

# Financing Whole-Person Health

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## Abstract

**Background:** Current payment models in the U.S. healthcare system are neither sustainable nor desirable. Expenses outpace revenue for most healthcare providers, while patients experience rising prices contrasted with inadequate health outcomes.

**Objective:** There is not a single, small adjustment that can remedy these issues; systemic problems require systemic solutions. One such solution involves whole-person care, an approach that emphasizes using diverse healthcare resources to align care with a patient's values and goals as well as treat a patient's physical, behavioral, emotional, and social risk factors.

**Methods:** In order to be most effective, whole-person care must be paired with a viable payment system that prioritizes positive outcomes and efficiency. The predominant fee-for-service payment system is not conducive to whole-person strategies.

**Results:** This paper examines the role of capitated payments, risk adjustments, social and structural determinants of health, and expense trends in an interdependent approach to healthcare industry system reform.

**Conclusion:** The Whole Health paradigm is optimized to improve both the financial performance of healthcare providers and the healthcare results of patients. Phased implementation is both feasible and sustainable.

## Keywords

Whole health, health policy, integrative medicine, preventative care, patient satisfaction, healthcare finance

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## Introduction

Within the United States healthcare industry, the dominant payment models are not only inefficient, they are fiscally unsustainable. In conjunction with current failures to address the patient as a whole and treat social needs, prompt payment reform is both prudent and necessary. Reforms such as population-based payment and whole-person care provide encouraging opportunities to improve patient outcomes as well as the sustainability of the healthcare industry as a whole.

It is well documented that most individuals have unmet needs spanning multiple systems, especially those who are under-resourced. Further, insufficient patient care coordination as well as failure to address upstream social needs has been linked to significant unnecessary spending.<sup>1</sup> Thus, there is a great need for coordination spanning multiple domains of medical and social care to not only improve overall patient health but also reduce costs.

Models of “whole-person care” offer a more integrated approach. While “whole-person health” is defined broadly and variably, most models nested beneath this label purport health care that is coordinated across multiple systems, patient-centered, proactive, and rooted in understanding a patient's goals and values.<sup>2</sup> One fairly developed example of this concept is the Veterans Health Administration's (VHA's) Whole Health System (WHS) model of care which offers a comprehensive and integrated approach to health—“empowering and equipping people to take charge of their health

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and well-being and live their life to the fullest.”<sup>3</sup> This approach has proven effective in not only improving patients’ experiences with chronic disease but also reducing unnecessary healthcare utilization and spending.<sup>4</sup>

After facing a global pandemic and observing the necessity of improving population health and reducing widespread chronic disease, the time is right to integrate Whole Health into new healthcare settings throughout the nation. However, without special attention to the method of payment and reimbursement for Whole Health-related services, the Whole Health approach cannot function as designed. Here, we define the Whole Health approach, survey the payment landscape, and evaluate the financial models that sustainably support Whole Health functionality such that implementing this approach is not only cost-neutral but profitable. In total, the case for implementing whole-person care extends beyond patient benefits. A Whole Health approach integrated with population-based payments is the most solvent and sustainable method for the healthcare industry in coming years.

### From Reactive and Disease-Based to Proactive and Person-Based

A well-recognized problem in healthcare today is the emphasis on reacting to acute conditions rather than preventing chronic conditions.<sup>5</sup> Due to a myriad of factors including time constraints and limited resources, providers often attempt to address health problems as isolated incidents rather than the consequences of broader social, environmental and lifestyle conditions.<sup>6,7</sup> Yet, chronic conditions can be best understood with greater context, specifically when invoking methods that target social and structural determinants of health. When social factors are incorporated with epidemiological factors, interventions are significantly more effective at improving chronic conditions, patient satisfaction, and patient adherence.<sup>8,9</sup> Whole-person health and, more specifically, Whole Health, encourage shifting the provider focus from the disease to the person.

One of the characteristics that differentiate a Whole Health approach from other value-based or diagnostic care programs is a strong emphasis on patient-centered, goal-driven behavioral changes. While physicians frequently encourage their patients to engage in healthier behaviors, they typically frame illness avoidance as a primary motivator, which has proven relatively ineffective.<sup>10,11</sup> When behavioral changes are motivated by positive goals determined by the patient themselves, patients are significantly more likely to adhere to those behavioral changes.<sup>12,13</sup>

Incorporating social and structural determinants of health and patient empowerment are highly effective strategies, but they are also complex and difficult to implement. In order to ensure continuity of care and data integrity across multiple public health disciplines, extensive diagnostic and analytic systems would need to be established. Numerous institutions have attempted such a comprehensive, systemic reform of

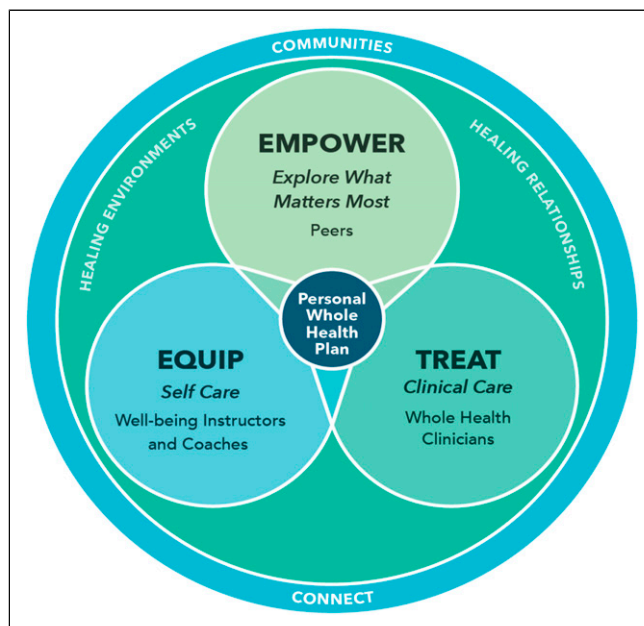


Figure 1. Whole Health Delivery Model.

healthcare and public health strategies, with mixed success.<sup>14</sup> A major limiting factor has been competing goals between the public, payers, and providers. Effective change requires compatible motivations.

### Whole Health

The Whole Health approach was first developed and implemented by the VHA in 2017. In its inception, the administration launched full-implementation flagship sites at 18 Dept. of Veterans Affairs (VA) medical centers.<sup>2</sup> The Whole Health model of care is centered on understanding a patient’s life meaning, aspiration, and purpose (MAP; i.e., unearthing what matters most to the patient). Thus, it moves beyond patient-centered care in philosophy and prioritizes care that incorporates a patient’s goals and priorities into healthcare decisions. Whole Health integrates allopathic and complementary and integrative health (CIH) practices with peer-led support, personalized health planning, Whole Health coaches, and well-being classes (Figure 1).

Initial results from the flagship sites at the VA are encouraging. Veterans have reported high levels of interest and engagement in utilizing Whole Health services. Similarly, veterans participating in Whole Health programming reported high levels of satisfaction as well as decreased stress and opioid utilization.<sup>4</sup> Surprisingly, data on veterans participating in the VHA WHS program in 2018 and 2019 demonstrated a 24% drop in total healthcare costs in the first 12 months among veterans actively participating in Whole Health.<sup>15</sup> Simultaneously, the total cost of care among non-participating veteran rose 6%. Because of these VA Whole Health model results, many organizations, corporations, and

institutions have expressed interest in implementing Whole Health in the private sector.

Importantly, the VA WHS model is able to integrate both clinically and fiscally within the traditional healthcare system because it relies on the VA's unique payment scheme—a capitation-based, single payer system. As such, a fixed amount of money is paid to the health system (in this instance, the VA) per patient per unit of time. This financing structure promotes the use of high-value, preventative, and cost-saving Whole Health services rather than discourage the addition of a new service as might be the case in an FFS arrangement.

## Brief History of Alternative Payment Models

The current US healthcare system did not evolve in a vacuum, nor is it the only logical form of providing health care in a business model. A brief historiography of the medical industry is useful in understanding the origins and alternatives to a system that can seem immutable.

There are the perennial legends that in ancient China, physicians were paid a retainer until the patient fell ill and then were paid nothing until health was regained.<sup>16</sup> According to some, prepayment schemes have been around in one form or another since medieval times.<sup>17</sup> In the 19<sup>th</sup> century US, there is also some evidence. Samuel Clemens noted in his autobiography that growing up in Hannibal Missouri, his parents paid the local doctor \$25 a year for taking care of the entire family regardless of their state of health.<sup>18</sup>

In the early 20<sup>th</sup> century, there were several nascent pre-paid programs in Oklahoma. Several major programs like Group Health Association in DC (1937), Kaiser-Permanente (1942), Puget Sound Health Cooperative (1947), Health Insurance Plan of Greater New York in New York City (1947), and the Group Health Plan of Minneapolis (1957) started up thereafter and which still exist in some form today.<sup>19</sup>

Prepayment or capitation found more visible use in the 70s and 80s in the health maintenance organization (HMO) era and was given a huge boost by the Health Maintenance Organization Act of 1973 (P. L. 93-222). Growth was slow despite good results. HMOs yielded identical outcomes with about 40% less hospitalizations but gained a reputation of denying care.<sup>20</sup> During the 1980s, a market consolidation took place in which the major insurance entities emerged the winners. These businesses eschewed the idea of health maintenance, embraced the Tax Equity and Fiscal Responsibility Act (P. L. 97-248), paid with Diagnosis Related Groups (DRGs) to hospitals, and developed preferred provider networks. Two major outcomes developed. First, since DRGs applied only to inpatient hospital services, hospitals and group medical practices expanded their outpatient services in order to offset revenues lost as a result of shorter

hospital stays.<sup>21</sup> Second, since DRGs were initially applied exclusively to Medicare payments, hospitals shifted unreimbursed costs to private health insurance plans which resulted in rapidly increasing costs for private insurance. Cost shifting intensified as CMS programs expanded.<sup>22</sup>

Parallel to these developments, the Veterans Administration sought better allocation methodology, as there was a persistent mismatch of allocations and workload.<sup>23</sup> In 1997, they launched the Veteran Equitable Resource Allocation (VERA) system which was based on a per capita allocation as opposed to the previous system which was based on historical expenditures. Initially, the allocations were based on 2 price groups to account for outpatient and inpatient components.<sup>24</sup> As the risk adjustment methodology developed, this was expanded to a morbidity-based price group system which has been stratified into 13 price groups with numerous classes under each price group. The importance of this 24 year evolution in the VA system is that the gains realized from a shift to capitation had mostly occurred prior to the implementation of VA Whole Health.

In the early 1990s, the insurance industry reinvigorated the spread of HMOs in response to an inexorable healthcare costs were inexorably climbing. Congress also tried to curtail this rise in costs with the Balanced Budget Act in 1997 but effectively negated the impact with the Balanced Budget Refinement Act in 1999 and the Benefits Improvement and Protection Act of 2000.<sup>25</sup> With the exception of the HMOs, provider payments were still primarily FFS and DRGs, which are in many ways equivalent to current “bundled” payments. From this history, it is clear efforts to develop the optimal payment method are perennial and somewhat redundant, yet still significant challenges, such as cost-control measures and health equity, remain.

## Overview of Payment Models and Aligning Incentives

Extensive policy research has focused on how to mitigate healthcare costs to the public, but this is an incomplete formula. In both nonprofit and for-profit healthcare systems, healthcare providers need to thrive under any proposed reforms. A successful model would improve health outcomes, lower costs to the public, and increase profits for the companies involved. These outcomes are not mutually exclusive.

Although individual healthcare providers are motivated by the desire to treat their patients, the healthcare industry as a whole responds most often to financial motivations in structuring how patients are treated.<sup>26</sup> Therefore, it is essential to ensure the greatest financial incentives are aligned with the greatest health results for the individual patient.

Figure 2 illustrates several of the dynamics at play when considering how payment models can incentivize patient health and well-being. The purple line indicates the degree to which a health system is financially incentivized to promote high-value, high-quality care and support individual patient

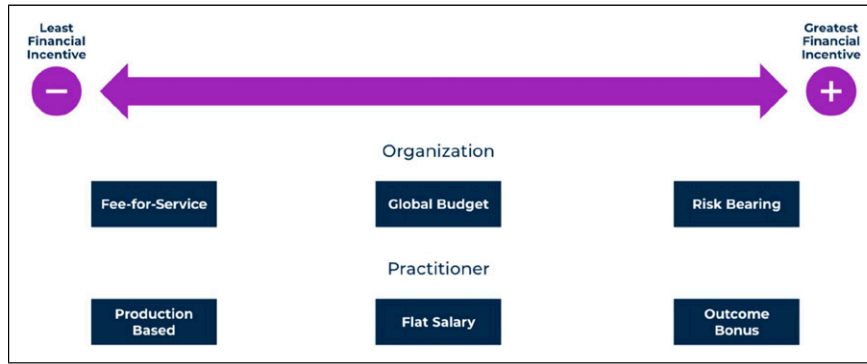


Figure 2. Financial Incentives for Wellness.





| <br>CATEGORY 1<br>FEE FOR SERVICE -<br>NO LINK TO<br>QUALITY & VALUE | <br>CATEGORY 2<br>FEE FOR SERVICE -<br>LINK TO QUALITY<br>& VALUE | <br>CATEGORY 3<br>APMS BUILT ON<br>FEE-FOR-SERVICE<br>ARCHITECTURE                                | <br>CATEGORY 4<br>POPULATION -<br>BASED PAYMENT  |
|---|--|--|---|
|   | <b>A</b><br>Foundational Payments<br>for Infrastructure &<br>Operations<br>(e.g., care coordination fees<br>and payments for HIT<br>investments)   | <b>A</b><br>APMs with Shared<br>Savings<br>(e.g., shared savings with<br>upside risk only)   | <b>A</b><br>Condition-Specific<br>Population-Based<br>Payment<br>(e.g., per member per month<br>payments, payments for<br>specialty services, such as<br>oncology or mental health) |
|   | <b>B</b><br>Pay for Reporting<br>(e.g., bonuses for reporting<br>data or penalties for not<br>reporting data)                                      | <b>B</b><br>APMs with Shared<br>Savings and Downside<br>Risk<br>(e.g., episode-based<br>payments for procedures<br>and comprehensive<br>payments with upside and<br>downside risk) | <b>B</b><br>Comprehensive<br>Population-Based<br>Payment<br>(e.g., global budgets or<br>full/percent of premium<br>payments)  |
|   | <b>C</b><br>Pay-for-Performance<br>(e.g., bonuses for quality<br>performance)  |  | <b>C</b><br>Integrated Finance<br>& Delivery System<br>(e.g., global budgets or<br>full/percent of premium<br>payments in integrated<br>systems)                                    |
|   |  | <b>3N</b><br>Risk Based Payments<br>NOT Linked to Quality  | <b>4N</b><br>Capitated Payments<br>NOT Linked to Quality  |

Figure 3. Types of Healthcare Payment—Alternative Payment Model Framework Health Care Payment Learning and Action Network.<sup>28</sup>

health and well-being. On one end of the spectrum, FFS is most aligned with a product-based payment system, offering incentives to both organizations and physicians to offer care in high quantities. FFS is the dominant model in the healthcare industry today, and as such, healthcare providers are reimbursed for each individual procedure conducted on an individual patient. This payment model is incompatible with public health goals in the long-term, incentivizing healthcare providers to ignore the prevention of chronic illnesses in favor of costly treatments.

Global budgets sit in the middle of the payment spectrum. This payment structure is also problematic because while it does not incentivize unnecessary medical care, there is still no financial incentive for either the organization or the practitioner to focus on better patient outcomes.

An alternative model is population-based payment, in which healthcare providers are rewarded for maintaining or improving their patients’ health. Capitation helps balance uneven profit margins for different procedures, reducing industry instability.<sup>27</sup> To mitigate risk, this model requires a robust risk adjustment methodology to track the predicted and potential health factors influencing various demographics to utilize health services.

### Payment Model Framework

The development of a payment model compatible with whole-person health, more specifically Whole Health, involves numerous transitions from existing models, though each step is progressively more efficient and sustainable. Figure 3 outlines the progression of alternative payment models (APMs) as described by the Health Care Payment Learning and Action Network, the details of which form a roadmap to fostering sustainable payment models that support whole-person health.

### FFS with No Link to Quality and Value

Payment models classified in Category I utilize traditional FFS that do not account for infrastructure investments, data reporting, or provider quality metrics. Diagnosis related groups that are not linked to quality and value are classified in Category 1. Category 1 is distinct from Category 2 in that it lacks any functional engagement in infrastructure investments and/or assessing the quality of the care delivered.

### FFS Linked to Quality and Value

Payment models classified in Categories 2–4 all incorporate some degree of value-based payment (VBP), payment models that incentivize good patient outcomes also known as “pay for performance” models. Specifically, Category 2 utilizes traditional FFS payments, but these payments incorporate investments in clinical services, reporting of quality data, and/or quality metrics for provider services. In



certain cases, such as vaccinations and colonoscopies, FFS appropriately incentivizes increased utilization of important services. In these cases, linking FFS payments to quality indicators can reinforce the right care at the right time. However, for the majority of services, Category 2 is a transitional step toward further APMs, intended to provide the opportunity to develop the delivery system improvements these payments enable.

As the evaluation literature demonstrates, subcategories 2A and 2B payments are often insufficient on their own to catalyze significant delivery transformations. Providers should use subcategories 2A and 2B payments as a transition to subsequent categories.<sup>29</sup>

### **APMs Built on Fee-for-Service Architecture**

Category 3 is based on an FFS structure that provides mechanisms for the management of health services provided for individuals. To accomplish this, payments are based on performance against a target. Payments in Category 3 are structured to encourage providers to deliver effective and efficient care. Episode-based and other types of bundled payments encourage care coordination because they cover a complete set of related services for a procedure that may be delivered by multiple providers.

Category 3 arrangements advance clinical integration and affordability to a greater extent than payments in Category 2 because accountability for reductions in low value care provides stronger incentives to manage healthcare costs and improve care coordination across the span of care.

### **Population-Based Payment**

Payment models classified as Category 4 involve prospective, population-based payments, structured to encourage coordinated, high-quality, person-centered care. Payments within Category 4 cover a wide range of preventive health, care coordination, and wellness services, in addition to standard medical procedures typically paid through claims. Additionally, replacing the volume-based incentives of FFS with population-based payments creates stronger incentives for providers to maximize quality within a budget. These characteristics create a self-reinforcing system of quality and incentivization. Safeguards can minimize insurance risk into population-based payment models by risk adjustments and stop-loss mechanisms to protect providers against unexpected cost increases for warranted care.

Progressively more comprehensive subcategories 4A–4C have the potential to carry significant advantages, expediting investments in care delivery infrastructure, incentivizing care coordination/transitions, and encouraging community health initiatives.

To be successful, different providers will necessarily travel at different paces and along different trajectories in the collective journey of health payment and delivery reform. But

over time, these APMs will offer an efficient and profitable method for most providers and stakeholders in the healthcare industry to transition to Whole Health.<sup>30</sup>

### **Expense vs Revenue**

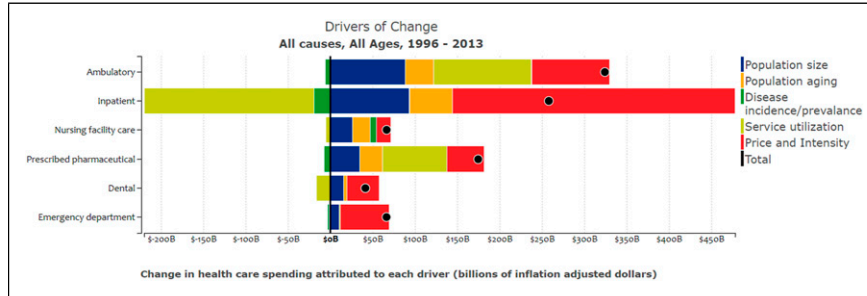
In addition to better serving public health, VBP informed by social determinants of health are also more profitable in the long term. The FFS model is still the most common reimbursement approach in the healthcare industry, with only 8% of hospitals or major healthcare providers participating in any significantly value-based system.<sup>31</sup> However, despite its dominance, the FFS approach is becoming increasingly unstable and unprofitable. A 3-year study analyzing healthcare provider networks found that the average profit margin declined by 39%, to only 2.56% in 2017.<sup>32</sup> Long-term predictions were even worse, the report calculating that expenses were growing 3% faster than revenue. Profits plummeted even more in the aftermath of the COVID-19 pandemic, which resulted in healthcare providers' median operating margins dropping 55.6%.<sup>33</sup>

A major contributor to the instability of the FFS model is an un-scalable expense-to-revenue formula. The foundation of healthcare provider revenue has been major medical interventions, especially inpatient procedures, but demand for these procedures has been decreasing (Figure 4).<sup>34</sup> As fewer of these procedures are requested, in order to recoup money, the providers raise the FFS procedures, which only further drives down demand. From 1996 to 2013, the median price of inpatient procedures increased 7.6%, while demand for those procedures decreased by 4.6% during that same period.<sup>35</sup> Given that many of these are life-saving interventions, this is a significant market response.

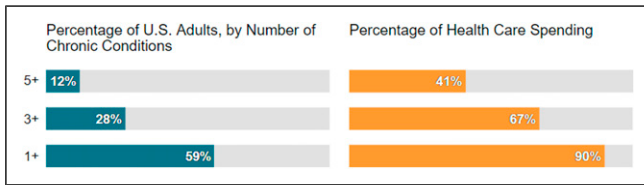
VBP models incorporating Whole Health strategies offer a potential method for healthcare providers to slow increasing expenses, thus improving operating margins. A comprehensive Whole Health approach implemented at the VA resulted in a 72% decrease in pharmacy outpatient expenses.<sup>36</sup> Systematic reviews of VBP models that incorporate many of the features of Whole Health concluded that healthcare expenses were significantly curtailed and quality of care significantly improved.<sup>37</sup>

### **Social and Financial Cost of Chronic Illnesses**

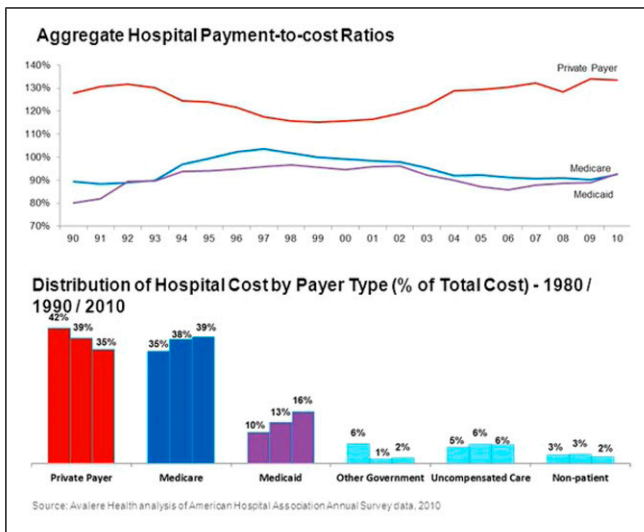
The increasing prevalence of chronic illnesses is another factor causing the current healthcare paradigm to lose money, and it is a factor that is only expected to increase. Chronic illnesses like diabetes, heart disease, and metabolic diseases account for the greatest percentage of treatments and have some of the worst expense-to-revenue ratios (Figure 5).<sup>38</sup> 59% of American adults now live with at least one chronic illness, 42% have more than one, and those with multiple chronic illnesses account for 67% of US healthcare expenditures.<sup>39</sup>



**Figure 4.** Tracking personal healthcare spending in the US | IHME Viz Hub (n.d.). Retrieved May 18, 2021, from <http://vizhub.healthdata.org/dex>.



**Figure 5.** Monica, 1776 Main Street Santa, & California 90401-3208 (2017, July 12). Chronic Conditions in America: Price and Prevalence. <https://www.rand.org/blog/rand-review/2017/07/chronic-conditions-in-america-price-and-prevalence.html>.



**Figure 6.** The Future of Oncology Reimbursement: Alternate Payment Initiatives—ppt video online download (n.d.). Retrieved May 19, 2021, from <https://slideplayer.com/slide/5914437/>.

Where a capitated Whole Health model could both mitigate the prevalence of chronic conditions and maintain corporate profits, FFS health care is not only unable to check the rise of these diseases, but is losing money in the process. An example can again be seen in the VA Whole Health implementation, which reported a 73% reduction in outpatient costs related to chronic illnesses in comparison to veterans engaged in standard care.<sup>40</sup> Research suggests that

comprehensive implementation of a Whole Health model would reduce the negative impacts of chronic illnesses to both the public and healthcare providers, reversing the negative feedback loop in the current system.<sup>41</sup>

### Trends in Healthcare Financing

Though the healthcare industry is still nearly 90% dependent on FFS for reimbursements, that payment model is becoming increasingly obsolete among the fastest-growing demographics in public health.<sup>42</sup> As Medicare and Medicaid become dominant reimbursement systems and are tied ever closer to VBP, focusing on private FFS payments becomes increasingly unsustainable (Figure 6).<sup>43</sup>

Extant FFS remain profitable by extremely small margins, but a combination of shifting trends toward government payers and the lack of solvency for those payers ensures they will eventually become consistently unprofitable. Medicare enrollment is growing more rapidly than private payers, and Medicaid is increasingly the dominant payer in the industry. The FFS structure currently struggles with a –5% margin per patient in either of these programs. The status quo of the healthcare industry entails losing money on the fastest-growing demographics in the market.

### An Optimal System: Whole Health and Population-Based Payment

The failure of the healthcare industry to address the systemic roots of chronic disease has ripple effects beyond the suffering of patients and profit loss of providers. US healthcare costs for chronic disease and the associated loss of productivity amounted to \$3.7 trillion, nearly 20% of the United States gross domestic product.<sup>44</sup> The healthcare industry is experiencing intense spikes in expenses as they attempt to address chronic disease treatment, yet it is estimated that by 2030, the number of Americans with 3 or more chronic diseases will nevertheless increase 267%.<sup>45</sup> As mentioned above, one impact of Whole Health in the VA was a significant reduction in the total cost of care (24% from baseline, 30% relative to non-participant veterans). Applied to the

national healthcare system, this would be the equivalent of \$1.1 trillion dollars in costs avoided. However, it is significant that this reduction took place in a system that had already been on VBP full capitation for over 2 decades. Thus, it is reasonable to expect that a shift to VBP and Whole Health from the FFS market could yield even greater reductions. Applying a systemic, Whole Health approach integrated with population-based payment poses the most promise to mitigate these costs by reducing both healthcare expenses and the prevalence of chronic disease as well as incentivizing providers to provide high-quality, high-value care.<sup>46</sup>

## Conclusion

The individual components of an optimal Whole Health model are not new and have manifested in a wide variety of forms. It is through incorporating these elements into a coherent system that an opportunity for innovation emerges.

The current decline and degeneration of the FFS payment system is trending toward pre-paid mechanisms with some degree of risk. This trend alone will reduce costs and improve quality regardless of the inclusion or exclusion of Whole Health. However, the Whole Health model resolves many of the challenges inherent to the current healthcare system as well as the individual patients navigating that system. An optimal approach incorporates population-based payment models, Whole Health patient goal-driven care, population health data, socioeconomic interventions, and behavioral medicine, all integrated within the current standard of care. By approaching health care and public health as part of an interconnected system rather than a collection of discrete parts, overall efficacy and costs can be improved for the public and economy alike.

Whole Health has demonstrated significant financial impacts, yet a focus on the financial and economic advantages of the Whole Health model should not detract from the impacts on the quality of human life. From an economic perspective, significantly reducing healthcare costs both makes fiscal sense for businesses and reduces the burden on people of lower socioeconomic status. From a social perspective, improving productivity and eliminating waste benefits the national economy, provides more opportunities for individuals to thrive, and encourages innovation. From a health perspective, addressing the fundamental causes of chronic disease not only improves healthcare margins, it reduces suffering and premature death for millions of people.

Whole Health cannot be effectively implemented in an FFS environment. Pairing Whole Health with an advanced payment model holds the promise of significant reductions in demand, total healthcare costs, and improved health status of the population. The healthcare industry must adapt in order to remain solvent and therein lies an opportunity to improve both their profitability and the care delivered to their patients.

Thus, how you pay for health care is critical but most important may be what you are paying for.

Creating a sustainable, solvent healthcare industry improves the stability needed to address public health crises. Capitation, value-based care, social and structural determinants of health, and systemic diagnostics could help ensure there is no contradiction between successful business outcomes and successful public health outcomes.

## Declaration of Conflicting Interests

The authors whose names are listed immediately below certify that they have no affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent licensing arrangements) that would be furthered by the subject matter or materials introduced in this manuscript.

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