

QUARTERLY HEALTH CARE REPORT

Cost, Quality and Access-to-Care Issues: International/ U.S. / State / Northeast Ohio

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Baldwin-Wallace College is pleased to offer its Quarterly Health Care Report by Professor Tom Campanella, director of the Health Care MBA program, as a courtesy to those in the healthcare sector. In it, Professor Campanella summarizes and comments on what's new on the critical issues of healthcare costs, quality and access to care at the national and international levels, as well as healthcare news of interest in Ohio and the Northeast Ohio region.

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SOURCES

Sources cited in this Quarterly Health Care Report are listed at the end of each article. The articles detailed in this Quarterly represent a summary or excerpts from the original articles that can be accessed in total through the associated source link at the end of each article.

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INTRODUCTION

Tom's Take on Health News of Note

The overall theme of this issue is articulated in my "Quarterly Rant," below which focuses on the "the good, the bad and the ugly" side of self-interest. Ultimately it is quite natural for rational beings to act in their own best interest. Healthcare stakeholders (hospitals, physicians, managed care organizations, drug companies, long-term care, healthcare suppliers, etc.), are obviously all rational entities that seek to survive and prosper financially. Surviving and prospering financially would also apply to non-profit entities (e.g. hospitals) since, as they say, "no margin, no mission."

In order to better understand how healthcare stakeholders survive and prosper financially, one needs to understand how healthcare is financed in the U.S. The government, on the federal and state levels, is responsible for almost 50 percent of U.S. healthcare related expenditures. Medicare, by far, is the biggest payer of health services and, as a result of this financial leverage, is the major influence on our current healthcare system. In fact, the individual private sector managed care organizations (MCOs) have mostly followed Medicare's lead, particularly regarding reimbursement methodologies, since they lack the financial leverage to effectively influence provider behavior on their own.

It is very rational for healthcare stakeholders to respond to the financial incentives that are embedded within Medicare's payment methodologies. Instead of having a payment system that would incent prevention, wellness, chronic-care management, efficiencies, better

quality and collaboration, Medicare has a payment system that rewards overutilization. This system does not factor in quality of services provided, is fragmented, and does not pay for prevention and wellness services in a meaningful and comprehensive way. Medicare payment policies are also the major factor regarding why we do not have a true primary care system, in that primary care practice is grossly underpaid versus other physician specialties.

What if the government, specifically Medicare, capitalized on the stakeholders' self-interest by incenting them to help mold a more value oriented healthcare system that strives for optimum cost, quality and access to care? What if the government played a role in developing an environment that fostered "real competition" between suppliers of healthcare services to meet the demands of the purchasers (consumers, Medicare, Medicaid, MCOs, employers, etc.) which could foster innovation, efficiency and value in the healthcare marketplace? We will address these questions and others in this issue of the Quarterly.

Specifically, this issue of the Quarterly looks at Accountable Care Organizations (ACOs), which is the new "hot topic" in healthcare. We will discuss the details of ACOs and the keys and barriers to their success. Finally, we will focus on answering the question: Are ACOs more hype than substance?

As a member of the "baby boomer" class, I have a vested interest in the future of the long-term care industry. You don't have to be a rocket scientist to figure out that the combination of the increased ranks of the elderly, the geographical dispersion of the family unit, and the financial challenges of the government, employers and consumers adds up to a major societal dilemma. In this issue we will start the discussion surrounding the question: What obligation does society have in addressing the long-term care needs of the elderly?

No issue created more division during the healthcare reform debate than the role of managed care organizations (MCOs). Ultimately, the future role of MCOs will be dependent upon their ability to provide value in the marketplace.

Further on, at the national level, we will explore the role of Medicare's newly established Independent Payment Advisory Board, and how it has lead to a real tug-of-war among the healthcare stakeholders.

Also under the national news, we delve further into another hot topic, that is, the role of primary care physicians. Much of the discussion focuses on the shortage of primary care physicians. It is not just a numbers issue surrounding primary care (as well as other physician specialties); under our new “reformed” healthcare system we will need physicians to assume much more of a leadership role. Will the physicians be prepared for this new world of healthcare?

Finally, we will discuss the financial challenges facing the State of Ohio. During the last budgeting cycle, Ohio plugged holes in the 2010-2011 biennial budget with \$6.5 billion in funding that won’t be available the next time. As a result of this pending financial crisis, Ohio has the opportunity to address some difficult political issues from both the expense and revenue side.

Quarterly Rave

“Hospital-onset infections: We have met the enemy, and we are winning.”

Who wants to get sick in the hospital? No one, of course. But all too often, Methicillin-resistant *Staphylococcus aureus* (MRSA) attacks patients while they are in the hospital. While not dropping as fast as the economy, the nasty bug seems to be declining, according to a study recently published in JAMA.

We addressed the issue of hospital-onset MRSA infections in prior issues of the Quarterly. ([See the October/November 2007 Quarterly Health Care Report](#) which was the fourth in a series of articles on hospital-onset infections.)

Per the JAMA study, “MRSA prevention programs that may affect MRSA transmission and infection are increasingly common in health care settings. Whether there have been changes in MRSA infection incidence as these programs become established is unknown; however, recent data have shown that rates of MRSA bloodstream infections (BSIs) in intensive care units are decreasing. From 2005 through 2008, the number of hospital-onset invasive MRSA infections decreased by 9.4% annually across the study period.” (“Health Care – Associated Invasive MRSA Infections, 2005-2008,” JAMA, August 11, 2010) (<http://jama.ama-assn.org/cgi/content/short/304/6/641?rss=1>)

Finally, it is also good news that CMS (the Center for Medicare and Medicaid Services) will be requiring hospitals to submit data on hospital-

onset infections which in turn will be posted in the future on the Hospital Compare website for easy access by consumers. Increased visibility of this data will further incent healthcare organizations to be proactive in addressing hospital-onset infections. As noted in my **Quarterly Rant** below, the publication of hospital-onset infection data would be an example of **“the good”** side of self-interest, since this publication will incent hospitals to address these infections.

While the battle of the bugs is far from over, hopefully the tide is turning. Hospitals do have something to celebrate in their recent success against MRSA. Let us hope that hospitals can continue their march to victory against this formidable enemy.

Quarterly Rant

Self-interest – “The good, the bad and the ugly”. No, I am not going to critique the old Clint Eastwood Western. When one thinks of self-interest, most people think of **“the bad”** or **“the ugly”** side of it. My “Quarterly Rant” focuses less on the ills (high cost, etc.) of our healthcare systems that is caused by the narrowly focused self-interest of the stakeholders, but more on the potential cures, or **“the good”** side of self-interest that could potentially be unleashed

As I noted in the Introduction, it is understandable and natural for healthcare stakeholders (e.g. hospitals, physicians, MCOs, drug companies, long-term care providers, government, employers, consumers, etc.) to focus on their own self-interest. In fact, all of us focus on our own self-interest when we invest in our education, search for the best jobs, focus on the health of our families, etc. Obviously, there is also an altruistic aspect to self-interest (e.g. supporting your favorite charity, volunteering in the community, etc.). Healthcare stakeholders also are in a fiduciary role with respect to their employees, stockholders, etc., as well as the community they serve (“No margin, no mission” as well as no jobs, is a very real-world perspective for both profit and non-profit healthcare entities).

The pursuit of self-interest has a clear economic significance. Adam Smith, the famous English economist, stated that the pursuit of self-interest is the catalyst that has propelled market economies. Adam Smith asserted in his famous treatise, “The Wealth of Nations,” that individual decision making is motivated by self-interest. Guided by the “invisible hand” of the market, this self-serving behavior, in turn serves to promote interests of

others. By example, Adam Smith further stated, "It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own interest." ("The Wealth of Nations," Adam Smith)

Economist Charles Schultze further expands on this economic principal of self-interest as applied to societal goals in his book, "The Public Use of Private Interest." Charles Schultze stated the following, "For a society that traditionally has boasted about the economic and social advantages of Adam Smith's invisible hand, ours has been strangely loath to employ the same collective intervention. Instead of creating incentives so that public goals become private interests, private interests are left unchanged and obedience to the public goals is commanded.

Collective intervention is not the same as collective coercion. While some element of coercion is implicit in any social intervention, the use of market-like incentives to achieve public purposes minimizes this element. And simultaneously, in dealing with complicated social interaction, incentives are more likely than centralized regulations to achieve effective and efficient results." ("The Public Use of Private Interest," Charles Schultze, Pg. 6, The Brookings Institute, 1977)

<http://books.google.com/books?id=AaIF-Eb8XDc&lpg=PA1&ots=w4mnqR-gVG&dq=charles%20schultze%20economics%20self-interest&lr&pg=PA3#v=onepage&q&f=false>

Now going full circle, what does all of this mean for healthcare? We need to develop a system that turns public goals (optimal healthcare system) into private (in this case, healthcare stakeholders) interests. Societal interests are clearly centered upon having a healthcare system that achieves that optimal level of cost, quality and access to care. As noted by Charles Schultze above, it should be a core role for government to develop a system that incents private entities (healthcare stakeholders), to pursue the societal goals (optimal level of healthcare cost, quality and access to care) because it's in the private entities' self-interest, not because the government has mandated or regulated it.

The following are some examples concerning the effective use by the government of the economic principle of self-interest vs. the use pure regulations (coercion) **(The good, the bad and the ugly)**:

1. An effective use of economic principle of self-interest **("the good")** is the government development of payment systems that reward providers for effectively delivering cost effective, quality care.

Examples include: pay for performance, medical homes, Accountable Care Organizations incentive payments, etc.;

2. The requirement that all MCOs must comply with a governmental cap on the Medical-Loss ratio is an example of addressing a societal need (lower healthcare costs) through regulations (**“the bad”**). The focus is now on the regulations rather than incenting MCOs to find innovative ways to bring better cost, quality and access to the marketplace. A better use of the economic principle of self-interest was the establishment of Health Exchanges that incented MCOs to compete on a level playing field from a cost, quality and access perspective. The better the MCO provided value in that market place the more it would be rewarded financially (**“the good”**);
3. Healthcare stakeholders narrowly focusing on their self-interest to the detriment of the overall healthcare system is an example of **“the ugly”** side of self-interest, as in the case of the inappropriate use of healthcare technology. If Medicare paid hospitals using a capitation or global model for taking care of its members, and these models were accompanied by quality guidelines, there would be more appropriate use of technology, which is an example of **“the good”** side of self-interest.
4. Hospitals lobbying against the publication of hospital-onset infection data for the consumer is an example of **“the bad”** side of self-interest. The government facilitating the publication of user-friendly healthcare cost and quality data by Medicare and MCOs to better engage the consumer is an example of the **“the good”** side of self-interest.
5. The government creating tax advantages for Health Savings Accounts (HSAs) is an example of **“the good”** side of self interest since it incents consumers to be better purchasers of healthcare services. The combination of user-friendly cost and quality data and the financially engaged consumer sets the stage for increased competition on the part of the suppliers of healthcare services (hospitals, physicians, long-term care facilities, etc.,) to meet the demands of the consumer, which in turn will foster increased innovation, efficiency and value in the healthcare marketplace - **“the good”** side of self-interest.

6. Pharmacy Benefit Managers (PBMs) not disclosing drug rebates that they receive to their employer customers, or brokers not disclosing MCO compensation relationships to their employer customers, etc. are examples of **“the bad”** side of self-interest. The government requiring disclosure and transparency of those arrangements will force PBM and brokers to compete for customer loyalty based on their ability to provide value to their relationship - **“the good”** side of self-interest.
7. Medicare and MCOs paying hospitals and physicians to keep their members healthy (preventive care, wellness initiatives, etc.) is an example of the **“good side”** of self-interest.
8. The government allowing employers, MCOs, etc. to create rewards (lower healthcare premiums, etc.) for employees who engage in wellness, disease management programs, etc., which in turn will create a healthier workforce, is an example of **“the good”** side of self-interest.
9. Another example is the government facilitating malpractice reform by requiring cases to be heard in front of judges that specialize in malpractice versus the current jury trial system that may lack objectivity. Hopefully, this change along with provider payment reform would create less of an incentive for defensive medicine (**“the good”**).
10. Finally, if Medicare paid providers for counseling services relating to end-of-life care, it could foster an environment of communication between family members. The environment would both educate the Medicare member and the family members regarding their options as well as allow the member to exercise their wishes concerning end-of-life care. This is an example of **“the good”** side of self-interest. Hopefully, rational minds would prevail and this “American way” of educating the public about their options would not be categorized as rationing healthcare or a death panel.

Cover Story

Accountable Care Organizations: What are they and what are the keys to their success?

"Is there more hype than substance?"

What are ACOs?

The hot topic in healthcare today is Accountable Care Organizations (ACOs). The health reform act instructed the Centers for Medicare and Medicaid Services (CMS) to create a national voluntary program for ACOs by January 2012. ACOs are provider groups that accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the group's clinicians. ACOs are rewarded in the form of shared savings if the group provides care to beneficiaries for less than the Medicare benchmark cost while meeting criteria for patient service and quality of care. ACOs are seen as one way to reduce the rate of increase in health care costs over time, while also improving the coordination and quality of care of the patients. **(See: CMS link on the specifics of ACOs: <http://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf>) (Also see: <http://www.bakerlaw.com/healthcarereform/#accountable%20care%20organizations>)**

ACOs will be largely based on physician practices but many ACOs will also include hospitals, home health agencies, nursing homes, and perhaps some other healthcare delivery organizations. There are at least five different types of practice arrangements that could serve as ACOs: integrated delivery system; multi-specialty group practices, independent practice associations, and virtual physician organizations.

What is the perceived value of ACO's from a societal perspective as it relates to positively impacting cost, quality and access to care?

As I have noted in prior issues of the Quarterly, our healthcare system is shaped by how we pay for services and what we pay for. Medicare, which is the largest payer of healthcare services, does not factor in quality of services provided and does not pay for prevention and wellness services in a meaningful and comprehensive way. Medicare payment policies are also the major factor regarding why we do not have a true

primary care system, in that primary care practice is grossly underpaid versus other physician specialties.

Siloed payment methodologies have also been a major contributor to the perpetuation of our fragmented health care system. Providers of care (hospitals, physicians, home health, skilled nursing, etc.) are paid by Medicare through different reimbursement methodologies that not only do not promote collaboration, but can also create financial incentives that can negatively impact both healthcare costs and quality of care.

ACOs are now touted by some as the “silver bullet” that will address all of the ills in our healthcare system. Obviously, this is an overstatement, but in theory ACOs do hold some promise of positively impacting cost, access and quality issues. As noted above, ACOs have the potential to bring together the fragmented parts of our healthcare system in a seamless way to better serve the patient. People with chronic illness would be the main beneficiary of such a coordinated approach. It is not uncommon for a senior citizen on Medicare to have more than five chronic diseases. The interplay of these diseases would lend itself to a coordinated care model.

In theory, the ACO model could lay the foundation for our healthcare system becoming a true healthcare system rather than the sick care system that exists today. As noted previously, ACOs are rewarded in the form of shared savings if the group provides care to beneficiaries for less than the Medicare benchmark cost while meeting criteria for patient service and quality of care. ACOs would then be incented to keep patients well, rather than provide only healthcare services. As noted in my **Quarterly Rant**, the government’s role of facilitating the use of ACOs, and rewarding better cost, quality and service is an example of “**the good**” side of self-interest.

As discussed in my initial comments, Managed Care Organizations (MCOs) historically have mostly followed Medicare’s lead, particularly regarding reimbursement methodologies, since they lack the financial leverage to effectively influence provider behavior on their own. Over time, ACOs could evolve into the major delivering care system in most communities in the U.S.

Based on the above, it sounds like we have found the “holy grail” of healthcare. Those of you that have been in healthcare for many years might react with a bit of skepticism. You remember the times when HMOs,

Physician Hospital Organizations (PHO), capitation, etc., were considered the next greatest cure for our ailing healthcare system, especially from a cost perspective.

Will ACOs be more hype than reality when it comes to addressing the issues of healthcare cost, quality and access to care? Hospitals are notorious for playing “follow the leader” as shown by this video (see link): <http://www.youtube.com/watch?v=IF8bK7AJyL0> There is no “silver bullet.” Yes, ACOs have great potential, but in order to successfully impact healthcare cost, quality and access to care, many factors need to be in play both within the ACO organization as well as from the payer side (Medicare, Medicaid, MCOs). As noted below under “keys” and “barriers to success,” there are still many challenges confronting ACOs to achieve their true potential as a model for providing cost-effective, quality healthcare.

What are the keys to success for ACOs?

First, we need to define what we mean by success. As one would say, “success” is in the eyes of the beholder. There are a number of ways to define success when it comes to ACOs:

- **On a national and a state level**, success would be defined if ACOs could play a major role in reducing cost trends in Medicare and Medicaid as well as improving quality (clinical and service) outcomes for their members;
- **On a local level**, success would be defined if ACOs could play a major role in reducing cost trends in the community as well as improve quality outcomes (clinical and service) for the residents;
- **Finally, from an ACO perspective**, success could be defined in one of two ways:
 1. **Solely from the ACO perspective**, success could be defined as the use of the ACO to increase a hospital system's power to leverage higher reimbursement rates from MCOs (“**the ugly**” side of self-interest);
 2. **ACOs that focus on the community** could define success as being rewarded for increasing the quality of life of the community in a cost-effective manner. This is an example of “**the good**” side of self-interest.

What are the major barriers to success for ACOs?

- As we have noted throughout this Quarterly, Medicare's current payment methodologies reward overutilization, especially as relates to the use of technology, and does not adequately compensate providers for primary care and preventive type services. ACOs, no matter how effectively developed, will not be able to have a real impact on healthcare cost trends if the current Medicare payment methodologies are the dominant form of provider reimbursement.
- Organizational inertia and resistance to change will be a major challenge for ACOs, especially those ACOs that are virtual organizations (independent organizations or physician practices that come together to serve a particular patient population).
- Tackling regulatory barriers to integration – Anti-trust, fraud and anti-kickback statutes will present challenges, especially during the early phases of ACO development when federal guidelines/restrictions, etc. are being debated;
- Primary care shortages – There is a shortage of both primary care physicians as well as other primary care providers (nurse practitioners, physician assistants, etc.).
- Inadequate physician leadership, which plays a critical role in the success of ACOs, could also be a major barrier to success.
- Finally, there is a legitimate concern that further consolidation of the provider community might drive up costs for everyone. One such battle is already brewing in Virginia between Carilion Clinic and Wellpoint. “Carilion owns the two hospitals in town and six others in the region, and employs 550 doctors. Carilion says it represents an ideal (ACO) envisioned by the nation's new healthcare law: a network that increases efficiencies by bringing more doctors and hospitals onto one team, integrating care from the doctor's office to the operating room.

Wellpoint vice president, Colin Drozdowski says Carilion Clinic rates are “among the most expensive in Virginia.” Per Wellpoint's Drozkowski, “Carilion will now have to demonstrate to employers and citizens of Roanoke Valley that this model can work.” (“Are bigger health-care networks better or just creating a monopoly?” Washington Post, Alec MacGillis, August 26, 2010) (<http://www.washingtonpost.com/>)

Tom's Take:

As discussed above, in order to really “bend the cost curve” fundamental payment reform is needed within Medicare. The major obstacle we face in making fundamental changes in how Medicare pays for healthcare services is the fact that “all savings represent lost income for somebody.”

An example of a change in payment methodologies that could bend the cost curve is Medicare’s use of some hybrid capitation or bundled reimbursement model. These reimbursement models have the potential of positively impacting the growth of high cost technology by incenting the use of medically appropriate services (**“the good” side of self-interest**). The logical place to start such an initiative would be integrated healthcare systems that provide tertiary services within or outside of an ACO.

The new law proposes demonstration initiatives focused on bundled services but, as discussed previously, given Congress’s track record, there is concern that the “real” impact of such payment methodologies on high cost, inappropriate technologies would be mitigated.

ACOs will provide both challenges and opportunities to independent physicians as well as to independent entities that provide care along the continuum (skilled nursing facilities, home health care, hospices, physical therapy companies, etc.). ACOs, (e.g. similar to the private sector auto industry, manufacturing firms, etc.), will need to address the “make vs. buy decisions” as they develop their ACOs.

For example, an ACO may discover that it is better to “buy” the services of an independent home healthcare company, rather than make (own) their own home healthcare company. In this case, the “make or buy” decisions of ACOs would then create both challenges and opportunities for independent home healthcare companies.

Finally, one financial approach to tie together a number of the ACO concerns noted above is linked directly to risks and rewards. Stephen M. Shortell, Lawrence P. Casalino, and Elliot S. Fisher, in the July 2010 issue of Health Affairs, proposed that “ACOs financial arrangement with Medicare could be structured by way of tiers which would be a function of the ACO’s infrastructure and financial stability to both effectively manage the targeted population and absorb the risk of full capitation or extensive

partial capitation and bundled payments.”

Tier 1 – The ACO at this tier might bear little financial risk but would be eligible to receive shared savings and bonuses if it meets quality benchmarks and reduces per beneficiary spending below an agreed-upon target. It could receive most of its payments on a fee-for-service basis.

Tier 2 – Organizations at this tier might be eligible to receive a greater proportion of savings if they achieve spending rates below a specified target, but they would also be at risk for spending above the target. They could be paid more through partial capitation and selected bundled payments.

Tier 3 – ACOs at this level would be reimbursed through full capitation or extensive partial capitation and bundled payments. They would be eligible for the highest level of reward but also exposed to the greatest amount of risk.”

(“How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations: Stephen M. Shortell, Lawrence P. Casalino, and Elliot S. Fisher, Health Affairs, July 2010).

<http://content.healthaffairs.org/cgi/content/abstract/29/7/1293>

INTERNATIONAL

Long-term care financing lessons from abroad?

“We cannot afford to wait.”

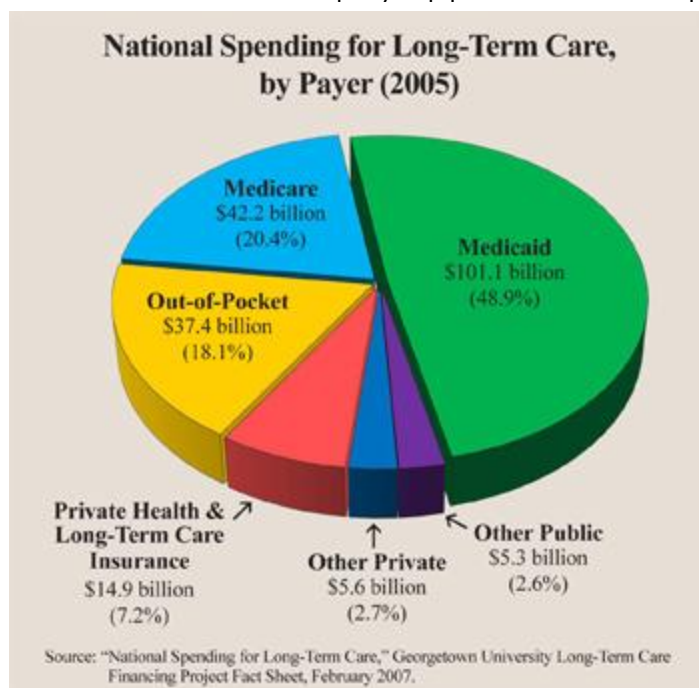
The issues of cost, access and quality relative to the long-term care (LTC) needs of the elderly are not unique to the U.S. All countries to some degree are faced with these challenges. As stated repeatedly in this and prior Quarterlies, there is no “silver bullet.” Just as the U.S. is evolving and experimenting with innovative approaches to address the needs of the elderly, so too are other countries. We must continue to learn not only from our own experiences, but also from those of countries throughout the world.

In the U.S., LTC is already predominately funded by the government through both Medicare and state Medicaid programs. (See pie chart below. Source: "The New Long-term Care Entitlement," Biff Jones and Joe Barnett, National Center for Policy Analysis, June 3, 2010) (<http://www.ncpa.org/pub/ba707>).

The governmental funding mechanisms that exist today don't incent sufficient efficiencies to materially impact the cost trends. States, which are already under severe financial stress, cannot absorb the rising costs relating to long-term care, which are predominately funded through their Medicaid programs, and continue to meet their other competing priorities (e.g. education, infrastructure, economy, public safety, the poor, etc.)

The major challenge in developing a financing model that focuses on long-term care is finding the optimum balance between societal responsibility and personal accountability. There needs to be a shared responsibility in some form between the stakeholders (consumers, employers, providers and the government) to effectively address this issue.

Howard Gleckman of the Urban Institute recently published a paper for the Commonwealth Fund concerning international comparison of funding for long-term care. Per Gleckman, "Most major industrialized nations have adopted a social insurance model to provide long-term care to all who need it. Purchase of insurance is mandatory, often through payroll taxes, although some nations also finance their long-term care systems with premiums and general fund revenues. Some provide cash benefits, others pay approved service providers directly, and still



others give consumers an option of receiving benefits in either form. While benefits are sometimes means-tested, all who are medically eligible receive at least some payment."

This paper reviews the experiences of France, Germany, Japan, the Netherlands, and the United Kingdom, and highlights some of the lessons the

United States can learn from each. Per Gleckman, "The European and Japanese experiences may provide useful lessons for the U.S. However, those models have not yet proved to be replicable in the U.S., where cultural norms suggest voters may be more reluctant to accept tax increases to fund long-term than citizens of other industrialized nations. "Long-Term Care Financing Reform: Lessons from the U.S. and Abroad," Howard Gleckman, The Urban Institute, The Commonwealth Fund, February 2010)"

<http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Feb/Long-Term-Care-Financing-Reform-Lessons-from-the-US-and-Abroad.aspx>

How has the U.S. responded to this pending long-term care crisis? As stated previously, and illustrated by the above pie chart, the U.S. currently primarily finances long-term care through two governmental programs (Medicaid and Medicare). Private long-term care insurance plays a relatively small role in the financing of LTC (also see [January 2006 issue of the Quarterly](#) which discusses long-term care insurance).

The recently passed Patient Protection and Affordable Care Act ("PPACA") signed into law on March 23, 2010 created a new program to assist in the financing of LTC. The following are excerpts from Karen R. Palmersheim's article in the American Bar Association's Health eSOURCE publication on the CLASS ACT; "The Act created a national, voluntary, long-term care insurance program through payroll deduction for active employees through the Community Living Assistance Services and Supports Act -- the CLASS Act.¹ The purpose of the CLASS Act is to assist individuals with functional limitations with maintaining their personal and financial independence to enable them to continue living at home and avoid institutionalized living.

Specifically, the CLASS Act provides a cash benefit to individuals impaired with performing some or all of the activities of daily living ("ADL") which are defined as eating, toileting, transferring, bathing, dressing and continence.² Cash benefits are available under the CLASS Act where: (1) an individual is determined by a licensed health care practitioner to be unable to perform at least two or three ADLs without substantial assistance for a continuous period of more than 90 days; (2) the individual needs substantial supervision to protect against threats to health and safety due to a substantial cognitive impairment; or (3) as otherwise determined by the Secretary of the Department of Health and Human Services ("HHS").³ The HHS Secretary is required to establish regulations for the CLASS benefit plan by October 1, 2012.⁴

While the individual may choose how to spend the daily benefit, the CLASS Act has certain guidelines for spending. The beneficiary must use the benefit “to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their [sic] choice in the community.”¹⁵ Examples of permissible uses are home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aids and nursing support.¹⁶ However, the CLASS Act specifically provides that benefits may be used to compensate a family caregiver providing community living assistance services and supports to a beneficiary.¹⁸

While enactment of the CLASS Act was favored by long-term care agencies, the Act's ability to have any significant impact on the provision of long-term care services is uncertain. It is unknown how many will choose to enroll in the program. Employers are not required to administer the Act's long-term care insurance plan for their employees, and some may not to avoid the administrative burdens. Further, employees can choose to opt out of the voluntary program, which is dependent on the participation of a sufficient amount of healthy individuals for its viability. Many employees may also not be willing to pay the estimated \$123 per month premium, either because of the cost or concern as to whether the program will remain solvent by the time the benefits are needed.

Receipt of CLASS benefits will not affect an individual's ability to receive other benefits available under state or federal law, including Medicare, Medicaid, Veteran, low-income housing or nutrition benefits.²⁴ The CLASS was not intended to provide full long-term care coverage. Instead, the benefits available under the Act are only intended to supplement other sources of funding, as costs for long-term care far exceeds the \$50 per day minimum benefit under the Act. While \$50 a day may not be enough to pay for a nursing home room, CLASS benefits should help some people avoid institutional care through financial support to maintain independence – which is what the Act was intended to do.” (“Will the CLASS Act Solve Our Long-term Care Crisis,” Karen R. Palmersheim, Locke Lord Bissell & Liddell LLP, Los Angeles, CA, ABA Health eSOURCE, June 2010 Special Edition)

<http://www.abanet.org/health/esource/Volume6/SE/Palmersheim.html>

Tom's Take:

As noted in the “Quarterly Rant,” given the societal implications (cost, quality and access) surrounding the issue of long-term care, the

government needs to play a key role. Ideally, the government should focus on creating incentives so that public goals surrounding long-term care (e.g. cost, quality, access) become private interests of the long-term care providers, the long-care insurance industry and the public at-large. Does the CLASS Act achieve that objective?

What additional programs, incentives, financing mechanism, etc. are needed to help address our long-term care concerns and also optimize our long-term care investment? Is long-term care an area that is best suited to be financed and managed strictly by the public sector? What financing system would incent the optimal use of our long-term care investment? Is the answer a two-tier system for LTC care (have & have-nots)? What, if any, obligation does society have in addressing the long-term care needs of the elderly? We will attempt to address all of these questions and more in future issues of the Quarterly.

Fast Facts:

- Two-thirds of people age 65 today will need some long-term care in their lifetimes.¹
- Of the 10 million Americans who need assistance with daily activities, 1.7 million live in the nation's 16,000 nursing homes and approximately 520,000 live in assisted living facilities.²
- Fourteen percent of Americans age 85 or older live in nursing homes.³
- A total of \$207 billion was spent on long-term care in the U.S. in 2005.⁴
- Of total long-term care spending, Medicaid spending accounts for 49 percent, Medicare accounts for 20 percent, out-of-pocket spending equals 18 percent and private health and long-term care insurance makes up 7 percent.⁵
- There are 52 million unpaid caregivers who contribute an estimated \$375 billion in value to the U.S. economy. ⁶

(Source of the above information:

<http://www.allhealth.org/sourcebookcontent.asp?CHID=72>

What future lies ahead for Managed Care Organizations?

“The answer will depend upon their ability to provide ‘real’ value or in the marketplace”

The passage of The Affordable Care Act (ACA) will impact the future role of MCOs in a number of ways. Specific parts of the law that will have the most impact on MCOs include the following: limitation relating to medical-loss ratio; health insurance exchanges and regulations relating to health-risk underwriting. The world of the MCO is also changing from a number of other perspectives. Large integrated healthcare systems are becoming more of the norm in communities throughout the country. These integrated systems will gain even more market power as a result of passage of Accountable Care Organizations which are discussed in detail in this issue of the Quarterly. Some of these integrated systems will, over time, also market directly to employers (mostly large self-insured employers) or large purchasing coalitions as direct providers of healthcare services, and as a result minimize or eliminate the need for MCOs in those cases.

As I discussed in this issue's "Tom Take on Health News of Note," changes in Medicare payment methodologies, especially relative to bundled payments, global fees, episode payments, etc., will also eventually filter down to the MCOs' bag of reimbursement methodologies. The passage of The Affordable Care Act (ACA) will also further magnify the importance of transparency of providers from a cost and quality perspective. The combination of an increased governmental role in supporting transparency efforts and advances in technology, etc., will also, over time, enhance MCOs' involvement in this arena.

The following are my comments relating to the above changes impacting the world of MCOs:

- **Medical-loss ratio** = "The National Association of Insurance Commissioners (NAIC)—a network of state regulators that has been charged with advising federal officials on implementing the health-reform law. Included in that work is defining "medical loss ratio" (MLR), which will determine what proportion of the health premiums

collected by insurers are used for patient care and what is considered administrative expense. The new law mandates that insurers meet tight requirements on MLR. As one would expect major lobbying is occurring by both the MCO industry and the provider industry relating to the final definition of the "medical loss ratio" (Source: "Defining Medical Expenses – An Early Skirmish over Insurance Reforms," John K. Iglehart, New England Journal of Medicine, August 4, 2010 – <http://healthpolicyandreform.nejm.org/?p=10441>)

Philosophically, I have a problem with the government regulating profits or even administrative expenses of an MCO. First of all, MCO profits represent a relatively small percentage of premium cost and, while administrative expenses represent a larger percentage of premium, administrative costs are still relatively small compared to the actual cost of care. Second, these types of rules have the potential of discouraging innovation on the part of the MCOs, which could ultimately negatively impact their customers and society.

The focus on insurance reform should be to incent competition between the MCOs (e.g. the use of the exchanges, etc.), not to regulate profits. If MCOs can market a competitively priced value oriented product that meets consumer demands, there should be no restrictions on their profits. Ultimately, though, this is a moot issue since the Medical-loss ratio cap is now law.

- **Health Insurance Exchanges** - The Exchange will provide the consumer and small business the ability to choose healthcare plans on an "apples to apples" basis, based on cost and quality indicators as well as benefit design. The goal of a health insurance exchange is to shift the market for health insurance from competition based on risk to competition based on price. Proponents hope that competitive insurance markets will drive price competition in the healthcare services markets as well.

While Health Insurance Exchanges are primarily focused on the uninsured and smaller groups, there is a strong likelihood that over time, these exchanges will be the dominant purchasing mechanism for small and medium size employers.

- **Health Risk Underwriting** – I am not in the position to determine the impact of these underwriting rules on the MCO industry. One would

think that larger insurance carriers would be in a better financial position to survive these changes.

- **The growth of integrated healthcare systems** – Large integrated healthcare systems will have added leverage in contract reimbursement negotiations with MCOs. This will create major challenges for smaller to medium size MCOs especially if they do not have a large membership in locales that are serviced by the integrated healthcare systems.
- **The evolution of more risk bearing provider reimbursement methodologies** - Managed care organizations (MCOs) have mostly followed Medicare's lead, particularly regarding reimbursement methodologies, since they lack the financial leverage to effectively influence provider behavior on their own. If Medicare implements more provider risk bearing payment methodologies (e.g., bundled, global, episode, capitation, etc.), the MCO industry, especially the larger MCOs, will attempt to emulate it.
- **Health Care transparency** – The government will play an enhanced role in making available user-friendly information to the consumer concerning cost, quality and service indicators of Medicare and Medicaid providers. MCOs will be in a position to leverage this information along with their own data to provide consumers information with the goal of transforming consumers to prudent purchasers of healthcare services.
- **Consumerism** – MCOs will continue to market Consumer Driven Health Care products as a vehicle to address the needs of their existing market as well as the new market of the younger purchasers who are mandated to buy insurance under the new law.

Tom's Take:

What does all of this mean to future role of MCOs? As originally noted in January/February 2007 issue of the Quarterly, Managed Care Organization, even prior to the passage of The Affordable Care Act (ACA), were attempting to evolve from their historical "traffic cop" role into more of a facilitator. MCOs have the data, resources and the expertise to play this facilitator role. Linking this facilitator role with products (tiered, value based benefit designs, etc.) that engage the

consumer with a financial stake in the transaction (deductible, co-pay, etc.), would be an ideal combination.

The combination of all of the above noted items (medical loss ratio, health insurance exchange, integrated healthcare networks, increases in risk-bearing reimbursement methodologies, healthcare transparency, consumerism, etc.) could potentially enhance the facilitator role of MCOs. Eventually all of the above changes will probably further promote the consolidation of the MCO industry which, given the new role of the MCO, will provide more of an equal playing field between MCOs and large integrated healthcare systems.

Specifically, the combination of the medical-loss ratio limitations, risk bearing reimbursement methodologies and large integrated healthcare systems would, over time, lessen or eliminate the role of historical utilization review on the part of the MCO to one that relies on risk bearing reimbursement methodologies supplemented by focused quality oriented initiatives.

MCOs can also play the facilitating role with integrated healthcare systems by working with them to better manage the “risk bearing” forms of reimbursement. Unlike the first go around with capitation in the 1990s when MCOs did not assist providers in managing risk-bearing arrangements, MCOs could play an active role through data exchange, wellness, prevention and disease management collaboration. This collaboration would not only assist providers to better manage their risk-bearing financial arrangements, it would create a healthier MCO customer population that would position MCOs to be more market attractive to employers, etc. (“**the good**” side of self-interest).

Do Managed Care Organizations provide value or just added costs?” The answer to that question really depends upon the MCOs themselves. As again noted in my **Quarterly Rant**, MCOs can have a narrow focus on ways to achieve their own self-interest (e.g. gaming the system to benefit own profitability at the expense of their customers and the community) (“**the ugly**”). , or MCOs could focus on initiatives, provider collaborations, etc. that optimize healthcare cost, quality and access for their customers and the community and in return receive profits, etc. (“**the good**”).

MCOs need to recognize that consumers and employers over time will become more of a prudent purchaser of healthcare services, which will enhance their search for value in the MCO market. Those MCOs that

can't demonstrate their value in the market place will have their role diminished or eliminated.

Medicare's Independent Payment Advisory Board (IPAB):

"Let the tug-of-war begin."

The new healthcare law established an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. IPAB's recommendations for controlling these growth rates must be implemented unless Congress adopts equally effective alternatives. Congress can only overrule IPAB with a two-thirds vote of both chambers.

John H. Ferman, a principal at Health Policy Alternatives, Inc, stated the following: "While the first set of recommendations is not due until 2014 with an implementation date in 2015, healthcare executives will soon hear from their national and state trade associations more about IPAB and be asked to help in a grassroots lobbying campaign to reduce, if not eliminate, the potential impact of the board's recommendations." As noted in my **Quarterly Rant**, this is an example of "**the bad**" side of self-interest. ("Healthcare Reform's Independent Payment Advisory Board," John H. Ferman, Healthcare Executive, Sept/Oct 2010)

As one would expect, this is a hot political issue. As noted above, lobbyists are already arming themselves for an intense battle. Since there is a strong likelihood, that Republicans will gain a large number of seats in this fall elections (possibly even taking control over the House), Congress may be more receptive to these lobbying efforts.

This is not an easy issue. Cuts in Medicare negatively impact provider incomes, healthcare organizations viability, and jobs. Conversely, Medicare costs cannot continue to grow at their current rate, to be viable in the long-term. The entitlement programs (Social Security, Medicare and Medicaid) budgetary impact in the not to distant future will become unmanageable. Add to this the fact that a good portion of the recently passed healthcare expansion efforts directed at the uninsured is going to be financed by cuts to Medicare spending growth trends and you have a major financial challenge.

Tom's Take:

As discussed in the last issue of the Health Care Quarterly, the problems relating to Medicare payment policies have been known for decades (covering 24 years of Republican presidencies and 13 years of Democrat presidencies), but Congress has never been able to address these politically sensitive issues. (Remember Medicare related expenses represent revenue to the healthcare stakeholders).

As again noted in the last issue of the Quarterly, it will be no easy task for the Government to "reform" Medicare, which is the rationale behind IPAB. In fact, during the early months of the healthcare reform debate, a number of key current or former legislators (e.g. Senator Tom Daschle) were proposing a completely autonomous board of healthcare experts that would be able to reform Medicare independent of Congress. These legislators cited their own experience in recognizing the impotence of Congress to implement change to materially impact the financial cost trends of Medicare.

I believe that John H. Ferman did identify a key concern relating to this formula approach to controlling Medicare cost trends. He stated the following, "Will the requirement that the IPAB submit annual proposals to control short-term Medicare spending combined with the laws' categorical restrictions encourage recommendations for short-term cuts rather than long-term changes that might in fact bend the cost curve?" ("Healthcare Reform's Independent Payment Advisory Board," John H. Ferman, Healthcare Executive, Sept/Oct 2010)

(<http://www.ache.org/whatsnew/>)

(<http://pubget.com/search?q=authors%3A%22J%20Ferman%22>)

Clearly the IPAB restrictive approach to controlling Medicare cost trends is not preferable to allowing Congress to exercise responsible due diligence in addressing both the short and long-term cost trends of Medicare. Sadly, as noted above, history has shown that Congress is much too susceptible to the political lobbying forces to act in a truly fiduciary manner in protecting the long-term financial future of Medicare.

A new role for Primary Care Physicians

“Will they be up to the task?”

It should be no surprise to discover that we have a shortage of primary care physicians in the U.S. Medicare is the primary reason we do not have a comprehensive primary care system. Medicare's payment rates to primary care physicians are so low that it incents medical students to go pursue other specialties. Managed Care Organizations have mostly adopted Medicare's relative payment rates that discriminate against primary care physicians. The new law also does not suggest any dramatic increase in primary care fee schedules.

The new law will provide funding for programs that have the primary care physician play a central role. Programs like the “patient centered medical home (PCMH),” a team based approach to delivering medicine. The PCMH practice is responsible for providing care for the entire patient's health needs or making appropriate arrangements with other quality professionals. This includes the provision of preventive care and treatment of acute chronic illness.

Primary care physicians will also play a major role in Accountable Care Organizations (ACOs) which are discussed in detail in this issue of the Quarterly).

Primary care physicians will receive compensation in the form of additional fee payments for Medical Home related services and potentially shared savings that are linked to ACOs achieving their targeted goals.

The role of physicians was discussed in a recent article in Health Care Affairs. The authors' comments are as follows: “In addition to having a motivation to learn, providers need the skills and tools to address the questions raised. These include, in particular, the use of evidence-based care management processes, the adoption of continuous quality improvement techniques, the ability to develop effective teams and the implementation of electronic health records and registries. Much has been written about each of these skills and tools, but they need to be considered as an integrated set of competencies required to effectively respond to the new payment incentives for providing better-coordinated, cost-effective care.” (“How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations,” Stephen M.

Shortell, Lawrence P. Casalino, and Elliot S. Fisher, Health Affairs, July 2010).(<http://content.healthaffairs.org/cgi/content/abstract/29/7/1293>)

Tom's Take:

In order to be successful, all of these roles would require the primary care physician to possess more than just great clinical skills. The primary care physician would need to demonstrate leadership, business acumen, collaborative style, teamwork, and be service oriented. The primary care physician must also have a basic understanding of our healthcare system and the roles of the various stakeholders.

Medical schools and residency programs need to lay the foundation for the development of true physician leaders for all specialties, but especially among the primary care ranks. That foundation would include a broader understanding of the societal issues of cost, access and quality in healthcare. The students need to understand the roles of the various healthcare stakeholders in order to foster better collaboration. Finally, the students need to develop leadership skills and team based approaches to address the needs of the patient population. Medical schools and residency programs would be doing a disservice to their students if they just focused on the clinical side of their education and did not help prepare students and residents holistically for the "real world" of healthcare.

Fast facts:

- The Center for Medicare & Medicaid Services (CMA) projects U.S. health care spending to almost double from roughly \$2.2 trillion (2007) to \$4.3 trillion (2017), while the share of GDP devoted to health care is expected to grow from 16.3% to 19.3%.
- The Department of Health & Human Services is a good source of information to help you improve your health, the health of your loved ones, and to assist those who need help with daily life. All of the topics open-up to display many links to helpful information. <http://www.hhs.gov/children/index.html>
- 2010 Health Care Survey Results (Aon Consulting):
"As is past years, Aon's survey indicates that medical plan costs are forecasted to increase at double-digit rates. Per Aon, the reasons for these increases include: increasing medical technology costs, increasing hospital costs, increasing price and utilization of

prescription drugs, poor lifestyles choices, cost shifting, and medical malpractice costs." ("2010 Health Care Trend Survey," Aon Consulting, Summer of 2010)

http://www.aon.com/attachments/2010_health_care_trend_survey_summer.pdf

STATE

Ohio's Pending Financial Crisis

"Are we willing to make the tough decisions?"

As noted in our last issue of the Quarterly, Ohio is facing major financial challenges in balancing their budget. During the last budgeting cycle, Ohio plugged holes in the 2010-2011 biennial budget with \$7.6 billion* in money that won't be available the next time:

1. \$4,168,141,224 - Federal Stimulus Monday
2. \$ 844,000,000 - Postponed 4.2% tax cut
3. \$2,609,703,585 - Other money sources (e.g. debt restructuring, spending lapses, borrowing from Ohio School Facilities Commission, etc.)

"Can Ohio Fix Its \$8* Billion Budget Hole?" Aaron Marshall, Cleveland Plain Dealer, March 14, 2010

<http://www.bing.com/profile/history?q=Cleveland+Plain+Dealer&FORM=O2HV83> **(*Note: The \$7.6 billion short-fall has been revised down to \$6.5 billion per the September 19, 2010, Cleveland Plain Dealer)**

Tom's Take:

As in other types of crisis situations, one can either sit back for the inevitable or decide to take a proactive role and confront the issues head-on. As a result of this pending financial crisis, Ohio has the opportunity to address some difficult political issues from both the expense and revenue side. There will not be just one easy fix, and there will be a lot of pain, but Ohio needs to set aside political ideology on both sides and focus on the short and long-term welfare of the state. The challenges that are facing Ohio are not just as a result of the recent national recession. The most glaring reminder of our state challenge has been the outflow of our young who travel to other parts of the country for

jobs. One is also reminded of our financial challenges when you recognize that much of our employment is tied to the government and healthcare institutions, which also are mostly tax exempt.

While this can be a trite financial term, Ohio must use a "zero-based" budgetary approach to challenge every area of governmental expenditures. We must use this time to address the difficult issues of funding for long-term care and higher education, as well as objectively decide if some areas of government should be privatized. We must also find creative ways to increase our revenue, without negatively impacting jobs, which will not be an easy task. In closing, our representatives must look beyond their own political agendas and act in the fiduciary role to which they were elected, which is to protect the welfare of the state and its citizens.

NORTHEAST OHIO

OneCommunity Receives a \$44.8 million Grant from the Federal Government

The Department of Commerce's Comprehensive Community Infrastructure program awarded a \$44.8 million grant to Cleveland's OneCommunity. The grant funds 64% of a \$70 million project that will add close to 1,000 miles of fiber and increase OneCommunity's footprint to 27 counties. An estimated 800 anchor institutions, including schools, hospitals, government offices and public safety facilities, will become subscribers to the expanded network. Many of these organizations do not have access to these services or cannot afford them today. The open network will also be used by other local providers to extend broadband service offerings to homes and businesses. (<http://www.onecommunity.org/about>)

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