Executive Summary

Overview

The American Heart Association (AHA) and the Duke-Margolis Center for Health Policy worked collaboratively to provide an overview of current care practices for addressing cardiovascular (CV) health and recommendations for how value-based payment (VBP) models can support the implementation of these care practices for providers and health systems along the VBP continuum. Building off of previous work under the Value in Healthcare Initiative, these care practices and recommendations were identified through a review of VBP models implemented by the Center for Medicare and Medicaid Innovation (CMMI) and a series of convenings with a national advisory council of experts representing a variety of perspectives.

Background

Heart disease remains a significant health burden for millions of individuals in the United States. Despite efforts, including the Million Hearts Initiative, key markers of CV health—increased prevalence of uncontrolled blood pressure, increased rates of cardiovascular disease-related events (e.g., emergency department visits, deaths), persistent disparities in heart disease-related risk factors—indicate the need for enhanced efforts to improve heart disease prevention and management. VBP is seen as a key pathway to improving care delivery for preventive services, such as risk factor screening, as well as management services for chronic diseases, such as heart disease. Compared to fee-for-service (FFS) models, VBP models provide greater flexibility in reimbursed services, supporting care teams and allowing clinicians to provide clinical and social services not traditionally reimbursed that can help maintain and restore heart health.

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Introduction

With one in three deaths caused by heart disease, stroke, and other cardiovascular diseases, there are clear opportunities to increase the value of the $214 billion per year in health care costs associated with these conditions. The American Heart Association's previous call to action to address urgent challenges in heart health documented opportunities at every stage in the care pathway, starting with missed opportunities for care to slow, stop, or reverse cardiovascular risk factors and their consequences, and continuing through the care provided for individuals with acute complications and more advanced disease needing more significant specialized interventions.

Figure 1, reproduced from that work, highlights some of the opportunities. The share of the population that is overweight or obese, with high-sodium diets, and physical inactivity has risen, with some evidence that community-based interventions like the Diabetes Prevention Program can help individuals modify these risk factors. Treatable risk factors for heart disease and stroke, including uncontrolled blood pressure, diabetes and pre-diabetes, are often undiagnosed, and among those who know they have these risk factors, there are large gaps in prescription of and adherence to evidence-based medications. At the more advanced stages of cardiovascular disease, there is considerable variation in use of intensive procedures such as angioplasty and left ventricular assistance. Individuals with more complex conditions benefit from coordinated care, ( )Tj-0.004 Tc ( )Tj-0.004 Tc ( )Tj-0.004 Tc ( )Tj-0.0-3 (an)2.2 Indive

major acute episodes of care like myocardial infarction or heart failure exacerbations, or built around major procedures. While these reforms have provided some important insights, there are open questions on how best to utilize the tools of value-based payment to improve heart health. Indeed, the Centers for Medicare and Medicaid Services (CMS) is undertaking a fundamental "strategic refresh" of its VBP initiatives, and Congress is also considering legislation to build on payment flexibilities as COVID-19 transitions from a pandemic public health emergency to an endemic state.

Figure 1. Cardiovascular Care Challenges Waterfall Showing the Challenges at each stage of the Disease Continuum. Adapted from: McClellan, M., Brown, N., Califf, R. M. & Warner, J.J. (2019). Call to Action: Urgent challenges in cardiovascular disease: A Presidential Advisory from the American Heart Association. Circulation, 139, e44-e54. Data derived from multiple research studies and sources (disparities in incidence, modifiable risk factors, patient activation, undiagnosed conditions before severe disease, use of first line therapies, disparities in treatment, declines in AMI and stroke visits during public health emergency, and hospice usage)

These policy reforms will not succeed in improving health and health equity and avoiding costly medical complications unless they succeed in addressing the opportunities for improving cardiovascular health. The purpose of this document is to provide an overview of current care practices for addressing heart health and recommendations for how VBP models can support the implementation of these care practices for providers and health systems along the VBP continuum. These care practices and recommendations build off the American Heart Association's and Duke-Margolis Center for Health Policy's previous Value in Healthcare Initiative and were identified through a review of VBP models implemented by the Center for Medicare and Medicaid Innovation (CMMI) and a 0 Tw 2.674 0 Td( )Tj-0.001 Tc 0.00

Current Status of Value-Based Care for Heart Health

Multiple VBP models have focused on improving heart health, with incentives to improve heart health-related care quality, outcomes, and overall cost. VBP models for heart health have been implemented in three main ways:

- *Population-Based Payment Models*: These models encompass the health care needs of a population (general or specialized) with providers accountable for the costs, quality, and outcomes of the attributed population. Such models generally attribute patients to an accountable primary care practice or health system, such as an accountable care organization (ACO). They aim to enable those accountable practices to direct more resources to cost-effective care reforms that otherwise would have little financial support, with the practices accountable for improving performance and outcomes without increasing total medical spending. The reforms in care practices these models have supported include more robust risk screening and assessment processes (e.g., individuals with diabetes or high blood pressure), as well as enhanced supports to help individuals manage their heart-related chronic conditions over time to prevent serious events and hospitalizations (e.g., individuals with congestive heart failure). To date, most of these models have involved relatively modest shifts from FFS payment – for example, "shared savings" or "upside-only" models, not bigger shifts that provide larger up-front payments not linked to traditionally reimbursed medical services. Even in models that have featured larger up-front payments and some downside risk, primary care practices have often had only limited engagement from specialists, who provide critically needed care and account for most of the medical expenses of individuals with heart-related conditions.
- *Episode-Based Payment Models*

specialized procedures and admissions for cardiovascular complications. However, there is still a need to make significant progress on key indicators of overall heart health since the impact of VBP efforts is dampened by a number of implementation barriers:

- limited support to enable beneficiaries to engage in heart health-related prevention and

risk factors like high blood pressure, lipid disorders, diabetes and pre-diabetes, and then to assure that heart-related chronic conditions are managed by teams involving specialty-care providers and others, not only to get good outcomes from hospitalizations and major procedures, but to avoid such acute events where possible. Preventive care practices can help prevent the development of heart-related conditions through activities such as risk-factor screening and education, self-measured blood pressure monitoring and control, and medication management for risk factors, particularly for hypertension and hyperlipidemia. Management practices focus on supporting individuals after heart-related procedures or acute events (e.g., CABG, AMI) as well as those focused on supporting the ongoing management of chronic heart conditions such as heart disease and congestive heart failure. Management care practices also include transitional care supports to promote post-procedure or post-event rehabilitation and recovery and enhanced coordination efforts.

Figure 2. Care Pathway for the Prevention and Management of Disease from the Person or Population Perspective.

= Acute medical events or procedures that can occur more than once and that initiate acute episode payments.

Designing the Next Generation of VBP Models for Heart Health

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To overcome the current challenges with VBP as well as to take a whole person

Critical Infrastructure Support	Timely access to claims data, key clinical data sharing, infrastructure to connect to community/social service providers.
On Ramp	On ramp of "starter" models based on practice capabilities, with transition to more advanced models; upfront payments for small practices to help build capabilities; technical assistance collaboration for practices that need/want.

Cardiovascular Specialized Care Models

Population-based models may need to be accompanied by models focused on more specialized care, which can address unique cardiovascular health situations. Specialty-care alternative payment models have generally had a focus on major acute events and procedures, even though most cardiovascular disease is chronic and many individuals with more complex needs would benefit from strong supports for efficient ongoing coordination between primary care practices and cardiovascular specialists. More and better coordination between primary and specialty care clinicians is critical to achieving effective whole-person cardiovascular care, integrating not just prevention and high-quality intensive care but also chronic-condi [illegible]

Flexibility to Pay for Team-Based Care	Models can support a variety of underused but valuable services delivered through team- based approaches to care, such as expanded cardiac)adtas3.2 (d)11 (C)-2.7app vaac

On Ramp	Reforms can be phased in through measures (like Medicare Advantage STARS)

coverage or co-pay reduction or elimination will lead to

how to use VBP-related information and data (e.g., priority quality and outcome measures) to inform care decisions.

- *Support implementation and rigorous evaluation of heart health-related care practices under VBP models.* Partner with federal agencies (e.g., Health Resources and Services Administration, Agency for Healthcare Research and Quality, National Institutes of Health), professional organizations (e.g., National Association of Community Health Centers, Patient Centered Primary Care Collaborative), certifying organizations (e.g., The Joint Commission) and health equity-oriented organizations (e.g., UniteUs, findhelp) with experience facilitating practice change, evaluating the impact of practice changes on beneficiary, provider and system-level outcomes, and advancing health equity-related goals.
- *Support advances in health technology infrastructure.* Partner with federal agencies (e.g., Office of the National Coordinator) and technology vendors to explore technology solutions, platforms and standards necessary to drive interconnectedness, increase access to high quality data and improve VBP model participants' data capabilities.
- *Incorporate multi-payer alignment into more VBP models.* Prioritize alignment of key heart health-related care performance measures, directional alignment of alternative payment models, and aligned reliable key data sharing to enable multi-payer progress on addressing the major gaps and inequities in cardiovascular health. Key goals and metrics related to cardiovascular care improvement should be incorporated in CMMI multi-payer initiatives and piloted through state and regional multi-payer collaborations.

Conclusion

The combination of concerning trends in heart health-related burden
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Appendix A: National Advisory Council and Staff for the Improving Heart Health through Value- Based Payment Initiative

National Advisory Board

Scott Berkowitz, MD, MBA
Johns Hopkins University Center for Innovative Medicine
Associate Professor of Medicine,
Chief Population Health Officer, and Vice President of Population Health; Executive Director, Care Transformation Organization

David Carmouche, MD Omnichannel Care Offerings Walmart, Senior VP

Sandeep Das, MD, MPH, MBA
UT Southwestern Medical Center, Parkland Center for Healthcare Innovations and Clinical Outcomes
Professor of Internal Medicine, Cardiology Division; Quality Officer

Nihar Desai, MD, MPH
Yale University, Center for Outcomes Research and Evaluation,
Associate Professor of Medicine; AssociateYale

Craig Kennedy, MPH
Medicaid Health Plans of America
President and CEO

Willie Lawrence, MD
Spectrum Health Lakeland Cardiologist; Medical Director of Health Equity &Lead, Center for Better Health; Chair, National Hypertension Control Initiative AHA

Rita R. Lewis, MPH, CPHQ, PCMH, CCE
National Association of Community Health Centers Deputy Director, Clinical Quality Improvement

David Platt, MD
VP and Medical Unit Head, Cardiovascular, Renal & Metabolism,
US Clinical Development & Medical Affairs
Novartis Pharmaceuticals Corp.

American Heart Association
Nancy Brown
Chief Executive Officer

Janay Johnson, MPH, CHES
Senior Policy Analyst

Melanie Phelps, JD
Policy Advisor
Healthcare Economics

Mark Schoeberl
Executive Vice

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