Health Reform - Next Steps

HOD Backgrounder

In the Fall of 2009, the House of Delegates had its first dialogue about Health Reform. The overarching mega issue question discussed at the time was “What needs to happen to engage ADA members as an integral part of future health care models?” Dialogue participants developed a better understanding of what was occurring on a state level and ADA national level in regards to health reform. The approved motion, resolved that:

- All ADA members are empowered and prepared to respond to legislation related to health reform in all “calls to action” by the Association.
- The Legislative and Public Policy Committee develop a plan, budget and evaluation tool for effective legislative training programs as an urgent need of the membership (a preliminary report from LPPC has been submitted).
- The Legislative and Public Policy Committee take an influential leadership role in all future public policy activities that will assure the inclusion of the RD in legislation and regulations.
- Affiliate dietetic associations and DPGs collaborate and build partnerships within and outside the association to effectively position health reform and all critical legislative and policy issues related to the role of the RD as leaders in food policy and nutrition services.

Since this important dialogue, health care reform has been passed consisting of pieces of legislation (the “Affordable Care Act”). On March 23, 2010, President Obama signed into law the Affordable Care Act. The law puts into place comprehensive health insurance reforms that will hold insurance companies more accountable and will lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans. The Affordable Care Act is intended to achieve three main goals: provide coverage for thirty-two million uninsured Americans; improve affordability and stability of insurance for those who already have it; and slow the growth of health care costs to reduce the federal budget deficit.

Passage of the Affordable Care Act puts the United States on the path to a new health care paradigm that has significant implications for the profession of dietetics. Under the new framework, health care will begin to shift away from the current fee-for-service payment model to one focused on preventive care and wellness, a patient-centered approach to treating multiple chronic diseases, and a reformed delivery system that includes more primary care providers, medical homes, and community-based health centers. These changes are vitally necessary to achieving the Affordable Care Act’s interrelated goals.

The American Dietetic Association (ADA) has been engaged in the health care reform debate from the beginning, and is stepping up its policymaking efforts during the next stage of health care reform: the process of implementing health care reform through state and federal rulemaking and state legislation. This implementation stage began almost immediately following passage of the Affordable Care Act and will likely continue for over a decade. This phase is in many ways the most important for ensuring RDs and DTRs play an integral role in the provision of health care pursuant to the Affordable Care Act.
Mega Issue Question:
What is the role of the RD and DTR in the implementation of health care reform on the state level?

Expected Outcomes: Participants will:
- Understand how health care reform impacts the public and themselves professionally.
- Identify the challenges and opportunities for RDs resulting from health care reform legislation.
- Identify what members must do to take advantage of these opportunities, and what must ADA do to ensure members have the necessary resources for success?

Backgrounders for the House of Delegates inform the readers on the mega issue and provide answers to the following questions throughout the document:
1. What do we know about the needs, wants and expectations of members, customers and other stakeholders related to this issue?
2. What do we know about the current realities and evolving dynamics of our members, marketplace, industry, profession, which is relevant to this decision?
3. What do we know about the capacity and strategic position of ADA in terms of its ability to address this issue?
4. What ethical/legal implications, if any, surround the issue?

To prepare the HOD for the discussions on health care reform, this Backgrounder provides information in relation to the four questions throughout the backgrounder and is framed by ADA’s historic efforts for health care reform, details key elements of the Affordable Care Act that affect our profession, and describes how ADA expects to leverage our grassroots network on the state and federal level to continually influence health care reform during the implementation phase.

Knowledge-based Strategic Governance is a mechanism for consultative leadership. It recognizes that “strategy” is the necessary and appropriate link in the Board’s role to govern the organization, the House’s role to govern the profession and the staff’s role to manage implementation. To assist you in thinking about the issue to be addressed, four key background areas are presented as standard questions used for each Mega Issue. These questions create an environment of awareness of what is known and what is unknown. A wide range of resources have been used to provide you with what is known.

ADA’s Historic Efforts and Our Current Challenges

ADA’s 2008 Policy Recommendations
ADA released its report, Health Care Reform in 2008 (included in the August 2009 HOD Backgrounder) in anticipation of the legislative health care reform fight. The report detailed the policy recommendations of ADA’s Health Care Reform Task Force focusing on “preventive and interventional health promotion and the care and the role of the RD in maintaining health and wellness; disease prevention; and chronic care management throughout the continuum of life—preconception to end of life care.” Both the Health Care Reform report and this Backgrounder are purposely narrow in their focus on those health care reform “issues that most directly affect ADA’s professional membership.” Thus, although certain major elements of the Affordable Care Act—such as the individual mandate, subsidies to purchase insurance, and many new insurance market rules—will be significant in achieving the Affordable Care Act’s above-outlined goals, they are beyond the scope of this Backgrounder that is limited to Registered Dietitians’ (RDs) and Dietetic Technician, Registereds’ (DTRs) role in health care reform.
The Health Care Reform Task Force’s five policy recommendations (Appendix A) were a politically calculated synthesis of the needs and wants of members related to health care reform legislation. Key principles include:

- The vital and unique role that nutrition plays in improving and maintaining an individual’s health as well as the health of all Americans should be explicit in US health policy.
- Right to the best quality of health care available from qualified health professionals, including Registered Dietitians.
- Nutrition services are critical to comprehensive health care delivery systems. Health maintenance, wellness, disease prevention and early detection, delay in disease progression, and intervention in chronic care management are necessary components of a comprehensive health policy.

Challenges and Opportunities

ADA was successful in that many policy recommendations were specifically incorporated into the Affordable Care Act, and others may be ultimately included as part of health care reform through implementing regulations or state legislation (Appendix B). We can expect that nutrition will be included as a component of preventive services and as a therapeutic agent in the management of chronic disease, and there are likely to be additional opportunities for our profession as a result of health care reform. There are, however, a number of important factors that could complicate our ability to seize these new opportunities:

- The Affordable Care Act’s inclusion of nutrition does not equate to the specific inclusion of RDs or DTRs, and it remains unclear at this time whether the provision of these services will be from RDs or from other health professionals;
- The Affordable Care Act merely authorizes the creation of the new programs and policies and thus only may provide new professional opportunities for RDs and DTRs. The Affordable Care Act does not appropriate (i.e., actually fund) the monies necessary to carry out most of the new programs, and does not guarantee any enhanced professional roles or new opportunities reserved specifically for RDs or DTRs; and
- Our competitors are engaged in aggressive advocacy efforts that—in the absence of a countervailing RD presence—may result in RDs being undervalued and omitted from state programs and delivery of services.

Health care reform’s focus on nutrition and preventive care will likely benefit the profession to some extent, but we can be assured of far greater benefits if we (1) better position ourselves to health insurers, physicians, and other decision-makers as the best qualified and most efficient providers of reimbursable services, and (2) actively engage policymakers and encourage them to adopt state and federal regulations that specifically include RDs and DTRs as eligible providers of particular services.

Health Care Reform Legislation and Our Profession

Health Care Reform Framework and Provisions

The Affordable Care Act, together with the funding foundation laid by American Recovery and Reinvestment Act of 2009 (ARRA), put the United States on the path to a new health care paradigm that has significant implications for the dietetics profession. The new framework for health care in America is notable in two significant ways relevant to RDs and DTRs: (1) a reorientation of the system toward preventive care and wellness, and (2) moving toward a patient-centered approach to treating multiple chronic diseases through a reformed payment and delivery system that includes more primary care providers, medical homes, and community-based health centers.
Preventive Care and Wellness

• **Background: The Obesity Epidemic, Chronic Disease, and Comorbidities**
  - In the United States, 45% of the population has one or more chronic conditions, including obesity and diabetes, and 75% percent of the nation’s aggregate health care spending is on treating patients with chronic disease.  
  - Yet even though the vast majority of these chronic diseases are preventable, less than 1% of total health care spending in 2009 went toward prevention. This allocation percentage continued, in which the largest fraction of the stimulus funds—1/6th or $122 billion—went to the Department of Health and Human Services, but less than 1% of that—or about $1 billion—went towards prevention and wellness. Still, preventive care advocates claimed even this small percentage as a historic victory, particularly the $650 million dedicated to chronic disease prevention, and funding is expected to see sustained increases.
  - It is the position of the American Dietetic Association that primary prevention is the most effective, affordable course of action for preventing and reducing risk for chronic disease. RDs and dietetic technicians, registered, are leaders in delivering preventive services in both clinical and community settings, including advocating for funding and inclusion of these services in programs and policy initiatives at local, state, and federal level.
  - Preventive care and wellness efforts will be directed in large part towards attacking the growing obesity epidemic, one of the most significant health care problems in the United States and the etiology of many comorbid conditions.
  - With regard to older adults, ADA takes the position that “older adults should have access to food and nutrition programs that ensure the availability of safe, adequate food to promote optimal nutritional status.”

• **Preventive Care Provisions**
  - The Affordable Care Act reflects a growing recognition that both enhanced preventive care and a healthier American population are medical and economic necessities for the United States. Provisions include numerous large and small grants and initiatives that, taken together, reflect a genuine shift in focus for the government—a shift that is likely to affect the practices of many health care professionals as well.
  - The Affordable Care Act particularly emphasizes preventive care for diabetes for two reasons.
    ▪ First, the prevalence of the costly epidemic is growing parallel to increases in obesity; it doubled between 1986 and 2006 to include 24 million Americans and cost the United States $174 billion in 2007.
    ▪ Second, “if the disease is caught in the pre-diabetes stage, initiating lifestyle changes can reduce the risk of developing diabetes by 58%.”
  - A sampling of the Affordable Care Act’s preventive care initiatives and programs that could provide new professional opportunities for enterprising RDs include:
    ▪ Approved preventive services will be free to Medicare and Medicaid beneficiaries to avoid the possibility that co-payments or other cost-sharing might dissuade them from obtaining preventive care; and
    ▪ RDs and DTRs will have the opportunity to compete for new preventive and wellness reimbursements and referrals from (a) the government from annual wellness exams and comprehensive risk assessment, and (b) private health insurers who will be required to offer expanded preventive care services without cost-sharing.
    ▪ Potential for expansion of Medical Nutrition Therapy in both Medicare and Medicaid recipients exists. To reduce health care costs, Medicaid will cover preventive services recommended by U.S. Preventive Services Task Force (USPSTF), including “intensive
nutrition behavioral counseling” for adults with “other diet-related chronic diseases,” an asset undefined phrase that could potentially include millions of beneficiaries who traditionally and disproportionately suffer from chronic diseases related to over- and under-nutrition;

- Wellness incentives for employees and behavior modification incentives for Medicare and Medicaid beneficiaries who meet specified health targets (e.g., for weight, cholesterol, or tobacco-use) recipients could contract with RDs to help meet the targets;⁹
- Grants to small employers that establish wellness programs;
- Grants to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, especially in rural and frontier areas;¹⁰
- Grants and funding through a Prevention and Public Health Fund for prevention, wellness, and public health activities including prevention research and health screenings, and the Education and Outreach Campaign for preventive benefits;¹¹
- Nutritional and calorie labeling on chain restaurant menus, menu boards, and drive-through displays, as well as on vending machines. The requirement applies to chains with 20 or more outlets operating under the same name, and requires them to provide additional nutrition information similar to that found on packaged foods on-site upon request; and
- Recognizing existing health disparities and the fact that prevention for diabetes is not a cure-all (given that millions are unaware they have the disease and millions more fail to get necessary care to stay healthy once diagnosed), the Affordable Care Act expands access for coverage, improves quality, and makes efforts to address disparities by investing in data collection and research about disparities and by focusing on cultural competency for health care providers.

- **Process of Determining Acceptable/Reimbursable Preventive Care and the USPSTF**
  - The USPSTF describes itself as “an independent panel of non-Federal experts in prevention and evidence-based medicine and is composed of primary care providers (such as internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists) [that] . . . conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. These recommendations are published in the form of “Recommendation Statements.”¹²
  - The Affordable Care Act generally requires coverage in government or group health plans without cost-sharing only for those preventive services recommended by the USPSTF (with a rating of ‘A’ or ‘B’) after completing its process of reviewing and assessing the available “evidence.”
  - The USPSTF’s published methods seem to favor randomized clinical trials (RCT); a method that many health care providers argue is too restrictive for evaluating evidence and may “inadvertently exclude many important findings and fail to support further relevant research.”¹³ As clinical practice—particularly among pediatrics—shifts from its focus on curing disease and infections to promoting health and reducing risks, they assert that “the tools used to gather evidence and measure the effects of health care interventions have not kept pace. Thus, the evidence supporting new, effective public-health-based approaches to child health promotion has not been given sufficient weight in the formulation of guidelines for care and reimbursement. Unless the existing evidence framework is modernized and broadened, health care reform efforts that promote evidence-based care may inadvertently limit the use of effective interventions and may undermine advances in child health.
- Recognizing this unique situation, the Affordable Care Act covers “evidence-informed preventive care and screenings” for “infants, children, and adolescents” as provided in the comprehensive guidelines supported by Health Resources and Services Administration (HRSA). ADA, affiliates, and members are encouraged to make public comment (similar that described below with regard to regulations and rulemaking) on both specific recommendations from the USPSTF and key questions for evidence reviews.
- ADA supports research in practice based settings via the Dietetics Practice Based Research Network.
- ADA’s Evidence Analysis Library and the Evidence-based Practice Committee are integral parts to ensuring that available research is analyzed so that RDs and DTRs can make evidence-based practice decisions. However, dietetics is a broad profession and not all settings lend themselves to RCTs nor do all areas of practice have the research available to make evidence-based practice conclusions.

Payment/Delivery System Reform and Access to Care

- Changing demographics of the U.S. population include unparalleled growth in the number of Americans eligible for Medicare based on age alone, with Medicare costs projected to rise until the program becomes unsustainable. In addition, massive spending on recipients with multiple and/or previously untreated chronic diseases are a significant element of that continued growth. An increasing number of Americans with longstanding chronic diseases but without a history of insurance or proper treatment for those diseases would, upon acquiring Medicare, begin to receive treatments with substantially increased costs because of the treatment delay. Recognizing that “[96%] of Medicare expenditures are spent on patients with multiple chronic conditions, and much of the rise in Medicare costs in recent years stems from treatment of chronic diseases,” the Affordable Care Act encourages a patient-centered approach for delivery systems that are shown to more efficiently manage multiple chronic diseases and provide incentives for providers to cure disease rather than treat illness.

- “A core purpose of the health reform law is to advance reforms in health care delivery through innovations in payment, technology, and other tools that have been shown to improve quality and reduce unnecessary or harmful spending. The primary policy engine for accomplishing health system change is the expanded authority given to the Secretary of Health and Human Services to undertake major pilot programs in health care delivery and organization that can be ‘scaled up’ as evidence of their impact emerges.”

- Health care delivery is expected to change dramatically as a result of health care reform:
  - Health reform will increase investments in primary care while testing innovative payment methods designed to reward high quality and value. The creation of a Center for Medicare and Medicaid Innovation will provide a platform for developing new approaches to paying for health care to encourage greater quality and efficiency. Currently, providers are paid more for providing more services, more complicated procedures, and more expensive care.
  - The long-run viability of the health care system depends on paying for and providing care in a way that yields value for the resources spent. For example, instead of paying providers according to the current fee-for-service model, Medicare and other payers may pay according to how well providers manage the care and health of their patients with chronic illnesses, like diabetes. Or they may start “bundling” payments for hospital procedures—instead of separate payments to hospitals and doctors involved in a patient’s care, a single reimbursement would cover an entire hospital stay for a medical procedure.
  - Under these payment approaches, providers demonstrating superior patient outcomes and prudent use of resources would be rewarded. Those who provide unnecessary, duplicative,
or avoidable services may not fare as well, and might strive to improve their care.\textsuperscript{17}

- The Department of Health and Human Services’ Interagency Workgroup on Multiple Chronic Conditions recently released a draft of its report “A Strategic Framework 2010-2015: Optimum Health & Quality of Life for Individuals with Multiple Chronic Conditions” (http://www.hhs.gov/ophs/initiatives/mcc/federal-register051410.pdf) outlining a framework for a new approach to addressing chronic illnesses. ADA provided comment to HHS on the report.

- **Health Disparities and Access to Care**
  - Health disparities arise in delivery systems minority and rural populations that often have (1) limited access to and the inability to afford health care, (2) limited access to qualified health care professionals, particularly primary care providers, and (3) higher than average rates of chronic disease.
  - Although medically underserved and minority populations experience many similar disparity rates (rural areas often include substantial minority populations), the shortage of health care professionals is particularly acute in rural counties and requires some innovative solutions.
  - Seventy-seven percent of rural counties have a primary care health professional shortage, and 10% of rural counties have zero primary care physicians.\textsuperscript{18} Of the 65 million Americans in communities with primary care provider shortages, 50 million live in rural areas;\textsuperscript{19} the shortage of RDs in rural America is similarly problematic.
  - Compounding the health professional shortage is the fact that rural inhabitants are among the least healthy overall, with “rates of chronic disease such as diabetes, heart disease, high blood pressure and obesity that are greater than urban or suburban population.”\textsuperscript{20}
  - The Affordable Care Act includes several provisions to ameliorate health disparities and improve access to care:
    - To help curb chronic disease, many of which are disproportionately prevalent in minority and rural communities; preventive services that are covered will require no out of pocket costs to anyone while still providing reimbursement to the provider.
    - Provide substantial funding for technologies, including, telehealth, that allow health professionals to remotely perform tasks that generalists or allied health professionals may be technically or legally unqualified to perform;\textsuperscript{21}
    - The stimulus package (ARRA) provided substantial funding for technology infrastructure and for the adoption of electronic health records. Implementation of the Affordable Care Act will speed the transition to electronic health records;
    - Because both community health centers and the National Health Services Corps serve as a vital health care safety net for rural and minority communities (providing preventive and primary health care services to 17 million people at over 7,500 sites nationwide), the Affordable Care Act increases funding by $11 billion over five years. These facilities and populations will continue to demand the services of RDs and DTRs whether provided remotely or while physically present;\textsuperscript{22}
    - To assist those who either lack access to providers or the ability to afford coverage, the Affordable Care Act includes two Medicaid-related mechanisms:
      1. the expansion of Medicaid to cover approximately 16 million additional people with incomes below 133% of the federal poverty level and
      2. an increase in the historically low reimbursement rates for Medicaid in both 2013 and 2014 that is expected to result in a significantly increased number of providers willing to accept Medicaid.\textsuperscript{23}
The expansion of Medicaid could result in significant opportunities for members if state and federal regulators are convinced of both the value and benefit of having an RD provide particular services covered by Medicaid under the Affordable Care Act; and

- Medical home waivers are allowed for state coordinated programs, and although RDs are listed as eligible providers, each state will implement regulations determining whether competitor providers are similarly eligible.

- **Delivery System Reform**
  - The “patient-centered medical home” (PCMH) and “accountable care organizations” (ACOs) models provide new opportunities for dietitians to work together with other health care professionals in a direct patient-management role.
  - Pharmacists, physicians, nurses, and others are shown to be effective in fighting patients’ chronic conditions, when each performs specialized tasks in collaboration with the others. This implies that opportunities exist for health professionals such as RDs.
  - Specialization and integrated care teams are the keys to the success of the PCMHs model:
    - Health centers often rely on physicians to perform care management functions that could be effectively performed by another member of the care team, such as a nurse or medical assistant. Recent studies have demonstrated the importance of providing care management services that are well integrated with the patient’s regular source of care. Using team members within the practice to provide clinical care management, care coordination, and patient self-management services frees up providers’ time, enables staff to work at the highest level their licensure or certification allows, and improves health outcomes for patients.
  - Relevant considerations for RDs related to delivery system reform and patient-centered health care include the following:
    - The Affordable Care Act makes RDs eligible for payment as part of a medical home team, but do not require that they are included on the team, placing the onus on RDs to convince PCMH teams that they can provide a high level of effective services to patients more efficiently than can the team without them. ADA’s website provides detailed information about “RDs in the Medical Home Model of Care” and positioning oneself as an integral part of the medical home team. (Available at [http://www.eatright.org/HealthProfessionals/content.aspx?id=7057](http://www.eatright.org/HealthProfessionals/content.aspx?id=7057));
    - Similarly, the Affordable Care Act makes RDs possible, but not required providers of home health services for a demonstration program. ADA’s 2009 Practice Paper: “Home Care-Opportunities for Food and Nutrition Professionals” is relevant for RDs potentially interested in the home health pilot program or interesting in providing home health services more generally. (Available at [http://www.eatright.org/About/Content.aspx?id=8395](http://www.eatright.org/About/Content.aspx?id=8395))
    - RDs may have an increased role in community health centers. The PCMH and ACO models have applicability for those in the social safety net, and experts are examining how “public hospitals and clinics, federally qualified health centers (FQHCs), rural health centers, and free clinics for the medically underserved—collectively referred to as safety net health centers or practices—regularly deliver on some aspects of the medical home model.” These safety net health centers will be crucial in delivery access to health care in underserved populations. Many of them are health care clinics located in schools to enhance care coordination and “integrate behavioral health and specialty care into care delivery,” and the Affordable Care Act includes grants to encourage them—with nutrition counseling by non-specified providers listed as an optional service.
Individual Insurance

- The Affordability Act includes a requirement for individuals to purchase health insurance. Although access to Medicaid was expanded, there will still be a significant number of individuals who will not meet the financial requirements for Medicaid coverage and will need to purchase individual health insurance policies.
- The Affordability Act’s mandate for individual health insurance calls for insurers to participate in insurance “exchanges”. The Affordability Act will create American Health Benefit Exchanges, where individuals who are eligible (133-400% of the federal poverty level) will receive premium and cost-sharing credits towards purchase of health insurance. Individuals who do not purchase individual health insurance will be fined up to 2.5% of household income.
- Regulations focus on how the Health Benefit Exchanges function. First, those eligible to purchase insurance through the exchanges would be individuals and small businesses that employ up to 100 workers. Each state must offer at least two multi-state plans, and one of those plans must be through a not for profit agency. Health Benefit Exchanges must also meet criteria for four types of plans in addition to a catastrophic plan. The catastrophic plan would be available to young adults.
- The Affordability Act calls for creation of four levels of qualified health plans (QHP). At a minimum, QHPs must include acute care, rehabilitation care, mental health services, prescription drug benefit, maternity and newborn care, pediatric services and preventive and wellness screening.

Insurance Coverage Reform

- Insurers will face a major change under the Affordability Act in that they can no longer deny insurance to those who fall into “high risk” categories.
- Additionally, insurers will not be able to place lifetime caps on coverage. Insurers offering individual plans will not be able to deny coverage based on pre-existing conditions or to increase rates for those individuals with pre-existing conditions as they were in the past. The provisions for pre-existing conditions will be phased in over four years. Individuals with pre-existing conditions will initially be placed into a temporary pool with subsidized premiums with final implementation in 2014.
- Finally, the Affordability Act guarantees insurance coverage for adult children until they reach the age of 26 years.
- Additionally, the amount of coverage offered by individual plans must meet one of several tiered levels in order to qualify. Individuals who qualify will be eligible for tax credits meant to offset the cost of health insurance. In order to keep rates affordable, insurers will have to carefully manage resources, evaluate quality of care and implement new care models.

Capacity and Strategic Position to Address the Issue

ADA’s Strategic Plan

One of ADA’s stated values is “Innovation—Embrace change with creativity and strategic thinking.” (See, Strategic Plan at http://www.eatright.org/strategicplan) Within our Strategic Plan, there are three goals, each with a number of strategies to meet the respective goal. Here, are only those goals and their strategies relevant to health care reform are listed.
- Goal 1: The public trusts and chooses registered dietitians as food and nutrition experts.
  - Create a respected brand
  - Establish value to the public through effective programs, services and initiatives offered by registered dietitians
• Goal 2: ADA improves the health of Americans.
  - Impact food and nutrition policies
  - Provide opportunities for members to participate in the legislative and regulatory processes at local, state and federal levels
  - Strengthen relationships with external organizations to further ADA initiatives
  - Inform the public about ways to improve its health
  - Equip members to conduct and use research in their work
  - Strengthen cultural competence to address health disparities

• Goal 3: Members and prospective members view ADA as key to professional success.
  - Enable graduates of CADE accredited programs and CDR credentialed practitioners to position themselves as the nation’s food and nutrition leaders
  - Provide relevant and valued products and services for diverse member audiences
  - Provide research and resources that can be translated into evidenced-based practice
  - Serve the needs of a changing demographic group of registered dietitians

Infrastructure and Communications: Members, Volunteers, and Staff

• ADA’s Grassroots Structure for Policy Advocacy
  - ADA is a member-based professional association where grassroots involvement of every member combines with an infrastructure of paid staff, a dedicated board and passionate volunteers to support our public policy mission at both the federal and state level. Member support for our public policy mission is critical, necessitating that ADA staff keeps members reasonably informed about relevant public policy issues, particularly issues requiring members’ advocacy on behalf of our profession. As part of our strategy to achieve Goal 2 (“ADA improves the health of Americans”) of the Strategic Plan, ADA recognizes the value in initiating and sustaining its involvement with both strategic partnerships and with broad coalitions of likeminded associations and organizations, such as ADA’s work with the Partnership to Fight Chronic Disease.27
  - Significant restructuring of the Washington, D.C. office in the months coincided with the health care reform debate in Congress, yet the dedicated staff in Washington continued to effectively advance ADA’s priorities on Capitol Hill and at federal agencies by teaming up with expert staff in Chicago, contracted professionals, and committed volunteer leaders who trained and advocated at the Advocacy Training Workshop (ATW) in the spring. The current restructuring in the Washington office demonstrates ADA’s commitment to public policy at a critical juncture for the dietetic profession by extending the resources available for us to make the necessary impact at the state and federal level. The commitment includes the addition of two ADA members to the executive team: Jeanne Blankenship, MS, RD, CLE (Vice President for Policy Initiatives and Advocacy); and Mary Pat Raimondi, MS, RD (Vice President for Strategic Policy and Partnerships). Their passion for ADA and longtime public policy experience on behalf of RDs and DTRs will be instrumental in crafting, refining, and carrying out ADA’s state and federal strategies for the implementation of health care reform over the next several years.
  - ADA staff members continue to prepare for upcoming opportunities to comment officially and unofficially on proposed rules according to their identified skill sets. As noted above, ADA commented on HHS’ interagency report on multiple chronic conditions. Staff with specific federal regulatory expertise, for example, has taken the lead in working with legislators and agency policymakers within CMS to support an enhanced role for MNT by expanding its category of preventive services beyond renal and diabetes to include a broad category of diet-related chronic diseases.
- Key volunteer and staff positions, committees and other elements within our grassroots advocacy network are extensive (Appendix C and D).

Communications and Training

- Constant, strategic, and effective communication between ADA staff, state affiliates, and members will be one of the keys to success during the implementation phase. ADA has developed a number of new communications tools and training strategies specific to health care reform implementation (such as the new Health Care Reform Web Portal and the state-specific analyses for affiliate PPPs, described below), while simultaneously enhancing those established tools and strategies (such as grassroots advocacy training workshops and webinars) that continue to be valuable mechanisms for encouraging member and affiliate involvement with state and federal policymakers.

- New Health-Care Specific Communications Mechanisms
  - To better facilitate communication about health care opportunities and help members respond to ADA “calls to action,” ADA has developed a toolkit for students (Appendix E) and RDs to get involved in the implementation process and are actively working with state affiliates to create state strategies RDs can follow during the implementation phase to ensure effective utilization of member talent within each state.

- Health Care Reform Web Portal:
  - The goal of the Web site is to provide a place for ADA members to go for complete information on health care reform opportunities for RDs. There will be between 20 and 25 initiatives detailed on the Web site.

- State-by-State Analyses:
  - ADA has completed a state-by-state analysis for current initiatives available in each state. The analyses include information on a variety of health care reform projects and opportunities; and
  - Information on anticipated dates/deadlines, relevant state links, and state agency contacts were provided. These analyses sent in mid-July, enabled affiliate public policy leaders to get started immediately in mobilizing a plan in their state.

- FNCE Programs (November 6 – 9, 2010 in Boston, Massachusetts)
  - **HOD Meeting (Friday November 5 and Saturday November 6, 2010):** The LPPC chair and Policy Initiatives and Advocacy (PIA) staff will present an update on Health Reform to the House of Delegates in advance of the dialogue session on the next steps in health-care reform. In addition, the PIA staff will share the association activities related to health reform, including the member training plan and communication pathway.
  - **Pre-FNCE Affiliate Workshop (Saturday November 6, 2010):** This workshop for policy and advocacy has been planned in conjunction with the previously scheduled affiliate leader training. This venue will provide an opportunity to strengthen the grassroots advocacy skills of affiliate leaders and is an opportunity to update attendees about Health Reform. The specific roles of public policy panel members including the PPC, SPR, and the SRS will be further defined with specific training on how to position the RD and DTR in the current competitive environment. Presentations and hands-on activities will include messaging and implementation strategies that foster the role of the DPGs as content experts. The evaluation component of the trainings will include participation feedback as well as outcome measures identified by the LPPC and PIA staff and reviewed with the Professional Development team prior to the execution of each training event. Evaluation results will be shared with the HOD and BOD.
  - **Nutrition Policy and Advocacy Track (Monday November 8, 2010):** For the first time in ADA’s history and at the suggestion of the LPPC Grassroots Task Force, an advocacy
educational track has been scheduled on Monday, November 8, 2010. The conference track will include three sessions focused on hot topics, discussions and a plenary session, and will include CPE credit. The morning session is entitled “What's Next in Health Care Reform? Challenges and Opportunities” and will discuss how state and federal health-care reform initiatives will impact nutrition services as well as the role of RDs in these programs. This panel will update on current federal activities and the much-discussed payment reform efforts including bundled payments and the patient-centered medical home. A special look at changes in Massachusetts after its universal plan was passed in 2006 may give a glimpse of what to expect as health-care providers. Speakers will focus on the roles of the RD and DTR in advocacy and positioning for best outcomes as these changes take place.

- **Affiliate FNCE Face to Face Meetings:** The PIA staff will continue to build upon the success of previous open communication forums for dialogue with affiliate public policy leaders. All affiliates participate in these meetings which occur in 30 minute sessions. During these sessions, affiliate leaders have the opportunity to dialogue directly with PIA staff and with their colleagues from other states. A member of the LPPC and the ADAPAC are requested to attend each of the scheduled meetings. A schedule will be made available for committee members to designate the sessions in which they are able to participate.

- **DPG Face to Face Meetings:** Face to face meetings will be scheduled on Sunday, November 7. LPPC members and staff will meet with DPG leaders to discuss policy issues and opportunities for collaboration with affiliates.

- **Comprehensive Grassroots Training**
  - In May 2010, an advocacy training workshop was held for state affiliate policy leaders. Leaders were trained in issues facing the profession including health reform and how to respond to these issues.
  - ADA will follow up with affiliate public policy leaders charged with leading the health care reform efforts in their affiliate. Affiliate leaders will be trained to work closely with their grassroots membership to organize their outreach for state initiatives and opportunities for health care reform. Members and leaders are encouraged to select only two or three initiatives and will actively track progress on those projects;
  - Action-oriented webinars giving timely communications related to health care reform are scheduled over the course of the entire year and include affiliates, general members, staff, and students;
  - ADA will specifically focus much of the grassroots training on the affiliate public policy panel, especially the newly-created State Regulatory Specialist (SRS) – The SRS will be charged with leading the drive for health care reform for each affiliate;
  - Affiliate leaders are actively encouraged to collaborate with DPG leaders and their state delegates to integrate all of the leadership and to rely on the expertise of these leaders for participation in these specific health care reform opportunities; and
  - ADA will include specific plans for outcome measures on our success with health care reform initiatives.

- **Existing Communications and Training Mechanisms (Appendix G)**
  - In addition to the new tools described above, ADA provides the following established mechanisms for training and communication throughout the implementation phase:
  - **Public Policy Workshop (PPW)** ([http://www.eatright.org/ppw/](http://www.eatright.org/ppw/)): ADA hosts an annual workshop that sets a goal for each state affiliate to arrange appointments to meet with their congressional representatives and two senators to discuss ADA’s key messages. In 2010, over 2,200 ADA members viewed the online 2010 Public Policy Workshop. The 2011 PPW will return to being an
in-person gathering, and will provide another venue for giving members additional information and training specific to health care reform;
- EatRight Weekly: ADA’s weekly e-newsletter, which replaced On the Pulse, will continue to provide timely updates with regard to health reform;
- Affiliate and DPG Newsletters will have detailed, timely information about state- and practice-specific health care reform trainings, implementation dates, and ways for members to get involved; and
- Journal of the American Dietetic Association: includes many articles on health care reform. The Journal will continue to be used as a communication pathway to practitioners and will provide time sensitive updates on various aspects of health reform, including restaurant menu labeling and workplace accommodations for breastfeeding women among others.

Background on Rulemaking

- There is a complex regulatory process (often referred to as “rulemaking”) that will flesh out the Affordable Care Act’s framework for health care reform and thereby determine the details of health care policy in the United States (Appendix G).
- Health care reform will affect nearly all Americans’, especially those covered by Medicare and Medicaid, and it is sure to profoundly impact health care providers, including RDs and DTRs. This is especially true in those instances where federal and state statutes and regulations may pit RDs in competition for reimbursements and eligibility standards with other providers. As professionals, we RDs know that our body of knowledge, training and skills are unique in the delivery of health care. And furthermore, as professionals we also know the importance of sharing this expertise with agency officials whose regulations will shape the care given the patients they treat.
- The regulatory process is of paramount importance to RDs. It is where the details of statutes are set, including such important considerations as which providers may participate in health care delivery and the circumstances of that participation. The table in Appendix B includes rulemaking details for those provisions in the Affordable Care Act where RDs are specifically included or contemplated, including (if available) the agency charged with authority and any set deadlines. Examples of these future regulations that will undoubtedly and broadly affect dietitians under health care reform include:
  - Determination of funding and grants for nutrition programs;
  - Setting parameters for various health care demonstration and pilot programs often by CMS (including the Patient Centered Medical Home Project scheduled for implementation later this year);
  - State pursuit of federal grant money that can benefit dietitians, such as community health grants;
  - Benefit design choices within Medicaid and other programs, such as requiring coverage of services such as dietary counseling;
  - Identifying which practitioners will provide services in health care programs, which is especially important since federal regulations often list RDs as providers while federal statutes usually contain “recommendations” as to who the providers should be; and
  - Setting Medicare standards for both a referral process and reimbursement rates.
- A number of experts are questioning states’ capacities for implementing health care reform and expanding their Medicaid programs, and we are almost certain to see significant variance among states in the manner and extent of implementation. Members must ensure that states must carefully “monitor federal guidance and regulations in all areas where state action is required or optional—particularly with respect to the exchanges, Medicaid, and insurance regulation . . . [in addition to] monitor[ing] federal implementation as it affects states, such as how the federal
government defines a medical home...”29 With so much at stake individually and for the profession as a whole, it is crucial that every member become involved to the fullest extent possible.

- The process of ensuring members are prepared to becoming actively involved will require enhanced communication between delegates and their affiliate public policy leadership. ADA and the LPPC recommend that delegates contact the PPC, SPR, or SRS prior to attending district meetings to better coordinate messaging to the district membership. In addition, ADA and the LPPC recommend that the PPPs work with delegates to create an affiliate plan to communicate more regularly with one another to allow the PPP to provide delegates with public policy updates.

- Much of the specific timing during the implementation stage of health care reform remains unknown at this point, including most of the dates on which state and federal agencies will publish official notices, propose regulations, or call for comments. Further, information related to the implementation of health care reform is quite literally changing daily, and is growing exponentially. It was in anticipation of these factors that the LPPC recommended that ADA enhance its efforts (as described above) to help affiliates develop effective public policy panels and member volunteers who are trained and ready to respond to with limited notice.

- ADA actively encourages affiliates and members to comment on an agency’s proposed rule, with the understanding that regulators will view comments as more meaningful, effective, and far-reaching if members first contact ADA’s regulatory experts and political staff to assist you in developing and incorporating the association’s views. By working with ADA and our colleagues from around the country, we bring to bear the force of experience, the power of scientific and evidence-based research, and our cumulative professional judgment to help shape the future of health care for all Americans.

**Positioning to Insurers, Physicians, and Policymakers**

- RDs position themselves as the nutrition experts through a variety of ways—face-to-face meetings with decision makers, lobbying, legislation, building relationships, providing evidenced-based research that MNT works, partnering and so on. Those states that see the greatest success have highly motivated, business-savvy RD leaders who coordinate their efforts and are persistent.

- The process to successfully positioned RDs to physicians, health insurers, and other decision-makers as the best qualified and most efficient providers of reimbursable services is not necessarily easy, takes time and commitment, but can be personally and professionally rewarding.

- For more specific information, ADA’s website is an excellent resource explaining the process by which a physician refers either Medicare or private insurance patients to an RD (http://www.eatright.org/HealthProfessionals/content.aspx?id=6863).

**Concerns and Awareness of Competition in the area of Nutrition**

**Marketplace for Dietitians, Nutritionists, and “Nutrition Professionals”**

- Health care reform clearly creates a demand for professionals qualified to provide nutrition services, but regulations will determine qualifications and eligibility. The Bureau of Labor Statistics (BLS) anticipates a 9.2% growth rate in the number of dietitians and nutritionists between 2008 (60,000 employed) and 2018 (66,000 antic. employed).30 However, given growth and net replacements, the BLS anticipates a total of 26,000 job openings for dietitians and nutritionists in 2018. Workforce capacity remains a concern, and ADA’s credentialing organization, CDR, is actively studying the issue.

- Within the marketplace for dietitians, clinical practice remains both the largest practice area and also one of the least well compensated. Non-clinical RDs and clinical RDs both have competitors in the marketplace for nutrition-related services, although clinical dietitians in the heavily regulated
facilities generally are protected from a serious competitive threat. The marketplace outside of acute care is substantially less regulated, and RDs face competition from traditional health care providers, non-traditional and holistic health care providers, and other professions like personal trainers. In growth areas such as prevention and wellness, client consulting and private practice, an array of competitors are already providing would-be clients with personalized health education and nutritional counseling where it is profitable and legal for them to do so.

- ADA is acutely aware of both the competition RDs and DTRs face and the likelihood that health care reform may increase competition in some practice areas. ADA is actively engaged in developing plans to succeed in this competitive environment and in ensuring that only genuinely qualified and licensed dietitians practice dietetics in those states that require licensure. However, to protect the public from unqualified practitioners, ensure the integrity of the profession, and comply with our code of ethics in this regard, ADA requires the assistance of every member in filing complaints with state dietetic boards when any of us becomes aware of unlicensed practice. This process is not utilized to fullest potential which leads state regulators to question the need for licensure which may ultimately lead to loss of licensure.

**Competition and Rulemaking**

- The extent to which unqualified competition is present and the type of professional with whom RDs will compete depends upon a number of factors, including (1) any applicable regulations or state laws limiting the eligibility of non-RDs to provide the nutrition services, (2) the entity or individual paying for the services, and (3) supply, specifically whether the number and capacity of available dietitians in the area is sufficient to meet the entirety of demand. As government funding for preventive care and wellness increases and private insurers continue expanding coverage to include additional reimbursements for visits to nutrition professionals, we can likely expect a growth in the number of health care professionals willing to provide nutritional counseling.

- Because of the ongoing shortages of health care professionals, RDs will likely face hearty competition in growth practice areas from other professionals with less education and training in nutrition. However, this may also work to our advantage by increasing the demand for RDs as other health professionals are too busy to address nutrition related issues or require additional assistance with patient care. Many existing regulations from CMS use the phrase “registered dietitians or nutrition professional” to describe the eligibility requirements, and define “nutrition professional” in such as way that states have some flexibility in determining that some individuals without the rigorous qualifications of RDs can provide some services. For those states that license nutritionists that are not RDs, it is likely that individuals may be eligible to provide some of the services promoted by the Affordable Care Act.

- Each and every state will make draft regulations during this implementation phase setting eligibility standards for each of the services detailed above that will effectively define RDs’ and DTRs’ competition for years to come. Given that tremendous impact on the profession, members must take action to advocate for regulations that protect the public by ensuring strict qualifications for providers.

**Ethical and Legal Implications/Considerations**

- The legal implications of health care reform are potentially staggering in both substance and form. It is not hyperbole to suggest that the state and federal rulemaking for health care reform will likely be the most important rulemaking process with the most significant legal implications this country has ever experienced. For our members, the rulemaking process alone will determine who is eligible to perform what reimbursable services, it will define the legal competitors for RDs in the
marketplace for the foreseeable future, and it requires compliance with an occasionally esoteric rulemaking process.

- At this stage, it is difficult to arbitrarily narrow the list of legal implications of health care reform. It is almost assured that lawsuits will be filed by various associations, as those harmed by a proposed rule will seek to kill it by any means available. But it is too early to make judgments about specific implications unless and until facts develop that permit a less generic and seemingly dramatic answer about open-ended implications. Until then, members and staff should be familiar with the basic contours of administrative law to ensure they feel comfortable advocating on behalf of ADA.
Appendix A: Health Care Reform Task Force’s Policy Recommendations

The Health Care Reform Task Force’s five policy recommendations reprinted below were a politically calculated synthesis of the needs and wants of members related to health care reform legislation:

1. The primary focus of any health care initiatives must be to improve the health status of Americans. The vital and unique role that nutrition plays in improving and maintaining an individual’s health as well as the health of all Americans should be explicit in US health policy.

2. Every American has a fundamental right to the best quality of health care available. This right includes access to (a) healthy food and (b) qualified health professionals, including Registered Dietitians.

3. Nutrition services are critical to comprehensive health care delivery systems. Health maintenance, wellness, disease prevention and early detection, delay in disease progression, and intervention in chronic care management are necessary components of a comprehensive health policy.

4. The nation has to address the increased costs of health care and act now to:
   a. Expand coverage of nutrition services to a broader range of services where MNT will improve health outcomes.
   b. Improve the coordination of health care and disease management. Include nutrition care provided by Registered Dietitians in team based programs and cover preventive and interventional nutrition services by individual RD providers.
   c. Improve and expand health information technologies and fully integrate nutrition status data into both medical records and personal health record systems. Health information technologies should continue to be geared toward improving health and health care quality; reducing unnecessary expenses and inefficiencies in the delivery of care.
   d. Support a viable economic infrastructure that patients can count on through sound, sustainable funding.
   e. Fair market value is the appropriate standard for nutrition services reimbursement.

5. Nutrition education, nutrition assessment, nutrition counseling and nutrition interventions are examples of the unique knowledge, training and skills RDs possess and will prove to provide unmatched value to the patient.¹
## Appendix B: Table of Relevant Provisions and Implementation Dates

<table>
<thead>
<tr>
<th>Provision</th>
<th>Senate H.R. 3590 - Patient Protection &amp; Affordable Care Act with amendments from House H.R. 4872 - Reconciliation Act of 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Aging. Preventive Services for adults 55-64</td>
<td>The Affordable Care Act establishes a grant program for state and local health departments and Indian tribes for: public health interventions, community preventive screenings, and referral and treatment for chronic diseases for individuals between 55 and 64 years old. Intervention activities include improving nutrition and increasing physical activity.</td>
</tr>
<tr>
<td>Workforce</td>
<td>The Affordable Care Act calls for an analysis of the current health care workforce (including registered dietitians) to determine gaps in delivery of care in underserved communities. Effective dates vary based on program.</td>
</tr>
<tr>
<td>Wellness/Prevention for Employees</td>
<td>The Affordable Care Act allows the Department of Health and Human Services and the Department of Labor to set discounts up to 50 percent of insurance premiums if the wellness program is determined beneficial for the employee. Effective January 1, 2011.</td>
</tr>
<tr>
<td>School-Based Health Clinics</td>
<td>The Affordable Care Act establishes grants to launch school-based clinics. Optional services include nutrition counseling, but providers are not specifically listed. Authorized to be appropriated $50,000,000 for fiscal year 2010.</td>
</tr>
<tr>
<td>Prevention Task Forces, etc.</td>
<td>The Affordable Care Act established a Preventive Services Task Force and a Community Preventive Services Task Force. Effective upon passage into law. The Affordable Care Act establishes a Prevention and Public Health Investment Fund – funding is set at $2.4 billion for 2010 and increases up to $4.6 billion by 2019.</td>
</tr>
<tr>
<td>Medicare Preventive Services</td>
<td>The Affordable Care Act adjusts current law to allow the Centers for Medicare and Medicaid Services (CMS) to determine whether and how to expand existing and establish new preventive services. MNT beyond renal and diabetes is specifically included in the list of services that CMS may potentially expand. The Affordable Care Act eliminates cost-sharing (co-payments and deductibles) for preventive services, making preventive care free for Medicare recipients. Effective January 1, 2011. The Affordable Care Act provides for an annual wellness visit that includes personalized prevention plan services with a health care assessment. Along with physicians and nurses, registered dietitians are listed as screening and counseling providers, and CMS must establish appropriate reimbursement policies and rules for referral. Specifically, CMS must determine when a referral is warranted and how many counseling sessions a patient can receive. CMS has 18 months from the March 23, 2010, enactment date to finalize regulations.</td>
</tr>
<tr>
<td>Medicaid</td>
<td>The Affordable Care Act establishes a five-year grant program to encourage Medicaid beneficiaries to adopt more healthy lifestyles, specifically related to weight reduction, cholesterol reduction, prevention of the onset of diabetes, and diabetes self-management. CMS will set the parameters for awarding grants. The Affordable Care Act includes coverage for those preventive services recommended by the United States Preventive Services Task Force (USPSTF). Because USPSTF currently recommends “intensive nutrition behavioral counseling” for adults with hyperlipidemia and “other diet-related chronic diseases,” CMS must determine (1) what constitutes “diet-related chronic diseases” for purposes of coverage and (2) who may provide the intensive counseling. USPSTF recommends referral to an RD after physician treatment. Effective January 1, 2011. Cost-sharing (co-payments and deductibles) for these preventive services are also eliminated. Effective January 1, 2011.</td>
</tr>
<tr>
<td><strong>Provision</strong></td>
<td><strong>Senate H.R. 3590 - Patient Protection &amp; Affordable Care Act with amendments from House H.R. 4872 - Reconciliation Act of 2010</strong></td>
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<td>----------------</td>
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<tr>
<td><strong>Home Health</strong></td>
<td>The statute provides for a demonstration program for direct, home-based patient care. CMS will set the parameters, and although RDs are listed as possible providers, this is merely a recommendation, not a requirement. Because the pilot program may later be broadly adopted with potentially significant impact for the profession, ADA can assist those working in home health who want to show the benefits of having an RD provide nutrition services. Those interested should follow carefully the rules for the program and application procedures when they are proposed in the coming months for more details and to determine their eligibility for the program. Effective January 1, 2012.</td>
</tr>
<tr>
<td><strong>Medical Homes</strong></td>
<td>MEDICAID: The Affordable Care Act allows for medical home waivers for state-coordinated programs focusing on (1) diabetes treatment and prevention and (2) treating cardiovascular disease and those considered overweight. Nutritionists are listed among providers, thus allowing for the inclusion of registered dietitians, although Congress did not identify them specifically. Instead, given their different licensing requirements and scope of practice, Congress deferred to individual states to decide whether RDs or others should be permitted to provide these services. Effective January 1, 2011. COMMUNITY SETTING: The Affordable Care Act establishes the medical home in public health programs and recommend the dietitian be included as a qualified provider and part of the medical home team, but CMS is given the authority to make the final determination.</td>
</tr>
<tr>
<td><strong>Nutrition Labeling of Menu items at Chain Restaurants</strong></td>
<td>The Affordable Care Act requires chain restaurants with at least 20 outlets to post calories on menus, menu boards (including drive-thrus), and food display tags, with additional information (fat, saturated fat, carbohydrates, sodium, protein and fiber) available in writing upon consumer request. The Affordable Care Act requires national uniformity so that there is consistency in information provided, and states and localities will not be able to require that chains provide additional nutrient information on menus. Calorie labeling must also be affixed to vending machines.</td>
</tr>
<tr>
<td><strong>Child Obesity Demonstration project</strong></td>
<td>The Affordable Care Act fully funds $25 million (until 2014) for a demonstration project aimed at reducing childhood obesity in community-based settings and schools through educational, counseling, and training activities. Effective immediately.</td>
</tr>
</tbody>
</table>
Appendix C: ADA Public Policy Structure

- **Affiliate Public Policy Panels (PPPs):** PPPs in each state consist of Affiliate Presidents, PPCs, SPRs, SRSs, and others within the affiliate who prioritize and oversee the affiliate’s public policy agenda of three to five issues.

- **Public Policy Coordinators (PPCs):** PPCs connect grassroots advocates to the larger program of ADA advocacy. They encourage grassroots training and participation in ADA and affiliate initiatives, follow through on ADA Action Alerts and help build and sustain grassroots networks. PPCs are the primary contacts for Public Policy Workshop advocacy in the state, and are familiar with ADA’s public policy processes and stances.

- **State Regulatory Specialists (SRSs):** The SRS is the new statewide position created after a recommendation of the LPPC Task Force in January 2010. SRSs are responsible for tracking regulations managed by state agencies that could affect the dietician profession, indentifying relevant agency decision-makers whose work impacts the affiliate’s goals and priorities, and initiating meetings with those agency officials to promote the value of RD- and DTR-provided services in state regulations and programs. A reprint of an article from the August 2010 issue of the *Journal of the American Dietetic Association* describing the new SRS role is reproduced in Appendix C, below.

- **State Policy Representatives (SPRs):** SPRs manage state and local advocacy agendas and tactics in their respective states. They identify state legislators in positions to affect dietitians’ professional standing as well as significant food, nutrition and health matters. SPRs coordinate the affiliates’ annual meeting in the governor’s office and organize the state Legislative Day activities.

- **28 Dietetic Practice Groups (DPGs):** Many Dietetic Practice Groups have appointed a Legislative Chair or Public Policy Liaison to follow issues relevant to the practice area and mobilize DPG members. DPGs will be critical in keeping their members aware of particular elements of health care reform implementation that specifically affect their professional practice area, such as availability of numerous demonstration programs and grants, opportunities in private practice from millions of new annual wellness exams, or the potential expansion of MNT. Further, the HOD requested in its October 2009 meeting that DPGs and affiliate dietetic organizations “collaborate and build partnerships within and outside the association to effectively position health reform and all critical legislative and policy issues related to the role of the RD as leaders in food policy and nutrition services.”

- **ADAPAC:** ADA’s political action committee, which collects funds from members for contribution to political candidates who support ADA’s priorities ([www.adapac.org](http://www.adapac.org)). Close relationships with elected officials are especially crucial now as ADA solicits congressional support during the rulemaking process (e.g., letters from representatives to regulators urging promulgation of regulations consistent with the Affordable Care Act’s congressional intent that specially qualified health care providers—such as RD or DTRs—provide certain services).

- **Legislative and Public Policy Committee (LPPC):** The Legislative and Public Policy Committee guides the establishment of the ADA’s public policy work including but not limited to activities related to national and state public policy, legislative, and regulatory issues. At the recommendation of the HOD, LPPC’s Grassroots Task Force worked diligently to develop much of the necessary framework for ADA’s implementation plan.

- **The Policy Initiatives and Advocacy (PIA) staff:** This group of ADA staff members located in the Washington, D.C. office work on food, nutrition, and health issues to influence policy at the federal, state and local levels. Dedicated to identifying issues and advocating for the profession, PIA also manages ADAPAC and provides support and training for the Dietetic Practice Groups and ADA affiliates nationwide.
The goal of the American Dietetic Association’s (ADA’s) affiliate public policy panels is to strengthen the grassroots structure of ADA to include a more comprehensive approach to shaping nutrition public policy. The panels develop a strong public policy agenda to increase grassroots influence in state initiatives impacting the registered dietitian (RD). The public policy panel, developed in 2006 by the Legislative and Public Policy Committee Grassroots Task Force, consists of several volunteer positions that work collaboratively with the affiliate president and leadership to help advance important federal and state legislative and policy issues.

The Legislative and Public Policy Committee (LPCC) convened a Grassroots Task Force last fall to consider additional approaches that ADA and the affiliates could take to enhance the effectiveness of the public policy panels in achieving nutrition policy goals. The LPCC sought new ways to enhance the work of the public policy panels to facilitate members working together to promote sound food, nutrition, and health policies at federal, state, and local levels. The creation of the public policy panels was a vital step that brought nutrition policy issues to the affiliate level. The LPCC wants to have a structure within the public policy panel for targeting regulatory and agency issues, realizing that states will begin to implement health care reform measures. “It is crucial at this time that affiliates be represented and connected to their state legislators and legislative issues,” states Sister Ladonna Woerdeeman, MS, RD, LD, CDE, chair of the LPCC. As a result, the LPCC 2010 Grassroots Task Force proposed expanding the public policy panels to include a new leadership role to fully address the complex issues faced by each affiliate—the State Regulatory Specialist (SRS). The figure shows the positions currently on the public policy panel.

**STATE REGULATORY SPECIALIST**

The SRS will work closely with the State Policy Representative and the public policy panel on state regulatory initiatives. Together they will focus their efforts towards reaching the affiliate’s public policy goals. The SRS will coordinate and work collaboratively as a member of the public policy panel and with ADA’s Washington, DC, office. ADA will provide training for the SRS along with the other members of the public policy panel.

Specifically, the SRS will be responsible for:

- tracking regulations managed within the state agencies, under the governor’s jurisdiction;
- initiating meetings with state agency officials promoting the services of the RD in state regulatory and programmatic initiatives;
- ensuring that the affiliate’s state agency and regulatory work is consistent with three priority goals established annually by each affiliate’s public policy panel; and
- identifying and decision-makers within state agencies whose work impacts the affiliate’s goals, particularly those that relate to access to RDs, dietetic technicians, registered (DTRs), and nutrition services and programs.

**SRS—THE RIGHT ROLE FOR NOW**

With the passage of health reform legislation, states are certain to be the center of action for years to come. The need for strategic and coordinated work efforts in state agencies will undoubtedly increase as health care reform unwinds and state initiatives are realized. ADA recognizes the need to position members in key areas to strategically develop the relationships that will ensure continuous leadership with regard to regulatory opportunities. In addition, there continues to be a need for increased and continuous monitoring of current legislative/regulatory initiatives due to the competitive environment contiguous to dietetics licensure. Tracking the regulatory issues and being a part of state agency committees and task forces are important steps to ensure RDs participate in policy development in the early stages.

Now, more than ever, food and nutrition issues are capturing the attention of state legislators. With prevention being the critical link that now connects nutrition to the dialogue, the RD who provides expertise in nutrition must be at the center of that dialogue. RDs and DTRs are being asked for input to develop solutions for multifaceted health and social problems. At the state agency level, this dialogue can begin with defining the status of regulatory initiatives surrounding nutrition access and services.

**STATE REGULATIONS**

New state regulations are continually drafted and can significantly impact the dietetics profession. It is important for affiliates to track this process and be aware of proposed regulations to which RDs and DTRs can provide input and expertise. When regulations are created without input from the dietetics community, the future of the profession becomes uncertain.

It is helpful to remember that tracking proposed regulations is a public process, and every state publishes proposed rules in the state reg-
**Public Policy News**

- **Affiliate President**: As the affiliate leader, the president provides overall guidance to the public policy panel leaders.

- **State Policy Representative**: Focuses on legislative initiatives, building relationships for political visibility in the governor’s office, and State Legislative Day; the State Policy Representative partners with the State Regulatory Specialist for state public policy positions.

- **Public Policy Coordinator**: Takes the lead on federal issues and ADA’s Public Policy Workshop; the Public Policy Coordinator also responds to action alerts on federal issues and coordinates affiliate federal initiatives.

- **Reimbursement Representative**: Coordinates issues involving reimbursement and insurance and third-party providers, and seeks opportunities for registered dietitians.

- **State Regulatory Specialist (2010 addition to panel)**: Targets state regulatory issues and makes connections with state agency officials who focus on food and nutrition initiatives; the State Regulatory Specialist complements the work of the State Policy Representative.

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**Figure.** Positions on the American Dietetic Association’s (ADA’s) affiliate public policy panels.

Indiana has resulted in RDs being integral leaders and team players for nutrition-related state initiatives. We could never have built program capacity and sustainability without it. The SRS position with support of the affiliate leadership and members will see positive outcomes for their members and the clients they serve.

The appointment of RDs and DTRs to these bodies will allow dietetics practitioners to impact critical decisions regarding nutrition policy. Recommend your colleagues today for these roles and raise the involvement of RDs in your state public policy work.

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**SRS and State Appointments**

State agencies continually create state boards, commissions, and task forces that study current policy issues and make recommendations for action by the department. By meeting with state officials, RDs gain increased visibility as nutrition experts within the state.

The SRS will seek opportunities for RDs to be appointed to state task forces, boards, and commissions. According to Brenda Richardson, MA, RD, LD, CD, Indiana Dietetic Association State Regulatory Specialist, "The SRS and regulatory work here in
Appendix E: Outline of Health Care Reform Toolkit

- Overview – ADA and Health Care Reform

- Summary of Coverage Provisions in the Patient Protection and Affordable Care Act

- Discussion of statute and provisions that may provide opportunities for RDs

- State Actions to implement Health Care Reform in the States
  - ADA Web site roll out
  - State by state template delivered to states
  - Training Webinars for leaders
  - Training Webinars for all members
  - Training Webinars for students
  - Training for reach out to grassroots leaders, including the affiliate public policy panels, the DPG leaders, the HOD delegates for coordination of ADA action in each state

- ADA at the Health Care Reform Table
  - How to seek opportunities for health care reform in general

- Health Care Reform Initiatives
  - (List of specific projects/opportunities)

- Step by Step Plan for Member Participation
  - Step by step guidance on best next steps to participate

- Additional Resources outside ADA
  - National Conference on State Legislators (NCSL)
  - Kaiser Family Foundation

- ADA Member Resources
  - Affiliate public policy panel lists with contact information
  - DPG leadership list with contact information
  - HOD list of delegates with contact information

- Advocacy Tips
  - Tips for calling your elected official
  - Tips for writing a letter to your elected official
  - Tips for conducting a meeting
  - Addressing your specific questions on health care reform with elected officials

- Follow up – closing the loop with ADA
  - Keeping ADA informed of your advocacy efforts
  - Survey for participation activities and outcomes
**Appendix F: Health Care Reform Educational and Training Plan (FY 2010-2011)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Audience</th>
<th>Format</th>
<th>Number of Attendees</th>
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<tr>
<td>August 2010</td>
<td>ADA Staff</td>
<td>Webinar</td>
<td>75</td>
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<tr>
<td>August 2010</td>
<td>ADA Leadership (HLT, BOD)</td>
<td>Webinar</td>
<td>30</td>
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<td>August 2010</td>
<td>Affiliate Public Policy Panel</td>
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<td>DPG Leadership</td>
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<td>August 2010</td>
<td>General Membership</td>
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<td>October 2010</td>
<td>Dietetic Educators</td>
<td>Webinar</td>
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<td>November 2010</td>
<td>HOD</td>
<td>Presentation Discussion</td>
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<td>January 2011</td>
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<td>Town Hall Meeting</td>
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<td>January 2011</td>
<td>Student Members</td>
<td>Webinar</td>
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<td>March 2011</td>
<td>Public Policy Workshop (DPGs, Affiliates, Students, Leadership and Members)</td>
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<td>600</td>
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<td>May 2011</td>
<td>HOD Update</td>
<td>Presentation</td>
<td>200</td>
</tr>
<tr>
<td>May 2011</td>
<td>General Membership (Link to Request Membership Renewal)</td>
<td>Webinar</td>
<td>1000</td>
</tr>
</tbody>
</table>

- CPEs will be available for each session.
- Events will be archived and available on the Health Reform section of the ADA website.
- No additional funding is required for this training plan, which utilizes funded and secured formats/venues.
Appendix G: Background on Rulemaking

There is a complex regulatory process (often referred to as “rulemaking”) that will flesh out the Affordable Care Act’s framework for health care reform and thereby determine the details of health care policy in the United States. Regulations may be of three types: proposed, interim final and final. Usually an agency faces a statutory deadline (ranging from 45 days to a year following enactment) for drafting a regulation, a process taking into account the complexity of the issue, the competing interests the rule-makers must consider, the urgency to get regulations in place, and other variables. If the cost of regulatory compliance could be considered expensive, the agency may refer the proposed rule to the Office of Management and Budget (OMB), located in the Executive branch of the President, for review and a cost analysis. In addition to helping the president in the development and administration of the annual federal budget among executive agencies, OMB also oversees and coordinates the government’s White House’s regulatory processes. This includes, in the words of OMB’s mission statement found at its website, reducing “any unnecessary burdens on the public.”

At this point, the proposed rule, and any attendant cost data, is published as a Notice of Proposed Rule-Making (NPRM) in the Federal Register, the government’s daily record of executive branch proposed and final regulations, documents, meeting notices and other events and information. The Federal Register is available online at www.federalregister.gov.

The Comment Period
A unique feature of the rulemaking process is the open period for public comments on an agency’s proposed regulation. Like other member-based associations, ADA provides comments on relevant proposed regulations. These are based on position papers, evidence analysis and insight from appropriate Dietetic Practice Groups. Individual comments are also welcome. ADA’s comments are posted at www.eatright.org in the Public Policy section under “rules and regulations.”

It is at this point that the comment process could become animated, especially if groups perceive that their interests are threatened, or could be advanced, by the proposed regulation. What can follow are often dueling analyses, sometimes prepared by private research firms or academics, under contract to the organizations with a deep interest in the proposed rule, detailing why the proposed rule is or is not in the public or their members’ interest. Although the rule-making process can excite intense association or industry advocacy (comment letters and other communications numbering in the thousands to an agency on a proposed regulation are not uncommon), the effort is often driven by data.

Final Rules
At the conclusion of the comment period, the agency then reviews the data and information collected in issuing its final rule. Although it is not obligated to include in the final regulation the comments it has received, the agency is required to explain why it has chosen to reject (or accept) the arguments presented for change in its proposed rule. A variation agencies occasionally employ is the “interim final” regulation. Under this device a final rule is issued, and takes effect immediately, but the public is provided with a brief period for comments, generally two weeks. Agencies have been known to operate under interim rules for years.

Final agency rules are included as part of an agency’s administrative law in the U.S. Code of Federal Regulations (CFR). For example, earlier FDA regulations governing nutrition labels for packaged food products, and CMS requirements for facilities to receive Medicare and Medicaid payments for services, among scores of other regulations, are part of the CFR. Within health care reform, the interplay of state and federal agencies will be of paramount importance. As discussed throughout, state rulemaking will determine many of the details of eligibility and reimbursement, but that state rulemaking must be done under the guideline set forth by the Department of Health and Human Services, which is specifically “authorized to promulgate regulations that define the parameters of state action and oversee or approve each state’s approach.”

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Online Resources

Implementation Resources
A number of particularly useful independent resources (think tanks, universities, foundations, journalistic enterprises, and governmental and quasi-governmental entities) have created and constantly maintain impressive repositories of information, critical analyses, and other detail about implementation often offered in an extremely approachable format:

Health Reform GPS
http://www.healthreformgps.org
Health Reform GPS is a website established by the Robert Wood Johnson Foundation and the George Washington University School of Public Health and Health Services offering information about health reform implementation.

Navigating the Implementation Process: Reform Overview, April 12, 2010
Health Reform GPS
This document from Health Reform GPS is a short overview of the reform law, with a separate section on immediate reforms.

Health Reform Implementation Time Line, April 27, 2010
The Kaiser Family Foundation
This in-depth timeline separates the provisions of the Patient Protection and Affordable Care Act into subsections and tracks the implementation of health reform between 2010 and 2014. The subsections include: insurance reform, Medicare, Medicaid, prescription drugs, prevention/wellness, tax changes, workforce and quality improvement.

Implementation Timeline for Federal Health Reform Legislation, April 13, 2010
National Governors Association
This timeline covering 2010 through 2018 is designed to help states prepare for reform implementation.

Near-Term Changes in Health Insurance, May 4, 2010
Health Affairs and Robert Wood Johnson Foundation
This health policy brief focuses on reforms to the private insurance market in 2010 and 2011, providing an implementation timeline.

Health Insurance Reform and Your State: The Case for Change
This interactive website features a map of the United States that allows users to click on any state and see the health reform changes that have been implemented to date in that state, and are coming up.

State Decision-Making in Implementing National Health Reform
National Governor’s Association, retrieved on May 26, 2010.
This comprehensive discussion draft written before reform outlines the major challenges states will face as a result of the passage of health care reform. The draft is intended to help states better formulate solutions for the difficult decisions they may face.

**State Actions to Implement Federal Health Reform**, May 20, 2010
*National Conference of State Legislatures*
This document consists of a state-by-state table outlining health reform implementation efforts via legislation and via governors’ executive orders. Among state efforts are the creation of task forces, the appointment of officials for health reform implementations, and proposals of legislation to alter or oppose federal actions.

**New Rules for States in Health Reform Implementation**
Alan Weil and Raymond Scheppach
This 5 page article stresses the importance for states to have a thorough knowledge of reform and detailed vision for implementation in order to ensure not only that residents obtain affordable coverage and the best access to healthcare coverage, but also that the state takes full advantage of multiple opportunities to obtain federal funding.

**Implementing State Health Reform: Lessons for Policymakers**
G. Volk and A. Jacobs
“Implementing State Health Reform: Lessons for Policymakers identifies the key questions that policymakers should consider when implementing health care reform, and also provides a set of related takeaways—particularly what must happen operationally pre- and post-implementation. The questions and takeaways are relevant to both state and national reform, in part because recent enactment of federal reform legislation will have enormous implementation implications for states.”

**General Online Resources with Updated/Changing Content**
- The Alliance for Health Reform ([http://www.allhealth.org](http://www.allhealth.org))
- The Kaiser Family Foundation ([http://healthreform.kff.org](http://healthreform.kff.org))
  - For an excellent summary of the Affordable Care Act by Kaiser, see [http://www.kff.org/healthreform/upload/8061.pdf](http://www.kff.org/healthreform/upload/8061.pdf)
- The Commonwealth Fund ([http://www.commonwealthfund.org](http://www.commonwealthfund.org))
References

2. For a brief discussion of the differences between the authorization and appropriation processes, see http://www.llrx.com/congress/authorization.htm.
6. ADA’s position paper “The Roles of Registered Dietitians and Dietetic Technicians, Registered in Health Promotion and Disease Prevention” is available on the ADA website (http://www.eatright.org/About/Content.aspx?id=8385) November 2006.
15. Id. at 4 (internal citations omitted).

21 Id. (“Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance.”)


26 Id. at 2; 3.

27 Website at http://www.fightchronicdisease.org/.


31 House of Delegates Motion, October 2009.