and they're going to expect price concessions in order for that to happen. They've got the volume. What you want is the volume. We providers want volume.

In my experience, unless you're capitated, they're not going to promise you any volume. They

don't have to promise you any volume once you are capitated. You're going to sit there -- it took me five years to get a capitated deal. It was difficult but I finally got it and I got it through physicians. I needed physicians in order to get that done.

Once you've got the capitated contract, the volume comes your way anyway because you're being paid a certain amount. You went from being paid 50, now all of a sudden you're being paid 100, but now they're going to give you so much volume to take care of that, now you've got an issue of being able to control your costs. The volume problem just went away.

So capitation can be a two-edged sword, but if you are on shared risk, if you're getting a per diem, there's no guarantee -- don't expect to have one -- that you're going to get X number of cases. Now, you might be able to negotiate a deal that says, "For the first thousand days, it'll be at 200 bucks. The next thousand days we'll give it to you at 175" or whatever. But don't expect them to say, "We're going to give you 600 days a month." In my experience, they

will not do it.

If they don't like what's happening at your facility, they will move volume. The provider in a managed environment, particularly one -- managed care is affected, by definition, the market overbedded, there's going to be winners and losers. It will force consolidation.

In my opinion -- I could be dead wrong, but some phi beta kappa out there is going to come along and going to try to discount Medicaid, and I hope that that individual is smart enough to realize that game is over; it's time to consolidate with someone else. Because you can't make up for it in market share if you're losing money on every sale. There's no way to do it. Economically it's not possible.

So it is a very strong force. Can managed delivery function without The Affordable Care Act? The answer is yes. So in the -- CMS has the ability to put all of this care coordination together by regulation, and it happens to be done through The Affordable Care Act, creating the dual eligible programs created through the waiver.

In California long-term care was not part

of managed delivery, never even thought about it. It was -- in my situation we needed a long-term care facility. We couldn't get one that wanted to do what we wanted, what we needed. We needed skilled care; we needed rehab. We didn't need intermediate care. So we built one.

And I repeated that several times. It turned out to be a great move. I mean, I learned a lot about managed care; I learned a lot about long-term care. I made every mistake in the book on some of those things, but if you don't have a component of a network that helps you maintain your profitability you do it. And I think that sort of creativity will be very apparent if managed care rolls out like I think it can.

The issue to be concerned about is that, when do you know when it's time to consolidate? And it's a hard -- it's a hard decision. My facility ultimately consolidated and joined what's now Dignity, was Catholic Healthcare West. Catholic Healthcare West at that time was losing a billion dollars a year, and facilities were clamoring to get into it. My facility, Marian Medical Center, was about the only profitable one

in Catholic Healthcare West. We did very well in our market under managed care because we were able to get that physician piece in place, and we were able to gain market share and essentially put our competition out of business.

I'm not proud of what I did because I think the other provider in town was there for a legitimate reason, but it was my neck or the competition's, and I just did it and I would do it again if I had to do it over.

At any rate, those are the types of behaviors that it fosters. I believe that consolidation is inevitable under managed care. We should expect that. You've seen it in Illinois already on the acute care side. What makes us think that long-term care will be exempt from that? I don't know what there is.

I think that the single biggest problem facilities will have is access to capital. I can relate to this from the acute care standpoint. Once you can't keep your facilities replenished, once you can't keep them modernized, once you can't keep your investment in technology up, you've crested and you're riding down the wave,

and you're going to get crashed. The trick is to keep riding that wave up, and you can only do it by getting access to capital.

Once you've built the engine, you've got to feed it. It's the same thing, once you've built facility, you have to give it occupancy. You've got to feed it, and you've got to feed it with enough money that allows you to access capital. To me that is the single biggest problem that everybody's got.

If you read the hospital regs today, their main concern is financing. Why is that? Reimbursements getting cut. One of the things under The Affordable Care Act, a lot of these savings are being created by reimbursement reductions to providers, and it's the same in long-term care. How are things going to be paid for? We're going to cut reimbursement. Where do you cut? It's great in Illinois. How do you cut Medicaid reimbursement in Illinois and expect people to stay in business? So it's a very curious strategic quandary that providers are finding themselves in.

On the accountable care side, there's a

clear opportunity to coordinate the care all across the continuum from the acute care side -- actually, from the preventive side. They want to prevent the service, they want to get you into neighborhood clinics, primary care. If it escalates to the point that it needs acute care, let's hope not, but then when it comes out, they're going to coordinate on the long-term care side. The accountable care organization is expected to provide coordination on the chronic disease aspect of the system.

Now, that's very curious because there are some acute care systems out there that are pretty good at dealing with chronic care issues, but there aren't that many, and most of them that I know are struggling with their ability to manage chronic disease, and they're going to need some help. That creates an opportunity for those of us that are working in long-term care.

Does it mean that the dual eligible program will follow the same model as the ACO? To a certain extent I would say yes. The dual eligible program starts with a SNF, and an ACO starts back in the neighborhood with a primary

care and goes to the acute care, then it transitions to chronic. The dual eligible program starts with prime, they start you with a SNF day. So somewhere along the line someone is going to have to manage that continuum.

Some of the plans are very sophisticated at doing this. Most of them are. So would they be open to new ideas? My experience is yes, they would be open to new ideas, but my experience is also that they are data driven animals. Physicians are data driven; so are health plans.

So if you come to me as a health plan and say, "Hey, we're great," I say, "Great. Prove it to me. Where is your data?" You've got to have the data. If you can't prove your point with the data, it's not going to be something that I'm going to waste my time on, which is the answer that I believe you'll get. They'll be very nice to you, but they'll tell you, "We need data supporting the case, ans we'll see that it works with our system."

They have already developed their algorithms; they have their case management down pat; they know how to get their utilization down.

If they can get the networks built out, I think we've got a force to be reckoned with. I think they'll do it over time.

Questions? I know that's a lot in a short period of time. I know I've lit everybody up and made you all feel happy.

Is it going to mirror my experience in California? Probably not. Strategically what's the likelihood that I'm right? I'd give myself a 90 and say strategically I'm real comfortable with this. Whether the networks get built out is the wild card. If the networks don't get built out, it just delays the process.

If you were the State of Illinois and you had the State's problems with Medicaid, what would you do? Illinois signed on to expand Medicaid. It has no choice but to go in that direction. Had no choice anyway.

Missouri, my state, had a commission -- I was on it -- to study the Medicaid problem. They said if they expand Medicaid, they can't do it without a bigger commitment to managed delivery.

Missouri has some sort of managed delivery network now called HealthNet, and it just does a

smidgen of the population. This one in Illinois that's rolling out is a massive effort. It's a big deal and strategically if it pays off, I think the providers will feel it. They'll feel it in a big way.

Is everybody going to go under? No. It's an opportunity for people to be very aggressive and to -- they can really capture a lot of market share with this. I've always felt -- and I've had this experience -- there are ways to skin a cat. You've got to be very aggressive, and you've got to be well financed. You can't be bureaucratically inclined with managed delivery. You've got to be able to move fast and make a decision, and you've got to be willing to lose a few. Not every decision you make is going to work.

But that's been my experience, and I will welcome any questions. Just take two cyanide tablets, call me in the morning.

MS. AVERY: With the systems which I'm trying understand, are they specialized? Like there will be a managed care business that specializes in making these referrals to long-term care facilities?

MEMBER SCAVOTTO: Oh, yeah. There's eight of them. In the MMAI project, the dual eligibles, there's a central Illinois region -- two MCOs that have been approved for that region. There's not that many people there. There's only about 18,000 in that project. In the metro area up in Chicago, there's six approved MCOs, and I think that's about 250,000 people that are estimated to be in that program.

As an anecdote, at one of the life services meeting, I think it was in Naperville back in March there were representatives of the plans there, and to a person, to a person every plan said they were looking forward to the conclusion of the demonstration project so they could go after 2 million enrollees in the Chicago market. They're all thinking it's a much bigger market after this demonstration project. I'm not aware that it's 2 million, but that's the number that they were talking about.

So they're acting like they're in this for the long haul. So there are plans, and they're the ones that are going to be owning the beneficiary, if you will. So if you have the

1 Medicaid enrollee, the beneficiary selects the
2 plan, selects the primary. And they can move
3 from plan to plan on 30 days' notice. That's the
4 Medicare advantage model. But once they're in
5 the plan, the plan owns them.
6 So you can leave the plan, but if you say --
7 if you insist on an MRI, and I ask your primary
8 and say we're not going to do an MRI if you don't
9 have the indications, that's the decision. You
10 can grade me lower on quality when you get your
11 rating, but right now my decision is what governs.
12 It's a tightly controlled network that's being
13 established.
14 MS. AVERY: And HFS credentials
15 these plans?
16 MEMBER SCAVOTTO: HFS.
17 MS. AVERY: Credentials them?
18 MEMBER SCAVOTTO: There's a three-way
19 contract between CMS, HFS, and the plan. The plan
20 is responsible for credentialing all the providers.
21 There are standards but the plan is responsible
22 for credentialing all providers. The plan will
23 credential physicians and all institutions.
24 It's hospital oriented. Probably if

you're -- Cece, do you see any of these contracts that come out that looks like a hospital contract? It looks like a hospital ambulatory care outpatient contract, and that's what they're giving to skilled nursing.

But, anyway, there are standards that have to be met on the credentialing side. That's the responsibility of the plan.

CHAIRMAN WAXMAN: Mike, on the dual eligible, are they giving out a Medicare rate and Medicaid rate?

MEMBER SCAVOTTO: Yeah.

MR. SHEETS: Sometimes they say Medicaid/Medicare, whichever is less, which means if you're not careful, you're actually going to get paid the Medicaid rate for a Medicare beneficiary.

MEMBER SCAVOTTO: Whenever you see contract language that says "lesser of," bend over and grab 'em. That's plan speak for that's not good.

CHAIRMAN WAXMAN: You're talking about 2, $300 per day difference.

MR. SHEETS: Some of them don't have

prices on them. They're signing up providers without price. They're saying "to be determined," and providers are signing them, personal providers are signing this stuff.

CHAIRMAN WAXMAN: Time to be an attorney for adult care.

MEMBER SCAVOTTO: You know what? It doesn't matter. Obviously, the better representation you have, that's to your advantage.

MR. SHEETS: Thank you.

MEMBER SCAVOTTO: I was thinking of Matt.

MR. SHEETS: That's what I would think of, too.

MEMBER SCAVOTTO: The lawyers can't help you on this one. This is strategy. This is where management helps out.

Now, I guarantee you Chuck's going to go in, and he's going to do a great job negotiating a contract for a single facility. I on the other hand, with my 20 facilities am going to walk in and say, "Can we work out a deal," and we'll work out a deal.

And the position I want to be in is for you

to say to legal, "Bring these guys on board." Because what will happen to Chuck is they'll say, "Well, I can't get this past legal," and they won't even let him talk to me.

It can be that bad. Now, maybe it hasn't been that way yet but I've seen that. The point -- you get the point. The more market leverage you have, the more bargaining power you have, and you can influence your destiny.

If you walk in as a single provider, you have to be someone they really want and they need in the marketplace or you're just going to get their standard terms and conditions.

CHAIRMAN WAXMAN: Judy, are you negotiating corporatewide --

MEMBER AMIANO: Yes.

CHAIRMAN WAXMAN: -- or facility by facility?

MEMBER AMIANO: We refuse to sign any contract that doesn't have a price attached to it.

It's been an interesting process. They've hired these third-party people to go out and just contract. They don't know anything about anything. You ask them a question, and they

don't even understand long-term care. So all except for two of the providers -- I won't say which two -- have kind of subcontracted. We've had these contracts put in front of us that I personally wouldn't understand why anyone would sign them, but people are just because they feel forced into that scenario. And that's -- mostly the stand-alones are doing that, but it's an interesting environment right now.

CHAIRMAN WAXMAN: Are you doing Manor Care across-the-board contracts or building by building?

MEMBER CREDILLE: Well, it's a pilot up here in Chicago, so it would be all of us, but we haven't signed the contracts.

CHAIRMAN WAXMAN: You haven't signed the contracts?

MEMBER CREDILLE: No. We have with the existing pilot, with the two providers for the existing pilot but not with the rest yet.

MR. SHEETS: And the Medicaid-onlys now are being sent a letter saying, "We're going to sign you if you don't pick a plan."

MEMBER CREDILLE: The due eligible

pilot is -- January 1 is, when you think about it -- at least that's today. And then in April it will be mandatory for a subset of -- we're not sure what the subset is, but whoever the subset is the State has defined, in April they will be mandated to go into one of the plans.

CHAIRMAN WAXMAN: Wow.

MEMBER SCAVOTTO: But they could move.

MR. SHEETS: The good news on that is there's some industrywide influence because the resident of the nursing home, the family always comes to the nursing home and says, "We have to sign up. Where should we sign up?" So the facility has a little bit of influence in terms of where to push them.

MEMBER AMIANO: But, Chuck, the fear of that, also, is that people can change their mind any given day, as well.

MEMBER CREDILLE: 30 days.

MEMBER AMIANO: So the amount of paperwork and time of staff to do this and accommodate it is going to be extensive.

MR. SHEETS: Good point.

MEMBER SCAVOTTO: That's the Medicaid

advantage rule, and CMS isn't going to change that but they're used to that. So it seems like an administrative nightmare, but they are used to it, and it's been working out okay. That's a feature the Feds want.

MR. SHEETS: There are some, though, they're a physician and they can't get their physician in any plan.

MEMBER CREDILLE: That's what we have right now. We have patients that we can say yes to, but there's no physician to follow them. Or we try to discharge -- this is just for the straight-up public aid now. There's no home health agency to take them. We have to call the plan and say, "Your patient is here. You want them out. You need to find somewhere; you need to find an agency that will take" -- it's really very difficult. The patient's caught in the middle.

MEMBER SCAVOTTO: And the provider might get caught on that one.

MEMBER CREDILLE: Well, yes, because they only approve to X day, and then they want them out. So we're picking up the phone because

it's free care.

CHAIRMAN WAXMAN: So you eat the care that's not --

MEMBER CREDILLE: We've called them and said, "We need to extend your patient because you haven't helped us find a placement." It's so disjointed because the network is the problem in Illinois, and it's rooted back in our reimbursement.

MEMBER AMIANO: But you'll see the same thing, Michael, speaking of California, the LA Times this weekend, Sunday's paper was these narrow networks because they're farther along than we are here. But they've made the network so narrow so people can't get the physicians they want.

MEMBER SCAVOTTO: Remember now, it's harder in Illinois because you're dealing with long-term care. In California the networks got built out quickly, but it was acute care.

MEMBER AMIANO: But what I'm saying in this new model they have completely narrowed all that.

MEMBER SCAVOTTO: They narrowed it.

Even with the broader networks, a well-managed plan -- what the plans would do is they'd come into a community and then say, "We've got this huge network; we've got all of the providers in the community." And then the sideshow, the side discussion is, "Okay. We've got that for marketing coverage. I'm only going to use you two guys. I'm not going it use everybody that's on my panel; I'm only going to use you two guys."

So there's all kinds of ways to narrow the network that are on the plan but not to the providers.

CHAIRMAN WAXMAN: Have they introduced the home character networks to such an extent that home health agencies don't want to participate?

MEMBER CREDILLE: That is what we're being told.

MEMBER AMIANO: Yes. As a provider, yes.

MEMBER CREDILLE: It's DME, home health, physician.

MEMBER SCAVOTTO: The network build out is a huge issue.

CHAIRMAN WAXMAN: So, actually, they don't really care that there's no place for them to go because they're not going to pay you.

MEMBER CREDILLE: Thus far they have been. We're only in the pilot now of the public aid patients not the dual eligibles.

MR. SHEETS: That brings up an interesting point. There's another provision in the contracts we've seen where if a network brings you a patient and you're a long-term care facility and it turns out that patient is not eligible for some reason, they're going to recoup the money from you. So they're putting you at risk, and they're bringing you the patient that allegedly is eligible for the benefit.

MEMBER SCAVOTTO: They're not going to back off on that.

MEMBER CREDILLE: Right now if it's -- a public-aid-pending patient falls out of the whole thing. If they're public aid pending, then they aren't being managed. It's very interesting. I don't know how they're ever going to fix that problem.

MR. SHEETS: They're going to have to

eat it. The providers are going to have to demand that the network guarantee that payment. If they're bringing you the patient and they want you to care for the patient, you shouldn't be at risk. That's their business model; right?

MEMBER CREDILLE: Right.

MEMBER SCAVOTTO: They shouldn't be taking them without the eligibility. It's not like Medicaid pending.

MEMBER CREDILLE: Right. They're not part of the plan right now. The State of Illinois -- the backlog of PA pending is so huge that eventually the State's going to have to fix that because those patients are going to be in -- what? There's nothing.

MEMBER SCAVOTTO: Put yourself in the position of the plan. Why would the plan accept somebody into the dual eligible program with eligibility being a question? Wouldn't do it because you've got to put all that money at risk.

So once you've got someone who is in the dual eligible program, you've got Medicaid certified and Medicare certified, as well. So that ought to solve the problem. Right now they

have -- the eligibility determinations are just taking forever in many cases, far too many cases, no hope in sight.

MEMBER CREDILLE: 18 months.

CHAIRMAN WAXMAN: Unbelievable. Wow. We may not have to worry about number of beds because no one is going to want to own a building.

MR. SHEETS: You can see how the quality of care -- we're worried about it because everybody is being pushed down. The lesser equipped buildings are dealing with sicker people. It's not good.

MEMBER SCAVOTTO: That is something that I have been talking about and so far to deaf ears many times. But the incentive is to push everything downstream, take the higher acute and push it down as low as you can.

Now, it doesn't take a Rhodes scholar to figure out that at some point you're going to be delivering care beyond your license, and this is a program administered by HFS, and if you're operating beyond your license, now you're coming under the jurisdiction of IDPH, and where are they going to end up on this thing? If you abuse

a resident or endanger a resident in any way, there's no question which way IDPH is going to go.

So if you're negotiating contracts, you need to be aware of the fact that that's the incentive that could also trap you into huge fines later down the road. That's where you need to talk to your attorneys and figure out how to get the best deal for that.

The plan is not going to take responsibility for that. They're going to say, "You accepted the patient. You knew what you're doing. If you get in dutch with IDPH, tough taco." I know there's no way to do it as an individual.

CHAIRMAN WAXMAN: Are there carve-outs with these rates? Are the pharmaceuticals part of the daily rate?

MR. SHEETS: The pharmaceuticals have their own issues with managed care from what I understand.

MEMBER SCAVOTTO: I don't know the answer to that. I would say based on my experience no.

MR. SHEETS: They can have different pharmacists now.

MEMBER SCAVOTTO: On the acute side we were able to get some carve-outs but very, very specific. You can do some carve-outs for meds and supplies like an implant. You can get the cost of the implant, and then you could get your rate, but you had to show them the cost of the implant was within their limits.

The carve-out option would be like if you had a specialty service, like if you were a great -- like if you were a skilled facility and you had an niche in renal or if you had a special dementia program. So you could get a carve-out like that, and that can be a very effective way to deal with it, and that takes you away from the necessity to partner up with the thundering herd and still get by as a single provider. It's hard.

CHAIRMAN WAXMAN: Not a very pretty picture.

MEMBER SCAVOTTO: What.

CHAIRMAN WAXMAN: Not a pretty picture.

MEMBER SCAVOTTO: Well, you asked.

Listen, it wasn't a pretty picture. It's -- California is a very difficult market, and if you

go to any of the major markets and talk to the hospitals about this, they'll say it's a struggle. "There's one price that we know we have to pay, and we're willing to pay that price. And because there's so many providers in the marketplace, we know that we can pay this price and get good quality. If you can't give it to us at that price, we'll go somewhere else." It is that simple.

MR. SHEETS: Mike, did they ever document savings in California from doing this?

MEMBER SCAVOTTO: No. But I can give you some anecdotes. I think in terms of public policy managed care is the only thing that ever slowed the increase in health premiums. The only thing that ever worked, and it was the capitated model that did it.

The other thing that happened -- talk about savings -- when I started in California in '82, there were a bunch of not-for-profit health care plans, Blue Cross being one, Kaiser being another. There were several. When I left, the only one that was not for profit was Kaiser. Everyone else had gone private just because there

was so much money in it. You're talking about managed care executives were making millions in stock and bonus payments, millions. It didn't help the cause in any way.

Did it save money? No. But it made money on the private side, but it was the only thing that worked to slow down the premiums. Then the capitated model fell out of favor.

The more you open up your network to individual choice, the less controlled you're going to have of your costs and your utilization, and that means your premiums are going to go up, and they're very sensitive to that.

It's very interesting now in Illinois because we don't know what the plans are going to get paid. They don't know what they're going to get paid, and they're still at the table.

CHAIRMAN WAXMAN: Any other questions for Michael?

MS. BURMAN: Were there any studies or analyses on the effect on quality of care?

MEMBER SCAVOTTO: We had statistics on quality. We weren't as strong on quality then as we are now. So no. I would say in my

experience what you wanted on quality was a reputation in your own community for being good.

What the plan didn't want was patients going to them with complaints, and they didn't want the physicians coming to them with complaints. More than anything else they wanted to satisfy the enrollees, the beneficiaries, and the patients, and the physicians. They could care less about the institutions. They needed them but they wanted the physicians and the patients to be happy. If you did that, you could keep them happy and do surgery on the wrong body part, and as long as they're happy the plan was fine. But, eventually, that would catch up with you.

So from the providers' standpoint, your costs, your revenues and costs are under such tight control that your only avenue of success, it's been my experience, is get it right the first time. So if you had a complicated case, take an extra day and get yourself organized, and even if your length of stay goes up a day, get it right the first time, and if you can't handle a case, give it to someone who can.

It caused us to think through every clinical

process that we did. I'm not kidding, every one. Normal delivery, C-sections, craniotomies, open-heart surgery, everything we did we had to think through every procedure to make sure that we had it right, and then we'd do it again. If you didn't get it right the first time, you were going to blow it, and then that's when you got complaints. But today they're much better at measuring out comps than we were then.

CHAIRMAN WAXMAN: Any other questions for Michael?

(No response.)

CHAIRMAN WAXMAN: Thank you very much.

MEMBER SCAVOTTO: Teach you to ask me again.

MR. URSO: Part two next meeting.

CHAIRMAN WAXMAN: Other business?

MEMBER CREDILLE: Did we set a date for our next meeting?

CHAIRMAN WAXMAN: Yes.

MS. AVERY: We did?

CHAIRMAN WAXMAN: I thought you said can we? And the answer is yes, we can. Yes, we will, absolutely. And I think we agreed we were

going to go to January so we avoid all the holidays.

MS. AVERY: With the understanding that the RFP committee will meet before that?

CHAIRMAN WAXMAN: Yes.

MS. AVERY: Frank, do you know our board meeting dates?

MR. URSO: I don't know beyond January. I know December.

MS. AVERY: Will it be the second --

MR. URSO: September 24th, November 5th, and December 17th is the scheduled meeting.

CHAIRMAN WAXMAN: So do you have a January calendar?

MR. URSO: Probably.

MS. AVERY: The second Tuesday is the 14th.

CHAIRMAN WAXMAN: It looks like that is a tentative date. Does anyone have any problem with January 14th of 2014?

(No response.)

MS. AVERY: Same location?

MEMBER RAIKES: Yes. Sounds good

to me.

CHAIRMAN WAXMAN: Any other business?

MS. AVERY: Can someone -- before we sign contracts or confirm this space, can someone check with the other associations to see if there's any meetings or anything because I think that's one of the issues we ran into today.

MEMBER AMIANO: Any what?

MS. AVERY: Any meetings scheduled with the other associations because that was one of the issues today, that there was something set up either here or in Boston or something.

MEMBER AMIANO: The one in Boston, though, it's just a handful of people that go to that. It's not a major association meeting.

CHAIRMAN WAXMAN: We talked about Phyllis' resignation. We have asked Phyllis to make a recommendation from her group because I think that group has information to share.

We did ask John to consider submitting a letter to become a member of the group, a full member since he's been coming pretty regularly, and we have lost an owner, so to speak in that Eli is not here with us anymore. So we again

need a couple of members if anyone has any ideas.

MEMBER AMIANO: Can you send an updated list of who is actually on or actually members versus guests?

MS. AVERY: I'll send a link to the Web site.

MEMBER AMIANO: That'd would be great. Thanks.

CHAIRMAN WAXMAN: Just as a point of information, Courtney and I are having lunch with Judy Olson --

MS. AVERY: Kathy Olson.

CHAIRMAN WAXMAN: I haven't met her, obviously. And she is now the chair of the mother board. So we'll see what she's thinking in terms of any changes or if she's happy with what's going on or if she needs to -- invite her to one of our meetings, maybe the one in December or November.

MS. AVERY: January.

CHAIRMAN WAXMAN: Any other issues for us?

Just for a serious moment because I don't have many, I thought today's discussion was

excellent. I thought the last two meetings that we've had have been very, very good and very productive. So thank you all for being here.

I think having that group is going to be beneficial. There certainly is a lot of unknown on the horizon and interesting to see how it shakes out. And, obviously, it will have impact on us.

Chuck, thank you for coming. And I need a motion to adjourn.

MEMBER AMIANO: So moved.

MEMBER RAIKES: Second.

CHAIRMAN WAXMAN: In all favor?

(The ayes were thereupon heard.)

CHAIRMAN WAXMAN: Thank you all. Drive carefully.

(Which were all the proceedings had in the above-entitled matter at the hour of 2:02 p.m.)

STATE OF ILLINOIS)
) SS.
COUNTY OF K A N E)

I, Paula M. Quetsch, Certified Shorthand Reporter No. 084-003733, CSR, RPR, and a Notary Public in and for the County of Kane, State of Illinois, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct, and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my Notarial Seal this 26th day of September, 2013.

Certified Shorthand Reporter
Registered Professional Reporter

My commission expires
October 16, 2013