S62847

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

LONG-TERM CARE FACILITY ADVISORY SUBCOMMITTEE

REPORT OF PROCEEDINGS had at the hearing of the above-entitled matter before the Long-Term Care Facility Advisory Subcommittee at the Bolingbrook Golf Club, 2001 Rodeo Drive, Bolingbrook Illinois, on July 16, 2013, at the hour of 10:05 a.m.

PRESENT:

MR. MICHAEL WAXMAN, Chairman;

MS. JUDY AMIANO, Member;

MS. TONIETTE COLON, Member;

MS. CECILIA CREDILLE, Member;

MS. CAROLYN HANDLER, Member;

MS. NEYNA JOHNSON, Member;

MS. PHYLLIS MITZEN, Member;

MR. DAVID RAIKES, Member;

MR. MICHAEL SCAVOTTO, Member;

MR. GREG WILL, Member;

ALSO PRESENT:

MR. FRANK URSO, Board Staff Counsel;

MR. MICHAEL CONSTANTINO, IDPH Staff;

MS. CLAIRE BURMAN, Board Staff;

MS. ALEXIS KENDRICK, Board Staff; and

MS. CATHY CLARKE, Assistant Administrator.

CHAIRMAN WAXMAN: Thank you all for joining us on this wonderful, delightful spring day.

Points of information: Courtney will not be joining us today. She is under the weather, as I think we might all be before this week is done, as I keep hearing.

If we can go around the table and introduce ourselves for people who are new to the group and for the sake of our court reporter, we can do that.

MEMBER COLON: Toni Colon, Illinois Department of Public Health.

MEMBER CREDILLE: Cecilia Credille, representative of Illinois Health Care Association.

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

MEMBER HANDLER: Carolyn Handler, hospice industry.

MEMBER AMIANO: Judy Amiano, I'm a provider for the Franciscan community.

MR. FLORINA: John Florina, visitor.

MR. FOLEY: Charles Foley, visitor.

MR. KNIERY: John Kniery, visitor.

MEMBER SCAVOTTO: Mike Scavotto, committee member.

MEMBER RAIKES: David Raikes, Laborer's Union Local 393.

MS. BURMAN: Claire Burman, Board staff.

CHAIRMAN WAXMAN: I'm Mike Waxman. I'm Chair.

MR. URSO: Frank Urso, Board staff counsel.

MS. KENDRICK: Alexis Kendrick, Board staff.

MR. CONSTANTINO: Mike Constantino, IDPH staff.

MR. MURER: Matt Murer, Board staff -- just kidding.

CHAIRMAN WAXMAN: Thank you, all, and welcome guests.

MR. CONSTANTINO: John, would you spell your last name for the court reporter?

MR. FLORINA: F-l-o-r-i-n-a.

MR. CONSTANTINO: Thanks.

Excuse me, Mike. I apologize.

CHAIRMAN WAXMAN: That's okay.

Did you make the trip all by yourself from Springfield?

MR. CONSTANTINO: No. Ms. Johnson came with me.

CHAIRMAN WAXMAN: Oh, good. Okay. That's a long, ugly drive by yourself.

MR. CONSTANTINO: She was with me.

CHAIRMAN WAXMAN: 55 is probably the most boring road in the country.

Anyway, Frank, do we have an official quorum?

MR. URSO: Yes. It looks like we have eight people that are officially members.

CHAIRMAN WAXMAN: Okay. Excellent.

In that case, I need approval of the agenda.

MEMBER HANDLER: So moved.

MEMBER RAIKES: Second.

CHAIRMAN WAXMAN: All in favor?

(The ayes were thereupon heard.)

CHAIRMAN WAXMAN: Any opposed?

(No response.)

CHAIRMAN WAXMAN: Motion carries.

I need a motion to approve the April 23rd meeting transcript. I'm sure all of you have read it.

MEMBER SCAVOTTO: Moved.

MEMBER AMIANO: Second.

CHAIRMAN WAXMAN: We have a motion from Mike.

Need a second.

MEMBER AMIANO: Second.

CHAIRMAN WAXMAN: Have a second from Judy.

All in favor?

(The ayes were thereupon heard.)

CHAIRMAN WAXMAN: Any opposed?

(No response.)

CHAIRMAN WAXMAN: Motion carries.

Matt, we are at your time. So feel free to take over. Matt, if you want to introduce yourself.

MR. MURER: Sure. My name is Matt Murer. I'm a health care attorney with the firm of Polsinelli. I'm also the chair of the health care group.

My practice is focused on representing

providers in the senior housing, long-term care space, and I've had the fortune or misfortune to spend the past few months up to my eyeballs in managed care contracting issues.

I was asked to come and just give a really quick presentation about the impact of managed care on the industry, and this is purely my opinion based on just what I see and what's going on.

I apologize if the discussion or the presentation is too general or too basic, but I'm going to try to cover what I think are kind of the big things. I've reviewed I think all of the managed care companies that are coming into Illinois. I've reviewed all their contracts and made comments to those and talked to providers about those. So let me just give a broad overview, and then I'll kind of drill down into what I think is the big effect of all this.

CHAIRMAN WAXMAN: Matt, may I interrupt you for one second?

MR. MURER: Yes, of course.

CHAIRMAN WAXMAN: We have two new members that have come in, so for the record, I'd

like for them to give their names to the court reporter, please.

MEMBER WILL: Greg Will, SEIU.

MEMBER MITZEN: Phyllis Mitzen, Health and Medicine Policy Research Group.

CHAIRMAN WAXMAN: Thank you, both. Matt, I apologize.

MR. MURER: No, no problem.

Illinois is in the process of essentially converting all of its Medicaid beneficiaries into managed care programs, and that means that they'll all be enrolled. It's a passive enrollment program, which essentially means that if they do nothing, they'll be enrolled into one of the programs.

It's a big pool, and all of the major managed care companies have come in to participate. Right now we're at this very interesting and exciting time where -- and by "exciting," I put that in quotes. If you've been in health care for more than a couple years, you know when you say "exciting," it means, Oh, God, hold on.

But you're in this exciting time where the

managed care companies are doing two things right now very intensely. One, they're enrolling beneficiaries because they need to prove to the State that they have enough beneficiaries to have a pool; and two, they need to create provider networks, and they're furiously doing that because if they don't have a sufficient provider network, they can't participate. So there is a mad rush right now to get these contracts signed and to get beneficiaries enrolled.

A lot of my clients have had the experience where the companies called them and said you have to sign a contract now, now, now. You have to sign it now. If you don't, you know, all these horrible things are going to happen, which is not true. The only one who is really under pressure right now is them.

But let me start going through some of these slides, and I'll just kind of tell you -- I'm sorry -- when I copied it, the heading got blotted out on the third one, Managed Care.

What I did is because I think that this is kind of a good way to think about it, I took the definition that HFS uses for managed care: "A

system of health care delivery designed to provide care that will reduce unnecessary utilization of services, control cost, increase access, and maximize quality."

When I read that, I was like that sounds fantastic. Right. I mean, who doesn't want to get rid of unnecessary utilization, control costs, increase access, and maximize quality. That all sounds awesome.

Then you go to the Merriam Webster's definition which is: "A system of providing health care that is designed to control costs through managed programs in which the physician accepts constraints on the amount charged for medical care and the patient is limited in the choice of a physician."

This sounds a little less good, right, because now we're talking about constraints. We're talking about limited choice, limiting things. That doesn't sound quite so good.

Then you get to the shorthand which I think a lot of people in the industry will talk about which is rationed care. This, I think, is where we get to kind of the crux of managed care and

what the impact is going to be for this industry.

You know, we talked -- this bullet point about a complex tug of war between supply and demand, right. So right now, as I said, all the managed care companies are out to get beneficiaries. The ones with the biggest pool of beneficiaries will have the best negotiating power against providers, right. The providers who are the most sought after will have the most negotiating power with the managed care company.

Here's the problem, though. This is the one thing that I don't know that a lot of my clients realize, I think they're realizing it now, but because Medicaid is such a big mover in long-term care, it's such a big piece of payment, it has a huge ramification for these providers.

If you're an orthopedic surgeon, if you decide you don't want to be in Medicaid managed care, it is a nonissue for you. If you are in long-term care, and most people have some component of Medicaid, this has serious implications for you.

And then I'm also going to talk a little bit about the dual eligible program which is

really where the meat gets cut off of the bone. That's where we're going to see the real excitement within the next five years.

So the other thing that's different is, and this is reflected in some of the problems with the provider contracts that are out there, managed care mostly deals with providers that have episodic interactions with their patients.

Again, orthopedic surgeons, you see them once -- you know, you assess them, you see them once presurgery, then you have the surgery, and then maybe a postsurgery, four times in one year.

In this program for our providers, whether you're a SLF or you're a SNF, you're living with a beneficiary, right. You're living with the beneficiary, so you're getting to see them a lot differently.

You know, what's interesting is, and what we don't know yet is utilization review is a big part of managed care. We go and we look and we see are you providing the right services at the right time and the right amount.

If I'm an orthopedic surgeon, it's easy to do a utilization review because I can say you did

too many postsurgery follow-ups. You gave them too little therapy, you did this, or you did that. That utilization makes sense.

If you think about a skilled nursing facility, how do you say -- how do you overutilize on that? Oh, you shouldn't have had this person in your facility seven days out of the week, it should have been four days. Send her to the park for three days and bring her back for another four days. You can't do that. We don't know what that's really going to look like, but we're going to see how that looks.

You know, the next slide I talk about -- because people look at these contracts, and they say, you know, what is it we're even looking at, and the contract is supposed to be a written expression of the two parties' agreement or a documented meeting of the minds. In these cases, it really is the third, which is the best deal that the parties could agree to.

Managed care companies are notoriously difficult to negotiate with. If you provide them with changes -- we have been successful. I've worked with the affordable assisted living

coalition as a group in responding back with comments, and that's been more powerful because we have a lot of providers. We're representing a lot of providers and saying we don't think this is good. Single providers have a much harder time.

So usually what it is is you say I object to these 10 things in the contract, and they say, Thank you very much. We'll think about changing one of those 10, and it's usually like a typo. Even sometimes typos they're reluctant or they refuse to change.

So I talked a little earlier about that tug, that push and pull. Right now the managed care companies are a little bit more open to negotiation because they're trying to get their networks built out, and that's -- I don't know what number this is. I should have these numbered.

Right now a lot of the SNFs, the skilled facilities don't want to be left out because they're being told if they don't do this, they're going to be the only one that doesn't do it.

Right now what's interesting is it's very

1 theoretical. There are very few beneficiaries
2 that are enrolled. So if you decided not to be
3 part of this program with Aetna, IlliniCare, or
4 Health Alliance, you might miss out on two or
5 three residents in a year. Five years from now,
6 depending on your Medicaid census, you could miss
7 out on half of your potential census. So that's
8 kind the pressure that's on here.
9 The big terms that we're seeing -- you
10 know, people say they get these -- I reviewed a
11 contract last night that had 38 pages in it, and
12 out of those, there are really -- these are the
13 ones I care about, reimbursement. This is the
14 most interesting thing to me, and this is one of
15 the big impact issues that providers and this
16 group should be thinking about.
17 In health care, and certainly long-term
18 care more than in other provider categories,
19 reimbursement has been less of a concern. The
20 people who are providers are like, What are you
21 talking about, Willis? That's not true. We've
22 been concerned about reimbursement for years.
23 But what I mean is reimbursement has always
24 been a known factor in our equation. Medicaid,

maybe we didn't like what Medicaid paid us, but we knew what they paid us, right. We are in the program, and we got X. Medicare, we knew exactly what they paid us. They would pay us Y. Private pay, we knew what we charged, and we knew what we could get.

There was no negotiation, and there was no discussion about what the right rate should be, and because of that long-term care providers do not have any experience in negotiating prices and fees.

These contracts, although right now they have -- most of them talk about giving you a guaranteed 100 percent of Medicaid rate, that is going to change. Those who read their contracts -- and let me talk a little bit about MMAI.

MMAI is a program designed to align both the Medicare and Medicaid programs in Illinois. So those individuals who are both Medicaid and Medicare eligible, dual eligible, they would also be in this managed care program, and you will not get paid by Aetna or IlliniCare or whoever you have a contract with to provide these services.

What I'm telling my clients under those contracts is read the reimbursement part because there are some of the contracts -- there's one in particular that says right now for your Medicare beneficiaries, we will pay you the lesser of 100 percent of Medicare, that's pretty good, right; your charged rate, private pay, that's pretty good; or Medicaid.

So for those providers who have signed up without thinking, they have just agreed to take a Medicaid payment for every Medicare person that comes through there, and that will be devastating to their bottom line.

Where we're at right now is -- you know, some people are signed up -- the good thing is that state law in Illinois allows you 90 days to get out of a managed care contract. That's provided in the law. It's a right of law.

We're going to see, I think, some people get burned. Oh, and the other thing under these contracts is you are entitled to get co-pays, and you're not entitled to write off that debt. So that's a double whammy on your Medicare and on your cost of reporting. So there's a hit in the

reimbursement.

So what's happening now is that providers are coming to me and they're saying, Matt, this looks really bad to me, and I said, Yes, it is really bad. I'm not a CPA, but I'm sure that those are not the rates that you want.

And then they say, What do I do?

The reason why providers are saying, I think, what do I do is because up until now, as I said, they have not had to negotiate price.

Some of the companies are going to -- I think are trying to negotiate early on where they're trying to get to this reduced rate. Like some are looking at a Medicare rate of 450, and they're willing to pay you 380 a day, and they're wondering if you'll come down.

Some are saying we'll give you 100 percent of Medicare, and they're I think two or three years down the road going to try to adjust those rates down, but that's where the real impact is going to be for providers is that three years out from now and we have all of the networks set up is that that's when the negotiations start.

Then the real negotiations aren't going to

be between the facilities and the managed care providers. The real negotiations are going to be between -- against other providers. Because then they will say we have 40 facilities in our network in your area, in the greater Chicagoland area. We don't need any more. So either take the rate reduction or get out, and that's going to be the tricky part.

What happens is and what's interesting about this is traditional managed care is they collect premiums and they drive rationing of care, right, to drive down the costs, and they make a bigger profit.

With Medicare and Medicaid managed care, the government has a set amount of money. It's not driven by these accepted premiums. It's driven by budget. It's driven by expenses. That's not likely to go up, right. Premiums go up every year. The amount that's in Medicaid and Medicare is probably not likely to go up at the same rate, so that pool is not going to get bigger. To maintain their profit margins, the managed care companies will continue to try to drive those rates down.

Now, the other thing that people haven't thought about I don't think enough is when you go through these main points -- term, termination, definition of services -- right, the scope of what it is you're required to provide under these contracts is very, very vague. What you don't want to get stuck in is agreeing to the discounted rate and providing more services than you normally would under Medicaid or Medicare.

The other thing that's a unique feature about this compared to long-term care and other providers, my orthopedic surgeon example, for example, is in every other setting, there's a way to shift those costs.

So if I'm a hospital and I'm going in a managed care situation, I can shift those costs by moving the patient out to a lower-cost setting, right, sooner, quicker. I can go to generic drugs. I can do a whole bunch of things to change that mix.

Managed care is -- or long-term care is somewhat unique in their place in the continuum. They have very little space to shift costs. There is no other place to send someone who

needs, you know, custodial care and ongoing supervision and oversight.

So what happens is instead of being able to cost shift, they're either going to have to become more efficient, be willing to accept less, or cut down the amount of Medicaid that they're willing to pay. That's going to cause a seismic change, I think, in the next five years in long-term care providers.

Some of those providers who have traditionally positioned themselves as primarily Medicaid, some of those are going to do really well. Some of those are going to do really poorly because they're going to have to -- if they're going to stay in that game, they're going to have to do really, really a lot better than everyone else. That doesn't mean better quality. That doesn't mean better efficiency, better care coordination. What that means is they could do it more cheaply. So I raise that.

You know, reconciling claim disputes -- what's interesting too is different traditional managed care is that -- and if you read the contracts, some of them are explicit about this.

Some of them are silent. If the State, and I will not cast aspersions on the State, but if hypothetically the State were to get so far behind in paying the managed care organizations -- although they say that's not going to be a problem, but hypothetically if that were to be the case, one of the managed care organizations went out of business, there is a very distinct question as to who would pay those claims.

Managed care companies have said not only will they not pay the claims, but they bear no responsibility, that the bankrupt shell, which all these are set up as pretty much anyway, you know, the chances of you getting paid are pretty far out there.

Another one that's an interesting thing that we haven't seen, and I don't think we'll see it in -- or it's not as big an issue for other providers is that many of the managed care companies have taken the position explicitly that if they tell you that they have a beneficiary who is qualified, please take them, we'll pay for their care; and two months later they determine

that that person was not qualified, they will recoup all of the money that they have paid you for that person, and then you will be stuck trying to get paid for that.

Now, that's a horrible prospect. When you add to that the current delay that is going on with Medicaid case workers who will be responsible for updating eligibility information, you have what I would consider an unqualified recipe for disaster. The managed care companies have said, We're going to recoup that money, we're going to pull back, and the providers will very much be on their own to take care of that.

The State, you know -- from what I've heard, the State has its own administrative problems to deal with. I don't think that they have a solution to that issue. So I would say in the first two years we'll see those problems, but since the beneficiary pool will be smaller, they will be small problems, but they will be exponential within five years. That problem has to be solved for this to be a viable system.

The other thing that I mentioned -- I talk about that negotiation of rates. California has

done this already. They just issued a report. I'll send it to Courtney to send around to everyone. I should have brought it. They talked about some of the problems that they had in the state when they did this because they're a year ahead of us.

One of the problems is that there were huge gaps in care because the managed care companies had not yet worked out the communication system and how to coordinate that care. Things weren't paid for, and in virtually every instance, the providers picked up the tab for that free care.

There were dialysis providers who couldn't get their beneficiaries in for dialysis services so they provided them free transportation. There were clinics that couldn't get coverage for certain things, so they provided free care. So there is a logistical issue that we're going to go through that's going to be painful and costly, and as is often the case, it's going to be very costly for providers.

The other thing that I expect to happen, and I hesitate to look into a crystal ball, but I think it's true, and I'm going to cheat a little

bit with the crystal ball because this case just came out this week in another state in the Medicaid managed care environment.

The provider sued the state, and they sued, and they said you violated federal law because you should have guaranteed a minimum Medicaid payment for these services. The managed care companies pay us so little, it's not enough for us to provide the care on, and we've had a tremendous loss, and now we're suing you.

And the Federal Court said no. There is no minimal requirement that gives you, the providers -- it's incumbent on you to negotiate a rate that's sufficient, and if you can't negotiate that, you shouldn't participate.

That is to me a wake-up call on how the providers need to think about this and what it's going to mean for the industry.

Having thought through all those issues, you know, what I also put out there as kind of a related consequence is that all of the tertiary providers that are involved in this, they will be affected by this as well -- pharmacies, therapy, all of them. They'll come a little bit later to

the party in the negotiation, but this is a game changer.

So the big issue to me is -- and in the Medicaid, you know, you're either going to figure it out or you're not going to figure it out. The Medicaid managed care, the dual eligibles, that's going to be a particularly tricky one to manage, and that's going to be the harder nut to crack.

So I'm going to keep going. These are just more kind of interesting points that are in there.

If you look through a lot of the contracts now, you'll see things that don't fit. That's because, and this is just again my guess, but I think it's right, the contracts that most of them have used are their physician contracts or hospital contracts that they have just marked up. In several of them they actually say, you know, you, provider, and then in the next paragraph it refers to you as the hospital.

They have inapplicable requirements. This is a slide from a different presentation about this issue, and I said Joint Commission accreditation because it's not required right

now.

After I gave this presentation, someone from the Joint Commission came up and started yelling at me about how that's not right. That's just a fine requirement.

I said, it's not a legal requirement. If providers want to agree that they're going to be Joint Commission accredited, then more power to them, but I don't know why you'd agree to another costly accreditation.

MEMBER AMIANO: The Blues just came out and said if you don't -- if you don't --

MR. MURER: The Blues, they do have that.

MEMBER AMIANO: And everybody wants the Blues, so. . .

MR. MURER: And my concern with that one is -- and I've seen that where the Blues are now requiring that accreditation. They have like a grace period that they'll allow you time to get enrolled.

MEMBER AMIANO: In the spring --

MR. MURER: Yeah.

MEMBER AMIANO: -- or you're out.

MR. MURER: I wonder to what extent there is an agreement between the Joint Commission and the Blues as far as that goes. Maybe there isn't, but I find it --

MEMBER AMIANO: It's a very costly process.

MR. MURER: It's incredibly costly. It's incredibly costly.

MEMBER AMIANO: For the providers, there's enough oversight right now from surveys and that, that you really don't need it.

MR. MURER: Just to put a little color on that, the Joint Commission, if you're a hospital, federal law allows you to use that accreditation as kind of a proxy for your onsite inspections. So what you're paying for is you're paying for the survey process, and it works fairly well.

For this industry, that becomes an additional cost on top of the State reviewing you as well as dealing with those fines and all that.

So what's interesting is is that as more of those things come through, the providers have to

1 choose if I want this contract, do I want that
2 added expense. So rates, again, will be driven
3 down, and costly requirements being put on top.
4 MEMBER HANDLER: In the hospice
5 industry, we're not required by the Joint
6 Commission. They're letting you, you know, offer
7 up an alternative. So there are alternative
8 accreditation organizations.
9 Certainly, the Joint Commission is not the
10 only one. Advocate is not Joint Commission
11 accredited anymore, and I'm confident they have a
12 Blues contract.
13 MR. MURER: Sure.
14 MEMBER HANDLER: So you might, you
15 know, suggest some alternatives to see if they
16 would consider that, and they're more cost
17 effective than JCAHCO.
18 MR. MURER: Right.
19 MR. FLORINA: Matt, do any of the
20 states have to keep status for nursing homes or
21 only hospitals?
22 MR. MURER: You know, not for nursing
23 homes because they'd have to get a -- change the
24 federal law.

1 For AL facilities, yes, there is some state
2 accreditations as proxy, but it's
3 like anything --
4 MEMBER AMIANO: It's not going to be
5 a full joint.
6 MR. MURER: Yes. I've never been an
7 advocate for that. I think you're trading one
8 for the other.
9 These other things you see that don't
10 really fit: Physician staff privileges, facility
11 based physicians, discussions about medical staff
12 membership. Then there's just some of the other
13 things that I see.
14 You know, you see language in there too --
15 there's one contract that says, If you provide
16 services that are insufficient, that's the fourth
17 bullet point, or inadequate, then they can impose
18 other sanctions. They can recoup money and
19 impose other sanctions.
20 I went to them and I said, you know, I
21 don't know what those other sanctions are, but
22 that certainly doesn't sound good. So we can't
23 agree to that.
24 Then, you know, the contract is just one of

the documents. You get a provider manual, there's an Internet manual, and there's generally inconsistency among those terms, and those inconsistencies can lead to recoupment and other problems further down the road.

One of the things that we -- I talked about this a little earlier. Who is responsible for incorrect eligibility determinations? The plans all say the provider, even though they play no part in the eligibility determination. They are not responsible for producing those lists, they are not responsible for processing those changes, and they are in the worst position to know about a change in eligibility. Everyone seems to be saying that they're the ones who should bear the financial burden for that.

MEMBER HANDLER: Are you seeing any managed care organizations consider alternatives? I mean, are they backing off on that requirement as you support negotiations against it or, you know, posting it?

MR. MURER: It's funny. One company that I was talking to, we had a discussion, and I said, This language is awful.

They said, Well, legally we're going to win this fight.

And I said, Well, that may be, but I don't want this language in the contract. That's one more hurdle we need to get over if we're going to fight about it.

Then they said, Well, no, we have to have it in here.

I said to them, I said, Well, my position is either it goes, or I can't agree to this contract, and I said, I'm willing to listen to any other language that you have.

And they just said no. They just walked away.

I said to my client on that, I said, we should just say no. There are two out of the eight that I think have the explicit language in it. You know, at least then you have something to fight about. It may end up becoming a non -- I shouldn't say nonissue, but it may become so clear that the providers are --

MEMBER HANDLER: At risk.

MR. MURER: Yeah. So at risk anyway, but I think you've got to at least try. You

know, you need to look at them to see who pays for the copies, recoupment without notice, which is pretty common in these, forced arbitration.

The other thing that's very different in these contracts than any other provider is acceptance of all beneficiaries. If I'm a hospital or again an orthopedic surgeon, it makes sense for Blue Cross to say to me you need to accept everyone we send your way because they don't want to be cherry picking, right.

I'm in the managed care contract just so that I'm listed in the directory, but I'm going to take the three people a year that I really want to see because they're going to be good, and then I say no to the 30 others.

If you're in long-term care, there's a little bit of an X factor in that. These people live with you and live with your other residents. So the beneficiary may be a qualified beneficiary and they may be enrolled in your program, but they may come in for an interview, and you may think to yourself, oh, no, this would be the worst admission we could make.

So one thing we push really hard for is

making sure -- and they have been actually pretty open to this -- allowing you to apply your admissions policies and procedures so long as they're not contrary to federal or state law.

MEMBER SCAVOTTO: Matt?

MR. MURER: Yes.

MEMBER SCAVOTTO: A minute ago you mentioned that there were two plans that were reluctant to agree to a change.

Can you identify those plans? Do you want to?

MR. MURER: No, I don't.

MEMBER SCAVOTTO: I'll ask you later.

MR. MURER: Yeah. You can ask me later.

So the big issue for me, I think, is the money -- and the reason why I say, no, is just because I've had a lot of negotiations with the various plans, and they have been very painful, and they're always at these presentations that I've given, and I've kind of made it a policy to be very unspecific in my presentations.

So the money, this is really what it is all going to be about. People who take their eye off

the ball on this for providers -- and, again, if you think about what we've had in the past as a group and maybe it's various associations, but as a group, we've gone to the government and tried to negotiate what we think is a fair rate. That's not going to happen anymore.

In effect, this breaks up that negotiating block, and now it has providers negotiating against each other, and there will be a race. Some will race to the bottom, right. They want more beneficiaries because they're willing to take less, and some of those will crash and burn, but they will -- like property values, they will drive down rates in those certain areas.

MEMBER AMIANO: I think the challenge is --

THE REPORTER: Can you speak up a little bit?

MEMBER AMIANO: I've met with all of the companies, and more than half of them aren't even publishing rates. So they're wanting you to sign a contract without all the elements, so to speak, the most important ones, and so it's challenging. And you're right. There were

providers who were signing those, which, you know, we're trying to advise people not to do that because it weakens the whole, just as you said.

So it's a really challenging thing, and the ones that are providing rates are at levels that you cannot survive at, absolutely cannot survive.

MR. MURER: Right. It will be devastating. I mean the good news --

MEMBER AMIANO: There is not a single good one.

MR. MURER: No. The small good news on these is that you do have the guaranteed 90-day out, but, you know, that leaves open the question so because this is all being individually contracted and you can't -- because of antitrust issues, you can't as a group all go out and negotiate your rates. It's illegal to do so, but that puts the providers at a distinct disadvantage in that.

Because everybody is kind of at different stages in the process, it makes it more difficult and that means, I think, we've got a greater potential for casualties, I'll call them,

financial casualties.

MEMBER AMIANO: Well, I think you've got different quality levels --

MR. MURER: Absolutely.

MEMBER AMIANO: -- which drives your cost as a provider. So if you're going to be in the lowest common denominator, you may thrive with these rates, but you're not going to do things the way that a quality provider would.

So it raises serious questions from the provider side of things about do you even stay in this business or not, which is not what the State is trying to accomplish by this. So it's challenging.

MR. MURER: Yeah. I don't think -- I have not mentioned -- I don't think you've seen one reference to quality in this because I think there's -- there isn't. There is no correlation between what is going to happen and the quality.

You'll see that there is a discussion in the program about implementing quality indicators and how those are going to be. I believe those quality indicators are just going to be a tool to drive rates down. They're going to choose the

ones that are the hardest to apply to, and they're going to use them to take money off of the table. I don't think you're going to get better outcomes as a result of this.

I do think the State is going to save some money. I think that the managed care companies that successfully navigate it, it won't be all of them, but it will be the majority of them will make a tremendous amount of money, and the providers will lose a tremendous amount of money.

So five years from now -- I'm very convinced that five years from now we'll be in a very, very different place. It will be a much more painful place to be because we'll be seeing the repercussions. Because even though it's 100 percent, you know, Medicaid rates that we're being promised right now, those will scale away within three years, and that's when the real competition and negotiation begins.

MEMBER AMIANO: I think it's when those rates apply to the Medicare eligible.

MR. MURER: Oh, absolutely.

MEMBER AMIANO: Their service provision is to get someone living there

long-term. It's a very different client base.

MR. MURER: Yeah. And so the last point I'll make in my cheery presentation is, you know, there's one thing providers should be doing now, that they should be financially forecasting worst-case scenarios both on patient mix and payment mix.

Before, you know, you had those big box, price paid Medicare and Medicaid. They now need to do a whole bunch of different scenarios. What if we had free managed care contracts, and the payment is X for the Medicare, the payment is Y for this Medicare? How is that going to look?

So, you know, they're going to need to understand -- today I would want to understand what rate is my break rate, that I cannot take anymore. Because I think some people are willing to guess and see how it plays out, but they really are going to need to financially profile and pro forma that to get to the right number. If they're willing to do that, I think they'll be in a much better position.

CHAIRMAN WAXMAN: Matt, are they making any adjustments in rates based upon

geography, like Chicago versus rural Illinois or southern Illinois?

MR. MURER: Well, because they're tying it to -- right now at least, tying it to either percentage of the rate -- I have seen geographic variation because there's a 92 percentage to tie that to, a variation, but I've also seen where there's different rate classifications.

But see you don't see that in your -- and that's again different. You don't see that when you're negotiating now because the only rate they're putting in front of you is your rate, right. So you don't know if the person is down -- certainly right now, I think, everyone in an area is getting the same offer, but there's no guarantee.

Three years from now, that's not going to be the case. That's definitely not going to be -- and you won't know -- you won't know what -- and, again, antitrust is going to prevent people from sitting down in a room and saying let's all figure out what our rates are or what they should be and let's go negotiate them.

That's a problem.

Yes.

MR. FOLEY: I guess our concern here also as this committee is how well this is going to affect continued planning for the State of Illinois, or how is this going to affect the programs, et cetera, et cetera.

Can you share any thoughts on that, Matt?

MR. MURER: Well, I think what it's going to do to the extent that the department is concerned about planning and Medicaid support, I think that is going to be a big issue. I think that, like I said, providers who have been focused in Medicaid, some are going to double down and do really well. Some are going to get hurt and probably run out of business.

So you're going to see a reconfiguration of where those Medicaid rates are at, and I think you're going to see a reconfiguration of what people are willing to accept and where. So that's going to change that map probably more dramatically.

You know, three years out, you'll see more change in Medicaid certifications in long-term

care facilities in one year than you probably saw in the prior 10 years before this went into effect. That's what I think. I think at that point people will start being like, We need to limit our liability, and the State will probably go through, if I were to guess, somewhat of a Medicaid shortage in some areas. I would guess.

CHAIRMAN WAXMAN: Along the lines of Chuck's question, I mean, one of our issues that we deal with almost every meeting is beds. Is Illinois overbedded? What is the occupancy rate? So using your crystal ball, managed care coming into Illinois is going to do what to the bed need ultimately?

MR. MURER: If I had to guess, and this is really -- this is like, you know, imagine the crystal ball is shattered on the floor. But if I had to guess, I would say what we'll see is -- it will be a different bed need because what I think we've had so far has been an evolutionary bed. Some facilities have gone off-line as they've really just gotten too old and need to either be replaced or just taken out, and others have kind of grown as they've needed

to. They want to do a new facility, or there's a little bit of a need.

I think that as the provider area kind of restructures itself, you'll see a need -- as some facilities go away, I think it will be accelerated. I think you'll still have bed needs, but you'll have a lot of replacement projects. I think people are going to have to do that to be more efficient in providing this. That's a guess.

MS. KENDRICK: Will there be a lot of consolidations, kind of similar to, you know, what's --

MR. MURER: Yes.

MS. KENDRICK: -- happening with hospitals?

MR. MURER: Yes. As far as consolidation goes, I think there are going to be a handful of people who do this really, really well and who excel at it, and I think there are going to be a bigger group of people who do okay, but then 25 percent will do it poorly, and they'll either get out or be run out.

MS. KENDRICK: Would they be able to

then renegotiate their contract with the Medicaid -- or the managed care provider? Like, let's say, two providers are saying I'm getting this reimbursement rate and I'm getting this, why don't we consolidate, and we could then get a better rate.

MR. MURER: Absolutely. So you'll see providers -- so, you know, right now -- and this, I think, is a universal in health care. Right now providers are reacting to this, and they're trying to figure out how exactly to react to what's happening as it's changing; but health care is a wonderfully inventive animal in that once the system settles and we know what it looks like, smart providers, aggressive providers then restructure themselves to fit the new reality and to take advantage of it.

There will be those that will do that, and they will go in -- they won't just be able to do well in this, but they'll be looking for economies of scale, they'll look for the right bed mix, they'll look for the right location, and they'll go and they'll say to the managed care companies, we'll offer you -- you know, we'll

take X rate, and we'll bring you 15 facilities, and, you know, you get this and this and this. We have seen that in every other part of the industry.

Kind of the one thing that I don't think we know yet is what happens to just Medicare. The dual eligibles are a big thing, but what happens to just Medicare. Just Medicare to be realistic and honest about it, that has been the cost shift in the float that allows long-term care to work the way it does.

If you significantly cut reimbursement through some kind of managed care plan or through some kind of significant rate cut, I don't know if the whole system -- the whole system honestly could fall apart because, like I said, most providers have another place to shift that cost to. They send that patient out somewhere else.

We can't do that, and so what would end up happening if you did that, you know, it would be chaos. It would be like 1995, '96. You'd have the vast majority of the large providers would be in bankruptcy.

MEMBER HANDLER: I'm actually seeing

language in contracts now that talks about that same -- the specific scenario where you're talking about consolidation and acquisition where it's saying that the lowest rate schedule applicable to those multiple organizations coming together is, in fact, the contract that would --

MR. MURER: Yep.

MEMBER HANDLER: -- you know, survive, if you will. Mostly on the physician side I'm seeing that because I negotiate both sides, but it's interesting because I did not see that before, and I think that some organizations are, you know, using their experiences from the private side into these contracts to sort of anticipate what they think might be happening down the road, and I thought that was pretty interesting, and it's pretty extensive language.

MR. MURER: Absolutely.

MEMBER HANDLER: I was surprised.

MR. MURER: So, you know, paying attention to these cases now and the insurance industry are, I think, good lessons. One that's an interesting one to think about is, you know, everyone in this room I know has gone to

Walgreens. There was that time about a year ago when Walgreens and Express Scripts decided to stop doing business.

That was pure and simple exactly what we're talking about. That was a managed care contracting issue that was about rates, and it was to see who would blink. As you can tell, you've got to be Walgreens to bring someone like Express Scripts to the table.

So think about those scales when you think about who is going be able to bring someone like Aetna or Blue Cross to the table to sit down and do that. Because honestly, I won't speak for the State, but I feel pretty confident speaking for the managed care company, if one facility somewhere in the State of Illinois doesn't want to take their contract, who cares. They care today because they want to network, but they aren't going to care five years from now.

CHAIRMAN WAXMAN: How does this discussion of managed care fit in the ACOs that people are trying to form?

MR. MURER: You know, I think that those are two separate discussions, but I think

that they have implications for each other because they really are two different programs. The problem you can run into -- so where we see the ACO and the ACA, federal reform, really coming down and coming to bear on long-term care is the bundle payment initiatives and then the readmission issue where hospitals are very interested in making sure that their providers aren't readmitting. That's where you see some alignment.

But the managed care companies -- those beneficiaries, the readmission beneficiaries, the bundle payment beneficiaries, they can end up becoming a managed care beneficiary as well. So those two are not so separate that we're not going to get -- I honestly don't know how those two are going to work themselves out, but that will be interesting to see.

You know, the pure Medicare beneficiary which is going to be your bundled payment at least for now, and the readmission ones, those are the gold. You know, those are the prime residents, patients that everyone is going to be concerned about, and they're going to become much

more valuable because all of a sudden the rest of the population, the rates and the payments have been driven down.

CHAIRMAN WAXMAN: Are you advising your clients to be a successful provider, you have to be involved in both ACO and managed care contracts?

MR. MURER: I think if you want to survive -- well, the managed care one I don't think people have a choice.

MEMBER SCAVOTTO: MMAI.

MR. MURER: MMAI. Well, yeah, if you're willing to forego that entire population, like if you're not going to take any Medicaid ever, then you can probably avoid it until some kind of Medicaid managed care becomes more prevalent, but that's a pretty small pool.

So I think you at least have to look at it and think about it. If I were a provider that didn't do any Medicaid, I would still be running through and looking at this because what you don't want to be doing, especially in today's environment, because even though you think you're separate from everything that's going on in the

reform world, is not paying attention to it because I think it's fair to say in the past three years or four years, we have had more dynamic fundamental change in the health care system then we've had in the past 20 years.

That's been the kind of realignment and restructuring of things, and we haven't yet seen that come through to our experience or to the payment yet; but it's all happened, like all the pieces are in place, and the next five years are going to be -- we're going to start feeling that both as providers -- and we're going to feel it more. Some providers have already felt it quite a bit, but we're going to feel it more. Our patients are -- and us as patients, we're going to feel it more.

Then on the reform side, I tell my clients you absolutely cannot ignore what's going on there because hospitals are going to be making choices for good or for bad, and that's just the reality of it.

Unless you are able to quantify and dictate -- you know, anyone who is not looking at their own outcomes, who is not quantifying their

own rehab outcomes, who is not quantifying their readmission rates, who is not quantifying their skin care, all of those things that are high markers of quality as we see it, if you don't have a fantastic understanding of that and how that ties into your own staffing and your own patient mix, it's going to be like showing up to the ball without a pretty dress. It's not going to be good. You'll be the only one.

CHAIRMAN WAXMAN: So it's a good time to be an attorney.

MR. MURER: Sadly, it is.

MEMBER AMIANO: When is there not a good time.

MR. MURER: Sadly, that's true.

CHAIRMAN WAXMAN: I just heard the admission rates of law schools, they're down 35 percent.

MR. MURER: That's a whole other hour-long presentation. The short answer on that is there are way, way, way too many attorneys. While it's a great time to be a health care lawyer, it's a great time to be a lawyer, I would never advise anyone, including my nephew who

starts at San Diego Law School this coming fall. I advised him not to go.

There's just way, way, way too many lawyers and way too many young lawyers right now. Like everything in the world, when we went through the recession, everything shrunk, and that is not coming back.

MS. KENDRICK: Can I ask you a question?

MR. MURER: Of course.

MS. KENDRICK: Does anyone from the State review these managed care contracts?

MR. MURER: That's a great question.

MS. KENDRICK: What if there's fraud, you know?

MR. MURER: You know, I don't -- in looking at all the contracts, I didn't see anything that jumped out at me as like fraudulent. It all jumped out at me -- in fact, a lot of them have provisions that strictly prohibit fraud, and they're pretty -- they're very savvy in their contracting.

So that kind of goes to kind of historically why we are where we are. The

managed care companies have been working on their contracts since 1990. So, you know, they've been doing this forever, and they have very, very good contracts, very good for them.

So there's nothing I think inherently illegal about any of them. All of that has been washed out 15 years ago or 10 years ago, but they're really good for them, and that's why they don't want to change anything in them.

It's funny when you have these negotiations and you say I want to change this, they always think you're trying to put in a loophole, and they just say no. They just often will say no, and that's only going to get worse. Once they have their networks, they're going to be more reluctant to negotiate.

MEMBER HANDLER: You're not negotiating with an attorney.

MR. MURER: No.

MEMBER HANDLER: You're negotiating with a frontline person, and on the extended-care side, they're usually the lowest of the low. They're the newbies, the greenbies. They have absolutely very strict parameters provided to

them.

You know, when you are negotiating, you know, a system contract or something --

MR. MURER: Sure.

MEMBER HANDLER: -- you're dealing with somebody who has some decision-making capability. On the SNF side and on the home care side, that group of people are generally -- they have no, you know, authority to change. They have to, you know, move it up the ranks, and that takes time, and that's how they're designed.

MR. MURER: Oh, yeah. Yeah. At the end of the day --

MEMBER HANDLER: So we're really at a disadvantage in this market for lots of reasons beyond just the language in the agreement but their structure.

MR. MURER: If anyone has any idea that the managed care companies -- that there is any stronger motivation than the money in this, disabuse yourself of that now. They have figured out every way to make that -- I'm not faulting them for that. That's their business. That is their business.

What's interesting is -- so if you think about it, you know, as an industry, we didn't have to negotiate those things before. It is now more important than ever that we figure out how to do that, and they're pros at it. So we'd better become pros too.

MEMBER CREDILLE: Yeah. I hear that Illinois's reimbursement is so low, that these managed care companies have gone into other states and been extremely successful.

I have met with several of them, and they can't figure out why they can't get physicians and contracts and home health agencies, and I said to them, Well, do you understand how low the reimbursement is here?

MR. MURER: Yeah.

MEMBER CREDILLE: So that's a scenario that my organization is in is that we enter into a contract, but you can't get physicians who will follow because they won't contract because the reimbursement is terrible. You can't get a home health agency.

So when the patient is ready to be discharged, there is nowhere for the patient to

go, and then the managed care company isn't going to pay for the patient to stay in the building, to your point. Then the patients are sitting in the facility with no payer and no mechanism in Illinois that is timely at all to discharge a patient, and where are you going to send them. There is nowhere for them to go and no payer.

MR. MURER: Yeah.

MEMBER HANDLER: Can their case manager step in?

MR. MURER: So in that scenario, the last question is who gets stuck with the bill? The answer is always going to be the provider.

MEMBER CREDILLE: The provider. The provider.

MR. MURER: And that the provider is going to get stuck with it is just a fact.

MR. FLORINA: Matt, would you still see us go in the same direction with managed care if we didn't have the Accountable Care Act or the changes to it on the federal level?

MR. MURER: Yes.

MR. FLORINA: Would the State of Illinois still be going this way?

MR. MURER: Yes. I think the train -- you know, even if they repealed the Accountable Care Act, that model with the train has left the station. In fact, I mean, I think just the sense is, and I'm not a provider, but my sense I get from talking to all providers all across the sector, hospitals, everywhere, this is the new reality that everyone is preparing themselves for.

Even if you dismantle the federal law, CMS sees the path. You know, they see the path, and what's interesting is that they are going to bend the cost curve down through reform, and they could do that through the Act, or they could do it through regulation, and all of that is just kind of happening at once. I just think that this managed care piece is an inevitability, unfortunately, and it's going to be ugly.

In fact, that kind of refusal to get physicians or inability to get physicians, inability to get home health agencies is actually really good for us as painful as it is because that's the only thing that's going to create that outside extra pressure to raise rates and

reimbursement.

But then some of the managed care companies will leave. There's no margin. Because the State has told them how much they're going to make in year one, in year two, and year three, and how much they're going to save. So those numbers are kind of -- I don't want to say they're locked in, but they're --

MEMBER HANDLER: They're driving the equation.

MR. MURER: That's right.

MEMBER HANDLER: It's being driven this way as opposed to --

MEMBER CREDILLE: Right.

MR. MURER: Right. So they're going to come and take all the providers' extra barrels of money that they've got lying around and, like you said, do they know how low the reimbursement rate is? But anyway, maybe I editorialize too much.

MEMBER JOHNSON: Didn't this managed care come in several decades ago?

MEMBER HANDLER: We've been around the block a few times.

MEMBER JOHNSON: History is repeating itself.

MR. MURER: It is, but it's different. It's different.

So what happened -- what I think happened in the '90s when we had a first wave of managed care and it seemed like everybody was going through it, but to be honest, not everybody. You still had tremendous variation with pension plans, private pay, PPOs.

So there was a movement to, quote/unquote, managed care that didn't touch Medicaid, that didn't touch Medicare, that didn't touch these big private pay groups. So it was like this painful anomaly that people hated, right, and so then we got these things that were better, which were PPOs and other things, and everyone didn't participate. People kind of choose -- it was very piecemeal.

What happened now -- and this is where the Affordable Care Act, I think, in some ways helped -- I put that in quotes because I'm not saying it's a good thing, but it has made this stick. We have reorganized the entire health

care system to make this work.

We took Medicaid, and we're taking Medicaid, and we're trying to push Medicare into managed care as well to Part D and other programs. We're pushing them into managed care. Our physicians, who are our X factors, the Affordable Care Act has pretty much gotten the hospitals to purchase all of them, right. So now everybody is playing ball.

We did do that in the '90s, but now that you've kind of found a framework -- the government found a framework by design or by stupid coincidence, it's forced the United States to actually think of itself in some ways as a giant loose HMO. We've even got the X factor of the uninsured, right.

If you look at -- you know, in the '90s, the pool of people that were in an HMO, I don't know what the percentage is, but I could probably say at its highest it was probably 40 percent, and if you look at everybody who is in one of those things that I mentioned that ties together, you're probably going to look at 80 percent now. So that changes. That's why I don't think we can

go back now. Because we've created this interlocked thing that no one is going to walk away from.

The other thing is the physicians have changed too, I think. A lot of the physicians who in the '90s fought for independence, the discussions we see with our hospital clients, and we represent 300 hospitals in 30 states, that the physicians are like we're fine. Require us. Pay us. Give us our guarantees. We don't need to have it anymore. It's just not working. There are some who are independent, but they're in the minority.

MEMBER JOHNSON: It's deju vu.

MR. MURER: It's deju vu, but it's worse deju vu. It's like this time we mean it.

MEMBER HANDLER: In some of our cases, it stuck; but in the Midwest it certainly did not.

MR. MURER: No, no.

MEMBER HANDLER: In the Midwest, it did not stick.

MR. MURER: No.

MR. URSO: Matt, have you given any

thought -- have there been many discussions about how the regulatory side of everything is going to be impacted by this?

MR. MURER: You know, I have been asked that. What I think is going to be the reality to that, and this is just my sense, I think from CMS's side, five, maybe longer, years ago, CMS decided we were going to pay for quality.

We've seen it in the hospitals where there's movement to look at quality indicators to determine what percentage of payment you're going to get, whether you're going to get an add-on. The five star system was kind of a bastardized version of getting that data set to look at skilled nursing facilities.

I think what we're going to see is in the next five years for Medicare, and I don't know if it will be the five star system, but it will probably be some offshoot of it, will become tied to those quality indicators for pay for quality. So even if you don't go into a full Medicare managed care, you're going to see payment variation based on those quality indicators.

So you're going to see on the survey side a whole list of inquiries to try to ensure accuracy, ensure quality.

On the State side, it will be interesting. I think what you'll see is probably a bigger focus on resident rights. Because what you'll get is you'll get providers -- if I were a provider, I'd be thinking about how I'm going to manage my population better. You know, how I'm going to say no to these people, how I'm going to move people out who are draining the funds out of my facility. So I think the State will probably become more concerned about that area.

Although I think the State -- and this is not just IDPH, this is every state agency I've dealt with in any state, anywhere, in any area. Because of how regulations develop, they develop three to four to five years later than the current events. There's just that time lag. So that we'll see that that won't, I think, happen for five years. CMS is a little quicker.

MEMBER AMIANO: If I could weigh in, I think some of the State should consider more regulatory because the providers are going to be

mandated, whether it's the Joint Commission or something, there needs to be some kind of status here because we keep adding on to the cost --

MR. MURER: Absolutely.

MEMBER AMIANO: -- and we're not taking anything away.

So to the extent that -- you know, pick whichever one you want, but the State has a lot more influence with like the Blues, for example, saying, you know, if you're going to do this new eligible program, be in it, but you're not going to require people to be Joint Commission accredited, you know, if they're already being surveyed; or if we choose to go Joint Commission, then we'll say you don't have do the annual surveys from the State.

But, you know, to keep adding cost to the system makes no sense at all, and it's duplicative.

MR. MURER: Right.

MEMBER CREDILLE: Well, and the new JCAHO surveys are now three and four days long, and they also gave notice that if you were not going to participate in Cook and DuPage

counties -- in the downstate areas, it's not applicable yet, but they gave notice. So if you're not going to be in the Joint Commission, then you're not going to participate. You're not going to get these patients. So you're going to sit with a four-day survey, and a three- to four-day JCAHO survey, unannounced.

MR. MURER: But the good news with JCAHO is that you can also spend $10- to $20- to $30,000 after the survey to use their consultants.

MEMBER CREDILLE: Right. That's a nice add-on also.

MR. MURER: It is. It's a bonus.

MEMBER AMIANO: So with that, I think, you know, how can we take away so we can keep costs down? Because all of these things are adding costs from the provider's perspective.

MR. MURER: I agree with that. If that's going to become kind of a presumed requirement for the managed care population -- and the states are going to have to -- they're going to have to figure out how to help make this work for the providers because they'll find out

they don't have a pool of providers anymore, so.

CHAIRMAN WAXMAN: Toni, have you, in your area, given thought to all this managed care stuff in any way, shape, or form in the survey process?

MEMBER COLON: You know, the big question we have for federal CMS and actually we've had meetings with the federal CMS is really to assist us in sifting through all the changes and how it's going to directly impact the regulatory process. We have heard from providers who say the things that you've heard today.

I mean, there's just so many changes across the board and what and how that will affect the regulatory process is still unknown, and there's just a lot of discussion. I don't really think federal CMS has really figured it out either.

MR. MURER: I agree.

MEMBER COLON: We're still trying to all navigate through this.

But yes, we've given it some thought. We have internal conversations, quarterly meetings with our supervisors, but there's still so many unknowns.

MR. MURER: I think part of that is, you know, we've seen the dates, the implementation dates from HMS get pushed and pushed. That's because this is really, really complicated, and if it goes wrong, it goes really horribly wrong. I think they're trying to accommodate that. But there are so many unknowns that I don't know if they'll be able to fully do that.

CHAIRMAN WAXMAN: So are you predicting there will be more push back, do you think, or more pieces will be pushed back?

MR. MURER: I do. I think, you know, the California report, the Kaiser Report talked about their MMAI, and they said it was particularly problematic, how it was rolled out, and that it was a lot of pain. So I'm hopeful that they'll push that date back because that's -- that's going to be bad.

CHAIRMAN WAXMAN: Any other questions for Matt?

(No response.)

CHAIRMAN WAXMAN: Well, we certainly appreciate you taking the time.

MR. MURER: Thanks for having me.

CHAIRMAN WAXMAN: Thank you for joining us.

MR. MURER: Thank you, guys. I'm going to go golf now.

CHAIRMAN WAXMAN: I think, Mike, has the number of home closings changed in the last couple months or any more filings?

MR. CONSTANTINO: No. We haven't gotten anything from IDPH in the last month or so.

MR. URSO: Unless it's happening and we don't know it.

MR. CONSTANTINO: What's that?

MR. URSO: Unless it's happening, and we don't know it.

MR. CONSTANTINO: Right. We don't receive notice until IDPH tells us.

CHAIRMAN WAXMAN: Toni, are you aware of any more home closings?

MEMBER COLON: There have been a few. There have been a few home closings, yes. I don't have a list off the top of my head.

CHAIRMAN WAXMAN: Are they basically

for financial reasons?

MEMBER COLON: A couple have been financial.

CHAIRMAN WAXMAN: Okay. We are at the CON application work group update.

Mr. Foley.

MR. FOLEY: Mike, I'm just going to ask a question.

How can this committee proceed with all of this unknown out there? We don't know what's going to happen. How can we plan anything? Where we've gone, you know, with all of this, nobody knows anything yet. So how do we really proceed?

MEMBER HANDLER: Can you speak up? I'm sorry.

CHAIRMAN WAXMAN: The question --

MEMBER HANDLER: I just couldn't hear.

MR. FOLEY: How do we, you know, proceed with this committee when we've got all this unknown out there? We don't know what's going to happen. It's hard to do any planning. We don't know what the State is going to do. We

don't know what the Fed is going to do. We don't know anything at all about health planning. So how can we really proceed with doing anything?

CHAIRMAN WAXMAN: I think I have two answers for you. From my perspective, and obviously I'm not the only one that has a perspective, my first answer is that I think we need to move forward based upon what we were charged to do, our directive.

On the other hand, you know, I have probably even, to be honest with you, a stronger issue in that, you know, there is a new Chair to be appointed to the CON Board who may come in and change this whole committee or change the Chair of the whole committee.

So I have some of the same issues you do or what your question raises because I don't know what's going to happen and when and if a new Chair is appointed. You know, I called Frank 18 times this week to ask about this. Frank and I did talk about that, and, you know, as of last week, he has no more information than we do about when a Chair will be appointed and what that Chair may do.

I mean, you know, sometimes the philosophy is leave well enough alone and move on, and sometimes it's like I've got 18 friends that want to do something in long-term care, and I'll change everything.

Your question is, you know, a good question, but my real gut says I think we need to move forward based upon what our directions have been and what the legislation has put into place and move forward.

Certainly, that's my opinion and everyone else in this room is entitled to their opinion and may have a whole different basis for doing that. I'll leave it in Frank's hands first.

MR. URSO: I don't have answers. I mean, we're dealing with a lot of unknowns internally as well as externally at this point. I don't have any information.

Do you guys, Mike or Alexis, have any information? We're waiting to see what's going to happen.

MS. KENDRICK: I mean, it seems the subcommittee should focus on those things that would not be changed in the future or that could

not be changed; and if that's working on the application or being hesitant about other ideas the subcommittee has floated around. You know, maybe you don't spend as much energy on those things because they might be impacted with what happens in the next three to five years, but focus on what the subcommittee can focus on right now, the things that are going to be --

CHAIRMAN WAXMAN: Anybody else have a feeling about that?

(No response.)

CHAIRMAN WAXMAN: So then I'll go back to the agenda.

Mike, anything to update on the CON?

MEMBER SCAVOTTO: There hasn't been any action since the last exchange of information between the staff and the work group. We've got a conference call on the 22nd at 3:00 o'clock, and we'll pick that back up. We kind of had a hiatus because of the legislative session, I guess, and so my report is fantastic. We did nothing.

CHAIRMAN WAXMAN: But you do it well.

MEMBER SCAVOTTO: We did it

absolutely well.

CHAIRMAN WAXMAN: Well, I think that's important, that you did it well.

MS. KENDRICK: Courtney said that a meeting request with the agenda will be sent to the subcommittee about that order.

CHAIRMAN WAXMAN: I know that staff had a lot of hospital issues and requests for meetings to deal with too.

Moving on to Item 6, long-term care reform discussion, addressing underutilized long-term care beds.

Who is playing with this item?

MR. CONSTANTINO: Well, Courtney originally had told me that she was going to handle this. Nelson's wife had a new baby. So he is not here. So I can give a brief overview of what we've done.

What you asked us to do, I think, was -- we looked at bed utilization in three different ways. We looking at bed peak rates, and that's information that we collect during our surveys, and then we looked at unoccupied bed rates calculated using 2011 data, and then we used a

three-year average. We also asked for information from HFS regarding the information they collect regarding their bed tax.

If you go to page 2 of that report, you'll see the results.

MR. URSO: Does everybody have their report?

MR. CONSTANTINO: I was hoping everybody had it. Yeah.

CHAIRMAN WAXMAN: There's a couple up here, if somebody needs one.

MR. CONSTANTINO: On page 2 of that report, you'll see the results that Nelson had come up with. As you can see, the data is pretty close. What we collect and what HFS is collecting is very close.

Once again, I will tell you, though, this is self-reported data. It's all self-reported. We do not audit it, but this is the best data we have.

MEMBER SCAVOTTO: And the conclusion was?

MR. CONSTANTINO: Well, my conclusion was I thought the information we were receiving

is good on our survey. It agreed to what HFS is getting, and I thought it's better than I expected, Mike.

MEMBER AMIANO: To interpret this, I just want to make sure I'm getting it properly, there's an 18 percent vacancy rate?

MR. CONSTANTINO: Yeah. Using a three-year average.

MEMBER AMIANO: And that's based on setup beds or licensed beds?

MR. CONSTANTINO: Licensed beds.

MEMBER AMIANO: Okay.

MR. CONSTANTINO: Okay. There has been some discussion about using peak beds, but that's a decision you would have to make.

MEMBER AMIANO: There's always that disconnect between what you really have a license for and what you're operating.

MR. CONSTANTINO: Right. Yeah.

MS. KENDRICK: Courtney had a note that this information was requested by Terry, and she was wondering maybe, Cece, if you would talk to Terry about this and if he had any feedback.

MEMBER CREDILLE: Okay. I can do

that.

MEMBER SCAVOTTO: So this is all about -- am I correct in this, this is about the use of -- it's about the wisdom of the 95 percent occupancy standard?

MR. CONSTANTINO: No, Mike. The statute requires us to determine active and inactive beds. That is language in the statute. Okay. We're trying to do that. It's taking us awhile.

MEMBER SCAVOTTO: Because we did have some discussion in this connection about getting to the 95 percent occupancy or 90 percent or whatever that percentage was.

MR. CONSTANTINO: Yeah. The standard is 90 percent.

MEMBER SCAVOTTO: This is something different.

MR. CONSTANTINO: Right. Right. We're trying to determine what is an inactive and what is an active bed, and we're required by statute to do that.

MEMBER SCAVOTTO: Okay.

MR. CONSTANTINO: And Terry has

suggested that we look at HFS data. He suggested that at the last meeting, and we did that.

MEMBER SCAVOTTO: Okay.

MR. CONSTANTINO: That's the data they collect when they do the bed tax. I was surprised that they were this close, that the data was.

MEMBER SCAVOTTO: So help me out again. So what does this tell us?

MR. CONSTANTINO: Well, in the table, you have -- in your peak beds data, HFS -- that's our data, HFRB, that's our data. That's the survey data we collect every year and then HFS data.

What we're telling you here is there's 15 percent unoccupied, 16 percent HFS unoccupied. So there's a difference of 1 percent.

MEMBER SCAVOTTO: I agree that's close.

MR. CONSTANTINO: Yep. And then the 2011 data, these are the licensed beds, and again HFRB is 23 percent, HFS is 22 percent.

We did a three-year average. HFS does not have three years yet. Our three-year average was

18 percent.

MEMBER SCAVOTTO: Okay. So now help me out some more.

What do we do with this new found knowledge? Do we do anything with it?

MR. CONSTANTINO: Well, I'd like to see us get to a point where we can determine what an inactive and active bed are. That's what we're required by statute to do. That's where I'd like to get, but we've been doing this for three years.

MEMBER SCAVOTTO: That's why I'm asking the question.

MR. CONSTANTINO: We started out with a pretty simple question, and I guess it's all Terry's fault. He's the one that caused all the trouble.

MR. URSO: Since he's not here --

MR. CONSTANTINO: Yeah. So we blame Terry.

CHAIRMAN WAXMAN: You know, I thought this report was -- you know, tons of information that I found really interesting to review. You know, of course, I, like some of you, have been

around long-term care for more years then I care to remember. So to see it facility by facility was, I think, eye opening, for me anyway. I don't know about the rest of you.

What we do with it, of course, is now a really valid question.

MEMBER SCAVOTTO: Thank you.

CHAIRMAN WAXMAN: And how we can, you know, put it to good use. Again, that kind of goes back to Chuck's question. What are we as a committee going to do that we can actually not spin our wheels and waste our time, but actually accomplish something that has the ability to move forward.

So, you know, maybe we can help define active and inactive beds and move it forward because that's certainly something that I don't think will change, and if it will help you, then we should be doing that.

MR. CONSTANTINO: No. That's what the General Assembly asked us to do. Generally, we try to do what they ask us to do.

CHAIRMAN WAXMAN: I mean, if this is something in the realm that we would make a

suggestion to the Mother Board, and they would then ask for it to become a rule. Because I don't think we can change it, but we can make recommendations on it.

So, Mike, your question -- the answer to your question is we can help him concretely define active and inactive.

MEMBER SCAVOTTO: Well, I mean, look at the agenda. It says we're addressing underutilized long-term care beds. So how are we doing that?

And I just keep asking -- I'm going to keep them on this same theme. Average occupancy in the State is, what, 78 percent, something like that? So we know that that's well below the 90 percent standard but -- so we have underutilized beds. So what? When managed care takes hold, we're going to have a lot more.

MR. URSO: I thought Claire had a hand in it. I'm sorry.

MEMBER SCAVOTTO: Has a what?

MR. URSO: I thought Claire had talked about what could be done with the excess beds. A moratorium was one of them.

MS. BURMAN: Oh, the different alternatives to just eliminating them? That's what you're talking about?

Yeah. At the last meeting --

MR. URSO: I don't think you were at the last meeting.

MEMBER SCAVOTTO: Yeah. I missed the last meeting, but that's okay.

MS. BURMAN: I don't know if you saw it, Mike, but there was a chart with proposed alternatives to just getting rid of the excess beds.

MEMBER SCAVOTTO: I did see that. I did see that and the moratorium. But even still if you put a moratorium, you're still going to have underutilized beds.

My question is what's the big deal if there's underutilized beds.

MS. BURMAN: That's why we were trying to have a discussion, and not just stopping with the moratorium issue, but proceeding down and then listening to other ideas people here would have. That was the point of the chart. It wasn't that these are your

choices. It was more to open up the discussion.

MEMBER SCAVOTTO: Okay.

MS. BURMAN: It's based on things that other states have done and are still doing.

MR. FOLEY: Like the bed sell concept -- buy-sell concept, which was another alternative.

I don't think we're ever going to find out an accurate bed count. The only way we're going to find out an accurate bed count is what the providers give you, and that obviously is going to be their licensed count.

Because as Terry even said at the last meeting, that their -- there has been times throughout the years -- he has worked at a facility that has 75 percent occupancy. There have been times throughout the year where he had used peak beds, maximum number of beds. So knowing that, they still will not give up any beds.

Now, the other item that we had talked about at one point in time was possibly having IDPH go in there and actually count beds because, you know, we've always heard the story where, you

know, a facility is licensed for 100 beds and does not physically have 100 beds because it's converted to office space or three beds went to private rooms, et cetera, et cetera. We've heard those stories. Okay.

That is probably the only way that you're going to ever do that. We had the argument also that, okay, if he has a three-bed ward and a third of them in a private room, that could also just be temporary. That's there just for that one patient. When that patient will discharge, I want to put those beds back in use again.

So it goes back into what I originally said, you know, I think we have to rely on each provider to give us their own, you know, bed count which is then obviously their licensed count. So then we're back to square one again.

MR. CONSTANTINO: Well, we had a fourth alternative, and that was IDPH -- or the Board would require every nursing home to hire an architect or engineer and count the beds, similar to what we did with the hospitals, and then we'd classify them into three categories.

We'd have a licensed bed count, and then

we'd have setup beds or staffed, and then we'd have beds in reserve, and then we had what we would call CON transitional or non-CON. But we didn't think that was a good idea because it could be costly. That's why we went in another direction based upon the utilization of the existing beds that you have -- that the facilities had.

MEMBER AMIANO: Can I just throw out, that the drivers when this stuff started coming years ago -- many of us around this table have been at this for a long, long time, having this discussion.

The external drivers are now different. With everything going to managed care and all of that, is all of this as relevant as it was back then, and are we chasing a rabbit that has long since gone in another direction?

So I guess I would ask this group to kind of maybe think about what are we trying to accomplish, and with the new external drivers in the marketplace, does it make sense?

Because frankly it feels wrong with the providers, sitting here saying that, gee, if we

can't trust providers to be filling out an application on a yearly basis -- it seems like you're saying you're not going to trust providers to do that, and that's kind of a challenge in and of itself, you know, that you have to hire external people to go around and count beds and have the surveyors there for four or five days to go around and count beds. It's really not that difficult.

MR. CONSTANTINO: Well, what I was trying to get at is we just need a definition.

MEMBER AMIANO: A definition, yes, I agree with you, Mike.

MR. CONSTANTINO: Because the auditor general is coming in to see us here shortly, and we'll be blaming some of the people in this room why we don't have the definition.

MEMBER AMIANO: I think the other thing that hasn't been brought up is people hold on to those licenses because some people attach a financial value to them. They're stakeholders, whoever they might be, and so while all of us know that there's no pure definition, there is no value to those beds per se, there is a certain

financial transaction to holding them. So I think that's why --

THE REPORTER: Can you speak up?

MEMBER AMIANO: -- they hold them so dearly.

CHAIRMAN WAXMAN: Did you need her to repeat what she said or is that for the future?

MEMBER AMIANO: By definition, there's no value to beds. You can't buy a bed right now, so to speak. But in certain financial transactions throughout the state, whoever the financial party is has a vested interest because her licensed bed has a value.

So that's where it's starting to get gummy for certain people in providing numbers, and they're probably happy to provide lower numbers, but they've got a financial incentive that they hold a license bigger than what they're going to operate at. I'm trying to say that's definitely a problem.

MR. CONSTANTINO: No. There's a facility --

MEMBER SCAVOTTO: I think she's right. I think Judy is right. We're seeing this

in our application work group. We're coming up against standards for the CON that just -- they made great sense 20 years ago. They don't make much sense going forward, and I think the message that we're coming up with is that we shouldn't hesitate to get over our -- get over the regulatory hang-ups. I know you have to work within the regulatory framework, but you've got a standard that says it's got to be X.

Well, we shouldn't be afraid to address the fact that the standard -- maybe the standard needs to change, and I know that takes a long time. Sometimes it's very difficult, but we need to do that in some of these things.

I don't -- business as usual in managed care will not be the standard operating procedure. Things are going to change. You're going to have to do a lot less.

MEMBER CREDILLE: But to do nothing, though -- past innovation in the industry and the long-term care industry is a critical piece of the health care continuum; and you heard him speak to the fact that where those patients fall and then there may or may not be other

alternatives, there is not a place for patients.

Where the long-term care industry has evolved on this segment of the business over time is a lot of short-term stays. There's a gap from where the acute care hospital used to have those patients, and if we don't look at the CON application as an example and what we might need to do differently, the industry isn't going to thrive.

MEMBER SCAVOTTO: That's right.

CHAIRMAN WAXMAN: Claire.

MS. BURMAN: We've had this discussion before, and what both of you are really talking about are rule changes, not the application change.

MEMBER SCAVOTTO: That's right. We're talking about rule changes.

MEMBER CREDILLE: We understand that.

MS. BURMAN: The application is a byproduct of the rule that comes after the rules are --

MEMBER CREDILLE: Correct. I understand that. I understand that.

MS. BURMAN: Okay. So it becomes

confusing to some people when we're talking about --

MEMBER SCAVOTTO: Claire, I don't think we're confused.

MS. BURMAN: I didn't mean you.

MEMBER SCAVOTTO: I often get confused, but I feel very clarified on this point.

MS. BURMAN: You know, I think, we have been presented with a number of possible changes that are coming forward in the next few years. I don't know that rule change is the big priority right now.

MR. FOLEY: But you can't change the rules if we don't know what the future it going to be.

MS. BURMAN: We don't know what the basic structure is going to be.

MR. FOLEY: That's right.

CHAIRMAN WAXMAN: Then, you know, Mike's frustration and Cece's frustration in trying to come up with a new application is that unless they change the rules, they can't adjust the application to current practices.

Mike, is that correct?

MEMBER SCAVOTTO: That's right.

MR. FOLEY: The only thing we can do right now, I guess, is just proceed with what we have until those rules are changed, I guess.

CHAIRMAN WAXMAN: Again, I think our goal or our charge is to present to the Mother Board our suggestion on how the rules should be changed because they then have to get it to legislation. Then we can adjust to the applications at the current events.

We have the right and the authority to present suggested rule changes for the Mother Board to act upon; correct?

MR. URSO: Absolutely. Absolutely.

MR. FOLEY: What am I missing here?

CHAIRMAN WAXMAN: What are you missing?

MR. FOLEY: We still can't do that.

CHAIRMAN WAXMAN: Why can't we?

MR. FOLEY: Because we don't know what's going to happen tomorrow.

CHAIRMAN WAXMAN: It doesn't make a difference. I think you present your rule

changes based upon what you know to be facts today.

MR. FOLEY: Today.

CHAIRMAN WAXMAN: Then five years from now, the rule changes -- or the world changes, and we present -- or whoever is sitting here will present new rule changes, but I think in order to move forward, we need to present what we think the rule changes need to be.

MR. FOLEY: But I guess for right now, we need to help Mike to come up with some sort of a definition.

Is that correct, Mike?

MR. CONSTANTINO: Yeah. We have been asked to define it.

MR. FOLEY: Okay.

MR. CONSTANTINO: To determine what active and inactive is.

MR. FOLEY: I think we should concentrate maybe on that for the time being.

CHAIRMAN WAXMAN: So if there's a body in the bed, it's an active bed.

MEMBER HANDLER: A live body.

CHAIRMAN WAXMAN: A live body.

MEMBER HANDLER: I work for hospice. We have bodies that are not alive.

MR. FOLEY: There's a lot of dead bodies.

CHAIRMAN WAXMAN: Are there other states that have defined active and inactive beds anywhere that we can copy?

MR. CONSTANTINO: I don't know.

CHAIRMAN WAXMAN: Claire.

MS. BURMAN: I can check for our next meeting.

CHAIRMAN WAXMAN: Mike might be in jail before our next meeting.

MR. CONSTANTINO: No. I plan on blaming Scavotto. I have no problem doing that.

CHAIRMAN WAXMAN: When do you need this by?

MR. CONSTANTINO: Well, no, no. It's --

MR. URSO: We've been needing it for two years.

MR. CONSTANTINO: Yeah. It's been in the statute for quite some time, since 2009.

CHAIRMAN WAXMAN: When is the auditor

general coming to visit?

MR. CONSTANTINO: They're coming in the next couple months, the next month or so. That's on a different subject pretty much.

CHAIRMAN WAXMAN: Well, then I think our starting point has to be if staff can research and see if any other state has defined active and inactive beds.

Does the hospital industry have those definitions.

MR. FOLEY: Yes.

CHAIRMAN WAXMAN: Can we start with --

MR. FOLEY: What's our definition, Mike, of a hospital active bed?

MR. CONSTANTINO: I don't know right offhand, Charlie. I don't know. Maybe Claire does, but I don't know.

MS. BURMAN: I don't know offhand either, but it's been around for a while.

MR. FOLEY: Yes. It's set up.

MEMBER SCAVOTTO: Waiting for business.

MR. FOLEY: Yeah. That would be a

good definition. You know, a bed is active when they're actually set up and staffed. We can consider that as being an active bed. If somebody wants to staff --

MS. BURMAN: Yeah. That's true.

MR. FOLEY: -- you know, a bed, then obviously -- to keep it open, obviously, that has to be an active bed.

I don't think -- correct me if I'm wrong. I don't think that a facility is going to staff a unit that is licensed if there's no body at all within that unit.

MEMBER CREDILLE: It goes back to the peak issue, where I might -- I might staff higher -- I'm sure John is shaking his head yes. You staff higher January, February, March; and historically, you can look at years of data, years of data, and the utilization is higher in January, February, and March. You'll have other blips during the year.

So I need those beds, and I'm staffing them, and I'm running them, but, you know what, in September, maybe not.

MR. FOLEY: So we need to come up

with a definition.

CHAIRMAN WAXMAN: Well, I think we start with Claire or staff doing research in two places. See if any other state for long-term care has defined active and inactive; and B, let's look at how they define it for hospitals.

If the time frame allows, then we can bring it back to our next meeting and get your definitions. It doesn't seem to me like if we have something to look at, that it should be that hard to do this.

Let's move on.

Do we have a meeting date after this one? Because if we're doing this every two months, we should have a meeting date sometime in September.

MEMBER CREDILLE: I think we do.

MS. KENDRICK: I don't have anything in Courtney's notes.

MR. CONSTANTINO: I don't know. I tried to look for it yesterday.

CHAIRMAN WAXMAN: I don't have anything marked.

MEMBER CREDILLE: I have September 17th. That we planned it on

September 17th.

CHAIRMAN WAXMAN: Okay.

MEMBER CREDILLE: A Tuesday.

CHAIRMAN WAXMAN: Okay. That's as good as any day.

Cece, did you make that up, or do you really have it?

MEMBER HANDLER: I have it on my calendar too.

MEMBER CREDILLE: I really have it. We set it, I think, at the end of the last meeting.

MR. CONSTANTINO: Well, we did 72 hours for hospitals.

MR. FOLEY: 72 hours.

CHAIRMAN WAXMAN: The next meeting is September 17th.

MEMBER CREDILLE: We didn't go beyond that.

CHAIRMAN WAXMAN: Okay.

MR. URSO: We don't have anything in between there, I don't think.

MEMBER CREDILLE: No, we do not.

MEMBER HANDLER: I don't think so.

MR. URSO: I have it in my book.

CHAIRMAN WAXMAN: Okay. So then staff needs to bring some definitions on active and inactive beds from other states or hospitals, and then we can agree to a definition. It doesn't seem like it should be that hard if we have something to look at.

Then we get back to Mike's question or Mike's -- Chuck's issue is that I think we, as a committee, should start looking at those rules that you want to change and send them up to the long-term care -- to the CON Board, the Mother Board.

MEMBER SCAVOTTO: We will.

CHAIRMAN WAXMAN: Do you want to make that part of your commitment?

MEMBER SCAVOTTO: Yeah. That's the idea. We've got several that we --

CHAIRMAN WAXMAN: Okay.

MEMBER SCAVOTTO: -- need to advance.

MS. BURMAN: Since it's a rule change, would it be good if we get input from everyone?

CHAIRMAN WAXMAN: We will once the

committee presents.

MEMBER SCAVOTTO: I think we're under the impression that we're getting input from staff at the same time.

CHAIRMAN WAXMAN: Are you talking about staff or --

MS. BURMAN: No. I'm talking about the other members.

CHAIRMAN WAXMAN: Well, I think --

MEMBER SCAVOTTO: Sure.

CHAIRMAN WAXMAN: -- if they present a report, then everybody will have an opportunity to --

MEMBER SCAVOTTO: People will get a chance to jump on it.

CHAIRMAN WAXMAN: You know, I have been on some committee phone calls, and we had 500 people, and that didn't work.

So I think if we keep the work groups on the smaller side and let them present and everybody have an opportunity. Especially if it gets, you know, sent to the committee prior to the meetings, so you can -- those that have an interest can.

My gut is that some people around the table because of the way the committee was instructed have not a great deal of interest in how to fill out the application. It's not part of who they are.

So I'm not sure that you'll have everybody with an idea of what goes. So I think the people who are on the committee working in the application world routinely, and I think, you know, they've had enough discussions that they know what is holding them back, and we will all have an opportunity to review it. I'm okay with the process.

Does anyone wish to express a different thought, that the rule changes on the application be generated somewhere different than the work group that's been working on this for eight years?

MEMBER CREDILLE: The conference calls are very exciting.

CHAIRMAN WAXMAN: I'm sorry?

MEMBER CREDILLE: They're very exciting. You're welcome to join us.

MEMBER SCAVOTTO: So, Cece, you've

been able to get something done without Waxman.

CHAIRMAN WAXMAN: Eli is your third member?

MEMBER SCAVOTTO: Yes.

CHAIRMAN WAXMAN: I don't honestly know what his position is or his situation is at the moment. I haven't talked to him in quite a while. So if we need another member, let me know.

MEMBER SCAVOTTO: He is going to be there. He says he will participate.

CHAIRMAN WAXMAN: Okay. Cool.

MR. CONSTANTINO: So you're going to provide us with your suggested changes on the 22nd -- Mike, or the 17th?

MEMBER SCAVOTTO: We've already provided you with some, but I think we need to go over that.

MR. CONSTANTINO: Yeah.

MEMBER SCAVOTTO: I think there's -- I've got to pick this up and reestablish where we are --

MR. CONSTANTINO: Okay.

MEMBER SCAVOTTO: -- because it's

been a couple of months that we've done anything on it. I think the last follow-up we had was at the end of April.

So I think for our group, we've got to figure out where first base is and reestablish that. At that time, we were thinking -- you know, with people coming in, and there's a standard, and there has been several instances where it seems like the standard is never met. So it makes you wonder if the standard -- if it's time to change the standard and get it in line with practice. That's basically what we're trying to do.

MR. FOLEY: You'd like the 90 percent.

MEMBER SCAVOTTO: The 90 percent is a good one. There was something about the number of beds. Was it 250 beds?

MR. FOLEY: The maximum number of beds.

MEMBER SCAVOTTO: I think that's what it was, and it just doesn't seem to make any sense, but nonetheless, I think our suggestion would be to get rid of the 250-bed maximum.

CHAIRMAN WAXMAN: Yeah. Because there's some homes that exceed 250. Am I misunderstanding what you're saying?

MEMBER SCAVOTTO: No. I don't think you are.

MR. CONSTANTINO: I think they were grandfathered into the program, those homes.

CHAIRMAN WAXMAN: I have been in some homes that have 400 beds.

MR. CONSTANTINO: Yeah.

MR. FOLEY: Well, the rule says specifically that if you go over the 250, you've got to document that you can provide personalization and quality of care. So it's not saying that you can't go over 250, you can.

MR. CONSTANTINO: No, it never --

MR. FOLEY: You can.

CHAIRMAN WAXMAN: Have you done any applications that exceed 250 recently?

MR. FOLEY: No. As a matter of fact, we try to do just the opposite and try to, you know, advise clients not to go that high, you know.

MEMBER SCAVOTTO: It's tough to make

that many beds work.

MR. FOLEY: Yeah.

CHAIRMAN WAXMAN: Cece, how many beds in Illinois?

MEMBER CREDILLE: Licensed for 200, I think, is the largest. Our average for Manor Care is about 150, I think, or 140, something like that.

CHAIRMAN WAXMAN: Yeah. I don't see that being an issue anymore.

MEMBER CREDILLE: Well, if you tied that -- there was a bed definition. There's a square footage easement in the application, a requirement of how many square feet you can have or not have. There's things that have been in the application for as long as I have been in the industry, and this hair is not really blond.

CHAIRMAN WAXMAN: Okay. I think, Michael, we would appreciate that. I know it's a lot of extra work for you to do that, but I also know that you've probably discussed this over and over again, so it's probably not --

MEMBER SCAVOTTO: We're ready to move on that.

CHAIRMAN WAXMAN: Okay. That is excellent.

Okay. Lunch is scheduled for?

MS. CLARKE: 12:30.

CHAIRMAN WAXMAN: 12:30. Okay.

Item 6, long-term care reforms discussion, addressing underutilized long-term care beds; is that this report?

MR. CONSTANTINO: Yeah. That was Nelson's report, yes.

CHAIRMAN WAXMAN: Okay. Follow-up items -- change of ownership/facility closure.

MS. KENDRICK: This was a meeting that was supposed to happen between staff and with IDPH staff, and because of scheduling conflicts, it hasn't happened yet, but hopefully, before the September 17th meeting, Toni and our folks can meet.

CHAIRMAN WAXMAN: Toni, is it you and them, or is it you and other members of your staff?

MEMBER COLON: Other members of my staff will also participate.

CHAIRMAN WAXMAN: Okay. In Chicago,

Springfield, Toni's house, what?

MEMBER COLON: Both. We'll have a teleconference, and everybody can conference, whatever works best.

CHAIRMAN WAXMAN: Okay. So this will come back to us on September 17th.

MS. KENDRICK: The next item Claire can address, the RFP.

CHAIRMAN WAXMAN: Claire, I heard the rumor that you're going to address this topic.

MS. BURMAN: Yes. That is a rumor. I'm going to confirm it.

CHAIRMAN WAXMAN: Claire is clear about that.

MS. BURMAN: I will confirm it in a very short piece of time.

As you may remember from the last meeting, I only received one response to the RFP that went out. It was from the University of Illinois at Chicago.

The basic question now is how the subcommittee wishes to proceed with this. We will be sending them a response agreeing to this arrangement, and I guess one of the questions is

does the subcommittee wish to form a work group that would work with the people that are going to put this study together, put together key questions that need to be answered, different kinds of information you feel are necessary?

CHAIRMAN WAXMAN: My gut is -- Mr. Foley, if you give me a minute. My gut is this again is a topic that we have kicked around for the last two years, and I would suspect that if we take a little bit of time September 17th, we could give you those questions just based on previous discussions; and if staff had a chance to review transcripts over the last couple years or 18 months, you'll have those questions in those transcripts.

Again, I think this is something that we have thought -- that we have discussed repeatedly many times, and I think it's all sitting there for you. Someone just needs to pull them out of the transcripts. I think the questions are there. Let us review it and move on.

MS. BURMAN: Well, these would be questions that are specifically for the task of the RFP.

CHAIRMAN WAXMAN: I thought we had done that.

MS. BURMAN: The buy sell.

CHAIRMAN WAXMAN: I thought we have had enough discussion on buying and selling.

And, again, please don't let me sit here dictating if others have different feelings about it.

So what do the rest of you think about that?

Someone is calling in.

I think that if we reviewed the transcripts, if staff reviews the transcripts, those questions are sitting there because we have talked about this so many times. But, again, if there is a different approach you'd like to take, I'm certainly wide open to it.

MS. KENDRICK: Maybe the work group is more for working out the details with the University of Illinois. Like if someone wants to be the point person for, I guess, talking with them. Maybe not so much -- I mean, we've already sent them answers -- or questions in the letter, but maybe if someone wanted to be more hands-on

with them.

CHAIRMAN WAXMAN: I think that's a valid question, yeah. I agree that -- so how does the university relate to this committee? Again, I think that's a very valid question, yes. Mike.

MEMBER SCAVOTTO: So procedurally -- and I'm asking because I don't know the answer, procedurally, is there an issue with the fact that there was only one respondent? Do you need any more than one?

CHAIRMAN WAXMAN: That's a good question. All right.

MEMBER SCAVOTTO: And have you already accepted the work for the University of Illinois?

MS. BURMAN: I don't believe that a response has been sent out yet. That is a good question. I believe that we sent them to every university in the state that would have a public health program.

MEMBER SCAVOTTO: Okay. So when you looked over the response, was it on point on all the issues?

CHAIRMAN WAXMAN: Who has reviewed the responses?

MS. BURMAN: Courtney. I haven't seen them.

MR. CONSTANTINO: Claire --

CHAIRMAN WAXMAN: Good question, Mike.

MR. CONSTANTINO: -- we're asking a work group to help develop the RFP, aren't we? Isn't that what the work group is?

MS. BURMAN: No.

CHAIRMAN WAXMAN: No. The RFP has already gone out.

MR. URSO: I think it's a liaison.

MR. CONSTANTINO: The RFP has already gone out?

MS. BURMAN: Yes.

MR. CONSTANTINO: Okay.

CHAIRMAN WAXMAN: And only the one university has responded.

So now there are two questions on the table. One is are we, as a committee, willing to accept only one response and move forward; and two, we don't -- the person who has reviewed

their response is not here today to talk about how that response matched the questions that we sent out, so. . .

MR. URSO: I think what Claire is trying to say is is there going to be a link, a liaison between that group, that external group and this committee?

CHAIRMAN WAXMAN: Absolutely.

MEMBER SCAVOTTO: A work group. A work group would be the liaison.

MS. KENDRICK: Maybe.

MR. URSO: Maybe.

MS. KENDRICK: That would be up for discussion.

MR. URSO: It's feasible or a person.

MEMBER SCAVOTTO: Yeah. Okay. Keep it small. I agree. Keep it small.

CHAIRMAN WAXMAN: Yes. I agree. I think there has to be a designated go-to group.

MR. URSO: Somebody who has your personal cell number.

CHAIRMAN WAXMAN: Yes. We can determine that, but I think the other two questions that are more important is how does

this group feel if there's only one response? But I can't answer that question without knowing what the response was, you know, personally but --

MEMBER HANDLER: I would ask the question did we get a declination? I mean, did the university say, no, we're not interested in this project? Do we have evidence that it went to the right place in the university? I mean, those are complex organizations with complex mail delivery systems.

So, I mean, do we have some kind of, you know, affirmation that it was received and somebody reviewed it and said, no, we're not interested, or did we -- was it silent?

MS. BURMAN: I believe it was just one response. That's how it was termed.

MEMBER CREDILLE: It was what, Claire?

MS. BURMAN: I believe there was just one response.

MR. URSO: One comment.

MS. BURMAN: Well, one response, period.

MR. URSO: So no other responses?

MS. BURMAN: I did not understand that she received any responses that were negative, saying no, we're not interested or --

MR. URSO: That goes to your point exactly, I guess.

CHAIRMAN WAXMAN: Yeah. Maybe we need to --

MEMBER HANDLER: Did somebody see it to say, yeah, no, we don't want to do this?

CHAIRMAN WAXMAN: I know that when I was bidding on RFPs from specifically county homes, some of them actually said, "Please respond if you are not interested."

Maybe we need to resend the letter with exactly that comment, "Please respond if you are not interested," so we know that it did get someplace.

MS. CLARKE: I helped Courtney put the letter out, and they did get to the right people because I made phone calls --

CHAIRMAN WAXMAN: Okay.

MS. CLARKE: -- to follow up. So I can tell you that much.

CHAIRMAN WAXMAN: Okay. Maybe Courtney or you need to make some phone calls and just verify that they're not interested. Maybe it just hit at a bad time. I don't know, but it's a valid question. Is one response and how good was that response to what we sent out?

MEMBER SCAVOTTO: I mean, to me that's a big deal. If they're on point with what you wanted in the RFP --

CHAIRMAN WAXMAN: Move forward.

MEMBER SCAVOTTO: I'm probably okay with it, if the price is right.

CHAIRMAN WAXMAN: The price is zero; right?

MS. BURMAN: I have no idea.

MS. KENDRICK: So do certain people want to maybe get on -- join this work group so they can evaluate that and then we'll --

CHAIRMAN WAXMAN: Well, there is no work group per se.

MS. KENDRICK: Is anyone interested in maybe doing that? I don't see why we couldn't set up a conference call in the next week or two to discuss it.

CHAIRMAN WAXMAN: Internally?

MS. KENDRICK: No, no, no. With the subcommittee members.

CHAIRMAN WAXMAN: I'm saying an internal, Courtney and staff and some of us.

MS. KENDRICK: Yes.

MR. URSO: Without the university people.

MS. KENDRICK: Yes. Sorry. Without the university people.

MEMBER CREDILLE: With or without the university?

MS. KENDRICK: Without.

MR. URSO: Without.

CHAIRMAN WAXMAN: To review their response. I mean, I would be a piece of that.

MEMBER HANDLER: I'm willing to help with that.

CHAIRMAN WAXMAN: One more?

MEMBER CREDILLE: I will. I will.

CHAIRMAN WAXMAN: Okay.

MS. KENDRICK: So Mike, Carolyn, and Cece.

MEMBER HANDLER: You'll have to call

me on my cell, though, just because I'll be out of town for a few days.

CHAIRMAN WAXMAN: Where? Maybe we'll come meet you.

MEMBER HANDLER: I'll call you from the boat. It will be moving.

CHAIRMAN WAXMAN: I guess that's a no.

MEMBER SCAVOTTO: Boy, you're perceptive.

CHAIRMAN WAXMAN: Well, that's why I get to sit up here.

MR. URSO: Have your roaming on or something.

MEMBER HANDLER: It will be on.

CHAIRMAN WAXMAN: Okay. So the conference call then will be to determine what we -- how we can review the -- our review of the responses and the question as to whether or not that was good enough to move forward or whether we need to look at other options and verify that the other schools did not have an interest in responding. Okay.

MS. KENDRICK: And Courtney may have

answers to all these questions. Unfortunately, she is not here, so. . .

CHAIRMAN WAXMAN: That is unfortunate, but okay.

That's the agenda. The other piece that's left, and I was going to save it for after lunch, but since lunch is 12:30, Frank sent out an e-mail that I hope all of you have read that talks about the fact that we need to get into a system of staggered memberships to allow people to serve on the committee effective --

MR. URSO: October 1st of this year.

CHAIRMAN WAXMAN: -- October 1st. So everyone is clear, it's October 1st of 2013. At 2013, then we have to take the 19 slots and convert them into one-year membership, two-year membership, and three-year membership based upon the bylaws that we have devised.

The initial concept was that we would entertain those people -- we would entertain to allow you to determine your own desires, whether you wanted to be on the committee for one more year, two more years, or three more years.

Since we are meeting in September, we don't

have to do anything with this today other than make us all aware that we do have to choose. If people decide that they don't want to choose, then I think whatever slots are undefined after September 17th, one alternative is Courtney, myself, and Frank will just then slot people into one-year, two-year, three-year terms. So let me rephrase that.

Between now and the 17th of September, if you want to say I want to be a three-year member, e-mail that to Courtney or email it to me, and then we will slot you in a three-year term. If on the other hand, you want to be a one-year term, send me that.

After the 17th, we will take membership and slots and take the open slots and define by some random process one-year, two-year, and three-year terms for those who have decided they don't want to particularly pick.

There are some open slots, and I'm not sure I know what that number is anymore. We will also include those, so that the committee is a 19-member committee, and we have allowed some slots to remain unoccupied for a couple different

reasons. We will just have an open slot that could be a one-year term or a two-year term or a three-year term, depending upon where everybody else falls.

Does that make sense? Does anyone have any problem with how we're going to do this?

MEMBER HANDLER: Michael, are you looking for names of people to come on to the board? What is the process for identifying potential new members so that if you're looking for us to assist in that process, we know what kind of --

CHAIRMAN WAXMAN: A couple things. We currently have 16 active members, which means that there are three open slots.

We tried to recruit someone from academia, and that has not worked. I mean, we've -- I don't know if interview is the correct word, but we've had discussions with certain people that were identified as being, oh, my god, these are really the coolest people ever, and they're from academia, and they would be great on the committee. It hasn't gone anywhere.

So we do have three open positions, and if

you are aware of someone who might fit into the criteria, get it on to Courtney, and she can begin the process.

MEMBER HANDLER: Are we looking for any kind of, you know, besides -- obviously, somebody from academia is an idea, but are there any other, you know, sort of skill set or background that you would be looking for?

CHAIRMAN WAXMAN: Obviously, someone that has knowledge in the senior care continuum. I don't think the committee was ever put together a mathematical equation of so many from long-term care and so many from home health and so many from labor unions. I don't think it was done that way. I think it was done to ensure that there was representation from all the fields.

So, no, I think at this point anyone who can fit into the committee that wants to be an active member and can bring some information is welcome to apply.

Can I just have a legal opinion that that's a good answer?

I think the one thing that unfortunately has prevented Mr. Foley from becoming an active

member is that anyone who is deemed a consultant per se was determined not to be eligible, but we certainly welcome them as an active participant.

Terry switched his role, so originally he could not, but now because of his new occupation, and he has relinquished his lobbying role, so he was qualified.

Chuck, if you want to close up your shop, you can join in. You can choose whether you want to make an income or --

MR. FOLEY: I think some people would like that.

CHAIRMAN WAXMAN: -- volunteer.

MR. FOLEY: That's what I'm going to do.

CHAIRMAN WAXMAN: All right. Anything else that would qualify as other business? Staff?

MS. KENDRICK: I don't believe there's anything else to discuss from a staff perspective.

CHAIRMAN WAXMAN: Do we have a report on how Lon is doing in his new world?

MS. KENDRICK: I think he's doing

well. Everything is going well. I think he is very busy, as you might imagine.

CHAIRMAN WAXMAN: I know he's working for the Governor's office.

MS. KENDRICK: Yes. So he is in charge of maybe about eight agencies.

CHAIRMAN WAXMAN: Wow.

MS. KENDRICK: From a legal perspective, you know, if they have issues, they call the Governor's office, and he would be their point person.

CHAIRMAN WAXMAN: So if I remember correctly, you are also an attorney; right? So have you assumed some of those roles too?

MS. KENDRICK: Not officially.

CHAIRMAN WAXMAN: That means you're doing it and not getting paid? That's usually what that means; right?

MS. KENDRICK: No. Well, like with everything in the state, the paperwork takes a long time. So you have to wait for things to be processed before things can happen.

CHAIRMAN WAXMAN: But the position changed?

MS. KENDRICK: Yes.

CHAIRMAN WAXMAN: Okay. I guess at this point, it seems like lunch may be showing up. So it will give us time to make phone calls, take potty breaks, and eat lunch and see what happens after that.

(Whereupon, a recess was had at 12:05 p.m., after which the proceedings were resumed at 12:38 p.m. as follows:)

CHAIRMAN WAXMAN: Does anyone have any new business they wish to put before the committee?

Phyllis.

MEMBER MITZEN: Well, it's not new business, actually, I mean, it really is just -- I mean, I guess it's a takeoff.

CHAIRMAN WAXMAN: We'll call it other business.

MEMBER MITZEN: Other business. It's really a takeoff from Matt's discussion.

Attached to your materials that you received is a piece that was created by the Health and Medicine Policy Research Group. It's

not dated, unfortunately, and it looks a little bit -- it was updated in January of 2011.

So obviously, the contracts have been passed, but what it did was provide a whole overview of long-term care and what was coming in at that time and what we knew at that time.

Actually, tomorrow morning, literally tomorrow morning, the Department on Aging is releasing a report that we just produced, and it will be very much updated -- not updated piece of this, but it's a fairly lengthy report about the impact of managed care on long-term care services and supports, of which you are a part of.

Our main focus was on community-based long-term care, but we do an extensive analysis of what's happening now and made very, very strong recommendations to the State on how to ensure quality.

I think what Matt was saying, at least for me and I'm sure for all of you around the table, is a huge wake-up call in terms of how are we going to assure that these people that we care about are going to be receiving the quality of services, the kind of services that they need in

a managed care environment where the goal is -- I mean, managed care organizations that are accountable to their shareholders or to their -- you know, or to the bottom line. Our bottom line, certainly, is how well our people are being cared for in our system.

So I'll refer you to the report. I can certainly -- when I receive it. We gave it to the department about a month ago, and now it's been vetted, and now it's being produced, and it should be out tomorrow. Assuming that it is, I will send a copy to Michael, and he can have it distributed then to the rest of you.

It's a rather long read. It's over 50 pages, I think. There's an executive summary, but there's a lot of good information in there and a lot of -- again, a lot of recommendations to the State on how we can ensure that long-term care is -- that the people are getting what they want in terms of -- I mean, our concern is our tax dollars are paying for this, and we want to make sure that people get what they're needing.

So I would say -- and I was a little bit surprised, I guess, after Michael's discussion

that there isn't more of a discussion about what is the purpose of this committee, where are we going, and I know that we have been on the road to somewhere, but he's right.

I have never in my 40 years in the field of aging seen the massive change. I wasn't in the field of aging when Medicare and Medicaid hit, but I'm sure it was the same kind of impact that happened then, and we don't know what the future is, but we're shaping it right now, or it's being shaped for us.

CHAIRMAN WAXMAN: I don't mean to interrupt you, but for those that aren't familiar, can you talk about briefly what your group is?

MEMBER MITZEN: Health and Medicine Policy Research Group. Of course. The Health and Medicine Policy Research Group was founded about 25 or 30 years ago by Quentin Young who is a physician in Chicago. He has always been concerned with access to health care and continues to be concerned. He is turning 90. A benefit for his -- the organization's benefit is coming up in October. I'll send you all

1 invitations.
2 But we are a think tank. We are pretty
3 local in our perspective, in Chicago and
4 Illinois. We are concerned with safety net
5 issues. About eight years ago, we formed a
6 center for long-term care reform where we are --
7 we have focused in on the issue of rebalancing
8 long-term care in Illinois or balancing long-term
9 care in Illinois.
10 That means Illinois is a state, as you all
11 know, that has been heavily weighted in terms of
12 its focus in long-term care on institutional
13 care, and there was a belief -- there has been a
14 belief that this can be shifted, that there can
15 be a shift, so that there can be more resources
16 in community-based long-term care, a partnership
17 obviously between long-term -- between
18 institutional care and then supportive housing,
19 and everywhere into then people's health.
20 So this is the philosophy that we have
21 promoted through the existence of the long-term
22 care reform segment of the Health and Medicine
23 Policy Research Group.
24 We are concerned with access to care. We

have worked closely with the Department on Aging. I serve on the OASAC committee and also on IDA's affordable housing task force. So I have been concerned with long-term care issues for a long time, for a very long time, and that's where Health and Medicine is.

If you look at our Web site, hmprg.org we produce a lot of materials that may be useful, and, of course, the new report will be on our Web site as soon as we get it.

CHAIRMAN WAXMAN: Does anyone have any questions of Phyllis?

Yes, ma'am.

MEMBER JOHNSON: I don't have so much a question as I'd like to piggyback on what Phyllis is talking about.

The long-term care -- I was in the program that just had legislation passed, House Bill 1192, that Governor Quinn just recently signed giving us access into the community and home-based settings.

What this will allow is ombudsmen to do and be our advocates for those who are eligible, if you will, who are in the community, who may have

complaints about services being provided or need an advocate for the due process or the appeal hearing aspect of managed care.

We will be hiring a managed care ombudsman as well as a home care ombudsman, and they will be going into the community, educating those managed care -- I think they call them clients -- members. They're calling them members.

MEMBER MITZEN: Yep.

MEMBER JOHNSON: So we're very excited about that, although we recognize and know that we have a lot to learn about the beneficiary aspect of it, but we aren't going to be the experts. We're going to be the advocates.

So we will not lessen our involvement in licensed long-term care facilities. We'll just be particularly following residents who are in long-term care transitioning into the community either it be via person or covert members, members -- or litigant members who are all part of those lawsuits, as well as the managed care members. We're excited about that.

MEMBER MITZEN: And we are -- actually Health and Medicine is working with the

State ombudsmen office to produce a report on how we can -- kind of a blueprint for how that can happen, that transition can happen, and we're very excited about that.

MEMBER JOHNSON: That is going to be very helpful for us as a tool to tailor our new changes or our role and responsibilities as ombudsmen.

CHAIRMAN WAXMAN: There certainly is a lot of change going on.

Toni.

MEMBER COLON: I actually just want to piggyback on what Neyna shared. Another bill that the Governor had signed relating to the community services bill that's being provided is a new registry that the Department of Aging is -- they're creating for caregivers, I believe it's paid caregivers out in the community that are found, I guess -- there's been an allegation that's been found to be substantiated for abuse, neglect, or some type of misappropriation, that their name will actually go on a registry, and that long-term care facilities will have access to this community registry, if you will, when

they're screening for potential candidates for employment.

So this is something that I'm working very closely with DOA on in developing. So I thought that was really interesting. It is an exciting time to be working.

MEMBER HANDLER: Would the public have access to that?

MEMBER COLON: No.

MR. URSO: I can't hear you.

MEMBER HANDLER: I asked if the public would have access to that.

MEMBER COLON: No. If you are a provider and you have gone through the security measures, you're a licensed provider, we may deem you access rights, but this is not for any person in the public to have access to.

That's just the way that it's set up currently. I don't know if that will evolve, but that, again, it's still --

MEMBER MITZEN: So who is going to be able to go on that registry?

MEMBER COLON: DOA, Department of Aging, whoever they believe administratively has

security access as well as providers that are currently licensed in the state that have been licensed through the Department of Public Health.

MEMBER MITZEN: Okay.

MEMBER COLON: And they have gone through security clearance.

MEMBER MITZEN: The people who are being listed on that, who is being listed on the registry?

MEMBER COLON: That have been found guilty --

MEMBER MITZEN: Guilty. Okay.

MEMBER COLON: -- of abuse and neglect or some sort of misappropriation that's been substantiated by the Department of Aging.

MEMBER MITZEN: Okay.

MEMBER COLON: I mean, it's evolving because it's just in the works, but I thought it would be very interesting to bring that up as well.

MEMBER JOHNSON: And the formerly known elder abuse program has now been renamed as the adult protection services or APS, and now they will not only be dealing with abuse in the

community but also abuse of elderly and disabled -- not elderly, disabled under the age of 60.

So they are in conjunction with the Office of the Inspector General, and they too will be on a learning curve and training of the elderly staff on dealing with the disabled now who are victims of abuse.

So we have a humongous amount of change on the horizon for both the ombudsmen, the elderly -- registry, just a lot of change.

CHAIRMAN WAXMAN: Anybody else want to -- are you talking about being abused or --

MR. FOLEY: Well, my son-in-law was always abusing me.

CHAIRMAN WAXMAN: Mr. Foley, what would you like to talk about?

MEMBER JOHNSON: The number is 1-800 --

MR. FOLEY: Thank you.

MEMBER SCAVOTTO: We don't care --

MR. FOLEY: As I'm hearing everything today, obviously, we're going to be expecting a lot of changes, you know, within the next three

to five years; and to assume that health planning is still going to be part of this and will play some kind of a role, this has been brought up before, and I'd like to maybe bring it up again, and that is in order to provide a full continuum of services out there because I can see with managed care that there also would be a greater need for alternative services, i.e., supportive living, assisted living, et cetera, that maybe, maybe, just maybe we should start thinking about the possibility of bringing those services under CON review, assisted living and supportive living.

I know the Act does not provide that right now, but obviously, that can change if it is the desire of the Board to look at it, but maybe it's something that this committee might want to think about and can make a recommendation to the Board.

CHAIRMAN WAXMAN: I totally agree with you. I mean, again, we're kind of looking at isolated pieces of the continuum, and, you know, I've said this 100 times. I have walked into so many assisted living buildings, and even in independent living buildings, and see people

that really need skilled services, and I don't know how that gets corrected, you know, unless some one group is overseeing that continuum.

Phyllis.

MEMBER MITZEN: It's really interesting to hear you say that, Michael, because I think on the one side you do see people in independent living who could use skilled services. This is an eyeball.

On the other hand, people have been looking at people in nursing homes and saying, with proper services, these people could live outside, at home where there's not heavy regulations, where people have independence and choice. So I think it's striking, and that's what we've been struggling with. I think it's how you achieve that balance.

Would your choice be to go into a nursing home if you needed a lot of services; or if there were enough services that come into your home, would you prefer to be at home?

MEMBER SCAVOTTO: I think that that ship has sailed. I do.

MEMBER MITZEN: That ship is out of

the dock. It's in the lake right now.

MEMBER SCAVOTTO: I think the managed care plans are in charge of this. It's a case managed operation. Illinois ranked sixth nationally in terms of institutionalization.

MEMBER MITZEN: That's right.

MEMBER SCAVOTTO: And that's a target. So you don't have to be a Rhodes Scholar to figure this out. People are going to come out of the nursing homes. There is not enough capacity in SLF to take everybody, and HFS is not releasing any more SLF applications.

So the question is going to be how are these people -- you have to be careful now. There's regulatory problems if someone is being -- if someone is in assisted living and they should be in skilled, that's the provider's problem. It's still going to be the provider's problem.

But 44 states already have some sort of assisted living interface with Medicaid. I'm not going to say that's going to happen in Illinois, but if they don't build out as SLF, than the managed care plans aren't going to have much

option. They have to do something.

I think the ship has sailed. We know what the mechanism is going to be. It is, I think, a real challenge to get these networks built out --

MEMBER MITZEN: Yes.

MEMBER SCAVOTTO: -- and I'm not sure that -- well, I am sure, that it's not going to happen the way it's prescribed. It's already been delayed twice, and it will be delayed again; but once it gets going -- in my experience with California, I see a lot of parallels from California.

California was a juggernaut, and it took years for that market to get resolved, and that can -- I believe that will happen in Illinois. There's just too much capacity.

You talk about consolidation, Alexis, there will be consolidation. It will happen. It has to happen. The question is how far downstream and how fast does the shakeout go. No one is going to know that. There's no place to say, okay, we're going to empty out the nursing homes, and that's a generalization.

We do know that HFS has said let's try to

eliminate ICF as a classification within three years. Now, let's just say they don't do it all, they do it half. You know, there's a lot of ICF that's in skilled, and that can go downstream. Do you have the capacity downstream to handle all of these people? Right now I'm not sure we do.

MEMBER MITZEN: I can tell you that the State probably does not. On the other hand, I just -- I read a report yesterday, and I don't think -- the numbers I'm not sure -- but the numbers of home health patients are growing. The numbers of something called "home nursing agencies" -- I've never heard of that before.

MEMBER HANDLER: Are those private duty?

MEMBER MITZEN: I don't know.

MEMBER HANDLER: You know, skilled -- there's Medicare, and then there's private duty agencies.

MEMBER MITZEN: Home health is Medicare, right. Then there's home nursing and then home services. They're just growing like crazy. People are buying licenses and evidently not using them, so that's a whole other story.

MEMBER SCAVOTTO: It's fine to take a change in the way it's paid for, and until it's paid differently, which is what the MCOs are involved with, capitation, they won't change.

In 2011 -- I just looked at some of this data. In 2011 in Cook County, which is the latest data that's available, 65 percent of all post-acute discharges from hospitals still went to skilled. 18 percent of them went to home health.

MEMBER HANDLER: But don't you think that's partly because of money?

MEMBER SCAVOTTO: That's the way it's paid for, exactly.

MEMBER HANDLER: Right. The care follows the money.

MEMBER SCAVOTTO: It's not going to change -- right. Right. And it's not going to change, until we change the way it's paid for.

MEMBER HANDLER: Yeah.

MEMBER SCAVOTTO: And that's what's about to happen with this managed delivery.

MEMBER MITZEN: Right.

CHAIRMAN WAXMAN: Is there any

inspection in SLFs or assisted living?

MEMBER COLON: Oh, yes. Sure.

CHAIRMAN WAXMAN: Okay.

MEMBER MITZEN: Public health.

MEMBER COLON: Yes. Regulates them.

MEMBER MITZEN: Public health regulates assisted living and HFS regulates SLF.

MEMBER SCAVOTTO: That's correct.

CHAIRMAN WAXMAN: Okay.

MEMBER MITZEN: I think the regulations are fairly similar, or at least they were when they first started.

MEMBER COLON: Oh, yes. HFS regulations, but we regulate the assisted living.

MEMBER SCAVOTTO: SLF is more of a social than a client model.

MEMBER MITZEN: They were supposed to both be social models. That was at least --

MR. FOLEY: That was the intent.

MEMBER MITZEN: That was the intent, correct.

MR. FOLEY: As was said, we were finding skilled a lot more independent, but in SLFs and assisted living, a lot of skilled

patients go in there.

On the other hand, long-term care, I think, as we have seen, our patient days have dropped dramatically in long-term care. It's not really long-term care anymore as it is short-term rehab, which is the way we're going, obviously tomorrow.

I read somewhere just not too terribly long ago that if in the future we might see as an assisted living/SLF facility that would be licensed as skilled under a floating license, whereby if you have a 100-bed, you know, facility, 50 beds will be licensed for skilled, but the whole building needs to meet skilled standards so that if that patient in this one unit, say, for instance, is skilled today -- or let's say she is assisted living today, and now she needs skilled care, she can still stay in her same room, you know, where you can obviously age in place.

You might have to go to another floor, to another wing, but your facility would still be licensed for 50 beds, okay, period, so you can have no more than 50 people obviously, you know, under that licensed category.

CHAIRMAN WAXMAN: I mean, wasn't that really what CCRCs were supposed to do?

MR. FOLEY: Yes. Okay. In a sense that's true, but you're moving them, though. They're not able to --

CHAIRMAN WAXMAN: Well, they're aging on campus, rather than a building.

MR. FOLEY: They're aging in place on a campus.

MEMBER SCAVOTTO: It's how you pay for them.

CHAIRMAN WAXMAN: I'm sorry?

MEMBER SCAVOTTO: It's how you pay for them. Medicaid doesn't apply to that.

CHAIRMAN WAXMAN: Correct.

MEMBER SCAVOTTO: Right now. Maybe it will later, but right now it doesn't.

MR. FOLEY: Well, I know they're getting a lot of opposition to this especially on the SLF side, but I do think that possibly, you know, we should start taking a look at that possibility. And that means SLF and assisted living understand.

MEMBER SCAVOTTO: What is that going

to accomplish?

MR. FOLEY: It could control a lot of unnecessary facilities being built out there, and obviously, foreseeing under managed care that we're having -- we need to find more alternative placements. We have a lot of unnecessary facilities out there being built, like we have or did have a lot of unnecessary nursing homes built years ago.

MEMBER SCAVOTTO: I'll go back to what Matt was talking about earlier today, and my sense of this is that your biggest -- if managed care shakes out -- we're not going to know how it's going to develop for a few more years.

MR. FOLEY: That's right.

MEMBER SCAVOTTO: Assume that it rolls. The biggest problem the provider is going to have is access to capital. The pressure on providers is going to be extreme. Their number one issue is going to be access to capital. The last thing on their minds will be building a new facility, in my opinion.

MR. FOLEY: It just depends also how regulations are going to pan out too in terms of

building construction. Right now what we're seeing obviously out there is all the facilities -- we don't see the 250-bed facilities. We don't see 200-bed facilities. We're seeing 150 and less, which obviously requires less capital.

We're also seeing out there even smaller skilled facilities, i.e., 35 and 40 beds in other states. We don't see that so much yet in Illinois, but I think we did have -- Frank, did we have -- or Mike -- a project approved on a campus where there were four or five small facilities, and they were all going to be licensed as skilled under separate licenses? Am I saying that correctly, under the green concept, the greenhouse concept?

MR. CONSTANTINO: Yeah. That was in Decatur -- Forsyth.

MR. FOLEY: Was that it?

MR. CONSTANTINO: Yeah.

MR. FOLEY: I think we're going to be seeing more of that, which means there's less cost and easier to obtain the capital then. No, you cannot build today 150-bed facility, as was

said earlier, and even think about Medicaid.

I mean, we're seeing a problem now -- the planning board has a project now that they have approved, and it's going to be 100 percent Medicaid for 122 beds, and they can't get financing because the numbers just don't work. You know, so there you're absolutely correct. You know what I'm talking about.

CHAIRMAN WAXMAN: What area?

MR. FOLEY: I'm sorry?

CHAIRMAN WAXMAN: What area?

MR. KNIERY: Mid-state.

MR. FOLEY: Mid-state area.

CHAIRMAN WAXMAN: The request is for the county pool?

MR. FOLEY: Yes.

Am I correct, Frank?

Frank nodded his head yes for the record.

CHAIRMAN WAXMAN: Are you saying, if I heard you correctly, that it's economically feasible to build four 30-bed skilled units than one 120-bed unit? Is that what I just heard?

MR. FOLEY: No. In that respect, freestanding -- that answer is no, freestanding;

but if you have three or four of those in a campus setting -- I don't know because I haven't seen those numbers yet, but what I am seeing is that is what's happening, but all of that is also dictated by licensure standards.

Licensure standards require a lot of items that just does not make it financially, you know, feasible, such as a nurses' station, such as 8-foot-wide corridors. There is a slew of things in there that make it virtually impossible to build a 30- or 40-bed freestanding facility today, you know.

She left when I wanted to talk to her.

But it's the standards that really dictates our costs today. So standards need to be looked at and modified, and obviously, I guess they are to some degree. I don't know.

Michael, have you -- is that correct or do you know?

MR. CONSTANTINO: Whether we're looking at standards?

MR. FOLEY: I mean, you know, standards -- I guess licensure. If they're licensed as a 30- or 40-bed facility like they

have in, you say, the Decatur area and Forsyth, so obviously they had to change their standards because I don't see how they could build a 35-, 40-bed facility with 8-foot-wide corridors and a nursing station and all the other requirements.

MR. CONSTANTINO: No. We used the same standards we've always used, Charlie.

MR. FOLEY: Okay. But then obviously there's more than one building on a campus setting that would make it financially viable. Because I agree with you, with freestanding it can't work. Freestanding it cannot work.

MR. CONSTANTINO: I don't think there were many Medicaid clients projected for those facilities though.

MR. FOLEY: No Medicaid?

MR. CONSTANTINO: I don't believe so, no.

MR. FOLEY: Okay. That makes a little bit of a difference, yeah.

CHAIRMAN WAXMAN: Anything else people want to put on the table?

It's fun to share current events. As

everyone has said today, health care is changing so dramatically and so quickly that, you know, there's information that probably all of us have seen.

Phyllis, if you do send me your article, I'll make sure it gets around.

MEMBER MITZEN: It's not an article. It's a report, and, yeah, I'll be glad to send it to you.

CHAIRMAN WAXMAN: Or just send it to Courtney.

MEMBER MITZEN: Okay.

CHAIRMAN WAXMAN: Then she will distribute it.

MEMBER MITZEN: Sure. I'll send it.

CHAIRMAN WAXMAN: Send it to Courtney, and we'll get it to the committee.

Anything else?

MEMBER HANDLER: Michael, the State Hospice Association is sponsoring a program in September. Is that something I can ask Courtney to share with the membership?

CHAIRMAN WAXMAN: I don't see why not.

MEMBER HANDLER: Okay. That's under the program information, and she can forward it on, if anybody is interested.

CHAIRMAN WAXMAN: Yeah. I suppose we never said that, but I guess if anyone has information that they'd like to share with the committee, please feel free to send it to Courtney and ask her to distribute it to the committee.

And, again, the issue you raised earlier, if you have some suggestions for membership, you know, please bring them forward to Courtney or Frank or myself.

Anything else?

(No response.)

CHAIRMAN WAXMAN: Then I will then entertain --

MEMBER SCAVOTTO: I'll make a motion that we adjourn.

CHAIRMAN WAXMAN: I'll an entertain an appropriate motion to adjourn. Michael.

MEMBER CREDILLE: Second.

CHAIRMAN WAXMAN: Cece was second.

All in favor.

(The ayes were thereupon heard.)

CHAIRMAN WAXMAN: Any opposed.

(No response.)

CHAIRMAN WAXMAN: Thank you all for coming. I appreciate it. Have a good evening, afternoon.

(Which were all the proceedings had in the above-entitled matter ending at the hour of 1:07 p.m.)

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

I, JOANNE E. ELY, Certified Shorthand Reporter No. 84-4169, CSR, RPR, and a Notary Public in and for the County of Kane, State of Illinois, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct, and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my Notarial Seal this 29th day of July, 2013.

Joanne E. Ely
Certified Shorthand Reporter

My commission expires
May 16, 2016.