HOW TO
PACKAGE
FUNCTIONAL
MEDICINE
FOR WIDESPREAD
ADOPTION

By: Tom Blue

LeadHealth®
Tom Blue and his collaboration with LeadHealth are developing an innovative and robust operational financial model for the delivery of patient-centered Functional Medicine.

This model incorporates a disruptive approach to the administration of health care that is demonstrating its ability to reduce cost while improving patient outcome in the battle against chronic disease.

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THE SINGLE GREATEST OBSTACLE TO IMPROVING HEALTHCARE IS THE WAY IN WHICH WE PAY FOR HEALTHCARE SERVICES.

The dominant payment model in the United States, and many other countries is the fee-for-service (FFS) system. The common, and escalating, criticism of FFS is that it rewards the quantity of care delivered (within the spectrum of services covered by payers) but not the quality or efficiency of that care.

The unsettling fact of the matter is that FFS actually rewards poor outcomes. Falling short of resolving patients’ health problems leaves people dependent on the healthcare system and drives further utilization of the services for which providers are paid.

In April 2018, this issue was bluntly addressed in an internal report from Goldman Sachs called “The Genome Revolution” in which the author overtly challenges the business model of actually curing diseases that would otherwise be chronic.

Because the FFS model rewards duplication of effort and lack of coordination among providers working in their various, organ system defined silos (cardiology, endocrinology, dermatology, GI, etc.), it removes any economic pressure for the healthcare system to reorganize itself to align with a modern understanding of systems biology. Further, it obstructs the natural tendency of providers to coordinate their efforts by forming multi-disciplinary care teams focused on efficiently resolving particular patient health issues.

In voicing their distaste for the FFS payment system, U.S. providers tend to focus their frustrations on its onerous administrative, coding, billing, and collections burdens. For Functional Medicine practitioners who have devoted themselves to addressing health issues by finding and addressing their underlying causes rather than hastily relying on costly symptom-suppression strategies, this frustration is multiplied. For these practitioners, third party FFS fee schedules don’t cover (or don’t sufficiently cover) much of the time, services, and personnel that are required to apply their skills in clinical practice.

Having lived in the FFS model for their entire careers, when they finally decide to break their dependency on the payer system and redesign their practice revenue models, most Functional Medicine practitioners actually continue to embrace the FFS model. They merely choose to bill patients directly on either a fee for service or fee for time (hourly) basis rather than relying on reimbursement from third party payers.

While certainly more viable than a practice model that hinges solely on third party FFS reimbursement, this approach doesn't begin to resolve the dysfunction inherent the FFS system and will never produce the health or economic outcomes that these practitioners are capable of delivering.

Capitation

The most common alternative payment model today is to allow providers a fixed annual budget to care for patients (aka. capitation). This model has its own serious shortcomings as the budgets are not set as a reflection of the health or healthcare needs of individual patients. When institutionalized, these fixed budgets drive long wait times for non-emergency care and give rise to an inevitable tension between cost-conscious payers and healthcare providers seeking to increase their budgets.
In the growing field of private-pay medicine, the fixed budget model (better known as concierge medicine or direct primary care) is less toxic but still fundamentally flawed for the same reason. It is impossible to establish a single budget to properly serve the needs and priorities of a diverse patient population without forcing lower utilizing patients to unknowingly subsidize the care of higher utilizers.

**At the level of a single practice charging a membership fee of roughly $100/month or more for primary care, this issue is reasonably well masked in three ways.**

1. The provider typically manages a much smaller population of 400-600 patient members, allowing all patients to enjoy a markedly superior service experience.

2. The multitude of ways by which patients ascribe value to the relationship with this type of practice allows providers to sustain a member base while subsidizing the care of more demanding patients with the fees paid by healthier members.

3. Using an alternative payment model to sell care to patients who purchase their services on a purely discretionary basis forces providers to differentiate themselves from other practices in their community. This market-driven mandate to provide some form of added value overrides the more corrosive behaviors that emerge from the system-wide application of the fixed budget (capitated) model.

While the membership model has proven viable for a number of providers, its imperfections are magnified when used as the sole means of compensating a Functional Medicine practitioner. **Two challenging factors tend to emerge:**

1. As practitioners grow their base of Functional Medicine knowledge and skills, the difference in the cost to the practice between serving the most, and the least demanding patients multiplies in comparison to that same cost differential in a conventional primary care practice.

2. Further amplifying this problem is the fact that Functional Medicine practitioners tend to attract an increasingly complex patient population as their skills and reputations develop.

Not unlike the global healthcare system, Functional Medicine practitioners need a better way for healthcare to be purchased that rewards the delivery of superior value to an individual patient.

**The Shift to Value**

This transition toward “value-based reimbursement” has been accelerating in the United States, but the term actually encompasses two very different approaches to payment. The first is a form of capitation that places healthcare organizations at financial risk for overages in the cost of managing all of the health needs of a given population. If costs are below the set threshold, providers share in the savings. If they exceed the threshold, providers are penalized.

At an institutional, or system-wide level, one can easily imagine the array of perverse behaviors this structure might motivate on the part of healthcare organizations as they desperately seek to contain cost while somehow managing to satisfy population-level quality metrics.
The crux of the problem is that capitation is an incentive system focused on reducing the overall cost of care delivered to a given population while failing to create motivation or accountability for creating value at the level of the individual patient. This model places the actuarial risk that should reside with insurance carriers onto the shoulders of providers who should be focused on creating value for individual patients. For this reason, it will never fully enable the payer system to realize its potential as a driving force behind real innovation in healthcare delivery.

**Bundled Payments**

“Care bundles are coming. To say you’re against learning and experimenting with them is like trying to shovel the tide.”

*(2015/16 PWC Strategy & Bundles Survey: Hospital Respondent)*

The second model under the umbrella of value-based reimbursement is called bundled payments. In a bundled payment system, providers are paid for the care of a patient across an entire care cycle. In the “bundle” are all of the services, tests, drugs, devices, etc. used to treat a patient in a given scenario such as a hip replacement.

Rather than paying for each element of the care as a stand-alone item, a price is established for the whole episode of care from pre-surgery through recovery and rehabilitation.

This revolutionary approach to purchasing healthcare may feel oddly familiar to you. That’s because it is. This is how you purchase pretty much everything other than healthcare.

If you want a table for your kitchen, you don’t buy a bag of screws, some wood, and sand paper from three different vendors and hope that things come together in such a way as to leave you with a stable surface to hold dinner off the ground. You buy a table.

It is similarly illogical for consumers seeking to achieve a particular health objective to purchase laboratory testing from one set of vendors, interpretation and prescriptive advice from another vendor, nutrition and lifestyle counseling from another, and nutritional supplements and other products from yet more vendors – all the while, never really knowing what this concoction of products and services will cost nor the odds that these purchases will harmonize to actually yield the result they want.

The 2015/16 PWC Bundles Survey, revealed that 80% of U.S. consumers would pick a well-designed bundle over their current care. The reason is that consumers tend to perceive and experience medical care as discrete episodes. A person in need of a knee replacement generally understands that addressing this need involves a process with a defined starting point that resolves with the achievement of a targeted objective or conclusion.

The concept is hardly new. In the U.S., arguably the main driver of the use of bundled payments has been the Centers for Medicare & Medicaid Services (CMS) with successful pilot initiatives dating back to early 1990s. Despite its promise however, many hospital systems, commercial insurance carriers, and group purchasing organizations prefer capitation, arguing that bundles are too complicated to design, price, negotiate, and implement.

Holding aside the virtues of the model for reshaping incentives around patient-level value creation, critics also tend to overlook the simplicity of administering bundled payments relative to FFS and capitation models.
Another significant skepticism held by critics is that an interdisciplinary care team will actually work together. To the contrary, physician groups across the U.S. and internationally have demonstrated the ability to successfully collaborate to implement bundles that have produced significant savings while measurably improving outcomes.

The Ideal Payment Model for Functional Medicine

As the healthcare system continues to wrestle with the transition to bundled payments, Functional Medicine practitioners should seize the opportunity that bundles represent today. The bundling of Functional Medicine interventions addresses a number of issues that are critical to accelerating the evolution of medicine to embrace root-cause focused approaches to chronic conditions.

1. **Consumer preference.** The simple fact that consumers have a clear preference to purchase, for a transparent price, healthcare interventions that target their specific objective(s) is reason enough for Functional Medicine practitioners to embrace this model.

2. **Patient engagement.** Beyond appealing to consumer preference, the bundled delivery of interventions mitigates the natural tendency present in all FFS models for patients to withdraw prematurely from the treatment process as their symptoms subside. Having committed mentally and financially to the entire episode, people are inclined not to cheat the process, or themselves, by disengaging before they have received the full value of their investment.

3. **Outcomes tracking and optimization.** Because the bundled payment model requires providers to work consistently to a defined care pathway within a set budget, providers that track and analyze outcomes are able to value optimize their bundles and establish an ever-expanding evidence base to support their interventions.

4. **Fair value exchange.** Whether providing bundles to individual consumers or to commercial and employer health plans, the bundled payment model returns the power from third-party payers back to clinical experts to determine the services included in the bundle and its price. On the basis of actual outcomes and value creation, the marketplace will either accept or reject the provider’s judgment regarding the fair exchange of value.

Functional Medicine practitioners have been known to lament the fact that their approach to managing health is not “well reimbursed” by payers. Consider the challenges facing any third-party payer that may wish to appropriately underwrite the cost of Functional Medicine services using the conventional, FFS model.

To prevent every provider in the system from up-coding visits to a new, Functional Medicine reimbursement level, the payer would need a reliable way of determining whether a “Functional Medicine visit” actually occurred. It would need the ability to confirm the provider was actually trained to provide this visit and to interpret Functional Medicine laboratory testing that provider may order. It would need a way to determine when and how to reimburse prescribed nutritional supplementation... and a way to value and reimburse the services of other care team members (i.e. health coaches).
This list of hurdles is far from comprehensive but serves to illustrate the point that FFS reimbursement is not the likely first step for the system-wide adoption of Functional Medicine.

Bundles, on the other hand, eliminate the great majority of these challenges. Because the bundle is attached to a provider (or provider group), payers are able to draw their own judgment related to that specific provider's ability to fulfill the service as promised.

Because the bundle proposes to address a defined health issue in exchange for a fixed price, payers are able to draw their own informed conclusion relative to the value proposition without being forced to make sweeping changes to its reimbursement policies.

Finally, because bundles are designed to target a specific health objective or care scenario, payers are able to more easily assess the return on their investment in the bundle.

For these reasons, it is difficult to imagine a vehicle more ideally suited than bundled payments to enable the healthcare system to embrace Functional Medicine at scale.

**Real-World Application of Functional Medicine Bundles by Employers**

The future of bundled payments for Functional Medicine has already begun to materialize. In late 2017, LeadHealth, a joint venture partner of the Institute for Functional Medicine (IFM) unveiled the first Functional Medicine-based bundled episode of care designed to serve high-cost autoimmune patients with one of five diagnoses that lead to long-term reliance on specialty medications (rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, Crohn's disease, and plaque psoriasis).

The LeadHealth bundle, which is based on a therapeutic framework developed by IFM in cooperation with the Cleveland Clinic Center for Functional Medicine, provides patients a high-touch and precisely choreographed 12-month episode of care delivered entirely via telemedicine (with the exception of lab draws). The episode is implemented by care teams lead by IFM trained physicians who are supported by Functional Medicine trained clinical nutritionists, coaches, and rheumatology and GI specialists.

LeadHealth has already engaged four self-insured employers in Pennsylvania and Tennessee to deploy the program, and early results have been extremely promising. The company plans to develop a menu of similar bundles for other chronic conditions that are well addressed by the root-cause focused, Functional Medicine approach.

LeadHealth has concluded that the largest driver of cost in most health plans is the unnecessary reliance on symptom-suppression medicine in the form of costly and ineffective disease management pathways that sentence plan members to ongoing, escalating reliance on medications and medical interventions. The company has observed that employers are spending large sums on chronic disease management when many of their chronically ill plan members would welcome the opportunity to deescalate or even reverse their conditions by finding and addressing their root causes.

**Bundled programs appear to be the ideal structure to enable employers to make these opportunities available to plan members in a highly controlled and measured way.**
ABOUT

Tom Blue
Chief Strategy Officer, LeadHealth®

Tom Blue is a veteran and pioneer in the field of private (“concierge”) medicine. As a builder of private physician practices since 2002, he has a unique perspective on the history and evolution of the industry and the ingredients for success at the practice level.

In 2009, Tom accepted the role of Executive Director of the American Academy of Private Physicians, the national professional association for private physicians. Under his direction, the Academy has re-branded itself, found its voice in the national media, and grown significantly to serve the ever-expanding ranks of physicians who are reinventing themselves and their practices across the United States. In 2011, Tom co-founded n1Health. As of 2014, n1Health had physician partners in 7 states and was the fastest growing firm of its kind. In 2015, Tom aspired to impact healthcare on a larger scale and Co-Founded LeadHealth.

He is a frequent speaker who in the last year, has been interviewed by the Wall Street Journal, CNN/Money, Business Week, and numerous other print, television, and radio media outlets in connection with his work.

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