

CARDIOVASCULAR PERSPECTIVE



Advancing Value-Based Cardiovascular Care

The American Heart Association Value in Healthcare Initiative

Despite tremendous progress and innovation in addressing cardiovascular disease (CVD) over the past half century, improving value in CVD care remains an urgent issue.¹ CVD is the leading cause of mortality and disability in the United States,² its clinical outcomes vary tremendously, and improvements in these outcomes are slowing.¹ Further, CVD costs are continuing to rise, and cardiovascular drug innovation is lagging.¹

These challenges are occurring at the same time as promising new care models and clear opportunities for biomedical innovation are emerging.¹ Yet these opportunities are not being broadly capitalized upon because the current payment system for cardiology, largely based on fee-for-service reimbursement, fails to provide incentives for care redesign. Fee-for-service reimbursement in cardiovascular care does not promote longitudinal management, focuses on illness rather than wellness, underutilizes nonphysician clinicians, encourages invasive and intensive treatments for later-stage disease instead of shared decision-making about treatment options or palliative care that improves quality of life, and separates primary care from cardiovascular specialty care.³ Consequently, CVD care remains fragmented, expensive, and uncoordinated, with lower quality than ideal.³

However, things are beginning to change: the current payment system has begun significantly shifting to value-based arrangements⁴ that support better cardiovascular care.^{3,5} As of 2018, 36% of all dollars are flowing through alternative payment models, up from just 25% a few years earlier.⁴ These value-based models, especially ones further away from fee-for-service, can provide significantly more flexibility around provision or reimbursement of services crucial to good cardiovascular care, such as care coordination, team-based care, remote monitoring, behavioral tools, and social and community interventions.³

We briefly highlight progress, challenges, and opportunities for value-based cardiovascular care and important next steps taken by the Value in Healthcare Initiative¹—a collaboration of the American Heart Association and the Robert J. Margolis, MD, Center for Health Policy at Duke University.

Mark B. McClellan, MD, PhD
William K. Bleser, PhD, MSPH
Karen E. Joynt Maddox, MD, MPH

LANDSCAPE OF VALUE-BASED POLICIES AND INITIATIVES FOR CVD NATIONALLY

The broad landscape of value-based cardiovascular policies and initiatives nationally shows progress in value and quality improvements in some models and none in others, indicating both the early state of efforts and need for more research. Another article³ in this issue of *Circulation: Cardiovascular Quality and Outcomes* and others in the field⁵ discuss this in greater detail, but a short summary is below.

There are 3 types of cardiovascular value-based payment models.³ First, episode-based models bundle payments for acute procedures and events during spe-

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cific time frames (eg, Centers for Medicare & Medicaid Services' Bundled Payment for Care Improvement program). These models have been the most common approach specific to CVD but have not achieved performance improvements.^{3,6,7} Second, primary care–focused longitudinal models tie payment to population-level cost benchmarks and quality performance metrics, with an emphasis on longitudinal care, care coordination, and risk factor identification and modification (eg, Accountable Care Organizations). They are not specific to CVD but often contain CVD-related quality measures or target patients with CVD. These models show initial promise in improving cardiovascular care cost and quality.^{3,8,9} Third, specialty care–focused models that include longitudinal care and disease management focus on specialized care for cardiovascular conditions. These are emerging in other specialty care areas (eg, cancer care, end-stage renal disease care)³ but are rare in CVD.

The biggest gap in the current landscape: there are no active cardiovascular-specific payment models focused on patients' longitudinal needs for disease prevention and management.

NEXT STEPS FROM THE AMERICAN HEART ASSOCIATION VALUE IN HEALTHCARE INITIATIVE

The Value in Healthcare Initiative¹ is taking the first steps in addressing this gap. Over the past 2 years, the Initiative identified 4 areas of focus and created 4 Learning Collaboratives to tackle those areas. The Learning Collaboratives are multistakeholder groups from across the cardiovascular care ecosystem, including patients, clinicians, health systems, government agencies, payers, and pharmaceutical, device, and technology companies.

One of the groups, the “Value-Based Models” Learning Collaborative, was directly tasked with developing recommendations for implementing value-based payment models for cardiovascular care. As they refined their scope and considered population health impact and implementation, they chose to develop a framework government agencies and commercial payers could use to create a heart failure value-based payment model with a longitudinal focus on disease management and prevention.³ The framework outlines the payment approach, patient population, triggers for attributing patients to the model, care delivery model, quality measurement and evaluation, and needed data sources.³

The framework also provides implementation strategies to overcome key barriers to putting the model into place, such as how to support the workforce and get clinician buy-in, implement the model in low-resource settings, leverage implementation science, and align

with existing infrastructure.³ The proposed model is designed to be a triggered sub-track compatible with Accountable Care Organizations—the most widespread and generally successful alternative payment model in the country. The proposed model could also be adapted by government agencies and payers via a similar process as this Learning Collaborative for other common, highly morbid population health-affecting chronic conditions that would benefit from a prospective value-based model.

The Initiative is also working to improve value of cardiovascular care through 3 other Learning Collaboratives. Their work will be published in *Circulation: Cardiovascular Quality and Outcomes* over the next 2 issues but is briefly summarized below:

- The “Predict and Prevent” Learning Collaborative developed a practical, evidence-based framework healthcare organizations, no matter their setting, context, capital, or population base, can use to support upstream stroke prevention and reduce stroke inequity. To accomplish this goal, the framework outlines a potential frontier recommendation program for predicting, preventing, and managing hypertension and atrial fibrillation and then discusses key implementation strategies to overcome known barriers (such as regulatory and policy challenges, data limitations, and medication adherence).
- The “Partnering with Regulators” Learning Collaborative, noting the pipeline of new cardiovascular drugs has become relatively limited and expensive compared with many other clinical areas, identifies how to improve cardiovascular drug and device development and evidence through more patient-centered research and clinical trials. They make short- and long-term recommendations on how to improve patient engagement and patient-centeredness of trials, expand use of real-world data and real-world evidence, ensure trial evidence meets evidence needs of regulators and payers, and expand the network of healthcare organizations participating in cardiovascular clinical research.
- The “Prior Authorization” Learning Collaborative identifies innovative solutions from the field to reimagine the existing cardiovascular prior authorization system as one more transparent, collaborative, and beneficial to the entire healthcare ecosystem, including clinicians, payers, industry, and most importantly, patients. They outline how prior authorization burden can be waived or reduced under value-based contracts (including how healthcare organizations can assume greater care management responsibilities) and innovative options for streamlining prior authorization.

Looking across the work of the entire Initiative, there are 6 crosscutting themes where more investment, work, and

advocacy is needed. First, flexible, value-based, alternative payment models are needed to achieve the change and innovation for which each Learning Collaborative advocated. Second, lack of equity in cardiovascular care and outcomes warrants immediate attention; flexible, team-based, patient-centered care models with a focus on social determinants of CVD are needed. Third, value of cardiovascular care will be improved if we equitably embrace emerging digital tools, wearables, and patient-generated data. Fourth, uniting informatics research communities, data privacy experts, healthcare systems, and patient communities on data standards and interoperability will be necessary. Fifth, implementation science offers evidence-based, systematic approaches critical to improving value of cardiovascular care. Last, and most important, there is a crucial need to better incorporate patient voice into assessments of value. A synthesis to be published in the July issue describes these crosscutting themes and next steps in more detail.

PUTTING VALUE IN CONTEXT

The Initiative's recommendations are being released at a time when attention is focused on the severe acute respiratory syndrome- coronavirus- 2 (SARS-CoV-2), coronavirus disease 2019 (COVID-19) pandemic, and will need to be considered within this context. The cardiac complications due to COVID¹⁰ are severe and may have long-term consequences for patients. Striking decreases in volumes, and thus in fee-for-service payments, resulting from social distancing and limitation of clinical activities to only those deemed urgent and emergent¹¹ have severely strained cardiology and primary care practices. These circumstances may limit practices' short-term ability to build out better care management systems based on risk surveillance, telemedicine, remote monitoring, and other needed modifications in care.¹¹

The COVID-19 pandemic also spotlights that both the US health system at-large and cardiovascular care require a greater emphasis on population health.¹¹ It is possible that some policy changes that took place as a result of COVID-19, namely a rapid move to implement telemedicine and relaxation of certain burdensome administrative requirements,¹¹ will further free practices and health systems to innovate in the delivery of cardiovascular population health.^{3,5} Lessons learned and changes made during COVID-19, if leveraged thoughtfully, could accelerate progress toward the type of CVD care delivery that would optimize value in the long run.

CONCLUSIONS

Overall, progress has been made in cardiovascular care, but significant issues remain, and progress is slowing.

The fee-for-service system, in particular, hinders the quality and value of cardiovascular care. The Value in Healthcare Initiative spent the last 2 years with 4 multistakeholder groups to tackle key issues in improving value of the cardiovascular care ecosystem. The Initiative outlined a longitudinal value-based payment model for heart failure, created a practical framework for upstream stroke prevention, recommended how to improve patient engagement and patient-centeredness of cardiovascular drug and device development and clinical trials, and identified innovative solutions for using value-based contracts to reimagine, reduce, and streamline prior authorization for cardiovascular therapies. Implementing these strategic priorities will require broad participation across the cardiovascular care ecosystem.

ARTICLE INFORMATION

Correspondence

Mark B. McClellan, MD, PhD, Robert J. Margolis, MD, Center for Health Policy
100 Fuqua Dr, Durham, NC 27705. Email mark.mcclellan@duke.edu

Affiliations

Robert J. Margolis, MD, Center for Health Policy, Duke University, Washington, DC and Durham, NC (M.B.M., W.K.B.). Cardiovascular Division, John T. Milliken Department of Internal Medicine, Washington University School of Medicine, St. Louis, MO (K.J.M.). Center for Health Economics and Policy, Institute for Public Health at Washington University, St. Louis, MO (K.J.M.).

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