Diabetes Self-Management Training
Accreditation and Medicare Reimbursement
Frequently Asked Questions (FAQs)

The Administration for Community Living 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 diabetes self-management education (DSMES) services. As we receive additional questions, we will update this resource.

Section Headings

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A. Abbreviations

There are many common abbreviations associated with DSMT that are used throughout this document. The first time an abbreviation is used, the spelled-out version and the abbreviation are presented; only the abbreviation is used thereafter. For ease of reference, view this list of the abbreviations.

B. Accreditation

1. Does the Diabetes Self-Management Program (DSMP), originally developed by Stanford University, meet the accreditation standards required for Medicare reimbursement?

   Without additional infrastructure, DSMP, originally developed by Stanford University (hereafter referred to as the Stanford DSMP model), does NOT have all the necessary elements to meet the ten 2017 National Standards for Diabetes Self-Management Education and Support, which are required for accreditation. However, DSMP can be used as the approved curriculum for DSMT and will meet the National Standards when the following enhancements are made:

   • An advisory group is established to promote quality;
   • A registered nurse (RN), registered dietitian (RD), registered pharmacist (RPh), or member of a health discipline that holds certification as a Certified Diabetes Educator (CDE) or Board Certification in Advanced Diabetes Management (BC-ADM) who meets the required
continuing education requirements provides overall direction and oversight for the workshop sessions. The clinician does not need to be present in the building while the workshop is conducted. (Note: To assure Medicare reimbursement, the clinician must be an RD);

- A quality improvement process is in place;
- An individualized assessment and education plan is developed jointly with each participant by the qualified clinician;
- The participant will be made aware of options and resources available for ongoing support after the DSMP workshop ends; and
- At the conclusion of the DSMES services, a summary of the DSMES services and a follow-up plan are completed with the participant and submitted to the referring provider.

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

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

Yes. The elements that you add to enhance DSMP are meant to meet the ten 2017 National Standards for DSMES. 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 DSMP model with supporting infrastructure allows an organization 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 in a manner that does not affect fidelity.

3. **What organizations are authorized to accredit DSMES services?**

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 – ADA or AADE.

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

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 National Standards for DSMES to ensure that you can provide the proper infrastructure and documentation. You control the timing for this step.

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• Next, deliver DSMP according to the National Standards with the required wraparound structure. This can take 6-8 weeks, depending on whether participants are offered session zero and/or a follow-up session.
• 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 AADE or 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 Administrative 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 quality coordinator overseeing DSMES services and the licensed instructor must be on the call. Others may also be on the call; it is up the organization applying for accreditation 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 certificate.

6. **Is DSMP the only model that can be used to achieve accreditation for DSMES services?**

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

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

Yes. Going through the accreditation process and seeking Medicare reimbursement offer you the opportunity to help sustain DSMP, but accreditation is not a requirement to offer the Stanford DSMP model.

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 DSMP without becoming 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 by becoming an accredited DSMES services provider. In that case, there wouldn’t be limits on the funding. Any health plan member with diabetes could potentially receive the service.

9. If lay leaders provide the group sessions, will this meet the National Standards for DSMES that are required for accreditation?

Yes. Standard 5 of the National Standards highlights and affirms the use of lay leaders or community health workers in the delivery of diabetes self-management education. The Standard clearly explains that lay health workers can contribute to diabetes self-management instruction and can play an important role in the process. The 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?

AADE and 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 organizations that wish to expand accessibility of DSMES services in their community. They offer the same services as the main location and are simply an extended copy of the accredited DSMES services. 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 accredited organization’s oversight structure and are required to follow all accreditation guidelines established by AADE and the accredited organization. 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 services as the parent site from which they are expanding. 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 accreditation application is submitted to 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 Medicare Administrative Contractor (MAC) of any new locations, as well as any additional professionals who will be linked to billing from those sites. Notification has to occur prior to delivery of the service.

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12. If there are multiple permanent sites, can one RD and one quality coordinator overseeing DSMES services 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 units (CEUs) that the licensed instructor 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 are not required to have CEUs, (if they are not a licensed professional) but they are required to have 15 clock hours of continuing education training within a 12-month period. CDSME training and motivational interviewing count. As long as you have a sign in sheet with the date, topic, start time, and stop time, the training can count toward the continuing education hours. CEUs are not needed.

15. What impact do the new 2017 National Standards have for an organization that is already accredited?

The expectation is that you will begin adopting the new standards now. When you are preparing for reaccreditation and/or audit, AADE/ADA will look to see that you have begun implementing and are fully adopting the new standards. Organizations that are in the process of applying for accreditation will now need to meet the new 2017 National Standards.

C. Billing and Reimbursement

1. Medicare benefits cannot include incentives to increase use of the service. Can participants receive the book that accompanies the Stanford DSMP model?

Yes. The books are not considered incentives. Organizations that are accredited to offer DSMES services 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 Services 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

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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 offering the clinical services. 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?**

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 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 an order for DSMT services from a physician, NP, or physician assistant (PA). For beneficiaries with a diabetes diagnosis who have Part C Medicare Advantage, the DSMT provider must first enroll as a provider with the applicable Medicare Advantage 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 two 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 two-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 (ADA or AADE).

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, 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 an RD).

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 or if there is any inaccurate filing of claims for services that were not rendered, the organization providing the service and the Medicare provider are liable. 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) 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. What is the difference between direct and general supervision and which is required for DSMT?

Under “general” supervision, the qualified clinician provides overall direction and oversight and 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 group DSMP sessions facilitated by lay leaders can be provided under general supervision of a qualified clinician.

13. Would you please explain the difference in how the National Standards define which professionals can provide supervision for DSMES as compared to which professionals the Medicare Administrative Contractor (MAC) can process claims for.

There are different requirements regarding which professionals can provide DSMES supervision. The National Standards for DSMES allow supervision to be provided by an RD, an RN, or an RPh who meets certain continuation education requirements. However, the CMS billing requirements will pay claims only for an RD. To ensure payment of the claim, you should use an RD. An RD can
also provide MNT, a service that will enhance your program and increase revenue. Under certain circumstances, an RN who is also a nurse practitioner (NP) can submit Medicare claims for DSMES.

14. 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.

15. 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 can 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.

16. 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.

17. 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 permitted 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 an 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 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 RD 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.
Another option for working with FQHCs would be to establish yourself as a Medicare provider and be recognized by Medicare to deliver DSMT. For Medicare recognition, you must first obtain accreditation by AADE or recognition by ADA; then, you must send a copy of the certificate to your MAC. You would need a written agreement to utilize space within the FQHC. Then you could file claims separately under your organization’s tax ID number.

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.

**D. 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.

2. **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.

3. **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.

**E. Medical Nutrition Therapy (MNT)**

1. **Does MNT require accreditation?**

   No. MNT does not require an accreditation process. MNT is a professional service provided by an RD. Dietitians 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 MNT, you must have an RD who is associated with your program. Only an 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 DSMP model, session two has significant detail on the necessary nutritional components that apply to managing diabetes. When session two is provided under the direction of an RD, 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.

3. **How can we incorporate MNT with DSMT? We are using the Stanford model for our Medicare DSMT services.**

   For billing purposes, DSMT and 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 MNT services. The coinsurance for DSMT is not waived. The CMS transmittal can be referenced at the following link:  

5. **Where can I find a referral form for MNT?**

   AADE and ADA have developed a form that you can use. Here is the link to download the form:  

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**F. State Roles**

1. **What is the state’s role with regard to the accreditation process?**

   Community Based Organizations 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 regarding training, counseling, etc.?**

   Yes. States can provide leadership and support to encourage a group, team, or coalition of Area Agency on Aging 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.

G. 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 coexist 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.

2. **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 DSMT 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. 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.

### H. 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.
3. **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 model 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 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 DSMP 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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