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STATE OF ILLINOIS  
HEALTH FACILITIES AND SERVICES REVIEW BOARD (HFSRB)  
LONG-TERM CARE FACILITY ADVISORY SUBCOMMITTEE  
METHODOLOGY WORKGROUP

VIDEOCONFERENCE  
Tuesday, September 8, 2015  
10:00 a.m.

HFSRB OFFICE  
69 West Washington Street, Suite 3500  
Chicago, Illinois 60602

-and-

IDPH ADMINISTRATION  
525 West Jefferson Street, 4th Floor  
Springfield, Illinois 62761

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A G E N D A

CALL TO ORDER

1. Roll Call
2. Approval of Agenda
3. Bed Methodology Report - Nelson Agbodo
4. Next Steps
5. Other Business
6. Next Meeting Date(s)
7. Adjournment

1 PRESENT BY PHONE:  
2 Steven Lavenda, Chair  
3 John Florina

4 PRESENT IN CHICAGO:  
5 Courtney Avery  
6 Alan Gaffner  
7 Juan Morado

8 PRESENT IN SPRINGFIELD:  
9 Nelson Agbodo  
10 William Bell  
11 Aashay Chavan  
12 Mike Constantino  
13 Paul Corpstein  
14 Charles Foley  
15 John Kniery  
16 Mike Mitchell  
17 George Roate

18 Midwest Litigation Services  
19 Angela C. Turner, CSR  
20 Illinois CSR #084-004122  
21 15 S. Old State Capitol Plaza  
22 Springfield, Illinois 62701  
23 (217) 522-2211  
24 (800) 280-3376

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MEETING

(Starting Time: 10:09 a.m.)

MS. AVERY: We have Steve Lavenda and John Florina on the phone.

Can we start with roll call?

MR. AGBODO: Nelson Agbodo, HFSRB staff.

MR. CHAVAN: Aashay Chavan. I'm a GPSI intern at HFSRB.

MR. ROATE: George Roate, Department of Public Health.

MR. CONSTANTINO: Mike Constantino, Department of Public Health.

MR. CORPSTEIN: Paul Corpstein, Public Health.

MR. BELL: Bill Bell, Illinois Health Care Association.

MR. MITCHELL: Mike Mitchell, Department of Public Health.

MR. FOLEY: Charles Foley, subcommittee member.

MR. KNIERY: John Kniery, guest.

MS. AVERY: Courtney Avery, HFSRB staff.

MR. MORADO: Juan Morado, HFSRB staff.

MR. GAFFNER: Alan Gaffner. I'm a member of

1 the Long Term Care Subcommittee, guest, Healthcare  
2 Counsel of Illinois, and Alden Network.

3 MS. AVERY: Steve, we're ready for you.

4 CHAIRMAN LAVENDA: Has everyone had a chance  
5 to review what Courtney sent out last week?

6 (No response.)

7 CHAIRMAN LAVENDA: I guess not.

8 MS. AVERY: And Bill Bell called me on --  
9 what was that -- Friday, like "Do you really expect  
10 this to happen?" But I explained to him that Nelson  
11 -- and that I didn't realize Mike was going to be  
12 available. Nelson and Mike will walk us through what  
13 they've come up with and then we'll have discussion.  
14 But we weren't expecting everybody to master the  
15 materials.

16 CHAIRMAN LAVENDA: I don't feel so bad now.  
17 All right then.

18 MS. AVERY: We apologize. Nelson is very  
19 particular about his work.

20 CHAIRMAN LAVENDA: I can see that. And he  
21 should be very proud. This is quite a presentation.  
22 This really spells it out.

23 But Nelson, I am going to turn this over to  
24 you to walk us through this.

1 MR. AGBODO: Okay. Thank you.

2 Well, first of all, I would like to  
3 apologize for the level of the report. I try to  
4 squeeze that down, but it's still a long report.

5 And there are pieces about the typing of the  
6 report. You know, Friday is not a good day to  
7 finalize a report. I did find some typos. And some  
8 of them that are very important, I will talk about  
9 that once I get to the page.

10 So I would like also to thank this group for  
11 giving me the opportunity to work on this project.  
12 As I am working on this, it's become very  
13 interesting. I did this report with the help of Mike  
14 Mitchell. I had Mitchell get all the data and also  
15 advice on the presentation of the report. Mohammed  
16 Shahidullah also helped with looking at some of the  
17 results, how to interpret them. And Aashay Chavan,  
18 our new intern, on computing and verifying some of  
19 the results. Thank you very much for helping on  
20 this.

21 The objective of this study was to select a  
22 methodology that will improve the location of  
23 projected beds between the 95 health planning areas  
24 in the state of Illinois. And to be able to do this

1 evaluation, we have first to define the  
2 methodologies. So like I said, it was five -- we  
3 have five methodologies to evaluate.

4 The first one that I call Current Illinois  
5 Methodology, so CIM-0. It is actually the definition  
6 that we have in administrative codes for long term  
7 care. So you're familiar with that. I am not going  
8 to go into detail. So the current formula we would  
9 be using for 40 years now to project bed needs.

10 The next one, so the second methodology we  
11 have evaluated in this report is the one I call  
12 Modified Current Illinois Methodology 1, so CIM-1,  
13 which is actually the CIM-0 without the minimum and  
14 maximum of 60 and 160 percent assumption. So we  
15 actually replaced that assumption by using -- by the  
16 area base use rate. So we use the area base use rate  
17 as the projected use rates.

18 The second method -- or the third that we  
19 have used in this analysis is the one I call Modified  
20 Current Illinois Methodology 2, CIM-2, which is the  
21 CIM-0 with replacement of the 60 to 160 percent  
22 assumption by 30 percent to 130 percent minimum and  
23 maximum. We get to this result to the two  
24 percentages by 1,944 trials or scenarios to be able

1 to get that. And I will explain the process we have  
2 used.

3 So the fourth one is Modified Current  
4 Illinois Methodology 3, which is CIM-0 with  
5 replacement of the 60 to 160 percent assumption by  
6 30 percent to 150 percent assumption. And that also  
7 we have done 1,944 different trials to get those two  
8 percentages.

9 But in this particular methodology, we  
10 changed the target occupancy rate of 90 percent to  
11 95 percent. So that's what is really particular  
12 about this fourth methodology.

13 So the last one, which I call Ohio  
14 Methodology Applied to Illinois Data, OMAI, was  
15 actually the suggestion from Don Reppy where we use a  
16 state flat need rate to do the projection.

17 So those are the five methodologies that we  
18 have evaluated. And in the evaluation, we needed a  
19 measurable definition of what we have been calling  
20 appropriate bed allocation.

21 The way we defined this concept in this  
22 evaluation is a projected allocation of beds that  
23 satisfy 100 to 110 percent of the needs and yields  
24 the highest correlation with prevalence of people in

1 need of long term care services in a health planning  
2 area.

3 So there's two things. First, the  
4 projection had to cover 100 to 110 percent of the  
5 needs. The need is actually the actual percentage.  
6 And the second criteria is that the projection had to  
7 correlate with the prevalence of people in need of  
8 long term care service in planning areas.

9 So far, do we have any questions?

10 (No response.)

11 MR. AGBODO: I just want to go slowly so you  
12 guys can understand how we did all of this.

13 So let me explain a little bit why we  
14 defined the appropriate allocation this way. When  
15 you look at the current formula definition or the  
16 rules, it's just that the essence of the role is that  
17 the projections cover the needs of each area and  
18 allow extra beds for the area, and that's why  
19 90 percent target occupancy rate is used.

20 So for us, when we do this evaluation on the  
21 five methodologies, we should be able to have that  
22 criteria and evaluate this material against these  
23 criteria.

24 Now, in the methodology, we defined three

1 categories of health planning areas. The first  
2 category, which we call -- go to page -- I am sorry  
3 for the -- it's on page eight. So we defined three  
4 categories of health planning areas.

5 The first one is undersupplied where it's  
6 the health planning area where the projected patient  
7 days were lower than the actual patient days.

8 And the second group, it's what we call  
9 appropriately supplied where the projected patient  
10 days were between 100 percent and 110 percent of  
11 actual patient days.

12 And the last group, oversupplied where the  
13 projected patient days were higher than actually  
14 110 percent. So this is one of the areas where we  
15 have in the report should be 110 percent of actual  
16 patient days.

17 Now, the rest of the process is to be able  
18 to do the projection using the five methodologies and  
19 evaluate each methodology on the likelihood to  
20 project most of the health planning area into the  
21 appropriately supplied categories. We also use the  
22 Mean Algebraic Percentage Error, MALPE, to measure  
23 the difference of the bias between the projected  
24 values and the actual values. The idea is to be able

1 to have a small MALPE. And small here would be  
2 between 0 and 10 percent. Ten percent because we are  
3 allowing 10 percent margin error or 10 percent gap  
4 between the projected and the actual.

5 The only thing we did in the analysis is  
6 that we evaluated each -- the projections from each  
7 methodologies against the distribution of  
8 disabilities. We actually used disability variable  
9 as a proxy to the number of people in need of long  
10 term care in each planning area.

11 So we measure the correlation between the  
12 projected value of bed projected values from each  
13 methodologies with the disability rate from each  
14 health planning area. So methodology-wise, that's  
15 what we have done.

16 And on page six, we summarized all the  
17 formula that we have used for all the five  
18 methodologies. So on the first column, you have the  
19 formula; the second column, you have the assumptions  
20 that goes under each methodologies for the formula;  
21 the input data next; and explanation of the  
22 methodology.

23 So I am going back to page -- the page  
24 before the introduction, executive summary. The top

1 paragraph gives all the results that we have from the  
2 hardest work. So the results show that the CIM-3  
3 projected the highest number of health planning areas  
4 into the category of appropriately supplied. And the  
5 average number projected into each category into that  
6 category was 26. Compared to the other, that's the  
7 highest number.

8 We also see that the MALPEs range from 0.65  
9 to 15.16 percent, which is the lowest MALPE. So  
10 compared to CIM-0 and CIM-3, we have seen that CIM-3  
11 when we compare CIM-0 to CIM-3, we see that CIM-3 has  
12 improved the projection of health planning areas into  
13 that the appropriated supplied category by  
14 100 percent, doubled the number. For CIM-0, it was  
15 15; and CIM-3 was 26.

16 Of the five methodologies, we're more likely  
17 to project the health planning area into the  
18 oversupply category. So it means that each of the  
19 material that we have evaluated project,  
20 over-projects number of beds for this, for the health  
21 planning area and at the state level as well.

22 Another major finding was that CIM-0, 1, 2  
23 and 3 are very sensitive to population data. Meaning  
24 that when the population data changes, the impact on

1 the outcome or the projected value, it's high  
2 compared to the OMAI, where we did not find any  
3 sensitivity to change in the population data.

4           So I would like you to look at page 10.  
5 It's where we have a figure that shows the state  
6 total patient days. Actual values from 2000 to 2013  
7 and projected values from 2000 to 2018. The black  
8 line is the actual patient days. So any of the lines  
9 are the projections. And you can see that CIM-3  
10 projected patient days is the one that is closest to  
11 the black line, the actual patient days. And the red  
12 line is the CIM-1 projected patient days, that's  
13 where we actually use the health planning area use  
14 rate -- base use rates as projected use rates. So  
15 that this methodology projects highest numbers when  
16 you compare to the other projections.

17           So 2002 and 2007, there was a shift in the  
18 population change. What's happened, this projection  
19 was done -- the estimate of population was done  
20 before the census. And after the census, the number  
21 was corrected based on the census number. And the  
22 change was about -- so they come between estimate for  
23 population before the census and the estimate for the  
24 same year after the census, the change between those

1 two values was about two percent. You can see how  
2 high those are -- projections went. So that's what I  
3 was explaining by sensitivity to population change.

4 But the orange line, which is the Ohio  
5 Methodology Applied to Illinois data, did not have  
6 any shape -- any change. I mean the trend was  
7 linear, even though there was no change in the  
8 population data.

9 So when you go to page 11, you realize that  
10 all the five methodologies have a high correlation to  
11 the disability distribution in health planning areas.  
12 So the coefficient was .99 for CIM-0; .99 again for  
13 CIM-1; .99 for CIM-2; CIM-3, .99; and OMAI, close to  
14 1. So all the five methodologies were highly  
15 correlated to disability distribution. So this does  
16 not segregate the methodologies.

17 So in conclusion, I'll say we have evaluated  
18 five methodologies on the likelihood of projecting  
19 number of beds that provide 100 to 110 percent  
20 patient days need coverage for Illinois health  
21 planning areas. The Modified Current Methodology-3,  
22 which differs from the Current Illinois Methodology  
23 CIM-0 with the assumption that HPAs projected use  
24 rates should be between 30 percent and 150 percent of

1 their corresponding health service area use rates and  
2 target occupancy rates should be 95 percent,  
3 outperformed any other methodology by increasing the  
4 number of HPAs with appropriate projection of patient  
5 days by 100 percent over CIM-0.

6 Due to linear modeling nature of the formula  
7 of all the five evaluated methodologies, none of them  
8 provide significant improvement of the allocation of  
9 beds between counties. However, the CIM-3 has  
10 performed better on this evaluation.

11 Each method provides bed projections highly  
12 correlated with disability distribution among health  
13 planning areas. Illinois Current and Modified  
14 Methodologies CIM-0, 1, 2 and 3 are significantly  
15 sensitive to changes in population estimates and  
16 projections.

17 So more elaborated modeling may by produce a  
18 projection with less bias and better allocation of  
19 beds between health planning areas. However, such  
20 methodology may be difficult to translate into law  
21 and to be implemented as well.

22 That's it. Do you have any questions?

23 MR. CORPSTEIN: Which one do you recommend,  
24 Nelson?

1 MR. AGBODO: The CIM-3.

2 MR. CORPSTEIN: I agree.

3 MR. AGBODO: The green line.

4 The green line, because first, it has a  
5 projection that is closer to the actual patient days.

6 And this just means that we can -- by using this  
7 methodology, we can reduce unused beds. I will  
8 explain that.

9 When we use 90 percent target occupancy  
10 rate, mathematically, the formula when we use that in  
11 the formula, what it does is increase a set level  
12 projection by 10 percent. So by doing that over many  
13 years, I believe that contributes to building unused  
14 beds in the system.

15 So for me, based on this study, if we want  
16 to reduce unused beds by policy, we'll have to reduce  
17 that extra bed we add to the number to the flat  
18 projection we do. And by decreasing the number that  
19 90 percent to -- I mean, increasing 90 percent to  
20 95 percent in the formula, what is going to happen,  
21 instead of multiplying the first level of projection  
22 by 10 percent, we'll be multiplying that number by 5  
23 percent.

24 So if we do that over many years, I can

1 calculate the actual, but I have not done it yet  
2 because it was not one of the objectives of the  
3 study. But if I calculate that, we can find when the  
4 unused bed can be taken out of the system by using  
5 the policy. That's one thing for the CIM-3.

6 The other thing is data, the CIM-3 allows  
7 appropriate allocation of bed for most of the -- I  
8 won't say most of. For more health planning areas  
9 compared to the CIM-0. So the study shows that the  
10 CIM-0 gave on average of 13 health planning areas the  
11 appropriate allocation of beds. But the CIM-3 gave  
12 26 -- actually gave the appropriate allocation to 26  
13 health planning areas.

14 So that's the difference. And I think it  
15 would be a big improvement.

16 Did I answer your question?

17 MR. CORPSTEIN: Awesome. Thank you. That  
18 was totally what my analysis was too.

19 MR. FLORINA: This is Florina on the phone.  
20 Can I get a question in?

21 MS. AVERY: Sure.

22 MR. FLORINA: Nelson, first off, thanks for  
23 the analysis. It's very in depth. Based on my  
24 review and not being a mathematician, I can't tell

1 you how accurate it is as to what we need to decide.  
2 But you have laid it out very well for us to be able  
3 to compare the options.

4 I basically had two questions. Without  
5 getting into too much detail. The first question is:  
6 Does the use of HSA versus HPA, planning area versus  
7 I don't know if that's statistical area, does that  
8 have an impact on how we calculate the distribution  
9 of beds throughout the state?

10 And the second question was: Based on page  
11 14, where you're showing your MALPE rates and  
12 percentages, does it indicate that Ohio has the least  
13 proper distribution of beds through planning areas?

14 MR. AGBODO: Well, I would like to start  
15 with the second question. Page 14. So page 14 shows  
16 a table on category of HPA and MALPE from 2008 to  
17 2013 and 2005 to 2010. So when we look through the  
18 column MALPE, we can see that the Ohio material  
19 applied to Illinois data for all the HPA together is  
20 18.2 percent, while the CIM-3 MALPE is 11.2 percent.

21 Like I said, when the MALPE is between 0 and  
22 10 percent, it's a good value. But when we go all  
23 the way to 18 percent, that's too high. It just  
24 means that the extra beds or the over-bedding is too

1 high for that methodology.

2 So based on that thought, you go to the  
3 categories: Appropriate supply, undersupplied and  
4 oversupplied. Where we have on my -- for the  
5 appropriately supplied category, it is 1.33 compared  
6 to CIM-3, 5.10 percent both on the range of 0 and  
7 10 percent.

8 When you go to undersupply, you have to  
9 minus 21 or 73 percent for OMAI and minus  
10 12.9 percent for CIM-3. This shows that OMAI,  
11 it's -- I mean, on the bedding, using OMAI, it's  
12 higher than the CIM-3. And when you go to bed  
13 supply, you compare those two methodologies, CIM-3  
14 and OMAI, you can also see that OMAI has a MALPE of  
15 50 percent -- 50.1 percent and the CIM-3  
16 19.8 percent. Again, in that basis, OMAI is  
17 over-projecting too much compared to CIM-3.

18 So based on this analysis, again, CIM-3,  
19 outperformed OMAI and any other methodologies.

20 MR. FOLEY: Nelson, it's John Florina again.  
21 I appreciate you going through that. My question was  
22 just trying to segregate the Ohio system from the  
23 Illinois system. Because the first four  
24 methodologies are Illinois' system. The last one is

1 Ohio.

2 If I am reading your MALPE information  
3 correctly, the Ohio system applying Illinois  
4 information has the best number as far as the  
5 appropriate supply of beds. But then it also has the  
6 worst number for undersupply and the worst number for  
7 oversupply.

8 Is that an accurate understanding?

9 MR. AGBODO: Yes, that's right. Yes.

10 MR. FLORINA: Thank you.

11 MS. AVERY: Nelson, can you go into a little  
12 more detail why that is? I think that is what John  
13 is needing.

14 MR. AGBODO: So I am looking at I would say  
15 13 years of data instead of just one year. What we  
16 just did was for 2008 to 2013. But if you look at  
17 the whole period, you will see that that's the  
18 summary actually you get on page -- so the summary of  
19 all these tables on page 11. So Table 4, number of  
20 HPAs by category of projected patient days and by  
21 methodology. So here we actually calculate the  
22 average over 2000 -- should be 2000 to 2013.

23 And if you look first at the numbers, the  
24 actual number of HPAs. CIM-0 only projected 13 HPAs

1 into the category of appropriately supplied. CIM-3,  
2 the number is 14; CIM-2, 19; CIM-3, 26; OMAI, 11. So  
3 on average, CIM-3 is doing a better job than OMAI.  
4 The percentage of number of HPAs over 95 health  
5 planning areas.

6 I think in my conclusion on this, first, all  
7 the methodology over-projecting, that's true for all  
8 of them. But if you compare the CIM-3 to OMAI, CIM-3  
9 has highest number of projected HPAs into  
10 appropriately supplied group and OMAI has the highest  
11 number in the category of oversupplied.

12 I don't know if that gives the detail you  
13 need.

14 MR. FLORINA: Nelson, thank you for the  
15 explanation. I am sure we have a lot of detailed  
16 questions, but I am not sure if it's appropriate to  
17 get into all of them into the minutia. But I was  
18 looking for the general overview of comparing these  
19 five to show that apparently there is a difference  
20 between Ohio's and all four of the other options you  
21 worked on regarding the Illinois system. That's  
22 where I was going with it.

23 MR. AGBODO: Okay. Thank you.

24 MR. FLORINA: Can you comment on HSA versus

1 HPA? And does that have an effect since you're using  
2 different geographic areas for data collection?

3 MR. AGBODO: I have not presented the  
4 results on HSA in this report because the unit of  
5 analysis here is the HPA. In the process we compare  
6 the health planning area use rates to the HSA use  
7 rates before we decide which use rates will be  
8 considered as projected use rates.

9 So if we are to produce this report on HSA,  
10 it will be difficult to have a projection using those  
11 methodologies. The only thing we can do is we go all  
12 the way to HSPA and we sum the number back to HSA  
13 level. Which in terms of comparison will not produce  
14 new information, because we actually -- we  
15 actually -- doing all the analysis on the detail  
16 level when we do the HPA, going back to HSA level,  
17 moving backwards will just give us I believe the same  
18 kind of pattern. So I did not do that analysis yet.

19 MR. FLORINA: Thank you.

20 MR. AGBODO: Thank you.

21 I would like to add that if you go to the  
22 appendix table from I think Table A-4, it starts  
23 actually A-4. But on page 17. That sums up HSA  
24 level that I was talking about. So starting from

1 page 17 to page 19. You have all the results of HSA  
2 level. And I think this actually gives an idea on  
3 where you have additional beds and where you have  
4 excess beds for all the four methodologies. It's  
5 kind of a summary that gives an idea of our bedding  
6 areas compared to other bedding areas in the states.

7 So I started this with 2018, most current.  
8 And I will say that this -- for the CIM-0, the CIM-0  
9 result here is comparable to the new and battery that  
10 I already published this much. You will see maybe  
11 one-half or one because of the rounding issue. But I  
12 have verified all the results against the one that is  
13 already published and they are very close.

14 Any other questions?

15 (No response.)

16 And for me, you know, this summary might be  
17 very helpful to you guys to be able to decide which  
18 one of the five methodologies satisfy maybe the topic  
19 or question that we are trying to address here.  
20 Because, you know, this is easier to understand in  
21 terms of number, especially number of beds for each  
22 health service area. So the analysis that I  
23 presented before I know has some measurement that you  
24 are not used to. But this is the actual number of

1 beds for each area and for me to be very helpful.

2           If you go to page 20, you have that detail  
3 by health planning area. So when you take HSA page  
4 20, so Table A-5. So you have the first year through  
5 2018. So I am going backwards so you have a more  
6 recent year data. So 2018, you take HSA1, all the  
7 health planning areas. So you have existing beds.  
8 Then the current CIM-0 projection. Then you have if  
9 there is a need or excess. So when there is excess,  
10 the number would be negative. When it's less need,  
11 the number will be positive.

12           So for example, Carroll has 82. It means  
13 that it's in need of 82 beds when you use the current  
14 methodology. DeKalb has minus 25. It means that  
15 it's excess of 25. Now when you go to CIM-1, Carroll  
16 has 67 need and DeKalb still has a negative number,  
17 so excess of 26. You go to CIM-2, Carroll has now  
18 excess of 28 and DeKalb has an excess of one bed.  
19 CIM-3, Carroll has a need for 48 beds and DeKalb 28  
20 excess beds. And when you go OMAI, you have 101  
21 needs for Carrell and DeKalb is 7 excess. So that's  
22 how you can read this table, you know, see in terms  
23 of numbers, which one satisfies the question we are  
24 trying to address.

1           So appendix, I would like you to go to the  
2 other table to explain how this should be read. So  
3 Table A-5 continues -- or no, start from page 20 all  
4 the way to page 51. And page 52 -- so page 52, we  
5 have the data on disability and projected beds by  
6 health planning areas, 2010 only. In all the report  
7 I use 2010 only.

8           So first, we have the health planning names,  
9 you have the population estimate, July 2010, and  
10 number of disables for the same year. And I would  
11 say that we get this number -- we got this number  
12 from American Community Service 2010.

13           So then you have we calculated the number of  
14 disables per 1,000 population. And the next five  
15 columns are the projections for each methodology,  
16 projection for 2010.

17           So the trend we are looking at here is to  
18 have -- where you have high number of disables, you  
19 have a high number of projected beds. That's the  
20 idea. You know, just looking at the number, you  
21 cannot just summarize that information. That's why  
22 we used the correlation coefficient to do that. Like  
23 I said, all the five methodologies has shown a high  
24 correlation between projected beds and disabled

1 distribution.

2           So when you go to page 54, I think page 54  
3 all the way to page 61. You have all the trials on  
4 minimum and maximum using CIM-2. So like I said, we  
5 did 1,944 different trials to get the minimum and the  
6 maximum that maximize the number of HPAs projected  
7 into the category of appropriately supplied.

8           So we started with 0.1 as minimum and 1.1 as  
9 maximum. Then we start -- we kept the minimum at  
10 0.1. We change the maximum by implementing by 0.05.  
11 So we went from 1.1 to 1.15, 1.20, 1.25, until we  
12 reach 1.95, and then we turned the minimum up to  
13 0.15. Then we start again 1.1 for maximum all the  
14 way to 1.95 and so on.

15           And in the rest of the column, you actually  
16 have the number of HPA projected into the category of  
17 appropriately supplied. So by doing this, we are  
18 trying to find the combination of minimum and maximum  
19 that use the highest number of HPA projected in that  
20 category.

21           And at the end of all this work, we found  
22 that it's the minimum of 30 percent and maximum of  
23 1 -- the maximum of 130 percent that give the highest  
24 number, which is I think, again, in this case was 26.

1 No, 18. I am sorry. Average was 18.

2 So we did the same work for CIM-3. So  
3 that's the table for that data on page 63. And  
4 again, same number of trials. 1,924 and a minimum  
5 and maximum that maximize the number of HPAs  
6 projected into the category of appropriately supplied  
7 were 0.3 and 1.5. That's in the average number in  
8 this case was 26.

9 Then you have the last table from page 70 to  
10 72. This is a summary of how each projection --  
11 actually I just provide here CIM-0, CIM-3 and OMAI  
12 projection. So those three methodologies have  
13 projected each health planning area in each of the  
14 three categories.

15 So for example, if you take Adams, CIM-0  
16 projected into the appropriately supplied category.  
17 And CIM-3 projected the same health planning area  
18 into under-supplied. And OMAI projected same health  
19 planning area into appropriately supplied category.  
20 By seeing that, you can also see how each methodology  
21 is projecting number of beds for each health planning  
22 area. And decides, you know, which one is the best  
23 according to the current issue.

24 Then the last page of 73 actually provides

1 two maps. One on -- actually, two maps on  
2 disability-free life, prelife expectancy. One is at  
3 birth and the other one at the age of 65 just to give  
4 an idea how long -- in how long people at age 65 will  
5 live with that disability in each health planning  
6 area.

7 And I think by going through all this table,  
8 I hope you will have more understanding of the data.  
9 From there, you can also have to select the best  
10 methodologies. But from this study, like I said,  
11 based on the framework, CIM-3 is the best.

12 MR. KNIERY: John Kniery. I am looking at  
13 your table ending page 72.

14 MR. AGBODO: 72, yes.

15 MR. KNIERY: So I am trying to understand  
16 completely what that means. It would appear that  
17 OMAI appropriately supplies 30 of the health planning  
18 areas. I just added them up. So could that --

19 MR. AGBODO: This is for the year 2008 and  
20 2013.

21 MR. KNIERY: Okay. So it appropriately  
22 supplies the most number of planning areas from --  
23 because CIM-0 only appropriately supplies 14; CIM-3  
24 only supplies 8; and OMAI supplies 30. So that would

1 appear that that would be the best model.

2 Are you telling me that the OMAI, when it  
3 oversupplies, it oversupplies exponentially compared  
4 to the others? Because what I am getting at, one of  
5 the questions I am looking at, when I go back to the  
6 planning area, I think on page 20 it starts.

7 MR. AGBODO: 20.

8 MR. KNIERY: So when I am seeing, like for  
9 HSA1, what I am seeing is the state of Illinois  
10 planning area -- the one thing I guess I was looking  
11 for and maybe we can have other discussions on it --  
12 if we use the Illinois methodology but use the state  
13 -- and didn't use HSA factor, only used the state  
14 compared to the planning area, which I think you were  
15 alluding to the Ohio does which is why you didn't do  
16 that calculation, which I understand. What it does,  
17 you will see in the Ohio methodology where there are  
18 large populations you have excess beds because those  
19 beds have already been built up. So what the  
20 Illinois methodology does, as an observation, it  
21 looks like that regionalizes health care.

22 MR. AGBODO: Uh-huh.

23 MR. KNIERY: And I guess that, to me, is one  
24 of the questions, is that what this subgroup wants to

1 do? That's something that we have to -- I think that  
2 was the point -- Mr. Bell, I don't want to put words  
3 in your mouth or Mr. Reppy's, but I think that's what  
4 their point was. What you have now is a  
5 regionalization of health care. And I think the  
6 approach Ohio is making -- and I am not necessarily  
7 an advocate for that, but we need to decide which  
8 approach. And I believe it becomes very clear --  
9 Nelson, your data is -- well, I love data, so I am  
10 enjoying this report. But I think that becomes very  
11 clear that's what we're doing.

12 Is that what we want to do as a state?

13 MR. AGBODO: Let me go back to the  
14 observation. First, you know, the table we are  
15 looking at the last page, 72.

16 MR. KNIERY: 73.

17 MR. AGBODO: The summary of all that  
18 information is on page 14.

19 MR. KNIERY: Okay.

20 MR. AGBODO: So you can see that the CIM --  
21 like I said, if we go to page 14. So for 2008 to  
22 2013, so CIM-3 actually supplies 30, right, projected  
23 30 health planning areas into appropriately supplied  
24 category. So you see that 30. And OMAI, it's 8.

1 That's just for that year.

2 But you go to 2005, 2010, you also have  
3 CIM-3 projected 26 HPA into that category, that  
4 appropriately supplied category. And OMAI is 30 now.  
5 So outperform -- OMAI outperform CIM-3 in that year.  
6 But in the subsequent year, it was CIM-3 that  
7 outperformed OMAI.

8 When you go to page 15, CIM-3 projected 14  
9 HPA in the appropriate category and OMAI was 9. And  
10 2000 to 2005, CIM-3, 18; and OMAI 12. And so you do  
11 that for all the years that we have studied in this  
12 report. So it will be 2013 down to 2000. And you  
13 will see that some years CIM-3 outperformed OMAI and  
14 some years OMAI outperformed CIM-3.

15 So on average, what we have as a final  
16 result, that's the average presented on page 11 where  
17 you see on average CIM-0 only projects 13 HPA  
18 appropriate supply category; CIM-1, it's 14; CIM-2,  
19 19; CIM-3, 26; and OMAI, 11. That's, on average,  
20 over 2000 to 2013. So looking at the average, CIM-3  
21 is doing a better job than OMAI. But if you look at  
22 the specific year --

23 MR. KNIERY: Sorry to interrupt. Isn't that  
24 also going to be that way if you were taking a

1 regionalized approach versus a state -- isn't that a  
2 little bit of a -- isn't that the difference? Or  
3 couldn't that explain part of the difference?

4 MR. AGBODO: Well, the idea of, you know,  
5 analysis by region and statewide, it's interesting.  
6 I just heard that from you and I think we can do  
7 that, whereby in this report, I don't think that the  
8 data is presented in a way that we can quickly see  
9 the result that those two levels. I mean, at the  
10 state level, yes.

11 MR. KNIERY: Right.

12 MR. AGBODO: As far as on the average, it's  
13 on the state level. But by region, so the region  
14 would be health service areas?

15 MR. KNIERY: Yes. The regions and the  
16 health service areas.

17 MR. AGBODO: We can calculate a map for the  
18 region as well. I haven't done that. We can look  
19 into that as well.

20 MR. FOLEY: Steve Lavenda, are you still  
21 there?

22 CHAIRMAN LAVENDA: I am here.

23 MR. FOLEY: As chairman of this  
24 subcommittee, I would like to hear your comments also

1 in relationship to looking at this more regionalized  
2 versus statewide.

3 Do you have any comments on that?

4 CHAIRMAN LAVENDA: Do I have any comment? I  
5 think this report breaks things down pretty well.  
6 You know, I really would like to study more before I  
7 make any comments on it. And I am kind of sitting  
8 here wondering what's the next step. I think we  
9 should probably present this to the committee and  
10 have some discussion on it as to, you know, whether  
11 we want to go with this CIM-3 or not or, you know,  
12 take the data search a little further. I don't mean  
13 to be evasive. It's just an awful lot of data hit at  
14 once. Also, I am very impressed with what you put  
15 together here.

16 MR. AGBODO: Thank you so much.

17 CHAIRMAN LAVENDA: You're welcome. You and  
18 your team did a great job.

19 I think we have to look at it regionally,  
20 because, you know, can't just look at it, you know,  
21 we have so many different areas of the state.  
22 Chicago and Cook County and everything is so  
23 different from most of the other parts of Illinois.  
24 And I think we do have to look at it how it affects

1 the different regions.

2 Does that answer your question, Chuck?

3 MR. FOLEY: Yeah, I think so. I do agree  
4 with that, Steve. It's difficult for us to amongst  
5 ourselves sit down and really talk about, evaluate.  
6 I mean, again, Nelson, I would like to echo also.  
7 There's an old saying: Very confusing, but yet  
8 amusing. That's the way I look at this.

9 I guess we want to look -- I guess forget  
10 what we're looking at. Going back I guess our  
11 overall objective was to -- we have all these empty  
12 beds in the state. What are they going to do with  
13 them? Now we got the new bed need methodology. It  
14 shows virtually there's no bed need hardly at all  
15 anywhere in the state. And I guess I am looking at  
16 this, you know, according to the associations between  
17 Mr. Gaffner and Mr. Bell, we got two of the  
18 associations here, my question would be: What is it  
19 that the industry wants? Does the industry want to  
20 see more beds? Less beds? I think it also goes back  
21 to them to some degree. And I think that would give  
22 us some idea as to which way to go with all of this.

23 Alan, do you have any comments?

24 MR. GAFFNER: I've got a couple of

1 questions. First, if I may, please. It's Alan  
2 Gaffner.

3 Nelson, I want to echo a slightly different  
4 compliment. And that is thank you for your  
5 willingness to use multiple models which shows the  
6 differences that you have been explaining.

7 And I apologize if I missed it when you said  
8 it as well as when I was reading. But on page 2,  
9 where it identifies the methodologies, none of those  
10 actually has a CIM-3 description. So I am wanting to  
11 make sure that if I use page 2 as my legend, so to  
12 speak, it doesn't identify a CIM-3 and the unique  
13 characteristics to that.

14 Have I missed something in relationship to  
15 how I can quickly see CIM-3 fitting into that  
16 methodology section?

17 MR. AGBODO: You are right. CIM-3 -- yes,  
18 CIM-3 was not presented on page 2, and that is  
19 something that I missed. But on page I-4, it's I-4,  
20 right?

21 MR. KNIERY: It's Roman numeral 4.

22 MR. AGBODO: We have spelled out the CIM-3.

23 So normally, on page 2, I shall include that  
24 in the bullets. So that would be corrected.

1           And on page 6, where all the five  
2 methodologies have been presented, we also have CIM-3  
3 in the terms of formula, assumptions, input data and  
4 explanation.

5           Again, I will include CIM-3 description on  
6 page 2. That was missed.

7           MR. GAFFNER: Good. Thank you. That at  
8 least helps me in that regard.

9           Another couple of questions and then I will  
10 try to respond to the question that Charles posed.

11           On all of these models, using the occupancy  
12 rate, was there any of them that used a rate -- I  
13 think we have had descriptions around the table at  
14 different times -- that the present occupancy rate  
15 being high does impact bed need and that these are  
16 there. They may not be able to be used. But I think  
17 we have talked about it more real world occupancy  
18 rate 70, 75, 80 percent.

19           Did any of these models, Nelson, use what I  
20 would call a more present day market occupancy rate  
21 to drive these results?

22           MR. AGBODO: Well, we tried 85 percent rate,  
23 but it's not presented in this report. The results  
24 show over-bedding, highly over-bedding. Actually, if

1 we -- this meeting be very helpful if we can have  
2 like a presentation where I can pull up like a  
3 spreadsheet, because the excess now -- all this  
4 calculation has been programmed where you can just  
5 change the rate and see new values. So you know,  
6 something that we can do as a group to see all the  
7 options.

8 But each time we change one of the  
9 assumptions, the user rate, for example, we have to  
10 add another 20 pages each time we do that. So it's  
11 just, you know, the report would be too big to read.  
12 But any other options can be done on the spreadsheet  
13 and you can see the results just in minutes. So if  
14 we are willing to do that, I would be happy to help  
15 on that.

16 MR. KNIERY: If I may. Alan, I just want to  
17 add on that, we might be talking two different things  
18 also. The bed need projection is one thing to set  
19 what the need is. But in terms of a target use rate,  
20 maybe that's on the review side. Maybe that's on  
21 looking at facilities within a service area when  
22 you're doing an application versus on the need side.

23 So you might want -- we might want to  
24 consider, at least talk about, the target utilization

1 of the area facilities being something less, because  
2 that's more real world than -- the methodology is  
3 more projections and finite need.

4 Does that makes a difference or is that a  
5 distinction without a cause?

6 MR. GAFFNER: No. It does provide a  
7 distinction. I understand what you're saying.

8 I think it answered my question in the sense  
9 that the percentages of either target and/or the  
10 existing parts of the formula, those numbers were the  
11 same with the exception of these one-line  
12 descriptions that indicated what different -- what  
13 different significant inputs were used on the five  
14 methodologies if I am able to pose that in a way that  
15 makes sense, Nelson. That's what was done. That one  
16 main difference is with those descriptions on page 2,  
17 I believe. But everything else was the same as what  
18 we have been using at present, is that accurate?

19 MR. AGBODO: Yes. The CIM-3 has the  
20 particularity to have a different -- now I won't call  
21 it occupancy rate anymore. I am not using 90 percent  
22 in this methodology, the CIM-3 methodology. Instead,  
23 I am using 95 percent. But the other methodology,  
24 all the four methodologies have the 90 percent. All

1 the four methodologies have the 90 percent.

2 Like I said, we also tried 95 percent that  
3 we have seen oversupply of bedding, high  
4 over-bedding. The graph on that one was way beyond  
5 any other graphs. So I would say the bias was too  
6 high. So I didn't suggest that. I didn't even cover  
7 that in this report.

8 But like I said, those are the things we can  
9 visualize on the spreadsheets and see what would be.  
10 If we want to work on that percentage, which one --  
11 from 0 to if we went to 100 percent, which one would  
12 be okay.

13 And I do like the distinction you just made.  
14 It just clarified something in my mind and I thank  
15 you for that.

16 MR. KNIERY: No problem.

17 MR. GAFFNER: Nelson, when you were talking  
18 about the data -- and that was early in your  
19 description -- that I think a 2002 or 2005 or '07  
20 timeframe was used, and you mentioned it was  
21 pre-census.

22 Could any of that data have also driven some  
23 of the results? That would have been about the time  
24 that the supportive living program got going if I am

1 thinking correctly.

2 MR. KNIERY: I was going to add that also,  
3 Alan. Thank you.

4 I think in 2002, you see between '03, '04  
5 and '05, you see a sharp decline in patient days.  
6 2002, I believe -- don't hold me to that -- was when  
7 that program was introduced and you started seeing  
8 private beds going online those following three  
9 years. And you see the same thing. They open the  
10 program back up I believe in 2007 and you see the  
11 same thing, '08, '09, '10 and '11. I would think it  
12 would be interesting if we could continue that.  
13 We're not quite there. But I think it might flatten  
14 out a little bit, because we haven't seen any new  
15 introduction of supportive living or the SLF program.

16 MR. GAFFNER: That's helpful. And maybe  
17 some of Nelson's additional either modeling or say  
18 look at that might reflect it.

19 Charles, let me go back to your first  
20 question. And thank you for letting me ask those  
21 before I forgot them.

22 Certainly, I don't have any formal health  
23 care counsel of Illinois position today. But I  
24 believe what we have sensed around the long term care

1 subcommittee table is that there are parts of the  
2 state where it would seem a realistic need for beds  
3 to exist, but it doesn't seem to percolate or bubble  
4 up into the formula.

5           And so we know that the bed need formula has  
6 been a part of the buy/sell program discussion and  
7 how all that interrelates. So I believe any time  
8 that we're able to get either more relevant data or  
9 data that seems to take us to where we want to go so  
10 that it helps indicate where there are some bed needs  
11 will be able to do a better care delivery work within  
12 the state.

13           So Charles, I don't know if that gives you  
14 the tie-it-up-with-a-bow answer you were looking for.  
15 But I think we have been challenged at times with  
16 data as to getting it into the system and the  
17 inability of even this department to be able to have  
18 the resources that they need to get data currently or  
19 to help them.

20           But I believe any time we're looking at this  
21 formula that it's time well spent, because I think,  
22 as I mentioned, it will get us a better product that  
23 translates into better availability and direct care  
24 for Illinois residents from Chicago to Cairo.

1 Thank you, Nelson, for answering my  
2 questions.

3 MR. AGBODO: May I ask, what data are you  
4 referring to?

5 MR. GAFFNER: I think we talked about the  
6 lag time in getting newer census data, for instance,  
7 into the projections. What was the data -- the  
8 sourcing that was used for this last bed need  
9 formula?

10 MR. AGBODO: For this last bed need formula,  
11 we use census 2010 as a base population data. And  
12 then we project to 2013 and we use the estimate --  
13 the 2013 data as the bed population data for the  
14 projection for 2018. And all the estimate and  
15 projection was done by us. Me and Mohammed  
16 Shahidullah. And that's what we -- we are suggesting  
17 to do moving forward. Because if we have control  
18 over the whole methodology, it would be easier to  
19 address issues that we are going to find in this,  
20 because we have the opportunity to look at the  
21 projections and estimates and correct things, update  
22 inventory as we go.

23 But if somebody else has the methodology and  
24 supplied -- the person is supplying us with the data

1 that we need to do the projection, we'll have a  
2 problem updating as quickly as we need. Because for  
3 projection, for example, once the recall has new  
4 data, beds and this data, we can go back and review  
5 our projection based on that. And if we found that  
6 the difference between what we did before and what we  
7 have updated is significant, we can go back and  
8 actualize our inventory. And that work can be done,  
9 you know, now it can be done very fast, because we  
10 already have a spreadsheet set up to do most of the  
11 calculation that is needed. And the delay that we  
12 seen before in inventory publication I believe can be  
13 cut back now. And we should be able to react to new  
14 need as fast as possible.

15 MR. KNIERY: Courtney, does that mean we get  
16 annual inventory now?

17 MS. AVERY: No. We'll see.

18 MR. AGBODO: So for me, there is no problem  
19 with data. We can have all the data that all the  
20 experts can have. Everything starts with the census  
21 data, which is public data. We just go to Census  
22 Bureau website and we download the data. And then,  
23 you know, we can do all the projections and we can  
24 generate new inventories.

1           For the patient days, we get this data from  
2 the surveys, the annual surveys that we do. So  
3 nobody else has that data except us. So all the data  
4 goes into this. I mean the inventory's accessible to  
5 us. So I don't think we still have a data issue.

6           MR. KNIERY: If I can expand a little bit.

7           MR. GAFFNER: Well --

8           MR. KNIERY: Please, Alan, go ahead.

9           MR. GAFFNER: I was just going to clarify  
10 that the providers have a stake in that too. And if  
11 we're not getting usable data you need for I know at  
12 times the provider can pushback and say we don't  
13 timely report this or that. But if we're not getting  
14 accurate or as timely information to the department  
15 as we need to calculate occupancies and things like  
16 that, then that makes it harder even when you're  
17 using good census data.

18           I wasn't just trying to only make that  
19 comment, Nelson, in regards to the department, but  
20 for the role that the providers have to make sure  
21 that timely and accurate data is used in the  
22 formulas.

23           MR. KNIERY: I was just going to add -- I'm  
24 John Kniery -- that we just filed an application.

1 And with the current bed need methodology, the  
2 facility won't be open until 2018. So you're looking  
3 at 2019, 2020 for fill up, which is already beyond  
4 the scope of the bed need. And that's just right  
5 now. That's not, you know, four months, six months  
6 from now when we're still using the same methodology.  
7 So I mean, that's an ongoing issue that we always  
8 have the give and take on.

9 MR. AGBODO: And two years from now, you're  
10 going to have different inventories. Maybe I don't  
11 know if that will call for update of the application,  
12 you know. I don't know. But in three years, this  
13 inventory this year will be updated again.

14 MR. KNIERY: I am going to work on Courtney  
15 to get it every year.

16 MS. AVERY: Legislative change.

17 MR. FOLEY: I guess it goes back to Steve.

18 CHAIRMAN LAVENDA: Yes.

19 MR. FOLEY: You were saying earlier we were  
20 going to make a recommendation back to the full  
21 committee, is that correct?

22 CHAIRMAN LAVENDA: Well, I think unless we  
23 want to debate this some more, I think we should  
24 present this to the full group.

1           Do you want to have a little discussion on  
2   that? Or do you think the next step would be talking  
3   to the different associations?

4           MR. FOLEY: Well, I don't know. I think,  
5   myself, I think it would be nice to have the input  
6   from the different associations, and again, try to  
7   get them involved and see what they want.

8           MS. AVERY: That was the purpose of making  
9   sure there was representation. We expect those that  
10  represent those associations to take this information  
11  back. So we can add it to the next full committee  
12  agenda.

13          MR. FOLEY: LSN is not here.

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

15          MR. FOLEY: I said LSN is not represented  
16  here today.

17          MS. AVERY: No, but they received that  
18  information.

19          MR. FOLEY: I meant Leading Age. I  
20  apologize. I meant Leading Age.

21          CHAIRMAN LAVENDA: I think we have to give  
22  Leading Age and HCCI and -- well, I am sorry. HCCI  
23  is represented there. Certainly, Leading Age should  
24  have time to look this over and make any comments

1 before the next time the board meets.

2 MS. AVERY: Keep in mind that the  
3 subcommittee probably didn't have full representation  
4 from -- well, this work group, from all three.

5 MR. GAFFNER: That's correct.

6 MS. AVERY: But it's always an open meeting  
7 and the materials go to everyone. So I guess that  
8 will be the next step that make sure we can reach out  
9 to those that are represented, give them a deadline  
10 to comment if that's what you choose to do, Steve.  
11 And then we can go from there.

12 CHAIRMAN LAVENDA: I think that's the best  
13 thing. We shouldn't leave it open-ended. We should  
14 give a due date and then make it with enough time so  
15 that we have time to look it over before our next  
16 meeting, which is -- Courtney, could you please  
17 remind me?

18 MS. AVERY: Well, should it come back here  
19 first in case there's some other things or do you  
20 want it to go directly to the full subcommittee?

21 CHAIRMAN LAVENDA: You're right. It should  
22 come back to the subgroup here.

23 MS. AVERY: Okay.

24 CHAIRMAN LAVENDA: In case there is some

1 tweaking or readjustments that need to be done.

2 MS. AVERY: Okay.

3 CHAIRMAN LAVENDA: Anyone have any comments  
4 on that?

5 MR. FOLEY: I agree with you, Steve.

6 CHAIRMAN LAVENDA: Okay.

7 MR. FOLEY: Whatever that means.

8 MR. GAFFNER: Steve, Friday after receiving  
9 from Courtney the work of Nelson, I forwarded it on  
10 to HCCI. And with the holiday weekend in between,  
11 you know, don't have any comments yet. But I tried  
12 to initiate that as fast as I could on Friday. And  
13 again, as I think the members of this work group  
14 know, I am attending as an interested guest. I am  
15 not actually on -- in fact, it may be Bill through  
16 IHCA may be technically the only -- one of the three  
17 associations that's actually on the work group. But  
18 I wanted to try to get that moving on so that they  
19 could be aware of it as soon as possible and see  
20 Nelson's work.

21 MS. AVERY: So Steve, this is Courtney.

22 For the next meeting of the full  
23 subcommittee, you just want a summary that what  
24 happened today, the discussion of this extra report

1 and feedback and that we're waiting on comment from  
2 the three associations? Because I am not sure you're  
3 going to meet or have time for them to comment prior  
4 to the next meeting.

5 CHAIRMAN LAVENDA: When is the next meeting?

6 MS. AVERY: I think it's in October.

7 CHAIRMAN LAVENDA: October 22nd.

8 MS. AVERY: Okay.

9 CHAIRMAN LAVENDA: October 22nd.

10 I don't know if there's time for us to meet  
11 again before then. Possibly. I mean, maybe that  
12 middle week of -- middle of October would be possible  
13 to meet again. Maybe we could even do a phone  
14 conference.

15 What are everyone's thoughts on that?

16 MS. AVERY: We can do, basically, the same  
17 setup. But if you want for the associations -- I am  
18 sorry -- to comment, do you want to set a deadline  
19 maybe September 25th or the 21st? I don't know their  
20 meetings that they do things formally and have to  
21 take it to a board or what. So that may be too soon.

22 CHAIRMAN LAVENDA: That may be too soon.

23 Why don't we give them to maybe the 30th?

24 MS. AVERY: Of September?

1 CHAIRMAN LAVENDA: Yes.

2 MS. AVERY: Okay.

3 CHAIRMAN LAVENDA: I mean, that's a little  
4 more than three weeks from now.

5 MS. AVERY: Okay. And then plan on the next  
6 step for meeting would be from work group?

7 CHAIRMAN LAVENDA: Right.

8 I am going to throw out October 13th or  
9 October 12th.

10 MS. AVERY: The 12th is a holiday again.

11 CHAIRMAN LAVENDA: Columbus Day. It's not  
12 on my calendar.

13 How about the 13th?

14 MS. AVERY: The 13th.

15 Nelson, would that give you enough time to  
16 get comments in and organized and figured out or  
17 would you need another week?

18 MR. AGBODO: I should be fine. I will be  
19 fine.

20 MS. AVERY: You going to work?

21 MR. AGBODO: I don't have any pressure now  
22 that I have the report ready. If there is anything  
23 to change, just type that in.

24 MS. AVERY: So we'll meet on -- schedule it

1 for the 13th.

2 CHAIRMAN LAVENDA: Okay.

3 MS. AVERY: Okay. All right. We'll check.

4 We can do the same setup if there is space available  
5 and the conference call number.

6 CHAIRMAN LAVENDA: Okay. Great.

7 Is there anything else? Any other comments  
8 or anything?

9 (No response.)

10 CHAIRMAN LAVENDA: I hate to meet and run,  
11 but I am being paged into a partnership meeting.

12 Is there anything else?

13 MS. AVERY: No, I think that's it.

14 MR. FLORINA: This is John.

15 MS. AVERY: I am sorry. John.

16 MR. FLORINA: Florina on the phone. Just a  
17 quick question.

18 Has any other option, as far as methodology,  
19 surfaced in the meantime we should be considering?

20 MR. AGBODO: Uh-huh. I will take the  
21 question.

22 MS. AVERY: Besides the Ohio?

23 MR. FLORINA: Anything.

24 MS. AVERY: Not that I am aware of.

1 Nelson, you?

2 MR. AGBODO: Yes, I think it's a good  
3 question. Actually had that in mind as well to ask  
4 everyone here to see what else --

5 MR. FOLEY: We looked at Missouri?

6 MR. AGBODO: -- looked at the table for  
7 compare. It would be just as good to compare now  
8 everything to find the best option.

9 But I will be updating this report based on  
10 the comments and send out a newer version. Just  
11 things like page 2 and insert the description of  
12 CIM-3. Some few typos that will be corrected.

13 MS. AVERY: Let me go back before Steve has  
14 to leave.

15 One of the -- I remember back maybe six  
16 months or less, we did ask for input on other states,  
17 and Ohio was the only one that we got from Don Reppy.

18 MR. FLORINA: Courtney, Florina again on the  
19 phone.

20 Just asking because the associations also  
21 have national representation, but there is more  
22 accessibility to, I would assume, national data or  
23 information on programs through those national  
24 associations. Just throwing that out. If you ask

1 state associations for any input on this report from  
2 Nelson, there might also be an opportunity to ask,  
3 "Do you have any other options to be considered?"

4 MS. AVERY: Okay.

5 CHAIRMAN LAVENDA: Okay. That's a good  
6 point.

7 MR. AGBODO: I would like to, if I may,  
8 to --

9 MS. AVERY: Let me -- Steve, do you have to  
10 leave now? So we can carry on?

11 CHAIRMAN LAVENDA: Would that be okay?

12 MS. AVERY: Yes. I will call you and update  
13 you.

14 CHAIRMAN LAVENDA: Okay. Thank you.

15 MS. AVERY: You're welcome.

16 CHAIRMAN LAVENDA: Have a good day,  
17 everyone.

18 MS. AVERY: You too.

19 Sorry Nelson.

20 MR. AGBODO: That's okay.

21 I would like to comment on the fact that the  
22 current Illinois methodologies has some -- I won't  
23 say limitation, but as far as the minimum and  
24 maximum, we cannot go in the sense that we cannot use

1 any kind of percentages. We try all possible  
2 combinations between minimum and maximum. Each time  
3 we change something to the 90 percent assumption, we  
4 have to redo trials on the minimum and maximum and  
5 find the ones that the combination that maximize  
6 projection of health planning area into the correct  
7 category. So the minimum and maximum cannot be just  
8 changed like that. I have to change based on a  
9 well-defined methodology.

10 So looking at the 90 percent, if we want to  
11 change that, we can't go down. Because if we go down  
12 to value like 85 percent, 75 percent, what we are  
13 trying to do is to increase the projected number of  
14 days and projected number of beds. So if we  
15 continue, if we want to take option from that -- from  
16 that range, the range of, you know, 90 percent down  
17 to, you know, downwards, it will not be good for what  
18 we are trying to achieve. I mean, of our bedding  
19 issue.

20 So the options that are available I think  
21 that will be helpful is going from 90 percent up. So  
22 we already tried 95 percent. We can try 100 percent.  
23 It just means that 100 percent would be the fair  
24 projection we do by multiplying the use rate by

1 projected population. We don't increase that  
2 anymore. We just take that number as it is and  
3 divide by 365 and get number of beds projected for  
4 each area.

5 I believe that's the way to go with this,  
6 because like I reported, the use rate is going down.  
7 It's been decreasing. And from 2005 to 2010, the  
8 decrease was about eight percent. So on the field,  
9 we are seeing a decrease of bed use. So a  
10 methodology that will project upward will not be a  
11 good approach.

12 Just I want to clarify that if people have  
13 other options as far as modifying the current  
14 methodologies on the use rates and the minimum and  
15 maximum, just keep that in mind that, you know, the  
16 best way to do this is going upward and not backward  
17 on the 90 percent assumptions.

18 Thank you.

19 MR. GAFFNER: Nelson, this is Alan.

20 Have there been any other state formulas or  
21 any of your colleagues with similar roles that you  
22 have liked or they have said to you using this  
23 indices or that data set, it's more meaningful than  
24 something maybe that we have in our formula? Or I

1 would be interested in your professional opinion as  
2 to what you see in some other state formulas.

3 Courtney is right. Ohio is the only one we  
4 have had presented to us. But are they that -- are  
5 all 50 of them pretty much that boilerplate or have  
6 some of the other states done some things with data  
7 that you would like to see done in Illinois?

8 MR. AGBODO: Okay. I can review the other  
9 formulas from the other states. I haven't done that  
10 yet. I only look at Ohio.

11 But what I will say about the Illinois  
12 formula right now is that the structure of the  
13 formula, it's in compliance with the standard  
14 projection theory. You see, you have a bed use rate.  
15 You make options on that bed use rate looking at the  
16 future, is that use going to increase or decrease or  
17 stay the same. You made that assumption based on  
18 your past data. If we do that for our data, it just  
19 means -- we have to decrease the user. Decreasing by  
20 eight percent. Right now, if I multiplied that by 10  
21 percent, we are actually increasing that. That's  
22 something that we are doing that builds unused beds  
23 in the system.

24 So what if I said assumption you put on that

1 bed use rate. You now have the projected use rate  
2 and you multiply that to the future population and  
3 then you get your need for that future population.  
4 That is a classic way to do projection.

5 But now, when I look at Ohio process, they  
6 are not following that theory, they actually have  
7 what they call need rate for the whole state. And  
8 then they applied that need rate -- actually, the  
9 need rate is calculated on the future population, not  
10 on the base population. So they calculate that on  
11 the future population of the state. And then  
12 distribute that among the counties, Ohio's counties.  
13 But here, we distribute that among the health  
14 planning area. I don't really understand that.

15 So I will be looking at the other states  
16 formulas and see what else they have as far as  
17 assumptions to the classic way of doing the  
18 projection.

19 MR. FLORINA: This is John Florina, if I  
20 could make a comment.

21 I look at this whole concept of planning for  
22 long term care for nursing home services to be a  
23 prediction on what demand for nursing home care would  
24 be based on population and those nursing home

1 services. The easy way out -- I am not suggesting  
2 this -- would be to reduce the target occupancy to  
3 match the existing beds. But I think that fails to  
4 address the whole concept of planning we're supposed  
5 to be dealing with for future needs.

6 It still doesn't account for the outliers,  
7 the competition for nursing home services that may be  
8 provided by assisted living or supportive living. So  
9 I don't want to convolute the process. I always  
10 looked at it as for planning what the future need  
11 would be, not to reduce or manage the existing beds.

12 So that's just my opinion on it. I don't  
13 know if that fits with how the committee wants to go  
14 forward. To me, that's more in line with what the  
15 health planning should be.

16 MR. FOLEY: Charles Foley.

17 When this whole bed need methodology came  
18 about years ago, it was based also on the fact that  
19 we had no other alternatives to long term care health  
20 care. Now we do. So obviously, that has a  
21 significant impact, you know, on these numbers.

22 So once again, we talked about this before.  
23 And that is, for instance, with assisted living and  
24 supportive living, to see if there is a way where we

1 could through the down score use some of those  
2 patient data, because we know there are nursing  
3 patients in assisted living. We know there's nursing  
4 patients in supportive living. We know there's  
5 nursing patients at home receiving home care  
6 services. Somehow that needs to be tweaked within  
7 our methodology. I don't know how to do that.

8 But we're looking at a methodology, once  
9 again, that's created on the fact there were no other  
10 alternatives and we have that today. We have a lot  
11 of it today, which is really affecting the patient  
12 data. You're never going to see a bed need out there  
13 anywhere given this current methodology, because it's  
14 not looking at the total picture, just part of the  
15 picture.

16 MS. AVERY: As we have agreed to disagree  
17 over that issue for years, Charles.

18 MR. FOLEY: I understand.

19 MS. AVERY: I don't think we'll be able to  
20 get to that point until we clear up how many beds we  
21 actually have that are operative in the inventories.  
22 So it's like that's possible to do what you just  
23 described, but we have to step back and do step one  
24 first and figure out what we actually have out there.

1 That's the whole issue with the data that's not  
2 accurate.

3 MR. FOLEY: Don't we actually have that  
4 already in terms of beds in use?

5 MS. AVERY: We don't know what it is.  
6 People are telling us that our inventory is wrong,  
7 that we're incorrect, that we're over-bedded, that  
8 those beds are in the system, but we all know that  
9 they're not. And we still can't determine, because  
10 of the lack of disagreement or definition, what beds  
11 are actually being used, which is driving a low  
12 utilization rate.

13 MR. FOLEY: So what you're saying is that we  
14 need to basically go back and do what the board did  
15 with hospitals and just start cutting beds down? At  
16 least those beds that are not being used.

17 MS. AVERY: And we would not -- I would stop  
18 short of saying that we were forced -- we would  
19 enforce it without the industries' input or  
20 agreement. But until the industry agrees this is  
21 what we're looking at and this is what we're going to  
22 hear, we can't build new facilities, because the  
23 board is saying we're over-bedded. But it's not  
24 actually the board that's saying it. It's the

1 industry that's saying it, because they have not  
2 voluntarily removed those beds as the hospitals have  
3 done in the past.

4 As we have been saying since we have all  
5 been participating in this overall subcommittee for,  
6 what, five, six years now, we always reach the same  
7 conclusion, that we don't know what is actually out  
8 there.

9 MR. FOLEY: So the associations themselves  
10 need to get together and figure out how we're going  
11 to get rid of dead beds. Bill? Alan? You want to  
12 try that again?

13 MR. CORPSTEIN: Why don't you put it on a  
14 memo to send out of the facility?

15 MR. FOLEY: Get rid of all your dead beds.

16 MS. AVERY: And then --

17 MR. FOLEY: I don't see how we're going to  
18 do it.

19 MS. AVERY: Then it goes to the point of  
20 define a dead bed.

21 MR. GAFFNER: That's true.

22 MS. AVERY: No one wants to define a dead  
23 bed.

24 MR. FOLEY: You're right, Courtney. You're

1 absolutely correct.

2 So again, it goes back to the question as I  
3 asked earlier. Does the industry actually want new  
4 beds or not? If they want new beds, we're going to  
5 have to create or tweak our methodology somehow to  
6 show a need for beds. If we don't want new beds,  
7 fine, we got it already. We're done.

8 MS. AVERY: Well, but we shouldn't create a  
9 false need.

10 MS. FOLEY: And I agree with you. That's  
11 what we have. That's basically what we do have. But  
12 until we get a handle on the actual number of beds  
13 out there, Courtney, you're absolutely correct. And  
14 I don't know how to arrive at that.

15 Mike, you got any suggestions?

16 MR. CONSTANTINO: No. I had my ass chewed  
17 out the last time we attempted --

18 MR. FLORINA: This is John Florina. The  
19 question is, have we ever asked the associations how  
20 they would like us to account for the so-called dead  
21 beds?

22 MS. AVERY: I don't think we directly asked  
23 the associations. Just the industry. We have never  
24 gone, as far as I can recall, to the associations

1 with the request.

2 MR. FOLEY: I don't mean to burden them with  
3 too many items to respond to, but we're going to ask  
4 them about their input on these five methodologies.  
5 We're also going to ask them if they have any other  
6 options regarding methodology.

7 Is it pertinent to ask them: Do you have  
8 any suggestions on how to deal with these beds that  
9 are licensed and no longer in use?

10 MS. AVERY: We kind of asked that question  
11 one time on a survey and we had a lot of pushback  
12 from it. It wasn't those exact words, but it was  
13 asking how many beds are not in use or something that  
14 we added to the survey and we got calls in a negative  
15 response from that. For that one question.

16 MR. FLORINA: This is Florina. I believe it  
17 was this year's 2015 annual service buyout, and they  
18 all balked at it. What is your response to what is  
19 outside of the annual survey? My understanding was  
20 they didn't know how to answer the question.

21 MS. AVERY: So maybe we can think of a way  
22 to do it where there is anonymous input. I don't  
23 know. I will think of something. We'll think of  
24 something.

1           MR. FOLEY: We talked about at one time I  
2 thought, at least it was suggested, creating a  
3 separate column in the inventory book and label that  
4 column, for lack of better expression, beds not used.  
5 And then base your bed need on the beds that are in  
6 fact in use. You got dead beds, you know, and  
7 they're right there and identified. And the question  
8 was, okay, so we have a column with dead beds. So  
9 what do we do with them?

10           And it was talked about these were the beds  
11 that could be looked at in terms of the buy/sell  
12 concept that we now know, you know, if we got this  
13 created column, these beds were not in use. So you  
14 know, it was talked about, but it was never further  
15 elaborated on or taken to the next level.

16           MR. ROATE: Like an exorcism to bring the  
17 beds back to life.

18           MR. FOLEY: All of a sudden, they come back  
19 to life again. That was said before too, George.

20           MR. CORPSTEIN: At the end of last year, I  
21 provided some numbers. I told them to ask the system  
22 for occupancy over the last four years based on their  
23 license level. And when we calculated that out --  
24 now this is just certified facilities, so any

1 facility that was licensed only; sheltered care or  
2 private pay was taken out. And my numbers came  
3 within a percent and a half of what the board's  
4 published occupancy rate is.

5 I don't know how else. Facilities aren't  
6 going to tell us for a lot of reasons I think. So I  
7 go by what they -- they're less likely to lie to the  
8 feds than they will any sort of -- me or any sort of  
9 questionnaire or what have you. And like I said, it  
10 came within a couple of percent, which I would say is  
11 the margin for error when you cut out that I didn't  
12 calculate any sort of sheltered -- or any licensed  
13 only facilities, which is a very small percentage, or  
14 the beds that the board doesn't even cover.

15 So like I said, that was almost like a  
16 percent or two what the board's actual occupancy rate  
17 was, like 76 or something like that. I don't know  
18 how you're going to get any more clear data than  
19 that.

20 MR. FOLEY: We even talked about having  
21 licensure when they do their surveys to go in there  
22 and count beds.

23 MR. CORPSTEIN: I have tried that so many  
24 times and I can't understand. I get pushback from

1 every single possible person I've told that to that's  
2 in survey processing. That sounds like this is  
3 something that -- I don't understand about the survey  
4 process where asking them is way beyond the question.  
5 I don't know why that would be. I am not a nurse. I  
6 am not a survey team. But I floated it to the last  
7 couple of administrations, and they're like "What?  
8 Are you crazy?" Which I would think is just a basic  
9 form of what you would do in a licensure survey. But  
10 clearly, I don't know enough about it.

11 MR. FOLEY: You would question that if  
12 they're doing a survey based on licensed capacity of  
13 100 beds, but they only have 80 beds actually set up,  
14 then how accurate is that survey reporting data?

15 MR. CORPSTEIN: Like I said, I don't get it.  
16 Every time I take this to the powers that be, it's  
17 just inconceivable that they would do that. Why that  
18 might be, I don't know. No one's given an answer.  
19 Too much workload. They're there for health.  
20 They're not there to count beds.

21 MS. AVERY: That's kind of the response I've  
22 gotten also, Paul, that the lack of resources and not  
23 being able have time outside of the actual surveys  
24 that are necessary to do so.

1 I thought it would be easy just to add it on  
2 if a surveyor was going out, "Hey, can you count  
3 these beds for us?" But it clearly doesn't seem to  
4 be that simple either.

5 MR. CORPSTEIN: One person takes a walk  
6 through, you know, hey, room one. I had it all set  
7 up so I could send to anybody at a moment's notice  
8 exactly how the facility is licensed, how many beds  
9 per room, what the room numbers are, etc., all  
10 prepared for this kind of thing. But like I said, it  
11 seems to be a nonstarter, but for reasons I can't  
12 explain.

13 MR. FOLEY: Courtney, is there a way --

14 MR. FLORINA: This is Florina again.

15 It's a simple process. Having been an  
16 administrator in a facility for 30-some years, it's  
17 an easy process. They already have lists of  
18 everything. There is no problem seeing which rooms  
19 are set up and which ones aren't. The state  
20 architect goes through as well. They have everything  
21 identified. It should not be an issue.

22 MR. CORPSTEIN: I agree.

23 MS. AVERY: I agree. We all agree on that  
24 one.

1 MR. FLORINA: So if the association suggests  
2 how to do it, maybe they have a better idea.

3 MR. FOLEY: I was going to say that,  
4 Courtney. I think we need to maybe take this back to  
5 the associations and let them help us in terms of  
6 identifying a way, a means, or something, to identify  
7 these so-called dead beds without affecting their  
8 overall license capacity.

9 MR. CORPSTEIN: I think we need a firm  
10 definition as to what you refer to as dead beds.  
11 There are plenty of beds that are pulled out and used  
12 as an office, what have you. But there's also rooms  
13 set up that no one has been in that bed in three  
14 years. Which one is a dead bed? Which one is not?  
15 Are they both or both not?

16 MR. FOLEY: We had that discussion before  
17 and I thought it was a bed that could not be set up  
18 within a 24-hour period. Is that correct?

19 MR. CORPSTEIN: Seventy-two.

20 MR. FOLEY: Seventy-two hour period?

21 MR. CORPSTEIN: And there really shouldn't  
22 be any such room. No facility should have a room  
23 that is licensed that has a couple of beds in it that  
24 it takes 72 hours to set up. Basically, to keep that

1 room licensed -- I can't refer to cert, but if you  
2 pull that bed out and put in a desk so the DON can  
3 sit there, how can that be 72 hours to put the bed  
4 back in there and pull the desk out? It just seems  
5 inconceivable. Unless you made changes to that room,  
6 which you're not allowed to. And if you did, then  
7 that room becomes unlicensed and you just lost a bed  
8 on your license, which I am sure it happens  
9 everywhere and no one reports it. That's fine. I  
10 get it.

11 MR. FOLEY: Then I guess we've got our back  
12 up against a wall. Unless we, you know, once again  
13 have the association help us out on this issue.

14 Bill, do you have any comments on that?  
15 Love to put you on the spot.

16 MR. BELL: As others, I have tried. I got  
17 myself in trouble. I will take it back and we'll  
18 have some discussion.

19 MR. FLORINA: It's Florina again.

20 I believe the regulations for nursing homes  
21 specify what an actual set up bed is. You have to  
22 have all the equipment and you have to be able to  
23 reconstitute it in a certain period of time. I  
24 believe they have the definition. They just have to

1 follow it.

2 MR. FOLEY: There you go.

3 MS. AVERY: So Bill and Alan, are there  
4 opportunities when the associations meet? All three  
5 of you meet. Like in a quarterly meeting or in the  
6 hallway.

7 MR. FOLEY: You're dreaming, Courtney.

8 MS. AVERY: Does that happen?

9 Well, you want me to dream and create this  
10 miracle, I am just trying to figure out a way to do  
11 it.

12 MR. BELL: There is -- Darlene Carney has  
13 reinstated the quarterly meetings for the  
14 associations. I believe the first one is sometime in  
15 October. So that could be a question that we float  
16 at that meeting and see what responses come out or  
17 whatever. But there is not routine regular meetings  
18 of the associations. I mean, they meet when there's  
19 legislative issues or concerns or whatever. But  
20 generally, they're each on their own. But this is an  
21 avenue -- or Darlene is trying to set up an avenue  
22 whereby the associations are all together to discuss  
23 similar or common problems or issues or they can get  
24 the information out to everybody in one space rather

1 than separate meetings. So that's coming up. That  
2 could be a possibility.

3 MS. AVERY: Okay. Alan, you were going --

4 MR. GAFFNER: Bill nailed it. I was going  
5 to say there have not been, recently in the past,  
6 those scheduled --

7 MS. AVERY: Okay.

8 MR. GAFFNER: -- meetings. It's been more  
9 issue driven around legislation usually that brings  
10 them together to try to be as unified as possible  
11 regarding budget, regulations, that type of thing.

12 But that doesn't mean if significant enough  
13 and the department was asking that to happen. But  
14 from what Bill's identified, at least there could be  
15 an opportunity coming up for this next quarter.

16 MS. AVERY: I will further discuss that with  
17 Bill and try to figure it out, and you, try to figure  
18 it out.

19 MR. GAFFNER: Absolutely.

20 MS. AVERY: Bill, if you can work on getting  
21 the date for me. I would appreciate that.

22 MR. BELL: Okay.

23 MS. AVERY: Okay. Let the miracles begin.

24 Anything else?

1 MR. GAFFNER: I just have one last question  
2 for Nelson, if I might, Courtney.

3 Nelson, when you were mentioning that the  
4 use rate has gone down, I just want to make sure,  
5 you're talking, since you're using the term rate,  
6 you're talking about a percentage then rather than  
7 actual patient days, correct?

8 MR. AGBODO: Both. The patient days is  
9 going down. If you see the graph on page 10, so the  
10 black line, the actual patient days is going down.

11 Now, in terms of percentage, we actually  
12 divide the actual patient days by the population. So  
13 for one year it was, you know, for example, take  
14 2010. So we take -- we have the actual patient days  
15 for that year and we also have the population  
16 estimate for the same year. Then we divide the  
17 actual patient days for that year by the population  
18 of the area. That's where we get the use rate. That  
19 use rate is also going down.

20 So it just means that, you know, even the  
21 population, when we factor in the population, we also  
22 see a decrease. So again, both patient days in  
23 actual values and use rate are actual value reported  
24 by the population, both are going down.

1           MR. GAFFNER: The state has the knowledge of  
2 SLF occupancy and/or patient days through the  
3 Medicaid system, right?

4           MR. FOLEY: Right.

5           MR. KNIERY: This group does not.

6           MR. GAFFNER: One of the things I am looking  
7 for here is -- and frankly, that's one of the things  
8 that troubles me a bit that AL is outside of some  
9 ability of a planning board to know what is out  
10 there. Because the occupancy of those, I believe it  
11 was perhaps John Kniery or Charles that earlier were  
12 talking about as those service lines have increased  
13 in utilization, there is no doubt that they have  
14 impacted the long term care side.

15           I was just interested in how we might be  
16 able to at least have that kind of data available to  
17 you. Assuming we can get it through HFS for SLPs.  
18 It's that AL side that I don't think there's any  
19 safety net to catch unless the state has some way of  
20 knowing what is out there. With that being a free  
21 market program, we don't exactly know how many folks  
22 are in that community. Unless maybe some of the rest  
23 of you do in your role or John and Charles do through  
24 just their work as planners.

1 MR. CORPSTEIN: You want the number of  
2 skilled residents in an assisted living facility?

3 MR. GAFFNER: No, not that.

4 I am looking for how that service line, the  
5 number of people that are being cared for there --  
6 because there is no doubt that some of those are not  
7 in the long term care pipeline as they would have  
8 been prior to those programs starting. And that's  
9 impacting and driving bed need.

10 MR. CORPSTEIN: Right. But I don't think  
11 total population in assisted living is going to be  
12 related to anything we're discussing here unless  
13 you're somehow pulling out the ones that could  
14 possibly be in a nursing home but are instead in  
15 assisted living. I don't know how you're going to  
16 tease that data out.

17 MR. BELL: But there used to be sheltered  
18 care.

19 MR. KNIERY: Or even ICF, which is still  
20 nursing.

21 MR. GAFFNER: That's right. That was -- and  
22 I appreciate Bill and John jumping in. That was what  
23 I was trying to drill down for.

24 Certainly, one who's independent, so to

1 speak, and uses an assisted facility and loves having  
2 a meal cooked, no, they're not going to be part of  
3 it. But I think the categories of care that we just  
4 indicated here are factors that are showing Nelson's  
5 trend lines on page 10.

6 I am not the data guru you are, Nelson. I  
7 am only offering a theory. I don't have anything to  
8 back it up. But the timing of the data and the  
9 downward trend seems to wrap itself around SL and AL.

10 MR. FLORINA: This is Florina. If I could  
11 chime in on that.

12 It's my understanding that all assisted  
13 living facilities go through annual surveys from  
14 Department of Public Health. If they're being done  
15 regularly, there should be some kind of data. I  
16 would hope at a minimum they're capturing occupancy  
17 or patient days.

18 And Chuck Foley made the comment earlier  
19 about DON scores. I don't know if they're being  
20 completed for everybody that goes into assisted  
21 living. But there is a source for at least doing  
22 some acute measurement.

23 I think there's some mechanisms out there to  
24 get this. But if we don't even consider the people

1 going into assisted living, it's killing our numbers  
2 because they're included in your population numbers.  
3 The total population as far as your fraction here as  
4 to who's going into some type of assisted living  
5 facility, we're counting them in the total population  
6 by age group, but we're obviously not reflecting them  
7 in how those facilities are utilized and they do have  
8 an impact on nursing home beds.

9 MR. GAFFNER: Point well made, John.

10 MR. FOLEY: And to add to that, pointed out  
11 a little bit ago, even those facilities that are  
12 licensed as ICF, immediate care, a skilled patient  
13 cannot go into an ICF bed, but yet those patient days  
14 are also counted in our methodology.

15 So that's -- you know, it can't be used.  
16 Just like whether they're assisted living or  
17 sheltered care. It's the same thing. Because even  
18 those facilities are being occupied by the MI  
19 population, which means a skilled patient cannot  
20 accommodate those beds.

21 So in all of this, we need to put all this  
22 together, yes, it kind of skews the bottom line of  
23 bed need somewhat. So you have got the number of  
24 beds and then you have got the population figures

1 that is used in terms of SLP and assisted living and  
2 now ICF beds. So all that, you know, combination of  
3 all of it, it does hurt us somewhat. It does bring  
4 up a lot of empty beds. Now, most of your ICF I  
5 think are full. So that really wouldn't directly  
6 have an impact.

7 MS. AVERY: In the larger scheme of things,  
8 what you're describing, is that a pretty large  
9 percentage? I mean, what you just described, in my  
10 head, says that it shouldn't skew that we are  
11 over-bedded as we are with no one reaching a targeted  
12 utilization rate, the current.

13 MR. FOLEY: I don't know what impact the  
14 population's projections would have, Courtney, in  
15 that the assisted living and SLF population  
16 projections are being counted. I don't know what  
17 impact that in itself would have. In terms of ICF,  
18 no, I agree with you. I think that number would be  
19 small. But never the less, it's a number that should  
20 be looked at. You know, whether it's a large impact  
21 or small impact, it still is impacting in the number  
22 of beds needed in an area.

23 MR. CORPSTEIN: It would impact it down,  
24 right? Because home health, there's plenty of people

1 that could be in a nursing home, but they're having  
2 it at home or in assisted living. Maybe we just  
3 start aiming lower. There's less need than when we  
4 started this meeting.

5 MR. FOLEY: The Act does say that we have to  
6 look at all alternatives out there. That includes  
7 home health care, assisted living, SLF, sheltered  
8 care, everything. If you're going to have a planning  
9 process, as we said many times past, you have got to  
10 look at the total picture, not just part of it.

11 MR. KNIERY: I think what's more manageable  
12 for this task might be looking at average length of  
13 stay on the utilization that we do have. That goes  
14 back to: Is 90 percent accurate? Is 95 percent  
15 accurate? Are we seeing a much shorter average  
16 length of stay? Not akin to hospitals, but further  
17 down, where I think 10 years ago, I know we did a  
18 study and it was an average length of stay was  
19 365 days. Now over 400 days. Now I think the  
20 average length of stay is near 100 days. Is  
21 90 percent accurate? Which means are those beds  
22 really excess or are they needed because of turnover?

23 That's a question I don't know we have a  
24 handle on regardless of which methodology, we don't.

1 I think that is something more tangible. Something  
2 we need to, as this group -- and I am not in this  
3 group, I am just a guest. I think that's something  
4 you can look at and have some influence on. The rest  
5 of it I think is way too far out there. I think your  
6 utilization rates for the other levels of care are  
7 influenced and are taken into account when you look  
8 at historical bed need and it gets better as you go  
9 along. Because it's absorbed. I don't think we  
10 should discount it by any means. I mean, personal  
11 preference, I think I made it clear. I think  
12 supportive living should be under the board's  
13 purview. That way you have a complete process that's  
14 more inclusive. But that's just me.

15 MR. BELL: Same thing. Assisted living and  
16 supportive living are the same thing. They should be  
17 together.

18 MR. CORPSTEIN: Can you characterize what  
19 kind of care is supportive living receiving? If you  
20 had to equate it to what we do already, it's most  
21 like --

22 MR. FOLEY: ICF.

23 MR. KNIERY: ICF. It's an apartment  
24 setting, but it's ICF. I mean, there is a very fine

1 line between sheltered care and assisted living and  
2 supportive living. I think the difference is 23-hour  
3 care versus 24-hour care.

4 MR. FOLEY: Brought up some good comments.

5 MR. GAFFNER: This is really helpful and I  
6 am glad the conversation has morphed along these  
7 lines. And let me back up.

8 Those factors are what prompted my question  
9 regarding some of the other state formulas. If there  
10 are some states that are factoring in some of what we  
11 talked about or if they found a way to manage that.  
12 And perhaps maybe they haven't. But those are  
13 certainly a very direct care of components that do  
14 affect bed need, bed occupancy, as well as target  
15 rates.

16 MR. AGBODO: I want to make a quick comment  
17 on the use rates. In this process of projection, if  
18 we take the population, we cannot sort some of that  
19 for people out of that. Because every person I would  
20 say in the state should be seen at the risk of going  
21 to long term care one day. Even if it's not going to  
22 happen for some people, but they're at that risk. So  
23 we devise the total patient days for the general long  
24 term care by that population that is already at risk.

1 That is consistent with use rate calculation.

2 So the other thing that I try to verify in  
3 this report is, okay, when we calculate the bed  
4 needed for each area, the distribution of that bed,  
5 does that distribution follow the distribution of  
6 disability in the state? Because you know, we don't  
7 want to see a distribution of bed where we get more  
8 bed to an area where there is low disability rate and  
9 we give a high number of beds to an area where there  
10 is low -- small number of beds to area where there is  
11 a high disability rate.

12 The good summary for that information is the  
13 correlation coefficient. It shows the correlation  
14 that no matter what methodology you take, the  
15 projection follow correctly the distribution of  
16 disability rate.

17 For HCS, the define -- the data that we have  
18 used is the functional disability. And to define  
19 this as a function -- limitation that includes one of  
20 the combination of the following six health issues:  
21 Hearing, vision, cognitive, ambulatory, self-care and  
22 independent living difficulties. I believe that  
23 those are the type of disabilities that send people  
24 to nursing homes. Because we also have the primary

1 diagnosis of the people or the resident of a nursing  
2 home. And you can see that there is, you know, the  
3 functional disability and the primary diagnosis have  
4 -- how do I say that -- both make sense.

5 So that's why in this analysis, since we did  
6 not have the data on the primary diagnosis for the  
7 general population, we have to use the disability --  
8 functional disability as a proxy to do the  
9 correlation analysis.

10 So I don't know if that -- I mean, if we  
11 have better data to really get close to the primary  
12 diagnosis of the general population, we can use this.  
13 So far that was the best data I have found is the  
14 functional disability.

15 MR. FLORINA: Again, can I make a comment  
16 again to Nelson's input?

17 MR. AGBODO: Yes.

18 MR. FLORINA: There's two sides to it that I  
19 am looking at here. One is accounting for the  
20 population, the total population regardless of what  
21 vocation they go to, nursing homes, assisted living,  
22 their own home. But the other is accounting for how  
23 many of those people are actually in a so-called  
24 institutional type setting. If I am counting

1 assisted living and supportive as institutional in  
2 this regard. We can account for those in the nursing  
3 home, because we report the data and we utilize it.  
4 But we're not, as far as I know, accounting for the  
5 data for those who are actually living in those  
6 alternative service areas.

7           So in order for us to evaluate what a true  
8 bed need is for nursing home services, is it  
9 appropriate for us to know how many of those beds are  
10 licensed and how many are being utilized for people  
11 who need services in assisted living or supportive  
12 living?

13           MR. AGBODO: Well, I don't have any answer  
14 to this comment. Because like I said, the way we  
15 calculate in needs, you know, it's classic. The use  
16 rate itself accounts for, you know, any other  
17 factors. The use rate, it varies on the general long  
18 term care use. And by calculating that from year to  
19 year, if we are seeing a decrease, it just means that  
20 people are going somewhere else. And that's actually  
21 that number accounts for in all the variables, all  
22 the factors that we want to add to this.

23           I don't think we should change something in  
24 the way we calculate it, that use rate. And moving

1 forward with that use rate, the bed needs that we  
2 calculate reflect truly the need for the long term  
3 care services.

4 Mike actually does all the calculation. I  
5 think he might help me on this one. As far as  
6 methodology, I don't really see any problem.

7 MR. FLORINA: Does that also account for the  
8 planning area differences? Because clearly, if you  
9 have a planning area that has assisted living  
10 facilities in it, it's going to skew the bed need for  
11 nursing homes more so than planning areas that don't  
12 have assisted living in it.

13 I am just curious if you still need to  
14 determine the actual beds available being utilized,  
15 not just the number of people that may need services  
16 because of the population data.

17 MR. CORPSTEIN: Are there any numbers that  
18 state how many possible skilled people are in  
19 assisted living? Does anybody have -- I mean, we  
20 keep referring to it all the time that assisted  
21 living is pilfering from nursing homes. But does  
22 anybody have any stats whatsoever other than  
23 antidote?

24 MR. BELL: Because that would be illegal,

1 because you can't have a skilled person in an  
2 assisted living facility.

3 MR. CORPSTEIN: Nor a shelter, nor an ICF.

4 MS. AVERY: That's not captured doing any  
5 kind of surveys for follow up with intake or nursing  
6 plans or anything?

7 MR. CORPSTEIN: In assisted living?

8 MS. AVERY: Or do people just document it  
9 the way they want to document it? Isn't there  
10 certain criteria you have to meet to go into those  
11 beds?

12 MR. CORPSTEIN: As far as I can tell, it's  
13 pretty freewheeling in assisted living. And I don't  
14 know what kind of stats, if any, that they're  
15 bringing. I doubt occupancy is going to mean  
16 anything to you unless you know the health behind the  
17 person that you're counting.

18 MR. BELL: What happens in assisted living  
19 is that there is criteria for being admitted into an  
20 assisted living. What happens though, as the person  
21 ages and they become more debilitated or whatever,  
22 that's where the problem resolves in that there is  
23 not someone going in and evaluating them and saying  
24 oh, okay, it's time for you to move. Well, that

1 upsets families tremendously, because they're happy  
2 with the assisted living facility that are usually a  
3 lot newer and a lot more amenities than a long term  
4 care facility would have. Then you run into that  
5 problem of trying to force that individual out of an  
6 assisted living into a long term care facility.

7 MS. AVERY: So I get what you're saying.  
8 But isn't that a risk for the facility if they're not  
9 providing appropriate care?

10 MR. GAFFNER: Absolutely.

11 MR. BELL: It's very possible. Yeah. But  
12 sometimes --

13 MR. CONSTANTINO: The reward is greater than  
14 the risk.

15 MR. BELL: The money and the family willing  
16 to look possibly the other way to keep that resident  
17 in that place, because they like it. It weighs out.

18 MS. AVERY: Until the resident is hurt or  
19 died at their hands because the appropriate level of  
20 care wasn't provided.

21 MR. BELL: At that point, you probably are  
22 calling the ambulance or something like that and then  
23 that person is then at that point judged not able to  
24 go back to the assisted living facility. You know,

1 because you also have that two-week period of time  
2 that you can be skilled if you have got some type of  
3 condition or something, then they start playing with  
4 that timeframe. And well, there are two weeks, but  
5 then for a week they were really good, now two weeks  
6 later back in that condition. There's all kinds of  
7 games played with that process.

8 MS. AVERY: Okay.

9 MR. GAFFNER: Bill really accurately  
10 described that. And it may be -- and thankfully that  
11 they do not pass away. But he described a very  
12 realistic everyday scenario where some clinical  
13 condition warrants an admission to the hospital or  
14 something like that. And then although the resident  
15 and family and facility have worked around it, so to  
16 speak, up to that there becomes some point at which  
17 they can no longer work around it. So that may move  
18 them on.

19 And of course, with that being private pay,  
20 until that family exhausts their ability to pay, that  
21 facility is not going to likely -- although the regs.  
22 Absolutely, the regs indicate what care can be  
23 provided. But if the facility was working with them,  
24 so to speak, there wouldn't be any incentive until

1 they reached the point that they couldn't pay. And  
2 then they either have to convert to an SLF category  
3 or maybe simply an AL all private pay facility. And  
4 then based on their business agreement, they would  
5 have to leave the facility and go somewhere. Likely,  
6 that would probably be at a point they would seek  
7 long term care.

8 MS. AVERY: Okay.

9 MR. GAFFNER: Through the Medicaid program.

10 MS. AVERY: Thanks.

11 Okay. Is there anything else you all want  
12 us to look at or outside of contacting the  
13 associations and asking for comment on the report  
14 that Nelson has put out and then following up to see  
15 how we can address and have a discussion with the  
16 associations regarding the beds?

17 MR. FLORINA: I think if you can get all the  
18 information, we would be doing fairly well.

19 MS. AVERY: I think we're doing great.

20 MR. BELL: Courtney, I will give Lynda  
21 Kovarik a call and ask her just what information that  
22 she gathers on surveys and if they have got any  
23 occupancy data. I know she keeps track of how many  
24 units there are licensed, but I don't know if they

1 count when they go in on surveys. But I will talk to  
2 Lynda and see what she has to say.

3 MS. AVERY: Okay. Great. Thank you.

4 Alan.

5 MR. GAFFNER: I am sorry. You were listing  
6 those items.

7 Did that include Nelson and staff looking at  
8 some other states?

9 MS. AVERY: Yes, we're going to.

10 MR. GAFFNER: I just didn't hear that.

11 MS. AVERY: That will be a question sent out  
12 also. Are there other states that you would like us  
13 to duplicate this process with?

14 MR. GAFFNER: Nelson can look on his own too  
15 through that, right?

16 MR. AGBODO: Yes, I will try to do that.

17 MR. GAFFNER: Thank you.

18 MR. AGBODO: I don't know if I will be able  
19 to find the formula or the material for all the  
20 states that have CON in place. But if anybody has  
21 that information on the formula on that methodology,  
22 I would be glad to get that. That would be easier to  
23 go quickly towards this.

24 MR. BELL: I hear Hawaii has a pretty good

1 system, but you probably have to do a visit, site  
2 visit.

3 MR. CORPSTEIN: Starting with Hawaii.

4 MR. AGBODO: That would be nice.

5 MS. AVERY: And maybe we can just do maybe  
6 five that's similar to Illinois with population. So  
7 two criteria CON state and maybe similar population.

8 MR. AGBODO: Okay. I will have to find a  
9 document describing the methodologies. And  
10 hopefully, I am thinking that some of them will be  
11 similar so we don't need to do all that. And then  
12 ones that's similar, we take one out of the ones that  
13 are similar and so we can carve out all the  
14 differences.

15 MS. AVERY: Yeah.

16 What we can do also is send out an e-mail to  
17 the Listserv. And I think I still have that. For  
18 CON states.

19 MR. AGBODO: That would be great.

20 MS. AVERY: Send a question out and  
21 hopefully people will respond. That might save you  
22 some time.

23 MR. AGBODO: That would be very helpful.

24 MS. AVERY: Okay. Anything else?

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(No response.)

MS. AVERY: All right. Thanks, everyone.

(Ending time: 12:36 p.m.)

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CERTIFICATE OF REPORTER

I, Angela C. Turner, a Certified Shorthand Reporter within and for the State of Illinois, do hereby certify that the meeting aforementioned was held on the time and in the place previously described.

IN WITNESS WHEREOF, I have hereunto set my hand and seal.

*Angela C. Turner*

\_\_\_\_\_  
Angela C. Turner

IL CSR #084-004122

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