

ARTICLE

CIRCLES FOR VALUE-BASED CARE MODELS

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**ABSTRACT:** The concept of value-based care (“VBC”) is that incentives (and disincentives) imposed on providers will lead to less expensive and higher quality healthcare. VBC models in the U.S. <sup>1</sup> date back to the “managed care” efforts of the 1980’s. Today, the VBC market value is forecast to grow to \$1 trillion. <sup>2</sup>

A large amount of data has been collected regarding the performance of various VBC models. Some have been modestly successful; others not at all. This article argues that value-based care is both laudable and achievable. However, its objectives are undermined by imposing on providers complex, burdensome, varying, and expensive “incentives”, often misaligned with the realities of everyday clinical practice.

TABLE OF CONTENTS

**BACKGROUND..... 3**

    THE IMPETUS FOR VBC MODELS..... 3

    LEGISLATION AND GOVERNMENT POLICIES..... 3

    VBC PERFORMANCE..... 3

*CMS Programs*..... 3

*Private VBC Programs*..... 4

**CHALLENGES WITH VBC MODELS ..... 4**

    INTRODUCTION..... 4

    COMPLEXITY AND COST ..... 4

    POORLY DESIGNED INCENTIVES ..... 5

    LACK OF MEANINGFUL STANDARDIZATION..... 5

    CLINICIAN EXPERIENCE ..... 5

    PATIENT AWARENESS AND EXPERIENCE ..... 6

**CIRCLES FOR VBC MODELS..... 6**

    GENERAL ..... 6

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TECHNOLOGY PLATFORM AND PROCESSES .....	7
SCALABILITY .....	7
HCP AND PATIENT USER EXPERIENCES .....	7
CLINICIAN AND PATIENT MOTIVATION .....	7
VBC AND REAL-WORLD EVIDENCE .....	7
FURTHER INFORMATION ON CIRCLES .....	8
<b>CONCLUSION .....</b>	<b>8</b>
<b>FOOTNOTES .....</b>	<b>9</b>

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**BACKGROUND**

**The Impetus For VBC Models**

Healthcare costs in the U.S., on a per capital basis and as a percentage of GDP, have been steadily increasing for decades. They are significantly higher than those of many other developed countries. At the same time, population health metrics are often worse.<sup>3</sup>

Moreover, there are substantial regional and other population group disparities in standards of care, healthcare access and outcomes.<sup>4</sup>

Consequently, the government as well as private payers have implemented a wide variety of VBC models. Each typically contains a mix of presumed financial incentives and disincentives intended to induce providers to control costs and improve “health quality” metrics.

Genuine value-based care is no longer merely a desirable objective. Failure to design and implement successful VBC models will have significant negative economic and political consequences.

**Legislation and Government Policies**

United States government programs relating to value-based care are the province of the Department of Health and Human Services (“HHS”). Accountable Care Organizations (“ACOs”) are overseen by the Center for Medicare and Medicaid

Services (“CMS”).

ACOs are but one of many VBC models tried over the years at the national and state levels.<sup>5</sup> Indeed, there are now many types of Medicare ACOs. In addition to national legislation, there are many similar state, local and private payer and corporate VBC programs.<sup>6</sup>

**VBC Performance**

**CMS Programs**

A good deal of information on ACOs performance is available from CMS, as well as the Medicare Payment Advisory Commission.<sup>7</sup>

That public information reflects mixed results. In its “Synthesis of Evaluation Results Across 21 Medicare Models 2012 – 2020”, the CMS summarized those results as follows:

“Fourteen of 21 models demonstrated gross savings to Medicare driven by improvements in inpatient admissions (ten models) and/or post-acute care (fourteen models). Seven models reduced emergency department visits and/or inpatient readmissions. Six models had net savings, six incurred net losses, and six models had no impacts on net spending.

Quality of care improved in a few models (two models improved self-reported beneficiary or caregiver experience of care

and four models improved mortality) but was mostly maintained.

Even with successful evaluation results and transformation efforts, models may face other barriers to national expansion. Generous financial incentive payments, which helped ensure robust participation in models, made it difficult for many models to demonstrate net savings.”<sup>8</sup>

There is also a good deal of analysis of Medicare ACO performance. Many experts feel that their effect on healthcare cost and quality has been the opposite of intended effects, and that they should be eliminated.<sup>9</sup> Others, while acknowledging the failure of ACO’s and similar government VBC models in many respects,

maintain that they are here to stay and can be fixed.<sup>10</sup>

**Private VBC Programs**

Measured by their continued growth and profitability, private insurance companies can be credited with the largest VBC successes.<sup>11</sup> This is in large part due to their superior data collection and analysis capabilities, as well as for-profit management structure.

At the same time, employers – which are often self-insured -- have seen success with wellness,<sup>12</sup> narrow networks<sup>13</sup>, corporate groups,<sup>14</sup> and other VBC models. As indicated in the cited and other literature, however, the performance of employer VBC models has been mixed.

**CHALLENGES WITH VBC MODELS**

**Introduction**

Value-based care implies two interrelated objectives – (i) controlling expenditures, and (ii) better quality population healthcare metrics. At a high level, improvements in “bending the healthcare cost curve”, or improving general population healthcare metrics, have to date been less than hoped for.

On the other hand, certain models – usually at a smaller scale – are pointing the

way on how to address VBC design and execution challenges. Some of the major challenges are summarized below.

**Complexity and Cost**

A review of the ACO Case Studies posted by CMS<sup>15</sup> reveals the complexity and cost associated with their design and implementation. Hurdles include additional staff, additional IT platforms, regulatory compliance, HCP and patient training/education and coordination

among multiple stakeholders.

Excessive administrative costs are estimated to represent 15% of the \$4 trillion annual healthcare spend, or over \$2,000 per person.<sup>16</sup>

All of this in an environment where many providers are facing severe financial pressures.<sup>17</sup>

**Poorly Designed Incentives**

By the government’s own numbers, far fewer providers have contracted with ACO’s than is necessary to make a material difference. Many enroll and then drop out. Those which are already efficient operations have little incentive to join. Clearly, the incentives are insufficient to overcome the cost and complexity for the great majority of providers.

**Lack of Meaningful Standardization**

To determine whether a specific clinical intervention should become a standard of value-based care, the data relating to that intervention need to be verifiable and consistently formatted in the context of a statistically significant population sample.

Moreover, those data must integrate standardized long-term outcomes in the relevant patient history and treatment protocol record.

Several impediments exist to achieving these goals:

- ❖ There are multiple data standardization approaches in modern healthcare.<sup>18</sup> In addition, various EHR’s have their own data formats. This results in non-reconciled aggregated datasets.
- ❖ Longitudinal outcomes are rarely captured in VBC initiatives. (Providers are not incentivized to do so.) Without long term outcomes data, meaningful safety and efficacy for a given intervention are impossible to determine.
- ❖ Outcomes assessment scores for many clinical interventions do not exist. To the extent they do exist, they also are often non-standardized.
- ❖ The IT and staff cost and complexity of attempting data standardization under the foregoing circumstances are often insurmountable.

**Clinician Experience**

The patient/provider interaction remains at the heart of successful healthcare outcomes and cost control. The challenges facing healthcare professionals are well documented. Reduced compensation, more stressful clinical environment, heavier administrative burdens, less time for patient care are major reasons for the forecast substantial shortage of healthcare professionals.<sup>19</sup>

Whether for larger hospital systems or smaller medical practices, many VBC models exacerbate these problems for the

very healthcare professionals expected to implement them.

**Patient Awareness and Experience**

VBC success depends on “buy-in” by the patient/beneficiary. This involves several elements:

- ❖ Patients’ understanding of why behavior change in the context of a particular condition and/or treatment protocol is likely to lead to better outcomes, at a lower cost to them.
- ❖ Patient incentives likely to induce long-term compliance with those protocols.

- ❖ In many cases, VBC models rely on telehealth, remote patient therapies (“RPT”) and monitoring (“RPM”), and other forms of home care. Especially for older populations, or indications involving cognitive impairment, RMP and RPT programs are challenging, poorly designed and/or inadequately reimbursed.
- ❖ A major goal of most VBC models is to include patient populations which are typically under-served. Providers serving these patient groups, however, are particularly poorly positioned to absorb the cost and complexity of most VBC models.

**CIRCLES FOR VBC MODELS**

**General**

There are many challenges to achieving the twin promises of lower costs and better healthcare metrics for broad patient groups.

Changing well established norms and expectations is unlikely to occur on the basis of laws and regulations alone. Indeed, in many ways, federal attempts to solve multiple challenges at once on a national scale have proved self-defeating. Conversely, the smaller, more focused, VBC efforts seem to have shown greater

success.

Also, trusting the inherent desire of providers to deliver proper care to their patients at a transparent and reasonable price is more likely to achieve the promise of value-based care.

Finally, the tools and processes needed to drive meaningful and positive VBC results need not be expensive or burdensome.

Circles have demonstrated this. They integrate the technology, processes, user experience, and low cost which make

support value-based care for practitioners around the world. A summary of the key Circles elements relevant to any VBC model follows.

**Technology Platform and Processes**

Circles utilize the clinical grade <sup>20</sup> and patented <sup>21</sup> clinician-facing [inCytes™](#) and patient-facing [Benchmark™](#) platforms.

They include patient enrollment, long-term outcomes capture, report generation, publication, single and multi-center administration, publication, industry funding, IRB support and other integrated capabilities.

Circles emphasize patient engagement, comprehension of medical conditions and proposed treatment paths, and long-term compliance.

**Scalability**

Circles support the identification, onboarding, and active involvement of providers within and outside of institutional and regional boundaries.

Their inherent flexibility accommodates efficient data collection from the small patient panel of small practices, as well as patient populations of virtually any size.

**HCP and Patient User Experiences**

Circles combine clinical grade functionality with excellent user

experience for all relevant constituencies.

**Clinician and Patient Motivation**

Circles processes are designed to provide meaningful and sustained motivation to providers as well as their patients.

**VBC and Real-World Evidence**

Regulators, legislative bodies, and payers recognize the potential of real-world evidence to improve healthcare outcomes and reduce costs. <sup>22</sup> This has led to a proliferation of registries <sup>23</sup> and study designs -- pragmatic, quality improvement, observational, and other. <sup>24</sup> A corollary is the requirement for more inclusiveness and diversity in clinical trial design. <sup>25</sup>

Circles are purpose-built to develop and extent statistically significant and clinically significant standards of care for any indication or patient population. <sup>26</sup>

Value-base care models should not be the sole province of large hospital systems. Circles put them within reach of small medical practices and smaller hospitals. This is key to delivering value-based to care to underserved patient populations.

Circles flexibility will also enable the “democratization” of various VBC models across a much larger group of providers than currently exists.

**Further Information On Circles**

[Circle Overview](#)

[Circles/What Is A Circle](#)

[KnowledgeBase](#)

[LinkedIn Corporate Page](#)

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**CONCLUSION**

Value-based care as a concept is here to stay. Many models will be attempted and discarded. Others, or at least some of their components, will demonstrably achieve their goals.

ACO’s and other VBC models designed and implemented at a national level –while probably necessary in our current healthcare system -- are bound to be cumbersome and face slow, uneven adoption.

But, as is often said, “politics is local”. Many VBC best practices will be developed at the regional or community level. Similarly, efficient VBC models can be expected from self-insured corporations for which healthcare costs are becoming a major strategic issue.

The definition of success for a given VBC model will differ from use case to use case. But, in all instances it should reflect the following elements:

- ❖ The ability to deliver evidence-based

treatment protocols to a defined population group for a defined indication.

- ❖ Long-term outcomes capture for those treatment protocols and patient populations.
- ❖ The ability, based on low cost and excellent user experience, to accommodate all patient groups, regardless of location or financial means.
- ❖ Transparent pricing reasonable for the care provided from the perspectives of both the patient and the provider.
- ❖ Incentives which respect a provider’s professional judgment, and are meaningful and minimally burdensome in the context of his/her clinical reality.
- ❖ Patient experience which informs, educates, and leads to high compliance.
- ❖ Minimal administrative and other implementation costs and complexities.

Circles can meet the foregoing elements, and support any value-based care model.



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**FOOTNOTES**

- 1 Although this Article focuses on the U.S. healthcare environment, many of its points are relevant to Europe and other countries which use a more centralized approach to budgetary allocations for healthcare.
- 2 McKinsey, 2022. <https://www.mckinsey.com/industries/healthcare/our-insights/investing-in-the-new-era-of-value-based-care>.
- 3 Peter G. Peterson Foundation, 2023. <https://www.pgpf.org/blog/2023/07/how-does-the-us-healthcare-system-compare-to-other-countries>.
- 4 KFF, 2023. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/>.
- 5 There is a large glossary of related VBC terms and entities generated by CMS and HHS. These include MSSP, MIPS, Pathways To Success, CHIP, ESRD, ACO Reach, AHRQ (to name a few). Some are renamed from time to time. See also the [AHRQ](#) (part of the HHS), and FDA requirements and recommendations regarding [post-market surveillance](#) and [real-world evidence](#).
- 6 These include “wellness”, narrow-networks, self-insured employer groups, and similar schemes.
- 7 For example, National Healthcare Expenditure data can be found [here](#). MEDCAP presents a detailed report to the U.S. Congress semiannually covering results of ACO and other initiatives relating to healthcare cost and quality. The reports also provide recommendations to Congress for improvement on both scores.
- 8 <https://www.cms.gov/priorities/innovation/data-and-reports/2022/wp-eval-synthesis-21models-aag>.
- 9 Stat, Sullivan and Kahn, 2021. <https://www.statnews.com/2021/08/23/stop-failed-accountable-care-organization-experiment/>
- 10 Health Affairs, McWilliams and Chen, 2020. [Understanding The Latest ACO “Savings”: Curb Your Enthusiasm And Sharpen Your Pencils](#).
- 11 <https://content.naic.org/sites/default/files/inline-files/2020-Annual-Health-Insurance-Industry-Analysis-Report.pdf>

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- 12 See for example US Bureau of Labor Statistics, 2021, What Constitutes A Successful Wellness Program, <https://www.bls.gov/opub/mlr/2021/book-review/what-attributes-characterize-a-successful-corporate-wellness-program.htm>. Harvard Business Review, What's The Hard Return On Corporate Wellness Programs, 2010, <https://hbr.org/2010/12/whats-the-hard-return-on-employee-wellness-programs>.
- 13 <https://www.humana.com/employer/group-benefits-101/how-to-choose-plans/myths-about-narrow-networks>.
- 14 For example, Health Transformation Alliance. <https://www.htahealth.com/>.
- 15 <https://www.cms.gov/priorities/innovation/innovation-models/ACO>.
- 16 Annals of Internal Medicine, 2020, <https://www.acpjournals.org/doi/10.7326/M19-2818>.
- 17 American Hospital Association, Costs of Caring, 2023. <https://www.aha.org/costsofcaring>.
- 18 Organizations such as the Agency for Healthcare Research and Quality, the Health Information Management Systems Society, the Bipartisan Policy Center, the eHealth Initiative, the Markle Foundation, the Sequoia Project, the Observational Medical Outcomes Partnership, and the Office of the National Coordinator for Health Information Technology have either promoted or published best-practice approaches to data standardization.
- 19 Forbes, 2022. New Survey Shows That Up To 47% Of U.S. Healthcare Workers Plan To Leave Their Positions By 2025. <https://www.forbes.com/sites/jackkelly/2022/04/19/new-survey-shows-that-up-to-47-of-us-healthcare-workers-plan-to-leave-their-positions-by-2025/?sh=1f3fb290395b>.
- 20 HIPAA, GDPR, Part 11, FHIR HL7 Compliant. Scalable. All data and edits fully auditable. Multilingual. Real-time 24/7 accessibility by patients and clinicians from any device in any location. Robust role, permission, clinician branding, and other customization settings
- 21 U.S. patent number 11720567, *Method and System For Processing Large Amounts Of Real-World Evidence*.
- 22 See for example [FDA, Real World Evidence](#), [FDA, Post-Market Surveillance Programs](#); [The 21st Century Cures Act](#); [NIH Grants Program For Real-World Studies](#); [Expect To See More RWE-Based Regulatory Decisions](#), Robert Califf, FDA Commissioner; [Use Of Real-World Evidence In Regulatory Decision Making](#), European Medicines Agency.
- 23 See [Registries for Evaluating Patient Outcomes: A User's Guide: 4th Edition](#), Agency for Healthcare and Quality and Research, U.S. Department of Health and Human Services.
- 24 See [Pragmatic Trials](#), NEJM, Ford and Norrie, [Quality Improvement Projects and Clinical Research Studies](#), Faiman, and [Quality Improvement In Practice](#), Backman.
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- <sup>25</sup> See for example, [Diversity and Inclusion In Clinical Trials](#), NIH; [Why Diverse Clinical Trial Participation Matters](#), Schwartz et al, New England Journal Of Medicine.
- <sup>26</sup> See [Transforming Medicare Coverage: A New Medicare Coverage Pathway for Emerging Technologies and Revamped Evidence Development Framework](#), Fleischer et al., Center For Medicare and Medicaid Services; [Center For Clinical and Translational Science/Product Development Pathways](#), Mayo Clinic. [What Is The Evidence For Our Standards Of Care?](#), Turka et al, The Journal Of Clinical Investigation.
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