American Heart Association.
Cardiovascular-Kidney-Metabolic Health Initiative™

CARDIOVASCULAR-KIDNEY METABOLIC HEALTH
PAYER ACTION TOOLKIT

A practical playbook to find compounded risk earlier, coordinate care, and align value-based incentives across cardiovascular–kidney–metabolic conditions.

How the CKM syndrome framework can help payers organize and enhance existing investments in prevention, care management, and provider partnerships around a coherent, evidence based approach.

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PAYER PROBLEM STATEMENT

Payers today manage cardiovascular, kidney, and metabolic diseases as separate conditions, across separate programs, specialties, and incentives, even though these conditions frequently coexist, accelerate one another, and drive a disproportionate share of total cost of care. These conditions are often addressed through condition-specific programs that are not aligned across workflows, incentives, or value-based arrangements.

As a result, many high-risk members are identified late in the disease continuum, after risk has already compounded and care has become fragmented, reactive, and expensive. This results in payers managing downstream costs and utilization rather than intervening earlier in the risk pathway.

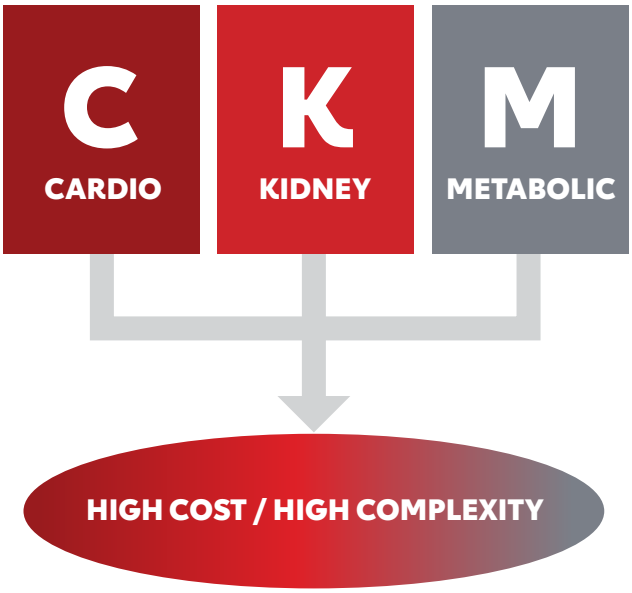
At the same time, payers face growing pressure to:

- **Improve outcomes and equity at the population level**
- **Control total cost of care across complex, multimorbid members**
- **Align care delivery with value-based and accountable models**
- **Demonstrate progress on prevention, not just treatment**

Current benefit designs, care management programs, and provider incentives are not consistently structured to support longitudinal, team-based coordination across cardiovascular, kidney, and metabolic risk. These programs are typically condition-specific and not integrated across CKM conditions.

This creates a strategic gap for payers:

They bear the financial and quality consequences of unmanaged CKM risk but lack an operational framework that can be integrated into existing programs, data workflows, and value-based arrangements to guide earlier identification and coordinated intervention.



Managing cardiovascular, kidney and metabolic disease in separate silos rather than a unifried risk continuum translates to higher complexity and downstream costs.

The 2026 AHA/ACC Cardiovascular-Kidney-Metabolic Syndrome Guideline presents an opportunity to reframe this challenge not as a collection of individual diseases, but as a connected, preventable risk continuum that payers can address through targeted programs, partnerships, and incentives aligned with value-based care.

WHY NOW:
THE PAYER VALUE PROPOSITION

Payers are at an inflection point. The convergence of cardiovascular, kidney, and metabolic disease is accelerating across populations. At the same time, payer decision-making is heavily influenced by near-term cost drivers such as inpatient utilization and emergency department use, as well as member turnover.

The CKM Syndrome Guideline arrives at a moment when payers are actively rethinking how they identify high-risk members, allocate care management resources, and partner with providers under value-based arrangements. Rather than introducing another condition-specific program, CKM provides a unified framework for understanding and managing interconnected risk earlier in the disease continuum.

For payers, the value of a CKM-informed approach is fourfold:

1 Earlier risk identification and intervention

CKM reframes cardiovascular, kidney, and metabolic disease as a progressive, connected risk pathway, enabling payers to intervene before members reach late-stage, high-cost disease. This supports a shift from reactive utilization management to proactive population health strategies.

2 Improved coordination and accountability

By emphasizing team-based care and shared ownership across primary care and key specialties, CKM creates a clearer structure for coordinating care, aligning incentives, and reducing fragmentation that drives avoidable utilization.

3 Alignment with value-based care and equity goals

CKM aligns naturally with value-based payment models, care management programs, and emerging CMS priorities. It also provides a framework for addressing social and structural drivers of risk that contribute to disparities, supporting payer commitments to health equity.

Importantly, CKM is not intended to replace existing programs, but to integrate with and enhance existing care management, population health, and value-based strategies. It offers a way to **organize, prioritize, and enhance** current investments in prevention, care management, and provider partnerships around a coherent, evidence-based framework.

In practice, CKM will initially function as a relabeling and alignment of existing programs, with targeted enhancements to how risk is identified, segmented, and managed across populations. Over time, as data and pilot programs demonstrate incremental impact, CKM may begin to influence how payers define high-risk cohorts, prioritize interventions, and refine program design. This evolution is expected to occur within existing operating and contract cycles, rather than requiring structural changes to benefit design or member turnover dynamics.

CKM gives payers a timely opportunity to move from managing downstream consequences to shaping upstream risk, improving outcomes while bending the cost curve across some of their most complex member populations.

4 Alignment with CMS Innovation (ACCESS Model)

The CMS Innovation Center's ACCESS model reinforces the shift toward outcome-based, technology-enabled management of chronic conditions- including cardiovascular–kidney–metabolic risk. CKM provides a practical framework for payers to align with these emerging models by enabling earlier risk identification, coordinated care, and measurable outcomes across connected conditions.

MAPPING THE PAYER PROBLEM TO OPPORTUNITY ZONES

Across all opportunity zones, CKM should be positioned as an integrative layer within existing payer workflows rather than a standalone program.

PROBLEM 1 ▶ Late identification of compounded CKM risk

What's breaking:

- Members are often identified only after CV, kidney, or metabolic disease has progressed.
- Risk is assessed condition-by-condition, not cumulatively.
- Interventions happen downstream when costs and complexity are already high.

OPPORTUNITY ZONE ▶ Earlier Risk Stratification and Population Identification

What payers can do:

- Use CKM as a connected risk lens to identify members earlier across conditions
- Prioritize members with overlapping or emerging CKM risk rather than waiting for a late-stage diagnosis
- Segment populations for proactive outreach and care management

Value created:

- Earlier intervention
- Reduced avoidable utilization
- Better targeting of care management resources

PROBLEM 2: ▶ Fragmented ownership and accountability

What's breaking:

- No single program or role "owns" CKM members
- Care responsibility is diffused across primary care and multiple specialties
- Payers struggle to align incentives across disconnected providers

OPPORTUNITY ZONE ▶ Care Coordination and Team-Based Models

What payers can do:

- Support or incentivize team-based CKM care models
- Enable roles such as CKM coordinators, care managers, and community health workers
- Clarify accountability through care pathways or program sponsorship

Value created:

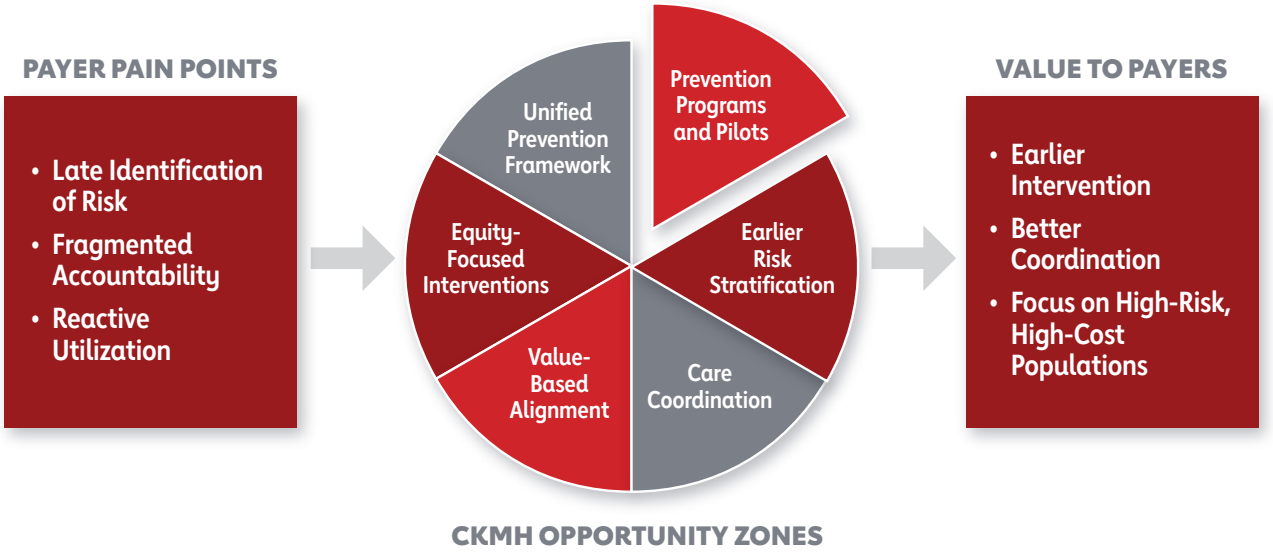
- Reduced fragmentation
- Improved care continuity
- More predictable outcomes across complex members

PROBLEM 3: ▶ Reactive utilization management dominates

What's breaking:

- Focus on prior authorization, utilization controls, and episodic interventions
- Limited investment in upstream prevention
- High-cost events drive strategy instead of long-term risk reduction

HOW CKMH REFRAMES THE PROBLEM INTO ACTION



OPPORTUNITY ZONE ▶ Prevention-Focused Programs and Pilots

What payers can do:

- Launch targeted pilots focused on high-risk CKM populations aligned with existing care management programs
- Shift resources toward longitudinal management of high-risk cohorts
- Partner with providers to test proactive approaches tied to outcomes

Value created:

- Fewer acute events
- Better member experience
- Lower total cost of care over time

PROBLEM 4: ▶ Misalignment with value-based care strategies

What's breaking:

- Value-based contracts often focus on single conditions or narrow metrics.
- Multimorbidity is not well-accounted for.
- Providers lack incentives to coordinate across specialties.

OPPORTUNITY ZONE ▶ Value-Based Payment Alignment

What payers can do:

- Embed CKM concepts into existing value-based arrangements
- Use CKM to inform bundled, shared-savings, or population-based models
- Align incentives around coordinated outcomes, not siloed services

Value created:

- Stronger provider alignment
- More meaningful accountability
- Better performance under risk-based models

PROBLEM 5: ▶ Persistent disparities and SDOH-driven risk

What's breaking:

- CKM risk is disproportionately concentrated in vulnerable populations.
- Traditional programs do not address social and structural drivers of disease.
- Equity goals are often disconnected from clinical strategy.

OPPORTUNITY ZONE ▶ Equity-Focused Interventions

What payers can do:

- Target CKM programs in high-burden geographies or populations
- Integrate social supports into CKM care models
- Align CKM efforts with equitable health initiatives and reporting requirements

Value created:

- Reduced disparities
- Better outcomes in high-need populations
- Stronger alignment with regulatory and public commitments

PROBLEM 6: ▶ Lack of a unifying prevention framework

What's breaking:

- Hypertension, dyslipidemia, CKD, and diabetes are managed in silos.
- Payers struggle to tell a coherent prevention story internally and externally.
- Prevention investments feel fragmented and incremental.

OPPORTUNITY ZONE ▶ A Unified CKM Prevention Framework

What payers can do:

- Use CKM as an organizing framework across existing programs
- Create consistency in language, metrics, and goals
- Establish CKM as a reference point for future prevention initiatives

Value created:

- Strategic coherence
- Better internal alignment
- Scalable foundation for future guideline-driven work

PRACTICAL ENTRY POINTS FOR PAYERS

Payer engagement is most likely to begin with data-driven population risk analysis or targeted pilot programs, rather than strategic alignment alone. Strategic alignment typically follows demonstration of measurable impact.

EMPLOYER AND REGIONAL ENTRY POINTS

Self-funded employers represent a viable entry point for CKM pilots, particularly where there is flexibility to test new approaches and focus on workforce health.

ROLE OF THE AMERICAN HEART ASSOCIATION

The Heart Association serves as a convener, framework owner, and technical partner, rather than an operator of payer programs.

CKMH is not a new program to fund.
It is a **SMARTER WAY** to organize the investments payers are already making.

CKM OPPORTUNITY ZONE
PRIORITIZATION BY PAYER TYPE

1. MEDICARE ADVANTAGE (MA)

Primary Business Drivers

- High prevalence of CKM risk
- Strong financial exposure to the total cost of care
- Heavy emphasis on quality, outcomes, and risk adjustment

Top Priority Opportunity Zones

- **Earlier Risk Stratification and Population Identification**
  MA plans benefit most from identifying compounded CKM risk early to prevent high-cost events and improve risk management.
- **ECare Coordination and Team-Based Models**
  MA plans already invest in care management and can extend this to CKM-focused coordination roles with relatively low friction.
- **Value-Based Payment Alignment**
  CKM aligns well with existing shared savings, capitation, and quality-driven contracts common in MA.

Secondary Opportunities

- Prevention-focused pilots
- Unified CKM prevention framework

2. MEDICAID (MANAGED CARE)

Primary Business Drivers

- High disease burden
- Significant SDOH impact
- State and CMS pressure on equity and access

Top Priority Opportunity Zones

- **Equity-Focused Interventions**
  CKM risk is heavily concentrated in Medicaid populations, making equity-driven CKM programs highly relevant.
- **Care Coordination and Team-Based Models**
  Medicaid plans already use CHWs and care coordinators, which map directly to CKM needs.
- **Earlier Risk Stratification and Population Identification**
  Targeting the highest-risk members and regions can drive measurable impact.

Secondary Opportunities

- Prevention-focused pilots
- Alignment with CMS innovation priorities

WHERE CKMH RESONATES MOST (BY PAYER TYPE)

MEDICARE ADVANTAGE	MEDICAID	COMMERCIAL
• Earlier Risk Stratification • Care Coordination • Value-Based Alignment	• Equity-Focused Interventions • Care Coordination • Early Risk Identification	• Earlier Risk Stratification • Prevention Programs and Pilots • Unified Prevention Framework

CKMH OPPORTUNITY ZONES

Each zone represents an area where payers already act today.
CKMH helps align and prioritize these efforts.

3. COMMERCIAL (EMPLOYER-SPONSORED)

Primary Business Drivers

- Employer affordability
- Productivity and workforce health
- Trend management rather than long-term risk alone

Top Priority Opportunity Zones

- **Earlier Risk Stratification and Population Identification**
  Identifying rising risk earlier helps employers manage long-term cost trends.
- **Prevention-Focused Programs and Pilots**
  Commercial payers can test CKM pilots tied to workforce populations and wellness strategies.
- **Unified CKM Prevention Framework**
  Helps simplify fragmented prevention offerings for employers and brokers.

Secondary Opportunities

- Value-based payment alignment (selective)
- Care coordination models (targeted populations)

4. INTEGRATED DELIVERY SYSTEMS/ PROVIDER-SPONSORED PLANS

Primary Business Drivers

- Clinical outcomes
- Total cost accountability
- Operational integration

Top Priority Opportunity Zones

- **Care Coordination and Team-Based Models**
  These organizations have the strongest ability to operationalize CKM care models across settings.
- **Value-Based Payment Alignment**
  CKM fits naturally into population-based and risk-bearing arrangements.
- **Unified CKM Prevention Framework**
  Supports internal alignment across service lines and specialties.

Secondary Opportunities

- Earlier risk stratification
- Prevention pilots

5. REGIONAL/BLUES PLANS

Primary Business Drivers

- Market differentiation
- Provider relationships
- State-specific dynamics

Top Priority Opportunity Zones

- **Prevention-Focused Programs and Pilots**
  Regional plans are well-positioned to pilot CKM programs with local systems.
- **Earlier Risk Stratification and Population Identification**
  Targeting high-burden regions or populations supports market relevance.
- **Care Coordination and Team-Based Models**
  Partnership-driven coordination models fit well with regional ecosystems.

Secondary Opportunities

- Value-based payment alignment
- Unified prevention framework

CROSS-CUTTING INSIGHT (IMPORTANT)

No payer type needs to act across all zones at once.
The most successful CKM engagement will:

- Start with **1–2 high-leverage zones**
- Use CKM as a framework, not a mandate
- Build incrementally toward broader integration

This prioritization allows the American Heart Association to meet payers where they are, while still advancing a consistent prevention and care coordination narrative.

POTENTIAL CKMH ENGAGEMENT PATHWAYS FOR PAYERS

Payers enter through data or pilots, then scale through alignment and partnerships.

Population Risk Analysis
Identify high-risk CKM populations and link to cost and utilization drivers.

Pilot an Opportunity Zone
Test targeted interventions for high-risk cohorts within existing programs.

Value-Based Alignment
Integrate CKMH into existing value-based care models and incentives.

Internal Alignment Around CKMH
Align internal teams after demonstrating measurable impact.

Learning Collaborative
Participating in a multi-payer CKMH learning network.

▶ Payers can start anywhere and increase engagement.

OWNERSHIP AND ORGANIZATIONAL ALIGNMENT

CKM does not naturally reside within a single function in most payer organizations today. Instead, it sits at the intersection of several existing areas responsible for high-risk populations, care delivery, and provider alignment.

In practice, ownership will typically emerge across three primary functions:

1. **Population Health/Clinical Strategy**

Often, the most natural entry point, as these teams are responsible for chronic disease strategy and population-level risk management.

2. **Care Management/Complex Case Management**

Responsible for high-cost, high-need members and well-positioned to operationalize CKM through care coordination and targeted interventions.

3. **Value-Based Care/Network Management**

Critical for scaling CKM through provider incentives, contract design, and accountability models.

Rather than creating a new function, CKM is most effective when it aligns these existing teams around a shared population, set of priorities, and framework for action.

Initial engagement should focus on convening stakeholders across these functions to avoid fragmented ownership and accelerate alignment.

BOTTOM LINE FOR PAYERS

CKM is not a new program to add. **It is a lens and framework** payers can use to better organize risk, coordinate care, and focus prevention investments where they matter most.

Each opportunity zone represents a place where payers already act today. CKM helps align existing efforts, prioritize high-impact interventions, and enable earlier, more coordinated action.

CKM engagement will typically begin with targeted analysis or pilots and scale over time through integration into existing programs and value-based models.

HOW PAYERS WILL ENGAGE IN PRACTICE

- Start with population risk analysis
- Focus on high-cost, high-risk cohorts
- Launch targeted pilots
- Integrate into existing value-based programs

Start with one population. → **Demonstrate value.** → **Scale what works.**

FINANCIAL LOGIC AND ROI SIGNAL

The financial rationale for CKM is grounded in the concentration of cost within a relatively small subset of high-risk members with overlapping cardiovascular, kidney, and metabolic conditions.

These members often drive a disproportionate share of inpatient utilization, emergency department visits, and downstream complications.

CKM focuses on improving how these populations are identified and managed earlier in the risk pathway. Even modest improvements in care coordination, earlier intervention, or delayed disease progression can translate into meaningful reductions in avoidable utilization.

Rather than introducing a new cost structure, CKM is designed to better manage the cost already concentrated within high-risk populations.

As a practical next step, payers can assess their own populations to identify where CKM risk is concentrated and how it aligns with current cost and utilization patterns. This analysis provides a clear starting point for targeted interventions and pilot programs.

American Heart Association®
Cardiovascular-Kidney-Metabolic Health Initiative™

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