Healthy Living Center of Excellence

Financial Sustainability Plan

(617)363-8319
JenniferRaymond@hsl.harvard.edu
www.healthyliving4me.org

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Executive Summary:

The Healthy Living Center of Excellence (HLCE) represents a unique collaboration of community-based organizations, aging service providers, health care systems, governmental agencies, and healthcare payors, all with the shared goal of transforming the traditional health care delivery system. Led by a medical care provider (Hebrew SeniorLife), a community-based organization (Elder Services of the Merrimack Valley), and an Advisory Council representing diverse community stakeholders, HLCE proposes an integrated delivery system which leverages the expertise and resources of the community to achieve better care, better health and lower costs. Through the use of bridge funding from federal and foundation grants, we anticipate that the HLCE will be fully sustainable financially within three years through a combination of Medicare/Medicaid reimbursement, contracting with third party payers, (including HMOs and ACOs), limited federal funding under Title IIID of the Older Americans Act, training and consultative services, limited ongoing philanthropic support, and organizational support from HLCE founders, Elder Services of the Merrimack Valley and Hebrew SeniorLife. The total budget for this proposal is $xxxxxxx annually. Key outcomes will be:

- Statewide dissemination and implementation of evidence-based disease management programs for older adults accomplished through regional leaders working with a centralized infrastructure;
- Greatly expanded volume of referrals to and participation in evidence-based programs, accomplished through use of a medical director to enhance engagement and integration with medical care providers and insurance carriers and additional awareness activities, including a virtual home for information about the programs;
- Enhanced quality, integrity and efficiency of the programs accomplished through the centralized infrastructure (including training, contracting, oversight, etc.);
- The creation of financially self-sustaining model of program dissemination, accomplished through establishing reimbursement models with payors and at risk providers.

In short, the HLCE will efficiently implement evidence-based disease management programs to empower older adults to actively manage their conditions and partner with traditional medical providers and community based social service agencies to achieve better health and better health care at lower costs. Achievement of this aim will be facilitated through six (6) regional coalitions encompassing the entire Commonwealth. These regional coalitions are identified below:
Financial Sustainability Plan

A detailed budget for proposals Years One through three is attached hereto as Appendix C. Beginning in Year Four (2016), it is anticipated that the HLCE will be fully sustainable with annual expenses of $XXXXXXX as set forth below.

To remain sustainable, HLCE will need to find ongoing funding in the amount of $XXXXXXX annually. The current Foundation requests for bridge funding are intended to position HLCE over the next three years such that in year four, the following sources of revenue can fully support HLCE infrastructure and activities:

I. Medicare Reimbursement (Diabetes Self-Management, Obesity, Mental Health) $XXXXXXX: As the result of accreditation by the American Association of Diabetes Educators and recognition by the Center for Medicare Medicaid Services, HLCE is eligible to bill Medicare for diabetes self-management assessment and intervention. Based on current billing rates minus program expenses, HLCE will receive income of $XXXX per participant in Diabetes Self-Management Education programs. Through marketing and program outreach to HSL primary practice members, HSL community dwelling seniors, ESMV served population, and partnership with additional local councils on aging, the HLCE will conservatively reach no less than 500 diabetic patients annually. The resulting revenue from Medicare will total $XXXX annually. HLCE has further been awarded Targeted Technical Assistance from the Administration for Community Living and will receive business consultant expertise to further explore additional Medicare reimbursement.
opportunities for evidence-based programs, including revenue from obesity and mental health benefits as well as reimbursement for other chronic disease self-management programs.

II. Third Party Payors (HMO/ACO) $XXXXXXXX: Third party payors, such as at risk providers in HMO and ACO settings, are incentivized to invest in evidence-based programs that demonstrate better care and health while reducing avoidable costs. During the initial three year funding period, HLCE will engage a medical director to develop pilots and build networks for program delivery within medical systems to concretely demonstrate program efficacy and cost savings. The medical director, Robert J. Schreiber, MD, will directly help physician groups and other health care systems to target those high risk elders appropriate for evidence-based self-management programming. As an experienced geriatrician, Dr. Schreiber will consult within primary care practices to imbed geriatric assessments and knowledge into patient care, allowing health systems to identify high risk patients with multiple co-morbidities and to identify the evidence-based interventions best suited for those individuals. HLCE resources will then be available to the medical practices for referral and scheduling purposes. Through the efforts of the medical director, HLCE will operate as a neutral platform for the imbedding of community based social supports within health care settings. In addition to sensitizing physicians practicing in the community to geriatric issues, Dr. Schreiber will further identify and educate the next generation of HLCE medical leadership to carry on the aim of integrating geriatric assessment, evidence-based programming and other community supports in
the health care delivery system. Specific activities performed by the medical director are more fully delineated in the attached Project Plan (Appendix C).

The evidence-based program delivery, however, must not be priced beyond the market rate for similar programs. Should third party payors be expected to cover 100% of HLCE costs, the per participant cost would be $xxxx (HLCE annual expenses divided by 2,500 participants). This rate would likely price programming out of the market, therefore additional sources of revenue would be necessary to support programs. The rate of $xxxx per participant will be explored as the acceptable rate for program delivery, with a goal of reaching at least 2,500 participants annually ($xxxx). These participants will include community dwelling seniors, members of HMO Medicare plans, patients within accountable care practices and medical homes, and patients of other at risk providers. Current grant funding from the Administration on Community Living, as well as Foundation funding will offer the opportunity for pilots with third party payors to determine feasibility as well as the appropriate process for ongoing program referrals.

III. Title IIID Direct Delivery and Salary ($$XXXXXXXXX): HLCE partners (including ESMV and other areas agencies on aging) are eligible to receive funding to implement evidence-based programming under Title IIID of the Older Americans Act. No less than $xxxx could be allocated to the salary of regional coordinators, HLCE centralized infrastructure, or direct delivery of programming. This figure represents both direct dollars allocated to HLCE partner ESMV as well as minimal dollars allocated to community based partners that will offset HLCE direct delivery costs.
IV. Training and Consultative Services ($$XXXXXXX $): HLCE will continue to market training and certification of the Healthy Eating for Successful Living program. This program is presently licensed by HLCE partner, HSL, which can provide national in-person and electronic trainings. The anticipated current demand for such trainings is further augmented by the demand for CDSME Master Trainings nationally. The HLCE staff consists of two (2) T trainers certified to provide such trainings throughout the country. Finally, HLCE will provide consultative services, particularly around obtaining accreditation for Medicare reimbursement and partnership with health care delivery ($$XXXXXXX annually). Additional information relative to such training and consultative services is set forth in the attached project plan (Appendix B).

I. ESMV/HSL Organizational Support ($$XXXXXXX $): HLCE founding partners remain committed to long term support to the centralized delivery and contracting structure. No less than $$XXXXXXX annually will continue to be allocated.

Additional sources of revenue to be explored during the bridge funding period include, but are not limited to:

A. CDSME programming as a contracted workplace wellness benefit for corporate partners;

B. Massachusetts Prevention and Wellness Trust

C. Ongoing philanthropic support