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**STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD**

LONG-TERM CARE ADVISORY SUBCOMMITTEE

MEETING

SEPTEMBER 27, 2011

ORIGINAL

NATIONWIDE SCHEDULING

OFFICES: MISSOURI Springfield Jefferson City Kansas City Columbia Rolla Cape Girardeau ■ KANSAS Overland Park ■ ILLINOIS Springfield

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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 September 27, 2011, scheduled to begin at the hour of 10:00 a.m., at the Bolingbrook Golf Club, 2001 Rodeo Drive, Bolingbrook, Illinois.

1 MEMBERS PRESENT:

Michael Waxman - Chairman
2 Eli Pick - Vice-Chair
Stephanie Altman
3 Cece Credille (for Mike Bibo)
Pete Vaughn (for Kelly Cunningham)
4 Teri Dederer
Patricia O'Dea-Evans
5 Carolyn Handler
Jonathan Lavin
6 Dave Lowitzki (and Greg Will)
Phyllis Mitzen
7 Timothy Phillippe
Michael Scavotto

8
9

ALSO PRESENT:

10 James Burden - HFSRB Member
Frank Urso - HFSRB Legal Counsel
11 Juan Morado, Jr. - HFSRB Legal Counsel
Courtney Avery - HFSRB Administrator
12 Cathy Clarke - Assistant to the Administrator
Michael Constantino - HFSRB Staff
13 Bill Dart - HFSRB Staff
Claire Burman - HFSRB Staff
14 Bonnie Hills - HFSRB Staff
Charles Foley
15 Jason Speaks
Terry Sullivan

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Reported by:

21 Karen K. Keim
CRR, RPR, CSR-IL, CRR-MO
22 Midwest Litigation Services
401 N. Michigan Avenue
23 Chicago, IL 60611
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AGENDA

CALL TO ORDER

1. Roll Call
2. Approval of Agenda
3. Approval of May 25, 2011 Minutes
4. Public Participation
5. Member Vacancy Discussion
6. Rules Update
7. Group Discussion -- "Nursing Home Use" Article
8. Work Group Break-out
9. Working Lunch
10. Reconvene Work Group Report
11. Next Meeting
12. Adjournment

1 START TIME: 10:11 a.m.

2

3 CHAIRMAN WAXMAN: I'd like to call the meeting
4 to order. I appreciate everybody coming. We made the
5 decision that we needed a face-to-face, so that we can
6 start delegating some work in some sub-groups, and that's
7 part of what we want to do today. There's no illusion on
8 my part that we'll finalize -- I believe we won't finalize
9 any of the project, but at least we can get started on them
10 and people can start forming work groups and work
11 accordingly.

12 Again, I appreciate you being here. We have
13 some people whose faces -- either because I'm old and I
14 don't remember or they haven't been here before. I'll
15 start here, because I do know my name. We'll go that
16 direction (indicating). I am Mike Waxman, and I do Chair
17 this committee. And we'll go that way (indicating).

18 MR. PICK: Eli Pick, Vice-Chair.

19 MS. AVERY: Courtney Avery, Health Facilities
20 and Services Review Board.

21 MR. FOLEY: Charles Foley.

22 MS. HANDLER: Carolyn Handler.

23 MS. O'DEA-EVANS: Pat O'Dea-Evans with Silver
24 Connections.

1 MR. PHILLIPPE: Tim Phillippe with Christian
2 Homes.

3 MR. SPEAKS: Jason Speaks from LSN.

4 MS. ALTMAN: Stephanie Altman, Health and
5 Disability Advocates.

6 MS. MITZEN: Phyllis Mitzen, Health and
7 Medicine Policy Research Group.

8 MR. LOWITZKI: Dave Lowitzki, SEIU Healthcare
9 Illinois.

10 MR. DART: Bill Dart, Department of Public
11 Health.

12 MR. CONSTANTINO: Mike Constantino Illinois
13 Department of Public Health.

14 MS. HILLS: Bonnie Hills, Public Health.

15 MR. SCAVOTTO: Mike Scavotto.

16 MR. VAUGHN: Pete Vaughn, Healthcare and
17 Family Services, for Kelly Cunningham.

18 MS. CREDILLE: Cece Credille, HCR ManorCare,
19 for Mike Bibo.

20 MR. SULLIVAN: Terry Sullivan, Illinois
21 Council on Long-Term Care. And I think I'm Terry Sullivan
22 today.

23 MS. CLARKE: Catherine Clarke, Illinois Health
24 Facilities and Services Review Board.

1 MS. BURMAN: Claire Burman, Illinois Health
2 Facilities and Services Review Board.

3 MR. MORADO: Juan Morado, Jr., I'm with the
4 Board.

5 MR. URSO: Frank Urso, counsel for the Board.

6 CHAIRMAN WAXMAN: At this point, we don't have
7 an official quorum count. As some of you may remember,
8 people who are sitting in as reps for other people cannot
9 vote. So, we'll hold off on voting on a few issues that
10 need voted on and see if we can gain some people. But we
11 certainly do welcome your input and appreciate you
12 attending.

13 Housekeeping, two things, the important things
14 in life. Bathrooms are around the corner. And has
15 everybody ordered their lunch that wishes to do so? If
16 not --

17 MS. AVERY: Cathy is coming around, if you
18 need to.

19 CHAIRMAN WAXMAN: Raise your hand if you need
20 to order lunch. Otherwise we'll move on.

21 MR. URSO: Mr. Chairman, we do not have an
22 official quorum.

23 CHAIRMAN WAXMAN: How many are we missing?

24 MR. CONSTANTINO: I count nine.

1 CHAIRMAN WAXMAN: One more?

2 MR. URSO: Need ten for a quorum.

3 CHAIRMAN WAXMAN: Somebody want to go to the
4 parking lot.

5 MS. MITZEN: I think Jon Lavin is coming.

6 CHAIRMAN WAXMAN: We'll just back up on the
7 voting issues until we see if we can get a quorum.

8 (Discussion held off the record.)

9 CHAIRMAN WAXMAN: Doctor, would you like to
10 introduce yourself since you --

11 MR. BURDEN: I'm late. Hi. I'm Jim Burden,
12 retired urologist.

13 (Discussion held off the record.)

14 MR. BURDEN: I'm a Board member and the
15 liaison to this subcommittee, which I hope to learn more
16 about today. I recognize some faces here.

17 CHAIRMAN WAXMAN: We're glad to have you,
18 Doctor.

19 Okay. We were talking about vacancies. As I
20 am aware, there is one open position, so we're kind of like
21 open to hear suggestions of people that may want to join
22 the subcommittee. What I do know as sort of the only
23 guiding rules from the original selection process is that
24 no consultants were to be included, and I believe that was

1 the only rule that was held to. Now, the person who
2 resigned did represent a union. The question that I don't
3 have an answer to is whether or not the person has to be
4 replaced by a union person or if we can make some other
5 suggestions as to a vacancy fulfillment.

6 We had sort of a discussion, Eli and I and the
7 Staff, and we were thinking maybe there could be some
8 purpose fulfilled or served by having someone with an
9 academic background. So, as you think about it, if you
10 have some recommendations of people that you'd like to join
11 our committee, please get them to Courtney.

12 MS. AVERY: Yes, and I'll pass them on to the
13 Chair, Mr. Galassie.

14 CHAIRMAN WAXMAN: Again, we are down a member
15 at this point in time, is the only one I'm aware of.

16 We are very, very happy to see the gentleman
17 that just walked in, because you do make a quorum. So,
18 would you introduce yourself?

19 MR. LAVIN: I'm Jon Lavin. I'm with Age
20 Options, the area agency in suburban Chicago.

21 CHAIRMAN WAXMAN: So we now officially have a
22 quorum. Thank you again for coming out in the rain. Now
23 we can do some official business.

24 So, I need approval of the agenda.

1 MR. PICK: So moved.

2 CHAIRMAN WAXMAN: Second?

3 MR. SCAVOTTO: Second.

4 CHAIRMAN WAXMAN: All in favor?

5 (Ayes heard)

6 CHAIRMAN WAXMAN: Opposed?

7 (No response)

8 CHAIRMAN WAXMAN: Motion carries.

9 Hopefully you've had a chance to review the
10 minutes, and do I have a motion to approve the minutes?

11 MR. PICK: So moved.

12 CHAIRMAN WAXMAN: Need a second.

13 MR. SCAVOTTO: Second.

14 CHAIRMAN WAXMAN: All in favor?

15 (Ayes heard)

16 CHAIRMAN WAXMAN: Opposed?

17 (No response)

18 MR. WAXMAN: Okay, the agenda item "Public
19 Participation" is there to simply see if anyone wishes to
20 address the group.

21 Frank, is that what that line is?

22 MR. URSO: Yes.

23 CHAIRMAN WAXMAN: Okay. Terry and Jason and
24 Chuck are the only ones that are not Board members, but we

1 sincerely appreciate your attendance. Do either of you
2 wish to have specific comments to the group, other than
3 your normal participation as we progress?

4 MR. SULLIVAN: I'm glad Chuck is here.

5 MR. FOLEY: And I'm glad Terry is here.

6 CHAIRMAN WAXMAN: We have another Board
7 member. We're going to be in excess of a quorum, so I
8 guess someone can leave, if they want.

9 (Laughter)

10 CHAIRMAN WAXMAN: Teri, would you introduce
11 yourself, Teri?

12 MS. DEDERER: I'm Teri Dederer with DHS Home
13 Services.

14 THE COURT: Okay. We are down to item six,
15 "Rules Update". Courtney, is that yours?

16 MS. AVERY: "Rules Update" is Claire's
17 department.

18 CHAIRMAN WAXMAN: Everyone recognize that
19 Claire is the lady that's been on the phone all of these
20 other meetings, and we're very, very grateful that she's
21 here with us today, her health is allowing her to be here
22 today.

23 Welcome, Claire.

24 MS. BURMAN: Thank you so much.

1 The good news is that the rules for long-term
2 care that this group helped put together were reviewed by
3 JCAR, the Joint Committee on Administrative Rules, and they
4 were passed. So now we're in an adoption stage where there
5 is some more paperwork, and that should be done by the end
6 of the week, when the rules shall be filed. The day the
7 rule is filed, it becomes effective. It will be published,
8 the rule will be published in the Illinois Register ten
9 days after that date, which brings us into October.

10 MS. DEDERER: Were there comments on it?

11 MS. BURMAN: No comments at all, no.

12 CHAIRMAN WAXMAN: Just points out what a great
13 job we did in making our rules.

14 MS. BURMAN: That's right, and I think that
15 they were pleased that we had a professional organization
16 like this subcommittee to work with. I think that added a
17 lot more credence to it, and they do understand that we
18 will be continually forming or developing the rules.

19 CHAIRMAN WAXMAN: I think that's really,
20 really important for all of us to remember, is that the
21 expectation is that we will continue to propose rule
22 changes and new rules and that, you know, the powers-to-be
23 above the Mother Board and -- that our reporting function
24 is expecting us to continue to create new rules and to

1 adjust to changes. So, always be aware that our work can
2 go on, and there is no pressure to meet any more time
3 deadlines, other than our own, to get through this process.

4 Has everyone had a chance to meet Juan Morado?

5 MR. MORADO: How are you doing? I'm the new
6 Assistant General Counsel for the Board. I started back in
7 June. I work with Frank, and this is my first Long-Term
8 Care meeting. Thank you for having me, and I look forward
9 to a productive meeting.

10 CHAIRMAN WAXMAN: One of the things that we
11 have to recognize about Juan is he talks an awful lot.

12 MR. MORADO: Too much.

13 CHAIRMAN WAXMAN: Our first meeting I think
14 that's about what he said, and we were there eight hours.

15 Juan, we're glad you're here, and I'm teasing
16 you, of course.

17 And here come more people.

18 After you sit down, would you introduce
19 yourself so everyone one in the room knows who you are?

20 MR. WILL: Hi, everyone. I'm Greg Will. I'm
21 with the SEIU Healthcare, Illinois-Indiana.

22 CHAIRMAN WAXMAN: Thank you.

23 Moving on, do you want to start -- Eli as he
24 has -- as I have gotten to know Eli, reads an incredible

1 amount of material and forwards on to me extremely
2 interesting and on-the-edge kind of material, and so I hope
3 all of you have read the article that he sent, but we'll
4 take a few minutes and let Eli highlight it and we'll
5 discuss it.

6 MR. PICK: I believe it was a --

7 MS. O'DEA-EVANS: I didn't get it. I didn't
8 get any e-mails about this meeting.

9 MS. HANDLER: I didn't either.

10 MR. URSO: Do we have your correct e-mails.

11 MS. O'DEA-EVANS: I was getting them before.

12 MR. PICK: Okay. For those of you who didn't
13 get the e-mail, the article is titled "Nursing Home Use by
14 Oldest Old" -- in quotes -- "Sharply Declines", and this
15 was a study that examined the patterns, use patterns from
16 1985 and compared it to 1999. So, the 15-year period that
17 was being compared saw a significant drop in -- when they
18 say "oldest old," they're referring to the 85 and older
19 group, and there are very specific reasons.

20 Now, I have read other articles that tried to
21 explain why nursing home occupancies have declined over the
22 last 20 years, none of which, in my opinion, did as good a
23 job of succinctly recapping multiple dynamics that occurred
24 simultaneously. What's commonly identified is the advent

1 of assisted living as being the primary reason, that older
2 folks have chosen as an alternative to nursing homes. This
3 article, I thought, did a very nice job of outlining a
4 couple of other dynamics that were occurring at the same
5 time.

6 But as a backdrop, in that same 15-year
7 period, the number of 85 and older persons in our
8 population in the U.S. increased by a million, which was a
9 dramatic increase in that period of time. So, it went from
10 about 5 million to 6 million, which is a pretty significant
11 increase. In addition, there were about a million assisted
12 living units that were developed around the U.S. at the
13 same time. But, that only accounts for -- according to
14 their analysis, about 600,000 of the million increase in 85
15 and older chose assisted living over skilled nursing or
16 nursing homes as a long-term care option. So, that's about
17 60 percent. That still leaves 40 percent of unexplained.
18 And what the article, I thought, did a very nice job is
19 identifying several -- as I said, several dynamics.

20 Number one, the 85 and older group are
21 significantly healthier now than they were 15 years ago.
22 There was a sharp decline in disability rates in that
23 population, and I believe -- I won't quote the number, but
24 let's say it was close to about half. So, a pretty

1 dramatic change, which meant that individuals in that age
2 bracket had significantly greater options for seeking
3 services and support, while at the same time, the number of
4 comorbid conditions remained the same. So, it really
5 speaks to the progress that our healthcare system has
6 evidenced in that period of time in that conditions are
7 being managed more effectively, there's been advances in
8 treatments that's really allowed individuals who are most
9 vulnerable in being most disabled to maintain levels of
10 independence that, obviously, in the mid 80's they weren't
11 able to do.

12 In addition, the other -- another significant
13 aspect is the rapid development of home and community-based
14 service waivers, that a significant number of seniors,
15 particularly in this "oldest old" group, were able to take
16 advantage of community-based services, as an alternative to
17 the nursing home, to provide support, which, obviously, in
18 the mid 80's, when that wasn't available, nursing homes
19 were their few options. That also impacted simultaneously
20 the growth of long-term care insurance, which is
21 interesting, because coming out of the skilled nursing
22 environment, my experience was we saw very few nursing home
23 stays covered by long-term care insurance. But what the
24 article points to is that the growth of purchasing

1 long-term care insurance policies really started in the
2 80's, and about 10 percent of people over the age of 65 in
3 the year 2000 owned long-term care insurance policies, and
4 overwhelmingly those individuals who needed long-term care
5 services chose to use their long-term care insurance
6 benefit for assisted living and home care, as opposed to
7 nursing home care. So, effectively, what it did is it
8 elevated the elderly out of the levels of poverty. So that
9 in order to access services in the past, Medicaid was their
10 few options, other than financing out of their own personal
11 funds. With the availability of long-term care insurance,
12 individuals are able to use insurance policies to cover the
13 cost of services, even though they don't have the personal
14 resources to fund those services for themselves.

15 So, in effect, what it did is about -- I
16 believe the article talks about to the tune of about
17 20-plus percent individuals have been elevated out of the
18 ranks of poverty, meaning they're not on Medicaid because
19 of long-term care needs.

20 And then the final item, the -- as states are
21 trying to reduce the number of Medicaid recipients in
22 nursing homes, the development of pre-admission screens and
23 the use of aging and disability resource centers to educate
24 seniors in the community on alternatives. The combination

1 of all these dynamics have really spelled an approximate 20
2 percent decline nationally in occupancy in nursing homes on
3 the average.

4 So, I thought in reading this article it did a
5 very nice job of kind of bringing together these multiple
6 dynamics, which really resonated with me when I read it
7 from my own experience, about what's happened over the last
8 20 years, and I thought it was directly relevant to our
9 discussions previously about -- in thinking about how to
10 design a need formula, that these dynamics need to be taken
11 into account in determining what the real need is for
12 skilled nursing services in the community, as compared to
13 the prior approach when these alternatives were not really
14 present.

15 Questions or comments?

16 MS. DEDERER: Observation. Now that you
17 mention the 20 percent, that's about the decline in nursing
18 home usage over that period of time, isn't it?

19 MR. PICK: Pretty close. That's not the only
20 item. It's one of the significant ones, but, again, I --
21 assisted living is the common one. When you look at the
22 regular press, everyone talks about assisted living as the
23 reason nursing home occupancy has declined. The
24 information that's contained in here really expands that

1 information to give us a much clearer picture of what's
2 going on.

3 CHAIRMAN WAXMAN: Tim, are you seeing an
4 increase in long-term care insurance?

5 MR. PHILLIPPE: No, not really, we do not see
6 an increase in our skilled buildings. I think it's
7 similar, that people are using it before they get to us.

8 MS. DEDERER: If that's an option.

9 MR. PHILLIPPE: If they have it.

10 MS. DEDERER: Some long-term care insurance,
11 in days of older, did not offer that home care alternative.

12 MR. PICK: The experience I have is the few
13 that did were generally for short-term stays. So, if
14 they're Medicare and Medigap policies didn't cover the
15 entire period and they needed a stay beyond those periods,
16 then we'd see an occasional long-term care insurance policy
17 being used, but not to the tune of 10 percent of the 65 and
18 older population. That's a significant number.

19 MR. URSO: Eli, I saw the Lewin Group did
20 this, and so they get involved in these types of things.
21 I'm just curious, since this is dated 2006 -- I think it's
22 excellent information -- have you seen or heard of any
23 follow-up to this?

24 MR. PICK: No, I have not. I haven't seen any

1 additional information, and I -- the Lewin Group, it's an
2 interesting group, because they come out of being an
3 asset -- they're essentially a commercial real estate
4 broker.

5 MS. HANDLER: They do a lot of healthcare
6 research.

7 MR. PICK: But underlying their reason for
8 being is trying to help the market understand what's going
9 on and providing -- as a result of those insights, helping
10 owners position their products for sale. So, this has been
11 a nagging question, obviously, for a long time about why a
12 precipitous drop in utilization has been continuing over
13 the last 20 years. So -- but I have not seen a follow-up
14 study.

15 MR. URSO: So, based upon what you said, it
16 sounds like assisted living is really moving up in terms of
17 priority of options for the elderly population; is that
18 correct?

19 MR. PICK: It demonstrates about 60 percent of
20 the decline is accounted for by assisted living, but home
21 care, home, community-based services are growing in their
22 prominence as an option. I think it's very illustrative
23 and indicative that when consumers are given the option --
24 which is what long-term care insurance did, is, "Here's a

1 pot of money, use it any way you want to" -- home care and
2 assisted living were the primary choices that people used
3 for their long-term care service needs being met. So, I
4 think that's very illustrative for us about the way
5 consumers are leaning, as far as what their preferences are
6 when it comes to what services they want.

7 MR. URSO: Curious fact, just listening to
8 this discussion, Dr. Burden, is that the Board doesn't look
9 at assisted living, the board doesn't look at home care.
10 So, I'm just putting that out there, that maybe that's
11 something that should be considered.

12 MR. BURDEN: I think that's a great point. I
13 mean, you're looking at 60 percent of the overall 20
14 percent, as I understood it.

15 MR. PICK: That's correct.

16 MR. BURDEN: I do consider that interesting.
17 As a urologist in practice, this was a significant finding
18 that we found in our practices. More and more of the
19 families of the elderly -- I didn't identify them as 85 and
20 older, but certainly I'll call 75 and older -- were no
21 longer coming to our offices, and nurses were servicing
22 them and giving a call to us regarding some of their
23 problems in our area.

24 MR. FOLEY: I just want to comment that in the

1 study that I believe Claire did, that around the country
2 there's probably about a half dozen states that do, in
3 fact, include assisted living, slash, shelter care, slash,
4 supported living as part of the CON process, because,
5 obviously, as Eli was pointing out, that's where it is
6 today. The problem we have in Illinois today with the
7 assisted living providers, I'm sure everybody will agree,
8 is the fact that they are now taking a level of nursing
9 care residents. We have to remember this is their home.
10 So, if they want to bring in home healthcare, that is their
11 right and prerogative. As you already all know, assisted
12 living is their home. We have the State Department on
13 Aging that receives millions and millions of Federal
14 dollars into that agency for the sole purpose and function
15 of keeping people at home. So, we have -- it's kind of
16 funny that we have one State agency that is basically there
17 to keep people out of nursing homes, yet we have -- excuse
18 me, I still call them Public Aid and Public Health -- with
19 their programs basically that offers that kind of services.
20 You've got State agencies competing against one another for
21 the State dollar.

22 MS. DEDERER: I have to object to that
23 characterization.

24 CHAIRMAN WAXMAN: One second. Tim. I saw

1 Tim's hand first.

2 MR. PHILLIPPE: I was going to say, in terms
3 of the recent years, in terms of our own experiences, this
4 has really speeded up, because more states, including
5 Illinois, have more Medicaid-waiver beds for an assisted
6 living type product. So, you have more people who have the
7 option of assisted living who didn't have it before, the
8 smaller communities, where they did not have assisted
9 living five years ago, six years ago. And then home health
10 was actually increasing dramatically. I sit on a board
11 that has multiple home health agencies, and it's amazing
12 the growth in home health services and the acuity they're
13 taking in home health care today, compared to even four
14 years ago. So, I think it's even moved faster, don't you
15 think?

16 MR. PICK: Oh, yes, it's accelerated, no
17 question.

18 MS. DEDERER: I'd really like to object to
19 that characterization of competing against one another.
20 I'd like to think that we are trying to be responsive to
21 the desires and needs of consumers, and if -- I mean, it's
22 like any other dollar. You know, Wal-Mart is out there
23 trying to figure out what consumers want, and they provide
24 it. There is competition, of course, with Wal-Mart. But,

1 you know, we're -- I think most of us are kind of in public
2 service and -- aren't we, kind of? Isn't it like
3 not-for-profit a lot, and we're supposed to be helping
4 folks.

5 CHAIRMAN WAXMAN: I don't think Chuck meant it
6 in a derogatory sense.

7 MR. FOLEY: No, that's absolutely correct, and
8 I do apologize for that.

9 CHAIRMAN WAXMAN: I think he was saying we
10 function in a society where there are options available to
11 people and there are State agencies that are trying to help
12 in that option, but, you know, is there some -- maybe more
13 ironic than anything else, the State is doing --
14 functioning this way.

15 Chuck, I don't want to put words in your
16 mouth.

17 MR. FOLEY: I want to add also, the Planning
18 Act also, I believe, specifies that we -- "we" meaning the
19 Planning Board and our review process -- should, in fact,
20 be looking at those alternatives that are available through
21 the Department on Aging. Is that not correct?

22 MR. URSO: Yes, that's a fair statement.

23 MS. MITZEN: I'm Phyllis Mitzen, and I would
24 like to interject in here. Not only is it in the Act, but

1 there are those of us around the table who are coming and
2 committed to this committee who represent those -- when you
3 talk about alternatives, from our perspective, we think
4 about nursing homes as an alternative, because it's one of
5 many alternatives that are available to people. And when
6 we're on this commission for long-term care, I don't
7 consider long-term care as being nursing home. I consider
8 long-term care as being a wide range of available services,
9 both housing and service options. And so I think that
10 that's the perspective that I'd like to see and the
11 language also that I'd like to see this committee embrace.

12 MS. DEDERER: Very nicely put. Thank you.

13 CHAIRMAN WAXMAN: I appreciate your comments.

14 MS. MITZEN: I do understand what the
15 obligations are of this group, but I think we're -- if it's
16 only going to be considered as those very, very specific
17 things, without consideration of everything else, then I
18 become superfluous, and I don't belong here.

19 CHAIRMAN WAXMAN: We certainly want your
20 opinion and everyone's opinion in terms of how to look at
21 long-term care. I only will find out -- before Frank
22 does -- that our scope of authority, though, isn't as broad
23 as the definition of long-term care is.

24 MS. MITZEN: I understand what the scope of

1 authority is, but without our -- we're sitting here for a
2 reason, I think.

3 CHAIRMAN WAXMAN: Yes. And, again, I
4 appreciate --

5 MS. MITZEN: And I think that that work, in
6 terms of looking at the three to five-year picture out -- I
7 don't think we can look ten years out, but I think in
8 looking, we have to transform some of our thinking, because
9 as evidenced from this article -- and, Eli, thank you so
10 much for finding this piece, because it was really helpful.
11 I think it's useful for the -- for all of us to be
12 reviewing this and the reasons why these things are
13 happening, and this is five years old, and things happen
14 really fast.

15 CHAIRMAN WAXMAN: And, again, we want
16 everyone's opinion, and the committee is made up the way it
17 is so that we get that broad spectrum of everyone who is
18 working the various stages of long-term care, the continuum
19 of long-term care. And I'll be very blunt. I think we
20 should have authority over assisted living -- but we
21 don't -- because assisted living is a major piece of
22 long-term care today. But right now, we don't have that
23 authority.

24 MS. MITZEN: If we don't take it into

1 consideration, we're not going to be fulfilling our
2 responsibility.

3 CHAIRMAN WAXMAN: And that's my point. My
4 point is we have to take the very broad perspective of all
5 of the spots on the continuum that everyone represents, but
6 when it comes back to us writing rules and suggestions, we
7 can suggest that some of those things become part of our
8 authority, but right now we don't have that authority. So,
9 I need to make sure that when we start talking about
10 changes and we're writing rules and regulations, we have to
11 be responsive to our authority. But I totally agree with
12 you, if we don't consider all of the aspects, we're doing a
13 disfavor to the committee, to ourselves.

14 MR. SULLIVAN: I'll pick up with what Phyllis
15 says. I'm increasingly uncomfortable with even the phrase
16 "long-term care" as it applies to anybody. It's a range of
17 senior care options that we're talking about, and even, you
18 know, the traditional nursing and rehabilitation facility
19 is not long-term care anymore either. The turnover we have
20 is incredible, you know, and Eli's facility turns over
21 every three months, and we have more than a hundred percent
22 turnover at this point state-wide, with last year 42,000
23 people leaving nursing facilities in less than three
24 months. It's a different business. None of us are

1 long-term care.

2 MR. LAVIN: I think there are some things that
3 are occurring in terms of looking at global expenses for
4 long-term care. I think in terms of the --

5 MR. SULLIVAN: For what?

6 MR. LAVIN: Global budgeting.

7 MR. SULLIVAN: For what?

8 MR. LAVIN: For long-term care.

9 (Laughter)

10 MR. LAVIN: I will hold to that. There is
11 such an animal. And I think we have -- so, I think we
12 really need to be able to look at the work of the Older
13 Adult Services Advisory Committee, which I used to be on,
14 and I think we need to try to be sure that if we look at
15 establishing principles for claiming that a new facility or
16 expansion should exist, that we find some way of including
17 these other factors, including what are the other available
18 services and alternatives and what are people using in a
19 particular area? I don't know if that's beyond our
20 authority or not, but maybe we should try to extend our
21 authority to reconsider what this is really all about.

22 CHAIRMAN WAXMAN: Again, I would like to
23 remind the group we're functioning with two kind of rules.
24 One is the exact language within the Regs that we can

1 propose changes to. We also have the ability to recommend
2 to the Mother Board changes that we'd like to see, such as
3 what other providers to the elderly should be part of our
4 group. Again, I think I'm not the only one that believes
5 assisted living should fall under our authority. So,
6 again --

7 MR. FOLEY: It needs legislative change,
8 though.

9 CHAIRMAN WAXMAN: Again, we can propose it.
10 We can't make it happen, but we can propose it to the
11 Mother Board and hopefully they will agree with us and they
12 will then propose legislative changes.

13 MS. O'DEA-EVANS: I just want to clarify, just
14 so we're aware. Assisted living is primarily private pay.

15 MR. PHILLIPPE: It's all private pay.

16 MS. O'DEA-EVANS: So, the supported living
17 facilities have some funding.

18 CHAIRMAN WAXMAN: Well, SLF's are all
19 Medicaid.

20 MS. O'DEA-EVANS: No, they're not.

21 MR. PICK: They're the only Medicaid
22 payments --

23 MS. O'DEA-EVANS: As we're looking at this
24 from a cost containment, as far as Illinois Medicaid

1 dollars going out, there's more of a need probably to limit
2 the supportive living facility structure, kind of fits in a
3 little tighter with what we're doing, from a financial
4 perspective.

5 MR. PHILLIPPE: Just one comment on regulating
6 assisted living Certificate of Need. Assisted living
7 really has been able to grow and develop to meet the needs
8 of what people want. So, by not having a limitation --
9 there wasn't even licensure for quite a while in
10 Illinois -- it allowed people to experiment, to create
11 programs, to really meet the demands of the market.
12 Including a Certificate of Need process, many people will
13 be against it, because they feel like it would stop all
14 innovations.

15 CHAIRMAN WAXMAN: I think the -- do you want
16 to say something?

17 MR. PICK: I was going to recap. I'm
18 sensitive to the time.

19 So, really, the purpose of distributing this
20 material was to stimulate thought and discussion in light
21 of having some broader understanding of what were the
22 market forces that got us to where we are, or at least this
23 material tells us where we were five, six years ago, and we
24 know that the market has continued to evolve and the pace

1 and rate of change has accelerated.

2 But there are other dynamics that are
3 occurring simultaneously. We have an economy that has
4 slowed down a lot of movement. There are many more seniors
5 who are -- have remained in their homes, even though they
6 might not have wanted to, because the economy has forced
7 them to remain there because they haven't been able to
8 access the equity out of their homes that they historically
9 have wanted to do. That has changed the dynamics in the
10 assisted living market, which this article doesn't address
11 at all, because it wasn't present at the time. So, there
12 are dynamics that are continuing to impact, and so, you
13 know, again, the purpose of distributing the article was
14 not intended to identify or define what the scope of work
15 is. It was really to expand our understanding about why
16 things are occurring, so that in the course of our
17 implementing our charge, which is to help reform public
18 policy in a way that expands and enables citizens to have
19 access to the services they need and want, that that's
20 really our purpose, and I think that that's -- and that was
21 the reasoning behind providing this information, is just to
22 give us greater insights into what's going on. And our
23 challenge is particularly significant when the formula that
24 we're working with is almost 40 years old. To me, that's

1 really the overarching charge.

2 CHAIRMAN WAXMAN: We'll take two more
3 comments.

4 MS. ALTMAN: I just wanted to say everyone
5 says "elderly" and "senior". It's increasingly not elderly
6 and senior. It's people with disabilities and mental
7 illness, and so -- and, again, we're talking about the
8 facilities, or that's my understanding of our charge here,
9 basically has been facility based, whatever those
10 facilities are going to be that come under the licensing.
11 So, it's one of the things that we've had trouble with here
12 anyway. We're not OASAC, we're not DSAC, the Disabilities
13 Services Advisory Committee. We're not rebalancing
14 long-term care. We're talking about the continuing need of
15 these kinds of facilities. And so to the extent that -- I
16 don't think we have as many people on this committee who
17 have that expertise, but to the extent that -- this really
18 isn't about seniors and the elderly increasingly,
19 especially in Illinois, especially under Medicaid.

20 MS. O'DEA-EVANS: I just wanted to point out
21 that this did come out in 2006, and it's interesting. I
22 just saw a study that was done by the ALFA, the Assisted
23 Living Federation of America, and they showed in 2008
24 almost a 25 percent decline in their use of their

1 facilities, which, of course, comes from a national
2 perspective, but, because it is private pay and because it
3 is, you know, part of the whole housing structure. So,
4 while this information is really good, it's very volatile
5 with what else is going on. That market especially is
6 impacted by that, because it is private pay, and I'm sure
7 if we looked at our own state, we would probably see an
8 increase in use of the supported living facilities during
9 that same time period for some of the same reasons. But I
10 haven't looked at that data. But that is an interesting
11 study. I would be happy to forward that to the members,
12 about that private pay segment.

13 CHAIRMAN WAXMAN: Chuck, I'd like to move on.

14 The documents that were e-mailed out are --
15 two of them were from past meetings. One is the -- both of
16 them were the work that Claire has done on the comparison
17 of CONS in other states and comparison of current trends.
18 So, I don't know if Staff brought any of those, extra ones
19 with them.

20 MR. CONSTANTINO: I've got a few.

21 CHAIRMAN WAXMAN: There are just a couple that
22 didn't get the e-mail.

23 When Eli and I met with Staff a little while
24 ago, we went back to the list of priorities and topics, and

1 we then were able to redefine them. This is the other
2 document that was sent out, besides the agenda, and we were
3 able to kind of make a more concise, priority summary. So,
4 what we believe ranks as number one, putting three kind of
5 concepts together, is modify current bed
6 formula/methodology, inputs and bed-need calculation, and
7 account for licensed beds that are not operational. So,
8 what I would like to do today is break into three work
9 groups and each group take one of the topics in line one
10 and begin thinking about that.

11 Now, I could do this the old-fashioned way, A
12 B C, but I want to try and see if people have their own
13 personal priorities in addressing one of the three that are
14 on that list and see if there are enough to form committees
15 for three of them if people break that way, if that makes
16 sense to you. So, by show of hands, how many people are
17 interested in working on modify current bed formula and
18 methodology?

19 (Indicating)

20 CHAIRMAN WAXMAN: We've got five. How many
21 would like to work on inputs and bed-need calculation?

22 (Discussion held off the record.)

23 CHAIRMAN WAXMAN: I'm trying to take the three
24 subjects on line one and make three working groups.

1 MS. MITZEN: Could you help us differentiate?

2 How do you separate one and two?

3 MR. SULLIVAN: And three.

4 MS. MITZEN: Three may be a separate issue,

5 but one and two are -- I guess three, are influenced --

6 MS. AVERY: Are we looking at number one?

7 MS. MITZEN: It's divided into three separate

8 things, current bed formula/methodology, inputs and

9 bed-need calculation, and account for licensed beds that

10 are not operational. That's the way I'm understanding.

11 CHAIRMAN WAXMAN: Yes.

12 MS. ALTMAN: And you want to break it into

13 three different ones?

14 CHAIRMAN WAXMAN: Yes.

15 MS. MITZEN: What's the difference between

16 one and two? Can you explain that?

17 CHAIRMAN WAXMAN: In my opinion -- Chuck?

18 MR. FOLEY: I was going to just make a

19 comment, the word "methodology" meaning also the formula.

20 So, the Planning Board does have in their rules an actual,

21 very detailed methodology that they use to calculate the

22 bed need. So, I think what this is trying to say is that

23 we need to look at that precise methodology formula and see

24 if that could be modified, changed, what have you.

1 And then item number two, inputs and bed-need
2 calculations, to me I look at that as being what needs to
3 be included or taken out of the current methodology, such
4 as do we or do we not include shelter care, assisted
5 living, supported living, et cetera.

6 Number three, I don't think that's -- I think
7 that's just a matter of us trying to figure out the number
8 of beds out there that are actually -- all beds are
9 licensed, but there are also licensed beds that are not
10 operational; whereas, we have a lot of facilities that have
11 three and four-bed wards that are being utilized as private
12 rooms, for instance, but yet still licensed for three or
13 four beds and not just one, and using them as one bed. So,
14 we need to get somehow a better handle on that. I think as
15 Mr. Constantino will indicate here, a few years ago the
16 Planning Board Staff did the same thing with hospitals
17 where they were able to go in there and to identify actual
18 beds in use.

19 Is that correct, Michael?

20 MR. CONSTANTINO: We do an annual bed survey,
21 yes.

22 MR. FOLEY: So, we could hopefully do the same
23 thing with nursing homes, because that's just a function of
24 the Staff.

1 MR. SULLIVAN: I kind of support the mild
2 revolt that's going on here. It seems to me that --

3 MR. PICK: I would call it an undercurrent.

4 MR. SULLIVAN: The expertise that goes in
5 these categories, it would seem to me you're dividing --
6 it's an artificial division. I think the people who are
7 interested in topic number one are interested in all three,
8 and it's a very tough one. I think in terms of the
9 interests of this group, as I'm looking around, the three
10 topics should be the three that are on here and not divide
11 us up, split us up literally with the first one.

12 CHAIRMAN WAXMAN: Well, then we are making a
13 bigger job, and I have no problem with that. Obviously,
14 when we put it together, it was -- that was one of the
15 thoughts. But, again, then I need people to understand
16 that we're not going to come out today with a solution,
17 other than a start to looking at all three of these topics.

18 So, again, I will go back and rephrase the
19 question. Are there enough people who are -- have an
20 interest in item two or three, so that we have three
21 working committees, one taking the first line item, one
22 taking the second line item, and one taking the third line
23 item, to begin working groups that way?

24 MS. DEDERER: You mean --

1 MR. PICK: As opposed to dividing one into
2 three.

3 MS. ALTMAN: Could you explain what the
4 ranking one and two, four and five, what that means and
5 just a little bit about what the third thing --

6 CHAIRMAN WAXMAN: It came from one of our
7 first meetings when we broke into smaller groups and we had
8 about twenty items listed of priorities, and then we
9 reformulated those twenty items into three line items. If
10 you want the original document, we have it.

11 MS. ALTMAN: I was just wondering why it was
12 one and two or four or five.

13 CHAIRMAN WAXMAN: Because that's the way we
14 did it.

15 MR. PICK: And we also combined a couple
16 items.

17 MS. ALTMAN: Can you also explain number
18 three, what's entailed in that, discussing other states
19 doing this or --

20 CHAIRMAN WAXMAN: The comment has -- there's
21 been discussion in this group on several meetings that
22 market supply and demand should have a larger role to play
23 in bed needs and that those people who are operators can
24 clearly explain that there are homes that have excess beds.

1 MS. ALTMAN: I understand what bed buying is.
2 I just meant what would we be discussing in this group,
3 about our State doing this or whether --

4 CHAIRMAN WAXMAN: How to do it.

5 MR. SULLIVAN: What other states are doing.

6 CHAIRMAN WAXMAN: The issues are geographical,
7 legal; there's a major accounting piece to buying and
8 selling beds. You know, if you are then going to allow
9 buying and selling beds, now you have created an asset. So
10 what happens to your balance sheet if you have excess beds
11 and if you buy them, that kind of stuff.

12 MS. ALTMAN: I get it. And then number two or
13 the second thing there, "incorporate programmatic aspects
14 of care," what does that mean that we would be discussing?

15 CHAIRMAN WAXMAN: There was, again, several
16 meetings where the concept of -- again, if we can use
17 Mr. Pick's nursing home -- or used to be Mr. Pick's
18 nursing home -- that he created several levels
19 of specialized care, such as trachs, vents, dialysis, and
20 cardiac, and whether that's a function that should be
21 included as to how we look at future needs and future
22 licensing requirements. In other words, is it possible
23 that we should be looking at homes -- look differently upon
24 a home that is proposing one or two specific kinds of

1 units? Because we all recognize that the acuity level
2 coming out of the hospital is much different than it was
3 two years ago or three years ago.

4 MS. ALTMAN: I understand. So, should we be
5 incorporating special features into the need. I get that.

6 MR. PHILLIPPE: Just to clarify, places that I
7 operate where we have bed buying, they don't have a
8 bed-need formula. They use the bed buying in lieu of
9 actually having a bed-need formula. So, that is confusing,
10 because there's no point in spending a lot of energy on
11 this if we're going to keep the same formula anyway or
12 modify the bed formula and keep it, because the bed buying
13 is in lieu of a formula.

14 CHAIRMAN WAXMAN: Claire, are you aware that
15 there are some states that have both?

16 MS. BURMAN: There are at least a couple of
17 states that do have the bed buying in place but it's within
18 a framework so that there is not a maldistribution. So,
19 beds are somehow assured of going to places where there is
20 a need.

21 MR. PHILLIPPE: Okay. That's good to know.

22 MS. BURMAN: It's within the framework.

23 MS. DEDERER: So, you're saying a home could
24 choose between trying to buy beds or going for a

1 Certificate of Need to expand?

2 MS. BURMAN: But it is within a structure, not
3 just go like wild fire, you know.

4 MR. LAVIN: Should that be selling
5 non-operational beds? Are those related, those two
6 concepts?

7 MR. SULLIVAN: That's the intention. They are
8 related and that's one of the reasons for the suggestion of
9 bed buying, is what do we do with empty beds? And right
10 now, the only thing a facility can do in Illinois is sell
11 the whole facility. Is it time where we get to the idea
12 of, if I have unoperational beds, can I sell those beds and
13 reduce my license and my CON Certificate?

14 MS. DEDERER: And address your mortgage
15 issues.

16 MR. SULLIVAN: And maybe have some capital to
17 do modernization.

18 CHAIRMAN WAXMAN: Okay. Are the three items
19 clear now for people to kind of choose if they have a
20 partial or a potential interest in working on one of those
21 three groups?

22 MR. PICK: Courtney just said that if bed
23 buying is not something that seems to be a high priority at
24 this particular point in time, we could take the first two,

1 work on those, and then come back to the bed buying.

2 MR. SULLIVAN: I think it's a priority.

3 MS. DEDERER: I think it's a priority, too. I
4 mean, from committees I've sat on, nursing homes are really
5 struggling with this whole issue of non-operational beds
6 and their mortgage, and they are not free to take those
7 licensed beds away, because then their mortgage rates go
8 through the ceiling. So, this is an economic issue, and
9 economics is number one, I think, for this whole issue with
10 nursing homes, isn't it? Nursing homes are dying out
11 there.

12 MR. PICK: Let's go with the three.

13 MS. BURMAN: One thing that is important by
14 still looking at the bed-need formula is that you're still
15 going to have applicants that want to construct a new
16 facility. You're going to have other people who want to do
17 different things. They don't have an excess of beds or
18 they don't have a relationship with another entity that
19 wants to sell beds to them. There's a lot of things going
20 on in the middle. You're always going to need to have some
21 way to determine the need for future beds within a small
22 time frame, say five years. And one of the important
23 pieces in the first line on this sheet of priorities is the
24 account for beds. Hopefully this group can come to a

1 conclusion as to what kind of beds we're counting. Is it
2 purely the licensed number? Is it the operational number?
3 Because whatever number you pick has to be the real number,
4 because it's the last step in any bed-need formula, if you
5 take away beds you already have. It's like making a cake.
6 The recipe says you need ten eggs -- it's a big cake.
7 You think, "I don't have ten eggs. I have some eggs
8 already," and you go and count and say, "I have six eggs."
9 So you only need four. But if you're subtracting the wrong
10 number, your number needed is all skewed.

11 MS. DEDERER: I think I missed the meeting
12 where this was discussed. How do -- if you buy the beds,
13 you're really just buying the licenses; then you still have
14 to do some construction, right?

15 CHAIRMAN WAXMAN: Maybe, maybe not. There are
16 some homes around that have space availability.

17 MS. DEDERER: Okay. So they could add beds.

18 CHAIRMAN WAXMAN: Yeah. The current Regs
19 allow you to add 10 percent beds simply by writing a
20 letter. So, if you have a hundred percent beds, you can
21 always add ten beds just by writing a letter and you can
22 also take ten beds out of operation the same way.

23 MR. PICK: The one thing we did say is if you
24 get additional beds, you have to use them, that you can't

1 inventory -- in other words, "I'm going to buy beds because
2 then I'm going to sell them later."

3 (Laughter)

4 MR. PICK: Seriously, this would occur.

5 MR. SULLIVAN: Haven't you ever heard of the
6 nursing home pit?

7 CHAIRMAN WAXMAN: If we allow beds to be
8 bought and sold, you have created a market for beds. So,
9 someone could try and corner the market on beds, inventory
10 beds. So there has to be some discussion about if you buy
11 a bed, how long can you have it without putting a body in
12 it, without putting it in operation.

13 MS. CREDILLE: It appears that Illinois is
14 over-bedded. If you look at some of the data that we've
15 shared, Illinois on paper is over-bedded. But the question
16 is are they the appropriate beds? As an operator, you
17 can't fill three-bed wards. Many times you can't fill
18 semis anymore, because the hospitals are all private pay
19 beds, so the consumer is looking for private pay. So, the
20 ability then to buy beds and create state-of-the-art
21 facilities is leverage then for the people who have
22 mortgage issues in their current nursing homes. They could
23 gain capital to create state-of-the-art beds in their
24 current facility, as an example, that would better meet the

1 needs of the consumer, because the consumer is looking for,
2 quite frankly, private pay beds, for the most part, on your
3 short-term stay patients, not necessarily your chronic,
4 although some of those patients -- primarily the private
5 pay patients who are dwindling -- but they're looking for
6 private pay beds also.

7 MS. HANDLER: Can I just ask you to clarify
8 for me, because you keep using the word "private pay beds,"
9 but what I'm really hearing is private rooms.

10 MS. CREDILLE: Private rooms. There's private
11 pay patients who are looking for a private room, and then
12 there are just in general, the population is looking for a
13 private room. The hospitals are all building private rooms
14 for infection control reasons, regulatory, et cetera, and
15 it's filtering down into the segment for senior services.

16 MS. MITZEN: I guess I would just like to
17 kind of flip the conversation around. Our purpose, I
18 think, is to assure that there is a combination to meet the
19 needs of what we're calling the consumers, the people out
20 there who need these services, and it's not to -- I mean,
21 obviously, we want to protect businesses, but the real
22 reason for a business being in business is to meet the
23 needs of the people who need those services, and I think we
24 need to keep the focus on that, so that we can -- so that

1 we're not protecting what was, but how do we change it so
2 that it meets the needs of the people who need those
3 services.

4 CHAIRMAN WAXMAN: Well, I think all we're
5 saying is that market supply and demand needs to be
6 included in -- may need to be included in how we create
7 beds in Illinois nursing homes.

8 MS. MITZEN: But we're a public body, so I
9 think it's more -- I know we're throwing around the word
10 "consumer," but I tend to like client better or people, you
11 know.

12 MR. PICK: If I may, there is another example,
13 and while the national and state-wide trend is definitely
14 moving in the direction of single rooms, you could have a
15 market area where the facilities that are available, one,
16 is successful in meeting the needs of the clients in that
17 market and others may not be as effective, and that
18 organization is limited in its ability to expand because
19 there's so many vacancies in that local market area, and
20 the bed-need formula may determine that there are no need
21 for additional beds, because there's adequate supply in
22 that market, but then the clients are denied services that
23 they want because it's not available in their local market.
24 So, bed buying provides an alternative in that scenario.

1 So, I think we need to be careful about not, you know,
2 imposing national or broader trends into local markets
3 where you may have unique circumstances that, you know, we
4 need to develop opportunities and options.

5 MS. MITZEN: I appreciate that. I
6 understand.

7 MR. PHILLIPPE: In terms of protecting the
8 client and also allowing for innovation, one of the things
9 that's different about Illinois is that our Medicaid rate
10 is very low, and we talk about --

11 CHAIRMAN WAXMAN: And we're proud of it.

12 MR. PHILLIPPE: I guess some people can be
13 proud of it.

14 (Laughter)

15 MR. PICK: And we wait eight months to get
16 paid.

17 MR. PHILLIPPE: I have two places in Ohio and
18 the Medicaid rate dropped from over \$190 to \$170 because
19 they said they need to learn from Illinois and be more
20 efficient.

21 (Laughter)

22 MR. PHILLIPPE: But, really, one of the false
23 concepts really in the Certificate of Need is that the beds
24 are a commodity and it's all the same in the state, like

1 gasoline. The beds are not the same. That's what Eli is
2 saying. Some buildings are very nice, some are old. Okay.
3 But the problem in meeting the need of the private pay,
4 private room, or maybe short-stay rehab person is that -- I
5 always hear the number -- about seventy percent of all of
6 the beds in Illinois has somebody who is funded by
7 Medicaid. That's what I used to hear, so I don't know if
8 it's changed, but that's what I used to hear.

9 MR. PICK: I think that's pretty close.

10 MR. PHILLIPPE: So, what that means is, yes,
11 if you allow change to allow aggressive building for that
12 handful, that 30 percent, that short-stay rehab, Medicare
13 or private pay, so they can have those nice rooms, that
14 means you're pulling those funds out of the other buildings
15 that are sharing that population today and that's helping
16 to fund better care for those clients who are on Medicaid.

17 MS. DEDERER: Yes.

18 MR. PHILLIPPE: And if you get aggressive
19 about changing it, it will be good for a few aggressive
20 buildings, and we, like everybody, will be trying to do
21 that. However, is it good for the other 65 percent or 70
22 percent of the people in the state of Illinois in a
23 Medicaid bed?

24 MS. DEDERER: It could be. We do have nursing

1 homes that are chosen in a community over other nursing
2 homes in a community and, therefore, as you said, some of
3 the nursing homes are getting more and more beds available
4 that nobody wants and the other nursing homes that are more
5 desirable, for whatever reason, are running out of beds.
6 But if you did a bed-need formula, there is no additional
7 bed need, because we sell all of the empty beds over here.
8 If this guy could sell his beds to somebody who has a
9 nursing home that people want to go to, if they could sell
10 beds that people don't want to go to to the places that
11 don't have beds that people do want to go to, then we are
12 meeting consumer needs and we are allowing a transition --
13 a way for nursing homes that maybe aren't doing so well to
14 phase out.

15 MR. PHILLIPPE: That's true, right, except
16 that as a builder, an operator, as an operator -- and we
17 also build -- you're not going to build anything new for a
18 Medicaid resident in the state of Illinois, are you? It's
19 not financially feasible. You cannot pay the debt, the
20 payment is too low to pay the debt.

21 MR. SCAVOTTO: That's right.

22 MR. PHILLIPPE: So, everybody who is building,
23 everybody that I have talked to lately, they're building
24 for short-term rehab or private pay, because they can't

1 afford, really, for Medicaid. The rates are too low to pay
2 the cost of the building.

3 MS. ALTMAN: That's building but not
4 existing -- there are existing buildings that are majority
5 Medicaid that are turning a profit, no matter how small
6 that profit is. They're literally not going under.

7 MR. PHILLIPPE: Because they're old buildings.
8 They don't have all of that debt on them today.

9 MS. ALTMAN: Okay. But there are facilities
10 that are succeeding, they are not under, they're not --

11 MR. PHILLIPPE: Right, but they're old
12 buildings. They could not build a new building to serve
13 that same number of people today and operate it without
14 huge financial losses.

15 MR. SCAVOTTO: That's right.

16 CHAIRMAN WAXMAN: Steph, I'd like to point out
17 that there's a difference between making a profit in
18 today's world on an accounting basis and having cash to be
19 viable, and I think when the State goes out six months in
20 reimbursement, you can show an income statement that has a
21 profit on it, but you're going to be struggling to meet
22 your payroll, unless you have deep pockets.

23 MS. HANDLER: Isn't it a 160 days?

24 MS. ALTMAN: No, I understand the issues in

1 terms of business, but when people look at that, though --
2 I mean, name facilities that would qualify as going under,
3 meaning they are closing, because of Medicaid delay payment
4 or payment.

5 CHAIRMAN WAXMAN: I asked Mike that question,
6 and since January, you found six?

7 MR. CONSTANTINO: Seven.

8 CHAIRMAN WAXMAN: Seven facilities that have
9 closed.

10 MS. HANDLER: Since January?

11 MR. PICK: If I may, I think we're having
12 committee discussions in the entire group.

13 MS. ALTMAN: I think we should do this as a
14 whole. It's not that big. We're -- it's -- we've got like
15 15 people, basically.

16 MR. WAXMAN: Okay. Let me bear my soul, if
17 you may.

18 MR. LAVIN: Can I ask just one question? When
19 we talk about bed buying, some states buy beds, is that
20 part of that discussion or not?

21 CHAIRMAN WAXMAN: It's open to discussion.

22 MR. LAVIN: Okay. Well, I agree that we're --
23 it's really hard to figure out what we're doing, if we're
24 having a full discussion.

1 MR. SULLIVAN: Mike is in the process of
2 bearing his soul.

3 CHAIRMAN WAXMAN: One of the issues I've heard
4 a couple of times is that some committee members are
5 feeling non-productive because there's not the opportunity
6 to do some concrete work and, consequently, the reason I
7 proposed with Staff that we go into three work groups is
8 that we can become productive via groups. However, I'm
9 also open to the fact that we continue our discussion. All
10 I want to do is make sure that people are feeling that
11 coming to this committee is a useful -- has a useful
12 purpose and that we are making progress. So, if discussion
13 needs to continue the way it is, I'm fine with that. If we
14 want to split into thirds and start working on a -- in each
15 of those groups on one of those topics, I'm fine with that,
16 too. I'm just trying to meet the needs of committee
17 members.

18 So, what is the pleasure of the group? Do you
19 want to continue this discussion in general and think about
20 our next meeting, having enough information to pick
21 subjects to begin working on them, or do you want to start
22 in to small groups today and work on it that way? I'm
23 open. The reason -- again, I'm being very, very honest
24 with you. As Chair of the committee, I'm trying to respond

1 to some of the feedback I have heard that, you know, we
2 haven't done anything, we haven't been productive, we
3 haven't written anything. So, I was trying to find a way
4 to move in that direction differently.

5 MR. LOWITZKI: It seems to me that these are
6 pretty big, important conversations that we'd end up having
7 to discuss as a whole group anyway. So, it just seems that
8 the work groups are going to be somewhat of a waste of
9 time, because you're going to have to repeat the same
10 conversations.

11 MS. ALTMAN: I agree with that.

12 MS. DEDERER: I agree.

13 MS. MITZEN: I'd like to add to that.

14 There's such a diversity of expertise in this room, and
15 this is a room that's bringing together two sides -- or
16 more than two sides of the broader issue, and I would
17 agree, I think we're -- in some ways we're educating each
18 other. I'm fascinated with what some of the people are
19 talking about with nursing homes and what the issues are
20 within the nursing homes and how that applies and how I can
21 filter that through my knowledge of long-term care. I
22 think it's useful for us to have this broader, educational
23 session, so that we can then nail it down or produce
24 something.

1 CHAIRMAN WAXMAN: Please understand that we
2 are in no time constraints. This doesn't disappear on
3 December 31st, any year. We are an ongoing committee. So,
4 I am fine if this committee continues the way we are going
5 right now. I don't have a problem with that. I just want
6 to make sure that everyone is feeling that they're
7 contributing and that we're making progress and we're
8 learning and we will eventually get to a point where we can
9 do that.

10 MS. MITZEN: We need a formula, is that
11 correct? Our formula is 40 years old? Is that what we're
12 working towards? To understand what we're --

13 MS. ALTMAN: That's one of the first things.

14 CHAIRMAN WAXMAN: It's one subject. The
15 ability to buy beds is a totally -- it's a related but
16 different subject matter, because even if we redo the bed
17 formulas, how many beds we need globally, it still doesn't
18 answer the question -- it doesn't solve the problem of
19 those beds that are not being used versus under-supplied
20 areas.

21 MS. MITZEN: So is there a sense of urgency
22 or a timeline during which we can operate and address
23 these? What's the time frame?

24 MR. LAVIN: I'd like to make a motion. Can I

1 move that we -- could I move that we start with the first
2 point, which is modify current bed formula, and work down
3 as a whole, so I know where we are and where we're going?

4 CHAIRMAN WAXMAN: That's fine.

5 MR. PHILLIPPE: Before that, can I clarify how
6 we operate? One of the difficulties --

7 MR. PICK: Wait. We have a motion on the
8 floor. There has to be a second.

9 MS. MITZEN: Second.

10 MR. PICK: Now you can have a discussion.

11 MR. PHILLIPPE: In terms of your point of
12 actually making progress, if we meet -- if everything is
13 done in this group and we meet every two months and we
14 spend a lot of time understanding the issues, theoretically
15 we can go on for years. So, the question is, are we able
16 to have groups that meet outside of this board meeting on
17 certain topics, by conference call or whatever, and then we
18 bring ideas to the Board? Because that would be the way to
19 speed up the process.

20 CHAIRMAN WAXMAN: Yes, we may do that, we may
21 absolutely do that.

22 MS. ALTMAN: We talked the first time that
23 there is the Opens Meeting Act problem is one of them, and
24 then my question is -- not that I have anything against any

1 court reporter -- is it in the statute that we have to have
2 these transcribed, these meetings? Every other State
3 committee, commission we're on doesn't have that.
4 Sometimes there's a recording. But is this a requirement
5 that we have a court reporter at all?

6 MR. LOWITZKI: And what does that mean when we
7 break into groups?

8 MS. ALTMAN: And are all of these transcribed?

9 MR. URSO: It is not transcribed -- or
10 mandated in the Act, but this is one of the vehicles, when
11 we have a transcript, that all the Board members have an
12 opportunity to see what this subcommittee is doing.

13 MS. ALTMAN: I see.

14 MR. URSO: If you did not have a transcript,
15 then it would just be people's recollection of what they
16 talked about. So --

17 MS. ALTMAN: I just thought that, given the
18 other subcommittees and committees that we're on, some of
19 the ones we've mentioned, including Healthcare and Family
20 Services, Medicaid Advisory Committee, et cetera, that are
21 like this, there's subcommittees and work groups that do
22 work, and under the Opens Meeting Act -- for instance,
23 Medicaid Advisory Committee has been going on for 25 years
24 or whatever, and it has each subgroup, and they comply with

1 Open Meetings. We don't have any court reporter or
2 transcription at any of the Board meetings or subcommittee
3 meetings. I'm just suggesting -- no offense whatsoever --
4 that it does impede discussion quite a bit, I know the ones
5 I've been to, to have the court reporter, because,
6 obviously, it's more like a hearing where we each testify
7 in turn. So, I think that impedes discussion, and I think
8 breaking into work groups, that will be even more
9 difficult. So, that's my thought.

10 CHAIRMAN WAXMAN: Well, I guess the first
11 question that you need to answer for everybody is that work
12 groups and conference calls are permissible?

13 MR. URSO: As long as you don't get involved
14 with an Open Meetings Act dilemma.

15 MR. PICK: Which is?

16 MR. URSO: Which is if you have a majority of
17 a quorum meeting together -- and your quorum is ten -- then
18 that triggers the Open Meetings. Okay? So, therefore,
19 you'd have to have an agenda, you have to post your
20 meeting, you'd have to have it in a public place, so on and
21 so forth. If you have a number below five, like three
22 members wanted to talk, two members, four members wanted to
23 talk, that would probably be permissible.

24 MS. DEDERER: Why not below ten?

1 MR. URSO: Once you get to five, which is
2 really -- you start impinging on the majority of the
3 quorum. The quorum is ten. Then you trigger the Opens
4 Meeting Act and you have to abide by requirements with the
5 Open Meeting Act.

6 MR. PICK: So you have to be below six.

7 CHAIRMAN WAXMAN: So work groups can't exceed
8 six?

9 MR. PICK: Five.

10 MR. URSO: Five.

11 CHAIRMAN WAXMAN: Work groups can't exceed
12 five. So, if ten people wanted to work on a topic, there
13 would have to be two groups, and then there would have to
14 be a meeting of the two groups, other than --

15 MR. PICK: Or they do it here.

16 MR. URSO: This is supposed to be an open and
17 transparent system, just like the Mother Board. All the
18 Mother Board meetings are all transcribed, and the hope is
19 that it doesn't impede any discussions. It's just that
20 it's very important when Staff, as well as the Board, wants
21 to know what happened at the last subcommittee meeting, we
22 can pull it off of a transcript, and one of the charges
23 that Staff have from the last meeting, from the Chair and
24 the Vice-Chair, is take a look at the transcript and pull

1 out the points that we thought people were interested in
2 and what people were discussing as concerns. Without that
3 transcript, we'd have a very difficult time doing that.
4 Plus, you'll have to remember, the last time this group
5 met, I think, was in May. I think it would be really
6 difficult if you didn't have a transcript. What did we do
7 in May? I will tell you one of the things, because I'm
8 re-reviewing the transcript -- I read it before and I am
9 reviewing it again -- as Pat said, we need to have a goal,
10 and I think that's still an important topic that I think
11 you might want to repeat, and then once you establish one
12 or two -- whatever you think, then you'll know where you're
13 going. So --

14 CHAIRMAN WAXMAN: We have a motion and a
15 second, and I'd like to call a vote.

16 MR. SULLIVAN: I would like to rise in
17 opposition to the motion, because the motion is that we
18 move down in the order that we have here. I think if we
19 get into the bed-need methodology, the inputs and the
20 bed-need calculation, we will get ourselves very bogged
21 down, because it's a very complex issue, and I think the
22 level of frustration will increase significantly. I would
23 recommend going in the reverse direction, because the bed
24 buying and the incorporating programmatic aspects are very

1 solvable complex problems that this subcommittee can tackle
2 and, I think, come up with some practical suggestions. The
3 bed-need formula and methodology is a very sophisticated,
4 complex thing where we need technical experts, and I think
5 we'll go round and round on that.

6 So, I am suggesting from his motion that we go
7 in the reverse, because I'm very worried that if we try to
8 tackle bed-need methodology first, we will go nowhere.

9 CHAIRMAN WAXMAN: So, you're agreeing with the
10 concept of the motion, that we tackle one at a time --

11 MR. LAVIN: Phyllis, will you accept the
12 amendment?

13 MS. MITZEN: Yes.

14 MR. LAVIN: We're accepted. I'll modify the
15 motion to start somewhere and end somewhere.

16 (Laughter)

17 MR. PHILLIPPE: Very clear.

18 CHAIRMAN WAXMAN: Okay. So let me paraphrase
19 your motion. The motion is that we start with item three
20 on your sheet and move up in our discussions. The purpose
21 of the motion is to put some organization to our
22 discussion, so that we are tackling one at a time and
23 getting some to a conclusion. Is that basically --

24 MS. ALTMAN: So, we are starting with bed

1 buying and the concept and then move up to the whole
2 formula?

3 CHAIRMAN WAXMAN: Yes.

4 MS. BURMAN: One of the reasons to start with
5 the bed-need determination is we already started it with
6 the presentations of what other states are doing with that
7 and with going through the formula itself and different
8 components, and if we go immediately to the bed buying, we
9 still need to factor in, as other states have done, how it
10 fits within the need that's been determined.

11 CHAIRMAN WAXMAN: Part of me agrees with
12 Mr. Sullivan, that the line item number one is very, very
13 complicated, very sophisticated, and I also agree that
14 working the way up would be somewhat simpler, and in that
15 process of that discussion, I think the committee will all
16 learn more than the bed formula and the bed needs during
17 that process. That's my personal opinion.

18 MR. PICK: So, point of order, we still have
19 to vote as to whether we're going to do them all in the
20 total group one at a time versus breaking up into small
21 groups, and then I think we can talk about the order. But
22 it seems like we've jumped right to the order without
23 making a decision.

24 CHAIRMAN WAXMAN: No one has made a motion

1 that we stay within the large group versus --

2 MR. PICK: It is his motion. His motion is
3 that we go through these items as a total group and then --

4 CHAIRMAN WAXMAN: I'm not sure somebody has
5 incorporated that. I heard that we take an item --

6 MR. LAVIN: I'm totally willing to amend this
7 motion to death. I mean, I trust that if we're working as
8 a group -- I just want us to have some concept of where we
9 are and where we're going.

10 CHAIRMAN WAXMAN: So, the motion that we're
11 looking at at this moment in time is, A, we stay as a group
12 as a whole and, B, we make a decision that after we agree
13 to that as to which order we will take the three items.
14 So, may I have a vote on that, and as weird as this is, can
15 I do a roll call or just voice vote.

16 All in favor of doing that -- staying as a
17 group as a whole and then we'll decide in which order to
18 take them, all in favor say "aye".

19 (Ayes heard)

20 CHAIRMAN WAXMAN: Any opposed?

21 MR. PICK: Me.

22 MS. ALTMAN: It's nothing personal.

23 MR. PICK: Nothing personal. Just my opinion.

24 CHAIRMAN WAXMAN: As this group is right now,

1 the motion passes.

2 So, now, the second issue is in which order do
3 we take them? There's two thoughts out there. One is we
4 take them in the order of the third, second, first; and
5 there's a suggestion we take them in first, second, third,
6 argument being that one is very complicated, very
7 sophisticated, and it may be easier to get some resolutions
8 to item three and two, which will fit into one when they're
9 complete. So, I'm open to, again, discussion about which
10 order we take them.

11 MS. O'DEA-EVANS: I think it's agreed that
12 formula is complicated, but, you know, as it has already
13 been broken down into five areas, I think if we look at
14 each area and discuss it -- like, if we're looking at the
15 Planning Areas, do we all agree that the Planning Areas,
16 you know, can stay the way they are, or do they need to be
17 revised? If we break it down into the specific components,
18 I think we can make some progress. We might not be able to
19 resolve everything, but at least we can figure out which
20 pieces do we have to really drill down into and are really
21 the thrust of the matter that needs some change. So, I
22 think that there's an advantage to us going with -- looking
23 at the formula. I think maybe the goal is too heavy to say
24 we're going to modify. I think first we have to go through

1 and evaluate the current bed formula, is it really
2 effective, or does it meet our needs, so we can identify
3 which pieces of the formula need to be adapted or really
4 looked at in more detail. I'm making a suggestion that we
5 do take it in order of how it is here.

6 CHAIRMAN WAXMAN: Are you making a motion?

7 MS. ALTMAN: Terry made a motion to do it one
8 way and Jon made a motion to do it the other way.

9 CHAIRMAN WAXMAN: What we did was took their
10 motion.

11 MS. O'DEA-EVANS: The motion was do we do it
12 all as a group.

13 MR. PICK: Right, and that passed.

14 MS. O'DEA-EVANS: Now it's like we're
15 discussing the -- we don't have a motion. We're just
16 discussing what order we should take it in.

17 MR. LAVIN: I suggest the Chair start us to
18 discuss an item so we can actually talk about something.

19 MS. MITZEN: I agree with Jon. Instead of
20 taking a break, if in fifteen minutes lunch can come, I
21 would like a little more discussion about item three and
22 item two and what might we -- what are the parameters?
23 What are we really talking about besides these few words on
24 this page? I mean, I just -- so that we have a framework.

1 Do we have a conversation about -- start with bed buying.
2 We had a little discussion about bed buying, and we have
3 more education now about the whole -- the scope of that
4 issue.

5 CHAIRMAN WAXMAN: I'm happy to do that. There
6 are some people here who do need a break, unfortunately.
7 The court reporter is the one that needs a break, so can we
8 start -- we'll pick it up as soon as we get back.

9 (Lunch recess)

10 CHAIRMAN WAXMAN: In between bites -- please
11 continue eating -- I would like to move forward.

12 We have decided -- and, again, for the
13 record -- that the list in front of you that has three line
14 items is the priority, is the ranking of the priority the
15 committee wishes to maintain. Hearing no objections to
16 that, then I ask the committee to choose the direction in
17 which they wish to attack these three priorities,
18 understanding that when you attack one, you really will
19 impact all of them at some point, but we still have to have
20 a focal point to begin, or we're going to be spinning our
21 wheels from now until whenever.

22 MR. FOLEY: I need to agree with my colleague,
23 Mr. Sullivan. The bed-need methodology/formula itself is a
24 very, very complicated formula, and we could talk about

1 that between now and doomsday. So, I'd like to suggest
2 that this committee -- somehow we just get five people just
3 concentrating on that formula only and let those five
4 people -- I don't care about the other issues right now,
5 but on the formula. Since it is very complicated, I think
6 we just need to get five people to discuss it and then come
7 back to this committee as a whole, you know, later on, with
8 ideas, suggestions, modifications, whatever.

9 MR. LOWITZKI: Let me counter that. It seems
10 to me the other way to look at it is for us, as a big
11 committee, to come up with principles on what we want out
12 of a new bed formula, right? And then give either a
13 subcommittee of this committee a charge to work on the
14 technicalities of that or even Staff at Public Health or
15 whoever. I don't think anyone at this table, like Terry
16 says, really has the expertise to get into the details of
17 the bed formula, especially not today, but we do have the
18 ability to come up with concepts and give people who do
19 have that expertise a charge to work with, and then they
20 can come back to us and say, "You gave us these principles;
21 here's the formula we came up with."

22 MS. ALTMAN: I agree with that, but I think
23 the one -- the second provision does seem to be -- I do
24 agree with Dave, but the second provision, incorporate

1 programmatic aspects of care into the bed-need formula,
2 that one in particular seems to be part of number one. So
3 if we were talking, if I understand correctly, about the
4 bed-need formula, as I think Pat said maybe, there's five
5 main components to it that we had identified, incorporating
6 these specialized care into -- if I understand the question
7 correctly, it would be if we were modifying the bed-need
8 formula, should one of the considerations, when you're
9 considering bed need, be that the Board take into account
10 specialized services the facility provides. That's part of
11 the first one.

12 So, I agree that we do it all at once, and we
13 go through the areas and have some kind of broad decisions
14 on that, and the bed buying, to me, is totally a separate
15 issue and is something separate. But it's a mechanism, if
16 I understand it correctly, a mechanism for facilities to
17 continue to remain viable in some other kind of business
18 model and I'm not exactly sure what the Board or
19 licensing -- if the Board actually has the authority or the
20 Mother Board has to say that nursing facilities are allowed
21 to have beds bought or whatever. But it stills needs to be
22 like a separate discussion from the bed formula/methodology
23 and whether specialized care is one of the components of
24 that.

1 MS. DEDERER: If I could respond to that, one
2 of the things we talked about was, when you're looking at
3 how many beds are needed in a specific geographic area, you
4 may have plenty of beds, but you also have nursing home
5 that's over the top in terms of how many people. How do
6 you address that?

7 MS. ALTMAN: And bed buying is one of the ways
8 to address it, but that really doesn't impact on the Board
9 deciding need or not. Like if a new facility is coming
10 forward or a modification facility is coming forward, I
11 think -- as it was presented, you're saying, "I'm changing
12 it this way" or "I need to build this kind of unit" or "I
13 need to build this facility and here's why: Because I
14 provide specialized care in rehab," "I provide vent
15 specific and there's no vent specific in the area." I'm
16 giving over simplification. But bed buying, I don't
17 understand --

18 MR. PICK: Well, if I can respond, I think
19 there are opposing philosophies that you can approach this
20 by. One is that, like the number of beds that are
21 available, you can also look at the number of beds by
22 program that are available, which makes it a very
23 restrictive process, or, alternatively, you can look at it
24 like the way the Department of Health currently manages

1 specialty Alzheimer's beds, where there is no restriction
2 on the number of beds that are available, but providers
3 need to demonstrate that they are able to deliver aspects
4 of the care that are required for that population, and
5 without that demonstration, they can't market to the
6 community as having a specialty program. It doesn't mean
7 that they can't provide the services. It just means that
8 they can't market that program. And right now, all of
9 these specialized programs, any facility can say they
10 have -- like rehab. Everybody says they have rehab.
11 There's a stark difference between a facility that says,
12 "When we have a patient who needs rehab we bring in a
13 therapist," versus a facility that has dedicated systems
14 and there is a much more sophisticated approach in
15 delivering that service. Facilities are going to be very
16 resistant to limiting their ability to offer the service.
17 I think the way we protect consumers is that they have to
18 demonstrate that they have the competency to do it before
19 they're able to market to the community.

20 MS. ALTMAN: That makes a lot of sense.

21 MR. PICK: So that's different than using a
22 need process to determine whether those beds are available.

23 MS. ALTMAN: I understand. About the bed
24 buying, though, where does that fit in?

1 MR. PICK: Bed buying to me is totally
2 different. I think Claire's comment is right on target,
3 that we have to integrate the bed buying with the need
4 formula, because as beds move from one location to another,
5 it then impacts that need determination, because if a
6 provider is now adding X number of beds through a purchase,
7 but there is still a need formula that doesn't recognize
8 those new beds coming in to the market, it throws off the
9 whole formula process of determining whether there is still
10 a need or not.

11 MR. SULLIVAN: One of the aspects of bed
12 buying, of course, from a public policy perspective is that
13 it does not increase the overall number of beds, and we can
14 certainly -- you know, we're almost getting into the topic.
15 We can talk about whether we want to restrict it to a
16 geographic area, saying that if you're buying beds from
17 another facility, it has to be within a county, drive time,
18 a certain thing. Now, interestingly, Missouri has it wide
19 open. You can buy beds from any part of the state and put
20 those beds anywhere else in the state. Of course, on the
21 state-wide area, no beds are increased, it just moves the
22 beds around. We talked to the head of the Planning Board
23 in Missouri, and he said at first that he was opposed to
24 the idea, he didn't like the idea, he said, but the

1 interesting thing is that over the years, the beds actually
2 did move from over-bedded areas to under-bedded areas,
3 without the State directing it. I mean, the marketplace
4 drove where people were going to put beds.

5 MS. ALTMAN: But it doesn't decrease beds.
6 You could move beds. It doesn't increase beds, but it
7 doesn't decrease beds. Is that correct?

8 MR. SULLIVAN: Right. The other geographic
9 consideration is like Ohio said that it had to be within
10 the county, and they found that was too restrictive,
11 because nobody wanted to buy beds in Cleveland but
12 everybody wanted to buy beds in the suburbs, and so it was
13 creating a maldistribution. So, they changed it so that
14 you can move beds to the next county.

15 MS. ALTMAN: No, I understand moving beds and
16 not increasing, but I guess my question is, until you
17 figure out bed need, it doesn't seem like you even know
18 whether you need bed buying. I mean, let's say you figure
19 out bed need and we look at the formula and we're
20 over-bedded everywhere. Let's just say that's true. You
21 would need no buying. You don't need to move anything.

22 MR. SULLIVAN: Except that you have facilities
23 that are doing very well and it allows them to expand,
24 without increasing the number of beds.

1 MS. ALTMAN: I understand.

2 MR. SULLIVAN: And it also allows the unused
3 beds to get used somewhere else more productively.

4 MS. ALTMAN: I understand what it allows the
5 facilities to do, but with all due respect, what does it
6 allow the State to do, in terms of me. I mean, again,
7 we're representing a public body, not consumers or clients
8 and not the facilities. So, I want to know what the need
9 of the State is in these areas and then decide whether
10 there needs to be any kind of bed buying program.

11 MS. BURMAN: There is one point that I forgot
12 to remind this group of, and it was brought up when we were
13 reviewing the very comprehensive set of rules that were put
14 together by the Associations. There was a proposal in
15 there to include in the rules a way to do the purchasing of
16 beds, and the reason we couldn't move ahead on that was
17 there is no statutory authority in Illinois for doing that.
18 Missouri -- the Planning Act in Missouri allows that. It's
19 a very clear statement. In Ohio, I believe it's the
20 Licensing Act that allows for that. We don't have that
21 right now in Illinois.

22 MR. SULLIVAN: And I'm not sure -- Frank, I
23 think there is a current -- I think the Department has
24 statutory authority based on the current Act.

1 MR. URSO: Well, you point out a section that
2 we need to discuss and I'll take a closer look at it and
3 see. I know you and I talked about that. I'm not sure
4 it's as clear as perhaps what Claire is talking about.

5 MR. WILL: I know in the past, like at OASAC,
6 the talk is that a legislative change is necessary.

7 MS. ALTMAN: Because the Older Adults Advisory
8 Committee had a whole separate subcommittee on bed buying
9 for three years and researching every aspect of it, and it
10 was -- it was an entire subcommittee on that, conversion
11 subcommittee. There was a proposal. I think there was
12 even legislative language and a Bill that may or may not
13 have been introduced.

14 CHAIRMAN WAXMAN: Stephanie, what group?

15 MS. ALTMAN: OASAC.

16 MR. PICK: OASAC, Older Adult Services
17 Advisory Committee.

18 MS. ALTMAN: A lot of these discussions are
19 the same. So, all of -- the Associations are on it. Eli,
20 you're on it; I'm on it, Phyllis is on it; Dave is on it,
21 SEIU; Jon Lavin. So, we all are on that same -- that's why
22 this has always been kind of -- we've discussed some of
23 this.

24 MR. PICK: We migrate from one committee to

1 the other.

2 MS. DEDERER: Why don't we take the words
3 of OASAC?

4 MS. ALTMAN: OASAC did a lot of work on it.

5 MR. PICK: If I can give a response,
6 Stephanie, to your last comment about even though there may
7 not be a bed need. As I mentioned in the example where you
8 have a local area where a facility may be full because it's
9 effectively meeting the needs of the consumers locally and
10 others are not and they have excess bed capacity, there may
11 not be a bed need, but that facility needs to expand
12 because consumers want to go there because their needs are
13 being met in a different way than the other providers are.
14 So the State bed formula wouldn't account for that, because
15 there are no beds available -- I should say there are no
16 beds available in the need formula. There are beds
17 available in that market area but not that the providers --
18 the consumers want to use.

19 MS. ALTMAN: So, you're see it's a mechanism
20 for getting better quality providers.

21 MR. PICK: Exactly. And innovation. If I
22 may, the other comment I wanted to make regarding Tim's
23 earlier comment regarding Medicaid services. Because I,
24 frankly, oppose the concept of we need to reach a lowest

1 common denominator to meet everyone's needs. What we do is
2 we deny the ability for services to reach their peak -- not
3 capacity, but their peak performance, because in order to
4 compensate for under compensated care in a Medicaid
5 environment, we're then limiting what the providers who are
6 incented to improve services are doing, because they don't
7 have the incentives anymore, and we go back to everybody
8 provides all services at the lowest common denominator.
9 So, I think philosophically we need to reconcile what's our
10 approach? Because if what we're saying is we have no
11 alternative, other than to bridge the gap that the State
12 reimbursement system establishes by under funding a
13 population, and the way we do that is by making sure that
14 everybody is providing the higher compensated care in order
15 to access that capital, even though they're not necessarily
16 the best provider, and, frankly, that is the current
17 approach.

18 MR. SCAVOTTO: It is, but you know what? I
19 think that's irreconcilable from a public policy
20 standpoint, and I think Tim's right. There's valid points
21 on your side. You're right. I think that's irreconcilable
22 until Illinois wants to pay more.

23 MR. PICK: I think that's irreconcilable.

24 (Laughter)

1 MR. SCAVOTTO: Exactly.

2 MR. PHILLIPPE: Like I say, we could take
3 whatever approach we want, but I just want to be clear we
4 think it through, because it is a public policy change. If
5 we open up and so we have a lot more development in the
6 state, because we -- people are building for the high-end
7 payers, it will have an impact on the people. It will
8 create more of a two-tier system, and the places that don't
9 seem to do well today will have even more difficulty in the
10 future.

11 MR. PICK: Unintended consequences need to be
12 addressed.

13 MR. SULLIVAN: Mr. Chairman, I would propose
14 that for the next meeting, we take a look at the specific
15 regulations for other states that have the bed buying, so
16 that we have a model in front of us, that we can get a
17 concept both of how it's working, and I know one of the
18 things that was most effective for the Association groups
19 was having a conference call with the Planning Board people
20 in those other states, saying, "How does this really work,"
21 because you can look at the Regulations, but it was the
22 conversations that really helped us get everybody's head
23 around what was good about it.

24 MR. SPEAKS: We could do that again, since we

1 did it before. If the group wants to do that, we have a
2 contact.

3 MS. DEDERER: Why would you do it again if
4 OASAC has already done it?

5 MR. PICK: OASAC didn't do it.

6 MS. ALTMAN: He's saying the Associations
7 called different states.

8 MS. DEDERER: Didn't OASAC have proposed
9 legislation?

10 MS. ALTMAN: We could find the proposed
11 legislation, et cetera that was done by the conversion
12 committee. AARP chaired it with you guys.

13 MR. SULLIVAN: Yeah, and, quite frankly, the
14 legislation was permissive rather than detailed. I mean,
15 it didn't -- it mentioned the concept, but it didn't get
16 into what does it all look like.

17 MS. MITZEN: Okay.

18 CHAIRMAN WAXMAN: Something that I've been
19 thinking about since this conversation. Has the other
20 committee done a lot of research on bed buying that they
21 can bring to us?

22 MS. ALTMAN: I wasn't on the conversion
23 subcommittee.

24 MR. SULLIVAN: Phyllis and I were.

1 MS. ALTMAN: What did you guys do for three
2 years?

3 CHAIRMAN WAXMAN: Is there stuff you guys
4 could bring?

5 MS. MITZEN: There's stuff.

6 MR. SULLIVAN: And the conversion committee
7 didn't just look at bed buying. We looked at a lot of
8 different ways, all of which could be incorporated into bed
9 buying, because if you have stake in a facility, there are
10 things you can do besides private rooms. You can do other
11 services. So, it was a -- I am excited about the concept,
12 because it opens up new business models for aging
13 facilities to do not just private rooms, but to do adult
14 daycare, to do -- to outreach into the community. And so I
15 think there's a lot of potential.

16 MS. MITZEN: It was a broader approach.

17 CHAIRMAN WAXMAN: Okay. So, for our next
18 meeting, if any of you would be kind enough to share what
19 you have -- how recent is this information, by the way?

20 MR. SULLIVAN: We could get the current stuff
21 by the next meeting.

22 CHAIRMAN WAXMAN: Okay. Which raises another
23 question -- yeah, send it to Courtney.

24 MR. SULLIVAN: Has Claire done anything

1 specifically with the bed buying?

2 MS. BURMAN: I have some of it in files, yeah,
3 and it would be easy --

4 CHAIRMAN WAXMAN: Could you get that to
5 Courtney.

6 Let me ask the committee the following: As
7 we're looking at these -- what's occurring in my mind is
8 that people are saying that all of these topics are
9 interrelated and there really isn't three priorities, there
10 is a priority, which is to attack one issue that
11 encompasses all of these topics.

12 MS. O'DEA-EVANS: Don't we have to break
13 things down?

14 CHAIRMAN WAXMAN: And I tried three different
15 times to get people to agree how to break it down. So I'm
16 looking for --

17 MS. ALTMAN: We didn't say break it up. I
18 think what you're saying is we already broke bed-need
19 formula into five major areas. So, why don't we take them
20 out and start discussing, right? They have them broken
21 down.

22 MS. O'DEA-EVANS: I'm just looking at the
23 basic formula, age group Planning Area, for each age group
24 there's a Planning Area, there's a projected population,

1 there's an actual math formula where you must apply the use
2 rate times the projected population. Then number two is
3 the projected patient days for each age group. Then
4 there's Planning Area total projected patient days or the
5 average daily census, and then there's projected Planning
6 Area bed need divided by the existing number of beds in the
7 Planning Area. That's like the basic formula.

8 MS. DEDERER: That's not that hard.

9 (Laughter).

10 MS. DEDERER: It gets really ugly, I guess.

11 MS. O'DEA-EVANS: But that's working off of
12 the existing -- that's like working with the existing
13 formula as it stands versus looking at what would be a new
14 formula or what type of formula you would want.

15 CHAIRMAN WAXMAN: The question then is do we
16 have to have a good understanding of what exists in order
17 to decide how to change it?

18 MR. PHILLIPPE: Usually that's a good start.

19 MS. O'DEA-EVANS: It's a starting point.

20 MR. PICK: Absolutely.

21 CHAIRMAN WAXMAN: So, Claire has already gone
22 through that, but I'm wondering if we need to have, for our
23 next meeting, a presentation from Staff in which we, once
24 again, go over exactly how those -- how that works.

1 MR. PICK: We did that already.

2 CHAIRMAN WAXMAN: So, do we not need to do
3 that again?

4 MS. MITZEN: It's how do we facilitate a
5 conversation? I think Dave is on target. How do we
6 develop the guidelines, the principles on which we should
7 base the -- our recommendations? I mean, there's some --
8 this is where we're starting from, but I think we can set
9 that aside now, and now we have to have a conversation
10 about what it should be. And certainly it should be
11 something that lasts for three to five years, not forty
12 years, in this environment that is changing so quickly.

13 MS. EVANS: I just think that we should maybe
14 discuss some basic assumptions. For example, you know, are
15 we feeling like we want to go towards -- we want to have a
16 process where if somebody wants to open a new facility,
17 that it's extremely cumbersome for them? Or do we want to
18 have a process that's transparent, for example? Or do we
19 want to -- do we have an assumption that we would really
20 like to go towards private rooms for the residents of
21 Illinois that are living in these places? There are some
22 basic assumptions that if we could kind of get out there
23 that at least we're working with, we can put that in to our
24 formula, because if we're not going to go with our old

1 formula, we're going to say our old formula we're not
2 really going to focus on -- but even something as simple as
3 Planning Areas, we haven't even discussed are Planning
4 Areas really appropriate? Are we still in agreement that
5 there should be these Planning Areas? There are basic
6 assumptions that we haven't gone through, and I think we
7 should go through these things point by point or just have
8 a general discussion about what our basic assumptions are,
9 about where we're going with this.

10 CHAIRMAN WAXMAN: So, let me ask you. Those
11 basic assumptions that probably encompass the five topics
12 that are there, do they need to be discussed in the large
13 group, or can we have work groups talk about those five
14 things, five work groups talk about and bring them back to
15 the whole group?

16 MR. LAVIN: I think we jumped over your first
17 statement. Should we look at this process presents, what
18 we have because of this planning principle? And I know
19 we've gone through and we've talked about all these
20 districts and sub-districts and we've divided by bed need,
21 but we didn't have -- we haven't had the 2010 census for
22 more than like three months since we started, and when we
23 look at where we're heading, is there any logic in really
24 saying what does this process look like? When you apply

1 today's population and the future population of this state
2 on top of it, maybe it will work fine. Maybe it takes into
3 consideration all of these things.

4 MS. BURMAN: Admittedly, the formula that is
5 in place right now is old, but, number one, I would compare
6 it with the other components in formulas of other states.
7 You have that information. That's in one of the documents.
8 The components are virtually the same. It is because these
9 are basic planning elements to arrive at conclusions of
10 this kind. You have to look at the usage. You know, you
11 have one facility, you have ten beds total. It's a tiny
12 town in Illinois and let's say you can fill eight of them
13 most of the time. In a year's worth of time, that's eighty
14 percent occupancy. That's all you're doing. You're taking
15 that usage and you're applying it to the projected
16 population. Because you want to look farther out than
17 what's happening -- well, it's not today, but it's two
18 years late, just because of our data. And so those
19 elements, I would be very surprised if those really change
20 after you really inspect them. There's a reason why that's
21 still in place.

22 MS. O'DEA-EVANS: My understanding is part of
23 the problem is also, though, that because occupancy rates
24 have been low, even if we have a goal of 90 percent of

1 occupancy, that that goal is probably too high of a goal,
2 based on our current occupancy rates. So I think that's
3 really a big part of that problem.

4 MR. PICK: I would disagree. It's not that
5 the occupancy target is off, it's that we're not accounting
6 for where people are using services, because it's taking
7 the population and only applying it to skilled nursing
8 facilities.

9 MS. O'DEA-EVANS: That's our domain.

10 MR. PICK: I think that rather than adjusting
11 the target, it's adjusting how we get to that target. So
12 it's the formula. If the formula is taking N as the total
13 population and then dividing it by the number of beds, we
14 know, because sixty percent of the eighty-five and older,
15 as you're accessing alternatives, that we're not going to
16 hit that target. So rather than reducing the target number
17 because sixty percent are using services that are not part
18 of our formula, what we need to do is modify the formula to
19 accurately account for of the sixty-five and older, how
20 many of them need skilled nursing services, rather than
21 assuming that right now, a static percentage determines how
22 many of them needs skilled nursing.

23 MS. ALTMAN: Eli, could you address the
24 sixty-five?

1 MR. PICK: The reason I'm using sixty-five and
2 older as an example is because it's the largest portion of
3 the share. The sixty-five and younger follow a similar
4 approach, it's just using a different multiplier, and,
5 again, it's off, because the population's ability to access
6 services has changed without the formula incorporating
7 those changes. So, the ability for the disability
8 population under sixty-five to have services in the home
9 that weren't available are not part of the formula.

10 MS. ALTMAN: I understand.

11 MR. PICK: So that's how it's changed. So, I
12 think the fundamental issue is that the formula, because it
13 only governs skilled nursing beds, has not incorporated an
14 element to address non-skilled nursing beds in part of its
15 calculation.

16 MR. SCAVOTTO: But if the use rate were
17 current, it would have that factored in.

18 MR. CONSTANTINO: That's correct.

19 MR. PICK: If the use rate were current and
20 incorporated the elements that the Lewin article addressed,
21 it could be updated.

22 MR. SCAVOTTO: Those factors would be included
23 in a current use rate.

24 MS. BURMAN: But the problem is not actually

1 the areas of the formula. It's the end piece where you
2 subtract the existing beds. The formula issue, the gross
3 need for whatever geographic area, you always have to
4 subtract out the existing beds which you already have in
5 place. If that number is not correct, then the number is
6 skewed. There's no way to get an accurate bed need.

7 MR. PICK: But it's just not beds, it's
8 services.

9 MS. BURMAN: No. That bed-need formula is
10 beds. Use rate reflect who's using those beds. Other
11 people decide to go somewhere else or stay home and have --

12 MR. PICK: No, I understand. The existing
13 formula with the current population numbers has bed need
14 determined in certain areas based on the population that's
15 present in that Planning Area. So, even though you take
16 the existing beds and subtract them and they're not being
17 used, what the disconnect is is that the services that are
18 being used in alternative to the beds are not being
19 factored in.

20 MS. BURMAN: Well, in a way they are because
21 of the use rate.

22 MR. FOLEY: You're talking assisted living.

23 MR. PICK: Assisted, all of these other --

24 MR. FOLEY: I heard this morning at least some

1 of the people here would like to maybe incorporate assisted
2 living, to look at the total picture, if you're going to do
3 a planning system.

4 MS. ALTMAN: Not just assisted.

5 MR. PICK: All services.

6 MS. MITZEN: We keep on saying "bed". What
7 does "bed" represent.

8 MR. SCAVOTTO: Charles, would you finish,
9 please?

10 MR. FOLEY: No, that's all right. Fine.

11 MR. SCAVOTTO: I'd like to hear what you have
12 to say.

13 MR. FOLEY: I lost my train of thought. Go
14 ahead.

15 MR. LAVIN: You were saying we should
16 incorporate the alternatives, and you used the term
17 assisted living.

18 MR. FOLEY: It includes, obviously,
19 everything. It includes assisted living, supported living,
20 home healthcare, and everything else. So, if we're going
21 to look at tweaking or doing whatever to our bed-need
22 formula, to the methodology, we're going to be wasting our
23 time in doing that exercise if the industry does not want
24 us to incorporate these alternative services as part of the

1 CON program, because if we're going to include those
2 services, if you're going to include assisted living,
3 patient days or home health or whatever, if you're going to
4 include that as part of the methodology, you have to bring
5 it under CON approval. I think a lot of people are going
6 to fight that.

7 MR. PHILLIPPE: Wait, wait. Is that true or
8 not? Does that mean to include in the calculation then, it
9 has -- the CON process has to approve the assisted living
10 or it just changes your formula?

11 CHAIRMAN WAXMAN: Changed the formula.

12 MR. FOLEY: Changes the formula, and I think
13 we have to bring that under CON.

14 MR. PICK: No. The problem is the parity. In
15 one environment you have a process that's governing how
16 much is available, and in another it's strictly market
17 driven. So, the market-driven forces can keep expanding,
18 which then drives down the governed service level, being
19 skilled beds.

20 MR. FOLEY: You can't have it both ways.

21 MS. DEDERER: Are you going to stop marketing
22 and call us Communists or what?

23 CHAIRMAN WAXMAN: Which of those do you want
24 to comment on, Claire?

1 MS. BURMAN: I think a couple of things popped
2 up, and now I'm not sure. There was one thing, though,
3 that I still think that a very important thing to clear up
4 is how do you want to count beds? Are we talking occupied,
5 which is going to be a bigger number? If you're
6 subtracting the bigger number from the gross need, you're
7 going to have a smaller number. If you use operational
8 beds, however you want to term them, you're going to have a
9 smaller number to subtract.

10 CHAIRMAN WAXMAN: But how do you track
11 occupied beds? I mean, every day that number is going to
12 change.

13 MS. BURMAN: Staffed beds not occupied.

14 MR. PICK: Because they're set up regardless
15 of whether a person is there or not.

16 CHAIRMAN WAXMAN: Okay. My mistake.

17 MR. PHILLIPPE: It seems like, just for future
18 discussion, the fact that we're going to talk about this,
19 it would be useful to come with the categories and we look
20 at them on a Power Point or something and then do what you
21 say. We got to break it down. Instead of bouncing around,
22 we start with one component, we move to the next. I think
23 we'll make more progress.

24 CHAIRMAN WAXMAN: Totally agree.

1 MR. PHILLIPPE: But the one thing that is
2 causing trouble, too, is that we continue to talk about the
3 bed need for long-term care, however you define long-term
4 care, as if it's gasoline and we've got cars and we've got
5 gasoline. Okay? First, the services are very different.
6 Gas is gas wherever you buy it, pretty much. We all
7 learned that twenty years ago or so. However, it's not the
8 same as what we have here, and so, people don't go into
9 skilled nursing care today unless they have a serious need.
10 Need concept fits them. People come into assisted living
11 without really having the same level of need. Need -- so
12 skilled nursing is need beds. People don't come there
13 because it's a fun to place to live. As you move away from
14 that into community services, then it becomes less of that.
15 And so some people who would be in assisted living would
16 never be in nursing, they wouldn't qualify. Some people
17 may be getting home services, and they would all qualify,
18 but maybe -- so I don't know in that part. Home health, I
19 know, always qualifies. But the need is different. So
20 we're trying to take something and say we have a specific
21 population that all have the same need. They don't really
22 have the same need. They're on a continuum. And, so,
23 however we try to tweak the formula, it's going to be
24 difficult, because the people who some days are supported

1 living -- and particularly assisted living -- they would
2 have never gone in a nursing home, period. Okay. They
3 don't meet that criteria need. They wouldn't choose it.
4 And then we also have the other issue, that we're treating
5 the provision of service like it's all the same. It's not
6 all the same. So, it's very difficult when you try to get
7 a formula and try to tweak it.

8 CHAIRMAN WAXMAN: I think Eli has been trying
9 to say that since the committee has been together, that
10 needs and services are extremely important. The types of
11 the services and the needs of the consumer are driving the
12 demand for long-term care beds today, and the formula
13 doesn't touch either of those subjects, and -- am I quoting
14 you correctly?

15 MR. PICK: Close.

16 CHAIRMAN WAXMAN: And that somehow or another,
17 we need to incorporate those concepts into the bed-need
18 formula. Otherwise we're going to continue missing the
19 mark of where the beds are being -- where the beds are and
20 where the beds should be.

21 MR. PICK: Correct.

22 MS. O'DEA-EVANS: It's still market driven,
23 because whether -- even if there is a high need, there
24 still has to be private payer, a provider, that has decided

1 they want to go into this business. Why do they want to
2 have a nursing home and build in a certain area? I mean,
3 there's still that component to it. We can decide that
4 there's a need, but it doesn't matter. We still don't have
5 a provider to provide beds in that area.

6 CHAIRMAN WAXMAN: What's interesting -- and
7 again, Chuck, I hope I'm not saying something I shouldn't,
8 but you and I had a conversation earlier, and it was clear
9 to me that your demand -- the demand for your services,
10 which is preparing CONS, has not declined at all, which
11 means that people do want to be in the long-term care
12 business in the state of Illinois, even though most of us
13 at this table sit here and say why? So --

14 MS. ALTMAN: That's my point, that people do
15 because the business is surviving and thriving. We've also
16 got three lawsuits on the front page of our newspaper every
17 day about people who don't need to be in a facility setting
18 that are there. So, the reality is there are a lot of
19 people who are in a facility setting not because they think
20 it's a fun place to live but because they got in there for
21 some reason or another and have no place else to go, or
22 they didn't know they could be cared for in the community,
23 or the services didn't exist in the community at the time,
24 or they don't have support services, or we don't have

1 enough housing. And those are people at all ages. So, we
2 have people in facilities and people choosing facilities.
3 So, the more we work on facilities repurposing themselves
4 and reexisting and changing, we are continuing to provide
5 something that a lot of people -- I agree there's high need
6 people, but a lot of them, based on the studies, don't even
7 need the requirements. It's a place for them to live, not
8 because it's a fun place to live, because it's the only
9 place for them.

10 MR. PHILLIPPE: They get stuck there.

11 MS. ALTMAN: They get stuck there sometimes.

12 And, you know, Paul Bennett did a huge report on that for
13 the State, and he showed that your chance of getting stuck
14 after 90 days is very high and especially when you're not
15 considered to be short-term rehab, have resources around
16 you, or be high income, because you're more likely to lose
17 whatever little housing you had, if you had any, and it
18 becomes a place to live. So, I think we have to deal with
19 that reality. I think around this table lots of times we
20 deal with the reality that is a bit of higher income,
21 rehab, "my mom had hip surgery and spent" -- that's not
22 really my clients. My clients are the people who have been
23 there for years, and most of them don't need to be there,
24 an institutionalized population. So, I think we need to

1 work that into this situation. And I don't know exactly
2 how to do that, Eli, but I think that's what we need to
3 look at.

4 CHAIRMAN WAXMAN: That's the needs and the
5 services and the component that Eli is talking about and
6 some others are talking about. And how does that get
7 incorporated into the formula? I mean, that is --

8 MS. ALTMAN: To me, that's like the most
9 important thing to incorporate. There are a lot of things
10 important to incorporate into this formula, but what county
11 it is and how people trade beds and stuff like that really
12 isn't my perspective. So what I bring to this is I don't
13 think there are people who don't need that facility there,
14 and it should be reserved for and the need should be
15 reserved for. Plus I want high quality and other things
16 you're talking about. But I agree, it's hard, when you
17 have assisted living, SLF's, community care program or the
18 other services to equalize them and figure out the need for
19 them in the community.

20 MR. FOLEY: I'm thinking you're not going to
21 be able to fit all of these wants and needs into a magic
22 formula. Number one, we are, in fact, talking about beds,
23 how the beds meet a particular area. The programs of
24 services, I believe, is a separate issue, and if we're

1 going to continue to have a planning process, a health
2 planning process, and look at the bed need, whether or not
3 there is a bed need or not, because we also have the
4 alternative for a variance, which we can address. But I
5 think as part of the CON application, then I think one
6 needs to look at and address what are the other kinds of
7 needs in that community other than just beds? This program
8 is just all about beds. That's all this program is about.
9 But I think we need to look at those other components, and
10 I think somehow, as part of your CON application -- and the
11 Act, I think, even allows us to look at home-based,
12 community services and is your facility going to provide
13 Meals on Wheels, are they going to do this or that,
14 whatever is needed. I think some kind of documentation
15 should probably be included within your CON application.

16 CHAIRMAN WAXMAN: We also have the purview to
17 address the application itself and suggest changes or
18 revisions to the application itself.

19 MR. FOLEY: We have a public hearing process,
20 and all of that is allowed for within a public hearing
21 process, you're absolutely correct. A lot of times in the
22 CON applications -- not very many of them, obviously --
23 there are good alternatives that people do, in fact, look
24 at other than just -- again, with the CON process, you're

1 looking at just beds. But there are other alternatives,
2 whether you build a large facility or a small facility, and
3 we've got to look at those alternatives. Plus, the
4 separate issue then becomes the other types of programs and
5 services that are needed in an area. Whether you build a
6 new facility, whether it includes all private rooms, that's
7 still yet another discussion, and I think we need to look
8 at that as well, because that is what the market wants to
9 see.

10 CHAIRMAN WAXMAN: Mike, under current Staff
11 procedures, is a decision for Staff to make a
12 recommendation in favor of an application solely based on
13 the formula, or does Staff look at the concept of home
14 services or the availability of other services in the area?
15 Is that incorporated in Staff's decision, or is it strictly
16 a numbers game?

17 MR. CONSTANTINO: We look at the calculated
18 bed need. We also look at demand for the service. The
19 applicant would have to identify patients -- not
20 patients -- residents that would utilize the proposed
21 facility. We also look at access issues in regards to
22 what's in the area, what other facilities are in the area.
23 Are they at 90 percent occupancy? So there's other
24 criteria we look at. Is there a maldistribution of service

1 based upon that under utilization of facilities?

2 MS. MITZEN: But am I understanding you
3 correctly, the look that you're doing is all based on the
4 other facilities in the area? You're not looking at other
5 ways that people could be getting these services?

6 MR. CONSTANTINO: Right. We're looking at the
7 long-term care facilities.

8 MS. ALTMAN: Not what else exists in the
9 community?

10 MR. CONSTANTINO: Right. That's all we have
11 jurisdiction over.

12 MS. MITZEN: When we talk about beds, we're
13 really talking about an array of service, right?

14 MS. O'DEA-EVANS: No.

15 MS. MITZEN: We're just talking about beds?

16 MS. O'DEA-EVANS: Right.

17 MS. DEDERER: But in the process of
18 determining how many beds --

19 MS. MITZEN: But the bed that's in that
20 facility represents services that are obligated to be given
21 to that person, right?

22 MR. SULLIVAN: The person drives the service.

23 CHAIRMAN WAXMAN: The word "services" has
24 taken on two different meanings in today's discussion, I

1 believe. The word "services" sometimes in our discussion
2 today has meant services to include home health and
3 supportive care, assisted living, any way that a consumer
4 can get their needs met, besides or including a long-term
5 care bed. So, what services are available can in our
6 discussions mean the whole continuum of care, including
7 home health and companion and assisted living, supported
8 living and skilled. The word "services" has also been used
9 today to talk about within a skilled nursing home the kinds
10 of unique kinds of departments or programs that are being
11 offered, such as therapy, such as cardiac, such as
12 dialysis, such as vents and trachs, and whether or not the
13 fact that a home is offering those unique services should
14 be distinguished from a home that's simply being a
15 long-term care housing place. So, the word "services" has
16 taken on two different meanings.

17 So, my question to Mike was, when the Staff
18 makes a decision to support or not support an application,
19 do they look at the availability of other services besides
20 long-term care beds when they say yes or no? And the
21 answer to that is no, they're only looking at available
22 beds.

23 Our discussion, I've heard several times, that
24 in order for us to really do a fair job to the public,

1 needs to incorporate all those services, because they are
2 available and sometimes one is a better choice than another
3 for a particular client, customer, and how are we going to
4 incorporate that when our authority rests only in a
5 long-term care arena?

6 MR. PICK: Bed.

7 CHAIRMAN WAXMAN: Bed.

8 MS. MITZEN: Or there may be a deficit of
9 those services that facility could be meeting in that
10 community.

11 MS. DEDERER: True.

12 MR. PHILLIPPE: True.

13 MR. FOLEY: Even today, one could follow an
14 application -- let's assume the scenario where there is a
15 bed need. And if there is an area where there is a bed
16 need, how those beds are being used are irrelevant. It's a
17 skilled bed, but if he wants to use it for vents, for
18 Alzheimer's, he could use them for whatever he wants.
19 Okay? Obviously, we have a lot of nursing homes that has a
20 supposedly separate and distinct unit for, let's say,
21 Alzheimer's. Okay? So, we're saying that maybe 50 beds
22 are specialized just in Alzheimer's only; so, therefore,
23 they're not available to the general geriatric population.
24 You have the issue where you have other facilities that

1 provides programs and services where there may be a need
2 today for something but tomorrow that need may be gone.
3 Today there may be a need for vent beds, so you grant a CON
4 for twenty vent beds. What happens tomorrow when that need
5 is no longer there and you have twenty empty beds? What
6 happens? Are those beds then given up? We don't have that
7 process today. Once those beds are granted, they are there
8 forever. If we're going to talk about specific uses for
9 beds for specialized, be it short-term, long-term --
10 because yesterday we were talking about long-term beds,
11 today we're talking about short term, but tomorrow it could
12 be long-term again. We don't know that, you know. So, we
13 have to be careful in how we select ourselves with these
14 different programs and services in terms of how they're
15 going to be used, to make sure there is flexibility, that
16 if the demand and need changes tomorrow, the facility can
17 change with that, period.

18 CHAIRMAN WAXMAN: You know, I think it's clear
19 that everyone around this table and those who aren't around
20 the table that are part of the committee come with
21 different philosophies, different goals, if you will,
22 different backgrounds. So, I am going to ask how this
23 group feels, that next meeting we can begin to be -- I
24 certainly don't want to say productive, because I think

1 today was very productive in sharing ideas and sharing
2 concepts and sharing even some frustrations. But I am open
3 to hearing how to structure our meeting, which will be in a
4 couple months. Do we have dates picked yet?

5 MS. AVERY: I was looking for the dates that
6 we had in the beginning and I can't find my sheet. I know
7 we had one set.

8 CHAIRMAN WAXMAN: So, the next time we gather
9 together as a group, I'm open to trying to find a process
10 that would make everyone feel that we are moving forward
11 and being productive and traveling down the road to get us
12 to a goal-oriented and a solution-based process. I'll
13 start with Stephanie.

14 MS. ALTMAN: I'd be interested in -- Claire,
15 it seems you know the most about different states and their
16 formulas. But I think you guys also talked to some states
17 about their formulas that they use on their facilities. If
18 any other state uses a methodology that incorporates in
19 some way other long-term care services other than -- is
20 there a state that somehow incorporates -- that takes a
21 county or area, looks at adult day, et cetera, et cetera,
22 and then tries to sort of stay -- some sort of balance on
23 that so that bed need is limited to true need for a
24 facility-based care? I guess that's a direction that would

1 help me, and then we could have a discussion maybe on how
2 that might be possible to incorporate that into a bed-need
3 methodology. How is that for a --

4 MS. BURMAN: I think one thing that,
5 hopefully, you're aware of already -- if not, I hope this
6 will be helpful. There is a bed-need determination
7 formula, but that's the starting point. All the criteria
8 that we use are to help determine what the need is. So, we
9 could very easily factor in a softer kind of rule, not a
10 formula, to incorporate all of these other things that we
11 are talking about that need to be considered.

12 MS. ALTMAN: I'd like that to be a discussion
13 at a meeting, how we incorporate those criteria into the
14 rule.

15 CHAIRMAN WAXMAN: Do you want Staff to do a
16 presentation on those other criterias as a starting point?

17 MS. DEDERER: In other states?

18 MS. ALTMAN: Or the ones in ours?

19 MR. LAVIN: Are we assuming that -- are we
20 looking at the other required criteria without thinking
21 about a formula?

22 MS. BURMAN: They all start with a basic
23 formula. It's understood in all of these other states that
24 you just start with that. That's not the whole show, not

1 the whole package.

2 MS. ALTMAN: I just want to understand. When
3 we have our formula and you have that criteria, the
4 criteria goes in to it, but you don't consider it in the
5 actual determination of need, whether these actual services
6 exist in this county?

7 MR. CONSTANTINO: No. We only look at
8 long-term care.

9 MS. ALTMAN: Right. So that's why I propose
10 that we incorporate it as one goal for discussion.

11 CHAIRMAN WAXMAN: So then at next meeting,
12 would you like Claire to present what those soft criteria
13 are?

14 MS. ALTMAN: That might be helpful.

15 CHAIRMAN WAXMAN: Or do you want to develop
16 your own --

17 MS. ALTMAN: I think it would be fine. We all
18 have it. You could send it around again. I would love to
19 hear from you Claire, but we could short-circuit it but
20 just reading that. You've given it to us. It seems like
21 we could read it.

22 MS. BURMAN: Do you want it straight from the
23 state as they print it, or do you -- I try to do summaries,
24 because you would be spending a lot of time.

1 MS. ALTMAN: Summaries would be helpful, if
2 that would be easy to do, but I think you sent us the
3 actual.

4 MR. FOLEY: So, Michael, would you kindly
5 explain exactly what she's going to be looking at? I guess
6 I kind of lost it there somewhere.

7 Claire, what are you going to be doing?

8 CHAIRMAN WAXMAN: What we are saying is
9 that -- what Claire has suggested is that there are some
10 other criterias that are not mathematical that people can
11 use in determining the approval or not approval of a CON.

12 MR. FOLEY: Such as home healthcare.

13 CHAIRMAN WAXMAN: Such as availability of
14 other services that someone could make use of besides a
15 long-term care bed.

16 MR. FOLEY: So we have all of this expertise
17 here in this room with various types of agencies and what
18 have you, community agencies and whatever. You know, I
19 remember years back -- and I'm going back several years --
20 that there used to be a Planning Board that would -- even
21 though it couldn't really ever stick, but it was strongly
22 implied they could make it stick. It was strongly implied
23 if you want to build this nursing home, you also have to
24 look at and consider other factors, such as "Are you or can

1 you provide, for instance, Meals on Wheels?" Whereas there
2 was a letter that was submitted from a local Area Agency on
3 Aging or something that says this community's needs, and so
4 the Planning Board at that time -- again, they couldn't
5 force anybody to do it, but it was kind of implied, "Could
6 you consider providing this type of program, services,"
7 whatever.

8 Going back to the bed-need methodology -- and,
9 Terry, I need help on this. Some of the research Claire
10 did, in some of the states they look at beds per thousand
11 instead of a fancy methodology, just a simple bed per
12 thousand, period, that's it, and years and years ago we
13 looked at that possibility, but it couldn't be done because
14 of the fact that our state was too large; hence, that's why
15 it was broken down into not only HSA's but also into
16 Planning Areas in order to identify the healthcare needs
17 within the smaller geographic area, rather than just
18 looking at beds per thousand, period. So, I think there's
19 some kind of a correlation where other states, I think you
20 might find, has a bed per thousand in your smaller states,
21 but your larger states, I think they moved to a more
22 sophisticated bed-need methodology. Do you think that's
23 true, Claire?

24 MS. BURMAN: Yes. I think it's related to how

1 high your population is.

2 MR. FOLEY: So, I guess what I'm trying to
3 say, maybe, maybe, just maybe, we see inputs from all of
4 these other programs and services out there, these other
5 agencies, to have them help us to identify what their needs
6 are in a particular geographic area, what needs are
7 lacking, you know, what you really truly need, and see if
8 we could ask a provider in that geographic area, "Could you
9 consider providing this kind of service?"

10 CHAIRMAN WAXMAN: I think -- Mike?

11 MR. SCAVOTTO: I appreciate the desire to take
12 the measure of assisted living, home healthcare,
13 community-based services. I don't see how we're going to
14 do that and stay within the scope of what we're supposed to
15 do, and I think fundamentally it gets down to the use rate.
16 And you, Charles, were talking about beds. I think we'd be
17 looking at days per thousand as another measure. If --
18 you're never going to have a leading indicator unless you
19 make an assumption, but you can get a decent peg on what's
20 happening in the marketplace.

21 And I would suggest that for future meetings,
22 just from my own perspective, that you and Eli get your
23 heads together and tell us how we're going to proceed.

24 (Laughter)

1 MS. O'DEA-EVANS: I have kind of a separate
2 issue. I know we've been talking quite a bit about
3 specialty services, such as Alzheimer's and vents and all
4 of that, but I think when we really have a bed shortage,
5 even though we have a lot of beds, it's because we have a
6 Public Aid recipient who has no other choices, who needs a
7 skilled bed, and the facility in their area isn't able to
8 provide a Public-Aid-only bed to them, because they're
9 using their beds for other purposes, and then we have a bed
10 shortage. And you could have 200 beds in a community and
11 not have one Public Aid bed available, and I think that is
12 really --

13 MR. SULLIVAN: What community are we talking
14 about?

15 MS. ALTMAN: Like every day.

16 MS. O'DEA-EVANS: That happens often, even in
17 Arlington Heights. I tried to find a Public-Aid-only bed.
18 There's a lot of facilities -- we have a lot of Public Aid
19 beds, but they're not able to give that bed to that patient
20 today. So, I think we are not addressing that and haven't
21 addressed that at all, because we could have beds and it
22 means nothing.

23 MS. HANDLER: But couldn't that potentially be
24 a subcategory of the bed formula?

1 MS. O'DEA-EVANS: Right. The intent --

2 MS. HANDLER: So we look at the needy
3 population.

4 MS. O'DEA-EVANS: The intent of what we're to
5 do is to not over build, not have too many beds available,
6 but we also have to look at the type of bed that is
7 provided and whether there is a need or not, not
8 necessarily based on how many beds there are.

9 MS. ALTMAN: The number one call that we have
10 in the northern suburbs and western suburbs for someone who
11 wants facility-based care is they are on Medicaid and can't
12 find a bed.

13 MS. O'DEA-EVANS: We haven't talked about that
14 at all.

15 MS. HANDLER: From a hospice perspective, we
16 have that same issue all the time, because we have patients
17 who are needing end-of-life care and Public Aid doesn't
18 have a place.

19 MS. O'DEA-EVANS: So we have to figure out a
20 way to tease that piece out of this.

21 MS. DEDERER: Or into it.

22 MR. PHILLIPPE: That is something -- you
23 talked about the bed-need formula is only the first
24 criteria. I've been in hearings where the issue of, yes,

1 looking at bed need. We also had a follow-up discussion of
2 are there Medicaid beds in this community, and something
3 was approved because the Board -- that's what I heard
4 anyway. I was just an observer. And the discussion was
5 back about a lack of Medicaid beds in the community and
6 people are leaving the community because they couldn't get
7 one. So, they did talk about it.

8 MS. O'DEA-EVANS: I also want to say
9 something, that there are providers who have Public Aid
10 beds but they don't allow people to use them.

11 MR. PHILLIPPE: We're talking about access.

12 MS. O'DEA-EVANS: Right. Just because you
13 have a Public Aid bed, license for a bed, doesn't mean that
14 you're allowing a recipient.

15 MR. URSO: Why is that?

16 MS. O'DEA-EVANS: Because they save them for
17 -- maybe they're a CCRC, and they save them for their
18 wealthy residents who run out of money. That's probably
19 the most common reason. Or they don't want to have a
20 Public Aid recipient in that bed because they are waiting
21 for a private pay person or a Medicare.

22 MS. ALTMAN: The most common we see is they
23 try to find some amount of money, so they know they can get
24 three, six, maybe nine months of that and they know they'll

1 have to transition it down to Medicaid.

2 The other thing we brought up at the very
3 first meeting is that we don't have a process here, once
4 you are determined to have need or a facility gets
5 approved, to check again after six months, twelve months,
6 as to whether they continue to meet what they said they
7 were going to do.

8 MR. PHILLIPPE: That's true.

9 CHAIRMAN WAXMAN: We talked about the
10 operator, whether the operator meets --

11 MS. O'DEA-EVANS: Do they keep the occupancy
12 rate up.

13 MS. ALTMAN: Yeah, do they do what they
14 promised to.

15 MR. FOLEY: Frank, for you, if I may. I
16 believe there's a way within our process where you could
17 have in the rules a -- because it has been done, whereby an
18 applicant must contact various agencies to get letters of
19 support from them or by, in their response, they could say,
20 "This is what we need," and then we could relate that back
21 to an application and see if the application does, in fact,
22 specifically address the need that that particular agency
23 is talking about, and that, I think, could -- would solve
24 some problems, maybe not all, but it would help out.

1 MR. PHILLIPPE: It would only solve the
2 problem if you follow up to see if they really did what
3 people said they were going to do.

4 MS. ALTMAN: And I don't think a letter is
5 strong enough. I think a lot of facilities could get
6 letters from the community.

7 MR. FOLEY: It's a follow-up.

8 MS. ALTMAN: Yes. I think what you need is
9 some real showing that you have determined the need and
10 that you can fulfill that in the community. Just like
11 hospitals have to show some sort of charity care, community
12 obligation, et cetera, nursing facilities should do the
13 same. What are they providing outside of their beds.

14 MR. URSO: You know, this is really --

15 MR. PHILLIPPE: It only applies to the
16 not-for-profits right now. We do. But the for-profits
17 don't have to do it.

18 MR. LAVIN: We're kind of looking at the
19 Certification of Need, if somebody wants to bring a new bed
20 in or move beds or whatever, and then we have this issue of
21 the fact that there are facilities -- that there is a need
22 for Medicaid beds and no one is meeting it. I don't see
23 that as part of a certification of need up-front. It's
24 almost like you have a renewal process to see if you are

1 meeting your community needs. So that might be something
2 to put into the concept, is that you need to renew your
3 need. It's an interesting concept.

4 MR. PHILLIPPE: Bankers won't like that one.

5 MS. O'DEA-EVANS: Someone promises, "We're
6 going to reserve twenty percent for Medicaid beds," but
7 there's no teeth to that. So they could promise us that
8 and then not provide that.

9 MR. URSO: You know, let me ask what I think I
10 know the answer to, Mike and Claire. A lot of states use
11 bed-need formula, bed need determination. Going into that
12 formula are a number of criteria or assumptions that
13 essentially support why that is a component. Am I right?

14 MS. BURMAN: Yes.

15 MR. URSO: So, my -- do you understand what
16 I'm trying to get at here? Would it be helpful for this
17 committee for Staff to break down what the individual
18 supportive components are for each of the bed-need
19 determination formulas, so that you could see all of the
20 assumptions that are utilized to come up with this formula?
21 Because what I'm hearing people say is, "What about this,
22 what about that, what about this?" And perhaps if we had
23 it clearly delineated, Staff could put it together, what
24 all the supporting structures are for that piece of

1 formula, then you could say, well, you're not looking at
2 that, you're only looking at that, why -- there are five
3 things here and maybe there should be ten things.

4 MS. ALTMAN: I believe we got that. She gave
5 us all of that. We've had -- we had all of the underlying
6 documents of all of the criteria. I think we have every
7 drop of that, if I'm not wrong.

8 MR. PHILLIPPE: I think we did.

9 MR. URSO: There seems to be a lot of
10 questions.

11 MS. ALTMAN: I don't think there's questions
12 about what is included in the components. I think what
13 we're discussing is what should be included. So what we're
14 saying -- for instance, we understand that some of these
15 criteria, what you called soft criteria, is not in the
16 actual methodology, but it's considered within it, and
17 you've given that to us. We're talking about bringing it
18 up so it would be hard criteria and, for instance, maybe
19 there would be a check on facilities after six months, or
20 they would have to do a set-aside and prove they did that.
21 So I think we know what is there now.

22 MR. URSO: That was my question.

23 MS. BURMAN: I think a way to incorporate
24 those concerns is put it in a criteria. They are all

1 important, each one of them is important.

2 MS. O'DEA-EVANS: Like now, if somebody wanted
3 to come into an area that looked over-bedded and they had a
4 mission of providing Public Aid beds, they would get turned
5 down because it's over-bedded.

6 MS. ALTMAN: I think we're at the meat of the
7 discussion that we tried to have six -- or whatever, a year
8 ago, which is exactly this. We had the presentations. We
9 saw what is included. We know how you are coming to your
10 conclusions, and we're suggesting, at least next time
11 maybe, to take up a couple of these suggestions to actually
12 include them, like set-asides, Medicaid, have those right
13 into the criteria, what is in the area, what do you have?
14 One suggestion was letters of support. I would suggest
15 something tougher than that, but I think we're at the point
16 where we could make those suggestions. We could be voted
17 down, that's fine, but I want to get to a point where we're
18 actually moving forward.

19 MR. FOLEY: Years ago we had variances. The
20 accessibility variance covered, I believe, everything that
21 we're talking about here, where we're saying there is an
22 access problem, that in this particular Planning Area beds
23 that are available are not accessible because of -- and it
24 was your job to document it. Since that was a variance, if

1 you say, "We're going to be one hundred percent Medicaid,"
2 again, there was no follow-up to that. After two years,
3 that facility, they could -- you know, practically 90
4 percent private pay at that point in time, you know. But
5 it's all about follow-up. But you can't do follow-up,
6 unfortunately, unless you have money for Staff. So that's
7 the problem.

8 MR. URSO: But in practical sense, this Board
9 does have the ability to put conditions on permits and
10 follow up that those conditions are being complied with,
11 and that is something we do every meeting.

12 MR. FOLEY: You have those other conditions,
13 yeah. So, I guess what I'm saying, maybe we need to go
14 back to accessibility variance. Very simple.

15 CHAIRMAN WAXMAN: Tim?

16 MR. PHILLIPPE: It's very complicated, but
17 some people know a great deal about bed-need formula and
18 know how to tweak it. So, the question I have, before you
19 finish is -- because we have could have a committee of
20 five, to move us along getting things done, where we have a
21 smaller committee given the task of coming up with some
22 ideas. At least we have something to start with at the
23 next meeting, saying we like it, we don't like it, we can
24 tweak it, rather than kind of breaking out here. I think

1 that was the original plan. Could we do that between
2 meetings?

3 CHAIRMAN WAXMAN: You can have a committee of
4 ten. No more than five can talk at a time to each other.
5 The subcommittee -- no more than five can talk at one time.

6 MR. URSO: No. If you have a meeting with 10
7 people, you're triggering.

8 CHAIRMAN WAXMAN: No, no. What I'm saying,
9 they could have a committee of ten but only five could be
10 on a conference call or only --

11 MR. URSO: What happens when the sixth person
12 joins?

13 CHAIRMAN WAXMAN: They can't. They have to do
14 two separate conference calls.

15 MR. PHILLIPPE: Some of you have worked on
16 this anyway.

17 MS. ALTMAN: Why don't we do some of this in
18 writing? When we first started the committee, my whole
19 understanding was this subcommittee was set up and a lot of
20 facilities were on it that weren't really consumers. Dave
21 Carvalho came in. He asked that a bunch of other people
22 get appointed. We all got appointed. We started this
23 situation, and we started with a draft of the Regulations
24 that Facilities and those groups had worked on, and then we

1 went there. Why doesn't everyone in writing put forward
2 their ideas -- or whoever wants to -- on how to change the
3 Certificate of Need and how they want to change it. So,
4 for instance, my idea is do it in writing to the whole
5 group, and then we'll discuss parts or all of that in this
6 meeting.

7 MR. PHILLIPPE: It will take a lot of time to
8 discuss ten plans. Some of you have already thought
9 through this. Couldn't we just get a group of five that
10 already know?

11 CHAIRMAN WAXMAN: The only concern I have with
12 your suggestion of a subcommittee getting together and
13 doing it is what Stephanie just addressed. So, if the
14 subcommittee is as diverse as the general committee, I
15 think it's perfect. I really do.

16 MR. PHILLIPPE: That's what it should be.

17 CHAIRMAN WAXMAN: So, I just didn't want it to
18 be a subcommittee of the people who worked on writing the
19 original. So, if the subcommittee of five or six is
20 diverse, I'm fine with that, and let them come back.

21 MR. PHILLIPPE: And that's what it should be.

22 CHAIRMAN WAXMAN: I'm fine with that. So who
23 is --

24 MR. URSO: Tim is volunteering.

1 MR. PHILLIPPE: No.

2 MS. DEDERER: Tim is volunteering. Stephanie.

3 CHAIRMAN WAXMAN: I would like volunteers. I
4 would appreciate people volunteering and recognizing that
5 they can't all be owners and operators.

6 MS. AVERY: And this is a bed-need
7 determination?

8 CHAIRMAN WAXMAN: I don't know. Tim will name
9 it.

10 MS. ALTMAN: I would think Eli would,
11 hopefully, want to be on it.

12 CHAIRMAN WAXMAN: I'll volunteer for him.

13 MS. ALTMAN: I was just saying ask him.

14 CHAIRMAN WAXMAN: Again, seriously, it could
15 be or six or seven people, as long as the phone calls don't
16 encompass more than five, or that makes you --

17 MR. URSO: I would say a subcommittee of five
18 or less.

19 CHAIRMAN WAXMAN: Okay. Five people.

20 MR. URSO: You could have a subcommittee of
21 this committee. You can include everybody you want, but
22 you're doing this subcommittee's work. So, I don't want
23 anybody coming and saying we're violating the Open Meetings
24 Act. I would say it has to be five people total maximum on

1 the subcommittee.

2 CHAIRMAN WAXMAN: And I think my concern is
3 that since the general rule was no consultants to the big
4 committee, I think that rule is probably to apply to
5 membership on a subcommittee also.

6 MS. ALTMAN: What's the consultant definition?

7 CHAIRMAN WAXMAN: A consultant --

8 MS. ALTMAN: To the committee?

9 CHAIRMAN WAXMAN: No, to the long-term care
10 CON.

11 MS. ALTMAN: A facility owner is different
12 from a consultant?

13 MR. PHILLIPPE: I can explain that. I'm not
14 an owner. When I go to an application for bed need, to get
15 a Certificate of Need, it's too cumbersome to do it myself.
16 I have to hire somebody to help me do it. Then I go to
17 somebody like Chuck, and they're the ones to do the work to
18 get us through the process.

19 MS. DEDERER: Why can't they participate?

20 CHAIRMAN WAXMAN: Because they have a vested
21 interest.

22 MS. DEDERER: And the facility owners don't?

23 MS. O'DEA-EVANS: The consultants have a
24 vested interest in making it complicated.

1 CHAIRMAN WAXMAN: But the diversification of
2 the committee was designed to prevent any owner from having
3 more than -- any group of owners having more than an equal
4 input than anybody else. So, that's why I want the
5 subcommittee to be made up of people who are not owners and
6 operators, who can bring in --

7 MS. DEDERER: But that would eliminate you
8 then, Tim.

9 CHAIRMAN WAXMAN: No, a majority of owners and
10 operators.

11 MR. PHILLIPPE: It should be a diverse group.

12 CHAIRMAN WAXMAN: Thank you. I'm trying to
13 say that.

14 MR. PHILLIPPE: But you are involving all
15 interests.

16 CHAIRMAN WAXMAN: Yes.

17 MS. DEDERER: But why not consultants?

18 CHAIRMAN WAXMAN: I did not make the rules. I
19 don't want to go there. I did not make the rules. I am
20 following the rules that are handed down.

21 MS. O'DEA-EVANS: Thank you for following the
22 rules.

23 MS. DEDERER: So sorry. Who made the rules?

24 MS. AVERY: We have one person on the

1 committee. We need four more.

2 CHAIRMAN WAXMAN: The rules are made by the
3 legislative people who put the Mother Board together.

4 MS. O'DEA-EVANS: I volunteer.

5 MS. AVERY: If you want to make diverse, you
6 have -- because, Pat, you're not really clearly an operator
7 or owner.

8 MS. O'DEA-EVANS: No, I'm not.

9 MS. AVERY: So Eli isn't.

10 CHAIRMAN WAXMAN: Eli is not an owner anymore.
11 For those of you who may not be aware, he sold his
12 facility.

13 MS. AVERY: So you probably want to put
14 somebody in policy.

15 CHAIRMAN WAXMAN: Well, Stephanie is -- Dave,
16 do you want to be on it, too?

17 MR. LOWITZKI: Sure.

18 MS. AVERY: Stephanie and Dave. We need one
19 more.

20 MS. O'DEA-EVANS: Tim.

21 CHAIRMAN WAXMAN: We have Tim.

22 MS. AVERY: We have Eli, Pat, Stephanie, Dave
23 and Tim.

24 MS. O'DEA-EVANS: Do we want to have an

1 alternate?

2 MS. AVERY: No.

3 MR. FOLEY: Are you going to have Staff
4 participate in this?

5 MS. AVERY: That's part of the notes I've been
6 taking for what other departments we might want to include.
7 I was thinking Claire, Mike, especially, and Mohammed,
8 we'll definitely get input from him.

9 CHAIRMAN WAXMAN: All right. So we have the
10 first subcommittee to look at the bed-need formula.

11 MS. DEDERER: I guess if this is an open
12 meeting, then I can come, as a non-member.

13 MS. ALTMAN: I'm not trying to annoy you here,
14 but we have -- the Open Meetings is different from how many
15 people can attend if it's not an open meeting. So, you can
16 have ten people as long as you post "Open Meeting". We
17 could have a subcommittee that has six or seven people on
18 it.

19 MR. URSO: Yes, you can.

20 MS. ALTMAN: As long as you comply with Open
21 Meetings.

22 MR. URSO: That's what I said.

23 MS. ALTMAN: So, we don't have to hold it
24 under five. That was just to hold it separately.

1 MR. URSO: If you didn't want to trigger the
2 Open Meetings requirements --

3 MS. ALTMAN: So, it's fine if we trigger Open
4 Meetings. I see no problem triggering Open Meetings.

5 MR. URSO: Then you're going to have to have
6 Staff help you --

7 MS. ALTMAN: Right.

8 MS. AVERY: If that's going to happen, you
9 have to make sure you let us know.

10 MS. O'DEA-EVANS: The next meeting is in
11 November.

12 MR. PHILLIPPE: Is Eli the Chair?

13 CHAIRMAN WAXMAN: Would you please, Tim?

14 MR. PHILLIPPE: So, who on the Staff is going
15 to help me see that something actually gets done?

16 MS. AVERY: Claire.

17 (Discussion held off the record.)

18 CHAIRMAN WAXMAN: The next meeting is November
19 29th. That was on the original calendar.

20 MS. DEDERER: Is that before or after
21 Thanksgiving?

22 MS. AVERY: After.

23 CHAIRMAN WAXMAN: So, your task, as I
24 understand it, is to come back with recommendations on what

1 subject?

2 MS. O'DEA-EVANS: On how to modify the current
3 bed-need formula.

4 MS. ALTMAN: What criteria?

5 MS. AVERY: I'll look back at the minutes and
6 see exactly what you said you would do.

7 CHAIRMAN WAXMAN: The next meeting is November
8 29th. Will it be here?

9 MS. AVERY: Probably.

10 MS. ALTMAN: I'm sorry. I have a question.
11 For the next one, I bring a motion that we do video
12 conferencing.

13 MS. AVERY: If we're going to bring back
14 information for you all and do a presentation, I would say
15 that the next one probably should be in person for the
16 discussion and the larger group, and then we can figure out
17 about the video conferencing.

18 MS. ALTMAN: All right. With all due respect,
19 we asked for video conferencing. We did a survey of
20 whether we wanted to do video conferencing. It said most
21 people preferred video conferencing. We didn't get video
22 conferencing at any point, even though DPH had video
23 conferencing, and in the video conferencing you can do a
24 Power Point. We do it all the time. We watch it on the TV

1 and we can discuss.

2 MS. MITZEN: And we're all used to meeting
3 like that.

4 MS. DEDERER: Yeah. The State doesn't allow
5 traveling.

6 MS. AVERY: The Planning Board pays for your
7 travel.

8 CHAIRMAN WAXMAN: Again, in this particular
9 meeting I thought we were going to break into work groups,
10 the next one too. We're still looking at a presentation
11 that I think everybody has to hear. My preference is I
12 like face-to-face, because I like to see what people are
13 doing. My experience with video conferencing is I watch
14 people read the newspaper, I watch people answer their
15 phone, I watch people do e-mails.

16 MS. ALTMAN: Mike, I get that. You said that
17 at the very beginning, a year ago, it's your preference,
18 and I know you're the Chair of this, but you also sent out
19 a survey and voted and people said they --

20 CHAIRMAN WAXMAN: I have never done what I
21 wanted to do. I'm fine with the next one video
22 conferencing. I'm just telling you why I prefer
23 face-to-face, and if you think we can be as productive or
24 more productive video conferencing, we'll try it.

1 Obviously, Chicago is a closer drive for me than here, but
2 I believe people tend to be more productive and responsive
3 when we're in one room together. But I have said from day
4 one that I would do what the committee wanted.

5 MS. AVERY: We'll check on the video
6 conferencing.

7 MS. O'DEA-EVANS: I do want to say that when
8 we have people on speaker phone, that's very problematic.

9 MS. DEDERER: That was horrible.

10 MS. ALTMAN: That did not work out.

11 CHAIRMAN WAXMAN: Is there anything else
12 anyone wishes to bring before the committee?

13 I need a motion to adjourn.

14 MS. HANDLER: So move.

15 CHAIRMAN WAXMAN: Second?

16 MR. PHILLIPPE: Second.

17 CHAIRMAN WAXMAN: We will meet again somehow
18 on the 29th of November.

19

20 END TIME: 1:55 p.m.

21

22

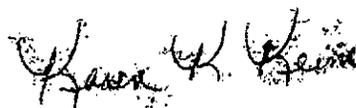
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CERTIFICATE OF REPORTER

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