

April 30, 2014

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*Re: Health Care Workshop, Project No. P131207*

Dear Ms. Schultheiss and Ms. Goldman:

The Academy of Nutrition and Dietetics (the “Academy”) appreciates the opportunity to submit comments to the Federal Trade Commission (FTC) regarding the “Examining Health Care Competition” workshop held March 20-21, 2014. With over 75,000 members comprised of registered dietitian nutritionists (RDNs),<sup>1</sup> dietetic technicians, registered (DTRs), and advanced-degree nutritionists, the Academy is the largest association of food and nutrition professionals in the United States committed to optimizing the nation’s health through food and nutrition.

**The Academy of Nutrition and Dietetics urges the FTC to contrast the superior training, competence, accreditation, and demonstrated effectiveness of outcomes between registered dietitian nutritionists with the credentials of other “nutrition professionals,” and reinforce the importance of dietetics licensure in assuring the integrity of the profession necessary to ensure consumer protection.**

**A. Licensure for the Dietetics Profession is Appropriate and Necessary**

America’s epidemic of nutrition-related diseases such as obesity and diabetes requires not only that consumers have adequate access to nutrition providers, but also to ethical, high-quality evidence-based care provided by professionals with *proven* outcomes. Licensed dietitians manage patients’ complex medical conditions or complications that require nutrition support, including tube feedings and parenteral nutrition requiring medical supervision and monitoring. Licensure and regulation of dietitians also eliminates confusion in the marketplace by preventing ineffective or incompetent individuals without a background in dietetics from being hired to provide expensive, ineffective treatments and benefit from reimbursement while purporting to be a dietitian nutrition expert. Dietetics licensure enables consumers, insurers, employers, and other allied health professionals to have confidence in the cost-effective and clinically-effective dietetics profession.<sup>2</sup>

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<sup>1</sup> The Academy recently approved the optional use of the credential “registered dietitian nutritionist (RDN)” by “registered dietitians (RDs)” to more accurately convey who they are and what they do as the nation’s food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions.

<sup>2</sup> In the first session of the workshop, Lisa Robin made a similar point: “I would just like to add that I think if you look at the welfare of the consumer-- and as I am, like you, a policy wonk, not health care professional-- but I need something to depend on when I’m looking at selecting a health care professional. And the licensure or certification, that serves as some sort of bar. So you know that the individuals have at least attained some minimum standard.”

There are important distinctions between unlicensed practitioners who provide general non-medical nutrition information to a group or individual versus licensed health professionals who provide individualized/personalized services to a client that will prevent, delay or manage their disease or condition. Many commenters seemed to conflate the two, suggesting that licensure was required in order to engage in non-medical nutrition education, wellness, or health prevention when that is not the case.<sup>3</sup>

Many differently licensed professionals whose scope of practice includes the field of nutrition can and do provide appropriate nutrition counseling without running afoul of any dietetics professional licensure statutes. In fact most dietetics licensure laws specifically recognize such overlap by including specific exemptions within the dietetics statutes. Despite the fact that scopes of practice for professions frequently overlap, people are licensed primarily to practice within the profession for which they were initially trained. Some licensed professionals may expand their individual scopes of practice by engaging in additional training in specialty areas, adjunct areas of focus (like nutrition), and through continuing education. Licensure does not limit such expansion of scope.

Not all “licensed dietitians” are “registered dietitians,” because becoming a registered dietitian requires a particularly rigorous internship with an accreditation that states do not typically require. However, all licensed dietitians should be trained in dietetics. If unlicensed individuals wish to provide in nutrition education without the requisite background in dietetics, they could apply to become certified or licensed simply as nutritionists, or instead as counselors, chiropractors, pharmacists, nurses, physicians, herbalists, health coaches, acupuncturists, naturopaths, athletic trainers, dental hygienists, or any of the other multiple professions whose scope of practice includes nutrition. They should not, however, attempt to weaken the integrity of dietetics licensure standards or piggyback onto existing dietetics licensure, thereby fundamentally changing the profession.

The Social Security Act defines Medical Nutrition Therapy (MNT)—the core of dietetic practice—as “nutritional diagnostic, therapy, and counseling services for the purpose of *disease management* which are furnished by a registered dietitian or nutrition professional . . . pursuant to a referral by a physician.”<sup>4</sup> MNT is thus distinctly different and more complex than providing nutrition education<sup>5</sup> alone or conducting wellness programs and requires the advanced skill set of specialist RDNs rather than unlicensed, differently qualified nutritionists, health coaches or athletic trainers. When licensed RDNs provide MNT, they take their patient’s health in their hands and must exercise professional judgment to prevent, treat or manage the patient’s diseases or conditions. Nutrition professionals conducting similar services without adequate education, practice experience, or oversight can cause substantial harm to their patients and clients. Licensure also provides a mechanism to sanction unethical, incompetent, or criminal conduct by practitioners and thereby protect the public.

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<sup>3</sup> See, e.g., Iowa Code Ch. 152A.3(6) (Individuals who provide routine education and advice regarding normal nutritional requirements and sources of nutrients, including, but not limited to, persons who provide information as to the use and sale of food and food materials including dietary supplements.)

<sup>4</sup> 42 U.S.C. 1395(vv)(1).

<sup>5</sup> The Academy defines nutrition education as “the formal process to instruct or train patient(s)/client(s) in a skill or to impart knowledge to help patient(s)/client(s) voluntarily manage or modify food choices and eating behavior to maintain or improve health.” Academy of Nutrition and Dietetics. Definition of Terms List. Available at <http://www.eatright.org/scope/>, accessed December 24, 2012.

Although licensure is primarily necessary to help protect the public, it is increasingly important in determining which types of providers will be reimbursed. Insurers prefer licensed practitioners because they have met defined standards of competency and qualification and produce beneficial results for patients that ultimately reduce healthcare costs. Dr. Joanne Spetz discussed the role of the private sector and safety during the first session of the workshop, suggesting “insurance companies can decide, we’re willing to reimburse a service provided by this provider but not that provider. So then you could arguably say, let the private sector decide what they believe is safe.” The private sector frequently operates in that manner, because insurers such as Blue Cross/Blue Shield have studied the cost and clinical efficacy of RDNs and designated them as the preferred providers of nutrition care services in many private-sector insurance plans. However, the Academy notes the possibility that the non-discrimination provision in § 2706 of the Public Health Act (as amended by the Affordable Care Act) may preclude insurers from hiring and reimbursing only those types of providers, such as RDNs, that the insurer believes are effective.<sup>6</sup>

### **B. Registered Dietitian Nutritionists are *the* Trusted, Effective Food and Nutrition Experts**

Registered dietitian nutritionists have been identified as the most qualified food and nutrition experts, according to the Institute of Medicine (IOM), most physicians,<sup>7</sup> and the US Preventive Services Task Force (USPSTF). In addition, RDNs provide nutrition care with better outcomes at a lower cost than physicians, nurse practitioners, and physician assistants. In fact, according to the prestigious IOM, “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.”<sup>8</sup>

The Academy is proud of the work it has done to develop a strong academic and experiential framework that ensures RDNs have necessary competencies to provide safe, effective nutrition care services. We value our partnerships with states that protect consumers by regulating the profession. Some commenters criticize state dietetics licensure statutes for being “predominantly patterned after the educational, exam, and practice requirements of RD[N]s.”<sup>9</sup> However, this approach actually makes sense, given that dietetics licensure statutes license dietitian nutritionists, than alternative nutrition practitioners, naturopaths, or chiropractors. As Barbara Safriet noted in the first session of the workshop, this integral role of private associations is the norm for professional regulation:

[There has always been government regulation but intrinsically dependent upon an enormously active and influential role for private, professional associations. That reliance continues today

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<sup>6</sup> Section 2706(a) of the Public Health Service Act (PHS Act),<sup>1</sup> as added by section 1201 of the Affordable Care Act, states that a “group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable state law.” *See*, <http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05348.pdf>

<sup>7</sup> Bleich SN, Bennett WL, Gudzone KA, Cooper LA. National survey of US primary care physicians’ perspectives about causes of obesity and solutions to improve care. *BMJ Open* 2012;2:e001871. doi:10.1136/bmjopen-2012-001871.

<sup>8</sup> Committee on Nutrition Services for Medicare Beneficiaries. “The Role of Nutrition in Maintaining Health in the Nation’s Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population.” Washington, DC: Food and Nutrition Board, Institute of Medicine; January 1, 2000 (published).

<sup>9</sup> Comment from Center for Nutrition Advocacy submitted March 10, 2014 at 7. Accessed April 30, 2014 at <http://www.ftc.gov/policy/public-comments/comment-00044-20>.

because the licensure examinations, the accreditation standards for professional education, both of our proxies-- if we want-- for competence, as preconditions for licensure. You must have graduated from a professionally accredited education program plus passed a professionally developed licensure examination, both proxies for competence.

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And the underpinnings of the content of our regulations, in the main, have been and still are developed by private professional associations.

The Academy notes that a number of comments submitted to the FTC responsive to this workshop suggest that the attainment of a graduate degree alone inherently makes one “better qualified”<sup>10</sup> than the academic programs required for registered dietitian nutritionists. Quite simply, that suggestion is inaccurate and wholly unsupported. Merely asserting that a credential is prestigious, that a certification exam is rigorous, or that a particular degree sufficiently prepares one for practice *does not make it so*. Instead, professional licensure should be based on objective ways of measuring academic programs, individual competencies, the quality of certification agencies, and practitioners’ effectiveness in providing health care.

### 1. Programmatic Accreditation

Even a cursory review of the coursework required to attain some of the degrees and credentials deemed satisfactory by some commenters makes clear that they are manifestly insufficient to assure the individual has the necessary competencies and skills to provide complex medical nutrition therapy for patients dealing with complicated, multifactorial diseases. *Many programs require no training in nutrition counseling or medical nutrition therapy at all.*<sup>111213</sup> Programmatic accreditation (not just accreditation of the school itself) verifies the content and quality of academic programs and ensures that graduates have received the knowledge preparing them to practice the profession with competence.

It is notable that to be eligible for reimbursement under Medicare (in addition to other requirements), a nutrition professional must have obtained “a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in *nutrition or dietetics*, as accredited by an appropriate national accreditation organization recognized by the

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<sup>10</sup> Comments by Alliance for Natural Health submitted March 10, 2014 at 1. Accessed April 30, 2014 at [http://www.ftc.gov/system/files/documents/public\\_comments/2014/03/00035-88877.pdf](http://www.ftc.gov/system/files/documents/public_comments/2014/03/00035-88877.pdf).

<sup>11</sup> One may obtain the Certified Clinical Nutritionist credential after online coursework from a non-regionally accredited institution with as little as an Associate’s degree and without ever taking a course in nutrition counseling, medical nutrition therapy, or nutrition assessment—the very core of the licensed dietitian nutritionist scope of practice. <http://www.cncb.org/CORE%20ACADEMIC%20REQUIREMENTS-2011.pdf>

<sup>12</sup> “Nutrition and Functional Medicine” degree: The University of the Western States will be offering an on-line Master's degree in Nutrition and Functional Medicine. There appears to be minimal requirements addressing MNT, and no counseling courses required. A “Nutrition through the Lifecycle” course and a course addressing metabolic syndrome and hypertension are only electives and are not required. [http://www.uws.edu/Academic\\_Programs/MS\\_Nutrition\\_and\\_Functional\\_Medicine.aspx](http://www.uws.edu/Academic_Programs/MS_Nutrition_and_Functional_Medicine.aspx)

<sup>13</sup> “Nutrition Science” degree: North Carolina State University Raleigh has a Nutrition Science Program that does not require medical nutrition therapy or counseling courses. <http://oucc.ncsu.edu/semester-display/CALS-11NTSBS-nosubplan-2101>

Secretary for this purpose.”<sup>14</sup> The Accreditation Council for Education in Nutrition and Dietetics (ACEND), the accrediting agency for the Academy, meets this high standard and has been recognized by the Secretary of Health and Human Services as an appropriate organization. The Academy is unaware of other nutrition organizations recognized by the Secretary with the authority to accredit academic programs.

### 2. *Accreditation of Certification Boards*

One hallmark of a qualified professional certification board is accreditation through a reputable third-party evaluation, such as that provided by the National Commission for Certifying Agencies (NCCA). According to the NCCA, “[a]ccreditation is the process by which a credentialing or educational program is evaluated against defined standards and is awarded recognition if it is in compliance with those standards.”<sup>15</sup> The Commission on Dietetic Registration, the credentialing agency that awards *seven* nutrition and dietetics certifications (including the RDN) has undergone the rigorous review by a panel of impartial experts and meets the standards required by NCCA, as has the American Clinical Board of Nutrition and the Certifying Board for Dietary Managers. To date, other less qualified certification boards for nutritionists (*e.g.*, Certification Board for Nutrition Specialists; Clinical Nutrition Certification Board; and Holistic Nutrition Credentialing Board) have failed to receive NCCA accreditation and presently do not meet the modern standards of practice in the certification industry, despite accreditation being routine for most health professions.

### 3. *Competency-based Recertification*

The 2003 IOM Report: *Health Professions Oversight Processes* cited the RDN *Professional Development Portfolio Recertification System* as an example of a system that enhanced professional performance.<sup>16</sup> As a further refinement to this process the Commission on Dietetic Registration (CDR) is currently in the process of validating practice competencies which will be incorporated into the recertification process in 2015. Dietetics is the first U.S. healthcare profession to establish a practice competencies -based recertification system. CDR’s five specialist certifications for RDNs all require recertification by examination every five years.

### 4. *Evidence of Effectiveness*

RDNs remain the most cost-effective, qualified healthcare professional to provide nutrition based lifestyle interventions, including MNT and evidence-based nutrition counseling and weight-loss management services. RDNs’ evidence-based national practice guidelines and Evidence Analysis Library<sup>17</sup> are the leading, respected tools for effecting positive nutrition health outcomes.<sup>18</sup>

In the first session of the workshop, Dr. Spetz asked, “Do we have evidence that there is better or worse quality of care from these different groups?” Ms. Schultheiss then added, “For example, you

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<sup>14</sup> 42 U.S.C. 1395(vv)(2)

<sup>15</sup> Institute for Credentialing Excellence. Accreditation Services. Accessed April 20, 2014 at <http://www.credentialingexcellence.org/p/cm/ld/fid=81>.

<sup>16</sup> 5. *Health Professions Oversight Processes: What They Do and Do Not Do, and What They Could Do.* *Health Professions Education: A Bridge to Quality*. Washington, DC: The National Academies Press, 2003 at 112.

<sup>17</sup> The Academy of Nutrition and Dietetics Evidence Analysis Library is a synthesis of the best, most relevant nutritional research on important dietetic practice questions housed within an accessible, online, user-friendly library. An objective and transparent methodology is used to assess food and nutrition-related science. The Academy’s Evidence Analysis Library (EAL®) website houses systematic reviews and practice guidelines related to the topics of food and nutrition and can be accessed at <http://andevidencelibrary.com/default.cfm?auth=1>.

<sup>18</sup> Myers EF. Evidence-Based Approaches in Nutrition Policy. *Nutrition Today*. 2013;48(5):228-233.

have registered dietitians or people who have degrees in nutrition that there is really no license because there's no evidence that one is-- they may be different, but one's not better than the other." The Academy looks forward to discussing these questions in depth with the FTC and shares below clear and convincing evidence that RDNs produce clinically significant and cost-effective outcomes. RDNs have demonstrated numerous competencies and outcomes that have not been achieved by less qualified and differently trained providers of non-medical nutrition services. To wit: a search of PubMed<sup>19</sup> produces no outcomes data or any review of the effectiveness of non-RDN nutrition professionals nor any mention at all of the credentials "clinical nutrition specialist" or "certified clinical nutritionist." RDNs being able to demonstrate their effectiveness may not make them "better" than differently qualified nutrition professionals, but the difference in reported outcomes data is a critical distinction in the professions that the FTC should recognize.<sup>20</sup>

MNT *provided by RDNs* is a widely recognized component of medical guidelines for the prevention and treatment of heart disease, diabetes, renal disease, obesity, cancers, and many other chronic diseases and conditions as well as in the reduction of risk factors for these conditions. As primary prevention, strong evidence supports achieving optimal nutritional status as a cost-effective cornerstone in the maintenance of health, well-being, and functionality. As secondary and tertiary prevention, MNT provided by RDNs is a cost-effective disease management strategy that reduces chronic disease risk, delays disease progression, enhances the efficacy of medical/surgical treatment, reduces medication use, and improves patient outcomes including quality of life.<sup>21</sup> Additional recent examples of RDN effectiveness include:

- For every dollar invested in an RDN-led lifestyle modification program there was a return of \$14.58.<sup>22</sup>
- The Lewin Group documented an 8.6% reduction in hospital utilization and a 16.9% reduction in physician visits associated with RDN-provided MNT for patients with cardiovascular disease. The group additionally documented a 9.5% reduction in hospital utilization and a 23.5% reduction in physician visits when MNT was provided to persons with diabetes mellitus.<sup>23</sup>
- For patients with heart failure, research indicates that three to four visits with an RDN improves the patient's quality of life, decreases fatigue and edema, and most importantly decreases costly hospitalizations.<sup>24,25,26</sup>

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<sup>19</sup> PubMed. Accessed April 30, 2014 at <http://www.ncbi.nlm.nih.gov/pubmed>.

<sup>20</sup> The Academy also notes that commenters such as the Center for Nutrition Advocacy make sweeping assertions as to impacts of licensure on increased risk of disease, cost, stifled innovation, and other areas, but fail to provide any evidence to support their claims.

<sup>21</sup> Grade 1 data. Academy Evidence Analysis Library, <http://andevidencelibrary.com/mnt>. [Grade Definitions: Strength of the Evidence for a Conclusion/Recommendation Grade I, "Good evidence is defined as: "The evidence consists of results from studies of strong design for answering the questions addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about generalizability, bias and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power."

<sup>22</sup> 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.

<sup>23</sup> Johnson R. The Lewin Group — What does it tell us, and why does it matter? *J Am Diet Assoc*. 1999;99:426-427.

<sup>24</sup> Arcand JL, Brazel S, Joliffe C et al. Education by a dietitian in patients with heart failure results in improved adherence with a sodium-restricted diet: A randomized trial. *Am Heart J*. 2005;150:716e1-716e65.

<sup>25</sup> Kuehneman T, Soulsbury D, Splett P, Chapman DB. Demonstrating the impact of nutrition intervention in a heart failure program. *J Am Diet Assoc*. 2002; 102:1790-1794.

- Overweight or obese adults participating in a medical nutrition therapy benefit sponsored through their insurer were compared with individuals who did not participate. After two years, the adults who received the MNT benefit provided by an RDN were twice as likely to achieve a clinically significant reduction in weight, experience greater average reductions in weight, and were more likely to exercise more.<sup>27</sup>
- The Centers for Medicare and Medicaid Services recognized that “[a] review of the literature (Kinn TJ. Clinical order writing privileges. Support Line. 2011; 33; 4; 3–10) supports that, in addition to providing safe patient care with improved outcomes, RDs with ordering privileges contribute to decreased patient lengths of stay and provide nutrition services more efficiently, resulting in lower costs for hospitals.”<sup>28</sup>

Although some commenters asserted (without any supporting evidence) that dietetics licensure laws resulted in increased cost of nutrition services,<sup>29</sup> the quality of RDNs’ evidence-based practice has yielded innovations that lower health care costs, improve care, and improve outcomes.<sup>30</sup>

### C. Telehealth

The emergence and rapid growth of telehealth and mobile technologies designed to improve the health of individuals, enhance patient engagement and lower costs should be recognized in this model as it offers new opportunities to increase access to care in urban, suburban and rural areas. Time spent by all qualified health care professionals (both physician and non-physician providers) using such technologies for assessment, treatment, evaluation and monitoring functions needs to be recognized in current and emerging payment models. Regulators such as the Centers for Medicare and Medicaid Services could expand traditional telehealth service policies beyond the current restrictions to incorporate rural Health Professional Shortage Areas (HPSA) or counties outside of a Metropolitan Statistical Area (MSA).

RDNs experience similar difficulties practicing across state lines as the nurses and physicians discussed at the workshop. Many dietetics licensure statutes currently permit licensure by endorsement or include specific exemptions authorizing practice for a limited number of days in a state in which one is not licensed. These approaches have been criticized as being confusing, costly and inefficient. We look forward to exploring the concepts of dietetics licensure compacts and uniform dietetics licensure applications.

Problems with licensure by endorsement or reciprocity among states arise from the fact that there is variation among the standard qualifications for nutritionists and dietitians in many (but not all)

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<sup>26</sup> Ramirez EC, Martinez LC, et al. Effects of a nutritional intervention on body composition, clinical status, and quality of life in patients with heart failure. *Nutrition*. 2004;20:890-895.

<sup>27</sup> Bradley DW, Murphy G, Snetselaar LG, Myers EF, Qualls LG. The incremental value of medical nutrition therapy in weight management. *Managed Care*. January 2013: 40-45.

<sup>28</sup> Federal Register Vol. 78, No. 26 at 9222. Accessed April 30, 2014 at <http://www.gpo.gov/fdsys/pkg/FR-2013-02-07/pdf/2013-02421.pdf>.

<sup>29</sup> Comment from Center for Nutrition Advocacy submitted March 10, 2014 at 3. Accessed April 30, 2014 at <http://www.ftc.gov/policy/public-comments/comment-00044-20>.

<sup>30</sup> Dr. Mehrotra noted the value of these types of innovations in the second session of the workshop: “But the real way we’re going to decrease health care spending, improve value, are these innovations in delivery, because they can be lower cost than our existing providers. And, also, because they can improve health, they can deter costly complications that might occur, such as hospitalizations, re-hospitalizations.”

licensure statutes. Alaska, Kentucky, Montana, North Dakota, Washington, and several other states have licensure or certification requirements for individuals that they license as a “nutritionist” that fall far below the federal standard for the “registered dietitian or nutrition professional” as codified in the Social Security Act<sup>31</sup>. This difference in standards could increase risk for harm to consumers by potentially authorizing unqualified practitioners to provide Medical Nutrition Therapy (MNT) and nutrition counseling who have taken as few as three nutrition courses in subjects such as “nutrient depletion & drug/herb interactions” or “dietary supplements.”<sup>32</sup>

#### **D. Summary**

The Academy appreciates the opportunity to comment on this important initiative and hopes to discuss these issues in greater detail in the near future. We are glad to serve as a resource if we can be of any help; please contact either Jeanne Blankenship at 202-775-8277 ext. 6004 or by email at [jblankenship@eatright.org](mailto:jblankenship@eatright.org) or Pepin Tuma at 202-775-8277 ext. 6001 or by email at [ptuma@eatright.org](mailto:ptuma@eatright.org) with any questions or requests for additional information.

Sincerely,

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Academy of Nutrition and Dietetics

Pepin Andrew Tuma, Esq.  
Director, Regulatory Affairs  
Academy of Nutrition and Dietetics

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<sup>31</sup> 42 U.S.C. 1395(vv)(2) (“[T]he term ‘registered dietitian or nutrition professional’ means an individual who—

(A) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized by the Secretary for this purpose;

(B) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

(C) (i) is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed; or

(ii) in the case of an individual in a State that does not provide for such licensure or certification, meets such other criteria as the Secretary establishes.

<sup>32</sup> See, “Eligibility Requirements for the Certified Nutrition Specialist<sup>SM</sup> (CNS) Credential,” upon which “nutritionist” licensure is typically predicated. Available at <http://cbns.org/certification/eligibility-requirements-for-the-certified-nutrition-specialist-cns/>. Accessed January 4, 2013.