

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, including timely and efficient participation of cardiologists and other specialists. But financial support for such team-based care is difficult under traditional payment approaches. Primary-specialty care coordination for heart health generally depends on billing for diagnostic imaging, laboratory tests, and in-person visits rather than more efficient, virtual coordination and timely and complete data sharing. Key support services for such individuals often have little financial support: team members including community health workers and practical nurses to understand the root causes of adherence problems, including social determinants of poor health, and to assure that high-risk individuals have access to needed care; remote monitoring systems; and rehabilitation programs to help individuals maintain or recover function. While there have been notable shifts in the pandemic toward telehealth visits, all of these challenges have become more pronounced during the public health emergency, due to reduced physical activity and increased stress, longer term cardiovascular consequences of COVID-19 infections, stretched acute and emergency care systems, and reduced access to in-person care.

The disproportionate impact of poor heart health among Black, Indigenous, People of Color (BIPOC) and socioeconomically disadvantaged individuals and communities is particularly troubling. Non-Hispanic Black adults are [40 percent](#) more likely than non-Hispanic Whites to have hypertension and less likely to have their blood pressure under control. Despite a high prevalence of risk factors such as hypertension, [racial and ethnic communities](#) are less likely than non-Hispanic Whites to receive beneficial treatments, such as angiography or percutaneous coronary intervention (PCI).

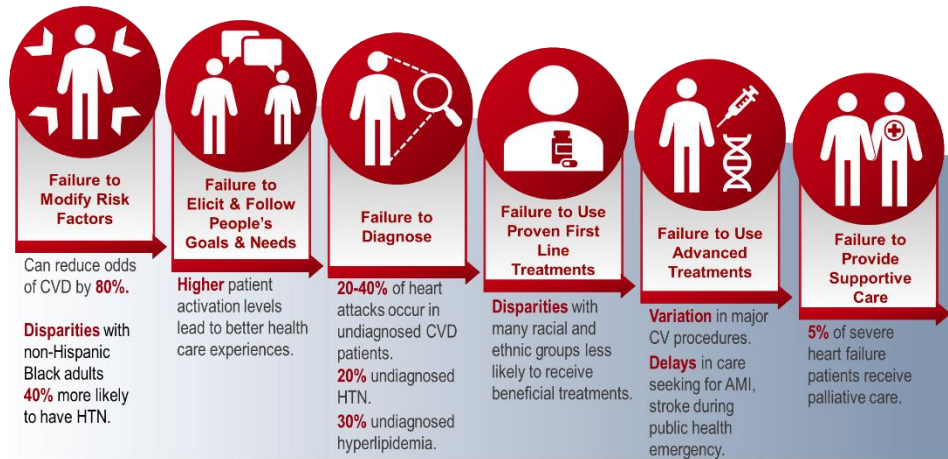


Figure 1. Cardiovascular Care Challenges Waterfall Showing the Challenges at each stage of the Disease Continuum. Adapted from: [McClellan, M., Brown, N., Califf, R. M. & Warner, J.J. \(2019\). Call to Action: Urgent challenges in cardiovascular disease: A Presidential Advisory from the American Heart 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](#))

Value-based payment (VBP) is an important pathway to addressing these heart health challenges as well as disparities in risk factors, treatment, and outcomes. Compared to fee-for-service (FFS) payment 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 in particular individuals. There have been multiple VBP models aimed at various aspects of heart health, such as ones focused broadly on cardiovascular risk reduction, or aiming to encourage specific evidence-based interventions to reduce risk factors, or built around specific 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.

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 series of convenings with the National Advisory Council for Improving Heart Health through Value-Based Payment, which included experts with backgrounds in VBP, heart health, and public health as well as patient representatives. (The Council roster is shown in Appendix A.)

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 for Specialized Care:* These models have focused on addressing care delivery generally during acute episode of care, such as the 30- or 90-day bundled episode payment models in Medicare’s Bundled Payment for Care Improvement-Advanced (BPCI-A) model associated with major events or procedures that start with a new hospitalization. These models generally hold specialists and the hospital accountable for total spending, quality, and outcomes for that episode of care. These episode-based models have had modest impacts on spending and short-term complications associated with heart-related procedures (e.g., percutaneous coronary intervention [PCI] or coronary artery bypass graft [CABG]), potentially because hospital DRG payments and readmission penalties associated with these procedures already provided strong incentives to limit costs and avoid procedure complications. They had [less impact on spending and outcomes associated with major acute cardiovascular complications](#) (e.g., acute myocardial infarction [AMI], unstable angina admissions, or CHF exacerbation admissions), potentially because the acute nature of the episodes – starting with the hospitalization – did not provide new flexibility or supports for better specialist-primary care engagement and other care reforms to improve the chronic management to prevent complications and avoid or delay major procedures.
- *Models to Address Specific Fee-for-Service Challenges for Quality & Cost:* Some models have also included targeted changes in payment, such as upfront payments to support specific care activities (e.g., risk assessment) or incentive payments for performance on specific quality measures. Some of these reforms have led to improved performance on specific measures, but they generally have not supported more substantial reforms in care models to address the major opportunities for heart health-related care improvements that we described above.

Overall, VBP models to date have helped to improve specific aspects of care for heart health, including some strengthening of primary care practices' ability to address cardiovascular risk factors and to improve chronic management of more complex patients, and some incremental improvements in 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 management behaviors, including support to address the social factors underlying many inequities in cardiovascular health;
- limited support for team-based and multi-disciplinary approaches to care, including efficient virtual coordination between primary and specialty care;
- lack of integration of timely, accurate, actionable beneficiary and clinical data to support such longitudinal care models, especially for individuals with more complex conditions; and
- insufficient focus on or resources to leverage specialty expertise, rehabilitation, and support services to help individuals with more severe disease avoid costly exacerbations, admissions, and intensive procedures.

The ongoing burden of poor heart health and the implementation barriers facing VBP efforts, coupled with the significant policy reforms under consideration to enhance VBP programs, suggest a more systematic approach to build on the lessons and gaps in VBP efforts to date could enable more meaningful and equitable progress in heart health.

Opportunities for Better VBP Design

While there have been challenges in meeting VBP's potential, there are multiple current opportunities for payment and care delivery reform. One major opportunity is to leverage the new CMS [strategic direction](#) for innovation in payment and care, which highlights five strategic priorities:

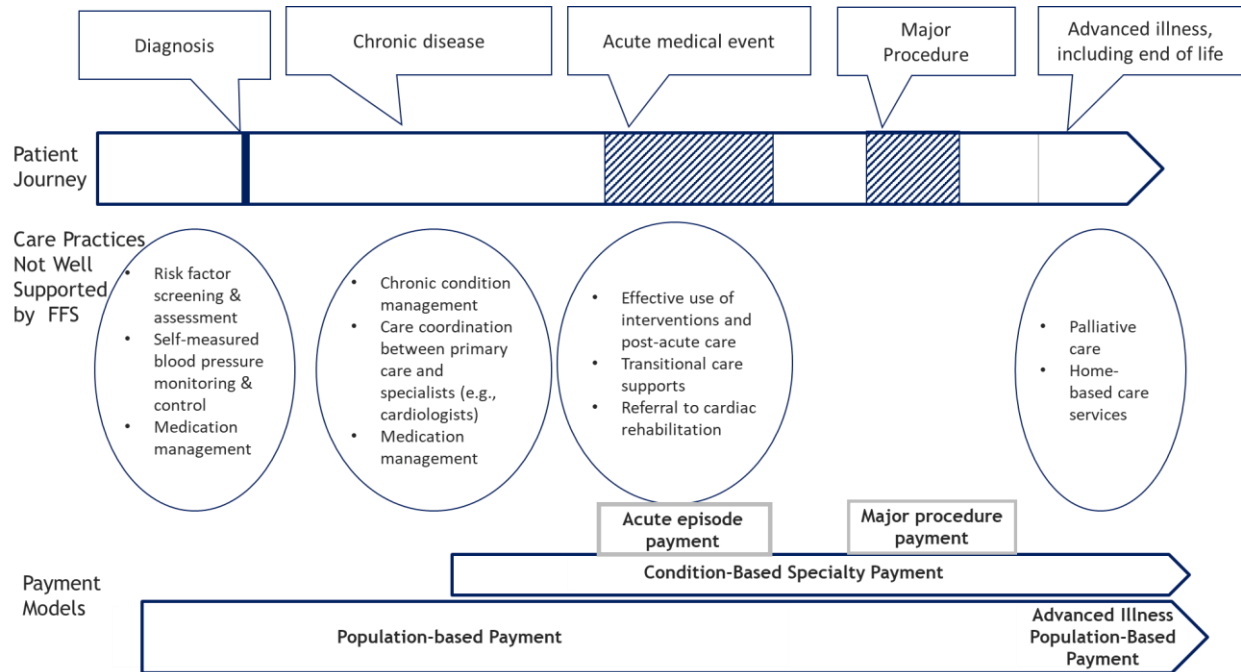
- Advance health equity
- Drive accountable care
- Support innovation
- Address affordability
- Partner to achieve system transformation

These strategic priorities align with what is needed to improve heart health. For example, the focus on driving accountable care encourages a more advanced, “whole-person” approach, aiming for all Medicare beneficiaries and almost all Medicaid beneficiaries to have access to advanced, coordinated, person-centered care, with strong primary care as well as well-integrated specialty care. In addition, CMMI's prioritization of health equity aligns with the need to address the persistent disparities in heart health-related risk factors and outcomes.

Moving Heart Health VBP to Focus on the Whole Person and Across the Care Continuum

The CMS emphasis on advancing whole-person, coordinated care presents important opportunities for improving cardiovascular health. CMS aims to support payment reforms that sustain reforms in care that do more to address the heart health gaps outlined in Figure 1 above. In particular, whole-person care can be grounded in a heart health-related care pathway or journey like that shown in Figure 2. From the individual's perspective, the care pathway should do as much as possible to maintain and restore heart health, by addressing behavioral and social risk factors and diagnosing and treating major 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.



/// = Acute medical events or procedures that can occur more than once and that initiate acute episode payments.
Figure 2. Care Pathway for the Prevention and Management of Disease from the Person or Population Perspective.

Designing the Next Generation of VBP Models for Heart Health

Implementing major care reforms successfully takes time and resources to develop clear leadership goals and change culture, to adjust team composition, to improve person-focused information technology, and to implement and refine the care reforms. While more “advanced” VBP models give accountable providers more flexibility in redesigning care to meet an individual’s needs, many providers are not ready to implement such reforms and will benefit from models that meet them where they are, including initial entry points with less advanced models (e.g., smaller shifts from FFS, potentially expanding over time) and technical and financial supports to develop the new capabilities needed to succeed in the advanced VBP models.

To overcome the current challenges with VBP as well as to take a whole person perspective, this section highlights specific considerations for how to improve different types of models, such as those focused on advanced primary care or broad populations, specialized care models, or those at the health plan level, to better address heart health. These considerations aim to:

- address key drivers of inequities in heart health-related care and outcomes;

- support team-based approaches to delivering heart health-related care practices;
- ensure health care providers have the resources and capabilities (e.g., timely and actionable data) needed to implement heart health-related best practices;
- enable individual beneficiary’s long-term engagement in heart health-related prevention and management behaviors; and
- support greater integration of specialists and supportive services into heart-focused care models.

Advanced Primary Care and Population-Based Models

CMS and other purchasers have a variety of alternative payment models aimed at improving care for broad populations, such as ACO models including the Medicare Shared Savings Program and recently announced ACO REACH direct contracting model, as well as advanced primary care, including the Primary Care First model, state advanced ACO and primary care reforms, and [employer-sponsored advanced primary care](#). Expanding these types of models successfully is foundational for the CMS strategic focus on accountable, whole-person care.

Table 1. Vision for Advanced Population-Based Models

<i>Model Component</i>	<i>Design</i>
<i>Measures and Accountability</i>	Accountability for key cardiovascular outcome measures (building on goals and outcome metrics for Million Hearts and other programs, such as hypertension and hyperlipemia and improved functional status), total costs, and reduced hospitalizations with avoidable cardiovascular complications or procedures, with improvements in use of evidence-based treatments to slow or halt disease progression
<i>Health Equity</i>	Measures should be stratified and reported by race and ethnicity; provide resources for addressing heart health-related inequities including underlying social drivers of health risks
<i>Coordination with Specialty Care</i>	Supports for integrating cardiologists, interventional specialists, and other specialized care providers for individuals with more complex cardiovascular needs into a seamless chronic care pathway to help prevent costly complications
<i>Flexibility to Pay for Team-Based Care</i>	Models can support a variety of underused but valuable services, such as cardiac rehabilitation via telehealth; varied team members, such as pharmacist-directed medication therapy management or community health workers; and may be coupled with a supportive benefit structure, such as lower co-pays for people engaging in care. Would need to be in the most advanced model with substantial accountability for total costs of care for greatest flexibility.
<i>Critical Infrastructure Support</i>	Timely access to claims data, key clinical data sharing, infrastructure to connect to community/social service providers
<i>On Ramp</i>	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 condition management. This is likely to require longitudinal models that more directly engage specialists over the chronic course of care, for example through condition-based or per-person payments that provide flexibility to support team-based models, collaborations, and interventions that provide better support for specialists to prevent hospitalizations and avoid costly procedures in

individuals with complex cardiovascular conditions and needs. The recommendations below highlight opportunities to achieve those goals.

Table 2. Vision for Advanced Specialized Care Models

<i>Model Component</i>	<i>Design</i>
<i>Longitudinal payment with nested relationships to specific episodes</i>	Shift to a chronic, person-focused payment approach via specialized care payment reforms that “nest” chronic cardiovascular disease management and acute episodes into comprehensive population/primary care payment reforms. The specialized care payment could transition to a per member, per month payment for greater flexibility.
<i>Measures and Accountability</i>	Key cardiovascular outcome measures and accountability (e.g., prevention of acute cardiovascular events, functional status measures, patient experience/ activation/ coordination measures)
<i>Health Equity</i>	Measures should be stratified and reported by race and ethnicity; provide resources for addressing heart health-related inequities including underlying social drivers of health risks
<i>Coordination with Primary Care</i>	Supports for integrating cardiologists, interventional specialists, and other specialized care providers for individuals with primary care providers in advanced population-based models
<i>Flexibility to Pay for Team-Based Care</i>	Models can support a variety of underused but valuable services delivered through team-based approaches to care, such as expanded cardiac rehabilitation via telehealth to improve function; team-based care, such as pharmacist-directed medication therapy management or community health workers; and may be coupled with a supportive benefit structure, such as lower co-pays for people engaging with such care teams. Would need to be in the most advanced model with substantial accountability for total cardiovascular care costs for greatest flexibility.
<i>Critical Infrastructure Support</i>	Timely access to claims data, key clinical data sharing, infrastructure to connect to community/social service providers
<i>On Ramp</i>	On ramp of “starter” models based on practice capabilities, with transition to more advanced models (especially for those clinicians practicing in larger, more well-resourced systems); upfront payments and greater savings for small or independent cardiovascular practices to help build capabilities; technical assistance collaboration for practices that need or want that assistance

Accountable Health Plans

While value-based payment is focused on clinicians, there are opportunities to encourage private health plans (including Medicare Advantage, Medicaid managed care, or employer-based care) to support better heart health. For example, common accountability measures can help align incentives between plans and their clinicians and patients, and fostering payment and insurance benefit design reforms can help support whole-person cardiovascular care pathways.

Table 3. Vision for Advanced Accountable Health Plans

<i>Model Component</i>	<i>Design</i>
<i>Measures and Accountability</i>	Key cardiovascular outcome measures and accountability (for populations, like from Million Hearts model, and with matching measures for key specialized care outcomes like heart failure, advanced/complex atherosclerotic disease, valvular disease)
<i>Health Equity</i>	Measures should be stratified and reported by race and ethnicity; provide resources for addressing heart health-related inequities including underlying social drivers of health risks
<i>Coordination with Specialty Care</i>	Supports for integrating cardiologists, interventional specialists, and other specialized care providers for individuals with more complex cardiovascular needs into a seamless chronic care pathway to help prevent costly complications
<i>Flexibility to Pay for Team-Based Care</i>	Models can support a variety of underused but valuable services, such as cardiac rehabilitation via telehealth; varied team members, such as pharmacist-directed medication therapy management or community health workers; and may be coupled with a supportive benefit structure, such as lower co-pays for people engaging in care. Would need to be in the most advanced model for greatest flexibility.
<i>Critical Infrastructure Support</i>	Timely access to claims data, key clinical data sharing, infrastructure to connect to community/social service providers
<i>On Ramp</i>	Reforms can be phased in through measures (like Medicare Advantage STARS) and other plan requirements over time.

Specific Actions for Achieving the Vision of Whole-Person Cardiovascular Care

The previous section provided a broad vision for supporting person-centered heart health-related care through further VBP reforms. This section dives deeper into how to advance implementation of this vision, by describing supporting actions that can be taken by CMMI and other payers. The range of actions is organized by the five strategic themes in the [CMS strategic refresh](#). Under each objective, the recommended actions are further categorized into those actions that can be taken to support all stages of VBP models, actions to support health care organizations earlier in their VBP journey (e.g., participating in pay-for-performance, shared savings models), and actions that can be taken for organizations in more advanced VBP arrangements (e.g., in models with greater downside risk and more population-based payments, where there is greater accountability for both total spending and outcomes).

Strategic Objective: Advancing Health Equity

CMS aims to embed health equity in every aspect of VBP models and increase focus on reducing health disparities underserved populations. Disparities in risk factors and access to effective primary and specialized care, and the resulting disparities in cardiovascular outcomes, are a large part of population-level health disparities. Consequently, intentional steps to address cardiovascular health inequities should be an integral part of VBP strategies. The recommendations below outline actions CMMI can take to support implementation of VBP models for the providers caring for communities most often affected by poor cardiovascular health and advancing progress toward eliminating disparities. While health equity should be incorporated into all VBP models, including less advanced models that can serve as entry points for providers with little VBP experience, more substantial actions to redesign care to eliminate disparities and achieve health equity-related goals will likely require the types of payments and flexibilities offered under advanced VBP models.

Across all VBP models

- *Identify heart health as a priority clinical area for the elimination of inequities.* Address long-standing disparities in heart health-related care and outcomes by including risk factor measures such as smoking status, hypertension, hyperlipidemia, and diabetes control rates as key outcomes of concern and report data on these outcomes by race and ethnicity across all VBP models.
- *Implement equity evaluations into the design and implementation of models.* Key components of an equity evaluation may include: 1) measuring differences in processes and outcomes across subpopulations of interest (e.g., race, ethnicity) at the beginning, in the interim and at the end of the reporting period; 2) measuring absolute performance to determine if there have been improvements across all populations; and 3) measuring access to care.
- *Support efforts to implement diverse, multi-disciplinary care teams under VBP models.* Encourage efforts to hire care team members from the communities they serve and the inclusion of team members (e.g., CHWs, social workers, behavioral health specialists) with expertise in delivering or connecting individuals to services addressing needs (e.g., mental health issues, food insecurity, language barriers) that can contribute to inequities.

Earlier-stage VBP

- *Provide resources for the identification of heart health-related inequities and provision of services addressing underlying needs that can drive inequities.* Organizations earlier in VBP often need more support to identify specific disparities in their accountable population and build the competencies to reduce those disparities. This could include

providing guidance and tools for the collection and analysis of data on sociodemographic factors (e.g., race, ethnicity, gender, language, income, education, or geographic measures of risk such as the [CDC Social Vulnerability Index](#)) to incorporate in quality improvement initiatives and performance measures, needs related to social determinants of health (e.g., food or housing insecurity, transportation access) and other factors (e.g., disability status) affecting health. It could also include investments in regional resources to help organizations address social needs, such as regional data systems to link health care providers to available social and community resources (e.g., [CMMI's Accountable Communities for Health](#); [North Carolina's Health Opportunities Pilots](#)).

- *Implement additional financial supports for providers caring for populations at high-risk for experiencing inequities.* Models specifically targeting rural providers and providers caring for underserved population should incorporate extra implementation supports (e.g., up-front payments), adopt the use of geographic-focused quality measures, and reward for improvements over time in care quality and outcomes. Additional payments might also come from including social risk factors in risk adjustment of payments to VBP providers.

Strategic Objective: Driving Accountable Care

Under this objective, CMMI aims to increase the number of people in a care relationship with accountability for outcomes and total cost of care, to facilitate implementation of person-focused care pathways. The recommendations below outline actions CMMI should take to both support providers in this journey toward increasing levels of accountability and ensure providers have the tools and resources needed to not only implement heart health-related care practices, but succeed in delivering on those care models through advanced VBP arrangements.

Across all VBP models

- *Support greater access to timely, accurate data for improving care.* Address concerns regarding delays, gaps, and inaccuracies in providing key actionable administrative, claims, and electronic record data by leveraging appropriate clinical data registries and electronic health record data to facilitate quality data collection and reporting, and timely and consistent sharing of payer data with accountable providers. This may include new electronic data that can be used to help assess appropriateness of care (e.g., CPT II codes on claims submission for revascularization procedures).
- *Streamline meaningful performance measures for quality improvement and reporting.* Examples of outcome measures include those that would be informative both to model evaluation and quality improvement activities (e.g., improvements in cardiovascular disease risk scores, blood pressure, or lipid levels; standard functional status measures; measures of major adverse cardiovascular events). Process measures (e.g., prescription of and adherence to guideline-directed medical therapy) may also be helpful.

Earlier-stage VBP

- *Include improvement on quality measures as a component of performance assessment.* Reward providers, particularly those less experienced in VBP or practicing in under-resourced areas, for improvements in quality measure scores on key outcome measures of heart health (e.g., hospital admissions for AMI) and evidence-based process measures related to heart health care (e.g., risk factor screening and adherence to guideline-based medical therapy).

Advanced VBP

- *Support innovative heart health-related care practices through a streamlined waiver process.* For model participants in advanced VBP models, allow broader payments to community health workers (CHWs) and for the delivery of cardiac rehabilitation via telehealth, pharmacist-directed medication therapy management and other innovative approaches to delivering heart health-related care practices as options under model waivers.
- *Improve data exchange and performance measures to facilitate care coordination between primary care and specialized cardiovascular care.* For models involving both primary and specialist care, provide technical support and implement standards for timely sharing of key data needed for patient management, and align performance measures to encourage collaboration.
- *Implement pilot VBP models focused on facilitating primary care and cardiology coordination.* Pilot the implementation of bundled payments for chronic cardiovascular care typically involving specialists as well as acute episode payments to complement and encourage active specialist engagement in population-based models that use FFS payments for specialty care (e.g., MSSP and REACH professional model), to give specialists more flexibility and support to participate in innovative models for jointly managing individuals with more complex cardiovascular needs to prevent further disease progression. Because individuals treated by accountable primary care practices and specialist practices are likely to have better outcomes and lower total spending, include additional financial incentives for primary care and specialty practices that are jointly accountable for such individuals. Use these pilots to emphasize the importance of primary-specialty collaboration and to identify feasible approaches for appropriate distribution of episode payments, and shared savings. Consider an advanced specialized care option as part of advanced ACO and primary care VBP options that provides greater flexibility to implement innovative specialty care models using a risk-adjusted, person-level payment rather than condition- and acute episode-based payments.

Strategic Objective: Support Care Innovation

Under this objective, CMMI aims to support integrated, person-centered care through activities such as providing or supporting greater use of technology, enabling dissemination of best practices and leveraging payment flexibilities. The recommendations below outline actions CMMI can take to facilitate care innovations specific to heart health that have the potential to support greater implementation of heart health-related care practices, as well as expand access to those care practices.

Across all VBP models

- *Support provider implementation of key clinical activities related to heart health by making key data available to providers.* Provide necessary data (e.g., individual's risk data) and implementation supports (e.g., technical assistance) to help providers develop customized implementation and evaluation strategies for activities such as screening for SDoH-related needs and educating individuals on blood pressure monitoring.

Early-stage VBP

- *Identify and disseminate best practices for managing risk factors and supporting primary and specialty care coordination.* Allow and encourage model participants to test protocols related to co-management of heart conditions by primary and specialty care

providers, including effective integration of cardiologists (e.g., clinical intensification protocols for managing the progression of heart disease; support for data sharing and telehealth consultations). Example protocols include the Million, [American Heart Association's Get with the Guidelines®-360° for heart failure](#), and the [American Heart Association and American Medical Association BP Treatment Algorithm](#).

- *Support peer-to-peer learning groups, particularly for providers delivering care to underserved and rural populations.* Facilitate sharing of lessons learned among providers regarding the care innovations they've implemented to meet the needs of their patient population.

Advanced VBP

- *Facilitate inclusion of community health workers in VBP models, particularly those involving Medicaid.* Facilitate inclusion of CHWs by clarifying promising payment options and qualification requirements, and work with CMS to develop tools to support the inclusion of CHWs in the care models implemented under VBP.
- *Support greater use of digital technology in the delivery of care for heart-related conditions.* Offer waiver flexibilities to providers encouraging the use of technology to engage individuals in their care and to facilitate care and coordination. Examples of technology uses include digital medicine programs for risk factor management, tools enabling data sharing across electronic health records, tools and platforms supporting remote blood pressure, weight, and activity monitoring, and tools that enable individuals to easily report on their functional status.

Strategic Objective: Improve Access by Addressing Affordability

Under this objective, CMMI aims to pursue strategies to address health care prices, affordability and reduce unnecessary or duplicative care. Affordability can be a significant barrier for individuals seeking to access heart health-related care such as cardiac rehabilitation programs or key medications such as anti-hypertensives. The recommendations below outline actions CMMI can take through benefit design pathways to reduce financial barriers to heart-health related care, as well as through pathways to identify both low- and high-value heart health care practices that can be targeted for intervention.

Across all VBP models

- *Increase transparency around the quality and spending on cardiovascular care.* Use aligned performance measures alongside consistent measures of population spending, episode measures for cardiovascular procedures and acute events (and rates of procedures and events), and emerging longitudinal cardiovascular condition-level measures to provide greater transparency around quality and spending on cardiovascular care. This will support more informed decisions to advance high-value care by providers and patients. Many of these measures can be calculated from claims and existing quality measurement systems and need not be limited only to providers in VBP models. Support multipayer efforts to align on measures and transparency.

Early-stage VBP

- *Pilot limited reductions in co-pays for high-value services or products related to heart health.* Collaborate with experts to identify services and tools where evidence indicates that expanded coverage or co-pay reduction or elimination will lead to improvements in outcomes without significantly increasing total medical spending. For example, evidence-based expansions of coverage for cardiac rehabilitation or (in collaboration

with Medicare Part D plans) for cost-effective drugs and screening tools may lead to increased spending on these products, but could have potentially offsetting reductions in costs of complications. CMMI's [recent pilot program for more affordable insulin access](#) for beneficiaries with diabetes may have applicability to other areas of cardiovascular drug therapy.

Advanced VBP

- *Allow reduction or elimination of co-pays for high-value tools or services related to heart health.* Collaborate with experts to identify those services and tools to be eligible for co-pay reduction or eliminations and utilize quality measures encouraging the use of these tools or services when clinically indicated. Because providers in advanced VBP models, Medicare Advantage plans, and Medicaid managed care organizations have substantial accountability for total costs of care, broader flexibility along with model examples of how to expand such coverage should be allowed. As in the case of similar benefit and coverage flexibilities that have already been implemented (e.g., for care management services, telehealth, and home-based care), such flexibilities should be implemented with guardrails and monitoring to assure that they encourage better cardiovascular care models and not favorable risk selection.
- *Allow use of administrative flexibilities and higher co-pays for heart-related services determined to be “low-value”.* Reduce the delivery of unnecessary or duplicative care by allowing administrative flexibilities (e.g., limit prior authorization to services identified as low-value) and implementation of higher co-pays for low-value care related to heart health unless clinically indicated. Consult with experts or available resources (e.g., Choosing Wisely) to identify low-value care services related to heart health.
- *Allow beneficiary incentive payments for participation in heart health-related preventive and management activities.* Address financial barriers to individuals' engagement in prevention and management behaviors through beneficiary incentive payments encouraging participation in risk factor management programs for smoking cessation and self-reported blood pressure monitoring and control, enrollment in and completion of cardiac rehabilitation programs (including those offered via telehealth platforms), or achievement of prevention and management goals (e.g., achieving target lipid or blood pressure levels).

Strategic Objective: Partner to Achieve System Transformation

Under this strategic objective, CMMI aims to align policies across CMS, HHS, and key stakeholders (e.g., payers, purchasers, providers, states, beneficiaries) to improve health care quality and costs and achieve health equity goals. The recommendations below identify key partnerships CMMI should pursue to ensure the heart-health related care practices are effectively implemented and beneficiaries are supported in becoming informed and active consumers of heart health-related care.

Across all VBP models

- *Leverage heart health promotion as an avenue for enhancing beneficiary awareness of and involvement with CMMI VBP efforts.* Focus on individuals and populations experiencing persistent disparities in heart health-related care and outcomes by working with consumer-focused organizations (e.g., American Heart Association) to facilitate beneficiary involvement in VBP redesign efforts and beneficiary education on VBP's influence on their care experiences and 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 and disparities, growing evidence and capabilities to redesign care to change these trends, and the implementation of an updated CMS strategic vision around value-based payment collectively amounts to an unprecedented opportunity for bolder actions to improve cardiovascular care and outcomes through VBP models. We have described a roadmap that CMS and stakeholders can take now to implement VBP reforms that provide access to comprehensive, person-centered cardiovascular care for all Americans. A clear strategy to build on current VBP initiatives to implement evidence-based cardiovascular care reforms should be at the heart of VBP initiatives in the American health system.

Appendix A: National Advisory Council and Staff for the Improving Heart Health through Value-Based Payment Initiative

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Note: The contents of this report do not necessarily reflect the opinions of the individuals who participated in the National Advisory Council or the organizations with which they are affiliated.