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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
217-782-3516

LONG-TERM CARE ADVISORY SUBCOMMITTEE
MEETING

The meeting of the State of Illinois Health Facilities and Services Review Board, Long-Term Care Advisory Subcommittee was held on April 11, 2011, scheduled to begin at the hour of 10:00 a.m., at the Holiday Inn, 411 South Larkin Avenue, Joliet, Illinois.

Reported by:
Karen K. Keim
CRR, RPR, CSR-IL, CRR-MO
Midwest Litigation Services
401 N. Michigan Avenue
Chicago, IL 60611

1 PRESENT:
Michael Waxman - Chairman
2
Eli Pick - Vice-Chair
3
Laurinda Dodgen
4
Carolyn Handler
5
Greg Will (for Dave Lowitzki)
6
Sherry Gutermuth (for Timothy Phillippe)
7
Stephanie Altman (via telephone)
8
Kelly Cunningham
9
Teri Dederer
10
Patricia Odea Evans
11
Clint Taylor
12
Michael Bibo
13
14 ALSO PRESENT:
Frank Urso - HFSRB Legal Counsel
15
Michael Constantino - HFSRB Staff
16
Bill Dart - HFSRB Staff
17
Claire Berman - HFSRB Staff (via telephone)
18
Charles Foley
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Terry Sullivan
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Jason Speaks
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AGENDA

CALL TO ORDER

1. Roll Call
2. Approval of Agenda
3. Approval of March 4, 2011 Minutes
4. Discussion by Chairman and Vice Chairman of Meeting with Health Facilities and Services Review Board
5. Status of Rule Making
6. Discussion of Next Steps
7. Unfinished Business
8. Comparison of Other States CON Programs regarding Long Term Care
9. Meeting Schedule
10. Adjournment

1 START TIME: 10:30 a.m.

2

3 CHAIRMAN WAXMAN: What I thought we'd do is
4 start at 10:30 -- which it's now 10:30 -- understanding
5 that we cannot vote on anything, but at least we can get
6 through some of the agenda items that are information
7 purposes and share information and do those kinds of things
8 that don't require votes. So, let me welcome everybody,
9 and can we do roll call so we do know who is here? I'll do
10 it. If we can start over there and identify yourself for
11 the record, please.

12 MS. GUTERMUTH: Sherry Gutermuth, Christian
13 Homes, sitting in for Dr. Phillippe.

14 MS. DEDERER: Teri Dederer.

15 MR. TAYLOR: Clint Taylor with the Laborers.

16 MR. URSO: Frank Urso.

17 MR. WAXMAN: Mike Waxman.

18 MR. PICK: Eli Pick.

19 MR. CONSTANTINO: Mike Constantino.

20 MR. DART: Bill Dart.

21 MS. EVANS: Patricia Odea Evans with Silver
22 Connections and Provena.

23 MS. CUNNINGHAM: Kelly Cunningham, Healthcare
24 and Family Services.

1 MS. DODGEN: Laurinda Dodgen, AARP.

2 MR. WILL: Greg Will, proxy for Dave Lowitzki,
3 SEIU.

4 MR. CONSTANTINO: Those on the phone?

5 MS. BERMAN: Claire Berman.

6 MS. ALTMAN: Stephanie Altman.

7 CHAIRMAN WAXMAN: Very good. The three
8 gentlemen in the back?

9 MR. FOLEY: Charles Foley.

10 Jason Speaks with LSN.

11 MR. SULLIVAN: And Terry Sullivan.

12 CHAIRMAN WAXMAN: Good. We also have Mike --
13 Mike, identify yourself, please.

14 MR. BIBO: Mike Bibo, representing Illinois
15 Healthcare Association.

16 CHAIRMAN WAXMAN: Thank you. We can't approve
17 the agenda. I do want to make the announcement that we had
18 a person resign as of about an hour ago. Jo Patton from
19 AFSCME resigned, so we will figure out what the procedure
20 is to get a replacement on the committee for that.

21 MR. SULLIVAN: Could I be AFSCME's
22 replacement?

23 (Laughter)

24 CHAIRMAN WAXMAN: No. I'm not even in charge,

1 and I know the answer to that question. Good try, Terry.

2 We will take that back to Chairman Galassie and see how he
3 wants to handle it. I will put your name out for him, to
4 let him know that you did volunteer.

5 MR. SULLIVAN: Okay. Thank you.

6 CHAIRMAN WAXMAN: The other issue is we are
7 missing Courtney, who had a death in her family. So, do we
8 know -- an uncle. So, she headed back to Detroit, so she
9 is not able to be here.

10 Okay. Last week, Tuesday, Eli and I made an
11 appearance before the Mother Board, and we did a
12 presentation of where we are at, what we've accomplished
13 and a list of things that we still have to do. I think if
14 I walked away with two impressions, it was -- three
15 impressions, it was our work is -- has been and was very
16 well received, an acknowledgement that we've accomplished a
17 lot. I think there was maybe a little bit of a lack of
18 understanding of how much more we have put on our list to
19 do. I think that we've identified the fact that we clearly
20 are taking the issue of nursing homes are very different
21 than hospitals and that we want to clean up as much of the
22 current processes and applications so that going forward,
23 there is that distinction, as well as looking at the
24 current bed-need formula and some other concepts. So, I

1 think it certainly was a little bit, to a few members --
2 that we have that much more work to do and that we will be
3 doing this for a little bit longer than maybe they
4 anticipated. I said 12/19. They didn't quite like that
5 year, but I thought it was a good estimate. Frank then
6 pointed out that the legislation is only good through
7 12/15?

8 MR. URSO: 2015. This has been designated as
9 a permanent --

10 CHAIRMAN WAXMAN: Right, so we're fine. We
11 said it last time. We met our first deadline. As most of
12 you know, I do have a sick sense of humor so --

13 MS. DEDERER: Are we a permanent --

14 CHAIRMAN WAXMAN: Yes.

15 MS. DEDERER: Why would they have been
16 confused?

17 CHAIRMAN WAXMAN: That there was that much
18 work left. They didn't envision that many topics that we
19 have identified.

20 MS. DEDERER: What did they think we would do
21 as a permanent --

22 CHAIRMAN WAXMAN: The second half of what has
23 been identified, which is to make sure that we keep the
24 rules and policies in compliance with current conditions in

1 the marketplace. That's the second phase. That's the
2 second piece of what the Act talks about, is to make sure
3 that we keep things as practiced in the marketplace, that
4 the rules and regs follow that.

5 The other thing, the one question that got
6 raised when we started talking about the buying and selling
7 of existing beds, a gentleman, Dave, raised the issue of
8 where was the public's interest in that. So that caused
9 some discussion, of which Eli did an incredible job,
10 excellent job, as usual, explaining that not only, as Dave
11 pointed out, that it was obvious the benefits to owners and
12 operators of nursing homes of being able to buy and sell,
13 but Eli was very good at pointing out where the public
14 interest lies in being able to move beds from not being
15 used to used in areas that seemed to be a good place to put
16 them. So, I think that topic may come back again, but I
17 think when relayed the understanding of why we're looking
18 at that whole issue.

19 Any questions about -- Frank, did I leave
20 anything out?

21 MR. URSO: No. I think you did a good job.

22 CHAIRMAN WAXMAN: Eli?

23 MR. PICK: You did a good job. As much as I
24 resist wanting to add to it, you did a good job.

1 CHAIRMAN WAXMAN: That's why I invite you.
2 Okay. Let's see. What else can we do that won't get us in
3 trouble? We have decided, as everyone has asked and
4 certainly we all agree, that we are going to develop a
5 meeting schedule. I hope all of you remember that the
6 meeting schedule was kind of impromptu, based upon the time
7 that we needed to get things done to meet the requirement.
8 That is now out of the way and, therefore, we can establish
9 a routine commitment of -- and I'm looking -- I'm thinking
10 monthly meetings, and we'll certainly send the schedule out
11 so that everyone is well aware of future meetings and can
12 plan accordingly. Now, there was a date, there was a
13 schedule that was published -- and thank you, Frank -- that
14 talked about some dates in July, September, November, but,
15 again, I think we may -- I think we should be meeting on a
16 monthly meeting. Does anyone have an opinion about that?

17 MS. ALTMAN: This is Stephanie. I just may
18 have to rethink our commitment, if it's a monthly,
19 in-person meeting. I thought that it would probably be
20 quarterly when we started. So, it seems pretty frequent.
21 Even like the Governor's Task Force Commission On Aging
22 only meets something quarterly. A lot of us are on so many
23 commissions and committees. I think meeting monthly is a
24 lot.

1 CHAIRMAN WAXMAN: Stephanie, would you be more
2 comfortable if it was every other month rather than
3 quarterly?

4 MS. ALTMAN: I guess I would have to consider
5 it, depending on what other people think. I think the
6 needs of the group are way more important than whether I
7 can handle it in my schedule, so I'd rather see what
8 everyone else thinks.

9 MS. EVANS: My concern is that, you know, when
10 we're trying to meet face-to-face -- and Illinois is a big
11 state. We have people coming from a lot of areas, and if
12 we could figure out a way to do some video conferencing, I
13 think that could be efficient. You know, every other month
14 is a lot. Do you think we can handle the business every
15 other month? I don't know.

16 CHAIRMAN WAXMAN: Other people, other thoughts
17 on the subject.

18 Chuck?

19 MR. FOLEY: I think given the work load that
20 is before this subcommittee, the important issues that are
21 before you, issues such as the bed-need methodology, issues
22 such as the elimination of Planning Areas, as what was
23 talked about previously, the writing of the entire rules, I
24 think there's a lot out there that needs to be done, and in

1 order to get it done efficiently, at least I think from an
2 outsider, that this committee should look at at least
3 meeting every month. Maybe after a lot of those issues
4 have been resolved, then it can revert back to a quarterly
5 basis.

6 MS. DEDERER: I would second the notion about
7 doing video conferencing. Maybe we can establish regular
8 locations in the state to video conference. We also talked
9 about forming subcommittees, and we have very much become a
10 working committee, and I don't know if we need to
11 necessarily have the whole committee meet every month or --
12 I don't know. I'm just throwing out some ideas. Because
13 as Stephanie said, I don't know that they really were
14 signing up to be a really grass -- not grass roots but, you
15 know, working committee. Advisory is a little different
16 than creating.

17 CHAIRMAN WAXMAN: Mike, maybe we can send a
18 survey out to the committee, asking them whether -- whether
19 they're in favor of a monthly, every other month, or
20 quarterly meeting and whether or not they're in favor of
21 teleconferencing or face-to-face, and we'll see what we get
22 back, and maybe in that same survey see if we can get an
23 agreement on a day of the week to meet.

24 MR. PICK: I echo what Teri is saying. I

1 think work groups would probably be another option we can
2 ask about in the survey. Rather than the entire group
3 working on everything together, we consider through the
4 survey whether people would be willing to be part of work
5 groups to address providing input on issues.

6 MS. DEDERER: And develop some issues to
7 present to the whole group. The other thing is, on the
8 survey you need to ask people are they willing to have
9 monthly meetings; if we have video conferencing, are they
10 willing to have monthly meetings; if we have
11 teleconferencing, are they willing to have monthly
12 meetings; if it's in person -- because I think you're going
13 to get totally different answers and, really, given the
14 State's abilities for video conferencing, that's much
15 nicer -- as Mike pointed out before the meeting, on these
16 speaker phones, the people on the phone can get caught off
17 if we're rustling papers, and we won't know it. If one
18 speaks -- on the video conferencing, everybody can speak at
19 once. Not that necessarily that's a good thing, but I
20 remember previous conference calls, people were trying to
21 say something and we couldn't --

22 MS. EVANS: I'd like to suggest, though, that
23 it's hard to envision our work. We don't really have --
24 like, if we could have something put together as far as a

1 grid of what types of projects we still need to resolve.
2 This is an outline, this isn't really -- it doesn't have
3 time frames attached to it. I don't know if that's what we
4 want to establish today, so we kind of know what all has to
5 be accomplished.

6 MS. DEDERER: Do you really want to put a time
7 frame on something, given how much difficulty and how much
8 we had to give up to get those rules in? I think the
9 reason this list is so long is we couldn't agree on the
10 stuff that's in the rules by the deadline.

11 MS. EVANS: For us to envision how much time
12 it's going to take, if we need to meet monthly or -- we
13 need to have some idea, yes, I would think. Otherwise we
14 are just basing it on our own personal needs instead of the
15 needs of the group.

16 MR. BIBO: Except if we met monthly, we can
17 get it done and then we don't need to meet -- once we get
18 it all done, if we don't need to meet but every other month
19 or once a quarter, once we get it all done, we're not faced
20 with the problem we have at this time of getting it all in.

21 CHAIRMAN WAXMAN: We have -- Carolyn has
22 arrived. Therefore, our quorum is in place, established.
23 So thank you. Do you want to identify yourself for the
24 record?

1 MS. HANDLER: Carolyn Handler.

2 MR. PICK: We very much appreciate your
3 efforts, Carolyn, to get here.

4 MS. DEDERER: Seriously.

5 CHAIRMAN WAXMAN: We'll bring you up to date
6 in two seconds, but we need to go back and do some stuff
7 here.

8 I need a motion to approve the agenda.

9 MR. PICK: So moved.

10 CHAIRMAN WAXMAN: Second?

11 MS. EVANS: Second.

12 CHAIRMAN WAXMAN: All in favor?

13 (Ayes were heard)

14 CHAIRMAN WAXMAN: Any opposed?

15 (No response)

16 CHAIRMAN WAXMAN: Okay. The agenda is
17 approved. Need approval of the March 4th minutes.

18 MR. PICK: So moved.

19 CHAIRMAN WAXMAN: Need a second.

20 MS. DEDERER: I'll second.

21 MR. URSO: I have one correction.

22 CHAIRMAN WAXMAN: A correction to the minutes?

23 MR. URSO: Yes. On page 9, line 10 of the
24 minutes, it says "also a state resource consumer". It

1 should say "also a state resources concern". "Concern"
2 should be the word, not "consumer".

3 CHAIRMAN WAXMAN: Thank you. Any other
4 corrections from the committee?

5 (No response)

6 THE COURT: Okay. All in favor?

7 (Ayes were heard)

8 CHAIRMAN WAXMAN: Any opposed?

9 (No response)

10 THE COURT: Okay. Thank you.

11 We were having a discussion about frequency
12 and -- of future meetings and publishing a calendar to
13 ensure that the people are aware. Where we left off is
14 we're sending out a survey to ask if people would prefer
15 monthly meetings, bimonthly meetings, quarterly meetings,
16 and whether they want to look at teleconferencing or
17 face-to-face and whether or not they would want to do work
18 groups as opposed to full board. So, Michael will get that
19 out.

20 We also announced that we did have one person
21 resign from our committee. Jo Patton from AFSCME resigned,
22 so we will let the Chair of the Mother Board know so that
23 the replacement can be picked.

24 Outside of that, you're up-to-date, other than

1 Eli and I gave a report of our presentation, which was
2 phenomenal at the --

3 (Laughter)

4 CHAIRMAN WAXMAN: Sorry. We can go back to --
5 if we go back to our agenda then, Status of Rule Making,
6 and who is speaking to that?

7 MR. URSO: Claire.

8 CHAIRMAN WAXMAN: Claire, we are going to talk
9 about Status of Rule Making.

10 MS. BERMAN: All right. Well, hopefully all
11 the paperwork that's required for the Illinois Register
12 will be filed today, and they do a very thorough review of
13 all of the paperwork and make sure the formatting is up to
14 their specs, that type of thing. I expect that it will be
15 published on the 22nd, which is a Friday. If for some
16 reason something needs to be corrected, then it would be
17 published the following Friday, which is the 29th of April.
18 The public hearing will be conducted on May 18th, and the
19 notice of the public hearing will be published in the
20 Illinois Register, together with the Rules. So that serves
21 as the notification of the public hearing. The site that
22 was selected was Municipal Building in Oak Forest, and the
23 address will be posted with all of the other information.
24 So that's the status as far as I know right now. I did

1 check early this morning and I've not heard back, so
2 hopefully it will be published ten days from today.

3 MS. DEDERER: And who is required to go to the
4 hearing, just Public Health staff, to answer questions?

5 MS. BERMAN: The public hearing is an
6 opportunity for anyone with interest in the Rules to share
7 their thoughts, pro or con or whatever. Staff will be
8 there to have people sign in and have some semblance of
9 order in terms of who speaks first, that type of thing, but
10 it is not meant to be a question and answer period.

11 MS. EVANS: So who is required to attend?

12 MR. URSO: We'll have a hearing officer there,
13 and there might be other people from the Department. We'll
14 staff the public hearing. Anybody from this committee or
15 the audience, of course, can attend. It's a public, open
16 meeting.

17 MR. PICK: But it's not required for the
18 committee members.

19 MR. URSO: It's not required for committee
20 members to be there, but they can if they want to.

21 CHAIRMAN WAXMAN: Any other questions for
22 Claire?

23 (Pause)

24 CHAIRMAN WAXMAN: Thank you, Claire.

1 MS. BERMAN: You're welcome.

2 MR. PICK: We already talked about next steps,
3 didn't we?

4 CHAIRMAN WAXMAN: Yeah, who is leading next
5 steps.

6 MR. URSO: I'll start and --

7 CHAIRMAN WAXMAN: Was that Courtney's?

8 MR. URSO: Yes, but I'll start. This, I
9 think, references this landscape document that everybody
10 has, and you'll recall that some months ago -- seems like a
11 couple years ago -- that you broke out into small groups
12 and came up with your various priorities. Those priorities
13 were then summarized and put on this document. Then, Bill,
14 do you want to just say how we got to this document then.

15 MR. DART: Sure. This was -- we took the
16 feedback that we had that we put on the board from the
17 small group sessions, and evaluated where they would fall
18 as far as, you know, the need to address them earlier in
19 the group's deliberations. So those are the high-ranking
20 ones. So, based on the meetings that we had and the
21 discussions as part of those meetings, this is how we kind
22 of ranked the issues in order of importance, to help lead
23 the group into probable areas that we would want to forge
24 into next. So, I think right at the top of the list we

1 have some of the big ones that would certainly be, you
2 know, major undertakings. Modifying the bed-need formula
3 and incorporating programmatic aspects of care, these are
4 really the key reasons this group consists, and I look
5 forward to addressing how we're going to come up with a
6 work plan to meet these needs.

7 CHAIRMAN WAXMAN: Mike, anything you want to
8 add?

9 MR. CONSTANTINO: No, Mike.

10 CHAIRMAN WAXMAN: Sorry, I didn't mean to
11 catch you off guard.

12 MR. CONSTANTINO: That's all right. I didn't
13 realize I was supposed to prepare something for that.

14 CHAIRMAN WAXMAN: No, no, no, I didn't mean it
15 like that.

16 Therefore, I guess at this point this group
17 can look at this list and see if our opinion of rank has
18 changed or if this is the rank we wish, to address the
19 issues we put into the list of things we want to
20 accomplish.

21 MR. WILL: I had one thing that I kind of
22 wanted to put on the table, because I was wondering about
23 this, and this is -- without getting at the issue of
24 whether they're rank has changed, whether we feel that one

1 of these issues is more important or something. But it
2 does seem like some of these, when we contemplate them,
3 where we come down on one of them is contingent on another.
4 I mean, just to give a couple of examples. For example,
5 the issue of variances, how we feel about variances would
6 depend, for example, on the bed-need formula, just to take
7 what was in the proposal of what the groups put out there.
8 The variances would be quite important, because there
9 wouldn't be a bed-need formula that would establish bed
10 need, so there would be a lot more coming, I would assume,
11 to the full Board through the variance process.

12 The other one, the bed-need formula itself,
13 where we come down on that could depend on the question of
14 different programs of care and specialized services. That
15 is -- you know, a bed need that tried to encompass all of
16 those might look different than if we had a discussion
17 about breaking some of those out, you know, without going
18 into what -- even guessing at what those might be. So, I
19 just suggest that. Even if this is the rank order of how
20 important we feel they are, there may be things where we
21 want to logically think through which ones are contingent
22 on which others.

23 MS. DEDERER: I think that's a brilliant
24 observation, and it's true view. There's a lot of things

1 that other states use as part of their Certificate of Need
2 process that we want to talk about, so they kind of need to
3 be done before the first one.

4 CHAIRMAN WAXMAN: Any other thoughts before
5 we --

6 MS. EVANS: I just have a question about how
7 exactly the ranking was determined.

8 MR. DART: It's been some time since we did
9 this. I think that it was -- we had conversations
10 following a few of the meetings, particularly after the
11 small group discussions, and we came up with this list, and
12 it was really kind of trying to determine which things will
13 drive the planning process, which ones need to be addressed
14 first versus which ones can kind of -- we can wait, there
15 could be some time before those were addressed.

16 MS. DEDERER: But wasn't it really how much
17 importance we put on it rather than putting in order of how
18 we would do it?

19 MR. DART: It was all of the discussions that
20 we had at the meeting. So, forgive me, Teri, it's been a
21 few months now, so it's hard for me to recollect what was
22 in our minds.

23 MR. URSO: Can I help you?

24 MR. DART: Yes, please do.

1 MR. URSO: We took notes and I think we
2 also -- if any of the groups had notes, we compiled those
3 notes, too, and then we waited for the transcript, because
4 you recall, after the small groups met there was a
5 discussion in the open session. And so we took a look at
6 the transcripts and we took a look at our notes and any
7 notes that anybody provided to us, and we had an internal
8 discussion among Staff, saying, okay, let's see if we can
9 flesh out exactly what the major issues are, and then we
10 decided maybe the simplest way -- and it was just a
11 proposal -- let's rank them from one to five. That's why
12 you see the roman numerals here, one being the most
13 important, five being the least important, based upon our
14 review of the minutes and the notes we took.

15 So, this is just a proposal that Staff put
16 together to try to narrow the issues and focus the issues
17 whereby the group can then decide where they want to go
18 first, and the gentleman over there in the corner made a
19 real good observation, that some of these might be coupled
20 together. So, in addition to doing that, we also tried --
21 and Claire put together the documents that she sent
22 everybody as to what other states are doing, too, to add
23 more data to the discussion.

24 So, does that answer the question?

1 CHAIRMAN WAXMAN: My impression was that it
2 was kind of based on our group work and the number of times
3 an item appeared in each group's presentation. So,
4 therefore, if all four groups raised that issue, then it
5 became probably number one. If one group raised it as
6 opposed to all four, it probably got a lower rank. That's
7 how I think it was put together.

8 MR. URSO: That's correct.

9 CHAIRMAN WAXMAN: And, again, I think your
10 point is well taken that some of these things are probably
11 contingent upon others, and I think as we go through the
12 list, we probably need to look at that and see if we can
13 tie some of these together and regroup them.

14 Are you suggesting that before we pick out of
15 this list, we let Claire do her presentation on --

16 MR. URSO: Sure.

17 CHAIRMAN WAXMAN: Does that meet with
18 everybody's -- so, before we pick how we want to start
19 working on these things, let's look at everything that
20 Claire has done.

21 And, Claire, thank you for an amazing amount
22 of work, to put these two documents together. But would
23 you like to walk us through them?

24 MS. BERMAN: Sure, I can try to do that.

1 The first one, the one that gives an overview
2 of the different kinds of long-term care services that each
3 state reviews, I started that back after I received the
4 draft rules from the Associations. The question came up,
5 you know, about what other states may or may not be doing
6 currently, and it's something that we had looked at for
7 quite a while as Staff, because we have other priorities as
8 well. And so I started looking, just because I knew,
9 actually, we should look at what other states are doing,
10 and I originally thought that I would do just a couple of
11 the larger states, and then in terms of looking into it, it
12 seemed to kind of take on a life of its own, and I ended up
13 trying to find as much information about as many
14 Certificate of Need states as I could find.

15 The other thing is, as a preface to all of
16 this, each state, of course, has its own unique way of
17 packaging their requirements. Some have a lot of their
18 requirements in the statute, straight from the statute.
19 Other ones have a couple of sentences giving them authority
20 for different things, but then most of it is in rules and
21 in separate packages of standards. So, it was a very
22 time-heavy project, and I think in some cases there are
23 areas that I did highlight as I want to go back to and try
24 to find more information, but this -- I would ask you to

1 please consider this as a starting point, just to give a
2 general idea of, number one, the type of reviewable
3 Certificate of Need services they have and then the
4 different actions that they would be looking at, which is
5 establishing a new service or a new facility, expanding an
6 existing one, modernization, those types of things, and
7 then I tried to look at what types of review criteria they
8 used for each type of project. And rather than copy all of
9 their rules for you, which I don't think anyone would want
10 to read through, I tried to put it in an outline form, as
11 you see. That was my basic approach to this, so you had an
12 overview of what kind of effort each state puts in to the
13 different kinds of projects.

14 Michigan -- I started with Michigan, because
15 they, I believe, revised all of their rules and standards
16 just a few years ago, and I thought that would be a good
17 one to start with in case they came up with something that
18 was hopefully remarkable, and as you can see on the one
19 document -- and this is -- I don't really have a header on
20 this group, but I think you can identify it by the bullet
21 points. It says "Draft", January 4th of this year. That's
22 the document I'm looking at.

23 Wherever they had standards printed, I tried
24 to put those in there as well, and those were the hard

1 things to locate. So, this was just a starting point. But
2 the interesting thing is all of the Certificate of Need
3 states -- and there are 37 plus Washington, DC -- every one
4 reviews long-term care. There are any number of states
5 that no longer review hospital projects. I thought that
6 was an interesting thing as well.

7 I think when we go to the next document, you
8 can see what kind of a bed-need methodology that Michigan
9 uses and everyone else, because that was the focus of the
10 other documents. So -- and, obviously, if one or more of
11 these states have sections that you're very interested in
12 and you would find to be more helpful than others, then
13 further research, of course, is always possible, as long as
14 you're not in a hurry and want it a week from the day that
15 you think about it, because it is time consuming, and I'd
16 like to -- whatever I put together for you, I would like
17 for it to be organized and clear so that it's a useful tool
18 to you in making your decisions.

19 I don't know if any of you had a chance to
20 scan any of this material, and I'd be happy to answer any
21 questions about the overview document, but that was the
22 intent of it, is to give you a rough idea of what other
23 states are looking at and the kinds of review criteria they
24 have in place when they examine all of these different

1 kinds of projects. As you can see if you just scroll
2 through it, there are some states that review everything
3 they can think of that falls under long-term care; they're
4 very, very thorough. There are a number of them that have
5 moratoriums, and very often the review criteria tend to be
6 very similar. I think the difference is in, perhaps, the
7 intensity of what they look at and also the number of
8 criteria. Their occupancy, where I could find it in my
9 search, I tried to put that in there, but really, that's
10 probably better defined in the bed-need methodology,
11 because most of them do include that as part of their
12 assessment.

13 If you look at -- I'm just scrolling through
14 myself. I'm looking at Iowa. Iowa has standards for
15 quality and for accessibility and acceptability and
16 standards for costs and financial feasibility and they have
17 a variety of different formulas for types of services. And
18 I apologize. This being the first document that I put
19 together, it is not in alphabetical order, and I know it
20 would be better and easier to find things if it was, but,
21 you know, I approached the second document, hopefully, a
22 little bit smarter, and that is in alpha order and,
23 hopefully, will be easier for you to find things.

24 But I was wondering, at this point are there

1 any questions about this first overview?

2 CHAIRMAN WAXMAN: Mike?

3 MR. BIBO: Claire, this is Mike Bibo. One of
4 the things I'd be interested in looking -- and I'll admit,
5 I have not had a chance to read this thoroughly, your
6 document, and I appreciate you going through the effort of
7 putting it together. It's very well done. I just haven't
8 had a chance to read it.

9 MS. BERMAN: Sure, sure.

10 MR. BIBO: But a lot of states that I deal
11 with -- and I deal with three other states besides
12 Illinois -- there's a clear line between a Certificate of
13 Need and determining that there is a need out there and
14 getting into a lot more issues that are more typically
15 considered licensing issues and backgrounds of applicants
16 and all of that. Does your document get into that, the
17 distinction between whether there's a need versus the
18 licensure, you know, getting into the background of the
19 applicant and that kind of stuff?

20 MS. BERMAN: Well, in one way or another, they
21 do all address need.

22 MR. BIBO: Illinois gets a little bit -- my
23 experience has been -- we get very much, down the road,
24 involved into the background of the applicants versus the

1 need, and I'm not saying that's right or wrong. I don't
2 know that that's right or wrong. I have opinions as to
3 whether that's necessary. But other states just get less
4 involved into that, at least my experience with other
5 states, and so I'd be interested in taking a look at that,
6 as to what scope do we need to be looking at when we're
7 talking about the background of applicants.

8 MS. BERMAN: Yes, that's a very important
9 issue, and it is in our Act as one of the things that we do
10 try to assess.

11 MR. BIBO: One of the other things, just so
12 you have -- I did see there's a few in here that do it.
13 Iowa does it. But out of the 37 states that you said have
14 a Certificate of Need process, how many of them include as
15 part of their own review of that process the MR/DD
16 Community?

17 MS. BERMAN: That I didn't assess.

18 MR. BIBO: I saw a few states did.

19 MS. BERMAN: Some of them do.

20 MR. BIBO: Iowa does, and there are a few
21 states that do, but as we move forward to see what the
22 scope of this is, currently, yes, the Act calls for the
23 Health Facilities Planning Board -- or whatever it's called
24 now -- to oversee it, but it doesn't necessarily mean it

1 has to be at the same level or the same set of rules that
2 we have for the nursing homes.

3 MS. BERMAN: Oh, it isn't, it isn't, and I
4 believe that the states that do have review of those
5 services, they do have separate review criteria for those,
6 because they are not -- you're right, they're absolutely
7 not the same kind of facility, and when we do get further
8 into this, if you want to pick out different specialized
9 services like that, I'm happy to do any kind of research
10 that may be necessary for that, if that's helpful.

11 MR. BIBO: Thank you very much.

12 MS. BERMAN: You're welcome.

13 CHAIRMAN WAXMAN: Terry?

14 MR. SULLIVAN: Terry Sullivan.

15 Claire, first of all, I am absolutely
16 impressed with the work you did and the research across the
17 nation. I think it's master's level or doctoral level
18 work, and I honestly think that you should publish it or
19 put it out on the internet, because it is the first really
20 good compilation and comparison of all of the states that
21 I've seen, and there's got to be some other policy wonks
22 besides us that get excited about this paper. I read
23 through it over the weekend and I got excited by it. It
24 was an outstanding piece of work, and I know that's because

1 I'm a policy wonk.

2 My brief observation is that there's not a lot
3 new under the sun. It is amazing how similar structures
4 and standards -- each state has its own little tweaking,
5 but they approach things in essentially the same way across
6 the board. Some have some things and others not.

7 In my mind, in terms of our priorities, and
8 looking over the list that we had and seeing what you did,
9 Claire, it still comes down to what kind of nursing homes
10 do we want to see in the future, given the public policy
11 objectives of the State and the realities of the
12 marketplace? And then, do we use bed need as part of that
13 whole process? Is it based on need and/or the public
14 policy objectives? And, obviously, depending on the state,
15 both of those come into play one way or another, and some
16 states are more obvious about it, others try to be
17 mathematical but end up sneaking in stuff anyway that are
18 less than mathematical.

19 But, Claire, this was an exciting piece of
20 work and I think a really good basis from where we're going
21 to go from here.

22 MS. BERMAN: Well, I very much appreciate your
23 comments, and I hope that it will be useful. I hope both
24 of them will be useful. That was the intent, and it was a

1 good learning project for me, because, like I said, I've
2 been involved in CON for a very long time, and the
3 long-term care side does not get as much attention normally
4 as the other pieces. So, this I found a very fruitful
5 endeavor, and I think as you narrow it down, things you
6 want to scope in on, I'm happy to dig further and talk to
7 other professionals, you know, within these other states.

8 I did have an interesting conversation with
9 the folks in Vermont. Vermont I had a terrible time
10 finding information on, because none of it is under the
11 Department of Public Health, and, actually, the review
12 criteria is under "Banking". But I did learn a lot of
13 things. I talked to several people that are associated
14 with all of these kinds of thoughts and issues, and I
15 learned that Vermont has a huge older population. It's an
16 older state population-wise, and it's not very heavily
17 populated, and a lot of their focus is on doing things in a
18 different way, and if I do have the time, I would like to
19 do just an in-depth study on how they handle their
20 long-term care issues and give that to you for your
21 consideration. I think it's -- it is so unique and
22 different that I don't know how much of it Illinois would
23 be able to embrace, but that's for the task force, the
24 Committee, to ponder and decide on. But that is something

1 I would like to be able to do for you, because I was very
2 revved up when I talked to these folks, because they seemed
3 to be very forward thinking, and I think they've had a lot
4 more time to think about it because of the type of
5 population they have.

6 So, that's -- that is how I see me helping you
7 whenever you need it, and I like doing research. I like
8 doing analysis. I like digging, and if you think of things
9 that you think will be helpful, then you just need to let
10 me know that.

11 CHAIRMAN WAXMAN: Frank, do you have a
12 question?

13 MS. EVANS: I do. I just had a comment.
14 First of all, I agree with Terry. I think you really
15 should publish this, because I can see where other
16 states -- it would give them a really great jump start on
17 their project, as it will us.

18 I found it interesting, though, it seems like
19 some of the states also include home health services --

20 MS. BERMAN: Yes.

21 MS. EVANS: -- under this umbrella, and in
22 Louisiana, you are saying that they don't use any bed
23 formula, but I know they have gone to monitoring the number
24 of home healthcare agencies that they're allowing, and, you

1 know, that's another -- that's an area that isn't in our
2 purview, but here they're not regulating the long-term care
3 facilities being developed but they're regulating how many
4 caregiver agencies. So, it is a bunch of apples and
5 oranges in a way, too, on how -- you know, how states are
6 approaching this. Did you -- can you speak at all about
7 Louisiana, when you talked to them?

8 MS. BERMAN: I'm sorry. Could you repeat
9 that?

10 MS. EVANS: Louisiana.

11 MS. BERMAN: They weren't very forthcoming
12 with information, unfortunately, but the woman that I
13 talked to, her delivery was very short, basically "No, we
14 don't, we don't use a formula", and, you know, "We look
15 basically" -- they look at the other components of need
16 assessment and accessibility and the background of the
17 applicant. That's always there. So, I didn't get a lot of
18 information from her, and I had -- I remember that that was
19 one of the states, when I tried to just go on line and look
20 at their web site, it wasn't very fruitful, and I believe
21 that's because I didn't know the right places to look, and
22 she never e-mailed section numbers for me to go to, which
23 many of the others were happy to do so. That fell short.
24 But if you have a special interest in what they do, then I

1 can look for it.

2 MS. EVANS: I just find it interesting because
3 they monitor the number of caregiving agencies that are
4 allowed. They're kind of getting into it at that level.
5 So, I was just wondering about that.

6 MS. HANDLER: I think the reason why they're
7 doing that in Louisiana is because they received a lot of
8 media attention in the late 90's, early 2000's for fraud
9 abuse in the home care business. They had a practice of
10 knocking on seniors' doors and signing them up for home
11 health. So, I think that might be partly in response to
12 that.

13 MR. URSO: I just wanted to say in response to
14 Mr. Bibo's comment that -- and Claire did say that -- that
15 there is a section in the Act that talks about fitness of
16 the applicant, and that's in Section 6, and so you can't
17 really go contrary to what the Act says.

18 MR. BIBO: No, no, but know what the others
19 are doing.

20 MR. URSO: It says, "The applicant is fit,
21 willing, and able to provide a proper standard of
22 healthcare service for the community, with particular
23 regard to the qualification, background and character of
24 the applicant." That's pretty clear in the statute that

1 that's one of the tenets of the Health Facilities and
2 Services Review Board's foundation. And I will say in
3 addition, I have sat in the meetings and other folks from
4 the Board have sat in meetings with the Illinois Department
5 of Public Health staff, and they have a real interest in
6 making sure that the Board, as well as themselves, take a
7 look at the applicant's care and fitness. So, I know
8 that's an important topic.

9 CHAIRMAN WAXMAN: Eli?

10 MR. PICK: Let me also commend you, Claire, on
11 the very comprehensive nature of your work. I also spent
12 some time over the weekend going through the document, and
13 what struck me is not just, you know, some of the
14 commonalities that run across states, but also how they
15 contrast in either a very broad, comprehensive look at the
16 entire long-term care continuum versus those that are
17 really just focused on nursing home beds, and it seems to
18 me that as -- our work needs to start with a conceptual
19 model. Where do we want to be? And if we look at the
20 summary and what's rank ordered, it would speak to a very
21 comprehensive review of what services are available and
22 whether they're adequate in providing access to the public
23 in their times of need. But our actual Rule doesn't do
24 that, that it's really just looking at a formula to

1 determine how many beds are needed in a particular service
2 area. So, that seems to me to be a striking contrast, as a
3 starting point, and that looking at even -- I mean, some of
4 the things that struck me in reviewing the document was
5 traumatic brain injury and ventilators seem to be coming up
6 over and over again as common in some of the states, as
7 being excluded from the bed-need formula because they felt
8 it was so different and that it needed to be treated
9 differently, but, by the same token, in other states that
10 were looking at assisted living and supportive living as
11 part of the assessment in determining adequate services to
12 meet the needs.

13 So, it -- I think from that perspective, it
14 really is all over the board and that as a group, I think
15 we need to start with, where do we want to be? Do we want
16 to be with our focus on how we determine a formula approach
17 to how many beds are available, and also for information
18 purposes, do we want to catalogue how many services other
19 than beds are available, versus do we want to really look
20 at the broad scope of what are the service needs of the --
21 not just the 65 and older but the total population? And
22 how do we integrate licensing, registering and providing a
23 certificate to determine who is able to provide services,
24 what types of services and where?

1 CHAIRMAN WAXMAN: Thank you.

2 Terry?

3 MR. SULLIVAN: In response to Eli -- and,
4 Claire, I'm glad you separated New York out and included
5 their entire rule, which not only do they have authority
6 over long-term care facilities but assisted living and home
7 care agencies and assign different formulas for each one,
8 of what the need for home care services, the need for
9 assisted living, the need for skilled nursing facilities in
10 each Planning Area. And before anyone wants to cut into a
11 comprehensive approach to planning -- unless Mike
12 Constantino will go screaming from the room -- you've got
13 to read the New York section. It is -- I would be afraid
14 that a Tea Party would get a hold of it and show how
15 government over regulation has gone absolutely haywire.
16 New York is daunting, and part of that is almost a
17 combination of this board and what OASAC ultimately wanted
18 to accomplish, which was an inventory of everything we do
19 in the state.

20 But I would be scared immensely that this
21 committee tackle something as comprehensive as that, Eli's
22 comments notwithstanding. It's a good public policy goal
23 but goes far beyond what the capabilities -- unless we want
24 to start meeting daily -- that we are ever going to

1 accomplish.

2 CHAIRMAN WAXMAN: Thank you, Terry.

3 Kelly?

4 MS. CUNNINGHAM: If I could offer something in
5 response to something Terry said and some of the other
6 comments made, one of the things that the State agencies
7 are working on now -- and it's just getting off the ground,
8 but we're required to do it under some State Medicaid
9 reform legislation, as well as there's some federal impetus
10 to this, too -- is to establish a long-term care unified
11 budget for this state, and Governor Quinn's budget,
12 introduced in February, began to identify several of the
13 agency appropriation lines that could be contemplated to
14 become part of a long-term care budget, and those range
15 from long-term care, the nursing facility lines to the
16 supportive living lines to home and community based waiver
17 funding in DHS and Aging, and the State agencies are really
18 charged with kind of tackling through this project and
19 looking at how we go about creating a unified budget. I
20 realize this isn't a capacity necessarily specific exercise
21 as is envisioned in some of these documents, but to look at
22 how the funding flows and how the budget works and what we
23 can put in place to allow for flexibility for funding
24 various segments of the long-term care continuum. So, I

1 just wanted to share that from more of the funding
2 perspective.

3 CHAIRMAN WAXMAN: And the State's time frame
4 for doing it?

5 MS. CUNNINGHAM: It's a short time frame.
6 We're looking at, again, something done within the next
7 year, but it's kicking off now as the budgets begin to go
8 through the appropriations process.

9 CHAIRMAN WAXMAN: Any other comments?

10 MS. EVANS: As it stands right now, assisted
11 living wouldn't have to follow through the CON process at
12 all.

13 CHAIRMAN WAXMAN: Correct. And, again, you
14 know, we have the ability to make recommendations to the
15 Mother Board who can then make recommendations to see if we
16 can turn it into a statute. So, if it's something the
17 Committee feels that needs to be addressed, that's the way
18 we can do it, and I think I stated the first time we met
19 that I think it's hard to look at long-term care globally
20 and not look at the assisted living issue at all. So, I
21 think it has to -- I would recommend that we make that
22 recommendation while we're doing our work, that it needs to
23 fall under somebody's purview who is looking at long-term
24 care beds.

1 MS. EVANS: Right now, you know, even when we
2 look at skilled beds, they're not all the same flavor. You
3 know, you have some that are being used for rehab and some
4 that are being used for long-term residential, and so even
5 having that lumped into one bucket makes it a little not
6 exactly -- I'm not sure what the word is. Not exactly --
7 we're not really looking at the same thing.

8 CHAIRMAN WAXMAN: Eli?

9 MR. PICK: I think we have other options. I
10 believe we should not limit ourselves to thinking that we
11 only have either a bed-need formula or none. There's many
12 points along that continuum, and I don't believe, looking
13 at this, that all of the different services need to be
14 measured and regulated or determined in the same manner.

15 I was struck by not just New York but by
16 Georgia. Georgia has got a bible that they follow. So, I
17 think we've got some intermediate positions that we can
18 take as far as making recommendations on determining how to
19 evaluate, number one, adequate services are available, and
20 how do we develop a system that promotes -- and I think
21 that's the key term -- promotes that services be available
22 and provide the access, as opposed to regulate, and I think
23 from a public policy standpoint, our role should be to
24 evaluate whether the system is promoting the outcome of

1 making services available where they need to be and at the
2 quality and the consistency that our public needs. I think
3 that's a point I want to really underscore, that there
4 isn't either a bed-need formula or open market as the only
5 options, that as a group, our job is to really determine
6 what is the best way to promote -- whether it's
7 community-based care, institutional care, transitional or
8 long-term, what's the best way for us to ensure that,
9 number one, the services that are needed are available,
10 and, as an American institution, that competition drives
11 the quality as opposed to regulation? I think when we get
12 caught up in the notion that we're going to regulate
13 quality to make sure it's there, we turn it into a
14 bureaucratic process that loses its control over what's
15 going on. Ultimately consumers have a choice, will yield
16 the best quality outcome, and I think that's -- as a
17 business man, that's ultimately what I believe, that
18 regulation can make sure that we prevent certain things
19 from occurring; it's competition that ensures that things
20 will occur.

21 CHAIRMAN WAXMAN: Teri?

22 MS. DEDERER: Do you really think that's going
23 on currently?

24 MR. PICK: Competition?

1 MS. DEDERER: No, competition driving quality.

2 MR. PICK: You're asking my personal opinion?

3 MS. DEDERER: Yes.

4 MR. PICK: It's limited by the system. There
5 is some of that activity occurring, but it's really
6 impacted by regulatory limitations.

7 MS. DEDERER: Regulatory?

8 MS. EVANS: The federal government has or CMS
9 has been pushing that there needs to be more transparency.
10 That's part of the Portable Care Act. They're really
11 pushing that -- they believe that the consumer needs more
12 information about what goes on inside so they can make
13 judgments about quality. Right now that information has
14 been very hard for consumers to get and they don't find out
15 until they're actually in a bed, and the transparency is
16 becoming the norm --

17 MR. PICK: Buzz word.

18 MS. EVANS: Yeah, buzz word.

19 MS. DEDERER: It would be nice to make it a
20 reality.

21 CHAIRMAN WAXMAN: If you have never visited
22 medicare.gov web site, where they do talk about nursing
23 homes and the infamous star rating, it's a start of a
24 quality measurement. We can argue if they're measuring the

1 right things and if they can even count what they're
2 measuring, but at least it's a start in that process.

3 MR. PICK: Don't get me started on the
4 five-star.

5 MS. DEDERER: Why.

6 MR. PICK: Why? Okay, you're going to get me
7 started.

8 MS. DEDERER: It's just a silly thing?

9 MR. PICK: No, it's not that it's silly. At
10 its fundamental level, its measurement system is designed
11 around the traditional, chronic long-term care model. So,
12 when you start to measure everybody with a single ruler --
13 this goes back to your question about does competition
14 really drive quality. Well, in this case it doesn't. It
15 drives the reverse. It drives mediocrity, because the
16 measurement system forces you, in order to end up with a
17 good score, to provide mediocre care, because that's what
18 the measure drives you to. So, don't get me started.

19 MS. GUTERMUTH: Well said.

20 CHAIRMAN WAXMAN: It's the same thing when a
21 newspaper in the Chicago area publishes the death rates per
22 thousand admissions to hospitals. Well, who comes out with
23 the worse rates? The best hospitals, because they're
24 taking in the most acute care cases. So, you know, if you

1 don't understand that concept, then you're going to think
2 "I'm not going to that hospital because more people die
3 there." Well, that's what the system is doing. It's
4 measuring a piece of a system and then putting it out to
5 the public to say, "Look at this and use it to make your
6 decisions."

7 MR. PICK: Right. It's global.

8 MR. URSO: So, do you think that this
9 committee should be looking at its own quality rating
10 system that would --

11 MR. PICK: Well, personally? No. I think that
12 would be a mistake.

13 MS. DEDERER: Why?

14 MR. PICK: Because it's too big of an
15 undertaking. I think that what -- as a committee what we
16 should be looking at is the structure. We can get to the
17 quality later, but I think fundamentally we've really got
18 to talk to the structure and that from the structure, we
19 can go -- delve deeper into how to determine applicants are
20 providing a level of quality that's acceptable. I truly --
21 I'm very much a market-driven, philosophically-oriented
22 person in that consumers will vote with their feet.

23 MS. DEDERER: But they can't. As Patricia
24 just said, if they're already in a bed, they don't know

1 what they just got themselves into.

2 MR. PICK: That's where they're at right now.

3 MS. DEDERER: Exactly.

4 MS. EVANS: To clarify, often those decisions
5 are not made by the patient alone.

6 MR. PICK: That's correct.

7 MS. EVANS: They're made by a care team and
8 family, and there's a lot of factors that we can't
9 necessarily measure or get our hands around. My biggest
10 concern is when we're trying to compare -- you know, do we
11 want a skilled setting right next to another skilled
12 setting, when, obviously, one is really a residential
13 setting and we need a skilled setting next to it, even
14 though this one is a low occupancy rate. And it makes it
15 very hard to measure where the needs are, because we're
16 calling them all beds and they're not all the same, and I
17 think when we -- just as we've tried to put together a
18 formula, that we have to somehow take into account the --
19 you know, what these beds are actually going to be used
20 for, and that's a piece that we are not in any way able to
21 address right now, and we don't even dictate to the
22 properties that exist what and how they're supposed to use
23 those beds. We just license a bed, and they could set the
24 whole thing up for residential Medicaid, and you could have

1 a hospital next door that has nowhere to send their hips
2 and their knees or the opposite. You could set up a -- you
3 could have a setting that's only doing rehab, not doing any
4 long-term care, and you have a huge need for Medicaid beds
5 for long-term care in the area, and it could look like
6 you're over bedded. So, we have a basic problem of they're
7 all beds.

8 CHAIRMAN WAXMAN: Chuck?

9 MR. FOLEY: I guess I kind of thought that
10 under the licensing portion of the Department of Public
11 Health, that if your license is "skilled", you have to meet
12 certain staffing requirements, certain departmental
13 requirements, such as physical therapy, occupational
14 therapy, et cetera, et cetera, so that when you're
15 "skilled" and your license is "skilled", you could take all
16 kinds of patients, even though the individual facilities
17 may not choose to do it that way.

18 MR. PICK: I don't believe OT/PT is a required
19 service.

20 MR. FOLEY: Under "skilled" it is.

21 MR. PICK: What's required is to meet the
22 needs of the patient.

23 MR. FOLEY: I thought under "skilled"
24 standards, you have occupational therapy, physical therapy

1 there for that license.

2 CHAIRMAN WAXMAN: Terry, do you know offhand?

3 MR. SULLIVAN: You are obligated to provide
4 the service whether you have it in-house or not. You have
5 to contract.

6 MR. FOLEY: So, the point being, I thought if
7 your license was "skilled", one has to assume -- it may not
8 be accurate, but one has to assume that they can take all
9 these levels of patients, be it vent patient or whatever.
10 Now, one facility may specialize in a certain category of
11 service, be it short-term, be it vent patients, renal
12 dialysis or whatever. That's all fine, well, good, and
13 great. But they're still under the umbrella as "skilled",
14 and I'd be afraid to have a different bed-need methodology
15 for each one of these different kind of categories. Now,
16 if one wants to apply, I think as the Association had
17 indicated -- for variance, that they want to do a
18 specialized care under the "skilled" category, I think
19 that's fine. I think we called it "innovative variance" of
20 some sort.

21 MR. SULLIVAN: Defined population.

22 MR. FOLEY: Or defined population or whatever,
23 which we have to change that wording, obviously, of defined
24 population. But let's not get ourselves into a grind here

1 where we're going to have a different bed methodology for
2 levels. That could change tomorrow. Yesterday we had
3 long-term care, today we have short-term, tomorrow we could
4 go back to long-term.

5 CHAIRMAN WAXMAN: I think if you accept market
6 forces and competition, I think that's one of the reasons
7 why some facilities create a unique population, because
8 it's a niche. It's still a business. You still have to
9 have people in a bed and you still have to have more people
10 in a bed that pays higher rates than other rates.
11 Otherwise you're not going to survive.

12 MR. FOLEY: The name of the game today is
13 survival, you're right.

14 CHAIRMAN WAXMAN: So, I think that's the
15 market piece we can never forget, is involved in how any
16 individual facility is going to survive. But we're still
17 going -- we still have to figure out where the beds need to
18 be.

19 Eli?

20 MR. PICK: I think the other important point
21 to underscore is there's a difference between an
22 organization that takes care of a patient type at a volume
23 of a hundred a year versus one that does a thousand a year.

24 MR. FOLEY: Which then takes quality.

1 MR. PICK: Exactly. While a facility may say
2 that they're capable of handling mentally-ill patients, if
3 they handle a hundred a year their competency level is
4 going to be very different than an organization that does a
5 thousand, and that's a balance that we have to determine,
6 because it does impact quality, and we -- I think as a
7 public policy group, that is our purview, is to say that a
8 minimum level needs to be X in order for an organization to
9 maintain its skill level, to be effective, and that if you
10 fall below that level, then you're not able, as much as you
11 want to, to really deliver a quality service.

12 MR. FOLEY: The thing that bothers me that I
13 don't want to see us get wrapped up into is that if a
14 facility files a CON under the defined population variance,
15 let's say for vent patients, that need could change
16 tomorrow.

17 MR. PICK: In what way?

18 MR. FOLEY: Well, the demand and need may not
19 be that great but yet he's still licensed for skilled, so
20 he could still take care of a long-term, skilled patient,
21 change his focus tomorrow and still take care of -- I want
22 to make sure that we still have that --

23 MR. PICK: I think we have to be careful not
24 to be so narrow that we're too prescriptive and eliminating

1 the market's ability to determine what services are needed.
2 But by the same token, we do need to safeguard the public
3 need, so that if somebody in Cairo, Illinois decides they
4 want to do vents because the hospital next door says "I've
5 got a problem discharging patients", but they end up taking
6 care of a hundred a year, they're not going to be very
7 effective, and there's a distinct difference between
8 chronic ventilators, those who won't get off a ventilator,
9 versus those who are weanable, and there's a different
10 skill level that is needed, and so even that requires a
11 distinction.

12 From my perspective, a chronic ventilator unit
13 doesn't require the same level of scrutiny and requirement
14 than one that holds itself out to be "we do weaning and
15 actively rehabilitate patients on ventilators to recover
16 function." So, a facility that does chronic vents who says
17 they also do weaning, their success rate is going to be
18 much, much lower if their volumes are lower. So, I think
19 fundamentally it goes to if we're a rehab-oriented
20 environment -- and "rehab" in the generic term, meaning our
21 goal is to restore function -- then we've got to have
22 enough volume going through the building to make sure that
23 the staff have the requisite skills to do that. But you
24 can't -- if you hold yourself out to be a rehab environment

1 and a very small percentage of the population you serve
2 ends up regaining function, there's something fundamentally
3 wrong, and I think as a public policy forum that's really
4 where we need to ensure, that we're establishing
5 thresholds, that these certain thresholds have to be met,
6 and without meeting those thresholds, you can't hold
7 yourself out in the market to say that you're such and such
8 when you don't produce it.

9 We're in a situation now where that can
10 happen. Any facility that is skilled can hold itself out
11 to be anything under the skilled umbrella, and they could
12 have never done it before, and on Monday, they're marketing
13 that they do it. Well, who ensures that the infrastructure
14 is there, that the skills are there that are necessary in
15 order to produce that outcome?

16 MS. EVANS: I think that's outside the scope
17 of what we're trying to do here, though, because what we're
18 trying to establish is is there a need for that bed.

19 MR. PICK: Well, I'm not sure -- I don't think
20 this group's responsibility is to police whether providers
21 are providing appropriate services. I think the group's
22 responsibility is to determine -- if I want to, as a
23 provider, hang out a shingle that I'm going to do this,
24 there needs somebody, some method to determine that A,

1 there's a need, and, B, I'm qualified to do it. I think
2 that is our purview.

3 MR. FOLEY: Isn't that coming under licensure?

4 MR. PICK: Unfortunately, in today's
5 environment, licensure is -- because we're a of generalist
6 mentality -- "Here's your skilled license; you can do
7 anything under the purview".

8 MS. DEDERER: But can't we also as a committee
9 recommend changes to the licensing requirements to allow
10 there to be the quality that you're talking about?

11 MS. EVANS: You know, there's also a
12 professional practice licensure. You really, as a
13 professional, are not to perform outside of your scope.

14 MR. PICK: Scope of practice, yes.

15 MS. EVANS: That relates to nurses,
16 physicians, respiratory therapists, therapists. So we
17 can't -- there's that element.

18 CHAIRMAN WAXMAN: Kelly?

19 MS. DEDERER: But if a nursing home owner
20 wants you to do something, are you going to say, "No, I
21 can't" --

22 MS. EVANS: Yes.

23 MR. PICK: You're supposed to.

24 MS. DEDERER: You're supposed to, but you need

1 your job.

2 MS. EVANS: But you want to keep your license.

3 CHAIRMAN WAXMAN: What I've seen all the years
4 I've been in this business, I've seen professionals say no,
5 that is outside their scope, and they will say no to an
6 owner.

7 Kelly?

8 MS. CUNNINGHAM: Just to maybe sort of tie
9 this together -- and, again, I come to this committee more
10 from the perspective of the Medicaid payment, the payment
11 side. But it seems to me what we're trying to do -- and,
12 Eli, maybe what you were trying to get at is that somehow
13 we have to -- and maybe we use rates for this as well, in
14 addition to licensure. Somehow creating something that
15 balances access with outcome, because we want enough
16 available to ensure that people can reasonably -- that it's
17 reasonably accessible to people, but we also want the
18 outcomes to have of a high quality. So, maybe one of the
19 tools that we use is the rate, the reimbursement rate or
20 something financially to get there.

21 MS. HANDLER: I think there is a rate
22 differential right now, maybe not from the State itself,
23 but anybody that gets put in a skilled bed on the Medicare
24 side is seeing a different rate. I come from a different

1 side of the equation -- which I do a lot of listening. We
2 will find patients in beds that are not rehabable. These
3 patients are not rehabable, and you can't get the patient
4 out of a rehab bed because there's an incentive to keep
5 that patient in the rehab bed, and once you're on the
6 train -- for those of you who have had a personal
7 experience in the long-term care market, in the healthcare
8 market at all with an elderly person, once you're on the
9 train, it's pretty hard to break the momentum of that
10 train, even if you're an informed consumer.

11 So, I think Eli's point about quality outcomes
12 is really something that we should not lose sight of,
13 because you don't want a patient in a -- you don't want a
14 patient sitting on a ventilator for long periods of time
15 that isn't really rehabable but there's a financial
16 incentive to do that and the family is not knowledgeable
17 enough, skilled enough, determined enough. You know, we
18 still have the dynamic of healthcare professionals are held
19 in higher esteem. Whether they should be or shouldn't be
20 is not the -- but I think it's the social structure. So, I
21 would like to say that we shouldn't lose sight of the
22 quality factor, some kind of way to measure outcome.

23 MR. BIBO: I don't disagree with what you're
24 saying about the type of people staying in beds too long,

1 but keep in mind, this is more of a provider group or
2 whatever; that really comes from the doctors. It's the
3 doctors that sign off and -- it's the doctors, in my case
4 it is, at least. We follow the orders.

5 MS. HANDLER: That's right, they do sign the
6 orders, but there are patients in beds that shouldn't be in
7 beds.

8 MR. BIBO: I agree with that.

9 CHAIRMAN WAXMAN: Terry?

10 MR. SULLIVAN: I don't think this committee
11 should lose sight of the quality, although the purview of
12 guaranteeing quality may not be within this subcommittee.
13 I think Kelly is heading in the right direction, because
14 ultimately the job of this committee and the Board is to
15 approve beds in as wide a definition as possible. Public
16 health enforces skilled standards in as wide a definition
17 as possible. Somehow there needs to be a certification
18 process for specialty care that has both a higher standard
19 and maybe with that a higher reimbursement that goes with
20 it. But that is what's missing both in licensure and in
21 the CON approval process, is do we want to encourage
22 specialization? Yes. We want to encourage specialization,
23 but, unfortunately, our licensure setup is headed towards
24 the broader definition of what is skilled and did you make

1 a mistake. I think, you know, previously we had the
2 Exceptional Care Program under Medicaid, which was sort of
3 a certification. You had -- to get the rate, you had to
4 meet certain standards and have certain staff and stuff
5 like that. We got away from that a little bit, although
6 the previous MDS 2.0 did have standards for different
7 levels of care, but then it all got blended together. But
8 I think either the Medicaid agency or even at Public
9 Health, a certification unit for specialty care is
10 certainly a recommendation that could come out of here.

11 MR. PICK: Exceptional Care also had an
12 evaluation process.

13 MR. SULLIVAN: Right.

14 MR. PICK: Staff came out and reviewed whether
15 the services they were capable of being delivered were
16 being delivered.

17 MS. DEDERER: And now it's all gone?

18 MR. PICK: Yeah, it's all gone.

19 CHAIRMAN WAXMAN: Our discussion is
20 incredible. I think it is very valuable and very
21 worthwhile.

22 Frank just handed me, hot of the press, this
23 document that was handed out at our very, very first
24 meeting. I'm going to rehand it out, and it's based on

1 what statute created us as a committee and what we are
2 supposed to look at and what our authority is. So, while
3 this discussion is very, very useful, I think we need to
4 take a couple minutes.

5 Is lunch scheduled for noon?

6 MR. CONSTANTINO: Yes. I just checked on it.

7 CHAIRMAN WAXMAN: So it's about ten of. Why
8 don't we hold all discussions for a few minutes, take --
9 get ready for lunch. Please reread this document, because
10 it does explain just exactly what our authority is, and
11 then when we come back with lunch, we will then -- I think
12 we're already into the discussion of what we want to do
13 next, so we can tie this together.

14 MS. DEDERER: Can I make a comment about that?
15 I thought that we also talked about the fact that even
16 though this is our mission, we could make recommendations
17 regarding other things that are interrelated that we
18 consider to be necessary.

19 CHAIRMAN WAXMAN: We have said all the time
20 that we can hand recommendations to the Mother Board, which
21 will then take it someplace else, such as the whole issue
22 of assisted living. So, yes, absolutely, but, again,
23 understand what we have the authority to do in terms of our
24 rule making versus what we can do in terms of our authority

1 to make recommendations.

2 MS. DEDERER: Right.

3 CHAIRMAN WAXMAN: So, if it's okay with you, I
4 would suggest we take a break.

5 MS. ALTMAN: Are you breaking now?

6 CHAIRMAN WAXMAN: Yes.

7 MS. ALTMAN: Okay. Sorry. This is Stephanie.
8 I had said that I can only be on until twelve. So I am
9 going off now. Is there anything that you need me to be
10 voted on or do you need me to call back in at a certain
11 point?

12 CHAIRMAN WAXMAN: Do we have to vote to pick
13 what's next on our list? No. I think we're fine,
14 Stephanie, and really do appreciate you being on the phone.

15 MS. ALTMAN: Thank you.

16 (Lunch recess)

17 CHAIRMAN WAXMAN: Take back up at 12:30.
18 Let's bring the meeting back. I think -- I don't know --
19 is Claire still on the phone?

20 MS. BERMAN: Yes, I'm still here.

21 CHAIRMAN WAXMAN: Again, Claire, I want to
22 repeat what everybody here has said, and hopefully you have
23 heard everybody commend you on the incredible amount of
24 work that you've done and the quality of the documents that

1 you have put out and, again, our great appreciation for
2 that. So, again, thank you.

3 MS. BERMAN: Thank you for your comments.
4 It's very encouraging. Yeah, but we'll see what you folks
5 develop and what your further needs are, and then I'm happy
6 to be involved in any way I can.

7 CHAIRMAN WAXMAN: We appreciate that, and,
8 hopefully, there will be a day soon we'll have you in the
9 room with us.

10 MS. BERMAN: Yes, I'm working toward that.

11 CHAIRMAN WAXMAN: Good.

12 I think a lot of the discussion I heard prior
13 to our lunch break really was leading us to the question of
14 what do we want to tackle next? So, I think, unless I'm
15 totally off base -- which I have been a few times in my
16 life -- that's the last issue we need to deal with in terms
17 of our agenda. So, the floor is open if somebody wants to
18 start talking about how we want to rank these issues and at
19 the same time the concept of work groups in terms of
20 ranking the issues and divvying them up via work groups.

21 Teri?

22 MS. DEDERER: I wondered if it might help if
23 we went through the list and figured out which of those
24 would we want to include with the bed-need formula or

1 bed-need process, Certificate of Need process.

2 MR. PICK: If I may, I -- before we get into
3 the details, what I would recommend is we step back and,
4 really, let's define the framework.

5 MS. DEDERER: That's what I was trying to get
6 to, maybe badly, but, I mean, define what you want to
7 include and then you pare this down, and then you have a
8 structure for what do we say yes or no to. Quality, yes or
9 no? Is it going to be licensing? This and that and work
10 down the --

11 MR. PICK: And we need to incorporate what was
12 handed to us as our charge, but to me, the first step is
13 we've got to reach consensus about what's the scope of what
14 we're doing. So -- and then once we do that -- because I'm
15 not sure there's consensus on incorporating all of these
16 elements. What we have to date is everyone has verbalized
17 their input on what they think should be included, and the
18 summary includes all of that, but I think we need to step
19 back, before we get into the details, and right from the
20 gitgo I think we start with the bed-need formula.

21 Do we all agree? Do we need one or don't we?
22 And if we don't, what is it that replaces it? If we agree
23 we do, what should it look like? We can't presume -- and I
24 think that's the danger. We can't presume that because

1 it's on this ranking list that everyone is in full
2 agreement that this is what needs to get done.

3 MS. DEDERER: Okay.

4 MR. PICK: So, I would say that my
5 recommendation would be that first and foremost, as a group
6 we come to some consensus of what's the framework. Then
7 from that we go into work groups and details of each of the
8 elements that need to be addressed and refined so that it
9 supports the conceptual model.

10 MS. DEDERER: So ask.

11 CHAIRMAN WAXMAN: Do you have a thought in
12 mind?

13 MR. PICK: Of --

14 MS. DEDERER: We want to know if we need a bed
15 formula or not. That's a place to start, so take a vote.

16 MR. PICK: And I think that the work Claire
17 did is extremely helpful, because now we see the national
18 landscape, that many of the elements that we've been
19 talking about is present in one way or another in various
20 states.

21 MS. DEDERER: Right.

22 CHAIRMAN WAXMAN: I think the point is well
23 taken that several of these items is contingent upon some
24 of the others. So, if we are in agreement that bed-need

1 formula is one of our significant issues, then my question
2 to the group is, off of the summary list, which of these
3 items or issues, as they're called, ties directly to the
4 bed-need formula?

5 MR. PICK: Isn't that a Staff task?

6 MS. EVANS: We have to give them the
7 directions.

8 MS. DEDERER: No, no, no. It would be what we
9 want.

10 CHAIRMAN WAXMAN: All right. Chuck?

11 MR. FOLEY: I'll take a stab at it.

12 I think along with No. I, we should be looking
13 at Roman Numeral No. III, 90 percent occupancy and what
14 does it mean, because occupancy, obviously, ties into bed
15 need ties into the methodology.

16 The next one, clarification on variances, I
17 think that all ties in with it, also.

18 IV may or may not. You know, I don't know
19 yet.

20 MR. SULLIVAN: It's part of the discussion.

21 MR. FOLEY: But, obviously, Roman Numeral V as
22 it relates to the process to allow for innovation and
23 person-centered planning, that's part of a variance, as
24 well as recognize geographic differences, which is part of

1 the Planning Areas versus the variances.

2 MR. SULLIVAN: Also, back up, the fourth one
3 down, definition of the service population is also related
4 to the input of the bed-need calculation.

5 MR. FOLEY: That's correct.

6 CHAIRMAN WAXMAN: So, if I can summarize, the
7 issue is modify current bed-need formula/methodology,
8 inputs and bed need calculations, account for licensed beds
9 that are not operational, and we're tying definition of
10 service populations to that. 90 percent occupancy and what
11 does it mean we're tying to that. Clarification on
12 variances and number of beds with variances, we're tying to
13 that. Process to allow for innovation and person-centered
14 planning we're tying to that. And recognize geographical
15 differences, we're tying to that.

16 Yes, sir?

17 MR. WILL: There's just one other I think
18 Charles kind of mentioned in passing, below the
19 clarification on variances, like the ninth one down where
20 it says "include other services in need calculation". Even
21 if we ultimately don't do that, that should be part of the
22 discussion.

23 MR. FOLEY: I think that's very important,
24 you're correct.

1 CHAIRMAN WAXMAN: So, we're adding to that
2 list, include other services and need calculation, HCBS --

3 MR. PICK: Home and community-based
4 services --

5 CHAIRMAN WAXMAN: SLF --

6 MR. PICK: Assisted living and others.

7 CHAIRMAN WAXMAN: Right. Any others we think
8 can tie to that group?

9 MS. CUNNINGHAM: Just a question with respect
10 to the last addition. Where in our charge are we given
11 authority to look at other services outside of the
12 traditional nursing facilities?

13 CHAIRMAN WAXMAN: We are not. What we're
14 purporting to do is to acknowledge that --

15 MS. DODGEN: Yes, we are, 2(a).

16 CHAIRMAN WAXMAN: 2(a)? Okay. Yeah, in terms
17 of discussion, it fits under 2(a). In terms of making
18 recommendations that things like assisted living should be
19 regulated within the same group as skilled homes, we don't.
20 But that's a recommendation, I think, that almost everyone
21 in this room thinks needs to be made somewhere.

22 So, does that help you, Kelly?

23 MS. CUNNINGHAM: Yes.

24 MS. DEDERER: And you're not proposing that

1 all of those come under this committee, just that they be
2 considered when determining bed need, I thought, right?

3 CHAIRMAN WAXMAN: Yes and no.

4 MR. PICK: We're still waiting to determine
5 whether that's what we're going to do.

6 MS. DEDERER: Well, understood, understood.

7 CHAIRMAN WAXMAN: I think whether skilled beds
8 and assisted living beds are regulated by this committee,
9 we're suggesting that somebody has -- regulates the whole
10 ballgame. Otherwise we're going to have what you have now,
11 which is how do we -- you know, one of the significant
12 competitors to the skilled bed is an assisted living bed.

13 MR. PICK: For chronic care.

14 MS. EVANS: Or SLF bed.

15 CHAIRMAN WAXMAN: Or SLF bed, and if you walk
16 through as many buildings as I have or Eli has or other
17 people have, you will hear the same thing, that there are
18 people in the wrong beds, that there are still --

19 MR. PICK: The other thing they say is they
20 are really sick.

21 CHAIRMAN WAXMAN: They need skilled care, and
22 there is nothing that really ties it together. So, I think
23 at one point somebody has to say --

24 MR. BIBO: When you say "regulate", you're

1 talking about from a Certificate of Need process?

2 MR. PICK: I would modify the term "regulate".
3 I think something that either monitors, evaluates or makes
4 a determination on what needs to be.

5 MR. BIBO: The need but not the care.

6 MR. PICK: Correct, that's absolutely right,
7 the need.

8 MR. BIBO: That's what I thought you meant,
9 but then I didn't want to get down the road and say, "Mike,
10 you said it right there, nodding your head okay. We took
11 over the world but that's okay."

12 CHAIRMAN WAXMAN: No, no, I meant the count.
13 Because you can't count and exclude a player. It's like
14 saying we're going to have a baseball game but we're only
15 going to count eight players but there's nine on the field.

16 MR. PICK: I would not presume what the system
17 is going to do before we define the system, which is really
18 the stage we're at. Whether it's to count, whether it's to
19 evaluate, whether it's to regulate, whether it's to
20 monitor, we're not sure yet. But I think what we are
21 agreeing on is that we need to define a system that
22 provides us the information to be able to ensure that there
23 is adequate access. Right? That's really the fundamental.
24 What comes from that is our work.

1 MS. DEDERER: Well, I thought you said you
2 wanted to determine first if people thought we needed a
3 bed-need formula.

4 MR. PICK: That's part of it.

5 MS. DEDERER: I thought you wanted to do that
6 first before you added all of these other things that
7 should be considered as part of it.

8 MR. PICK: Well, my evaluation of the
9 discussion is if we determine we need a bed-need formula,
10 we have all of these contingent items that are dependent on
11 a bed-need formula. If we determine we don't need a
12 bed-need formula, then we've got to come up with a
13 different way to incorporate all of these elements.

14 CHAIRMAN WAXMAN: And I thought I heard
15 agreement that we need a bed-need formula, so I'm kind of
16 moving in that direction.

17 MR. PICK: I'm not sure that's the case.

18 MS. DEDERER: Why don't you ask?

19 MS. EVANS: Why don't we have that discussion
20 first?

21 MR. PICK: Just what I've been advocating for.

22 MS. DEDERER: Could I add another item to our
23 list for discussion -- and that would be the use of
24 outcomes data, quality of care -- to the equation?

1 MR. PICK: In the bed-need formula?

2 MS. DEDERER: Not the bed-need formula, you're
3 right. I'm sorry. You're right.

4 CHAIRMAN WAXMAN: All right. If I presume
5 something that isn't quite true, then, again, I apologize.
6 So, if there are some people who don't believe a bed-need
7 formula is one of the significant issues this group is to
8 deal with, then I'd like to hear that.

9 MR. SULLIVAN: I'm sorry. What's the
10 question?

11 MR. PICK: The question is do we need a
12 bed-need formula?

13 If I may, I don't believe that we need a
14 bed-need formula to ensure the results that we're talking
15 about. I -- my basis for this comment is the bed-need
16 formula methodology has historically been the only way
17 we've been able to determine how many beds are available,
18 how many people are in the population. Our discussion
19 today is much broader than that, and it talks about what
20 are all of the service capacities, the dimensions of
21 services, and how do we ensure that the public has access
22 to the service it needs. And I personally don't believe
23 that the bed-need formula is the only option in order to do
24 that.

1 CHAIRMAN WAXMAN: From a legal, statutory
2 point of view, can we go at this through some method other
3 than a bed-need formula?

4 MR. URSO: I think that you can. Mike, do you
5 have any thoughts on that?

6 MR. CONSTANTINO: I believe they can.

7 MR. URSO: I don't think the Statute dictates
8 that you have a certain process. They said establish the
9 procedure and the procedure would establish the rules. So,
10 that is what this committee has control over, essentially.
11 All right? What do the Rules look like today and what
12 should they be like tomorrow?

13 CHAIRMAN WAXMAN: I want to make sure we don't
14 have an hour discussion on something we can't do. So,
15 we're clear that we can do some other methodology than just
16 the bed-need formula. Thank you, sir.

17 Terry?

18 MR. SULLIVAN: Looking over Claire's excellent
19 work, specifically with regard to the bed-need formula --
20 and I was impressed that all the states seem to have two
21 elements to the bed-need formula, and all of them start
22 first of all with the demographics of how many seniors do
23 we have in the Planning Area under 65, 65-74, over 75, some
24 states over 85. It's interesting how they all start there

1 with the -- well, how many seniors we have, which is a good
2 statistical way to start to say what kind of services do we
3 need.

4 The second step in that process, though, gets
5 very hinky. It gets mysterious. Sorry for that technical
6 word. And the question comes up, so if we have 4,000
7 seniors in this Planning Area and then break it down by
8 age, how many long-term care beds do we need to serve those
9 seniors? And the answer to that in all of the states is
10 all over the board, anywhere from 30 per thousand to 53 per
11 thousand, which is quite the range. The average nationally
12 is 44. But depending on what happens in each state, it's
13 like, well, let's have a little less than that, let's have
14 a little more than that, whatever. In fact, just about
15 every state says -- in fact, who was it -- Michigan, I
16 think, or Delaware came up with the concept of reasoned
17 consideration in determining how many long-term care
18 beds -- because there really isn't much of a statistical
19 formula for that, and as you talk to the different states,
20 it's like, "Well, why did you come up with 53?" "Well, it
21 was argued in the Legislature and the Legislature
22 determined da, da, da, da, da," all based on what they
23 wanted to accomplish. So, in one sense it starts
24 statistical and ends up being let's pick a figure that

1 politically we can all live with. That's step one.

2 Let me just finish step two. Step two in most
3 of the states then takes Planning Area occupancy and in
4 some states they try to blend it into a formula.

5 Interestingly, I found most states use it as a -- I don't
6 want to say a veto, but it's like, yes, it says planning
7 need but if, in fact, there is not 90 percent, 93 percent,
8 95 percent, even 97 percent occupancy in each of these
9 areas, well, then we're not going to pay any attention on
10 the bed-need formula because, obviously, if we have 400
11 empty beds and the bed need says that we need a hundred
12 more, it's an overrule -- maybe not a veto, an overrule.

13 So, my impression is that three-quarters of
14 the states basically said yes, we have a bed-need formula
15 but if, in fact, we have too many empty beds, that
16 overrules the formula, in which case it does lead you to
17 the question, outside of conceptual planning purposes, do
18 we need a bed-need formula to determine whether we need
19 more beds in an area? And I think occupancy becomes an
20 interesting concept. In some states it's not only the
21 average of 90, 93, 95, 97, but each nursing home in the
22 area has to be at 93 or 95.

23 Why not head that direction?

24 CHAIRMAN WAXMAN: Chuck?

1 MR. FOLEY: Well, thank you, Mr. Sullivan.
2 I'm going to go in the opposite direction, if I may, and
3 say that this whole thing -- the reason why we're here is
4 to plan for the future needs of our elderly population in
5 the future. It's not anymore the elderly population,
6 because we are seeing even those younger than 65 going into
7 nursing homes for the short-term rehab. Okay? We have in
8 the state of Illinois what is called Planning Areas, which
9 we had an earlier discussion on where the state is divided
10 up into eleven different Planning Area and within each one
11 of those Planning Area -- Health Service Areas and within
12 each of those Health Service Areas we have Planning Areas.
13 So, therefore, what we're trying to do here is trying to
14 determine in the future what are the healthcare needs of an
15 area and a specific geographic area, and the only way to
16 accommodate this is not to draw a 30-minute hypothetical
17 circle but to lock in into a Planning Area where you can
18 identify specifically what the population is, and we can
19 determine from that whether or not only is there a need for
20 skilled beds, but maybe even something more important in
21 terms of another category of service within that, if you
22 want to go that far tomorrow. We may see where in this
23 particular geographic area, we don't need anything at all
24 or we may need a lot more beds.

1 So, I think to do away with the bed-need
2 methodology -- I have to agree, it's not the perfect thing
3 out there. It does, in fact, need to be tweaked in order
4 to accommodate the assisted living, supportive living
5 population. It needs to be tweaked to accommodate somehow
6 home health services that you would have out there, because
7 those are all very important components in identifying the
8 healthcare needs of residents and where they're come from.
9 So, I think we need as a planning agency, as a planning
10 committee here, we need to plan for the future, and to do
11 that, I think we do need a bed-need methodology.

12 CHAIRMAN WAXMAN: Other opinions, please?

13 MS. EVANS: Well, how many people in this
14 group are, you know, statisticians? Do we have any in our
15 resources.

16 So, as far as us, like, being able to develop
17 an actual formula, you know, we can give input to it, but
18 it is a -- it is specific to a Planning Area. We have
19 really two different issues, and that is are we really
20 looking at the skilled side and what the skilled needs are,
21 or are we looking at the residential side and what the
22 residential needs are? There's two different areas to look
23 at.

24 We also -- again, I don't know if we ever --

1 it doesn't seem like we ever really followed the formula
2 that we have. It seems like even though we have a formula,
3 we don't follow it. We look at it as well, gee -- we look
4 at it as just one piece of the whole proposal that is put
5 forth, and if there isn't a need, there's still stuff
6 getting built, even if it looked on paper to not have a
7 need, from what I can tell.

8 CHAIRMAN WAXMAN: Mike, the formula was used,
9 wasn't it?

10 MR. CONSTANTINO: Yes, the formula was used.
11 The Board has discretion whether or not to approve a
12 project whether there is a calculated need or not.

13 MS. EVANS: So, it's just like one component
14 of the entire picture. It's not the beginning, end,
15 everything. So, it's important that we have some tools
16 that Staff can use to make a determination is something
17 completely off target or not. I think that they would want
18 that, from my understanding, you know, to have some tools
19 to be able to say this is a well-planned -- there's a need
20 here, to be able to determine whether there's a need or
21 not.

22 CHAIRMAN WAXMAN: Kelly?

23 MR. FOLEY: And even if there is not a need,
24 that's when you have the opportunity to address a variance,

1 which has been suggested and introduced in our draft here.
2 So, if there is not a need in a particular area, but in
3 case we can address whether we want to identify a specific
4 defined population or whatever -- and, of course, it's up
5 to the Board and the Staff to determine whether or not that
6 criteria and need have been met.

7 CHAIRMAN WAXMAN: Kelly?

8 MS. CUNNINGHAM: What I was going to share is
9 when Terry went through some of the stuff that's been put
10 together -- and it does seem -- and I haven't reviewed it
11 probably as close as I should have -- that many of the
12 states that are looking at bed needs start with the senior
13 population, and I believe that is really -- that that's not
14 a path that we should be going down. We need to look maybe
15 not just at additional settings of care, like assisted
16 living and supportive living and waiver services, but
17 different populations, especially the younger populations.

18 I just recently did some analysis, and I
19 didn't think to bring it today, but looking at the past 10
20 years from the Medicaid perspective, how we break up the
21 days that we pay for in nursing facilities settings, and
22 not only -- and I have that broken into age ranges. Not
23 only are the nursing home days dropping overall, not
24 precipitously but over time, but it's very clear how much

1 the average age is dropping and how we're seeing growth in
2 the much younger population. So, I think, you know, how we
3 can sort of incorporate that kind of information into a
4 formula that is not just focused on a senior population,
5 that somehow we need to get at all components of the
6 long-term care population.

7 CHAIRMAN WAXMAN: Teri?

8 MS. DEDERER: Couple things. One of the
9 reasons the states would all have a different number per
10 thousand is we all have different levels of what
11 constitutes long-term care. In Illinois -- and we probably
12 have more than some states, than other states. And I guess
13 the other thing is with all of the data that we do have
14 from Public Health and from HFS, it seems like we should
15 probably be able to go back and look at what the
16 utilization is in different parts of the state in nursing
17 home facilities and SLF's, which have been around for a
18 number of years, assisted living, to look at how it's been
19 used and look at it as a statistical means of how it might
20 be used. Are we happy of what it's been so far? Are we
21 happy with that? And move forward from that.

22 MR. PICK: Let me go out on the limb here.
23 Perhaps what I would suggest that we consider is instead of
24 a bed-need formula, it's a service-need formula and that

1 fundamentally, it's the Board that ultimately makes the
2 decision of whether they approve or disapprove of a
3 project, regardless of any formula anyway. So, from -- an
4 approach that I think would be productive is for us as a
5 planning group to really look at service need. What are
6 the services that are available in an area? What's the
7 need? And how do we evaluate someone who wants to develop,
8 whether it's a nursing home or a service that fits into
9 this rubric of what are the needs.

10 MS. DEDERER: We don't regulate home health.

11 MR. PICK: We don't have to.

12 MS. DEDERER: Yes, you do, because somebody
13 has to pay for the services that you want to declare a need
14 for, and the need might outstrip the resources for that
15 kind of care.

16 MR. PICK: I think Mike Constantino's last
17 comment is really what is influencing my statement. The
18 Staff, in using that need formula to recommend whether
19 there's a need for that project or not, is not the final
20 arbiter anyway.

21 MS. DEDERER: No, it won't be. Does that
22 mean -- if that's the case then, we don't need to have any
23 of this discussion, because much of the stuff we would
24 recommend to the Board, it is out of our purview to put it

1 in Rule. So, if they're not going to bother to do anything
2 that we would recommend, then we're pretty much done here.

3 MR. PICK: But they're asking for our
4 recommendations, just like they ask the Staff.

5 MS. DEDERER: Then you have to have a basis on
6 which to make those recommendations. Some of us believe
7 that the basis that has been used in the past does not
8 encompass all of the things that should be considered and
9 that those things need to be added. I don't care if you
10 call it a formula or what you call it, a list of
11 considerations, here's what we calculated, X per thousand
12 and here's.

13 MR. PICK: We're not disagreeing, Teri.

14 MS. DEDERER: Okay. One of the things that
15 concerns me the most is the occupancy and the quality of
16 care in those homes, and I don't think we're measuring that
17 very well, because we haven't had the staff to really go
18 out and measure it. So, we don't even have any data
19 available to us. I think it would be a terrible crime to
20 say, "no, you can't build", if you know that nobody wants
21 to use the facilities in the area and the under utilization
22 is based on the quality. On the other hand, I think it
23 would be criminal to let somebody build it or to recommend
24 that they build it, when you've got good homes, well

1 utilized, high occupancy. So you have to have some basis
2 for making a determination.

3 MS. EVANS: Or good homes with low occupancy.

4 MS. DEDERER: Or good homes with low
5 occupancy, exactly.

6 MR. PICK: Teri, we're not disagreeing with
7 anything you said.

8 MS. DEDERER: You said you don't want a
9 bed-need formula.

10 MR. PICK: No. What I'm suggesting as an
11 alternative is a service-need formula that could easily
12 incorporate all of the elements you just listed.

13 MS. DEDERER: But I don't think -- I don't
14 know if -- Kelly, you can jump in. I don't think you can
15 have a comprehensive service-need formula when you only
16 control the resources for nursing facilities.

17 MS. EVANS: But we asked them to do their
18 homework and put together a market analysis. That's one of
19 the things that is in our Rule, correct? We all decided
20 that we wanted them to go through that academic experience.
21 So, part of it might be to require that they look at, you
22 know, what other services are available as far as, you
23 know, is there a SLF, what are the assisted living beds
24 there? So, we're asking them when they do their market

1 analysis to take a look at the -- you know, what is being
2 utilized in their own community. You know, we can't
3 possibly have something that's going to fit -- it's so
4 different. If you have property in Hoffman Estates where
5 there's, you know, assisted living places and retirement
6 communities with assisted living floors -- it's a huge,
7 dense conglomeration. You're not going to be able to use a
8 statistical formula that is really going to give you a
9 picture like you could when you use a market analysis and
10 drill down and say there's this and this and this, and if
11 you're the operator who is proposing to build a site,
12 you're going to have to look at the fact that, "Gee, this
13 is my competition, and I have to really plan out. You
14 know, do I want to go after a residential component here
15 when I have all of these competing residential components?
16 Do I see that there's a need for a skilled "-- you know,
17 kind of to make the argument of the type of property that
18 they're proposing. You know, how much are they going to
19 have in a rehab-type focus? How much are they going to
20 have in a more residential, long-term focus? You know,
21 that's where I think we're missing kind of the flavor of
22 planning. You know, it all should be looked at from that
23 market perspective, and I'm not sure we can come up with
24 like a number, you know, crunching piece that's going to do

1 all of that.

2 MS. DEDERER: But would you call that a needs
3 assessment or a resource assessment? Is it an assessment
4 of need or is it an assessment of the available resources?

5 MS. EVANS: I Think needs and resources are
6 hand in hand. One fills each other's pieces. It's a
7 puzzle.

8 MS. DEDERER: I would say that need outstrips
9 resources widely throughout the state.

10 MR. URSO: I think this committee has the
11 authority to define the terminology any way they see fit,
12 and they can incorporate anything they want. But what you
13 have to keep in mind, I think, is that according to the
14 statute today, the Health Facilities Planning Act, the
15 Board has the authority over skilled and intermediate care
16 and also MR/DD care. That's the range of their
17 jurisdiction. If you want to see a larger continuum and
18 the Board have more jurisdiction over different types of
19 cares and modalities, then you've got to incorporate that
20 into your thinking and you have to justify it and why you
21 think that the Board's authority should be expanded or
22 narrowed, I suppose either way.

23 CHAIRMAN WAXMAN: Chuck?

24 MR. FOLEY: I was just going to say the same

1 thing. Are we really jumping the gun here in that do we
2 have to have the Mother Board's blessing, that they would
3 feel comfortable in taking this to a Legislature, that we
4 need to get our Act changed in order to include, for
5 instance, the full picture of assisted living, supportive
6 living, which is not part of our Act today? We may just be
7 jumping the gun here. I don't know.

8 MR. URSO: I think this committee has the
9 flexibility to make whatever recommendations -- I said this
10 before, previously. I think if some of the recommendations
11 are going maybe a little far afield in terms of what the
12 statutory authority are -- and I don't mean that in a
13 negative fashion -- you need to justify it. That's all.

14 CHAIRMAN WAXMAN: And I don't think they would
15 answer the question until we present them some
16 documentation. So, I don't think we can call up and say,
17 "We're thinking of X Y Z; is that okay with you?"

18 MR. FOLEY: I just don't want to go through
19 this whole exercise and then --

20 CHAIRMAN WAXMAN: But I think we have to go
21 through the exercise, as we agree as a group, and present
22 all of it to the Mother Board to get a response.

23 MR. URSO: These are the experts, people
24 around this table. The Board is looking for this group of

1 experts to come up with something. And so maybe it's
2 something that's not already contemplated.

3 CHAIRMAN WAXMAN: And I think from the brief
4 period that Eli and I had with them the other day, that
5 they are both wide open to our suggestions and willing to
6 hear our thoughts, as well as have not thought about it
7 themselves. So, I think -- at one level they're thinking
8 here (indicating), but on the other hand, we're thinking
9 here (indicating), and they are open to here (indicating).
10 But we have to have it well documented and well thought
11 out.

12 Terry?

13 MR. SULLIVAN: I think there is a big
14 difference between assuming the authority to approve home
15 health -- adult healthcare and assisted living and
16 including those resources as part of the formula. I think
17 this committee has the authority -- jurisdiction to include
18 them in a formula. If we said but we also have authority
19 over those, this meeting would become a lot more crowded
20 very quickly.

21 CHAIRMAN WAXMAN: I don't think we're saying
22 that, Terry. I think we're saying all those pieces need to
23 be considered. I don't think anyone is saying -- except I
24 did a little earlier -- that we want control over all of

1 it.

2 MR. SULLIVAN: I would recommend -- there's
3 part of me that wants to have a really good, comprehensive
4 formula that includes all of those resources and put them
5 all in together, a lot like New York has tried to do --
6 and, again, I would challenge anyone who wants to have a
7 comprehensive formula, read what New York did. I think
8 they had the same objective, but the outcome is an
9 elephant.

10 MR. PICK: It's not where we have to end up.
11 Again, a service formula doesn't necessarily mean that as a
12 body we're dictating what services become available. It's
13 merely as a body we're incorporating those services into
14 their decision process. So, I agree with what you said. I
15 think it would be a huge mistake to do what New York and
16 Georgia did, and that's to establish criteria for each
17 element of the service and the continuum to receive a
18 certification or certificate to begin providing services.
19 I think it's equally a huge mistake for us to continue to
20 evaluate whether there's a bed need without looking at what
21 else is going on in the environment.

22 CHAIRMAN WAXMAN: Kelly, do you have a
23 thought?

24 MS. CUNNINGHAM: Well, I really agree with

1 Eli.

2 MR. PICK: Why are you laughing?

3 MR. SULLIVAN: She's shocked.

4 MS. EVANS: Trying to get over that now.

5 (Laughter)

6 MS. CUNNINGHAM: I'm really trying to process
7 this, because I've kind of come around on this a little
8 bit. I guess I think -- I work a lot on supportive
9 living --

10 CHAIRMAN WAXMAN: Which is why I went to you.

11 MS. CUNNINGHAM: Like, when we have an open
12 solicitation, we require as part of the application a
13 market study, and nobody should get offended by what I say,
14 but it's like we get the best market studies money can buy,
15 and sometimes, you know, without a lot of -- unless we
16 define exactly what we expect to see in that market study,
17 we can have a market analysis support the existence of
18 supportive living anywhere at any time, any size. And I'm
19 afraid that that is what -- I guess I want to sort of be
20 conscious of that, that when we have this -- and I also
21 come from the background of the Older Adult Services
22 Advisory Committee, and one of its first statutory charges
23 was to develop a service inventory. Seven or eight years
24 later, they're still working on it. It's been nearly

1 impossible to do for lots of different reasons, most of
2 which I don't understand.

3 But I think these things are good. I agree
4 that they have to be there. I guess I'm maybe just a
5 little cynical. Like how do we make sure that what we get
6 is actually pure solid information as the basis to make a
7 decision?

8 CHAIRMAN WAXMAN: I think two things, if I
9 may. One is I like to remind the group that we have on our
10 list to revise the application. So, in that process, we
11 can say then we want the following market studies or
12 whatever other things we want to include in the application
13 that may or may not be there.

14 And I think the second thing is that we also
15 have a very competent -- and I'm using the word in its
16 highest quality -- very competent staff that is going to
17 review the applications and make recommendations. So, I
18 think those are two kind of safeguards we have in our arena
19 in this discussion.

20 MR. SULLIVAN: I'm still struggling with Eli's
21 conundrum in his Planning Area where it shows that there is
22 a bed need and we have empty beds. It shows that the
23 current bed-need formula is inadequate. I mean, I think we
24 all agree on that. So, what do we do to change that? And

1 do we go with a comprehensive formula that would require
2 lots of statisticians and lots of work on the part of the
3 Planning Staff, quite frankly at a time when more staff are
4 not being encouraged by the State of Illinois. I don't
5 know how -- I agree with Kelly. I don't know how we get
6 there. It's a great objective. How we get there, I don't
7 know if it's in any of our capabilities.

8 CHAIRMAN WAXMAN: So, are you advocating for a
9 service-need concept or a bed-need concept?

10 MR. SULLIVAN: I'm going for an occupancy
11 concept, as most states do.

12 CHAIRMAN WAXMAN: So you're putting a third
13 concept on the table?

14 MR. SULLIVAN: No. It's the second part of
15 need. If there are 400 empty beds in a Planning Area,
16 where's the need? The market is driving empty beds.

17 MR. PICK: Right.

18 MS. DEDERER: But it might not be driving
19 empty beds because there's no need. It might be driving
20 empty beds because the places are not places people want to
21 be.

22 MS. HANDLER: So, why don't we incorporate all
23 of those concepts into the evaluation process, bed need,
24 occupancy, and service? Why can't you look at service and

1 beds? If beds is the fundamental framework for providing
2 the service and there are specialty services, why can't you
3 just incorporate all of those together? I mean, if there
4 are empty beds and there's a service need, then I think
5 that warrants a look at -- the provider feels like even
6 though there are empty beds and there is a need for the
7 service, you can look at the need for the service, need for
8 the bed, and then the Board has to make its best decision
9 based on, you know --

10 MR. SULLIVAN: And I don't disagree with that.
11 What is the need of this project and are there empty beds,
12 I think are the two critical factors. The formulas don't
13 guide this process in terribly accurate ways.

14 CHAIRMAN WAXMAN: But the beds can be empty
15 because the services demanded aren't available in those
16 beds.

17 MR. SULLIVAN: That's correct. So I'm not
18 disagreeing with need.

19 MS. HANDLER: So why not buy the empty beds?
20 So why instead of adding beds, why can't we have a system
21 where you're buying those beds?

22 CHAIRMAN WAXMAN: Do you want to open that can
23 of worms. I'm teasing you. That was the one question,
24 when I raised that to the Mother Board, that Eli and I got

1 questions on, and he handled them very well.

2 Yes, Chuck.

3 MR. FOLEY: I think that one of the major
4 problems that this current bed-need methodology has is the
5 fact that -- and what's happened in Mr. Pick's Planning
6 Area is that the bed need was so large because it was a bed
7 need projected out to ten years, and if that bed need was
8 projected to like only out to five years, I don't think
9 that that number would be that high. So, I think one of
10 the major components in trying to tweak the current
11 bed-need formula is go back to a five-year projection
12 versus a ten-year projection, and I think then when you
13 talk about occupancy and you talk about empty beds, it goes
14 back to the old theory that the Board has heard a thousand
15 different times: What is an empty bed? Why do you have
16 empty beds? And, obviously, there's a lot of reasons why
17 we have empty beds. It's the quality of the facility, it's
18 old facilities that have three and four bed wards that's
19 not being occupied anymore.

20 So, just because they have a 70 percent
21 occupancy rate does not mean that -- you know, that
22 facility could be making money and happy and could be at a
23 hundred percent even though seventy percent of the beds are
24 being utilized.

1 CHAIRMAN WAXMAN: I think the beds are empty
2 today for much different reasons than they were five years
3 ago.

4 MR. FOLEY: I agree with you.

5 MR. SULLIVAN: I think as most states do.
6 That's why most of the states have a -- yes, there's no bed
7 need right now, but it's in a planning area. The occupancy
8 gets to 93, 95, 97 percent that -- obviously we don't have
9 to project out five years, ten years, three years, fifteen
10 years. When a planning area hits a certain occupancy
11 level, that indicates that there's a need for additional
12 beds. So, that seems to be a driving standard in a lot of
13 the states, depending on whether we want to pick 93, 95 or
14 97, like New York.

15 MS. DEDERER: But, I mean, we don't have
16 automatic population growth throughout the state. Some of
17 our areas are about as dense as they're going to get and
18 there will not be any growth. Other areas are wide open
19 and who knows what's going to happen.

20 MS. EVANS: Other areas are losing population.

21 MS. DEDERER: Absolutely.

22 MR. PICK: Again, that's why I go back to
23 service then, because you could end up with a large volume
24 of vacant beds and unmet services still be present, which

1 is, again, why I think we need to incorporate these
2 different elements. Clearly, we have to look at how many
3 beds are available, how many are occupied, what services
4 are being offered, and are we meeting the needs.

5 CHAIRMAN WAXMAN: So, what I'm hearing -- I
6 think what I'm hearing is that we're looking for a
7 methodology that incorporates bed needs, service needs and
8 occupancy.

9 MS. EVANS: What's the difference between bed
10 need and occupancy?

11 MR. PICK: Bed need is theoretical.

12 MR. SULLIVAN: It's a formula.

13 MS. HANDLER: Bed need is almost like
14 capacity, and then occupancy is how much of it has been
15 filled.

16 MR. URSO: Mike, does the Board define that?

17 MR. CONSTANTINO: Yes, the Board defines
18 occupancy of long-term care at 90 percent. Bed need is
19 determined by the formula we currently have in place.

20 THE COURT: Okay. So if there is consensus
21 that we're looking to put something together in terms of a
22 policy that's going to incorporate all three elements, do
23 we all think that that is conceivable, that we can sit here
24 as a group or in work groups and come up with a policy that

1 incorporates that?

2 MR. BIBO: Are we talking about a policy that
3 would incorporate them as threshold limits, or just
4 considerations, issues to be considered?

5 CHAIRMAN WAXMAN: I would say issues to be
6 considered, because, as Mike has been kind enough to
7 indicate, regardless of any and all, the Board will still
8 vote one way or the other based on some criteria other
9 than -- or in some cases other than Staff's recommendations
10 and Staff using our threshold -- our considerations.

11 MS. DEDERER: Has anybody been at the Board
12 meetings to see if there are considerations that they have
13 used that they've articulated when they decided to do
14 something?

15 CHAIRMAN WAXMAN: I'm sure that gentleman has.

16 MR. CONSTANTINO: There's been instances
17 where -- part of the Obama stimulus package, there were
18 grants to build long-term care facilities, and it's
19 difficult for the Board to turn something like that down.
20 That was never one of our criteria. We were negative on
21 the report, but they granted and approved. There are other
22 issues that come in and are involved at times. That one
23 comes to mind readily.

24 MS. CUNNINGHAM: Just a question for Mike.

1 Does the availability of financing sometimes play a role?

2 I mean, in addition to that specific grant?

3 MR. CONSTANTINO: Oh, sure. Everything we're
4 seeing now is done through the government, financing for
5 new facilities.

6 MS. CUNNINGHAM: But is the availability of
7 financing part of the bed-need formula?

8 MR. CONSTANTINO: No, no. It's part of the
9 financial and economic criteria we would use to review.

10 MS. DEDERER: But is it something to sway the
11 Board?

12 MR. PICK: If I may, isn't it the reverse? If
13 the financing is not available, the Board won't approve it.

14 MR. CONSTANTINO: Well, yeah, if the Board
15 thinks that the applicants do not have the financing, yes.

16 MR. PICK: So then it's a stopper.

17 CHAIRMAN WAXMAN: What I'm hearing is that
18 most of the financing today is HUD financing.

19 MR. CONSTANTINO: Yes.

20 CHAIRMAN WAXMAN: Okay. If we agree, if this
21 committee agrees that we're going to incorporate all three
22 criterias, going back to this list, the things that we
23 indicated as being contingent upon the criteria, do we
24 still agree that those criteria -- these other items

1 indicated are still contingent upon those three items? And
2 I'm trying to get an opinion and consensus that we now can
3 move forward to start writing a policy, incorporating these
4 things.

5 Terry have I confused you? If not, I'll say
6 some more.

7 (Laughter)

8 MR. SULLIVAN: You're saying there's a
9 consensus, and I certainly hear that there is a consensus
10 on occupancy and service need. Does the committee want to
11 go for a bed-need formula in addition to that?

12 CHAIRMAN WAXMAN: I think I heard that.

13 MR. PICK: That's my sense of -- not everybody
14 necessarily agrees, but I think there's a general consensus
15 that all three elements need to be there.

16 CHAIRMAN WAXMAN: And relying upon the rest of
17 the application and Staff interpretation to lead the Board
18 to the right picture.

19 MR. SULLIVAN: Okay. So then the question
20 becomes what goes into the bed-need formula?

21 CHAIRMAN WAXMAN: No, the question becomes
22 what's in that policy that incorporates bed need as one
23 piece, occupancy as a second piece, and service as a third
24 piece?

1 MS. DEDERER: But we also get to discuss how
2 you determine bed need, right?

3 MR. PICK: We haven't made --

4 MS. HANDLER: We haven't gone there yet.

5 MS. DEDERER: No, no, no, no. It's not like
6 we're going to take the existing bed need and plug it into
7 this group of three. It's one of those things that we
8 we'd --

9 MR. PICK: Right.

10 CHAIRMAN WAXMAN: All I'm looking for now is a
11 big picture agreement that we have picked up a consensus on
12 those three concepts to be part of our policy and that
13 things that we earmarked off of this list are contingent to
14 those or part of those three concepts and they all need to
15 be addressed in that policy, and if we're going to go into
16 a work group, then that is what the work group is going to
17 look at. Although, I think this is so important that I
18 think the work group needs to be the entire committee.

19 Carolyn?

20 MS. HANDLER: I think there are some things on
21 this list, when it comes to service, that we don't want to
22 lose sight of. When you look at the second item it says
23 incorporate problematic aspects of care. I think that gets
24 to service as opposed to --

1 CHAIRMAN WAXMAN: So you want to add that to
2 this list?

3 MS. HANDLER: Yes. I didn't specifically go
4 through this whole list, but I think anything that relates
5 to service or volume of bed or occupancy --

6 MR. SULLIVAN: It's the whole.

7 MR. PICK: It's everything. It validates what
8 we're saying makes sense, because as an over arching
9 formula, we want to make sure that all of these elements
10 that the work groups have determined are important are not
11 only incorporated but are critical to making the over
12 averaging policy effective.

13 MR. FOLEY: I assume that once we do, in
14 fact -- I apologize -- once the committee brings itself to
15 these small work groups, that all of this could be subject
16 to change because maybe they'll find that it can work
17 better or not work at all. So all of this can be changed.

18 CHAIRMAN WAXMAN: Absolutely. Although right
19 now I'm thinking that as critical as this piece is, the
20 work group is going to be the committee, unless there's
21 some logical way to make this into small units, and I'm
22 open to suggestions on that entirely.

23 MR. PICK: Well, I think the over arching
24 principle is the entire committee's work. The sub-parts

1 can be broken up into work groups.

2 CHAIRMAN WAXMAN: So maybe we can go back in
3 this list again and find some smaller subjects and give
4 that to work groups. So, I think our next assignment is to
5 take the three principles and put a general policy together
6 and think how we attach these principles to it. Agreed?

7 MR. PICK: Yes.

8 CHAIRMAN WAXMAN: I hear one agreement. I
9 hear two agreements. You're not agreeing, Teri?

10 MS. DEDERER: No. Well, because how can you
11 say something general, make a general policy, if you don't
12 take into account some of these things?

13 CHAIRMAN WAXMAN: All I have said is that we
14 will write a general policy that incorporates the three
15 concepts and then we will delineate under that general
16 policy the specifics of the more particular or the more
17 specific elements into that -- how those all relate to the
18 general policy.

19 CHAIRMAN WAXMAN: Bill, do you have anything?

20 MR. DART: I think, Teri, that what he's
21 saying is right.

22 MS. DEDERER: Okay. I agree.

23 MR. DART: It's not ignoring the list. It's
24 just that we're viewing the list through these three key

1 items.

2 MS. DEDERER: Okay.

3 CHAIRMAN WAXMAN: Mr. General Counsel, are you
4 okay with what we have gotten to so far?

5 MR. URSO: Yeah, I'm very comfortable, if the
6 committee is comfortable.

7 CHAIRMAN WAXMAN: All right. Are we at a spot
8 now where we can call it a day and -- okay. Can we pick
9 the next meeting, because I think by the time Staff gets
10 out the survey and we get -- tally the data, we could be
11 three months down the road, because I have a feeling it's
12 not going to come out with any agreement at all.

13 MR. BIBO: Currently we have the next meeting
14 scheduled for May 24th.

15 CHAIRMAN WAXMAN: I'm open to whatever day
16 works.

17 MR. URSO: What would you like for the Staff
18 to do in preparation for the next meeting, too? I think
19 that's part of the conversation.

20 MR. PICK: Can I make a recommendation?
21 Perhaps what I think might be helpful is if the Staff could
22 take a first crack at drafting, based on the discussion,
23 what this might look like and then circulate that among the
24 committee members certainly who are here, as well as the

1 ones who were not able to make the meeting, so that they
2 can provide some feedback, and then hopefully we'll get a
3 running start.

4 MS. DEDERER: I think that's a great idea.

5 CHAIRMAN WAXMAN: Mike, Bill, are you okay
6 with that?

7 MR. DART: If it's like a concept type of
8 presentation?

9 CHAIRMAN WAXMAN: That's all it is.

10 MR. URSO: Could we see if Claire has any
11 comments?

12 CHAIRMAN WAXMAN: Claire?

13 MS. BERMAN: Yes. I was listening intently at
14 the discussion, and I think there are a lot of elements
15 that have to be considered if you want to go with any kind
16 of a need formula, whether it's for beds or just services,
17 and if you were going to go with beds, then it kind of
18 brings you back also to a little piece in there about
19 getting an accurate count of the existing beds, which I
20 believe was brought up by the work groups, and that would
21 also be part of the consideration, because if you don't
22 know the true number, then all of the need numbers are
23 skewed, and there may be need in areas where it was
24 previously thought that there was none.

1 CHAIRMAN WAXMAN: Then I guess -- I think
2 you're right and appreciate your thoughts. So that when
3 you're writing your concept paper, maybe with that concept
4 paper is to identify elements that we need to determine to
5 incorporate, like number of real beds, the number of make
6 believe beds and what -- some discussion about determining
7 needs. So, bring -- if you can bring to the committee --
8 which would be an incredible task, but you guys have met
9 every challenge so far, so I have no fear that we can't
10 give you more -- concept paper and then the elements that
11 maybe Claire has identified, and you guys can think about,
12 when you get together, of the things that really need to be
13 incorporated into that concept paper, and that will help us
14 make sure that we are trying to put together something that
15 is realistic and possible to get to.

16 Claire, does that make sense?

17 MS. BERMAN: Yes, yes, it does.

18 CHAIRMAN WAXMAN: Okay. Is it also -- maybe
19 if you'd have time to go back to this list and see if there
20 is a way to group some of these elements together so that
21 we can assign them to maybe four work groups. Does that
22 make sense?

23 MS. BERMAN: Yes.

24 MR. DART: Okay.

1 CHAIRMAN WAXMAN: Off of the summary list
2 there are topics that really tie together very nicely and
3 they could be a work group related task. I know we're
4 asking a lot, and I appreciate your help.

5 Yes, ma'am?

6 MS. DEDERER: Data. I think what you're
7 saying is we don't necessarily have current data on
8 occupancy. The last data we have is 2008, and maybe we
9 can -- not this meeting but the next time -- have somebody
10 explain to us what the data system is and why it takes so
11 long to make it current. There are other states that can
12 put this out, and I'm assuming we have a data system or
13 programming or capacity -- I don't know -- that makes it
14 hard to put those items out, because they're all turned in
15 in a computer form, which makes you think that it's going
16 to run into a data system and spit back out, but I don't
17 think that's the case.

18 MR. BIBO: Doesn't the report we fill out each
19 year give occupancy versus beds?

20 MR. CONSTANTINO: Yes. 2009 is available;
21 2010 we're in the process of collecting it. I think
22 they're probably 15 facilities that have not responded,
23 long-term care.

24 MS. DEDERER: Is that what delays it?

1 MR. CONSTANTINO: Yes. It's also reported
2 data.

3 MS. DEDERER: I understand that, but is that
4 what takes so long?

5 MR. BIBO: We do have '09?

6 MR. CONSTANTINO: We do have '09. We've had
7 that for quite a while.

8 MR. BIBO: And as some of that data we can
9 overlay the SLF beds based on what's out there, both what's
10 approved -- both what's operated versus what's been
11 approved?

12 MR. CONSTANTINO: Authorized, yes.

13 MR. BIBO: And we can do the same thing with
14 assisted living within public health, overlay that
15 separately. So that's all data we can collect.

16 MR. PICK: The limitation of the long-term
17 care report is it reports the census on the last day of the
18 year. So you don't have average census for the year.

19 MR. CONSTANTINO: No.

20 MR. PICK: But you have number of admissions,
21 number of discharges, starting census, ending census for
22 the year.

23 MS. HANDLER: Could Staff send the 2009 report
24 out by e-mail?

1 MR. CONSTANTINO: Sure. Do you want all
2 facilities or just the State summary?

3 MS. HANDLER: Just the State summary, and then
4 could you also send the survey form?

5 MR. CONSTANTINO: The survey form, yes.

6 MS. HANDLER: Just out of curiosity, what's
7 the implications if a facility does not fill it out.

8 MR. CONSTANTINO: Yeah, they're fined.

9 MS. DEDERER: How much?

10 MR. CONSTANTINO: Right now it's \$1,000.

11 MS. DEDERER: And apparently some facilities
12 don't care?

13 MS. HANDLER: \$1,000 per day?

14 MR. CONSTANTINO: No, just \$1,000. We want
15 the data. The data is more important.

16 MS. DEDERER: Than what?

17 MR. CONSTANTINO: The money.

18 MS. EVANS: That's what's wrong with Illinois.

19 (Laughter)

20 MS. DEDERER: If you want the data, a heavier
21 fine might produce it faster.

22 MR. PICK: There is a presumption that
23 punitive action is what causes people to execute. I
24 suspect this has nothing to do with the money. These

1 facilities probably don't have the money to pay the fine
2 either.

3 MR. URSO: That's why we're bringing it up now
4 so Terry can talk with his constituents.

5 MS. DEDERER: If that's the case that tells us
6 that facility is dysfunctional. If they can't produce a
7 report --

8 MR. CONSTANTINO: It's usually the same ones
9 every year.

10 MS. DEDERER: Okay. But are they -- so are
11 they really dysfunctional or indifferent?

12 MR. CONSTANTINO: Some of both.

13 MS. CUNNINGHAM: Some probably have many more
14 problems.

15 MS. EVANS: It's like the least of their
16 focus.

17 CHAIRMAN WAXMAN: Okay. So are we okay in
18 terms of where we're ending today and what we'll look at
19 next time?

20 MR. PICK: Yes.

21 MR. URSO: We might have other small caucuses
22 perhaps.

23 CHAIRMAN WAXMAN: There was a May 24th date
24 given some time ago. Is that still a good date for most of

1 the people here?

2 MS. DEDERER: What day of the week is that?

3 MR. PICK: Tuesday.

4 CHAIRMAN WAXMAN: It is a Tuesday. It's the
5 Tuesday before Memorial Day.

6 MR. SULLIVAN: The last week of the
7 Legislature.

8 MS. DEDERER: Oh, that's bad.

9 MR. BIBO: You're awfully helpful, Terry.
10 When has that been the last week of Legislature?

11 MR. SULLIVAN: Quite a few years now. We
12 haven't gone overtime for a while.

13 MS. DEDERER: Should you move it up or back so
14 it's not the last week of the Legislature?

15 MR. PICK: I would hesitate to move the date.

16 MS. EVANS: Yeah, because it's already been --
17 stuff has been scheduled around it.

18 MR. CONSTANTINO: Can we publish that,
19 Michael?

20 CHAIRMAN WAXMAN: Yeah.

21 Were you happy with this place?

22 MS. DEDERER: Oh, yes.

23 MR. PICK: Lunch was pretty good.

24 CHAIRMAN WAXMAN: At the request of counsel,

1 we're going to start at 10:30.

2 MR. CONSTANTINO: Starting time is 10:30 for
3 that meeting?

4 CHAIRMAN WAXMAN: For that meeting.

5 MS. DEDERER: And you'll let us know which
6 location?

7 CHAIRMAN WAXMAN: We'll try for this one. So
8 10:30 to 2:30, May 24th. We'll try for this place again.
9 Hopefully we'll have some more people join us. That's a
10 month, better than a month.

11 MR. PICK: And it's on the schedule already.
12 Motion to adjourn.

13 CHAIRMAN WAXMAN: Want to thank staff again
14 for everything they've done, and I appreciate their help at
15 the other meeting, too.

16 MR. PICK: And Claire in particular.

17 CHAIRMAN WAXMAN: Claire, if you need a letter
18 written to your boss or something, let us know.

19 MR. CONSTANTINO: Can we put Claire's
20 information out on the web? Anybody have a problem with
21 that?

22 MR. PICK: No, not at all.

23 MR. URSO: I just want to check to make sure
24 it's okay. I don't see a reason why, but just double check

1 that.

2 CHAIRMAN WAXMAN: Any unfinished business that
3 was on the agenda that we kind of went over or went
4 through, I guess.

5 Okay. I will take a motion to adjourn.

6 MR. PICK: So moved.

7 CHAIRMAN WAXMAN: Need a second.

8 MS. EVANS: Second.

9 CHAIRMAN WAXMAN: All in favor?

10 (Ayes were heard)

11 CHAIRMAN WAXMAN: Any opposed?

12 (No response)

13 CHAIRMAN WAXMAN: Meeting adjourned.

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15 END TIME: 1:35 p.m.

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CERTIFICATE OF REPORTER

I, KAREN K. KEIM, CRR, RPR, a Certified Court Reporter in the States of Illinois and Missouri, do hereby certify that the proceedings in the above-entitled cause were taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action, and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

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