How arrhythmia detection drives VBC success

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Why is CV care a VBC priority?

Payers are incorporating cardiovascular care into VBC models

Cardiovascular (CV) disease remains one of the most expensive areas of care, accounting for an estimated $220.2 billion in annual direct spending.[1] As specialty spending continues to rise, payers are increasingly pursuing value-based care (VBC) models.[2] These models can hold providers accountable for total cost of care (TCOC), quality outcomes, and long-term population health rather than volume alone.[3] In response, payers are expanding CV-focused payment models designed to reduce avoidable utilization, improve chronic disease management, and better coordinate care across settings.

These emerging models place greater emphasis on prevention, earlier risk identification, and stronger collaboration between primary care providers (PCPs) and cardiologists.[3,4] Rather than focusing on discrete episodes of specialty care, population-based and TCOC arrangements reward providers for identifying risk sooner and preventing costly downstream events.[4] CMS's new Ambulatory Specialty Model (ASM), for example, encourages participating heart failure cardiologists to prioritize preventive care, PCP collaboration, and total cost of care management.[3]

For CV service line and system leaders, these changes create both new expectations and new opportunities. As payers bring health systems into TCOC and specialty-focused value-based arrangements, healthcare executives are increasingly looking to cardiology leaders to identify sources of avoidable cost, improve care coordination, and support population health goals. Success in these models will depend on cardiology's ability to move beyond procedural care and play a more active role in managing CV risk across patient populations.

> *"When arrhythmias go undiagnosed, patients may end up in acute care settings unnecessarily. Earlier diagnosis, through clinical vigilance, gives providers an opportunity to intervene sooner, helping reduce avoidable utilization and supporting the goals of value-based care."*
>
> Ken Boyle
> Sr. Director Health Economics and Value Insights, iRhythm

How earlier arrhythmia detection supports VBC success

Earlier diagnosis can shift care from reactive to proactive management

Early arrythmia detection is an underutilized tactic for meeting TCOC pressures. Advances in ambulatory ECG monitoring and wearable technologies are making earlier CV risk identification more scalable,[5,6] helping providers identify risk sooner and intervene earlier.[6]

Atrial Fibrillation (AF) frequently presents in acute-care settings; nearly half of AF-related ED visits in a nationwide analysis resulted in inpatient admission, and CDC reports more than 454,000 annual hospitalizations with AF as the primary diagnosis.[7,8] Earlier diagnosis may give providers time to intervene and manage risk before patients enter the system through a crisis event.

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In a retrospective Medicare analysis, a long-term continuous monitoring strategy (of up to 14 days) was associated with higher odds of a new arrhythmia diagnosis within 90 days and lower incremental acute-care utilization, compared with other ambulatory cardiac monitoring modalities.[9]

By identifying patients before they present through a crisis event, these capabilities can help shift diagnosis and management from high-cost acute settings to more proactive outpatient care.

"Finding an arrhythmia or another concerning signal early gives us time to pause, investigate, and plan with the patient instead of reacting to a crisis."

Dr. Nehal Gheewala
CMO, Claremedica

Earlier arrhythmia diagnosis can reduce downstream care costs

While earlier diagnosis can help move care upstream, it may also reduce the downstream costs associated with delayed arrhythmia identification. For example, undiagnosed atrial fibrillation alone is estimated to cost the U.S. healthcare system $3 billion annually, highlighting the potential value of earlier detection and intervention.[10]

The financial impact of arrhythmias often extends beyond initial diagnosis, with downstream events contributing to higher TCOC, avoidable utilization, and performance challenges in risk-based contracts.

Where healthcare organizations capture value from earlier arrhythmia

Arrhythmia type	*Potential downstream event*	*Cost implications*
Atrial fibrillation	Stroke	Hospitalization, rehabilitations, long-term disability care
Bradyarrhythmia	Syncope leading to falls and fractures	Hospitalization and rehabilitation
SVT*	Symptomatic tachycardia	ED utilization

**Supraventricular tachycardia*

Earlier diagnosis supports goals common to Medicare Advantage, accountable care organizations (ACOs), Medicare Shared Savings Program (MSSP), and other risk-based models by reducing avoidable utilization and improving management of high-risk populations.[4,11]

Primary care can strengthen trust and reduce leakage when it leads the diagnostic journey

Patients may be more likely to trust and return to the clinician who identifies the problem, guides next steps, and coordinates specialty care. Proactive diagnosis often allows primary care to serve as the "quarterback" of care, directing patients to specialty support when needed and bringing them back into longitudinal care afterward. Thoughtful workup before referral may reduce unnecessary specialty visits, improve specialist access, and help keep care within the organization.

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How healthcare organizations can make progress

Understand where arrhythmias create risk today

Organizations should first determine whether arrhythmia represents a meaningful source of unmanaged risk within their population by asking themselves:

- Where do care gaps, avoidable utilization, or specialist access challenges create opportunities for earlier detection?
- How often are arrhythmias being diagnosed after an ED visit, hospitalization, stroke, or other acute event rather than through planned outpatient care?
- Which populations generate the highest CV utilization and may be at risk for delayed arrhythmia diagnosis?

Start with populations where risk is highest

Patients with diabetes, heart failure, chronic obstructive pulmonary disease, chronic kidney disease, coronary artery disease, and cardiovascular-kidney-metabolic syndrome represent key populations for earlier arrhythmia detection.[12]

These patients often experience symptoms such as fatigue, dizziness, shortness of breath, and exercise intolerance.[8] Symptoms associated with common chronic conditions may overlap with those of arrhythmias,[13-17] delaying diagnosis and contributing to downstream complications. Prioritizing these populations can help organizations identify patients who may benefit most from earlier monitoring and diagnosis.

Build workflows for efficient interpretation and referral

Earlier detection only creates value when organizations have clear processes to act on the findings. While many PCPs are comfortable identifying potential concerns, they often need guidance on which patients should be monitored, how findings should be interpreted, and when specialty escalation is warranted.

Establishing PCP-cardiology workflows can provide that support while enabling PCPs to manage lower-acuity findings and preserving specialist capacity. Clear interpretation and routing protocols can further reduce uncertainty, inconsistent follow-up, redundant testing, and unnecessary referrals by ensuring abnormal findings receive appropriate follow-up without automatically generating a cardiology referral.



"First, recognize that arrhythmias may be overlooked when symptoms overlap with common comorbidities. Second, coordinate between PCPs and cardiology to ensure appropriate interpretation, routing, and follow-up."

Ken Boyle
Sr. Director Health Economics and Value Insights, iRhythm

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18. Unless otherwise noted, all information in this quick guide came from Advisory Board interviews, research, and analysis.

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Project director
Jennifer Heipp, Director of Research
HeippJ@advisory.com

Contributing research team
Binqi Chen, Senior research analyst
Emily Schmidt, Senior writer and editor

Contributors
Dr. Nehal Gheewala, DO
Chief Medical Officer
Claremedica

Ken Boyle, DC, MBA, HEOR-C
Sr. Director of Global Health Economics and Value Insights
iRhythm

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