

The Clinical Dietetics Workforce Crisis

A National Imperative — Compensation, Workforce Reform, and Federal Nutrition Policy Alignment

Prepared for dietetics leadership, federal nutrition policy stakeholders, and the Academy of Nutrition and Dietetics

To	National Dietetics Leadership · Federal Nutrition Policy Stakeholders · Academy of Nutrition and Dietetics Members
From	Independent professional analysis (practicing Registered Dietitian Nutritionist, RDN, LDN; no employer, sponsor, or commercial funding)
Date	May 18, 2026
Subject	U.S. national analysis of clinical Registered Dietitian Nutritionist (RDN) compensation, workforce supply, and the implementation infrastructure required to deliver federal nutrition policy in the Make America Healthy Again (MAHA) era. All wage data are U.S. national means and medians from the BLS Occupational Employment and Wage Statistics May 2025 release (5/15/2026).

Executive judgment

A credible national clinical RDN minimum of **\$48.08 per hour (\$100,000 per year)** is the level the U.S. labor market already pays peer master's-credentialed clinical professions (PT \$105,280, OT \$101,280, SLP \$98,170, RN \$101,420; even associate's-degree Respiratory Therapist \$87,300 — all 2025 U.S. national means).

This is not aspirational. It is the floor below which federal nutrition policy — the MAHA Commission, the 2025–2030 Dietary Guidelines, and CMS's January 2026 Malnutrition Care Score expansion — cannot be operationalized given the post-OBBBA workforce contraction now underway.

This is not only a market argument. It is a public-health, workforce, federal-policy-implementation, and pipeline-equity argument.

The Clinical Dietetics Workforce Crisis

A National Imperative — how federal nutrition policy, the chronic-disease burden, and an uncredentialed wellness market are creating a workforce mismatch that endangers public health.

A data-driven analysis · BLS OEWS May 2025 · CDC NHANES 2021–2023 · CMS NHE 2023 · OECD Health Statistics 2024 · peer-reviewed literature · federal policy documents through May 2026.

Bottom line up front. The United States is simultaneously elevating nutrition to the center of federal health policy (Make America Healthy Again Commission, Executive Order 14212, January 2026 Dietary Guidelines), absorbing the largest chronic-disease burden in its history (~60% of adults with at least one chronic condition; ~\$4.87 trillion in annual health spending), and watching the credentialed Registered Dietitian Nutritionist (RDN) workforce contract under economic forces that have made the credential economically marginal for candidates without external subsidy. **At a U.S. national mean wage of \$77,130, the RDN earns 13% less than an associate's-degree Respiratory Therapist (\$87,300), 31% less than a Registered Nurse (\$101,420), and 37% less than a Physical Therapist (\$105,280) — peer credentials in the same employment settings.** Peak public demand for credentialed nutrition expertise is being met by a \$480 billion uncredentialed wellness market where peer-reviewed evaluations of high-engagement social-media nutrition content find evidence-based accuracy in roughly a third of posts. This memorandum proposes compensation reform, federal Medical Nutrition Therapy coverage expansion, credentialing-anchored workforce investment, and patient-safety-grounded scope clarification — the implementation infrastructure that federal nutrition policy presupposes.

1. Three concurrent crises — and one missing workforce

Crisis One — The MAHA Moment

Federal nutrition policy has been rewritten. Executive Order 14212 (Feb 13, 2025) established the President's MAHA Commission. The May 2025 Assessment names ultra-processed food as a leading driver of childhood chronic disease. The September 2025 Strategy launches 128 initiatives. The January 2026 Dietary Guidelines for Americans 2025–2030 marks a process reset.^{1–4} Across all four documents, the RDN credential is largely absent from workforce-funding language. HHS's nutrition-competency framework references uncredentialed roles such as "health coach" and "functional nutritionist."^{5,6}

Crisis Two — The Chronic-Disease Demand Curve

~60% of U.S. adults have at least one chronic disease; ~40% have two or more.⁷ Adult obesity is 40.3%; severe obesity 9.4%.⁸ Diabetes affects 38.4 million Americans; prediabetes affects 97.6 million.⁹ Hypertension affects 47.7% of adults.¹⁰ Pediatric obesity hit 21.1% in 2021–23 (vs. 13.9% in 1999–2000).¹¹ Poor diet drives an estimated 318,000–600,000+ U.S. deaths annually and ~\$1.1 trillion in associated healthcare and productivity losses.^{12,13} Chronic disease and mental-health conditions consume ~90% of \$4.87 trillion in U.S. health expenditures.¹⁴ CMS's GMCS expansion to all adults 18+ (Jan 2026) doubles the RDN inpatient workload denominator.¹⁵

Crisis Three — The Credibility Gap

The U.S. wellness economy is \$480 billion and growing 5–10% annually.¹⁶ Three-quarters of U.S. adults take dietary supplements; the U.S. supplement market is \$54.8 billion (2024).¹⁷ 54% of Americans get food and nutrition content from social media — 76% of Gen Z trust that content.¹⁸ Peer-reviewed analyses find only 36% of viral TikTok nutrition content is accurate; only 14.3% of U.S. Instagram nutrition posts cite evidence; over 90% of influencer nutrition posts carry commercial conflicts.^{19–21} LLM-generated nutrition advice achieves clinical appropriateness 55–73% of the time.²² Dietary supplements drive ~23,000 ED visits per year.²³

The synthesis. Three independent forces — federal policy elevation, population-level demand, and an uncredentialed information market — converge on a single conclusion: the country has never needed credentialed nutrition expertise more. Yet the RDN workforce is structurally contracting.

2. The federal policy shift — nutrition without credentialing

The Make America Healthy Again Commission, established by Executive Order 14212 on February 13, 2025, made chronic disease — and nutrition's role in driving it — the central organizing principle of federal health policy.¹ Its May 2025 Assessment identified four primary drivers of childhood chronic disease: poor diet/ultra-processed food, environmental chemical exposure, physical inactivity, and over-medicalization.² The September 2025 MAHA Strategy operationalized this with 128 named initiatives across HHS, USDA, FDA, NIH, CDC, and the Surgeon General's office.³ The Dietary Guidelines for Americans 2025–2030, released January 7, 2026, completed the realignment.^{4,24}

The professional implications are striking. The Strategy's named workforce investment includes a \$5 million NIH nutrition-education challenge for medical schools, nursing programs, residencies, and dietitian programs; more than 50 medical schools committed to a 40-hour nutrition curriculum.²⁵ Dietitian programs are listed as eligible but are not the named beneficiary. HHS's 71-competency nutrition framework for medical education references "nutritionists," "health coaches," and "functional nutritionists" — titles that are legally unprotected in most states — without anchoring referrals to the CDR-issued Registered Dietitian Nutritionist credential or to Medical Nutrition Therapy as a defined scope.^{5,6,26}

SNAP food-restriction waivers (18 states approved through 2025), the Whole Milk for Healthy Kids Act (signed January 14, 2026), and reductions to the Local Food for Schools program create population-level nutrition mandates without expanding the credentialed workforce that would operationalize them.^{27,28} Peer-reviewed analyses in *Frontiers in Health Services* (2025) and the *Hastings Center Report* (2025) raise the same concern from different starting points: the MAHA framework introduces nutrition as a population-level policy lever without specifying the credentialed delivery infrastructure.^{31,32}

The credentialing gap, stated plainly. Federal nutrition policy in 2025–2026 has scaled rapidly. The credentialed nutrition workforce has not been named, funded, or scoped to deliver it.

3. The chronic-disease demand curve — \$4.87 trillion at stake

The demand side for clinical nutrition expertise is not abstract. The CDC's most recent data document a chronic-disease epidemic with a measurable dietary signature.

The U.S. chronic-disease burden

National prevalence — adults except where noted

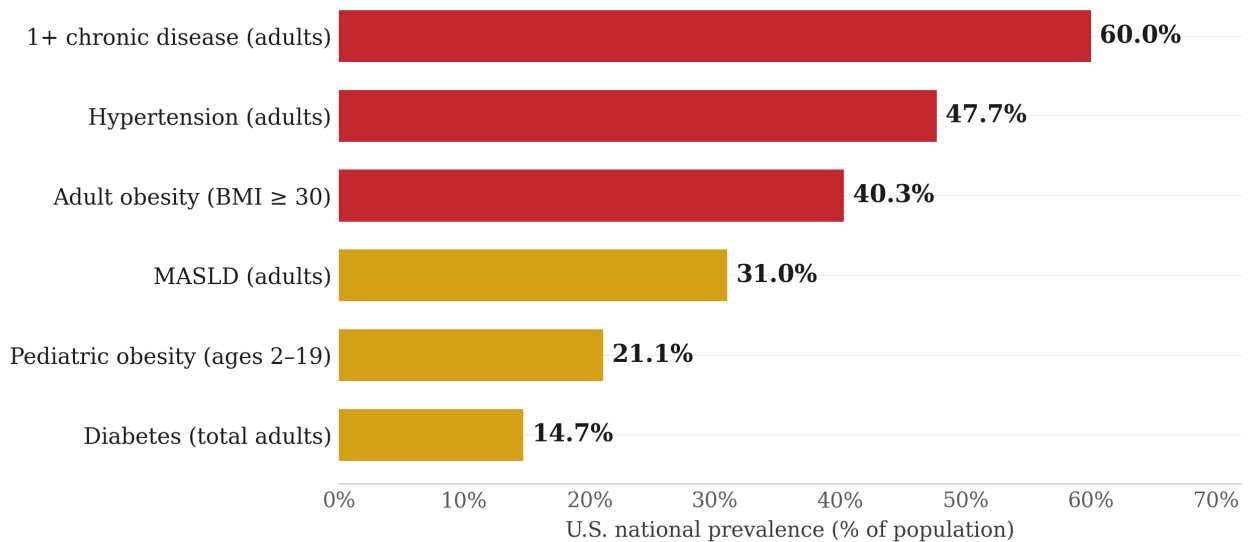


Figure 1. National prevalence of chronic conditions — NHANES 2021–23 (adult obesity, hypertension, pediatric obesity); CDC 2024 (diabetes); NHANES 2017–20 imaging (MASLD); CDC overview (≥ 1 chronic disease).

The dietary contribution to mortality is measurable. Micha et al. (*JAMA*, 2017) attributed 318,656 of 702,308 U.S. cardiometabolic deaths in 2012 (45.4%) to suboptimal intake of ten dietary factors.¹²

Diet drives roughly 318,000 U.S. cardiometabolic deaths a year

Micha et al., *JAMA* 2017 — attributable mortality by dietary risk factor

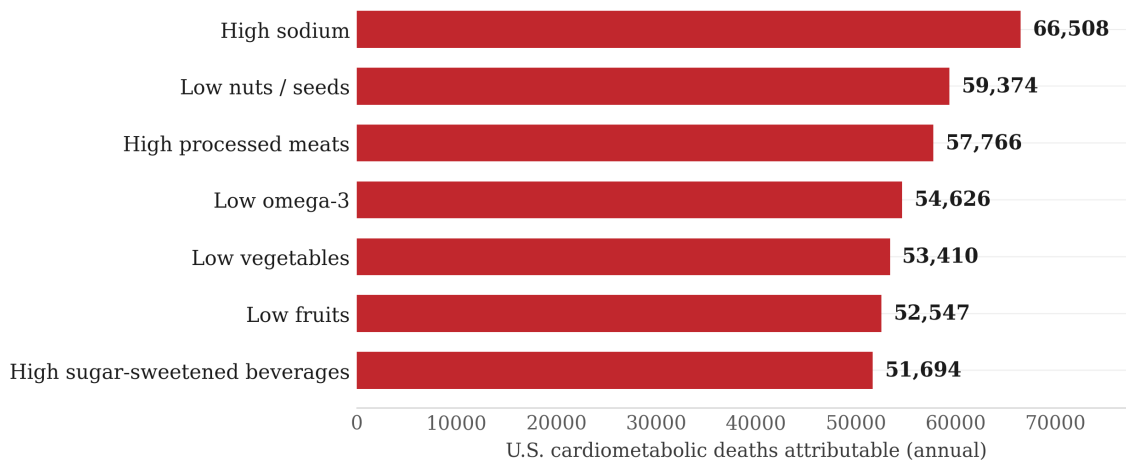


Figure 2. Diet-attributable U.S. cardiometabolic deaths by risk factor (annual). Source: Micha et al., *JAMA* 2017.

The Tufts Food is Medicine Institute (2023) estimates poor nutrition is responsible for over 600,000 U.S. deaths annually and \$1.1 trillion in associated healthcare and productivity costs — roughly 10,000 diet-related deaths per week.¹³

Diet-related disease costs more than \$1 trillion annually

Tufts FIM 2023 · Milken Institute · ADA Diabetes Care 2024 · AHA Circulation 2024

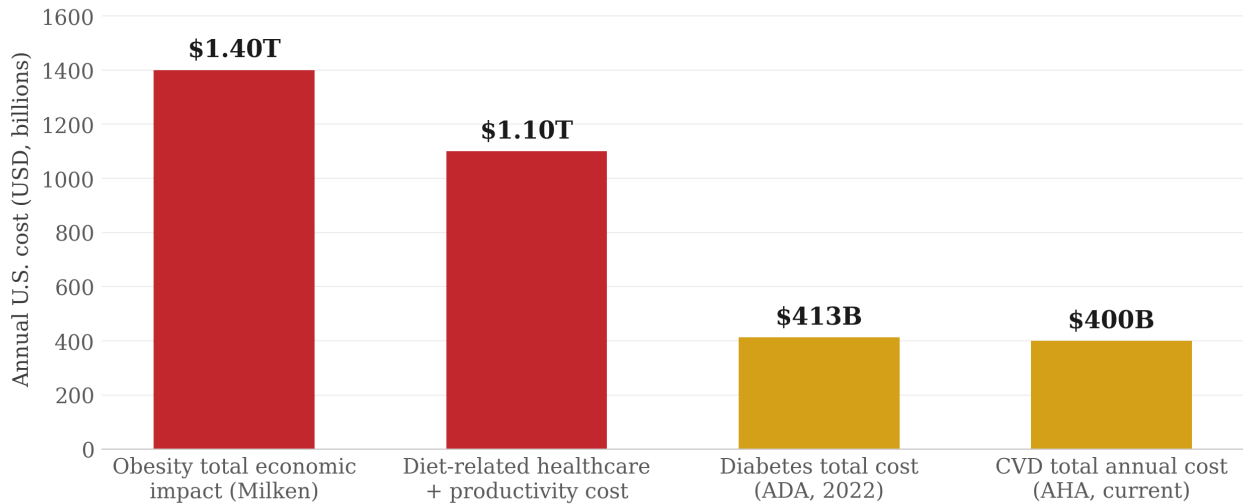


Figure 3. Annual U.S. cost burden — diet-related disease. Tufts FIM Institute (2023); Milken Institute; ADA Diabetes Care (2024); AHA Circulation (2024).

3a. The aging-into-Medicare demand wave.

The CMS Malnutrition Care Score expansion (Jan 2026) doubles the inpatient denominator. The larger demographic shock is post-acute. The U.S. 65+ population is projected to grow from ~62.1 million (2024) to ~77.9 million by 2035 — roughly +10,000 Americans aging into Medicare every day for the next decade.⁶⁶ The 85+ population, the highest malnutrition-risk cohort, nearly triples by 2050 (6.7M → 18.6M).⁶⁶

The aging-into-Medicare wave runs through 2050

U.S. 65+ and 85+ population projection — Census Bureau P25-1144 / Vintage 2023

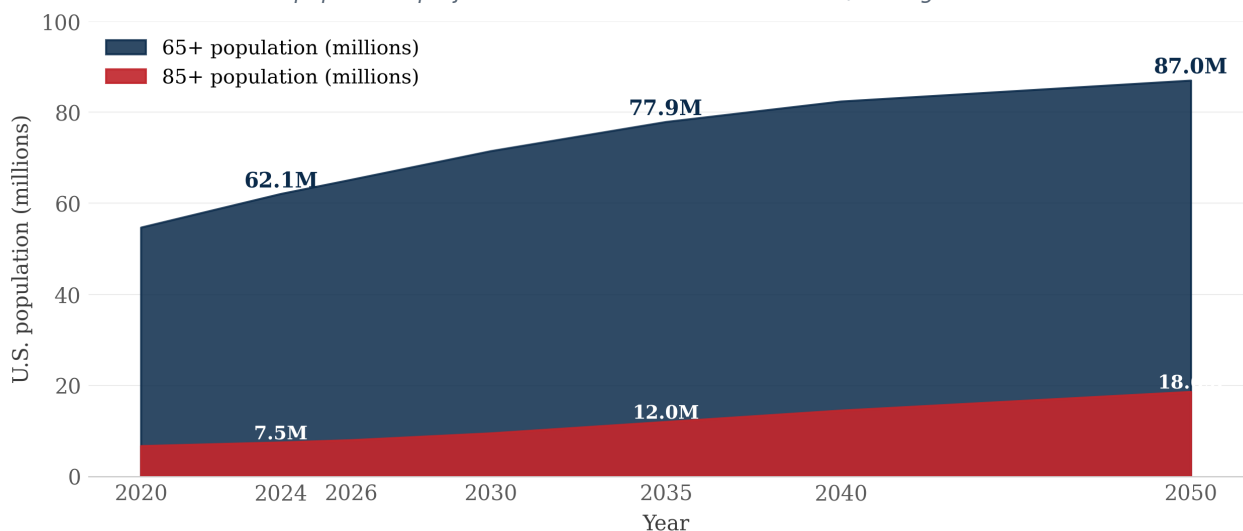


Figure 4. U.S. 65+ and 85+ population projection through 2050 — Census Bureau P25-1144 / Vintage 2023.

Of approximately 14,742 CMS-certified U.S. nursing facilities serving ~1.24 million residents, the workforce data show roughly 5,930 RDNs employed in NAICS 6231 Nursing Care Facilities — approximately 0.40 RDN FTE per facility.^{67,68} The CMS Payroll-Based Journal does not currently track RDN hours-per-resident-day as a mandatory staffing category, which is itself a measurement gap given the scale of incoming demand.⁶⁹

3b. Medical Nutrition Therapy — the evidence base.

The clinical case for Medical Nutrition Therapy (MNT) delivered by RDNs is among the strongest cost-effectiveness arguments in U.S. medicine. Berkowitz et al. (*JAMA Internal Medicine*, 2019) found medically tailored meals were associated with 16% lower monthly medical costs and 49% fewer hospitalizations across 807 high-cost patients over four years.⁷⁰ The Valladares et al. analysis of the MQii cohort (*JPEN*, 2021) demonstrated 24% relative-risk reduction in 30-day readmissions for malnourished patients receiving nutrition care plans, with malnutrition-coded readmissions costing 26–34% more than non-malnutrition readmissions (~\$16,900–\$17,900 per readmission).⁷¹ Wang and Mozaffarian (*J Am Heart Assoc*, 2023) microsimulation of produce-prescription programs for diabetes-affected adults projected cardiovascular event prevention with favorable cost-effectiveness ratios.⁷²

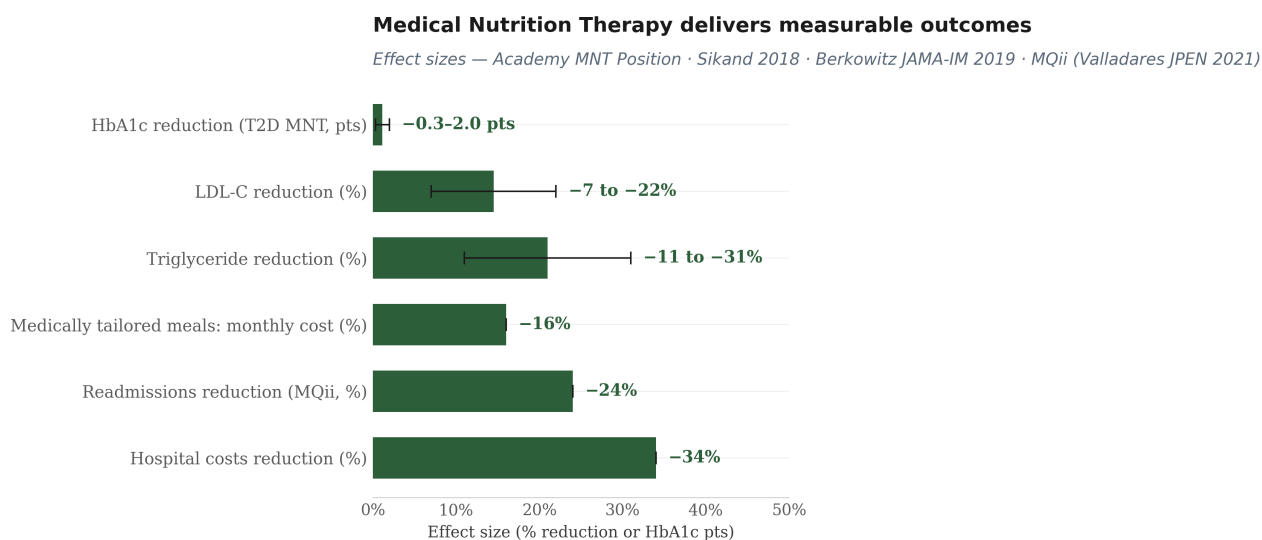


Figure 5. Medical Nutrition Therapy — documented clinical and cost effect sizes from contemporary peer-reviewed evidence.

The Centers for Medicare & Medicaid Services expanded the Global Malnutrition Composite Score (renamed Malnutrition Care Score, MCS) from adults 65+ to all adults 18+ in the Hospital Inpatient Quality Reporting program effective January 1, 2026.¹⁵ All four MCS components — screening, RDN nutrition assessment, malnutrition diagnosis, and an RDN-developed care plan — are now expected for every adult inpatient admission. The denominator expands from approximately 17 million adults 65+ to approximately 33 million total annual U.S. adult hospital discharges.

3c. The access-to-outcomes data gap.

The HRSA Area Health Resources File provides RDN counts at the state level but not the county level — meaning the federal workforce dataset does not currently enable county-by-county measurement of RDN provider density.⁷³ No federal "Nutrition Health Professional Shortage Area" designation exists, despite the analogous federal designations for primary care, mental health, and dental health. This

measurement gap is itself a policy finding: federal infrastructure cannot direct workforce resources to areas of greatest nutrition need because the access measure does not exist.⁷⁴

4. The uncredentialed wellness economy and the information gap

The supply-and-demand imbalance is not theoretical. While the credentialed RDN workforce contracts (Section 5), an uncredentialed wellness economy has scaled to meet — and largely capture — public demand for nutrition guidance.

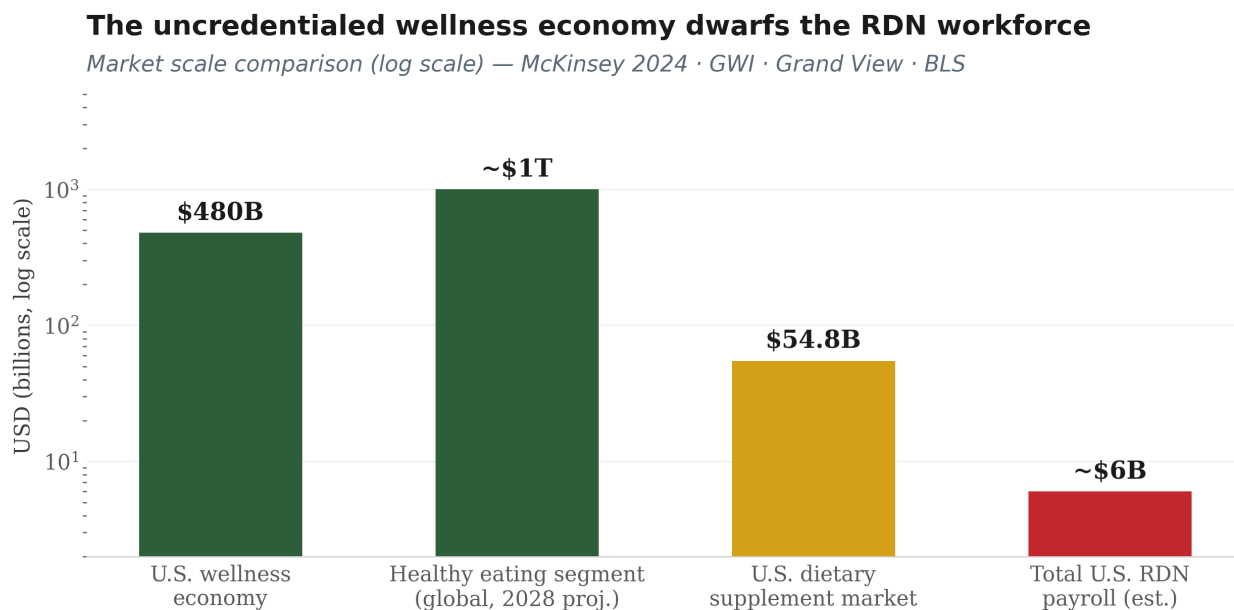


Figure 6. The uncredentialed wellness economy dwarfs the credentialed RDN workforce. Sources: McKinsey 2024; Global Wellness Institute 2024; Grand View Research; BLS OEWS.

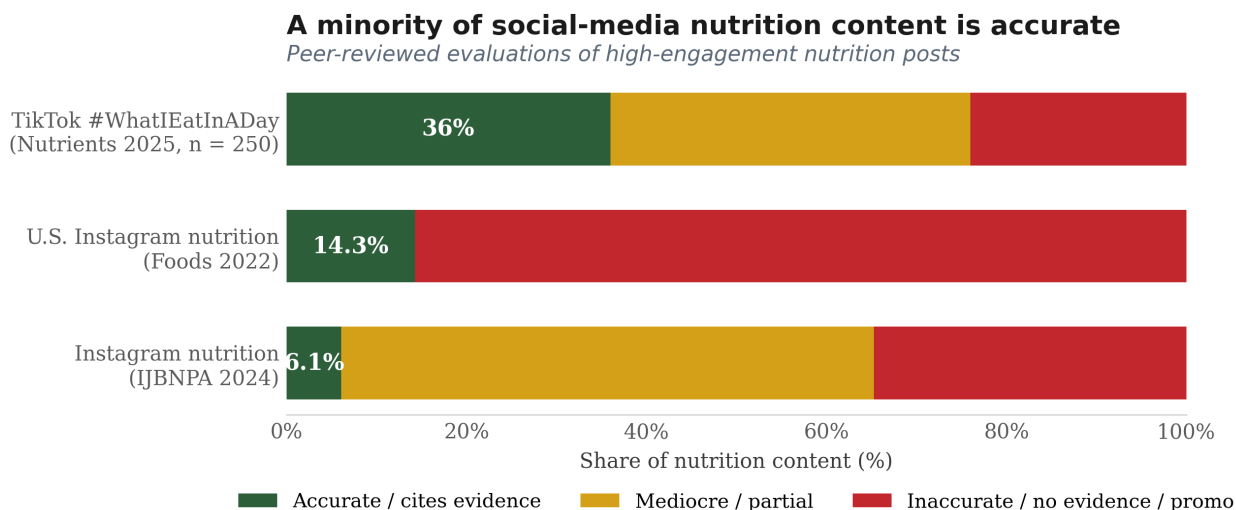


Figure 7. A minority of high-engagement social-media nutrition content is accurate. Peer-reviewed evaluations: *Nutrients* (2025); *Foods* (MDPI, 2022); *IJBNPA* (2024).

The harms are not hypothetical. Geller et al. in *The New England Journal of Medicine* (2015) estimated 23,005 emergency department visits and 2,154 hospitalizations attributable to dietary-supplement adverse events annually, with young adults aged 20–34 representing 28% of visits.²³ A growing peer-reviewed literature documents associations between algorithmic social-media exposure and elevated eating-disorder symptom scores in adolescents.^{49,50} Recent FTC enforcement actions against deceptive weight-loss and wellness marketing (Noom 2022 settlement, ongoing influencer-disclosure actions) confirm that the regulatory architecture currently relies on reactive post-harm enforcement rather than scope-of-practice prevention.^{51,75}

5. The workforce supply collapse

The credentialed RDN workforce is not stable — it is in absolute decline for the first time in the modern series. Five concurrent pressures are visible in the primary data.

5a. The CDR registry is shrinking.

The Commission on Dietetic Registration's registry of RD/RDN credential holders reported 114,209 active credentials as of March 23, 2026; by May 11, 2026, the figure was 113,616 — a net loss of 593 credential holders in seven weeks.⁵²

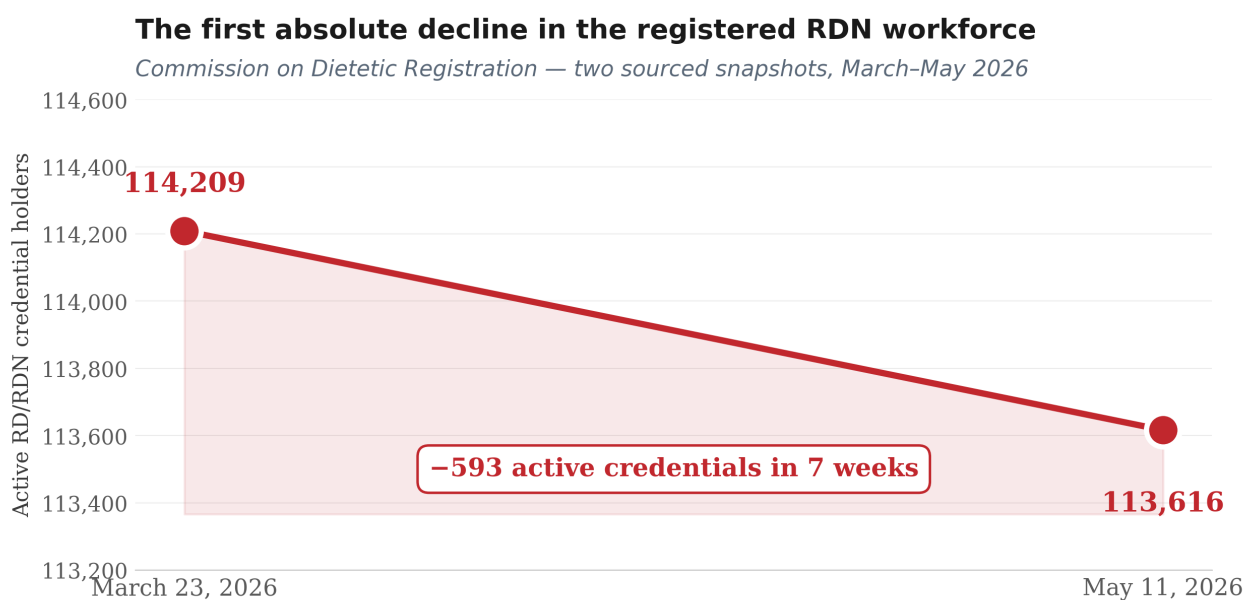


Figure 8. Commission on Dietetic Registration — two CDR-sourced snapshots, March and May 2026.

5b. The training pipeline has collapsed.

ACEND reports enrollment in Didactic Programs in Dietetics fell from 24,423 (2014) to 14,170 (2024) — a 42% decline.⁵³ The Master's-degree requirement, mandatory for exam eligibility since January 1, 2024, extends the credential pipeline from 5–6 years to 7–8 years.⁵⁴

The undergraduate RDN pipeline has lost 42% of its capacity

ACEND Didactic Programs in Dietetics — U.S. enrollment, 2014–2024

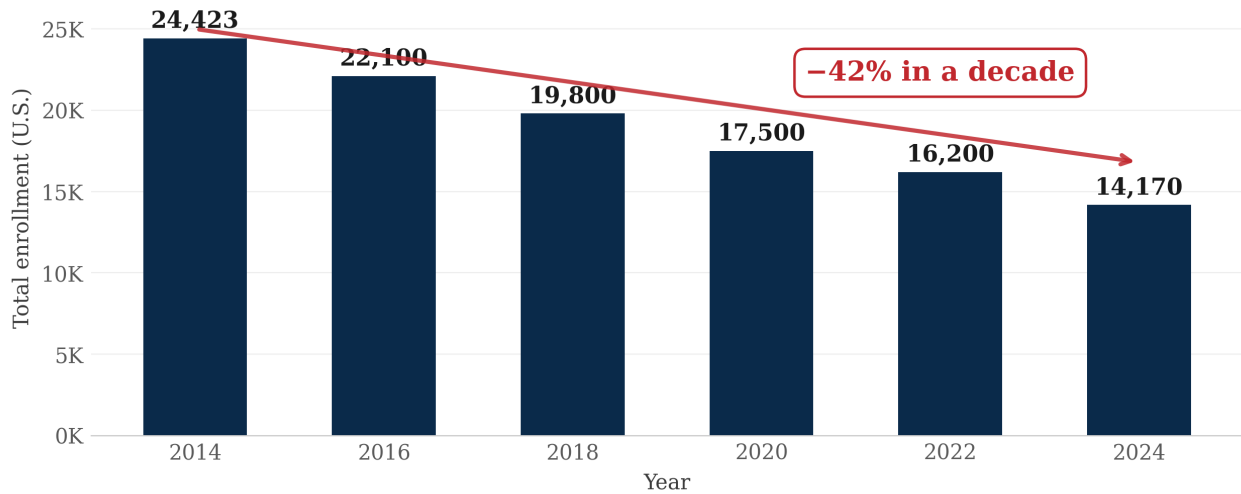


Figure 9. ACEND Didactic Programs in Dietetics — U.S. enrollment, 2014–2024.

Unfilled Dietetic Internship positions rose from 905 (2019) to 2,405 (2024), the first year in modern record that unfilled DI positions exceeded filled ones.

The match has flipped

U.S. Dietetic Internship — unfilled vs. filled positions, 2019–2024

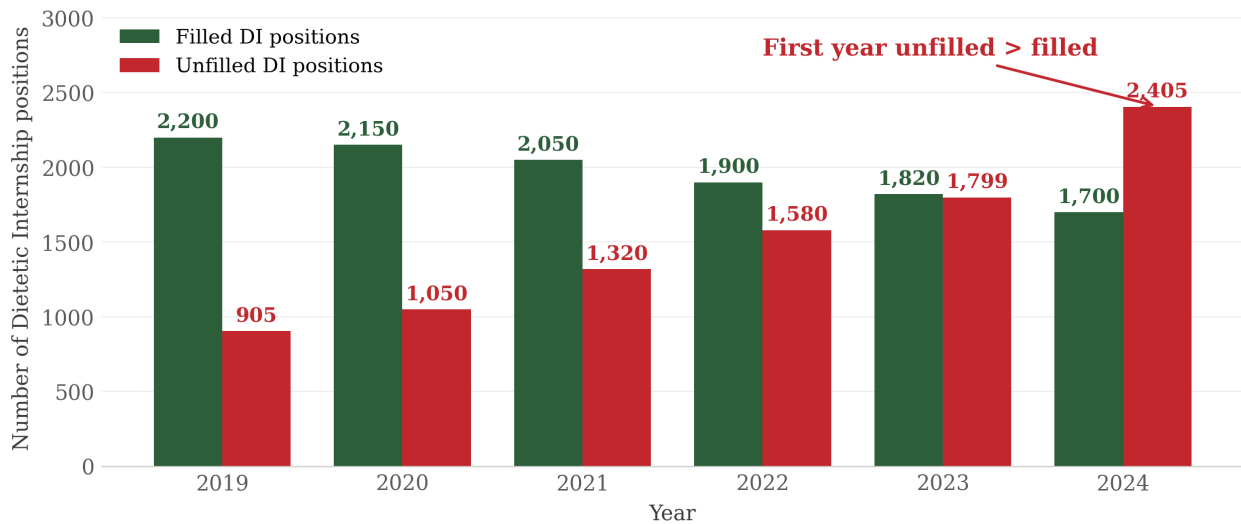


Figure 10. U.S. Dietetic Internship match — unfilled vs. filled positions, 2019–2024.

5c. The clinical share of the workforce is falling.

CDR registry data show inpatient clinical RDNs declined from approximately 38% of working RDNs (2021) to 28% (2024) — an estimated ~11,000-person net loss from inpatient clinical settings in three years.⁵⁵

Inpatient clinical share has fallen 10 points in three years

CDR workforce — share employed in inpatient settings, 2021–2024 (~11,000 net loss)

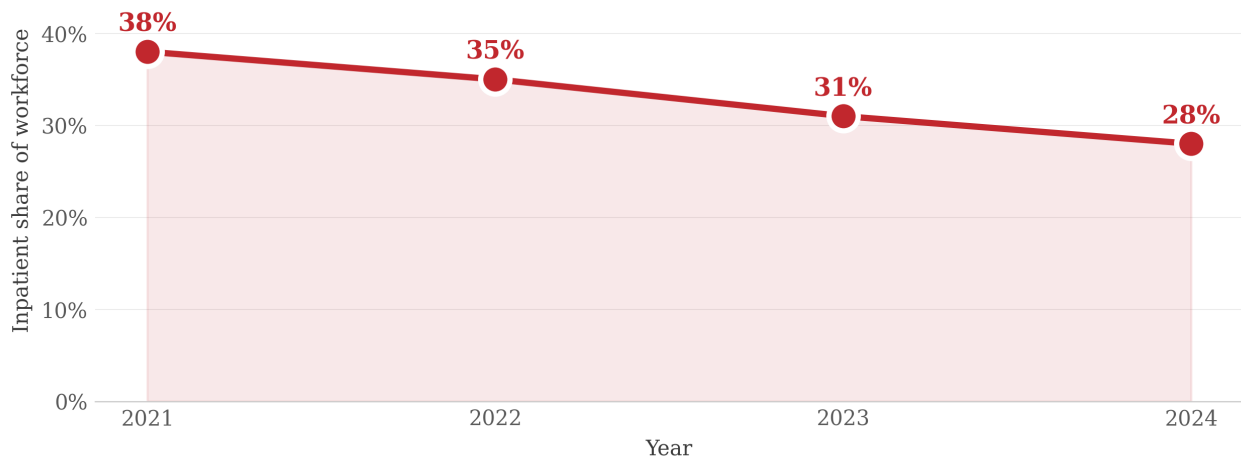


Figure 11. National CDR workforce share employed in inpatient clinical settings, 2021–2024.

5d. The federal student-loan architecture is changing in 2026.

The One Big Beautiful Bill Act (OBBBA, signed July 4, 2025; effective July 1, 2026) eliminates the Grad PLUS federal loan program for new borrowers, caps lifetime federal graduate borrowing at \$100,000, and ends new enrollments in PAYE, ICR, and SAVE income-driven repayment plans, replacing them with a new Repayment Assistance Plan (RAP) for borrowers after July 2026.⁵⁷ IBR (Income-Based Repayment) remains available for existing borrowers and qualifying new borrowers. The all-in cost to earn an RDN credential — Bachelor's, Master's, supervised practice, exam — ranges \$185,000–\$336,000 when institutional and opportunity costs are combined.⁵⁸ The Master's-only portion typically costs \$50,000–\$120,000; the high end of this range alone exceeds the new \$100,000 federal graduate cap.

5e. Demographic composition is undiversified.

The U.S. RDN population is 91% female and approximately 75% non-Hispanic White, showing less than 5 percentage points of demographic shift from 1990 baselines.⁵⁹ The U.S. population is approximately 13.6% Black, 19.5% Hispanic/Latino, and 50.5% female.⁶³

The RDN workforce does not look like the patient population

Demographic composition — RDN workforce vs. U.S. population (CDR · Census 2024)

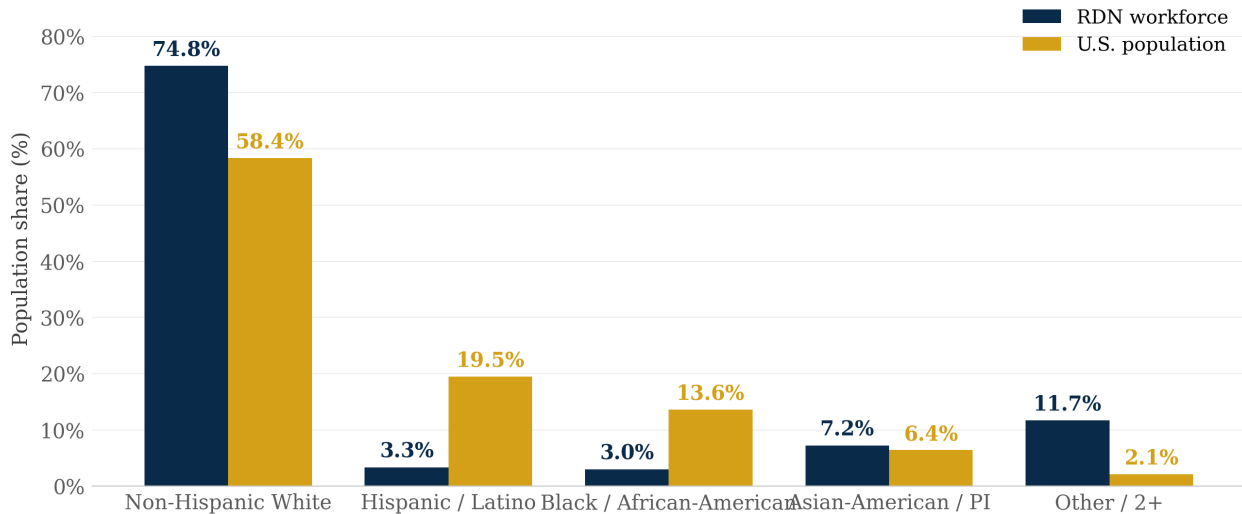


Figure 12. Demographic composition — RDN workforce (CDR Workforce Demand Study) vs. U.S. population (Census 2024).

Five concurrent pressures, one trajectory. Registry decline. Training-program collapse. Clinical-share contraction. Loan-financing cliff. Demographic narrowing. None of these forces is reversing in the next 36 months. Under prevailing wage, tuition, and post-OBBBA financing conditions, the standard-amortization return on the RDN credential is negative for graduates in typical major-metro cost-of-living markets without external subsidy.

6. The compensation math — and the market floor

The BLS Occupational Employment and Wage Statistics May 2025 release (5/15/2026) provides the cleanest national wage benchmark for the RDN profession (SOC 29-1031, Dietitians and Nutritionists). All figures in this section are U.S. national means and medians.

U.S. RDN mean annual: \$77,130 • **median annual:** \$76,400 • **hospital RDN mean (NAICS 622100):** \$78,710 • **total employment:** 77,570 (+14.6% vs. 2019).⁶¹

The clinical wage ladder

U.S. national mean annual wages — BLS OEWS, May 2025

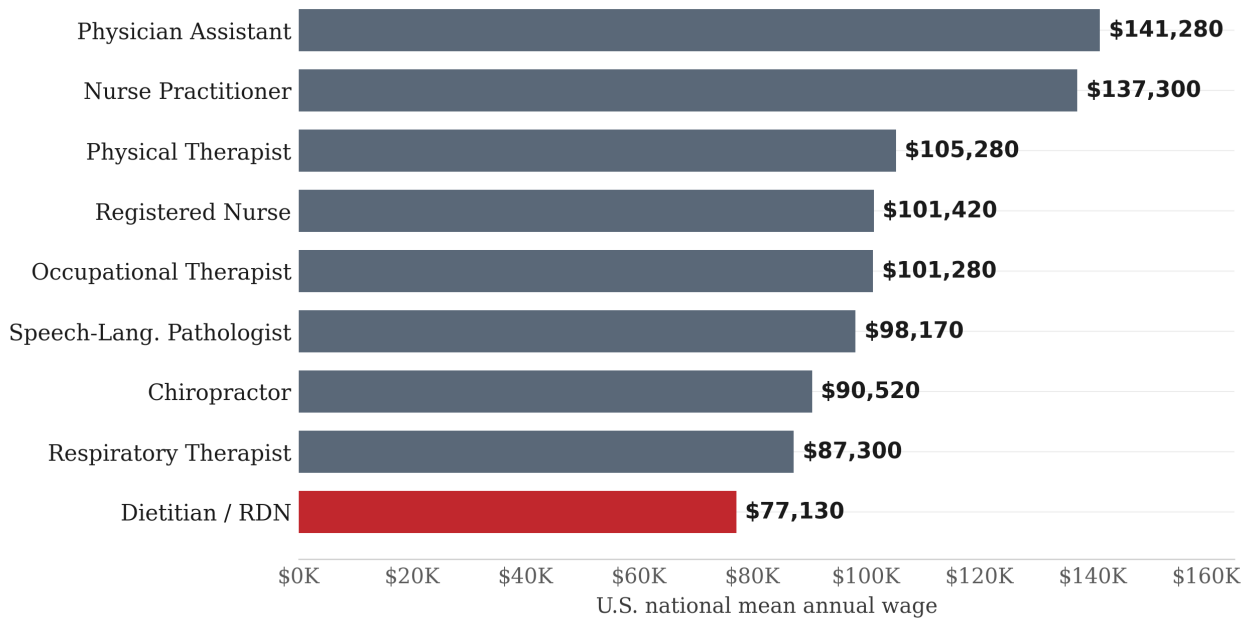


Figure 13. U.S. national mean annual wages, clinical healthcare occupations — BLS OEWS May 2025.

Every clinical peer earns 13-83% more than the RDN

Wage premium vs. U.S. RDN national mean (\$77,130) — BLS OEWS May 2025

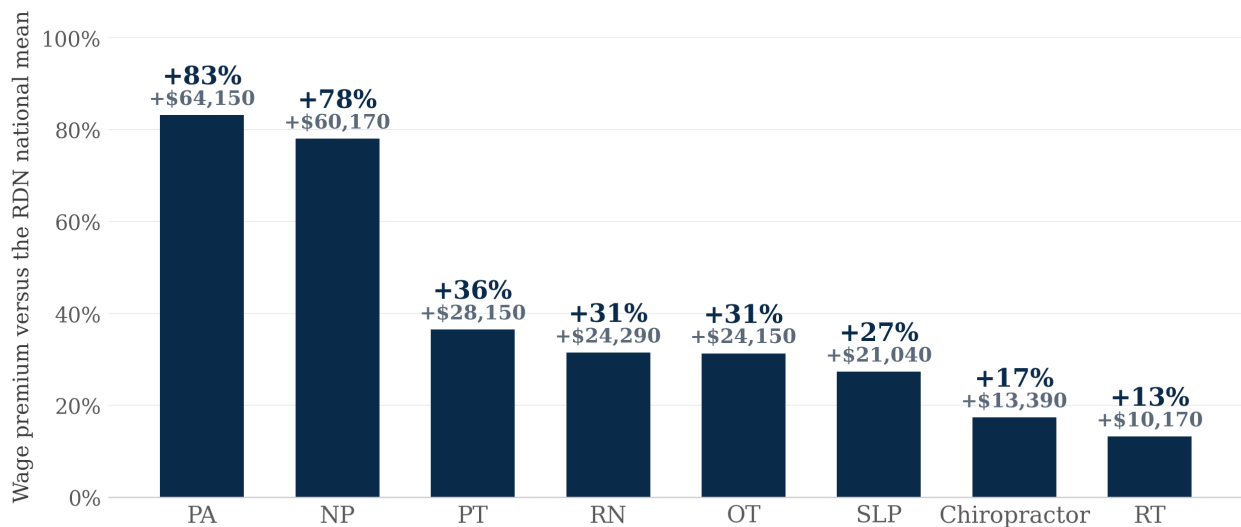


Figure 14. National wage premium versus the U.S. RDN mean, by clinical peer occupation.

The single clearest comparison. An associate's-degree-prepared Respiratory Therapist earns \$10,170 more on average than a Master's-prepared Registered Dietitian Nutritionist — nationally, in the same year, on the same BLS data source.

6a. Real wages have declined.

National RDN wage growth from 2015 to 2025 (BLS OEWS) was +32.0% nominal — fractionally below the +35.9% U.S. CPI-U growth for the same period.⁶² Adjusted to 2015 dollars, real U.S. RDN wages declined approximately 2.8% from 2015 through 2025.

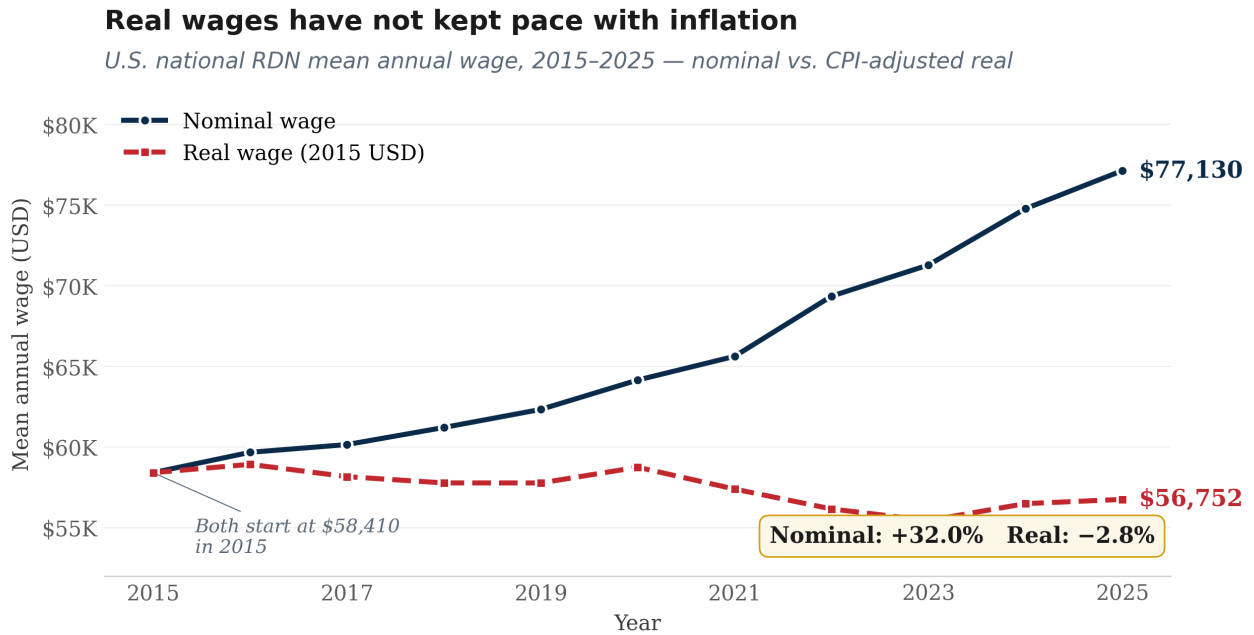


Figure 15. U.S. national RDN mean annual wage, 2015–2025 — nominal vs. CPI-adjusted real (2015 dollars). Nominal +32.0%; real -2.8%.

6b. RDN wages cluster at the bottom of dietetics-sector industries.

Within the SOC 29-1031 dietitian occupation, hospital and nursing-care facility settings — the dominant clinical employment industries — pay the lowest mean wages. Federal government dietitians earn \$94,490, outpatient care \$84,160, and home health \$86,840 — but only ~13% of approximately 77,570 U.S. RDNs work in these higher-paying industries combined.⁶¹

Clinical settings sit at the bottom of the dietetics wage range

RDN mean annual wage by NAICS industry, U.S. national — BLS OEWS May 2025

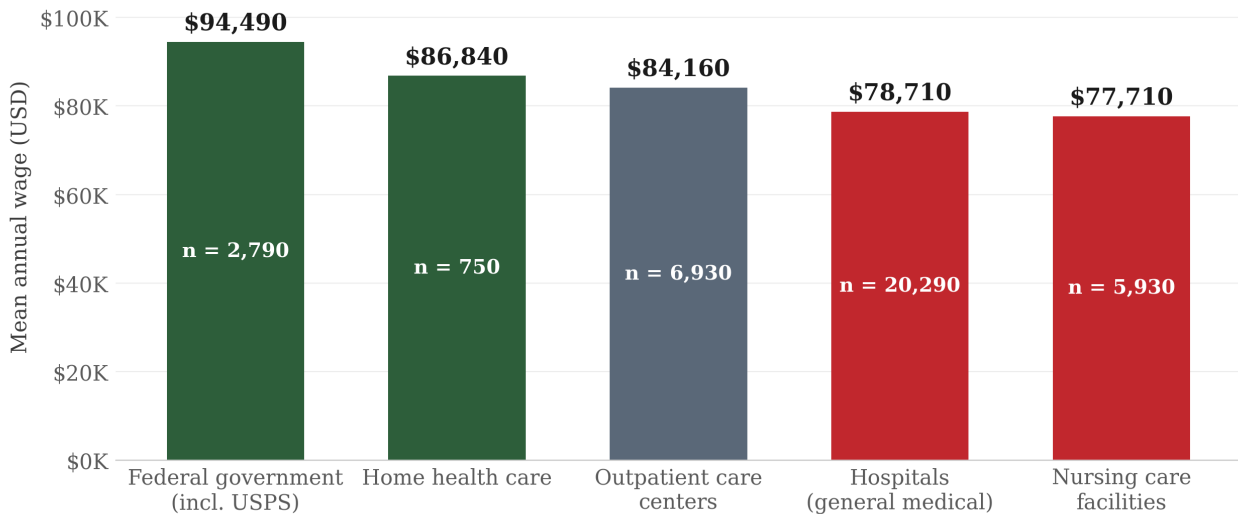


Figure 16. RDN mean annual wage by NAICS industry, U.S. national — BLS OEWS May 2025.

6c. The debt math under prevailing conditions.

At current 2025–26 federal graduate-loan rates (~9% blended, post-OBBBA), the typical \$185,000–\$336,000 all-in RDN credential cost cannot be amortized at the national mean wage in any market with typical major-metropolitan cost-of-living. Under a conservative single-person urban budget (\$35,000/yr living + 22% effective tax + 10-year Standard amortization at 9%), the RDN at the national mean wage clears only +\$688 annually — essentially zero margin. At a more typical major-metro cost of living (\$42,000/yr), the RDN scenario goes to -\$6,312 annually, while every peer master's-credentialed clinical profession (PA, NP, PT, OT, SLP, RN, RT) remains positive in both scenarios. *Note: Chiropractor (DC) is excluded from this comparison because the Doctor of Chiropractic is a professional degree eligible for the higher OBBBA professional-school loan cap (~\$200K) and for Public Service Loan Forgiveness through qualifying employers — a different federal-financing architecture than the master's-level RDN credential.*

The RDN is the only master's-level clinical credential whose math fails

Take-home at U.S. national mean wages, 9% blended grad-loan rate, 10-yr Standard

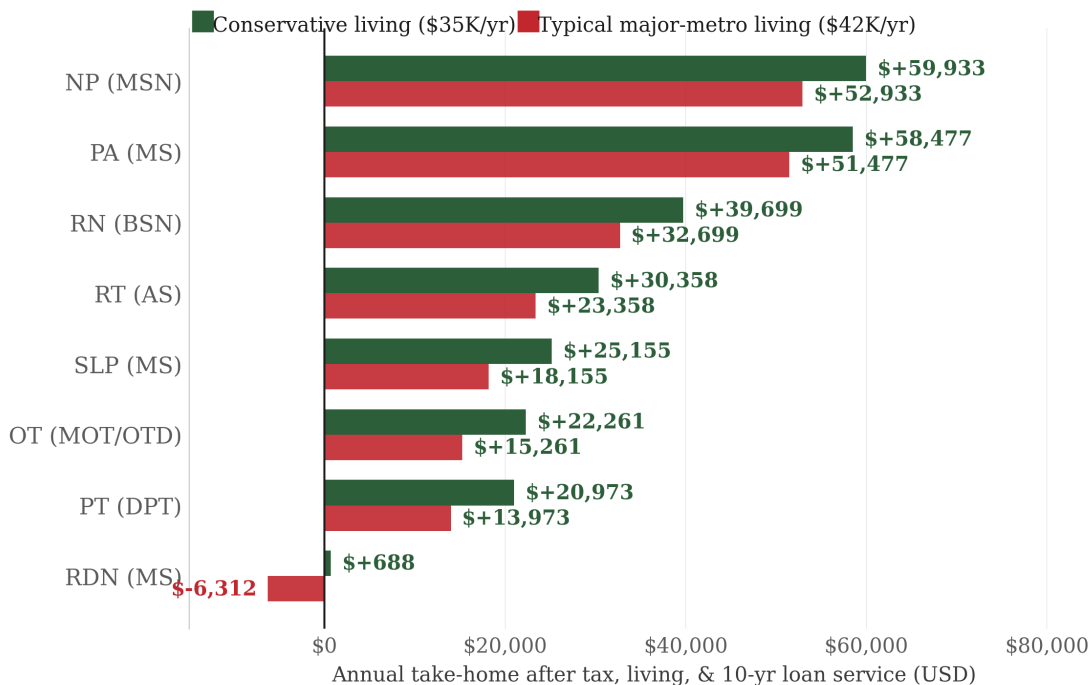


Figure 17. Annual take-home after tax, basic living, and 10-year Standard amortization at 9% blended graduate-loan rates — two cost-of-living scenarios at U.S. national mean wages.

The credential economics no longer reach a worker. Under prevailing wage, tuition, and post-OBBBA financing, the RDN delivers no meaningful margin at the national mean wage even under conservative cost-of-living assumptions, and goes negative under typical major-metro conditions.

6d. International benchmark — peer-economy ratios put the U.S. in context.

The internal U.S. peer wage ladder argument is reinforced by international comparison. Credentialed clinical dietitians in peer economies earn the following PPP-adjusted approximate annual wages:^{76,77,78}

U.S. dietitian wages, in international context

Credentialed clinical dietitian / dietitian-equivalent wages, PPP-adjusted USD

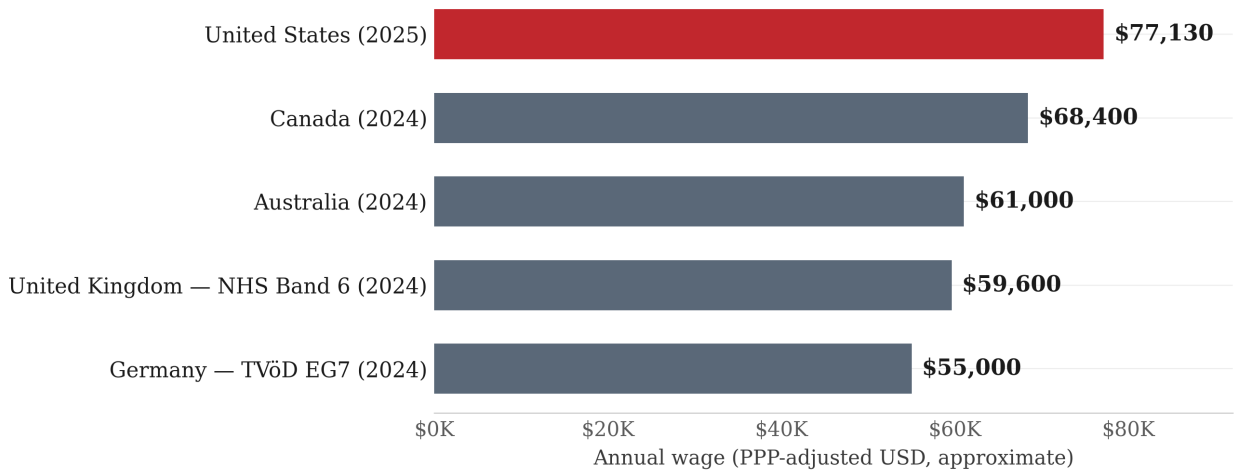


Figure 18. International credentialed-dietitian wages — PPP-adjusted USD approximate values, 2024. Sources: Statistics Canada NOC 31121 / Job Bank Canada; NHS Employers Agenda for Change 2024/25; Dietitians Australia; TVöD-VKA Entgeltordnung (Germany).

The U.S. wage benchmark sits at the high end nominally, but within peer economies, the credentialed-dietitian to peer-clinical ratio is qualitatively different. In the NHS, Band 5–7 dietitians fall within the same Agenda for Change pay scale used for RNs and most allied health professionals — meaning credential-equivalent pay parity is institutionally enforced.⁷⁷ The U.S. pattern — Master's-credentialed RDN below associate's-degree RT — is not the OECD norm. It is the U.S. structure.

6e. State-level wage variation and the federal-floor rationale.

National means mask a 50–60% intra-U.S. wage range. BLS OEWS May 2025 state-level data show the highest-paying states (California ~\$94K, Oregon ~\$89K, New Jersey ~\$89K, New York ~\$88K, Alaska ~\$87K) and the lowest-paying states (Mississippi ~\$63K, West Virginia ~\$64K, Louisiana ~\$66K, Alabama ~\$67K, Arkansas ~\$67K).⁶¹

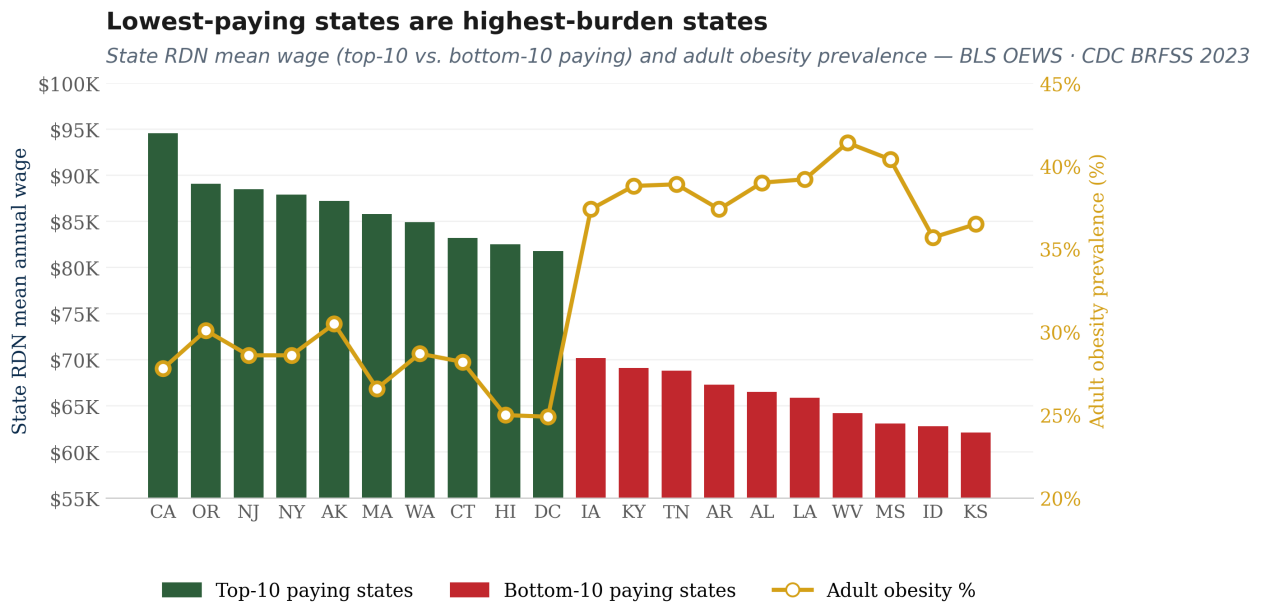


Figure 19. State-level RDN mean annual wage (top-10 paying vs. bottom-10 paying) plotted against adult obesity prevalence (CDC BRFSS 2023).

The pattern is the geographic mechanism that makes a federal floor — rather than a state-by-state solution — the appropriate policy response. The states paying the lowest RDN wages are simultaneously the states with the highest adult obesity prevalence (38–41% per CDC BRFSS 2023) and the highest age-adjusted diabetes and cardiovascular mortality.⁷⁹ The wage-disease correlation runs in the wrong direction: highest patient need, lowest workforce compensation, predictably lowest RDN density per capita. A state-by-state wage approach systematically fails the patient populations that diet-related disease most heavily afflicts. A federal floor — anchored to Medicare MNT reimbursement (Section 9b) — addresses the geographic dimension of the workforce gap that state legislatures cannot.

7. The OBBBA cliff (effective July 1, 2026)

The One Big Beautiful Bill Act, signed into law July 4, 2025, restructures federal graduate-student loans effective July 1, 2026.⁵⁷

Elimination of the Grad PLUS Loan program for new borrowers. Federal graduate borrowing is capped at unsubsidized Stafford loan limits (\$20,500/yr; \$138,500 lifetime aggregate including undergraduate).

Lifetime federal graduate borrowing cap of \$100,000. The high end of typical RDN Master's tuition (\$120,000) alone exceeds the new federal cap; cost-of-living, supervised-practice fees, and exam fees fall outside it entirely.

New income-driven repayment landscape. New borrowers after July 2026 cannot enroll in PAYE, ICR, or SAVE — these plans sunset for new enrollment and are replaced by the new Repayment Assistance Plan (RAP). IBR remains available for existing borrowers and certain qualifying new borrowers.

The Fall 2026 entering cohort is the first whose mandatory Master's training cost may exceed the federal lifetime borrowing cap and who face a transitional repayment-plan landscape with reduced flexibility relative to the pre-OBBBA architecture.

8. Diversity and pipeline equity

The Registered Dietitian Nutritionist workforce is one of the least demographically diverse credentialed clinical professions in the United States. The OBBBA financing changes (Section 7), against this baseline, will systematically narrow the pipeline. Candidates without intergenerational wealth — who, in U.S. data, are disproportionately Black, Hispanic/Latino, first-generation, and rural — will face a credential whose all-in cost exceeds federal financing capacity.

Pipeline equity is a public-health issue. Patient-provider concordance is associated with measurable improvements in care engagement, trust, and outcomes in nutrition counseling.⁶⁴ A demographically narrowing RDN workforce in a demographically broadening U.S. patient population reduces the system's capacity to deliver concordant care.

9. The recommendation — a national workforce reform

The credentialed nutrition workforce — the only delivery infrastructure with a rigorously evaluated efficacy base for clinical nutrition therapy — is contracting under economic forces that have made the credential mathematically marginal. Federal nutrition policy, chronic-disease demand, and CMS quality measurement have all moved decisively in the direction of requiring more credentialed nutrition expertise. The workforce gap is structural, not cyclical. Four reform priorities are proposed.

9a. Compensation reset: a credible national minimum of \$100,000 / \$48.08 per hour for clinical RDNs.

The BLS OEWS May 2025 national data demonstrate that this floor is independently validated by the market for peer master's-credentialed clinical professions. PT (\$105,280), OT (\$101,280), and SLP (\$98,170) — same education tier, same patient population — sit at or above this proposed floor. RN (\$101,420) and even the associate's-degree Respiratory Therapist (\$87,300) also exceed it. The proposed \$100,000 RDN minimum is the level the U.S. labor market already pays peer clinical credentials in the same employment industries, and the threshold at which post-OBBBA debt amortization becomes feasible for candidates without external subsidy.

9b. Federal Medical Nutrition Therapy coverage expansion.

Current Medicare MNT coverage is limited to diabetes, chronic kidney disease (non-dialysis), and 36 months post-kidney transplant only.⁸⁰ Reimbursement under current scope is itself unfavorable.

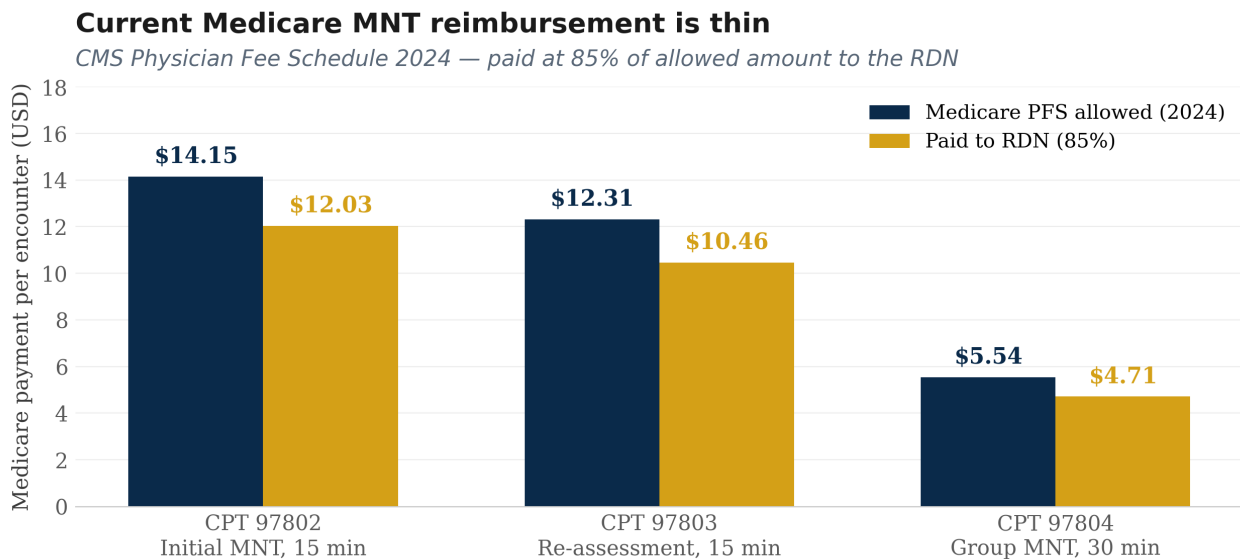


Figure 20. Current Medicare MNT reimbursement — CMS Physician Fee Schedule 2024, paid at 85% of allowed amount to the RDN.

Medicare MNT utilization among eligible beneficiaries has remained in the single-digit-percent range across multiple analyses — the credential is reimbursed too narrowly and too thinly to function as an independent revenue stream.^{81,82}

The Medical Nutrition Therapy Act (H.R. 6199 — Kelly/Kiggans; S. 3934 — Collins/Peters, 119th Congress, introduced November 2025) would expand Medicare MNT coverage to obesity, hypertension, dyslipidemia, cardiovascular disease, malnutrition, cancer, eating disorders, gastrointestinal disease (including celiac), HIV/AIDS, and Secretary-designated conditions — a four-fold expansion of covered indications.⁸³

Pending legislation would quadruple MNT scope

Medical Nutrition Therapy Act — H.R. 6199 / S. 3934, 119th Congress (Nov 2025)

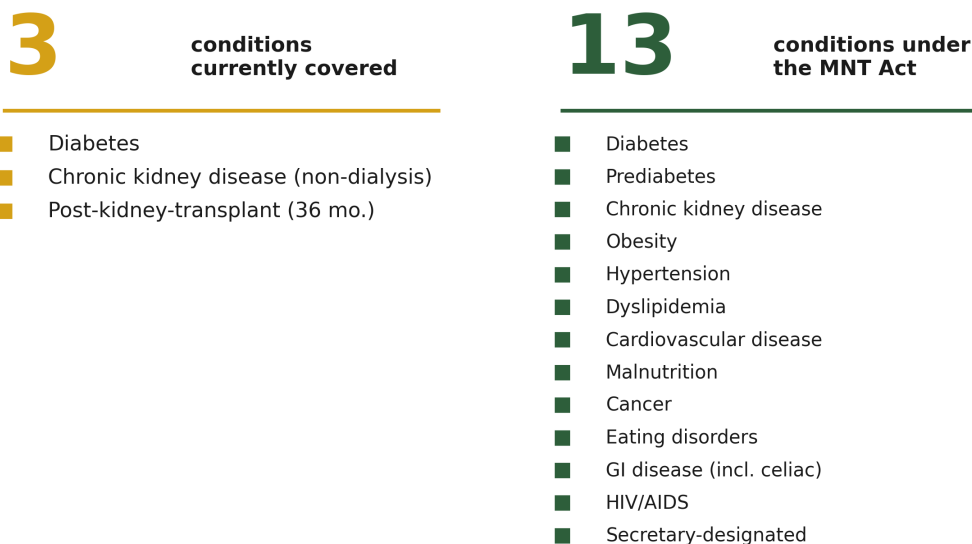


Figure 21. Pending Medical Nutrition Therapy Act expansion — Medicare MNT coverage indications, current vs. proposed.

The MNT evidence base supports each expansion: Berkowitz *JAMA Internal Medicine* 2019;⁷⁰ Valladares *JPEN* 2021;⁷¹ Wang/Mozaffarian *J Am Heart Assoc* 2023;⁷² *Health Affairs* 2024 50-state medically tailored meals analysis.⁸⁴ Passage and CMS rulemaking would create the reimbursement architecture to support a \$100K national floor without unfunded mandate to hospitals.

9c. Workforce pathway investment — credential-anchored.

Federal nutrition workforce investment under MAHA should be explicitly tied to the CDR-issued RDN credential, not to credential-neutral "nutritionist" or "health coach" categories. Investments should include paid pre-RDN apprenticeships and supervised-practice positions at federally qualified health centers; loan-forgiveness pathways for RDNs serving in underserved areas (modeled on NHSC); HRSA Title VII grants directed to ACEND-accredited programs at HBCUs, HSIs, and tribal colleges to address the pipeline equity gap (Section 8); and the creation of a federal Nutrition Health Professional Shortage Area designation to enable workforce-allocation funding (Section 3c).

9d. Patient-safety scope clarification — addressing the credibility gap.

The 23,000 annual ED visits and 2,154 hospitalizations from dietary-supplement adverse events (Section 4) and the documented harms from algorithmic social-media nutrition exposure are patient-safety findings, not commercial-protection findings. A federal-level definition of Medical Nutrition Therapy as a clinical scope of practice — anchored to the RDN credential as the named provider, parallel to how Medicare and state licensure currently anchor physical therapy and occupational therapy — would clarify which clinical nutrition interventions belong inside the medical regulatory system and which belong to general consumer-information markets. State-level licensure portability (a Dietitian Compact, modeled on the Nurse Licensure Compact and the PT Compact) would reduce barriers to RDN practice across state lines, particularly relevant for telehealth-delivered MNT serving rural and underserved patients.

10. Counterarguments addressed

"RDNs accept lower wages because the work attracts mission-driven candidates — this is preference, not market failure." The 2024 inflection points cannot be explained by preference: DI unfilled positions exceeding filled for the first time in modern record, the first absolute decline in the CDR registry, and a 42% collapse in ACEND DPD enrollment over a decade are population-scale signals of supply contraction, not a stable preference equilibrium.

"Hospitals will substitute nutrition assistants or RN-delivered counseling if RDN wages rise." CMS regulatory architecture forecloses this substitution: the Malnutrition Care Score expansion (Jan 2026) names the RDN as the provider of nutrition assessment and care plan, and Medicare MNT reimbursement is statutorily limited to the RDN. Substitution would jeopardize Hospital IQR scoring and forgo MNT reimbursement.

"Reimbursement-side reform alone could close the gap; a wage floor is unnecessary." MNT coverage expansion (pillar 9b) is the reimbursement architecture; the wage floor (9a) follows from amortization arithmetic that is independent of payor mix. Without the floor, an RDN under post-OBBBA financing in a typical major-metro market cannot service training debt regardless of how much MNT is reimbursed at the institutional level. Both interventions are required; neither is sufficient alone.

11. Implications for FNCE 2026 and the field

FNCE 2026 convenes at a structural inflection: the MAHA Strategy is operational, the new Dietary Guidelines are in effect, OBBBA loan changes take effect July 1, 2026, and the CDR registry has just registered the first absolute decline in modern record. The data presented here are offered as a contribution to that policy discussion.

12. Disclosure and scientific integrity

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Methodology. Data presented are drawn from primary federal statistical sources (BLS, CDC, CMS, USDA, ASPE, HRSA), peer-reviewed literature, official policy documents, and OECD Health Statistics 2024. All U.S. wage figures are national means and medians from BLS OEWS May 2025 release; no MSA or state data is substituted for national values except where explicitly noted (Section 6e).

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