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Introduction

The Academy of Nutrition and Dietetics' vision, “A world where all people thrive through the transformative power of food and nutrition,” emphasizes the importance of ensuring ALL people have access to food and nutrition. One key piece of having access to food and nutrition is having coverage for nutrition services provided by registered dietitian nutritionists (RDNs), the nutrition experts. Ensuring that Medicaid, the nation’s largest health insurance program insuring 1 in 5 Americans, covers medical nutrition therapy (MNT) provided by RDNs significantly impacts the number of people having access to food and nutrition expertise. Providing Medicaid beneficiaries with access to RDNs further addresses the Academy’s Strategic Plan’s impact goals including:

- Increase equitable access to nutrition and lifestyle services.
- Improve health equity through access to MNT services.

If we are to truly strive to reach the Academy’s vision, then coverage for RDN-provided MNT by Medicaid is crucial.

Medicaid, unlike Medicare, varies state by state. Each state establishes its own scope of covered services within a broad set of national guidelines. The majority of Medicaid beneficiaries nationwide receive Medicaid program health care services through Medicaid Managed Care programs. States aim to reduce Medicaid program costs and better manage utilization of health services by contracting with various types of Managed Care Organizations (MCOs) to deliver services to their beneficiaries. In most cases, MCOs accept a set member per month (capitation) payment for providing health care services to Medicaid beneficiaries. Learn more about Medicaid on the Academy’s Eatright Pro website. For more information about Medicaid MCOs or to view a Medicaid Managed Care webinar, visit this page on the Academy’s website.

The Patient Protection and Affordable Care Act (ACA) created expanded opportunities for RDNs to provide MNT under the essential health benefit category of "Preventive and Wellness Services." Under the ACA, preventive care services for which RDNs could be recognized as providers include:

- Diet counseling for adults at higher risk for cardiovascular disease
- Obesity screening and counseling for all age groups

Many states have successfully advocated for coverage of RDN-provided MNT services as part of their state Medicaid program. The Academy’s Eatright Pro website has more details about these success stories. As a result of increased access to MNT by RDNs, Medicaid beneficiaries in these states have increased access to MNT to better prevent or manage their health. Additionally, RDNs can benefit from additional payment opportunities and add value to the health system in helping to achieve the triple aim – better care, improved health, and lower costs.

To determine the status of RDN-provided MNT coverage under your state Medicaid program, refer to the Decision Tree in Appendix A and state specific Medicaid information on George Washington.
University’s report on Medicaid Coverage for Obesity Services. After reviewing the Decision Tree, if you determine that your state does not currently offer RDN-provided MNT services under the state Medicaid program, confer with your affiliate leadership and Public Policy Panel (PPP) to decide if there is interest in pursuing advocacy in this area. This toolkit will guide interested affiliates through the process of advocating for coverage of RDN-provided MNT in their state’s Medicaid program.

Medicaid Alternative Payment Models (APMS):

The tools and resources outlined in this toolkit can be used to advocate not only with your state’s Medicaid program but also for the inclusion of RDNs in Medicaid alternative payment models (APMs). Keep in mind, your strategy may vary depending on the way Medicaid benefits are managed in your state.

The Academy’s website has information on APMs and value-based care, including MCOs, as well as more information on Medicaid MCOs in your state.
Advocacy in Action

Understanding your role as an advocate is key to your affiliate’s success in advocating for inclusion of RDN-provided MNT coverage in your state’s Medicaid program. Being an “advocate” or engaging in “advocacy work” means that you educate and influence people about policy topics. Your voice has exponential power and influence when aligned with the Academy, your affiliate and its members and external strategic partners. A unified voice strengthens advocacy for RDN-provided MNT coverage in your state Medicaid program. Partner and openly communicate throughout the advocacy process with your affiliate leadership, affiliate PPP, the Academy’s Nutrition Services Coverage staff and the Academy’s Policy Initiatives and Advocacy staff.

To review more about advocacy, refer to the Academy’s Grassroots Advocacy Guidebook and Grassroots Advocacy Toolkit, available on the Public Policy Leaders’ online community of interest.

Deciding Your Approach: Is the Environment Ripe?

The Academy’s Nutrition Services Coverage staff and Policy Initiatives and Advocacy staff will help you determine whether the environment is ripe in your state to advocate for RDN-provided MNT and identify the most effective strategies for obtaining it. The information you gather should guide the development of your advocacy talking points. Here are some things to research and consider when deciding your approach:

1. **Define Your Goal:** “What is the problem and why is advocacy the solution?” Framing the discussion in terms of a discrete problem and effective solution is the foundation of a successful advocacy plan.

2. **Conduct a Gap Analysis:**
   - What are the gaps in coverage that the affiliate is seeking to address? (e.g., RDNs as Medicaid providers, specific benefits or coverage issues, medical policies, special populations, etc.)?
   - What work has been done in the past in your state? Talk to current and past PPP members, especially the State Regulatory Specialist and Reimbursement Representative, and your state lobbyist (if you have one) to learn the history of Medicaid-related work by the affiliate in the past.

3. **Determine Current Coverage:** Make sure you have all the facts about current RDN-provided MNT Medicaid coverage in your state. See Appendix D for a worksheet to collect this information. Keep in mind, if the state has Medicaid Managed Care, there may be differences in benefits/coverage/requirements for each MCO in the state. Research answers to the following questions:

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• What are the most costly chronic diseases in your state? Is there an impact through nutrition? Is there nutrition coverage for patients with these conditions?
• Who has benefits for nutrition counseling/MNT? (e.g., adults, pediatrics, special needs, etc.)
• What is/are the benefit(s)? (e.g., number of visits or sessions, time period)
• What conditions or requirements must be met? (e.g., diagnoses, medical policy/clinical guidelines)
• How to get paid? (e.g., referral requirements, place of service, provider type)

4. **Consider Current Licensure Status:**
   • What is the status of licensure for RDNs in your state?
   • How does licensure/certification status impact the ability to become Medicaid providers? (e.g., are Medicaid providers required to be licensed or certified by the state)

5. **Gather Real Life Stories:**
   • In your current state, are there real-life success stories to show medical improvements as a result of nutrition counseling?
   • In your current state, are there real-life stories to share where a patient deteriorated because they could not access an RDN and/or could not afford to pay out of pocket for nutrition counseling?
   • If success stories are not available in your state because of little to no coverage, make connections with colleagues in states with robust coverage and share the impact. Keep in mind, when sharing from other states, it’s best to reach out to neighboring states or states with like-minded views on coverage of healthcare services.

6. **Research Terms and Their Definitions**, such as “health care provider” and others included in the state’s benefit package to ensure that “registered dietitian nutritionist” or the equivalent would fall under the “health care provider” category. If not specified, determine how provider types are determined. Is it related to licensure; related to other federal (Medicare) or private insurance benefits? This information provides a fuller picture of where access barriers may exist and can inform your strategy and approach. Use states’ language recognizing RDNs as recognized providers as examples your state could adopt to share with stakeholders. Visit the Academy’s web pages for a **map of licensure statutes and information by state**.
7. **Complete Political Mapping**: Political Mapping involves identifying and describing those elements of the political environment that shape the way in which policy processes work, and reflects the current political environment. Currently prevailing ideologies and opinions, the extent to which the political system is functioning as intended or dysfunctional, whether state officials are pursuing an expansion or a contraction of government services, and assessments about other issues and your state priorities will be factors in determining whether and how to customize your approach and talking points.\(^1\) Consider your state budget. States share in the cost of Medicaid and must weigh these expenses against competing needs. Aspects of state budgets, such as deficits (where permitted), budget neutrality requirements, etc. may impact your approach. For example, if MNT benefits are added, it could mean that absent increased revenue, other services are cut.
- Consider state level government priorities as well as priorities for the governor and state insurance commissioner.
- Determine if your state expanded Medicaid coverage recently. States that have newly expanded Medicaid may be in need of health care providers to deliver the U.S. Preventive Services Task Force (USPSTF) obesity screening and counseling services for which you could advocate for RDNs to be recognized providers. Refer to [this page on the Academy’s website](https://www.eatrightpro.org/) for more information.
- Complete the political mapping process as early as possible and update your political map regularly. Keep in mind state level government priorities as well as priorities for governor and state insurance commissioner. As the political environment changes as a result of an election or your advocacy efforts, your political map should, too.

8. **Identify the State’s Delivery System**: Medicaid programs are offered in a variety of delivery models which could include a traditional fee-for-service plan, a MCO plan or a mix of both. Is it more effective to meet with your state Medicaid staff or directly with MCOs? Which group typically leads in expanding coverage for certain services? If the majority of the Medicaid population in your state is enrolled in MCOs, it may make sense to meet with those individual entities. At minimum, since MCOs must offer at least the same benefits as the state’s traditional Medicaid program, a meeting with your state Medicaid staff to change coverage of the traditional program would create a ripple effect to the MCOs.

9. **Identify and Leverage Private Insurance Coverage Data**: Research MNT benefits that are typically covered by private insurance companies and employers in your state to better understand both what the minimum coverage may be and what typical coverage includes. Make connections with private insurers that are pro-RDN and use their success stories and data to promote Medicaid coverage expansion.

10. **Determine If Your State Has Medicaid Waiver Options**: A Medicaid waiver is a provision in Medicaid law which allows the federal government to waive rules for a state that usually apply to the Medicaid program. The intention of a waiver is to allow individual states to accomplish certain goals, such as reducing costs, expanding coverage or improving care for certain target groups within that state. Waivers can provide alternative pathways to coverage and influence your approach. [Research waivers in your state on CMS’s website](https://www.medicaid.gov/).  

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\(^1\) Tips on Legislative Advocacy. American Bar Association.  
[www.americanbar.org/content/dam/aba/administrative/homelessness_poverty/Tips_on_Legislative_Advocacy.pdf](https://www.americanbar.org/content/dam/aba/administrative/homelessness_poverty/Tips_on_Legislative_Advocacy.pdf)
Coalition Building

Coalition building with other stakeholders around shared goals lends exponential strength to your voice. A coalition is a group of organizations and individuals working together to influence outcomes on a specific problem or issue, and they are useful because they expand the impact beyond what an individual organization may achieve and can be an effective way to consolidate resources to achieve a common goal. They also provide a forum for sharing information and facilitate cooperation among grassroots organizations and community members. Before developing a new coalition, be sure that there isn’t already an existing group with the same or similar mission that could be used to achieve your desired ends.\(^2\) Follow these steps below.

1. **Choose the right partners.** Partnerships are a key part of successful advocacy. Building a coalition takes time. Ensure you are including representation from all relevant stakeholders. Capitalize on existing relationships the affiliate or affiliate members have. Identify groups that may have goals that align with those of your affiliate. There may also be value in developing relationships with other health care provider groups, organizations or professional associations that have successfully advocated for coverage for services. Consider other state affiliates of national organizations to create an inter-disciplinary approach. For example, state chapters of the American Diabetes Association, the American Heart Association and the American Cancer Society may be very supportive on MNT coverage issues. Community child welfare organizations may also be interested in collaborating to expand coverage for child nutrition services. Connect with your State Advocacy Representative (STAR) regarding the STAR program through the Obesity Care Continuum for potential coordination of efforts. Read more about the STAR program in the handbook for OOC STAR program members.

2. **Build relationships** with those groups and build engagement around your shared goal(s). Some of these groups may already be members of advocacy coalitions you can join.

3. **Define and prioritize goals** with partner groups early on to help foster early buy-in and engagement. Collaborating across organizations may initially require putting aside your own priorities, but by building consensus with the right partners over time, a win-win opportunity can be experienced by all.

Meeting with Decision Makers

Regardless of your state’s political climate, it is important to develop a relationship with your state’s Medicaid office. “The engagement of a state’s Medicaid director facilitates decision-making, collaboration with counterparts at other state agencies, and can build momentum for new initiatives or policy changes.”

Relationships take time to develop and require regular contact over time. Because many Medicaid director positions are appointed, political turnover may necessitate the development of new relationships. Here are tips to develop a relationship with your state Medicaid director, and/or medical directors of your state’s MCOs, which is essential prior to any “ask”.

Prior to Your Meeting:

- Do your homework! Preparation will help to anticipate questions and allow time for you to prepare your responses.
- Familiarize yourself with the office function and role of staff which you will meet.
- Know the local Medicaid “lingo”; for example in some states the Medicaid program has a specific name, like Medi-Cal in California.
- Know the population demographics in your state – rural/urban, race/ethnicity, primary disease burdens – so you can link state trends in rising health care costs to limitations in access and delivery of disease management interventions and preventive care.
- Find out if Medicaid expansion or MNT is a priority or if the state is focused on remaining cost neutral.
- Identify studies and references that speak to the situation in your state which can be cited to support your “ask” environment.

Schedule a “get-to-know-you” meeting:

Schedule a get-to-know-you meeting with your state Medicaid director, state insurance commissioner, governor, or other healthcare committee leader. (See Appendix E for contact information.)

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At the Meeting:

- Introduce the affiliate and its priorities.
- Help decision makers understand what RDNs do, particularly in Medicaid in your state or elsewhere – be clear, direct, offer evidence of effectiveness linked from patient experience down to dollars saved.
- Seek to understand the needs of the Medicaid office/program. What are the health needs of their member population? What are their social determinants of health most impacting?
- Offer solutions, not just critiques. Advocates often make the mistake of pointing out problems to state agencies without proposing concrete solutions.

For Meetings with an “Ask”, Follow these Steps:

- Do your homework. Refer to the Deciding Your Approach section and the State Specific Data Gathering section. Also be prepared to reference specific studies cited later in this document, especially if those studies are particularly relevant to your state.
- Incorporate the state specific data you gather into your talking points which are outlined in the Advocacy for MNT section. Practice using the talking points. Be prepared to introduce yourself, your affiliate, and other collaborators at the meeting.
- Think of a personal story related to the topic that you can share to put a “face” to the issue. Refer to the Grassroots Advocacy Guidebook for more tips for effective storytelling in advocacy.
- Remember to practice the “Ask.” This is the purpose of the meeting.
- Be prepared to address potential opposition.
- Prepare “leave behind” materials. A clear connection should exist between talking points and leave behind materials.
- After the meeting, be sure to send the following:
  - A thank you note to the staff you met with.
  - Additional information you promised to share after the meeting.
  - A summary of your meeting to Academy staff at reimburse@eatright.org.
Advocacy for MNT

The flow chart below outlines steps for incorporating MNT services (Tier One) as well as details to address MNT’s impact on disease/conditions and frequency of intervention (Tier Two). This information will be critical to consider as you finalize your talking points for your meetings.

Talking Points to Support Tier One or Tier Two MNT Coverage

Clearly define the ideal language as well as acceptable parameters in case of necessary compromise.

**Your ultimate goals are to ensure nutrition services are covered in your state’s Medicaid program and RDNs are designated as providers.** State officials will most likely request information on the diseases and/or conditions where MNT services are effective, and the number of MNT visits needed to positively impact health outcomes. Make sure you have this information available for your meeting. Talking points for the two tiers of coverage are presented below to frame your negotiations. The goal is to be successful in achieving Tier One coverage, but the political climate within a particular state may require falling back to negotiate MNT coverage outlined in Tier Two.
Talking Points – Tier One

RDN-Provided MNT Services – Coverage for All Diseases/Conditions, No Cap on Visits

The Academy encourages coverage of cost-effective MNT provided by RDNs for obesity prevention and all nutrition-related chronic diseases and medical conditions, including hypertension, obesity, cancer, and prediabetes, consistent with USPSTF recommendations and national clinical guidelines.

- Improved health outcomes using MNT by RDNs have been published in the areas of diabetes, hypertension, disorders of lipid metabolism, HIV infection, pregnancy, chronic kidney disease, and unintended weight loss in older adults. In addition, RDNs have demonstrated improved outcomes related to weight management.5
- RDNs have expertise in delivering nutrition counseling, cognitive behavioral strategies and other MNT services for prevention, wellness and disease management.
- The National Academy of Medicine, formerly the Institute of Medicine, found that “the Registered Dietitian is currently the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.”
- By using their expertise and extensive training, RDNs deliver care that is coordinated, cost-effective, and supports higher performance in pay-for-value models of care.
- Evidence shows that involvement by RDNs in beneficiary care prove to have a substantial effect on both the health of the beneficiary as well as cost savings. See the Return on Investment section below for examples.


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Talking Points – Tier Two

RDN-Provided MNT Services – Disease Specific, Recommended Number of Visits

If the all-encompassing Tier One cannot be achieved, all conditions for wellness, prevention and chronic disease management for both children and adults should be covered but the number of visits or hours allowed should be negotiated. To determine the number of visits or hours to recommend, refer to the information from the Academy’s Evidence Analysis Library (EAL) noted below and national clinical guidelines. You may also use information on the benefits typically covered by employers and private insurance carriers in your state as a guide to a reasonable negotiation level.

The number of hours to advocate for under tier two should align with the recommendations outlined in the EAL. Of note, the number of hours should not fall below the Centers for Medicare & Medicaid Services’ (CMS) minimum number of hours Medicare allows per year for MNT in Medicare (three hours per condition in the first year, two hours in subsequent years, with additional hours allowed if there is a change in diagnosis and/or medical condition that makes a change in diet necessary). Only use CMS’ standard as a minimum level of inclusion if others inquire about level of coverage from various government programs. However, do ensure that the level of coverage in your state is at least at or above CMS’s standard.

The following summary data is from the EAL:

- For weight loss in adults with overweight or obesity, the RDN should schedule at least 14 MNT encounters (either individual or group) over a period of at least six months. High-frequency comprehensive weight loss interventions result in weight loss. For weight maintenance, the RDN should schedule at least monthly MNT encounters over a period of at least one year. High-frequency comprehensive weight maintenance interventions result in maintenance of weight loss.6

- In adults with disorders of lipid metabolism, RDNs should provide three to six visits for MNT to further improve a patient’s lipid profile. The magnitude of low-density lipoprotein cholesterol (LDL-C) reduction increases with additional visits or time spent with the RDN. Studies report that further reduction in total cholesterol (↓19% with four RDN visits vs. ↓12% with two RDN visits) and LDL-C (↓21% with four RDN visits/180 minutes vs. ↓12% with two RDN visits/120 minutes) were observed.7

- In adults with hypertension, the RDN should provide MNT encounters at least monthly for the first year. After the first year, the RDN should schedule follow up sessions at least two to three times per year to maintain reductions in blood pressure (BP). A strong body of research indicates that reductions in systolic BP up to 10mm Hg and in diastolic BP up to 6mm Hg were achieved.

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in the first three months of MNT provided every other week for at least three sessions. Similar significant reductions in BP were reported at six to 12 months when MNT was provided at least monthly, or with follow-up provided after five or more sessions. Sustained reductions in BP for up to four years was reported when MNT was provided at least two to three times per year.8

- In adults with type 1 and type 2 diabetes, the RDN should schedule three to six MNT encounters during the first six months and determine if additional MNT encounters are needed. In studies reporting on the implementation of an initial series of RDN encounters (three to 11; total of two to 16 hours), MNT significantly lowered HbA1c by 0.3% to 2.0% in adults with type 2 diabetes and by 1.0% to 1.9% in adults with type 1 diabetes during the first six months, as well as optimization of medication therapy and improved quality of life. The RDN should implement a minimum of one annual MNT follow-up encounter. Studies longer than six months report that continued MNT encounters resulted in maintenance and continued reductions of A1C for up to two years in adults with type 2 diabetes, and for up to 6.5 years in adults with type 1 diabetes.9

- In adults with prediabetes, the RDN should provide MNT encounters for individuals who are at high risk for type 2 diabetes and increase the frequency of encounters to optimize outcomes. Studies reported that increased frequency of visits resulted in greater improvements in certain metabolic and anthropometric outcomes.10

- For adults with heart failure (NYHA Classes I - IV/AHA Stages B and C), the RDN should provide an initial MNT encounter lasting 30-60 minutes, with a follow-up encounter four to six weeks later, and determine if and when additional MNT encounters are needed. Research reports that this frequency and duration of medical nutrition therapy resulted in a significant decrease in sodium intake, as well as maintenance of serum sodium levels and body weight.

- For adults with advanced heart failure (NYHA Class IV/AHA Stage D), the RDN should provide an initial MNT encounter and additional follow-up encounters as often as every two weeks. Research reports that this frequency and duration of medical nutrition therapy resulted in increased exercise tolerance, higher physical component scores on quality of life measures and decreased anxiety, as well as maintenance of body weight.

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Other Talking Points:

Referral Requirements

In your discussions with decision-makers, the topic of potential referral requirements for RDN-provided MNT services may come up. We recommend not raising the topic, but rather waiting for others to raise it. Ideally, clients would be able to self-refer to an RDN for preventive and disease-management MNT services to reduce barriers to access to care, such as the need for a physician referral or prior authorization. If decision-makers in your state insist on referral requirements, advocate for language that permits referrals from all health care professionals with order-writing privileges within your state scope of practice (e.g., MDs, DOs, NPs, PAs). Note, you may also want to check your current licensure laws for RDNs to determine if referrals are required through those provisions.

Cost-Sharing Requirements

Another topic that may be raised by state decision-makers is cost-sharing, which refers to whether a client is responsible for a co-payment or deductible associated with a service. To encourage their utilization, the ACA includes provisions that waive cost-sharing requirements for preventive services with a Grade A or B rating from the USPSTF. Since MNT meets that criteria having received a Grade B rating, advocate for waiving cost-sharing requirements for these services.
<table>
<thead>
<tr>
<th>Component</th>
<th>Tier 1</th>
<th>Rationale</th>
<th>Tier 2</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any condition for wellness, prevention, and chronic disease management in children and adults</td>
<td>MNT is a proven, effective service for the prevention and treatment of a wide range of conditions/diseases in both children and adults. (supported by USPSTF recommendations)</td>
<td>Any condition for wellness, prevention, and chronic disease management in children and adults</td>
<td>MNT is a proven, effective service for the prevention and treatment of a wide range of conditions/diseases in both children and adults. (supported by USPSTF recommendations)</td>
</tr>
<tr>
<td>Cost-sharing requirements</td>
<td>Waive</td>
<td>Consistent with preventive services under ACA; MNT has Grade B rating from USPSTF</td>
<td>Waive</td>
<td>Consistent with preventive services under ACA; MNT has Grade B rating from USPSTF</td>
</tr>
<tr>
<td>Number of visits covered</td>
<td>Unlimited visits (and hours) annually</td>
<td>Based on the Academy’s EAL; overall, greater frequency of visits may lead to more success in implementing and sustaining behavior change.</td>
<td>Based on recommendations outlined in the EAL. At minimum, 3 hours annually per condition; additional visits available with physician documentation of medical necessity for more MNT</td>
<td>EAL</td>
</tr>
<tr>
<td>Qualified providers of MNT services</td>
<td>RDNs</td>
<td>RDNs are the most cost-effective, qualified healthcare professional to provide MNT (supported by the Institute of Medicine, who recognizes the RDN as “the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.”)</td>
<td>RDNs</td>
<td>RDNs are the most cost-effective, qualified healthcare professionals to provide MNT (supported by the Institute of Medicine, who recognizes the RDN as “the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.”)</td>
</tr>
<tr>
<td>Referral requirements</td>
<td>Self-referral and referral from licensed health care professional</td>
<td>Self-referral promotes access to preventive services and individual self-management of health</td>
<td>Referral from licensed health care professional with order writing privileges</td>
<td>Referral supports “medical necessity” of service. Broad definition of “health care professional” supports access to services in rural and medically under-serviced areas.</td>
</tr>
</tbody>
</table>


12 The Academy’s Evidence Analysis Library can be found at www.adaevidencelibrary.com.

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Return on Investment

States may find the following data useful when demonstrating that RDN-provided MNT is cost-effective and yields a positive return on investment. Refer to the individual studies referenced in the EAL for exact outcome numbers and other data.

- Ten studies were reviewed to evaluate the cost-effectiveness, cost benefit and economic savings of outpatient MNT delivered by RDNs, involving in-depth individualized nutrition assessment and a duration and frequency of care using the Nutrition Care Process to manage disease. Using a variety of cost-effectiveness analyses, the studies affirm that MNT resulted in improved clinical outcomes and reduced costs related to physician time, medication use, and/or hospital admissions for people with obesity, diabetes and disorders of lipid metabolism, as well as other chronic diseases.\(^\text{13}\)

- Four studies in adults with overweight and obesity reported significant effects of MNT provided by a nutrition professional on weight loss. Weight loss ranged from 3.1kg to 5.8kg and 4.9% to 7.9%, with an average of four to 12 visits per year. All studies reported cost benefit or cost-effectiveness effects of MNT provided by a nutrition professional (RDN or equivalent) in adults with overweight or obesity. Cost of interventions ranged from $240 to $328 per person per year. One study reported an MNT benefit of $0.03 per member per year. Studies also reported improvements in quality of life years gained (average, 17 years), reduction in body-weight-related disease burden (0.10% and 0.05%) and reduction in inpatient admissions (2.8% vs. 22.5% in usual care). Incremental cost-effectiveness ratios, a statistic used in cost-effectiveness analysis to summarize the cost-effectiveness of a health care intervention, indicated a cost savings ranging from $52,230 to $99,852 with dietary interventions.\(^\text{14}\)

- Consistent evidence supports the cost-effectiveness, cost benefit and economic savings of outpatient MNT provided by a nutrition professional (RDN or equivalent) in patients with disorders of lipid metabolism (three or more MNT visits over six weeks to three months). Using a variety of cost-effectiveness analyses, the studies affirm that MNT resulted in improved clinical outcomes (total cholesterol and LDL-C, -6% to -13%; triglycerides, -11% to -22%; HDL-cholesterol, +4%; BMI, -4%; quality adjusted life years, +0.75 years to 0.78 years) and lower medication use (savings of $638 to $1,456 per year) in patients with disorders of lipid metabolism. Increased time spent with a nutrition professional resulted in greater improvements.\(^\text{15}\)


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MNT significantly lowered HbA1c by 0.3% to 2.0% in adults with type 2 diabetes. Based on an estimated savings of $820 for each 1% decrease in A1C, cost avoidance is calculated at $246 to $1,640 per person per year.\textsuperscript{16}

**State-Specific Data Gathering**

Information specific to your state will help to support your case for inclusion of RDN-provided MNT in your state Medicaid program. Here are some resources where you can find state specific information:

- **Essential Health Benefits Benchmark Plans:** [www.cms.gov/cciio/resources/data-resources/ehb.html](http://www.cms.gov/cciio/resources/data-resources/ehb.html)
- **George Washington University Report on Medicaid Coverage for Obesity Services:** [blogs.gwu.edu/njannah/medicaid/](http://blogs.gwu.edu/njannah/medicaid/)
- **National Association of Insurance Commissioners:** [www.naic.org/state_web_map.htm](http://www.naic.org/state_web_map.htm)
- **National Governors Association:** [www.nga.org/governors/](http://www.nga.org/governors/)
- **State Medicaid Directors:** [medicaldirectors.org/about/medicaid-directors/](http://medicaldirectors.org/about/medicaid-directors/)
- **State Medicaid website:** [medicaldirectors.org/about/medicaid-directors/](http://medicaldirectors.org/about/medicaid-directors/)
- **The Henry J. Kaiser Family Foundation:** [www.kff.org/state-category/health-status/](http://www.kff.org/state-category/health-status/)
  - Use this resource for data on a particular health issue. Compare your state’s data to national figures and track issues over time.
- **The Patient Centered Primary Care Collaborative:** [www.pcpcc.org/initiatives/state](http://www.pcpcc.org/initiatives/state)
- **USDA Food Environment Atlas:** [www.ers.usda.gov/foodatlas](http://www.ers.usda.gov/foodatlas)
  - This interactive web site provides county and state data on food accessibility, participation in food assistance programs, food insecurity, local foods and diabetes rates.

Next Steps

Change doesn’t happen overnight. Advocacy is a long-term process that requires ongoing attention. Maintain enthusiasm around your advocacy plans by offering clear and tangible next steps, and setting realistic goals and expectations. Once coverage is approved, take advantage of the opportunity to inform regulations and policies. Offering to help develop or review draft language could help to ensure policy details align with your goals. Closely monitor all points of the process by soliciting RDN member feedback to identify and troubleshoot implementation challenges that may arise. Educate affiliate members on new regulations and policies and encourage them to become Medicaid providers. For more examples for what could be a part of your next steps, take a look at the case studies in appendix G. Be sure to stay up to date on successes in other states, new interested parties, new research, and powerful personal stories to continue to share with decision makers.
Summary

Advocating for RDN-provided MNT coverage by your state’s Medicaid program directly supports the Academy’s vision and strategic plan as well as state and federal goals of improving the health care delivery system in order to achieve the triple aim – better care, improved health, and lower costs. To increase the impact of your efforts, ensure a unified voice and strategic approach by collaborating with affiliate leadership, PPP, and Academy staff. The Academy staff are here to support you every step of the way. Consistent, bidirectional communication between your affiliate and Academy staff during the advocacy process is vital to ensure you are receiving the most up-to-date information and resources from the Academy. Additionally, for the Academy staff to provide you with the most helpful information, it is important to keep them abreast of your advocacy efforts and progress. Email updates to reimburse@eatright.org.

In addition to presenting a unified voice from the Academy, consider collaborating with other stakeholder groups to advocate together and build a cohesive strategy that, when implemented, will improve the health of a vulnerable population, Medicaid beneficiaries. When meeting with decision makers, advocate for the coverage outlined in tier one. If a fallback position in negotiation is needed, advocate for tier two using the disease-specific number of visit recommendations from the EAL. Refer to the return on investment data to support your advocacy efforts and be sure to gather and use data specific to your state. Together, a clear strategy will be developed as you explore advocacy for RDN-provided MNT coverage in your state’s Medicaid program. Your efforts will be a big step towards improved health equity for a significant number of people in your state and will create exciting new opportunities for RDNs.
Appendices

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Appendix A: Medicaid Decision Tree

Does Medicaid in your state have MNT benefits?

1. Contact the former Reimbursement Representative and/or State Regulatory Specialist to find out whether s/he can provide any information.

2. Visit your state Medicaid’s website to start researching benefits for nutrition services.

3. Check your state’s Medicaid physician fee schedule online to see if 97802-97804 are payable codes & whether some kind of benefit exists.

4. Call your state Medicaid Office if you are unable to verify the benefit for MNT via the website.

Many state Medicaid programs do not have MNT benefits, since it is not federally required.

Confer with your affiliate leadership and public policy panel to determine whether appropriate to pursue.

Maintain documentation about benefits and nutrition counselling policies that you can share with the Academy, members, and leadership.

Does the affiliate want to pursue efforts for the state Medicaid program to recognize/enroll RDNs as independent Medicaid Providers?

Determine RDN provider status: Does your state enroll the RDN as an independent provider?

Understand benefits for MNT in adult and pediatric populations. For what conditions/diagnoses? # of visits/or units, other requirements. Obtain clinical guidelines and/or policies if possible.

Try one or more of the following to find out:

Obtain enrollment information.

Share Medicaid program nutrition benefits with members through affiliate communications and website.

Provide a link to provider enrollment on affiliate website.

Total Food Cost:

NO

Confirm RDN can provide MNT in a practice if the MD is the billing provider (called “incident to”)

NO

RDNs cannot provide MNT to Medicaid beneficiaries.

YOU

NO

Does the affiliate want to pursue efforts for the state Medicaid program to recognize/enroll RDNs as independent Medicaid Providers?

YOU

YOU

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## Appendix B: Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appropriation Bill</strong></td>
<td>Provides funding for government agencies and programs.</td>
</tr>
<tr>
<td>Reference</td>
<td>Grassroots Advocacy Toolkit&lt;sup&gt;17&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Authorization Bill</strong></td>
<td>Establishes or continues a federal agency or program, establishes conditions under which the program operates and authorizes or approves funding. An authorization bill does not provide the actual funding, which is done in the appropriations bill.</td>
</tr>
<tr>
<td>Reference</td>
<td>Grassroots Advocacy Toolkit&lt;sup&gt;17&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Capitation</strong></td>
<td>A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.</td>
</tr>
<tr>
<td>Reference</td>
<td>Centers for Medicare &amp; Medicaid Services Glossary</td>
</tr>
<tr>
<td><strong>Centers for Medicare and Medicaid Services (CMS)</strong></td>
<td>A federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children’s Health Insurance Program, and health insurance portability standards.</td>
</tr>
<tr>
<td><strong>Children’s Health Insurance Program (CHIP)</strong></td>
<td>Established in 1997, CHIP provides federal matching funds to states in order to establish medical coverage sources for individuals under age 19 whose parents earn too much income to qualify for Medicaid, but not enough to pay for private coverage.</td>
</tr>
<tr>
<td><strong>Cost-Sharing</strong></td>
<td>The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn’t include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.</td>
</tr>
<tr>
<td><strong>Current Procedural Terminology (CPT)</strong></td>
<td>A code set that is used to report medical procedures and services to entities such as physicians, health insurance companies and accreditation organizations.</td>
</tr>
</tbody>
</table>

<sup>17</sup> To access the Grassroots Advocacy Toolkit, contact the DC office of the Academy of Nutrition and Dietetics.
| **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** | A comprehensive and preventive child health program for some Medicaid- or CHIP-enrolled individuals under the age of 21. EPSDT includes periodic screening, vision, dental and hearing services. Reference: [Centers for Medicare & Medicaid Services Glossary and Acronyms](https://www.cms.gov/Medicare/Coding/index.html) |
| **Essential Benefits** | A set of 10 categories of services health insurance plans must cover under the ACA. These include doctors’ services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Some plans cover more services. Specific services may vary based on the state’s requirements. Reference: [Centers for Medicare & Medicaid Services’ Healthcare.gov](https://www.medicaid.gov/medicaid/index.html) |
| **Fee For Service (FFS)** | A payment model where services are unbundled and providers are paid for each procedure or service separately. Reference: [Centers for Medicare & Medicaid Services Glossary and Acronyms](https://www.cms.gov/Medicare/Coding/index.html) |
| **Federal Medical Assistance Percentage (FMAP)** | The portion of the Medicaid program which is paid by the Federal government. Reference: [Centers for Medicare & Medicaid Services Glossary](https://www.cms.gov/medicaid/glossary) |
| **Federal Poverty Level (FPL)** | A measure of income issued every year by the DHHS used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage. Reference: [Centers for Medicare & Medicaid Services’ Healthcare.gov](https://www.medicaid.gov/medicaid/index.html) |
| **Fiscal Year (FY)** | The fiscal year is the accounting period for the federal government which begins on October 1 and ends on September 30. Reference: [United States Senate Glossary](https://www.govinfo.gov/content/pkg/CONGRESS-CONREGULL/CONREGULL-2007.pdf) |
| **“In lieu of” Services** | Considered substituted services covered under the State Plan, under 45 CFR Section 438.3, these alternative services must be deemed by the state to be medically appropriate and cost-effective substitutes, included in the MCO contracts and must be voluntary for members. “In lieu of” services are counted as medical costs in MCO capitation rates. These critical decisions—the setting in which a service is delivered, the type of provider who delivers the service and the... |
| **The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)** | A system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States.  
Reference: Centers for Disease Control and Prevention |
|---|---|
| **Managed Care Organization (MCO)** | In the context of Medicaid, MCOs contract with state Medicaid agencies and accept a set per member per month (capitation) payment to deliver Medicaid health benefits and additional services to enrollees.  
Reference: Centers for Medicare & Medicaid Services Glossary and Acronyms |
| **Medicaid** | A joint federal and state program that helps low-income individuals or families pay for the costs associated with long-term medical and custodial care, provided they qualify. Although largely funded by the federal government, Medicaid is administered by each state, and programs may vary.  
Reference: Centers for Medicare & Medicaid Services Glossary and Acronyms |
| **Medicaid and CHIP State Plan** | A Medicaid and CHIP state plan is an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state.  
Reference: Medicaid State Plan Amendments |
| **Medical Loss Ratio (MLR)** | A basic financial measurement used in the ACA to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The ACA sets minimum medical loss ratios for different markets, as do some state laws.  
Reference: Centers for Medicare & Medicaid Services' Healthcare.gov |
| **Pay-for-Performance (P4P)** | A health care payment system in which providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.  
Reference: [Health Affairs](https://www.healthaffairs.org)

| **Primary Care Provider (PCP)** | A physician (MD – Medical Doctor or DO – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.  
Reference: [Centers for Medicare & Medicaid Services’ Healthcare.gov](https://www.healthcare.gov)

| **Rural Health Clinic (RHC)** | A public or private hospital, clinic, or physician practice certified by the federal government as being in compliance with the Rural Health Clinics Act. The practice must be located in a medically underserved area or a Health Professional Shortage Area and use at least one physician assistant, nurse practitioner, or certified nurse midwife on-site at least 50 percent of the time to deliver services to rural populations. A physician must also be available to supervise the team. Designation as a rural health clinic brings several advantages, including Medicaid reimbursement and drug purchasing availability similar to Federally Qualified Health Centers.  
Reference: [Centers for Medicare & Medicaid Services Glossary and Acronyms](https://www.medicaid.gov)

| **Section 1115 Waiver** | Under section 1115 of the Social Security Act, the Secretary of DHHS is authorized to waive compliance with many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to “promoting the objectives of” the Medicaid program while continuing to receive federal Medicaid matching funds. The waivers, which are granted (or renewed) for five-year periods, are administered by CMS.  
Reference: [Kaiser Commission on Medicaid Glossary](https://www.kff.org)

| **Value Added Services** | “Value added” services (e.g., non-medical, social support services) are defined by the DHHS under 45 CFR Section 158.150 as services/activities that  
(i) Improve health quality.  
(ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.  
(iii) Are directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.  
(continued on next page)
(iv) Are grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations. 

(See reference for additional information.)

Costs for “value added” services may be counted as medical rather than administrative, and therefore be incorporated in the MCO’s medical loss ratio.


<table>
<thead>
<tr>
<th>Value Based Payment (VBP)</th>
<th>Broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures of quality and/or cost or resource use.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reference</strong>:</td>
<td><a href="http://www.chcs.com">Center for Health Care Strategies, Inc.</a></td>
</tr>
</tbody>
</table>

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Appendix C: FAQs

1. Where can I find evidence on the effectiveness of MNT?
   The Academy’s EAL provides a host of data that supports RDNs and MNT coverage of various chronic conditions. Visit the EAL at: www.andeal.org/.

2. What tools/resources should I use when meeting with decision-makers?
   The Academy offers members a variety of materials that translate information from the EAL into user-friendly messages to use with decision makers, including but not limited to the following:
   - MNT Advocacy: A Set of All Handouts
   - Medical Nutrition Therapy MNTWorks® Kit
   - 3rd party payer brochure
   - Blue Cross Blue Shield of North Carolina study (published in journal)
   States decision makers often also want to see local information that supports RDNs and MNT coverage in their area. Gather local data from colleagues and clients across the state, including testimonials on the impact of MNT provided by RDNs and outcomes data on RDN effectiveness. Remember to follow HIPAA privacy laws to protect patient data that is confidential.

3. The Medicaid staff are looking for a definition of “Medical Nutrition Therapy” and “Registered Dietitian Nutritionist.” Where can I find these definitions?
   Definitions for terms such as “Medical Nutrition Therapy” and “Registered Dietitian Nutritionist” and others are listed in the Scope of Dietetics Practice Framework Sub-Committee of the Quality Management Committee’s Definition of Terms List at www.eatrightpro.org/scope. Use of these standardized definitions will ensure consistency within and across states.

4. What key points do I need to include in my communications with decision-makers?
   Letters to decision makers should include the following points:
   - Inclusion of nutrition services
   - MNT as a benefit offering
   - RDNs as providers of nutrition services
   - Cost effectiveness of RDN-provided nutrition services
   - Quality and safety issues and MNT

5. What is the role for Federal Regulations in Medicaid?
   It is the role of federal government to define federal Medicaid requirements along with defining minimum state provider options and authorities. The federal mandate does NOT include coverage for Nutrition Services.

6. What is the role for individual states regarding Medicaid coverage?
   States have a great deal of flexibility in designing and administering their Medicaid program. Utilizing broad federal regulations to design and manage their own Medicaid program, states determine program eligibility and covered services, define who can provide those services, set payment rates/fee schedules, and identify models for payment. States also have the choice
of covering other optional benefits beyond those required by Federal law. As a result, Medicaid eligibility and benefits can and often do vary widely from state to state.

7. Are states required to cover preventive services for adults under the Medicaid expansion provision of the ACA?

States must cover preventive services for adults newly eligible for Medicaid under the ACA, but this is not required for the group of adults enrolled in or eligible for traditional Medicaid prior to the ACA’s expansion of the program.

8. What are considered preventative counseling benefits?

- Healthy diet counseling to prevent cardiovascular disease
- Obesity screening and counseling (adults & children)
- Prediabetes screening and referral for intensive behavioral counseling interventions

9. How does the increasing use of APMs in Medicaid programs impact how I advocate for MNT?

A growing number of Medicaid programs are requiring the use of alternative payment models to pay providers, as one way to incentivize the delivery of health care services that will lead to improvements in health outcomes. APMs - not straight fee-for-service payments - provide practices with different forms of payment that can enable greater flexibility in what services the practice can provide. An example might be MNT that might not otherwise be a reimbursable service in a state Medicaid program in fee for service model. When advocating for coverage of MNT services provided by RDNs under APMs, focus on the inclusion of specific language that requires such services as part of the bundle or episode of care. For example, recommend language that allows Per-Member-Per-Month payments to be used to integrate RDNs into provider practices. Also focus on the value RDNs bring by helping to reduce the total cost of care.
Appendix D: Medicaid MNT Reimbursement Inquiry Tool

Date: _________________________________ Name: ______________________________________________________

Representative: ____________________________________ Source of data collected: ___________________________

Delivery System: Traditional Medicaid ☐ MCO ☐

Name of MCO (use a separate form for each MCO): ______________________________________________________

Benefit Period: _________________________________________ to _________________________________________

*Can RDNs provide Nutrition Counseling/Medical Nutrition Therapy services?  Yes ☐ No ☐

If yes, indicate the following CPT codes they can bill: 97802 ☐ 97803 ☐ 97804 ☐

Is preauthorization required? Yes ☐ No ☐

Is this benefit limited to a specific diagnosis or co-morbidity? Yes ☐ No ☐

If yes, which ones? __________________________________________________________________________

Is this benefit limited to a specific population? Yes ☐ No ☐

If yes, indicate which ones: Adult ☐ Pediatrics ☐ Other: _______________________________________

Are RDNs considered eligible as providers? Yes ☐ No ☐

If no, who are considered eligible providers? ____________________________________________________

Is there a physician referral needed? Yes ☐ No ☐

Are there limits to getting paid by practice setting? Yes ☐ No ☐

If yes, what are the limits? _____________________________________________________________________

Are there limits to getting paid by number of units: Yes ☐ No ☐

If yes, what are the limits? _____________________________________________________________________

*RDNs may be able to provide and bill for additional services; capture these details on the next page(s).
Additional Nutrition-Related Services Covered by State Medicaid Program

Visit the CPT and G Codes page on the Academy’s website to find additional codes RDNs may be able to bill.

Date: _________________________________ Name: ______________________________________________________
Representative: _____________________________ Source of data collected: __________________________________

For any service RDNs are able to provide under the delivery system, fill out the following details:

Name of Service: ____________________________________________________________

Codes to bill: ________________________________________________________________

Benefit Period: ___________________________ to ____________________________

Is preauthorization required? Yes ☐ No ☐

Is this benefit limited to a specific population? Yes ☐ No ☐

Is this benefit limited to a specific diagnosis or co-morbidity? Yes ☐ No ☐

If yes, which ones? __________________________________________________________

Is this benefit limited to a specific population? Yes ☐ No ☐

If yes, indicate which ones: Adult ☐ Pediatrics ☐ Other: __________________________

Are RDNs considered eligible as providers? Yes ☐ No ☐

If no, who are considered eligible providers? __________________________________

Is there a physician referral needed? Yes ☐ No ☐

Are there limits to getting paid by practice setting? Yes ☐ No ☐

If yes, what are the limits? __________________________________________________

Are there limits to getting paid by number of units: Yes ☐ No ☐

If yes, what are the limits? __________________________________________________

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Appendix E: Resources and References

General

- Electronic Clinical Quality Improvement (eCQI) Resource Center. ecqi.healthit.gov/.

• Medicaid Manager Care Market Tracker. Henry J Kaiser Family Foundation. 2019. [www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?activeTab=map&currentTimeframe=0&selectedDistributions=total-medicaid-mcos&sortModel=%7B%22coll%22:%22Total%20MCOs%22,%22sort%22:%22desc%22%7D](www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?activeTab=map&currentTimeframe=0&selectedDistributions=total-medicaid-mcos&sortModel=%7B%22coll%22:%22Total%20MCOs%22,%22sort%22:%22desc%22%7D).


• U.S. Preventive Services Task Force (USPSTF) Grade Definitions. [www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions](www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions).

**From the Academy**


• Grassroots Advocacy Guidebook. Academy of Nutrition and Dietetics. 2018. [18](#)

• Grassroots Advocacy Toolkit. Academy of Nutrition and Dietetics. 2018. [18](#)


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18 To access the Grassroots Advocacy Guidebook, contact the DC office of the Academy of Nutrition and Dietetics.

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• Resources to Promote MNT Coverage. www.eatrightpro.org/payment/nutrition-services/promoting-nutrition-services/resources-for-promoting-nutrition-services.

State-Specific Data Gathering

Information specific to your state will help to support your case for inclusion of RDN-provided MNT in your state Medicaid program. Here are some resources where you can find state specific information:

• Essential Health Benefits Benchmark Plans: www.cms.gov/cciio/resources/data-resources/ehb.html
• George Washington University Report on Medicaid Coverage for Obesity Services: blogs.gwu.edu/njannah/medicaid/
• National Association of Insurance Commissioners: www.naic.org/state_web_map.htm
• National Governors Association: www.nga.org/governors/
• State Medicaid Directors: medicaiddirectors.org/about/medicaid-directors/
• State Medicaid website: medicaiddirectors.org/about/medicaid-directors/
• The Henry J. Kaiser Family Foundation: www.kff.org/state-category/health-status/
  ○ Use this resource for data on a particular health issue. Compare your state’s data to national figures and track issues over time.
• The Patient Centered Primary Care Collaborative: www.pcpcc.org/initiatives/state
• USDA Food Environment Atlas: www.ers.usda.gov/foodatlas
  ○ This interactive web site provides county and state data on food accessibility, participation in food assistance programs, food insecurity, local foods and diabetes rates.

Here are some of the resources used in the case studies in Appendix G:

• Nevada Medicaid Services Manual: http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C600/Chapter600/

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• South Dakota Medicaid Professional Services Billing Manual: https://dss.sd.gov/medicaid/providers/billingmanuals/

Resources for Definitions from Appendix B

• Centers for Disease Control and Prevention (CDC): www.cdc.gov
• Center for Health Care Strategies (CHCS), Inc.: www.chcs.org/
• Centers for Medicare & Medicaid Services: www.cms.gov/apps/glossary
• Centers for Medicare & Medicaid Services’ Healthcare.gov: www.healthcare.gov/glossary/
• Electronic Clinical Quality Improvement (eCQI) Resource Center: ecqi.healthit.gov/
• Healthcare.gov: www.healthcare.gov/glossary/cost-sharing/
• Health Care Payment Learning & Action Network: hcp-lan.org/
• The Kaiser Commission on Medicaid Glossary: kaiserfamilyfoundation.files.wordpress.com/2013/05/mrbglossary.pdf
• Ohio.gov: www.healthtransformation.ohio.gov/Portals/0/OHT%20Web-Archive%20docs%202011/OHT%20Glossary%20of%20Terms%20v2.pdf?ver=2012-06-13-114309-873
• United States Senate Glossary: www.senate.gov/reference/glossary_term/fiscal_year.htm
**REIMBURSEMENT FOR MEDICAL NUTRITION THERAPY BY RDNS IN NEVADA**

**PRIOR AUTHORIZATION REQUIREMENTS**

Prior authorization is required when the service limitation has been met and recipients require additional or repeat training sessions beyond the permitted maximum number of hours of treatment. This can occur if there is a change of diagnosis, medical condition, or treatment regimen related to a nutritionally related disease state.

To request authorization, complete form FA-9 and use the online prior authorization system to complete/submit required information online.

**COVERAGE AND LIMITATIONS**

1. MNT is covered for recipients diagnosed with diabetes, obesity, heart disease, and hypertension. It is initiated from a referral from a primary care physician, PA or APRN and includes information on labs, medications and other diagnoses. MNT includes:
   a. A comprehensive nutritional and lifestyle assessment determining nutritional diagnosis.
   b. Planning and implementing a nutritional intervention and counseling using evidence-based nutrition practice guidelines to achieve nutritional goals and desired health outcomes.
   c. Monitoring and evaluating an individual’s progress over subsequent visits with a registered dietitian.

2. Coverage of services includes:
   a. Initial nutrition and lifestyle assessment.
   b. One-on-one or group nutrition counseling.
   c. Follow-up intervention visits to monitor progress in managing diet.
   d. Reassessments as necessary during the 12-rolling month episode of care to assure compliance with the dietary plan.
   e. Four hours maximum in the first year.
      i. Additional hours are permitted if treating physician determines a change in medical condition, diagnosis or treatment regimen requires a change in MNT.
      ii. Additional hours beyond the maximum four hours in the first year require prior authorization.

---

iii. Documentation should support the patient’s diagnosis of the specific condition, along with the referral from the physician managing the patient’s condition.

iv. The documentation should also include a comprehensive plan of care, individualized assessment and education plan with outcome evaluations for each session, as well as referring physician feedback.

v. There should be specific goals, evaluations and outcome measures for each session documented within the patient’s records.

f. Two hours maximum per 12 rolling month period in subsequent years.

g. Services may be provided in a group setting. The same service limitations apply in the group setting.

3. MNT is not to be confused with Diabetic Outpatient Self-Management Training
   a. The DHCFP considers Diabetic Outpatient Self-Management Training and MNT complementary services. This means Medicaid will cover both Diabetes Outpatient Self-Management Training and MNT without decreasing either benefit as long as the referring physician determines that both are medically necessary.
   b. See MSM Chapter 600, Attachment A, Policy #6-10 for DSMT coverage.

4. MNT is only covered for the management of diabetes, obesity, heart disease and hypertension-related conditions.

5. MNT may be provided through Telehealth services. See MSM Chapter 3400 for the Telehealth policy.
1. "Medical nutrition therapy" is the use of specific nutrition services to treat an illness, injury, or condition. Medical nutrition therapy services include nutrition assessment, intervention, and counseling.

2. "Registered dietitian nutritionist" has the same meaning as "registered dietitian" in Chapter 4759 of the Revised Code.

3. "Licensed dietitian" has the same meaning as "licensed dietitian" in Chapter 4759 of the Revised Code.

PROVIDERS
1. Rendering providers. The following eligible providers may render a medical nutrition therapy service:
   a. A registered dietitian nutritionist; or
   b. A licensed dietitian.

2. Billing ("pay-to") providers. The following eligible providers may receive Medicaid payment for submitting a claim for a medical nutrition therapy service on behalf of a rendering provider:
   a. An independent registered dietitian nutritionist;
   b. An independent licensed dietitian;
   c. A professional medical group; or
   d. A fee-for-service ambulatory health care clinic.

COVERAGE
Payment may be made for the following three medical nutrition therapy services listed in "Current Procedural Terminology," published by the American medical association (AMA), www.ama-assn.org:
1. Initial assessment and intervention;
2. Reassessment and intervention; and
3. Group counseling.

CLAIM PAYMENT
Payment for a covered medical nutrition therapy service is the lesser of the submitted charge or the amount shown in appendix DD to rule 5160-1-60 of the Administrative Code.

5101:3-4-34 Preventive medicine services.

A. Preventive medicine is that part of medicine engaged with preventing disease and the maintenance of good health practices. The purpose of preventive medicine is to take a proactive approach to avoiding disease, disability, and death.

B. Medicaid-covered preventive medicine services may include, but are not necessarily limited to:
   1. Routine infant checkups;
   2. All healthchek (EPSDT) services in accordance with Chapter 5101:3-14 of the Administrative Code;
   3. Immunizations in accordance with rule 5101:3-4-12 of the Administrative Code;
   4. Gynecologic examinations that include pelvic and breast examinations, and pap smears;
5. Pregnancy prevention/contraceptive management visits and services in accordance with rule 5101:3-21-02 of the Administrative Code;
6. Pregnancy-related services in accordance with rule 5101:3-21-04 of the Administrative Code;
7. Mammography services in accordance with rule 5101:3-4-25 of the Administrative Code;
8. Required physicals for employment or for participation in job training programs, when the employer does not provide a physical free of charge or when other available funds do not pay for an employment physical. Documentation to support that the physical was performed for employment must be in the patient’s medical records. If the recipient is over age 20, providers should bill the proper office visit code (not preventive visit code);
9. The required physician visits and annual chest x-rays for long-term care facility residents;
10. Required annual physical examinations for individuals living in residential facilities licensed by the Ohio department of mental retardation and developmental disabilities. This annual examination is not required for those individuals who are receiving ongoing medical services from a licensed physician;
11. Prostate cancer screening tests;
12. Glaucoma screening in accordance with Chapter 5101:3-06 of the Administrative Code;
14. Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit;
15. Medical nutritional therapy
   a. When medical nutritional services are provided by a registered dietitian, providers should do the following:
      i. Use the medical nutrition therapy codes 97802 to 97804;
      ii. Use the AE modifier; and
      iii. Bill under the national provider identifier of the supervising physician, physician assistant, or advanced practice nurse.
   b. When medical nutritional services are provided by a physician or physician assistant, providers should use the appropriate evaluation and management or preventive medicine code.
   c. When medical nutritional services are provided by an advanced practice nurse, providers should use either the medical nutrition therapy code or the appropriate evaluation and management or preventive medicine code; and
16. Tobacco cessation counseling (99406 and 99407) and classes (S9453) are covered for the following populations:
   a. Pregnant women; and
   b. Children under the age of twenty-one.
Nutritional Therapy Services in South Dakota

Nutritional therapy is covered under South Dakota Medicaid for individuals when ordered by the physician or other licensed practitioner as part of the care and treatment of a medical condition or a malfunction in the gastrointestinal tract. Nutritional therapy must be the sole source of nutrition for individuals over the age of 21 years. Nutritional supplementation is covered for individuals under the age of 21 years.

Nutritionists and dietitians must be licensed according to the provisions of South Dakota Codified Law (SDCL) Ch. 36-10b or licensed in their state of practice according to licensing standards not less stringent than South Dakota. Medicaid recipients are limited to 1 hour of services a day and 5 hours of services a year. Medicaid recipients under 21 years of age may exceed these limits with a prior authorization if additional services are medically necessary. Services must be provided according to a written plan.

DEFINITIONS

The following terms are defined according to Administrative Rule of South Dakota (ARSD) §67:16:42:01.

1. Enteral nutritional therapy — nutritional therapy by way of the small intestine through nasogastric, jejunostomy, or gastrostomy tubes.
2. Nutritional supplement — specialized formulas required to increase a child's daily protein and caloric intake.
3. Nutritional therapy — specialized formulas or hyper alimentation which serves as the sole means of nutrition and is required when nutrition cannot be sustained through oral feedings due to a chronic illness or trauma.
4. Parenteral nutritional therapy — nutritional therapy by intravenous injection or also referred to as total parenteral nutrition.

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PROVIDERS

Nutritional therapy may be billed to South Dakota Medicaid by enrolled durable medical equipment (DME) or pharmacy providers. These claims must be submitted on a CMS 1500 claim form.

ENTERAL NUTRITIONAL THERAPY

Enteral nutritional therapy is covered when the recipient has a functioning gastrointestinal tract but cannot maintain weight and strength commensurate with the recipient’s general condition because of a medical condition or illness or pathology to or the nonfunctioning of the structures that normally permit food to reach the digestive tract. This service is subject to additional restrictions based on the age of the recipient at the time of service.

ENTERAL NUTRITIONAL THERAPY FOR INDIVIDUALS UNDER AGE 21

Enteral nutritional therapy, oral nutritional supplements, and electrolyte replacement for recipients less than 21 years of age are covered when the following conditions are met:

- The recipient is not institutionalized and services are delivered in the recipient’s residence. An individual’s residence does not include an acute care hospital, a nursing facility, an intermediate care facility for the individuals with intellectual disabilities, or an institution for individuals with a mental disease;
- If eligible for the Supplemental Nutrition Program for Women, Infants, and Children operated by the Department of Health, the items and services are not available under that program or the physician’s order exceeds the amount allowed under that program; and
- The items are ordered by a physician.

Oral nutritional supplements are covered when a child cannot maintain normal protein or caloric intake from a daily nutritional plan or when a normal infant formula cannot be tolerated because of a condition or illness.

No prior authorization is required for recipients under 21 years of age. However, the provider must maintain a current Certificate of Medical Necessity and the physician or other licensed practitioner’s prescription on file.

ENTERAL NUTRITIONAL THERAPY FOR RECIPIENTS AGE 21 AND OLDER

Enteral nutritional therapy for a recipient who is 21 years of age or older is covered if all of the following conditions are met:

- The recipient is not institutionalized and services are delivered in the individual’s residence. For purposes of this rule, an individual’s residence does not include an acute care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a mental disease;
- The recipient has a permanently inoperative internal body organ or an inoperative body function;
• There is a physician or other licensed practitioner order or prescription for the therapy and sufficient medical documentation describing the medical necessity for the therapy;
• The provider has completed and received prior authorization from South Dakota Medicaid; and
• Enteral nutritional therapy is the only means the recipient has to receive nutrition.

PRIOR AUTHORIZATION REQUIRED FOR ENTERAL NUTRITIONAL THERAPY FOR RECIPIENTS AGE 21 AND OLDER
The Division of Medical Services must authorize the use of enteral nutritional therapy for an individual 21 years of age or older before the service is payable by South Dakota Medicaid. The DME – Nutrition Prior Authorization information can be found in the Prior Authorization Manual. Before authorization is given, the provider must submit the following:
• A copy of the prescription for the needed therapy;
• A copy of the certificate of medical necessity signed by the prescribing physician giving the reasons the person is unable to receive adequate nutrition by normal means;
• The applicable procedure codes for the nutritional formula;
• The provider’s usual and customary charge for the items or services, including formula, durable medical equipment, and supplies; and
• Documentation regarding other requested routine medical services, such as home health services

If there is no change in the physician or other licensed practitioner orders and a three-month reauthorization is being requested, documentation need only include the physician’s certification that the individual continues to need nutritional therapy.

If the therapy changes a new authorization must be obtained or if the condition is not permanent the authorization may not exceed three months.

The provider is responsible for submitting the documentation for a new authorization. Authorizations will be given from the date of contact.

PARENTERAL NUTRITIONAL THERAPY
Parenteral nutritional therapy is covered if all of the following conditions are met:
• The recipient is not institutionalized and services are delivered in the individual’s residence. A recipient’s residence does not include an acute care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or an institution for individuals with a mental disease;
• The recipient has a permanently inoperative internal body organ or an inoperative body function such as severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the recipient’s general condition;
• There is a physician’s order or prescription for the therapy and medical documentation describing the diagnosis and the medical necessity for the therapy;
• The provider has completed and received prior authorization from South Dakota Medicaid; and
• Parenteral nutritional therapy is the only means the recipient has to receive nutrition.

PRIOR AUTHORIZATION REQUIRED FOR PARENTERAL NUTRITIONAL THERAPY
The department must authorize the use of parenteral nutritional therapy services before they are payable. Before authorization is given, the physician/provider must submit the following:
• A copy of the prescription for the needed therapy;
• A copy of the certificate of medical necessity signed by the prescribing physician and giving the reasons the person is unable to receive adequate nutrition by normal means;
• The applicable procedure codes for parenteral nutrition;
• The provider's usual and customary charge for the items or services, including formula, durable medical equipment, and supplies;
• Documentation regarding other required routine medical services, such as home health.

If there is no change in the physician's orders and a three-month reauthorization is being requested, documentation need only include the physician's certification that the individual continues to need nutritional therapy.

For conditions that are not permanent, an authorization may not exceed three-months. Authorizations are given from the date of contact.

NUTRITIONAL THERAPY AND NUTRITIONAL SUPPLEMENTS LIMITS
The list of covered enteral therapy, oral nutrition, electrolyte replacement, and parenteral therapy services and supplies are maintained on the Department's website. The following restrictions also apply:

Therapy services and their associated rates of payment are subject to review and amendment under the provisions of ARSD § 67:16:01:28.

Enteral therapy for individuals age 21 and older and parenteral therapy must have prior approval from the Division of Medical Services.

Equipment necessary to administer the parenteral or enteral nutritional therapy are covered under the provisions of chapter ARSD § 67:16:29.

RATE OF PAYMENT
Payment for nutritional therapy, nutritional supplements, and electrolyte replacements is the lesser of the provider's usual and customary charge or the applicable fee listed on the Department's website.
When no fee is specified for nutritional formulas, payment is limited to 60 percent of the provider’s usual and customary charge. Supplies and administration kits are paid at 90 percent of the provider’s usual and customary charge.

BILLING REQUIREMENTS

A provider submitting a claim for reimbursement must submit the claim at the provider’s usual and customary charge. The claim must contain the applicable procedure codes for all items and services provided. A claim may not be submitted for parenteral therapy or for enteral therapy for adults, age 21 years and older, without prior authorization from the Division of Medical Services.

A claim for intermittent home health skilled nursing visits must meet the requirements of ARSD § 67:16:05.

PARENTERAL REQUIREMENTS
Costs of professional intervention services, such as nursing and dietary services, which are pertinent to parenteral therapy, are included in the cost of the parenteral therapy.

ENTERAL REQUIREMENTS
Enteral nutrition that is administered orally must be billed with the “BO” modifier attached to the corresponding HCPCS code.

Enteral nutrition is billed at 100 calories = 1 unit

Wyoming

DIETITIAN SERVICE COVERAGE POLICY WYOMING MEDICAID – EFFECTIVE JULY 1, 2016

Beginning July 1, 2016 licensed (or the equivalent in the state where the services are being rendered) dietitians are able to enroll and bill directly to the Wyoming Medicaid program.

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### LIMITATIONS
- Dietitian services must be ordered by a physician or nurse practitioner.
- Medicaid clients 21 years of age and older are subject to a service cap limit of 20 visits per calendar year.
- Medicaid clients under 21 years of age do not have a cap limit on visits.

**NOTE:** Review Chapter 6 for the complete Cap Limit and Cap Limit Waiver policy and procedures.

### COVERED CPT CODES AND DOCUMENTATION
- **97802** – *Medical Nutrition Therapy; Initial Assessment and Intervention, Individual, Face-to-face with the Patient, Each 15 Minutes* – Maximum allow 4 units per day
- **97803** – *Medical Nutrition Therapy; Re-Assessment and Intervention, Individual, Face-to-face with the Patient, Each 15 Minutes* – Maximum allow 4 units per day
- **97804** – *Medical Nutrition Therapy; Group (2 or More Individual(s)), Each 30 Minutes* – Maximum 2 units per day

Medical Nutrition Therapy documentation shall contain the following elements:

A. **Date of MNT visit along with Beginning and Ending Time of visit;**
B. **ICD-10 code** – defines type of visit/counseling;
C. **Subjective Data:**
   1. Client’s reason for visit
   2. Primary care physician
   3. History
      a. past and present medical
      b. nutrition including food patterns and intake
      c. weight
      d. medication
      e. exercise
D. **Objective Data:**
   1. Laboratory results (if available)
   2. Height, weight
   3. BMI
   4. Calorie needs
   5. Drug/nutrient interactions
E. **Individual Assessment of Diet/Intake:**
   1. Laboratory results (if available)
   2. Height, weight
   3. BMI
   4. Calorie needs
   5. Drug/nutrient interactions
F. **Plan:**
   1. Individualized dietary instruction that incorporates diet therapy counseling and education handouts for nutrition related problem.
   2. Plan for follow-up.
   3. Documentation of referral for identified needs.
4. Send a letter to the client’s physician describing dietary instruction provided and progress. A copy of the letter should be placed in the client’s medical record.

G. Date and legible identity of provider:
   1. All entries must be signed and dated by the provider.

ADDITIONAL INFORMATION

- Enrollment application
- Medicaid payment is payment in full and no balance billing is allowed. For additional Medicaid information please review the provider responsibilities located in CMS 1500 Manual and your provider agreement
- All National Correct Coding Initiative (NCCI) editing applies. For additional information and code lists visit NCCI
- On July 1st, 2015 – Medicaid implemented an electronic claims mandate. All claims must be submitted electronically. For additional information regarding Wyoming Medicaid’s free billing software review Chapter 8 in the CMS 1500 Manual or contact EDI Services at 1-800-672-4959 option 3
- October 1st, 2015 – ICD-10 diagnosis codes will be required on all claims
- Contact Provider Relations for billing questions, client eligibility verification, etc. 1-800-251-1268, M-F, 9 am – 5 pm MST.
Appendix G: Case Studies

Case Study 1: Ohio Medicaid

Background:
Before 2011, Ohio Medicaid coverage status had initially been limited to:

- Bureau of Crippled Children (now Bureau of Children with Medical Handicaps) paid for home services and products for eligible participants.
- Select prenatal clinics throughout the state included dietary counseling when provided by RDNs to Medicaid beneficiaries diagnosed with gestational diabetes; this was recognized as a covered benefit when billed with CPT code S9470.
- County hospitals included an RDN-provided care in various outpatient clinic teams throughout the state. Reimbursement for their services could be considered a “bundled payment.”

The ACA allows public insurance money to be spent on preventive care. Given these limitations for RDNs in the state of Ohio and these potential new opportunities brought on by the ACA, the state Affiliate Legislative Committee Chair initiated an advocacy effort for expanded coverage.

Developing Relationships and Reviewing the Climate:
The Ohio Affiliate Legislative Committee Chair, Pat McKnight, began the process in 2007 when she approached the director of Medicaid, Barbara Edwards, for MNT reimbursement. The director and subsequent directors she approached all denied her request. Despite the denials, a relationship between the state affiliate and the Department of Medicaid formed.

In the spring of 2011, the Office of Health Transformation was formed within the Ohio Department of Medicaid, and new Medicaid director, John McCarthy, was appointed. The Ohio Affiliate determined this climate was right to take the next steps in defining a request.

The first goal was to form a relationship with this new Medicaid director who was holding public town meetings in healthcare institutions around the state. Pat McKnight asked Heather Butscher, the affiliate’s delegate, and Karen Stanfar, the Cleveland district public policy representative, to attend the Cleveland-based town meeting to see if they could somehow approach the subject of MNT coverage with him. To their dismay, nutrition was not discussed during the presentation, so they approached the Director as he was packing up and asked if he would consider adding preventive nutrition services to the list of covered services. Director McCarthy responded that he would consider the request if they sent a formal business proposal outlining the details of the request. A task force of affiliate RDNs was then formed to prepare this proposal.

Identifying Key Issues:
The task force included Jane Korsberg, (Affiliate Reimbursement Representative), Karin Palmer (Cleveland District Reimbursement Representative), Karen Stanfar (Cleveland District Public Policy Chair) Heather Butscher (Affiliate Delegate) and Greg Avellana (Columbus District Public Policy Representative). Their first task was to find out more information about (a) the current status of Medicaid

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24 Thank you to Karen Stanfar, MPH, RDN, LD for this case study.

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reimbursement and (b) reimbursement issues that required improvement through a survey of Ohio hospitals. One hundred hospital nutrition departments were contacted by phone to complete the survey through an interview process with results recorded in an online survey tool which would also analyze the results. The team of five called the one hundred hospitals listed in the hospital association directory; however, only thirty-four dietitians responded to the phone call and ultimately agreed to be interviewed.

The data was compiled, and findings included the following:

- Most services were provided in county hospitals.
- Many patients who were referred for MNT did not schedule appointments due to lack of coverage.

Additionally, a chart of the most common conditions for which patients were referred for medical nutrition therapy was developed using survey results. The results of this needs assessment became a focal point of the proposal which Karen Stanfar began to write.

![Pie Chart: Most Common Conditions For Which Patients are Referred for Medical Nutrition Therapy (MNT)](image)

**Defining the Request:**
Through a process of identifying key issues, developing relationships, and reviewing the climate, the Ohio legislative committee was able to start defining the request with administrative employees in the department of Medicaid to prepare a draft administrative rule that allowed reimbursement for MNT.
This formal, written proposal was reviewed by other affiliate leaders in Ohio including Marsha Schofield and Cyndee Stegman for content and comparisons of language to the rules of other state Medicaid departments. The proposal underwent several revisions and the final version was signed by Cyndee Stegman, the Ohio Affiliate President in November of 2011.

During the proposal revisions, Pat McKnight followed the process of ACA compliance initiative in the Medicaid offices. She had shared one of the proposal drafts with the staff there so that the regulatory rules could be drafted with the preferred language. The final proposal was completed and signed at the same time as the legislative rule was presented for hearing to Director McCarthy and other Medicaid officials.

**The Result:**
The proposed administrative rules that include the MNT codes were filed for review in November 2011. The Medicaid proposal was used as support for the addition of these MNT codes at two hearings. The Administrative Rule as proposed needed some corrections, which were then made. In December 2011, it was ruled that several preventive services were to be added as covered benefits under Ohio Medicaid beginning January 1, 2012:

- Tobacco cessation
- Colonoscopy
- Mammography
- GYN exam
- Glaucoma screening
- Prostate CA screening
- Medical Nutrition Therapy

It was determined that billing for these services must be done by a Medicaid certified provider; unfortunately, the RDN was not recognized as a certified provider and could not bill Medicaid directly. However, due to further efforts that extended into May of 2017, the following were eventually realized:

- Medicaid numbers awarded to RDNs upon application.
- Medicaid beneficiaries could now see RDN in a facility or in private setting.
- Physician referrals still required.
- Training offered by the Department of Medicaid to any RDNs who had applied for a Medicaid number.
- Traditional Medicaid which is administered by public employees pays RDNs.

**Advocacy Efforts Continuing into 2018:**
Once reimbursement rules became effective, the staff in the Department of Medicaid began to focus on the number of RDN providers with Medicaid numbers and patient utilization, both of which were insufficient to support the service. The office promoted the MNT benefit on their website while members of the original team promoted becoming a Medicaid provider through presentations at state public policy day meetings. A barrier discussed between the advocacy team and Medicaid staff was the lack of MCO networks open to RDN providers. Because 80% of funds were redirected to MCOs,
utilization would remain low without the opening of these networks. These networks were finally opened in 2018 through a series of letter writing from private practice dietitians, administrators for the Ohio Bureaus of Children with Medical Handicaps, and pressure from Medicaid ombudsmen.

Issues continued concerning Ohio’s largest MCO, which began recognizing Ohio RDNs as out-of-network providers but continues to refuse dietitians in-network status.

Lessons Learned:
Ohio RDNs have been very visible with Medicaid for over 10 years. Ohio RDNs have found visibility, visibility, visibility "at every table" eventually pays off. To succeed, RDNs must understand that the process is arduous and requires long-term attention from those initiating the changes. They must also understand that the business of credentialing and contracting is essential to proceeding; it cannot be presented as a demand if supportive relationships between the regulatory agencies and the affiliate is desired. In addition, dietitians undertaking the responsibility of becoming a Medicaid provider must display credible business conduct and promote utilization of their services through education and marketing to other healthcare professionals and government agencies.
Case Study 2: Wyoming Medicaid

Background:
In 2015, the Wyoming Academy of Nutrition and Dietetics (WAND) established some Public Policy Panel priorities related to their state’s Medicaid program. They were looking to focus on (1) bringing legislative awareness to the cost effective care RDNs provide, (2) drafting a bill that changes state statutes so MNT would be a covered service under Medicaid, and (3) ensuring that RDNs would be recognized as health care providers for these services. When advocacy efforts began based on these priorities, RDNs in Wyoming were unable to contract directly with Medicaid and could only provide services ‘incident to’ a physician or physician assistant. The state’s reimbursement representative and public policy coordinator worked together on these efforts, and in the end they saw some wonderful success.

Identifying Key Issues:
The first step was to identify key issues that advocacy efforts would aim to solve in the state. Around the time these efforts began in 2015, the Wyoming residents at greatest risk of obesity and related chronic disease had the worst access to nutrition counseling as a preventive service. While MNT and diabetes self-management training were covered services under Wyoming Medicaid, licensed dietitians were required to provide and bill for those services ‘incident to’ the physician. The service provision policies, as written, made utilization of MNT services difficult, which ultimately resulted in a primary health care access problem.

Determining Needs:
Once key issues were identified, the second step was to determine what would need to change or happen in order to make progress on ensuring more Wyoming residents would obtain coverage for nutrition services provided by RDNs under the state Medicaid program. In December 2014, the WAND reimbursement representative and public policy coordinator met with the provider operations administrator in the Division of Healthcare Financing, the Medicaid Analytics, Informatics, MMIS, and Special Projects Unit (AIMS) Manager, and the provider services manager of the Wyoming Department of Health to identify exactly which statutes/rules/policies would need to be changed to reach their goals. Following the meeting and many email correspondences, the small team learned that a state statute change was necessary for RDNs to be recognized as direct health care providers for Wyoming Medicaid.

Developing Relationships and Reviewing the Climate:
Once the team learned that a state statute change would be necessary to make progress on their goals, they then moved on to the third step, developing relationships with individuals and organizations to assist them in meeting their goals. They connected with one legislative member in the House of Representatives who was willing to support necessary statute changes and the State Insurance Commissioner served as a resource for identifying and understanding current applicable health care

Thank you to Georgia Boley, MS, RDN for this case study.

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The team also continued to try to connect with more legislative members monthly through calls and emails.

Additionally, the Wyoming Medical Society was identified as a supportive organization willing to help. Together, this team started work to define the request to authorize Medicaid payment for services rendered by a dietitian.

Defining the Request:
The legislative member made sure this proposal for a statute change got on the appropriate legislative committee (Wyoming’s Joint Labor, Health, and Social Services Committee) agenda to present the proposed changes. The advocacy team at WAND attended one of their meetings ahead of time in order to meet members of the committee during breaks, and to observe the process of presenting a requested statute change.

The main focus of this request was to emphasize how it was a primary health care access problem for Wyoming residents. In addition to this argument, they also included the four main points:

1. Licensed Dietitians are recognized as direct health care providers for all other health insurance plans in the state.
2. While RDN services are already part of Wyoming Medicaid, evidence of these services are hidden under hospital and “incident to” care and cost. This makes it more difficult to track utilization and value of dietitian services in the state.
3. There is minimal cost associated with nutrition services provided by RDNs. Over Wyoming’s 884,988 Medicaid member months in state fiscal year 2015, the first cut at an annual cost estimate would be approximately $27,000.
4. There is high value to these services; one study showed for every $1 invested in RDN-led programs, there was a $14.58 return on investment related to prevention of disease progression and subsequent overall health care cost.

The Result:

Effective July 1, 2016, licensed dietitians in the state of Wyoming are now able to enroll and bill directly for MNT to the state’s Medicaid program, with the following limitations:

- RDN services must be ordered by a physician or nurse practitioner.
- Medicaid clients 21 years of age and older are subject to a service cap limit of 20 visits per calendar year.
- Medicaid clients under 21 years of age do not have a cap limit on visits.

Considering where they started, this was a significant win for RDNs in Wyoming.
Lessons Learned:
1. It is a long process- patience is necessary.
2. Because Wyoming is very conservative state, we emphasized the fiscally responsible argument to covering MNT services provided by RDNs. We found that paying attention to the priorities and ideology of our audience was an important component to our success.
3. Resources that were helpful:
   a. The Academy’s resources such as Medical Nutrition Therapy MNTWorks® Kit
   b. The General provider information manual (accessed 10/13/15; pp. 201-222)
   c. The Incremental Value of Medical Nutrition Therapy in Weight Management (accessed 10/13/15)
   d. Franz Fuchs- e-mail to Representative Barlow dated 9/24/15.
   e. Wolf AM, Crowther JQ, Nadler JL, Bovbjerg VE. The return on investment of a lifestyle intervention: The ICAN Program. Accepted for presentation at the American Diabetes Association 69th Scientific Sessions (169-OR), June 7, 2009, New Orleans, LA.
Case Study 3: South Dakota Medicaid

The following is a compilation of documents supporting the South Dakota Medicaid State Plan proposed amendment to include coverage of MNT provided by RDNs licensed in the state of South Dakota. Sample documents include proposed language, estimate of fiscal impact on state budget and letters of support.

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3495
FAX: 605-773-5246
WEB: dss.sd.gov

Strong Families - South Dakota's Foundation and Our Future

December 21, 2018

Richard Allen
Associate Regional Administrator
Centers for Medicare and Medicaid Services
1661 Stout Street, Room 08-148
Denver, CO 80224

Re: South Dakota Medicaid State Plan Amendment SD-18-007

Dear Mr. Allen:

Please find enclosed South Dakota's Medicaid State Plan Amendment (SPA) SD-18-007. The SPA implements changes to the South Dakota Medicaid State Plan regarding independent mental health practitioner services and dietician and nutritionist services. The SPA clarifies coverage and reimbursement of independent mental health practitioner services including the providers allowed to provide services. The proposed SPA also clarifies coverage for medically necessary medical nutrition therapy provided by nutritionists and dietitians and provides a corresponding reimbursement methodology. Funds associated with this SPA were appropriated by the state legislature during the 2018 legislative session. The SPA revises Attachment 4.19-B Introduction page 1 and page 11 as well as Supplement to Attachment 3.1-A page 11.

South Dakota requests an effective date of December 1, 2018. The Department estimates there will be a $396,579.00 federal fiscal impact associated with this SPA in both Federal Fiscal Year 2018 and Federal Fiscal Year 2020. It is estimated that $53,370 will be due to coverage of nutritionist and dietician services and $343,209 will be due to additional independent mental health practitioner provider types being allowed to enroll and bill for services.

The State conducted Tribal Consultation beginning with notification on October 22, 2018. We have attached a copy of the notification sent to the Tribes. Public notice was published in the South Dakota REGISTER, http://sdl legislature/docs/rules/ Register/10222018.pdf, on October 22, 2018. We received no comments during the public notice period. Four comments were received for the department's corresponding rules package. The four comments expressed support for enrolling additional independent mental health practitioners.

If you have any questions regarding this package, please contact Sarah Aker, Deputy Director of the Division of Medical Services, 700 Governors Drive, Pierre, SD 57501-2291, e-mail sarah.aker@state.sd.us, or telephone (605) 773-3495.

Sincerely,

Lynee A. Valenti
Cabinet Secretary

CC: Brenda Tidball-Zeltlinger, Deputy Secretary
    William Snyder, Director
    Sarah Aker, Deputy Director

| **DEPARTMENT OF HEALTH AND HUMAN SERVICES**  | **FORM APPROVED**  |
| **CENTERS FOR MEDICARE & MEDICAID SERVICES** | OMB NO. 0938-0193  |
| **TRANSMITTAL AND NOTICE OF APPROVAL OF** | **STATE:**  |
| **STATE PLAN MATERIAL** | **South Dakota**  |
| **FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES** |  |
| **TO:** REGIONAL ADMINISTRATOR |  |
| **CENTERS FOR MEDICARE & MEDICAID SERVICES** |  |
| **DEPARTMENT OF HEALTH AND HUMAN SERVICES** |  |
| **1. TRANSMITTAL NUMBER:** | **3. PROGRAM IDENTIFICATION: TITLE XIX OF THE**  |
| SD-18-007 | **SOCIAL SECURITY ACT (MEDICAID)**  |
| **2. STATE:** |  |
| **South Dakota** |  |
| **4. PROPOSED EFFECTIVE DATE:** |  |
| December 1, 2018 |  |
| **5. TYPE OF PLAN MATERIAL:** (Check One): |  |
| ☐ NEW STATE PLAN | ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN | ☐ AMENDMENT  |
| **6. FEDERAL STATUTE/REGULATION CITATION:** |  |
| 42 CFR 440.60 and 42 CFR 447.201 |  |
| **7. FEDERAL BUDGET IMPACT:** |  |
| a. FFY 2019: $ 306,570.00 |  |
| b. FFY 2020: $ 306,570.00 |  |
| **8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:** |  |
| Attachment 3.1-A page 11 and Attachment 4.19-B introduction page 1 and page 11 |  |
| **9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):** |  |
| Attachment 3.1-A page 11 and Attachment 4.19-B introduction page 1 and page 11 |  |
| **10. SUBJECT OF AMENDMENT:** |  |
| The State Plan Amendment (SPA) clarifies coverage and reimbursement of independent mental health practitioner services including the providers allowed to provide services. The proposed SPA clarifies coverage for medically necessary medical nutrition therapy provided by nutritionists and dieticians and provides a corresponding reimbursement methodology. |  |
| **11. GOVERNOR'S REVIEW (Check One):** |  |
| ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT | ☐ OTHER, AS SPECIFIED:  |
| ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED |  |
| ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL |  |
| **12. SIGNATURE OF STATE AGENCY OFFICIAL:** |  |
| Lynne A. Valenti |  |
| **13. TYPED NAME:** |  |
| Lynne A. Valenti |  |
| **14. TITLE:** |  |
| Cabinet Secretary |  |
| **15. DATE SUBMITTED:** |  |
| December 21, 2018 |  |
| **FOR REGIONAL/OFFICE USE ONLY** |  |
| **17. DATE RECEIVED:** |  |
|  |  |
| **18. DATE APPROVED:** |  |
|  |  |
| **19. EFFECTIVE DATE OF APPROVED MATERIAL:** |  |
|  |  |
| **20. SIGNATURE OF REGIONAL OFFICIAL:** |  |
|  |  |
| **21. TYPED NAME:** |  |
|  |  |
| **22. TITLE:** |  |
|  |  |
| **23. REMARKS** |  |
| FORM CMS-179 (07-92) |  |
South Dakota which also holds a manufacturer's or distributor's license in another gaming jurisdiction may use slot machines in the entity's South Dakota casino that were acquired through the manufacturer's or distributor's license in another gaming jurisdiction. After a hearing and considering SDCL § 42-7B-22 and ARSD 20:18:18:14:01, the Commission on Gaming has determined that the entity may not use slot machines in its South Dakota casino that were acquired through the manufacturer's or distributor's license in another gaming jurisdiction. The Declaratory Ruling is dated October 15, 2018.

NOTICE:

The Department of Social Services intends to make changes to the South Dakota Medicaid State Plan regarding nutritionist and dietician services, and independent mental health practitioner services. The proposed State Plan Amendment (SPA) provides coverage for medically necessary medical nutrition therapy provided by nutritionists and dieticians, and corresponding reimbursement methodology. It also clarifies coverage and reimbursement of independent mental health practitioner services including the providers allowed to provide services. Funds associated with this SPA were appropriated by the state legislature during the 2018 Session. The SPA revises Attachment 4.19-B Introduction page 1 and page 11, and Supplement to Attachment 3.1-A page 11. The Department intends to make this SPA effective December 1, 2018 and estimates it will have a $396,579 federal fiscal impact in Federal Fiscal Year 2019 and a $396,579 federal fiscal impact in Federal Fiscal Year 2020. The SPA can be viewed on the department's website at http://dss.sd.gov/medicaid/medicaidstateplan.aspx. Written requests for a copy of these changes, and corresponding comments, may be sent to Division of Medical Services, Department of Social Services, 700 Governors Drive, Pierre, SD 57501.

FILINGS IN THE SECRETARY OF STATE'S OFFICE: (None)

NOTE REGARDING ADOPTED RULES:
The following agencies have permission from the Interim Rules Review Committee to charge for adopted rules: the Division of Insurance, the Cosmetology Commission, the State Board of Examiners in Optometry, the State Plumbing Commission, the Board of Nursing, the Department of Social Services, the State Electrical Commission, the South Dakota Board of Pharmacy, the Real Estate Commission, the Gaming Commission, the Department of Revenue, and the Department of Labor and Regulation for Article 47:03.

REMINDER OF HEARINGS SCHEDULED

<table>
<thead>
<tr>
<th>Date</th>
<th>Department of Health: Amend rules to add newly emerging communicable diseases with public health impact to the Category II reportable diseases and condition list and clarify the methods of reporting; 45 SDR 48, October 1, 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-22-2018</td>
<td></td>
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<tr>
<td>10-23-2018</td>
<td>Department of Health: South Dakota Board of Pharmacy: Amend rules to provide for an organized way of handling complaints and discipline for the Board of Pharmacy; 45 SDR 43, September 24, 2018.</td>
</tr>
<tr>
<td>10-23-2018</td>
<td>Department of Labor and Regulation: South Dakota Board of Accountancy: Amend rules to update references; add language to waive certain requirements; update definitions, program measurements, criteria and standards for continuing professional education; and repeal rules regarding the South Dakota peer review program; 45 SDR 55, October 9, 2018.</td>
</tr>
<tr>
<td>10-23-2018</td>
<td>Department of Labor and Regulation: South Dakota Board of Massage Therapy: Amend rules to increase annual fees from $45 to $65 per year and the initial license fee from $75 to $100 on massage therapists in South Dakota; 45 SDR 56, October 9, 2018.</td>
</tr>
</tbody>
</table>
Good Morning,

Please find attached materials regarding South Dakota Medicaid state plan amendment (SPA) 18-007. The proposed SPA provides coverage for medically necessary medical nutrition therapy provided by nutritionists and dieticians and provides a corresponding reimbursement methodology. The SPA also clarifies coverage and reimbursement of independent mental health practitioner services including the providers allowed to provide services. The department intends to make this SPA effective December 1, 2018.

Please contact us within 30 days with any comments.

Sincerely,
October 22, 2018

RE: South Dakota Medicaid State Plan Amendment #SD-18-007

The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan regarding nutritionist and dietician services and independent mental health practitioner services. The proposed State Plan Amendment (SPA) provides coverage for medically necessary medical nutrition therapy provided by nutritionists and dieticians and provides a corresponding reimbursement methodology. The SPA also clarifies coverage and reimbursement of independent mental health practitioner services including the providers allowed to provide services. Funds associated with this SPA were appropriated by the state legislature during the 2018 legislative session. The SPA revises Attachment 4.19-B Introduction page 1 and page 11 as well as Supplement to Attachment 3.1-A page 11.

The Department intends to make this SPA effective December 1, 2018. The Department estimates there will be a $396,579.00 federal fiscal impact associated with this SPA in Federal Fiscal Year 2019 and a $396,579.00 federal fiscal impact in Federal Fiscal Year 2020.

Please contact me within 30 days of receipt of this message with any questions or comments.

Sincerely,

[Signature]
Sarah Aker
Deputy Director
Division of Medical Services
South Dakota Department of Social Services

CC: Lynne A. Valenti, Cabinet Secretary
    Brenda Tidball-Zellinger, Deputy Secretary
    William Snyder, Director
Medicaid State Plan Amendment Proposal

Transmittal Number:  SD-18-007

Effective Date:  12/01/2018

Brief Description: The State Plan Amendment provides coverage for medically necessary medical nutrition therapy provided by nutritionists and dieticians and provides a corresponding reimbursement methodology. The SPA also clarifies coverage and reimbursement of independent mental health practitioner services including providers allowed to provide services.

Area of State Plan Affected: Attachment 4.19-B and Supplement to Attachment 3.1-A

Page(s) of State Plan Affected: Revises introduction page 1 and page 11 of Attachment 4.19-B as well as page 11 of Supplement to Attachment 3.1-A.

Estimate of Fiscal Impact, if Any:  
2019 $396,579.00
2020 $396,579.00

Reason for Amendment: Cover medically necessary medical nutrition therapy provided by nutritionists and dieticians. Clarifies independent mental health practitioner services including providers allowed to provide services.
6d. Other Practitioner Services

1. Physician Assistants. See service limitations under section 5a of this attachment.

2. Nurse practitioners other than Pediatric or Family Nurse Practitioners. See service limitations under section 5a of this attachment.

3. Certified Registered Nurse Anesthetist. See service limitations under section 5a of this attachment.

4. Nursing services which are determined medically necessary by the Department, and are limited to no more than 16 hours of nursing during a calendar quarter.

5. Independent mental health practitioner services are covered when a diagnostic assessment has been prepared that includes a primary diagnosis of a mental disorder. The independent mental health practitioner must prepare an individual treatment plan and provide treatment directly to the recipient. The maximum allowable coverage for all psychotherapy services may not exceed 40 hours of therapy in a 12 month period. The 40 hour limit may be exceeded with a prior authorization. Independent mental health practitioner services may only be provided by the following individuals:
   a. Psychologist;
   b. Licensed professional counselor - mental health;
   c. Licensed professional counselor working toward a mental health designation;
   d. Clinical nurse specialist;
   e. Certified social worker - PIP;
   f. Certified social worker - PIP candidate; or
   g. Licensed marriage and family therapist.

6. Nutritionist and dietician services must be ordered by a physician or other licensed practitioner. Nutritionists and dieticians must be licensed according to the provisions of SDCL Ch. 36-10b or licensed in their state of practice according to licensing standards not less stringent than South Dakota. Medicaid recipients are limited to 1 hour of services a day and 5 hours of services a year. Medicaid recipients under 21 years of age may exceed these limits with a prior authorization if additional services are medically necessary. Services must be provided according to a written plan.
ATTACHMENT 4.19-B
INTRODUCTION

Payment rates for the services listed below are effective for services provided on or after the corresponding date. Fee schedules are published on the Department’s website at [http://dss.sd.gov/medicaid/providers/feeschedules/](http://dss.sd.gov/medicaid/providers/feeschedules/). Effective dates listed on the introductory page supersede the effective dates listed elsewhere in Attachment 4.19-B. Unless otherwise noted in the referenced state plan pages, reimbursement rates are the same for both governmental and private providers.

<table>
<thead>
<tr>
<th>Service</th>
<th>Attachment</th>
<th>Effective Date</th>
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<tr>
<td>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)</td>
<td>Attachment 4.19-B, Page 4</td>
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<td>Physician Services</td>
<td>Attachment 4.19-B, Page 6</td>
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<td>Optometrist Services</td>
<td>Attachment 4.19-B, Page 9</td>
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<td>Chiropractic Services</td>
<td>Attachment 4.19-B, Page 10</td>
<td>April 1, 2018</td>
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<tr>
<td>Independent Mental Health Practitioners</td>
<td>Attachment 4.19-B, Page 11</td>
<td>April 1, 2018</td>
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<tr>
<td>Nutritionist and Dietician Services</td>
<td>Attachment 4.19-B, Page 11</td>
<td>December 1, 2018</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Attachment 4.19-B, Page 12</td>
<td>April 1, 2018</td>
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<tr>
<td>Durable Medical Equipment</td>
<td>Attachment 4.19-B, Page 13</td>
<td>April 1, 2018</td>
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<tr>
<td>Clinic Services</td>
<td>Attachment 4.19-B, Page 15</td>
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<td>Dental Services</td>
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<td>Occupational Therapy</td>
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<td>Speech, Hearing, or Language Disorder Services</td>
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<td>Dentures</td>
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<td>Prosthetic Devices</td>
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<td>Eyeglasses</td>
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<tr>
<td>Diabetes Self-Management Training</td>
<td>Attachment 4.19-B, Page 26a</td>
<td>April 1, 2018</td>
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<tr>
<td>Community Mental Health Centers</td>
<td>Attachment 4.19-B, Page 26a</td>
<td>April 1, 2018</td>
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<tr>
<td>Substance Use Disorder Agencies</td>
<td>Attachment 4.19-B, Page 26b</td>
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<tr>
<td>Nurse Midwife Services</td>
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<tr>
<td>Personal Care Services</td>
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<td>Freestanding Birth Centers</td>
<td>Attachment 4.19-B, Page 39</td>
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<tr>
<td>Professional Services Provided in a Freestanding Birth Center</td>
<td>Attachment 4.19-B, Page 39</td>
<td>April 1, 2018</td>
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TN# 18-007
SUPERCEDES Approval Date ___________ Effective Date 12/01/18
TN# 18-004
6d. **Other Practitioner Services**

1. Physician Assistants. Reimbursement will be 90% of the fee established under Physician Services, Section 5 of this attachment.

2. Nurse Practitioners. Reimbursement will be 90% of the fee established under Physician Services, Section 5 of this attachment.

3. Certified Registered Nurse Anesthetists. Payment will be made following the anesthesia service provisions of Section 5 of this attachment.

4. Nursing Services. Payment will be based on reasonable and allowable costs for the service provided.

5. Independent Mental Health Practitioners. Payment will be the lower of the provider’s usual and customary charge or the amount established on the State agency’s fee schedule website [https://des.sd.gov/medicaid/providers/feeschedule/dee/](https://des.sd.gov/medicaid/providers/feeschedule/dee/).

6. Nutritionist and Dietician Services. Payment will be the lower of the provider’s usual and customary charge or the amount established on the State agency’s fee schedule website [https://des.sd.gov/medicaid/providers/feeschedules/dss/](https://des.sd.gov/medicaid/providers/feeschedules/dss/).
October 15, 2018

Department of Social Services
Administrative Rules
700 Governors Drive
Pierre, SD 57501

Re: 67:16:41:03

Judge Teresa Schulte and the Department of Social Services:

I am a licensed marriage and family therapist (LMFT) and am writing to support the proposed rule changes for 67:16:41:03. Marriage and Family Therapy has been a licensed profession in SD for 23 years. Our scope of practice as defined in law allows us to treat all mental health disorders. We have education and supervision requirements similar to those who are already defined in the rule to provide mental health services for Medicaid recipients. We are designated by state law to be Qualified Mental Health Providers (QMHP), and are reimbursed by all other health care insurance companies with the exception of Medicare.

I have been an LMFT since 1996. I have supervised Family Practice Residents for 23 years in their behavioral health rotation in addition to having a private practice. Ironically, those residents have been able to be Medicaid providers while I haven’t. 95% of the referrals to my private practice come from Family Physicians. It will now be a privilege to be able to receive their Medicaid referrals as well.

These rule changes will give LMFTs equal job opportunities alongside of other mental health providers and will encourage well trained professionals to stay in SD.

I am also supportive of including the other named professions in the proposed rule changes.

Thank you for your consideration of including LMFTs in the proposed rule changes. We are eager to serve the people of SD.

Sincerely,

Ramona Wade, MA, LMFT, QMHP
October 19, 2018

Teresa Schulte
Dep’t of Social Services
700 Governors Drive
Pierre, SD 57501

Dear Teresa,

Lutheran Social Services supports the proposed amendments to administrative rules 67:16:41:01, 67:16:41:02; 67:16:41:03, 67:16:41:09; and 67:16:41:10. Our specific comments are as follows.

• Mental health counseling has been a core service and focus for LSS for over 30 years. We provide individual, family, group, couples counseling using licensed, master’s level clinicians to individuals in Sioux Falls, Rapid City, Watertown, Aberdeen, Milbank, Sisseton, Mitchell, Brookings, Wagner, Yankton, and Sturgis. In the last three years, we have also provided tele-health services to individuals in 93 communities across South Dakota.

• We are accredited by the Council on Accreditation for Children and Families and DSS, Division of Behavioral Health for outpatient substance use services. All of our counselors (regardless of their licensure level) receive regular clinical supervision both in one-on-one and team settings.

• In recent years, our most pressing operational challenge has been our ability to recruit licensed social workers and counselors who are able to bill to Medicaid and other third party payers. This challenge is most acutely felt in our rural communities and in the northeastern region of the state and has limited our capacity to meet local needs. We currently have five vacant clinical therapist positions.

• LSS supports the proposed amendments to expand the definition of who may bill Medicaid to include licensed social workers and counselors who are in pursuit of the highest level of licensure. This change will enable our agency to fill vacant positions and sustain access to care for individuals in need of mental health services.

• We also support the proposed amendments to clarify coverage for collateral contacts. Collateral contacts are an essential component to providing effective treatment services. In many situations, and especially with adolescents, it is necessary to communicate and collaborate with parents or other family members, teachers and other professionals as indicated in the treatment plan.

LSS greatly appreciates the ongoing efforts of the Department of Social Services to assure that Medicaid recipients have adequate access to quality mental health treatment, especially in our rural communities.

Sincerely,

Betty Oldenkamp
President/CEO

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October 15, 2018

Department of Social Services
Administrative Rules
700 Governors Drive
Pierre SD 57501

Judge Teresa Schulte and The Department of Social Services:

I am a South Dakota LMFT and Registered Play Therapist and am in support of the proposed rule change in 67:16-41:03 to include LMFTs as Medicaid providers. As LMFTs, we are trained to work with children and families, however in SD, even when LMFTs have an opening to accept a new child and their family into counseling, we must refer Medicaid recipients to other licensed providers who are eligible to accept Medicaid, and who often have a waiting list.

I—and other LMFTs in the state—am willing to serve the children and families who are Medicaid recipients and believe that approval of this rule change will provide Medicaid recipients access to mental health care without the burden of a waiting list.

I support the inclusion of LMFTs, and all providers listed, as Medicaid providers to ensure that Medicaid recipients receive the mental health services they need as soon as that need is evident. I believe that the state will benefit financially long-term from young children and their families receiving needed mental health services early, saving money by decreasing the need for future behavioral interventions within the school system, visits to medical providers for mental health-related issues and rates of inpatient stays at mental health facilities.

Thank you for your time and consideration of this rule change.

Sincerely,

Emily Learing, MA, LMFT, RPT
Licensed Marriage and Family Therapist
Registered Play Therapist
October 15, 2018

Department of Social Services
Administrative Rules
700 Governors Drive
Pierre, SD 57501

RE: Support of Rule Change 57:16:41:03

I am a LMFT (Licensed Marriage and Family Therapist) in South Dakota and am supportive of the proposed rule change to include LMFTs as Medicaid providers. The surrounding states of Iowa, Minnesota, and Nebraska already include LMFTs as Medicaid providers. In addition, I know of LMFT's who have considered moving to South Dakota, but upon finding out that they could not be Medicaid eligible in South Dakota decided to move to a state where they could be a Medicaid provider. This rule change can have far ranging impact on keeping current LMFTs in the state and also bringing in new, well trained professionals. This is a win/win for the state of South Dakota when highly trained, licensed, revenue generating professionals choose to live and work in South Dakota.

Thank you for your time and consideration.

Kristiana Benson, LMFT, QMHP
Appendix H: Sample Advocacy Form Letter

Use affiliate’s letterhead

Date

Medicaid director name and address

Dear xxx:

Everyone agrees that health care costs are skyrocketing. Achieving cost savings for (insert state’s name) Medicaid while improving the quality of health care coverage is easier than you may think. The xx (insert state’s name) Academy of Nutrition and Dietetics and the Academy of Nutrition and Dietetics believe that by leveraging the expertise of registered dietitian nutritionists (RDNs) for prevention and disease management services, you can achieve this goal. 

(Insert state’s name) Medicaid, as a federally-funded and state-administered program, needs to effectively fund patient care while containing total costs. We have personally encountered situations where individuals with limited incomes and who are enrolled in (insert state’s name) Medicaid are referred by their physician or the health care team for Medical Nutrition Therapy (MNT) services, yet state provisions have erroneously excluded MNT services, and the individual reluctantly is unable to obtain nutrition services. By investing in RDN-provided nutrition services, you can allow individuals enrolled in (insert state’s name) Medicaid to experience the benefit of working with an RDN.

RDNs are the most cost-effective, qualified healthcare professionals to provide MNT. MNT is distinctly different than nutrition education and requires advanced skills beyond those of other professionals. According to The National Academy of Medicine, formerly called the Institute of Medicine, “the registered dietitian is currently the single identifiable group of healthcare professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.” By integrating the best available evidence with professional expertise and client values, RDNs can improve outcomes for patients with conditions such as diabetes, kidney disease, obesity, heart disease, cancer, HIV/AIDS, and more. Additionally, patients who receive MNT have fewer doctor visits, less hospitalizations, and are less reliant on indefinite drug treatment therapies.

Now is the time to focus on prevention and wellness. Achieve quality care and decrease your total costs by including RDN-provided MNT services in (insert state’s name) Medicaid provisions. An investment in the services of an RDN today can save you money tomorrow. Thank you for taking the time to consider the positive impact nutrition services can have for (insert state’s name) Medicaid recipients. One of our committee members will be contacting you soon to schedule a meeting to further discuss this issue at your convenience.

Sincerely,

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