

**Diabetes Self-Management Training (DSMT)**

**Accreditation and Medicare Reimbursement**

**Frequently Asked Questions**

The Administration for Community Living (ACL) and the National Council on Aging (NCOA) have compiled this list of Frequently Asked Questions (FAQs) about Diabetes Self-Management Training (DSMT) to help state and community-based organizations as they work toward accreditation, reimbursement, and sustainability of their diabetes self-management education (DSME) programs. As we receive additional questions, the FAQs will be updated.

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| ***Accreditation*** |

**1. Does the Stanford model Diabetes Self-Management Program (DSMP) meet the accreditation standards required for Medicare reimbursement as is?**

The Stanford model, without additional infrastructure, does NOT have all the necessary elements to meet the [2017 National Standards for Diabetes Self-Management Education and Support](http://care.diabetesjournals.org/content/diacare/early/2017/07/26/dci17-0025.full.pdf), which must be met for accreditation. However, the Stanford DSMP can be used as the approved curriculum for DSMT and will meet the National Standards when the following enhancements are made to the program:

* A planned strategy for ongoing input from stakeholders and experts to promote quality and enhance participant utilization of the services is documented;
* A registered nurse (RN), registered dietitian (RD), or registered pharmacist (RPH/PharmD) that meets the required continuing education requirements and is available and on site during the group class to provide clinical supervision (Note: To assure Medicare reimbursement, the clinician must be an RD);
* An individualized assessment and DSMES plan is developed by the licensed instructor together with the participant and the DSMES team members;
* The participant is made aware of options and resources available for ongoing support of the initial education and selects the option(s) that will best maintain his/her self-management needs;
* A follow-up plan is developed jointly by the licensed instructor and each participant to communicate to the referring provider recommended clinical follow up, as well achievement of the DSMES goals/outcomes; and
* A quality improvement process is in place.

When packaged in this way, the Stanford DSMP can become an accredited program.

**2. Can we add the infrastructure elements required for accreditation to the Stanford DSMP model without violating program fidelity?**

Yes. The elements that you add to enhance the Stanford DSMP model are meant to meet the ten 2017 National Standards of Diabetes Self-Management Education. However, these infrastructure elements are offered around the Stanford model in a manner that allows the program to be provided with fidelity to the original design. The combined approach of the Stanford model with supporting infrastructure allows the program to pass accreditation, which is a requirement for reimbursement by Medicare. As with any licensed Stanford model program, you will still use trained lay leaders and follow the entire six-week Stanford curriculum. The additional elements that are offered to meet the National Standards are provided before and after the workshop sessions in a manner that does not negatively impact program fidelity.

**3. What organizations are authorized to accredit DSME programs?**

Currently, there are two CMS-approved national accreditation organizations, the American Diabetes Association (ADA) and the American Association of Diabetes Educators (AADE). Every Medicare Administrative Contractor (MAC) must honor successful completion of accreditation by either entity – AADE or ADA.

**4. What is the average time that it takes for a community-based organization to go through the entire process of accreditation for their DSME program?**

There is considerable variation in the timing of the process. While certain aspects are standardized (e.g., the time it takes to deliver your pilot workshop), others are not. Below are some considerations that affect the timing:

* Find and negotiate with a Medicare provider or apply and receive approval to be your own Medicare provider. You control the timing for most of this step. Note: This step is not required for accreditation but should be considered as part of a long-term sustainability plan for your program.
* Review the accreditation standards and ensure that you can provide the proper infrastructure and documentation. You control the timing for this step.
* Next, deliver the Diabetes Self-Management Program (DSMP) according to the standards, with the required wraparound structure. This takes 8 weeks.
* It will likely take another two weeks for you to complete the application for accreditation, although you may be able to complete it while the workshop is taking place.
* You will then need to submit your application to your choice of either the American Association of Diabetes Educators (AADE) or the American Diabetes Association (ADA).
* Upon completion of the review, the accrediting organization you chose (AADE or ADA) will schedule a site visit or telephone interview. Your availability will determine the timing on this step.
* At the end of the site visit or telephone interview, the accrediting organization will indicate whether or not you will be accredited. It generally takes another week or two to receive the certificate of accreditation.
* This final step is not required for accreditation, but it is a key contributing factor for long-term sustainability. Upon receipt of the accreditation certificate, the Medicare provider must submit a copy of accreditation certificate to their Medicare Administration Contractor (MAC) as proof of completion of the accreditation standards. The provider will then be formally recognized by Medicare as an approved provider of DSMT.

The full process, including your test class, can take from 4-6 months, and for many organizations, it takes longer. The length of time will depend on your degree of readiness, as well as the time and resources that you commit to prepare the application once you make the decision to become accredited. Going through the process requires a full commitment on behalf of the organization that is applying and the key partners that will be involved.

**5. How long does it normally take to receive the certification after submitting the application to AADE or ADA?**

It shouldn’t take longer than 4-6 weeks. The accreditation organization will review your application and may ask for additional information. Then, a telephone interview will be scheduled. The program coordinator and the licensed clinician must be on the call. Others may also be on the call; it is up to program as to whom else should participate. At the end of the interview, you are notified of a “pass” or “fail” status; then it takes another week or two to receive the accreditation.

**6. Is the Stanford Diabetes Self-Management Program (DSMP) model the only type of program that can achieve accreditation?**

No. Stanford DSMP is only one example of an evidence-based model that can serve as the curriculum when applying for DSMT accreditation. There are other models, as well.

**7. Can we still provide the Stanford DSMP without seeking accreditation?**

Yes. Going through the accreditation process and seeking Medicare reimbursement offer you the opportunity to help sustain your diabetes program, but accreditation is not a requirement to offer the program.

**8. Since the accreditation process takes so much time and effort, why should we bother, when we can just sign a contract with a health plan to pay us for the Stanford DSMP that is not accredited?**

There is nothing to preclude you from signing a contract with a health care entity to offer your non-accredited program. However, if health plans are paying for a program that is not accredited, it is likely that the costs are being covered through administrative funds, which are limited. It would be a better business model with more potential for expansion to offer the structured DSMT benefit through an accredited program. In that case, there wouldn’t be limits on the funding. Any health plan member with diabetes could potentially receive the service.

**9. Can a program that uses lay leaders for the group sessions meet the National Standards for Diabetes Self-Management Education and Support required for accreditation?**

Yes. Standard 5 of the 2017 National Standards highlights and affirms the use of paraprofessionals (e.g., lay leaders and community health workers) in the delivery of diabetes self-management education. The Standard clearly explains that paraprofessionals can contribute to diabetes self-management instruction and play an important role in the process. They must meet the 15 clock hours of annual training that are required relative to the role they serve on the team and must report directly to the licensed clinician. The 2017 National Standards can be referenced at the following link: <http://care.diabetesjournals.org/content/diacare/early/2017/07/26/dci17-0025.full.pdf>.

**10. How many accredited sites can we have for our accredited DSME program?**

The Association of American Diabetes Educators (AADE) and American Diabetes Association (ADA) each have specific requirements related to the number of sites.

AADE - The base accreditation fee covers up to 10 community sites; there is an additional fee for each branch location. As defined by AADE, **community sites** are for DSME programs that wish to expand accessibility to their community. They offer the same program as the main location and are simply an extended copy of the accredited DSME program. All billing for these services goes through the main location. A **branch location** operates semi-independently from the primary program base location. These locations must be establishments within the same healthcare system entity. They fall under the original program’s oversight structure and are required to follow all accreditation guidelines established by AADE and the program. Please refer to the following link for additional information on community sites and branch locations as defined by AADE: <https://www.diabeteseducator.org/docs/default-source/legacy-docs/_resources/pdf/accred/Site_Description.pdf>.

ADA - The base accreditation fee covers one **primary** **multi-site**, which is the parent site. This site may have additional multi-sites or expansion sites associated with it. There are no additional fees for **expansion sites**, which are locations that offer the same program as the parent site that they are expanding from. However, there is a fee for each additional **multi-site**, which is an additional location that is able to operate semi-independently from the primary site. Please refer to the following link for more detailed information about multi-sites and expansion sites as defined by ADA: <http://professional.diabetes.org/sites/professional.diabetes.org/files/media/erp-expansion-vs-multi-site-final.pdf>.

**11. Can new sites be added after the application is submitted to the national accreditation organization (AADE or ADA)?**

Branch locations and community sites can be added at any time by going into your online profile with the national accreditation organization. There may be additional fees, depending on the number of sites. (Please reference question 10 above.) Be sure to notify your MAC of any new locations, as well as any additional professionals who will be linked to the billing from those sites. Notification has to occur prior to delivery of the service.

**12. If there are multiple permanent sites, can one RD and one coordinator be listed as responsible for all sites?**

Whatever works for you in terms of coverage is acceptable, as long as it is reasonable.

**13. What is the period of time for counting the 15 continuing education credits (CEUs) that the instructor (clinician) is required to complete?**

The window for the continuing education is a 12-month lookback from the day the application is submitted. If the application is submitted on January 1, 2017, you must document 15 CEUs in the previous 12 months on or before January 1, 2017.

**14. Is continuing education training required for lay leaders?**

Lay leaders require 15 clock hours of training each year. The training must be related to the role they serve on the team. Chronic disease self-management education (CDSME) program initial leader training, refresher training, motivational interviewing, inservice training, and webinars provided by the Administration for Community Living (ACL), the National Council on Aging (NCOA), or other professional organizations can count toward the requirement. There must be a sign in sheet with the date, topic, start time, and stop time for each training. Note: A CEU certificate is not required.

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| ***Billing and Reimbursement*** |

1. **Medicare benefits cannot include incentives to increase use of the service. Can participants receive the book that accompanies the DSMP (Diabetes Self-Management Program)?**

Yes. The books are not considered incentives. Programs are required to provide diabetes self- management support materials to participants as an essential part of the education process.

**2. About how long does it take to get a Medicare number to become a Medicare provider, not counting anything related to completing the DSMT accreditation requirements**?

It takes anywhere from approximately 3-6 months to get a Medicare number.

**3. Can a group of providers get a Medicare number together**?

There are no group numbers. However, a provider can have multiple locations or sites. A popular approach for collaborating providers is to establish a Management Service Organization (MSO) or an Independent Practice Association (IPA). Under this structure the partnering organizations form a new legal entity that serves as the management arm for the established set of services. This entity will obtain a separate Medicare provider number and list the service locations of each partner as the sites of service. The MSO or IPA will provide shared Health Information Technology, billing, management and support services for the members. In exchange the members will have shared costs of the infrastructure to support the delivery of shared services. (Please reference Question 10, page 4, under the “Accreditation” section, for an explanation of branches and community sites.)

**4. Our community-based organization has just become a Medicare provider, and now we are discussing whether to handle the billing ourselves or outsource it. What are the pros and cons for each approach?**

Billing is very complex and involves a lot of time and effort. Generally, community-based organizations don’t have a lot of knowledge about billing codes. Consequently, if you do it yourself, you are more likely to have billing errors with rejected claims. Outsourcing tends to be more efficient and effective because billing companies have the specialized knowledge and systems to submit and track claims, as well as to correct errors. The billing entity takes care of everything for you, and you can focus on operating your program. There will be a cost to outsourcing, generally a percentage of the amount that is collected. Getting a percentage is a benefit to the billing company and to you. For them, the more they collect, they more they make. For you, there is no cost, until claims are paid.

**5. If a Medicare provider partner is already billing for other diabetes services, can they also bill for DSMT (Diabetes Self-Management Training)?**

Yes. As long as the provider is accredited to provide DSMT and is recognized by Medicare, the DSMT service can be delivered in conjunction with other services.

**6. Is there a limit to the number of units billable on a particular day for one beneficiary?**

No. However, while there is no limit, you may target yourself for an audit if, for example, a beneficiary gets 10 hours of education in one day. Also, DSMT and Medical Nutrition Therapy (MNT) cannot be billed on the same day. In addition, there are specific rules applicable ONLY to Federally Qualified Health Centers (FQHCs) that put limits on the number of billable services that can be provided each day.

**7. Which Medicare beneficiaries are eligible for the DSMT, and how many hours are they eligible to receive?**

Beneficiaries must have a diagnosis of diabetes, be enrolled in Medicare Part B, and have a referral or order for DSMT services from their physician, nurse practitioner (NP), or physician assistant (PA). For beneficiaries with a diabetes diagnosis who have Part C, Medicare Advantage (MA), the DSMT provider must first establish a contract with the applicable MA plan prior to providing services to a member of the plan.

Under the original Medicare program, Medicare provides reimbursement for up to 10 hours of DSMT during the initial 12 month period following submission of the first claim for this benefit. CMS will also reimburse for follow-up training provided to eligible beneficiaries after they have received the initial 10 hours. The follow-up training is 2 hours and is available every calendar year after the first year that the beneficiary uses their initial benefit (10 hours) – as long as the beneficiary continues to have a diagnosis of diabetes. NOTE: This means that a beneficiary can only use that initial 10 hour benefit once. The follow-up 2 hour benefit can be used every year thereafter.

**8. Can any Medicare provider bill for DSMT?**

Yes, if they meet all the requirements. Medicare providers that wish to bill for the delivery of DSMT must ensure that they are registered as a Part B provider and that their diabetes program is accredited by one of the two Centers for Medicare & Medicaid Services (CMS)-approved national accreditation organizations.

**9. If we are a Medicare provider, can DSMT be the only service that we bill?**

No, DSMT cannot be the only service billed to Medicare. However, Medical Nutrition Therapy (MNT), for example, which is often offered in conjunction with DSMT, can be the primary service, with DSMT billed as a secondary service. (Note: MNT must be delivered by a registered dietitian).

**10. Who is liable for the delivery of DSMT and what happens if Medicare is fraudulently billed for the service?**

The organization that bills for the delivery of DSMT services is ultimately responsible for the accuracy of claims submission. Therefore, if fraudulent billing occurs for services that were not rendered, the organization providing the service and the Medicare provider are liable for the fraud that occurred. Therefore, it is very important to do background research, proceed with due diligence, and seek legal counsel when you are considering partnering with another organization to serve as the Medicare provider for a service that you offer. If the concern is regarding malpractice, because DSMT is a health education program that is offered under referral from the patient’s physician, there is limited malpractice risk.

**11. What are MACs and what is their role with regard to DSMT reimbursement?**

A [Medicare Administrative Contractor (MAC)](https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/what-is-a-mac.html) is a regional health insurer contractor that is responsible for processing both Medicare Part A and Medicare Part B claims. When you submit a claim to Medicare, the MAC, designated to cover your geographic area, processes and pays the claim on behalf of the Centers for Medicare & Medicaid Services (CMS).

**12. I understand that there are some differences in how the national accreditation organizations (AADE and ADA) and the Medicare Administrative Contractors (MACs) view supervision. What are these differences and what supervision is required for Medicare to pay a DSMT claim?**

There are two issues related to supervision which the national accreditation organizations and the MACs interpret differently. The first is general vs. direct supervision. Under “general” supervision, the qualified clinician does not have to be in the building when the service is provided, whereas under “direct” supervision, the clinician MUST be in the building when the service is provided. The national accreditation organizations—the American Diabetes Association (ADA) and the American Association of Diabetes Educators (AADE)—accept general supervision for accreditation purposes. However, the MAC for Jurisdiction 5 (Kansas, Missouri, Nebraska, and Iowa) denied a claim when supervision was not provided on site, and CMS has stood by the MAC’s decision. This means that even though a service provided under general supervision meets the AADE and ADA standards, Medicare will NOT pay for it. Other MACs have paid claims when general supervision was provided, and CMS has stood by their decisions too. MACs interpret policies, and CMS makes them. Until CMS establishes a national policy, we recommend that direct supervision be provided to assure that Medicare will pay for the service.

The second issue is a difference of opinion about which disciplines can provide the supervision. The national accreditation standards say that supervision can be provided by a registered dietitian, (RD), a registered nurse (RN), or a registered pharmacist (RPh) who meets certain continuation education requirements. However, some MACs, including the one for Jurisdiction 5, have denied claims if the supervision was not provided by an RD. To ensure payment of the claim, you should use an RD. An RD can also provide medical nutrition therapy (MNT), a service that will enhance your program and increase revenue.

AADE and ACL have made formal appeal to CMS for resolution of these issues. We will update this response if and when there are any new developments on CMS’s position.

**13. Do we need to verify that participants have Medicare**?

It is important to get a copy of the Medicare card to verify the name and number that is listed on the card. A lot of errors in billing are made because of name mismatches or wrong numbers. Getting a copy of the card can save you a lot of time and effort by ensuring that the claim is filed correctly, so that you don’t have to refile because of billing errors. Many organizations are now scanning the cards.

People are skeptical about giving copies of their Medicare cards, and they should be because there has been a lot of Medicare fraud. It is important for the Area Agencies on Aging and other aging service organizations to educate people about why and when they should present their card (e.g., at a doctor’s office or when receiving a Medicare service) and to let them know that it is safe to do so.

**14. We don’t have a process to bill outside of Medicare yet. So, how do we handle coinsurance?**

You must still attempt to collect. This could be accomplished by sending an invoice to the coinsurance plan. You should establish a policy to identify whether or not each participant has coinsurance. It is best practice to get a copy of the participant’s coinsurance card if possible or something from the participant confirming the Medigap policy. A lot of organizations are scanning the cards. It would benefit you to develop a process to bill the coinsurance, as doing so would increase your revenue for DSMT.

**15. If a participant doesn’t have a Medigap policy, are we required to bill the patient for the copayment?**

Medicare requires you to ask for payment, but you don’t have to collect. This requirement can be met by a verbal request for payment. If the request is denied, this should be documented; you must demonstrate that you asked.

**16. If we provide DSMT at a Federally Qualified Health Center (FQHC), can we bill for those services**?

Yes, you can work with the FQHC and operate within their space. It is important to understand, however, that FQHCs get an enhanced reimbursement rate for individual DSMT sessions for Medicare patients which is greater than the reimbursable amount for non-FQHC providers. As a result, FQHCs are not allowed to bill for group sessions. The enhanced rate is a set fee per encounter; it is not based on the amount of time that the service is provided. If you intend to work with a FQHC, you must take into account the multiple regulatory changes that impact billing and collection for FQHCs as compared with non-FQHC providers.

You could work with the FQHC to offer medical nutrition therapy (MNT) before or after the group session and bill for that. MNT is billed in 15 minute increments. You would design your sessions so that participants come in early or stay late for a 15 minute encounter with the registered dietitian to discuss what they learned, how they will make the changes that are desired, and how they can overcome barriers that impede their self-management goals. You would document that time and bill for it.

FQHCs should be interested in working with you because the Health Resources & Services Administration (HRSA) expects them to grow the number of patients they see every year. Their rate could be reduced if they don’t increase number of new patients and the number of encounters per patient. There is not a set expectation as to the number of new patients per year; every FQHC has an individual negotiation project award, and the project officer assesses them individually. The number of Medicare and Medicaid patients and encounters is documented on their Uniform Data System Report (UDS) report, which is a performance report that they submit to HRSA. In order for them to take credit for those encounters, the dietitian has to be included on their UDS report.

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| ***Documentation*** |

1. **How should attendance be documented?**

The licensed person should set up an encounter form, requiring each participant to sign in at every session that he or she attends. The signed encounter form should be maintained to provide proof that the person was there. This is your source document if you are audited.

1. **Can the test class documentation be submitted on paper, or must it be electronic?**

The documentation can be completed on paper. You can de-identify participants and scan the documentation as part of your application process.

1. **Who maintains the record when one organization is accredited to provide the service and another does the billing?**

For accreditation, the entity that holds the accreditation is subject to audit. However, the entity that bills is responsible for the Medicare audit. If one entity is accredited and another is doing the billing, both should maintain a full copy of the record.

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| ***Medical Nutrition Therapy (MNT)*** |

**1.** **Does Medical Nutrition Therapy (MNT) require accreditation?**

No. MNT does not require an accreditation process. MNT is a professional service provided by a registered dietitian (RD). Dieticians can use lay leaders to support the delivery of MNT under their supervision. Any licensed RD who is associated with a Medicare provider can provide and bill for the delivery of MNT to eligible Medicare beneficiaries.

**2. We’ve provided DSMT for many years. We’ve never provided MNT. Where do we start?**

In order to provide medical nutrition therapy (MNT), you must have a registered dietitian who is associated with your program. Only a registered dietitian (RD) is approved to provide MNT services. Lay leaders and other support staff can assist in the delivery of MNT, as long as there is appropriate supervision by the RD.

The focus of MNT is on the impact of nutritional intake on the management of diabetes. In addition, DSMT has always had a component that focuses on nutritional education. In the Stanford Model of DSMP, session two has significant detail on the necessary nutritional components that apply to managing diabetes. When session two is provided under the direction of a registered dietitian, along with additional infrastructure and components, it has the potential to meet the requirements of MNT, as long as there is appropriate infrastructure in place to support the MNT service delivery.

1. **How can we incorporate MNT with DSMT? We are using the Stanford model for our DSMT program.**

For billing purposes, DSMT and medical nutrition therapy (MNT) cannot provided on the same day. You will exhaust your hours for DSMT and still have more classes to offer (the Stanford base is 15 hours/2.5 hours per week x 6 weeks). Once you have exhausted DSMT, you can provide one-on-one MNT sessions before or after the group session to address issues that come up during the group sessions. You must document the start and stop time of the individual session with the RD, the topic covered, and any recommendations.

**4. Will our participants who receive MNT services have to pay out-of-pocket expenses?**

The Affordable Care Act waives the deductible and coinsurance/copayment for certain

Medicare-covered preventive services, including medical nutrition therapy (MNT) services. The coinsurance for DSMT is not waived. The CMS transmittal can be referenced at the following link:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r864otn.pdf>

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| ***State Roles*** |

**1. What is the state’s role, specific to the accreditation process?**

Community Based Organizations (CBOs) may experience challenges in identifying and negotiating a mutually beneficial relationship with a Medicare billing partner, and the support of the State Unit on Aging and/or State Department of Health can be very important. States can also provide information regarding local resources for program referrals. Medicaid managed care organizations (MCOs) pay close attention to what states want and are inclined to please the states. Therefore, when approaching an MCO, CBOs may want to have a discussion about the importance of diabetes education in their specific state.

**2. Can states be helpful in guiding local Area Agencies on Aging (AAAs) regarding training, counseling, etc.?**

Yes. States can provide leadership and support to encourage a group, team, or coalition of AAA partners and other community-based evidence-based program providers to collaborate in providing services, learning from one other, and leveraging strengths. By forming a group or a network, they are in a better position to approach Medicare Advantage plans, managed care organizations (MCOs), and other health care entities; they will be seen as stronger and more appealing as a collective entity, rather than a single organization.

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| ***Marketing and Recruitment*** |

1. **There are a number of programs providing DSMT in my community, so haven’t they already helped everyone who needs the service?**

No. DSMT is one of the most under-utilized Medicare benefits. According to CMS analysis, published in November 2016, only 5% of eligible Medicare beneficiaries with a diagnosis of diabetes have used their DSMT benefit.

Clinical models of DSMT and community-based models can co-exist in communities. It will take the synergistic efforts of both models to reach the large proportion of the Medicare population that are not currently using this essential benefit.

1. **How can we work in the community to help other DSMT providers see that there are plenty of people with diabetes for everyone, and where should we focus our efforts to get enough referrals to grow and sustain our program?**

You might start the conversation by pointing out that only about 5% of people who need diabetes education training are receiving it. Then, you will need to understand the marketplace in your area to know where to focus your efforts. Hospitals generally have their own programs and are not as likely to work with you. However, most outpatient clinics or physician offices don’t have diabetes programs, so that would be a good place to start. The new MACRA rules include performance measures for physicians; they will have to show outcomes. You can get traction on that. They will want to keep their patients out of the hospital, and a diabetes education program can help with that.

You should try to get those referrals, and you can deliver the feedback to them. Capture the niche that isn’t part of a hospital-based system. You might start by approaching the practice manager, who is concerned about clinical outcomes.

You should also register as a direct provider of DSMT and MNT with the top Medicare Advantage Plans in your market. All Medicare Advantage Plans are required to cover all Medicare covered services, including DSMT. The plans have a provider enrollment department; you don’t need a special contract – just becoming a provider allows you into the network.

A third approach is to explore partnering with accountable care organizations (ACOs). If you have identified an ACO in your area, it is helpful to target each of the physicians that are members of the ACO. For every ACO, you can pull the list of doctors who are participating. It is very common that community physicians, who are linked with an ACO, have limited access to DSMT resources. In addition to ACOs, organizations with bundled payment, a risked based payment model, are looking for more support for their population.

**3. How can I find out how many Medicare beneficiaries are in my specific market?**

CMS provides monthly [Medicare enrollment data](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html?redirect=/mcradvpartdenroldata/). Once you go to this webpage, you can make a quick assessment of the numbers in your area by reviewing the Medicare Advantage Penetration Table: MA State County Penetration.

You will be prompted to download a file that has the current Medicare and Medicare Advantage enrollment to the county level for every state and territory in the United States. You can then look up the statistics relevant to your area.

**4. Many Medicare beneficiaries in my community are in Medicare Advantage plans or enrolled in an accountable care organization (ACO). Should I still consider pursuing DSMT classes for Medicare beneficiaries?**

Yes. Even in markets that are considered to have high Medicare Advantage plan enrollment, such as San Diego and South Florida, 50% or more of Medicare beneficiaries are NOT in MA plans. There are also potential possibilities for contracting directly with Medicare Advantage plans to provide DSMT to their enrollees.

ACO participation mandates that the patients served are not be enrolled in a Medicare Advantage plan. All of the individuals served by an ACO are participating in the Original Medicare. In addition, ACOs are prohibited from applying limits on service utilization by their patients. Lastly, the DSMT service is complementary to the goals of the ACO program. ACOs are expected to be successful by expanding access to preventive health services for their population of patients.

In other words, no matter where you are located, there are still plenty of Medicare beneficiaries with a diagnosis of diabetes who can benefit from self-management education.

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| ***Partnerships*** |

**1. We are considering partnering with private health plans to reach more people. What advice can you give us to help them see the benefit of the diabetes education services that we offer?**

All insurance plans, including Medicare Advantage plans, are graded according to Healthcare Effectiveness Data and Information Set (HEDIS) measures, which are heavily weighted towards diabetes outcomes, so it is good for the plans to offer diabetes education because it is proven that beneficiaries that attend accredited diabetes education programs have improved health outcomes and lower costs of care. Having an accredited program demonstrates that you are a strong partner, making it easier to negotiate to become a network provider for the managed care plan. You should highlight your reach, as well as your ability to meet the National Standards for provision in community settings.

**2. We have established a partnership with a health plan and just signed a contract. What comes next?**

You should have discussed and come to an agreement about what needs to be documented and reported. This should be spelled out in the contract. Additionally, you will need to agree upon a process for getting the health plan members who would benefit from the program signed up for diabetes education classes. Don’t assume that the health plan will automatically refer members. It is your job—not the health plan’s—to grow your business. Having access to the members to sign them up for the classes is very important, and filling your classes should be a priority.

1. **What suggestions do you have for partnering with the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) to offer DSMT through their national “Everyone with Diabetes Counts” initiative?**

“Everyone with Diabetes Counts”is a health disparity reduction program paid for by the Medicare Trust Fund. The focus of this initiative is on minority populations and those who live in rural areas. All participants must have traditional Medicare. Each QIN-QIO is responsible for operation of the program in multiple states. There are two models of programs that QIN-QIOs can offer either the Stanford DSMP or the Diabetes Empowerment Education Program (DEEP) from the University of Illinois, Chicago. To meet their objectives, QIN-QIOs are required to complete a pre-post survey on the participants and must have a certain number of completers.

Most QINs have not met their objectives in terms of the numbers of completers they must reach, which requires a corrective action plan. This challenge with enrolling and retaining participants presents an opportunity for Area Agencies on Aging (AAAs) and other community-based DSMT providers to discuss partnering with their respective QIN-QIO to help increase the number of people who complete the program via the Stanford model.

It is important to explain to the QIN-QIO how you can help achieve their goals by increasing the number of program completers. You can also offer to administer the pre-post surveys. You should request and negotiate a reasonable payment for the services that are offered. The payment can be a flat rate or a rate per completer; the cost of administering the surveys should be included in the rate.

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