Purpose

This resource is designed to disseminate learnings that have contributed to the success of community-based organizations (CBOs) in becoming Medicare providers and billing Medicare Part B to help sustain evidence-based chronic disease self-management education (CDSME) programs.

Background

The Administration on Aging (AoA) within the Administration for Community Living (ACL) has provided funding and support to build capacity for, scale, and sustain CDSME and other evidence-based programs for many years. NCOA’s Center for Healthy Aging serves as ACL’s National Resource Center to provide leadership, technical assistance, and resources to support aging and disability-related community-based organizations across the U.S. in developing integrated, sustainable program networks for CDSME and other evidence-based programs.

In recognition of the need for CBOs to build proficiency in business acumen to develop viable, integrated care models for CDSME programs, NCOA developed an online Roadmap to Community-Integrated Health Care. The Roadmap contains four broad components: 1) Leadership, 2) Policy and Advocacy, 3) Learning Collaboratives, and 4) Community-Integrated Health Care Toolkit. This resource is one of many found in the multi-tiered, online Community-Integrated Health Care Toolkit. After reading this resource, we encourage you to take time to peruse the Toolkit and select from other online tools and resources within its extensive library to support your efforts.

Twelve Strategies for Success

1. **Timing is everything.** Organizations go through many different stages in their development, and it is important to consider timing and readiness to invest the effort that is required to integrate your CDSME programs with the health care sector. For example, it is generally not a good time to start a new initiative when an organization is undergoing a change in leadership, an internal reorganization, or a downsizing. A CBO
should be operating in a relatively stable environment internally to start a new venture, while having enough flexibility in its structure to launch and support a new initiative.

In determining the timing of your new initiative, it is equally important to take into account conditions in the external environment. Learning about health care initiatives that are being offered in your state and region will help you identify opportunities for health care integration and become aware of potential competitors in the marketplace. For example, many major hospitals are already offering Diabetes Self-Management Training (DSMT) as a Medicare benefit. In this environment, CBOs would need to develop a strong value proposition to demonstrate the added value their services could bring to the hospitals. It would also be a good idea to target other health care providers, e.g., independent physician practices, that don’t offer DSMT for their patients.

2. **Ensure that there is an adequate infrastructure for CDSME programs.** The work of developing an integrated care model for Medicare reimbursement is a big undertaking. Therefore, it is recommended that you have an adequate and well-established infrastructure for CDSME programs before you endeavor to obtain Medicare reimbursement. Without an adequate pool of leaders, trainers and workshops, you could invest a significant amount of time and resources in the effort but ultimately fail because you are unable to respond to the needs of your health care partners. Once you have an established program that is well known and respected in the community, you will be better positioned to start down the path toward Medicare reimbursement.

3. **Secure commitment from Top Management.** A great deal of time, energy, and resources are required to progress through the stages of organizational change to achieve Medicare reimbursement. Therefore, it is essential that the executive director, board of directors, and members of the senior management team are committed to provide leadership for the initiative. Senior managers can effectively convey to employees how the initiative fits within the framework of the organization’s vision, mission, values, and goals. The executive director or a designee from the senior management team should work alongside staff who are responsible for implementation of the project to set realistic objectives and a timeline that align with the organization’s priorities, ensure that the necessary resources are allocated, make executive decisions to keep the project on track, and build community support for the initiative.

4. **Identify start-up funding to support the effort until the break-even point can be reached.** Community-based organizations that have been successful in achieving Medicare reimbursement have consistently conveyed the importance of having seed monies, such as a grant, foundation support, or funding from another reliable source to support the project until the Medicare services are well established. Achieving Medicare reimbursement is a significant accomplishment toward sustaining CDSME programs. However, service volume is necessary for a program to become viable. Increasing volume to the break-even point can take a year or longer beyond the initial date of reimbursement for a Medicare claim. Therefore, it is essential to plan ahead to ensure
adequate funding for Medicare Part B services. Over time, as volume increases, the need for supplemental funds will decrease. Once the break-even point is reached or exceeded, the services will be sustainable without additional funding. NCOA’s Break-Even Worksheet will help you determine the costs associated with delivering your services and the number of workshops that need to be offered to break even.

5. **Designate a program coordinator to be responsible for the service.** Designating someone to be responsible for Medicare services will help ensure forward momentum of the initiative. Generally, COBs assign these duties to a key staff person who is involved with the implementation of CDSME programs. The CDSME program coordinator is a good fit for this role because he/she thoroughly understands the model originally developed at Stanford University, has generally established community partnerships, and has an investment in long-term sustainability of the program. Some organizations have a registered dietitian who can serve as a valuable resource in working toward national accreditation of diabetes self-management and support (DSMES) services, which is a requirement for Medicare reimbursement of the Medicare Part B Diabetes Self-Management Training (DSMT) benefit. If you plan to offer the DSMT benefit, the 2017 National Standards for DSMES provide specific guidance for the necessary wrap-around structure, including a quality coordinator overseeing DSMES services, who is responsible for program coordination and quality assurance activities.

6. **Conduct a needs assessment and a market analysis.** Developing an integrated, sustainable business model for Medicare Part B product lines requires careful thought and planning. A needs assessment is a systematic method to help you to determine the need for the service and gaps that exist in service delivery. The Program Planning section of NCOA’s website contains some tools that you can use when conducting your needs assessment. Conducting a market analysis to determine how you will position your services in the marketplace is also a useful exercise. NCOA’s Market Analysis Worksheet is an excellent tool that takes you through a series of questions to help you develop a strategy for projecting your potential sales and market share to successfully compete in the marketplace.

7. **Forge partnerships with more than one health care entity.** The saying, “Don’t put all your eggs in one basket” is applicable when building partnerships. Several CBOs spent an undue amount of time working toward a partnership with one organization, only to have it fall through. In hindsight, they wished they would have engaged more than one partner initially. Doing so would have enhanced both the efficiency and effectiveness of their initiative.
8. **Begin building a referral network early in the process.** A valuable lesson learned by CBOs is the importance of starting to build referral partnerships with health care entities, while simultaneously working toward Medicare reimbursement. Dedicating resources to build a strong referral network early on is a key strategy for program sustainability. If you wait until you are a Medicare provider before starting to think about referrals, it is not likely that you will have enough referrals to fill your workshops. Without an adequate flow of referrals, you will not be able to increase the volume of your business enough to address the service gaps in your community or to cover the costs of your program. The findings from your market analysis will help you target potential referral partners who can benefit from the services you offer.

Developing partnerships is an ongoing and dynamic process that starts with engaging key staff and building trust. Enlisting leadership buy-in from the organizations, identifying one or more champions, and working collaboratively toward outcomes that are mutually beneficial to all organizations involved are keys to success. The [Partnership Development](#) section of NCOA’s Community-Integrated Toolkit provides information about the stages of partnership development, as well as in-depth resources about partnering with different types of health care organizations, including hospitals, accountable care organizations (ACOs), federally qualified health centers (FQHCs), and patient centered medical homes (PCMHs).

9. **Don’t make billing an afterthought.** In retrospect, CBOs that have achieved Medicare reimbursement wish they would have considered billing sooner. There are a number of factors that should be taken into consideration when filing a Medicare claim, including deciding which organization will serve as a Medicare provider, determining whether to conduct billing internally or outsource it, and ensuring that clinicians who are responsible for supervision are registered as Medicare Part B providers and have their national provider identifier (NPI) linked to the designated Medicare Part B provider. Further, it is crucial to develop a clear, written billing process that includes
verifying Medicare coverage of participants, defining the roles and responsibilities of the clinical and back office staff, and describing the steps for filing and reconciling claims. Billing discussions should begin during the planning phase, and decisions should be implemented in a timely manner to avoid a delay in reimbursement.

10. Create a project team. Community-based organizations that have been successful have identified key staff members within their own organization, as well as within partnering organizations, to form a project team. Relying on only one person versus a team can cause setbacks in achieving the desired goals if the designated person resigns, goes on extended leave, or is assigned new duties. A team approach is a good way to secure buy-in from the organizations involved. Additionally, you will benefit from the unique knowledge, experience, and skills that each person brings to the team and be able to share roles and responsibilities to keep the project on track.

11. Hold regularly scheduled meetings. Once the project team has been formed, it is important to hold regularly scheduled meetings to build trust, set a common agenda, and work through challenges together to accomplish mutually established goals. The project coordinator is generally responsible for coordinating the team meetings and maintaining the communication flow.

Utilizing a team process, a formal agreement, such as a memorandum of agreement (MOA), a memorandum of understanding (MOU) or a contract, should be developed to define the scope of responsibilities for each organization. A contract is a legally binding agreement, which should be developed when monies will be exchanged for services that are provided. A contract should also describe the services, the timeline for delivery, and the rates.

12. Stay persistent in your efforts. Without exception, CBOs have faced various challenges, setbacks, and unexpected twists and turns as they ventured forth to achieve Medicare reimbursement. When there is a challenge or barrier, it is important to collaborate with your team and use critical thinking skills to develop possible solutions. You may also want to seek consultation from NCOA’s Center for Healthy Aging or another reliable source. Whether you modify your objectives or timeline or rethink your partnerships, it is important to stay committed to your long-term goals. Working toward Medicare reimbursement is not for the faint of heart, but it has significant benefits for program sustainability that can best be obtained by using the strategies described in this Tip Sheet and accessing other resources from NCOA’s Community-Integrated Health Care Toolkit.

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