2025 POLICY PRIORITIES

Executive Summary

The American College of Lifestyle Medicine (ACLM) represents over 13,000 physicians and health professionals dedicated to addressing chronic disease through lifestyle interventions. Founded in 2004, ACLM focuses on educating and empowering clinicians to use evidence-based therapeutic interventions like nutrition, physical activity, sleep, stress management, social connection and avoidance of risky substances to prevent and reverse chronic diseases. Unlike other medical associations, ACLM does not accept funding from the pharmaceutical or food industries.

ACLM advocates for a healthcare system that prioritizes lifestyle medicine (LM) as the first line of treatment. Despite the high prevalence of chronic diseases among U.S. adults and children, unhealthy lifestyle behaviors continue to drive up healthcare costs. Current medical education and payment systems do not adequately support lifestyle medicine, which is essential for effective chronic disease treatment and prevention.

ACLM's policy priorities include 1) lifestyle medicine medical and health professional education 2) proper payment and quality measure alignment for LM Interventions 3) military readiness with LM training, delivery models, and research and 4) addressing chronic disease health disparities through lifestyle medicine. These priorities aim to transform the healthcare system to focus on root-cause, whole-person care. Each are outlined in greater detail below.

Introduction and Current State

On behalf of the over 13,000 physician and health professional members of the American College of Lifestyle Medicine (ACLM), we appreciate the opportunity to outline important policy priorities for the health care transition team for President-elect Trump. We believe these policy priorities which ACLM members embody every day in their practices are in alignment the goal of the new Administration to finally begin to turn back the tide on the epidemic of chronic disease plaguing our population, and, in fact, are necessary elements in any strategy that hopes to be successful in this undertaking.

Founded in 2004, the non-for-profit American College of Lifestyle Medicine is the nation's only interdisciplinary and multispecialty medical professional association dedicated to educating, equipping and empowering physicians and health professionals to address root causes of chronic disease through evidence-based therapeutic lifestyle interventions—including nutrition, physical activity, sleep, stress management, positive social connections and avoidance of risky substances—**to prevent, treat and even reverse** chronic diseases. Unlike most other medical professional associations, ACLM accepts no funding from pharmaceutical or food industry to support our work.

Clinician members of ACLM have been promoting a transformed healthcare system with a focus on root-cause lifestyle medicine as a first-treatment approach for the past 20 years. ACLM's vision is a world wherein lifestyle medicine is the foundation of health and all health care and our mission is to advance evidence-based lifestyle medicine to treat, reverse, and prevent non-communicable, chronic disease. The power of lifestyle medicine (LM) transcends all healthcare specialties as we see examples of implementation in nearly every area of healthcare across the entire care continuum.

While prevention of lifestyle-related chronic diseases is ideal, 60% of U.S. adults have already been diagnosed with one or more chronic diseases.[1] If the adult incidence of chronic disease was not alarming enough, according to the U.S. Centers for Disease Control and Prevention, as of 2021 more than 40% of school-aged children and adolescents had at least one chronic health condition.[2]

Unhealthy lifestyle behaviors are continuing to escalate the unsustainable upward trajectory of U.S. healthcare spending, driving as much as 90% of the healthcare dollars and putting our nation at severe economic risk.[3,4] Most chronic diseases are caused by a short list of risk factors: **smoking, poor nutrition, physical inactivity, and excessive alcohol use**.[5] Lifestyle-related chronic conditions are not properly addressed within medical and health professional education nor are there proper payment systems within our fee-for-service dominant healthcare system to address their root causes. The current healthcare ecosystem emphasizes and incentivizes disease and **symptom management** through increasing quantities of pills and procedures instead of acknowledging and rewarding achievement of health restoration, disease remission, medication de-escalation and chronic disease prevention through **root-cause treatment approaches**.

When you look at chronic disease clinical practice guidelines (CPGs) for hypertension[6,7], type 2 diabetes[8,9] cardiovascular disease[10], obesity[11] and cognitive decline[12], you'll see lifestyle interventions listed as the first treatment approach. Most pharmaceutical drugs, including the new GLP- 1 medications, also list diet and exercise as crucial elements to successful long-term outcomes, and research shows that many surgical interventions also benefit from a perioperative lifestyle intervention for best and most sustainable health outcomes.[13] Health restoration and disease remission for a variety of chronic diseases is possible. Studies demonstrate that the same modifiable unhealthy lifestyle factors, when dosed appropriately, can be used to treat and reverse[15]existing chronic diseases and prevent future disease.[16-24] Despite this, lifestyle medicine approaches are far from the standard of care in our current, volume-based FFS healthcare system, nor are they emphasized in most value-based care arrangements.

As a medical professional body representing conventional medicine clinicians, we have discovered barriers in the current health profession education and healthcare delivery ecosystem that make it difficult for healthcare professionals across the country to deliver the type of evidence-driven, relationship-based, root-cause, whole-person care that can achieve true health and health restoration. These barriers have shaped our policy priorities, which are detailed below and include: 1) **l**ifestyle **m**edicine **m**edical and **h**ealth **p**rofessional **e**ducation 2) **p**roper **p**ayment and **q**uality **m**easure **a**lignment for LM Interventions 3) **m**ilitary **r**eadiness with **LM t**raining, **d**elivery **m**odels, and **r**esearch and 4) **a**ddressing **c**hronic **d**isease **h**ealth **d**isparities **t**hrough **l**ifestyle **m**edicine.

Lifestyle Medicine Medical and Health Professional Education

Incorporating lifestyle medicine, particularly nutrition education, in medical and health professional schools is imperative to begin addressing root-cause treatment approaches earlier in health professions careers. Unfortunately, physicians receive little to no training in nutrition, physical activity, sleep, stress management, or social connection in most medical schools and residency programs,[25] with data showing that an overwhelming majority feel ill-equipped to provide the kind of expert guidance their patients need in these areas.[26] According to an article in STAT,[27] " the average medical school student spends less than a day learning about obesity, despite the fact that over 40% of adults and 1 in 5 children in the U.S. have it, according to some estimates."

The newly updated Harvard Law School Food Law and Policy Clinic "Doctoring Our Diet" report[28] says "At the graduate medical education (GME) level (the residency/fellowship stage of medical education), nutrition competency requirements are not included in the general requirements for GME programs – known as the Common Program Requirements – and are limited or absent in the specialty-specific requirements for most specialties. In a 2017 survey of 646 cardiologists, 90% reported that they did not receive adequate nutrition education to advise their patients on nutrition, even though 95% believed it was their personal responsibility to provide this type of advice.

The current healthcare ecosystem perpetuates the narrative that once a chronic disease is diagnosed, it can only be managed with ever-increasing amounts of pills and procedures for the lifetime of a patient. This

narrative denies the evidence that with properly dosed therapeutic lifestyle interventions, patients can often

achieve disease remission and health restoration. It also perpetuates a healthcare system that relies heavily on increasing doses of pharmaceuticals and surgical interventions to manage symptoms while never addressing underlying root causes of disease.

Moreover, we know that one reason physicians and other clinicians are leaving the profession is frustration that they are not healing patients—the reason most went into medicine. Lifestyle medicine training has the ability to support better health behaviors for clinicians who are delivering care, as well as providing tools to restore health rather than just manage disease symptoms. One study has shown that clinicians who practice LM are at a lower risk for burnout, which could help address healthcare workforce shortages.[29]

ACLM is committed to filling the gaping void in medical and health professional education. We provide hundreds of hours of undergraduate, graduate (residency) and continuing medical education (CME) courses and curricula on lifestyle medicine and the treatment, prevention and remission of chronic diseases. Young clinicians and healthcare faculty are demanding this type of training, which we see reflected in the exponential growth of our academic programming and curricular resource use. Our lifestyle medicine residency curriculum, for example, is being adopted at rapid rates across the country with more than 170 residency sites and over 370 residency programs adopting our lifestyle medicine residency curriculum since its inception in 2018.

We believe taking steps to expand the practice of lifestyle medicine is an absolutely necessary part of any strategy that hopes to create a healthcare workforce capable of helping to stem this epidemic tide of chronic disease, improve patient outcomes, reverse the trend of physician burnout, and contain the growth of health care spending in this country. With proper clinician education for healthcare professionals across the education continuum, all clinicians could practice root-cause medicine. In doing so we could see a restoration of American health and the shift toward prevention of future chronic disease.

Proper Payment and Quality Measure Alignment for LM Interventions

The current healthcare system is not designed or optimized to financially support or measure therapeutic lifestyle interventions as treatment or adjunctive therapy in either fee-for-service or value- based payment settings. Not only are most lifestyle interventions poorly reimbursed compared to other therapeutic approaches, in some cases, the current quality measure system unintentionally penalizes providers for achieving better health outcomes using lifestyle interventions.

The low financial reimbursement associated with the use of multi-modal, interdisciplinary delivered therapeutic lifestyle behavior change interventions in fee-for-service settings is illustrated by the following examples.

> *Patients who are overweight (but not yet obese) are eligible to be enrolled in Intensive Behavioral Therapy for Obesity to address modifiable lifestyle-related health behaviors to achieve weight loss and reverse overweight or obesity. The CPT code (G0447) for this service reimburses $25.30 per 15-minute increment for a physician, and when delivered in a group reimburses $12.32 per 30 minutes (CPT G0473). If certain targets are reached more visits are allowed.* ***The maximum income a clinician can receive for furnishing 5.5 hours of IBT for obesity is $556.60 per patient or $101.20 per hour of time****, which doesn't even cover the hourly salary of a physician, not to mention any additional healthcare team members or administrative time necessary to deliver the service. Despite the low value on reimbursement, IBT has been shown to be effective at achieving weight loss and better health outcomes[30].*
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> *Another example is the diabetes prevention program (DPP), which focuses on modifiable lifestyle changes to prevent someone from transitioning from a diagnosis of prediabetes to full type 2 diabetes and has been proven to be more effective than medicine.[31] The CPT code (G0886) reimburses $25 per in-person or distance group visit per hour, with incentives for weight loss built into the program.* ***The maximum reimbursement per beneficiary per year to deliver the DPP is $768 for 22 hours of time*** *(not to mention any administration time to support the program) which equates to about* ***$35 per patient per hour of time.***

In RVU-based FFS settings it is much more financially rewarding to see a large volume of patients, which doesn't allow for relationship-based, interdisciplinary, root-cause, lifestyle-change focused interventions that are required to achieve improved health outcomes.

In addition to financial disincentives and misalignments in fee-for-service medicine for delivering therapeutic lifestyle interventions, there are also barriers to delivering LM value-based payment arrangements and quality measure misalignments, summarized in the points below.

Difficulty Demonstrating Improvement with Current Benchmarking
Due to their preventive approach, LM practices often have healthier patient populations. This makes it increasingly difficult to show year-over-year improvements, as required by many value- based models.

Quantifying Long-Term Preventive Care Value
Current metrics don't fully capture the long-term impact of lifestyle interventions, leading to an underappreciation of LM's role in reducing healthcare costs and improving quality of life.

Payment Delays
The extended lag time (up to 18 months) in reimbursements can prevent practices from implementing high value LM interventions such as shared medical appointments, creating financial strain.

Misalignment with Capitation Models
Capitation models don't adequately account for the initially time-intensive nature of LM interventions and the ongoing work required to maintain high health standards.

Disease Remission Protocol
Lack of clarity on risk adjustment for diseases in remission, managed through lifestyle interventions - clarity is requested for whether risk adjustment diagnoses that are in remission due to lifestyle interventions can continue to be documented and coded. Once a disease is in remission, continued management through lifestyle interventions and support is needed - which comes with corresponding resource utilization and cost. However, patients' indicative values (i.e. labs) may have returned to normal range. The ICD10 literature does not seem to contemplate such a scenario, but rather than chronic disease will continue to persist indefinitely. If physicians were no longer able to code that the disease is still present but in remission, they would be penalized for actually achieving better health will continue to bear the cost of the intervention. This seems at odd with the underlying intent of risk adjustment - to correctly compensate for the cost of providing care for a given condition.

Medication Adherence Quality Measures
Quality measures that measure medication adherence, when the disease can be effectively treated through lifestyle medicine alone. This penalizes physicians and encourages over prescribing.

Illustrative Example:

An LM trained primary care physician (PCP) may effectively prevent a patient with diabetes and chronic kidney disease (CKD) from progressing to more severe conditions like stage 4 CKD, congestive heart failure, or heart attack through aggressive attention to risk factors. In contrast, a more passive traditional PCP might spend less time or effort to treat the lifestyle-related root causes of chronic disease and see the same patient develop these high-risk diagnoses.

Paradoxically, under Medicare value-based care (VBC) contracts, the traditional PCP would be rewarded with a larger bonus payment due to the higher benchmark or budget assigned to patients with these diagnoses (potentially $5000 or more per affected patient per year).

Meanwhile, the LM PCP, despite providing more intensive lifestyle counseling and coaching, would

receive lower reimbursements due to their success in preventing these high-risk diagnoses.

This scenario creates a perverse incentive that financially rewards passive care over proactive lifestyle approaches. Furthermore, LM PCPs are often precluded from billing for lifestyle counseling under models like PC Flex or ACO REACH and are forced to maintain care teams without adequate revenue streams. This can potentially lead to financial difficulties for practices, as Progressive Health of Delaware experienced in 2022 under Medicare Direct Contracting.

Additionally, while LM practices prevent disease progression, their patient panels are still aging. Older age is a significant risk factor for adverse health events but is not captured in HCC risk coding, potentially disadvantaging LM practices.

The financial reimbursement and quality measure misalignments associated with the use of therapeutic lifestyle behavior change interventions is not only problematic from an economic perspective, it is unethical to patients. As a matter of informed consent, patients should be educated about and offered lifestyle interventions that can be effective at treating the root causes of chronic conditions, and in some cases, putting them into remission. Patients should be aware of these options and offered them alongside other treatment options. Providers who deliver lifestyle interventions should also be able to do so in a financially sustainable way and ideally rewarded for preventing costly conditions from developing.

Overall, more pills and procedures alone will never address underlying health behaviors that continue to drive the escalating chronic and mental health epidemics in America. It is only when modifiable health behaviors that contribute to the leading chronic conditions are addressed in clinical care settings, reimbursed properly, measured, and covered by insurance, will we truly be able to achieve a healthier America. We need aligned incentives and quality measures that reward better health outcomes across the spectrum of chronic disease (regardless of process) along with a removal of penalties and barriers that providers who deliver better health regularly experience.

Military Readiness with Lifestyle Medicine Training, Delivery Models, and Research

The prevalence of chronic disease, obesity, overweight and mental health issues among our recruits, as well as our active duty, pose a threat to national security and may reduce our ability to deploy effectively. It is estimated that over 40% of Active Duty Service Members (ADSM) were diagnosed by a physician with at least one of eight chronic preventable conditions: hypertension, back pain, diabetes, asthma, angina, high cholesterol, heart disease, and bone/joint/muscle injuries including arthritis.[32] In regard to recruitment, a 2022 Pentagon study shows that **77% of young Americans would not qualify** for military service without a waiver due to being overweight, having mental or physical health problems, or a history of prior drug use.[33]

In addition, poor health behaviors during and after military services, especially in areas of physical activity, nutrition, tobacco, and alcohol are also the **highest drivers of the significant health disparity within veteran populations.[34]** In fact, although healthier upon entering military service, after they serve, separate, or retire, veterans are some of the unhealthiest Americans in the country.

The growing burden of unhealthy behaviors and subsequent chronic disease is a threat to military readiness, national security, and our Nation's economy. The financial burden of suboptimal lifestyle habits to the DOD are significant with the following estimates: tobacco use: ~1.8 billion[35], obesity- related health care costs: ~1.25 billion[36], and excessive alcohol consumption: ~1.1 billion[37]

With $58.7B allocated by the DOD to healthcare spending in 2024, root-cause lifestyle medicine prevention and treatment strategies are essential to U.S. military recruitment, retention, and overall resilience.

ACLM has been working closely with leaders across the military—Air Force and Space Force, in particular—to advance lifestyle medicine training, certification, clinical practice models and novel research for active-duty service members and veterans. In partnership with the **United States Space Force** (USSF),

ACLM recently launched an innovative training program to enhance Space Force service members' health and performance by providing the **USSF Guardian Resilience Team** (GRT) with evidence-based lifestyle medicine education, training and certification.

Advancing lifestyle medicine training, certification, clinical practice models and novel research for active- duty service members and veterans is imperative to achieving a healthier America.

Addressing Chronic Disease Health Disparities Through Lifestyle Medicine

In 2018, health disparities were estimated to cost the U.S. economy $451 billion[38]. Estimates also show that advancing health equity and empowering people with chronic conditions to achieve better health outcomes would save $2.7 trillion in medical costs and $1.1 trillion in less absenteeism over 10 years[39].

While there are many stakeholders working to address health disparities across the healthcare ecosystem, ACLM created the Health Equity Achieved through Lifestyle Medicine (HEAL) Initiative to address lifestyle-related chronic disease health disparities through lifestyle medicine strategies. Through, our HEAL initiative ACLM has worked to equip clinicians with education, tools and support needed to address lifestyle-related chronic disease health disparities in rural and urban populations through underrepresented in medicine (UIM) and community health center (CHCs) scholarship programs, community conversations, HBCU outreach and through the integration of structural competencies into our existing resources. All of these efforts are imperative to achieving an equitable and effective healthcare delivery system.

Conclusion

While we recognize that healthcare transformation through a lifestyle medicine, root-cause clinical approach cannot solve for all factors that contribute to health and health outcomes in the U.S., **it is one of the solutions that is already being leveraged by clinicians across the country with great success**.

Working synergistically with policies aimed at addressing the environmental and social factors, including our ultra-processed food system, will be necessary to move the needle on chronic disease.

A transformed healthcare system in America should have a goal of **reducing the need for medication, high-cost surgical interventions, medical devices and detection services. Outcomes should focus on achieving health restoration for many patients and preventing future lifestyle-related chronic conditions from proliferating.**

It is only when lifestyle factors that contribute to the leading chronic conditions are addressed for all citizens through proper healthcare workforce training, clinical delivery models and proper payment will we will truly be able to achieve a healthier America. Remaining idle is a threat to our national security, could increase current health disparities and is economically unsustainable. Clinician members of the American College of Lifestyle Medicine have been promoting a transformed healthcare system and focus on root-cause lifestyle medicine for the past 20 years. ACLM and our dedicated clinician members would be happy to answer questions related to any of the information shared in this policy briefing document.

Questions? Please contact Chief Integration Officer Kaitlyn Pauly at kpauly@lifestylemedicine.org.

Best in health,

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