Policy Brief:

Adjusting Quality Measures for Improved Cardiovascular Outcomes Through Better LDL-Cholesterol Management

PARTNERSHIP TO advance cardiovascular health

FAMILY HEART FOUNDATION

INTRODUCTION

The United States is in the midst of a cardiovascular crisis. After decades of progress, cardiovascular mortality is rising again, reaffirming heart disease as America's number one killer.[1] Moreover, more Americans under the age of 55 are dying of severe heart attacks—and women of this cohort are dying at higher rates than men.[2]

These troubling trends highlight major gaps in both primary and secondary prevention. Every year, 800,000 Americans suffer a heart attack— and one in four of these events is recurrent. Within a year of an initial heart attack, patients face a 25% chance of being hospitalized with another.[3] While obesity and diabetes are well-recognized risk factors, the strongest predictor of another cardiac event is having already suffered one. If the U.S. health care system cannot prevent secondary events, where the highest risk patients are so obvious, tackling the monumental task of preventing primary events will remain even more elusive.

Clinicians know that low-density lipoprotein cholesterol (LDL-C) is a primary causal factor for cardiovascular disease.[4] Yet current practice and policy fail to properly support the measurement and control of LDL-C. Despite a clear link between elevated cholesterol and recurrent events, only 9% of patients have their cholesterol tested within a month of a heart attack; after three months, the rate is still only 30%.

But change is on the horizon. In March 2026, the American College of Cardiology, the American Heart Association and nine other leading medical associations released updated guidelines on lipoproteins in the blood.[5] The guidelines reintroduce LDL-C goals for the first time since 2013, providing distinct goals based on patients' risk assessment: LDL-C goal <100 mg/dL for those at borderline or intermediate risk, <70 mg/dL in those at high risk and <55mg/dL for those at very high risk of ASCVD events.

Currently, national quality measures from the National Committee for Quality Assurance (NCQA) and the Center for Medicare and Medicaid Services (CMS) are still aligned with the recommendations from the 2013 ACC/AHA Cholesterol Guidelines. They are long overdue for an update. By introducing LDL-C measurement into quality goals, as the March 2026 recommendations suggest, there is a greater awareness, alignment and incentive to provide improved patient-centered care. With widespread awareness and adoption of the 2026 cholesterol guidelines, clinicians may identify patients at highest risk for adverse cardiovascular disease outcomes, with updated quality measures incentivizing optimal prevention and treatment.

What Are Quality Measures and Why Do They Matter?

Quality measures are tools used by NCQA and CMS to evaluate how well health plans and health care practitioners (HCPs) deliver evidence-based, effective and safe care. These measures guide clinical practice, inform public reporting and link payment to performance.[6]

Quality measures set national standards of care. They determine what health plans and practitioners prioritize, how success is tracked and where accountability lies. For patients, these measures support care that is timely, appropriate and effective. For HCPs, they shape both practice patterns and reimbursement.

Currently, for cholesterol management, NCQA and CMS measure only whether a patient with atherosclerotic cardiovascular disease (ASCVD) has been prescribed a statin. This process fails to capture whether LDL-cholesterol levels are controlled, missing the most meaningful outcome for patients.

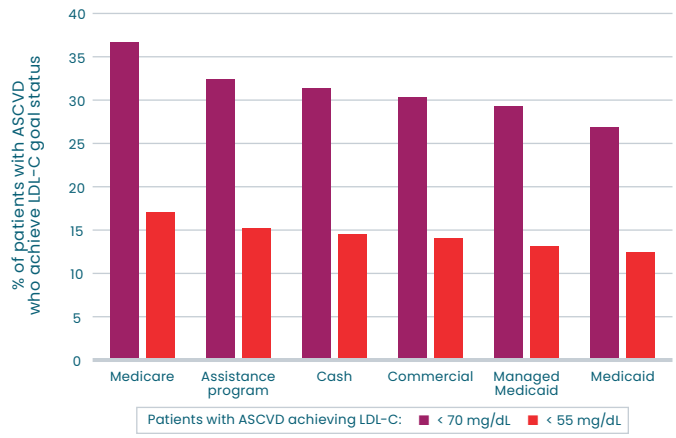
To make real progress, the U.S. must *measure what matters*. Clinicians, and the guidelines that inform their practice, must measure the problem driving so much cardiovascular morbidity and mortality. Updating quality measures to incentivize LDL-C screening and treatment to a standard goal is a long-overdue correction that will save lives, improve outcomes and reduce costs.

BEYOND STATINS

Statins are highly effective at lowering cholesterol but prescribing them does not guarantee that LDL-C is adequately managed.[7] Some patients do not respond sufficiently, require additional therapies or discontinue treatment due to side effects. Current NCQA and CMS measures, which equate statin prescription with control, overlook these realities.[8]

At the Academy of Managed Care Pharmacy (AMCP) Nexus meeting in October 2025, the Family Heart Foundation presented a poster on control of LDL-C by payer type in people with ASCVD during 2023. Overall, only about 1/3 of people with ASCVD are achieving an LDL-C goal of <70 mg/dL, regardless of payer type.[9]

Percentage Reaching LDL-C Goal Status by Payment Type



In contrast to this data on LDL-C control, NCQA recently published the statin performance data from the same year (2023), showing that >80% of individuals with ASCVD were achieving the statin prescription quality measure.

Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)

Measurement Year	Commercial HMO	Commercial PPO	Medicaid HMO	Medicare HMO	Medicare PPO
2023	81.8	82	79.3	86.1	85

This dichotomy between achievement of the quality measure and actual control of LDL-C indicates that the current statin quality measure is insufficient to ensure that people with ASCVD are achieving a desirable level of LDL-C. By assuming prescription equals success, CMS and NCQA miss a crucial opportunity. Measuring what matters—patients' cholesterol—encourages testing, management and reduction of cholesterol levels to safe thresholds.

The Case for MEASURING LDL-C

Robust evidence shows that lowering LDL-C directly reduces cardiovascular risk. Measuring LDL-C allows clinicians to track progress, intensify treatment and improve adherence.

Over a quarter of all U.S. adults have high LDL-C. For those with recurrent cardiovascular events, nearly two-thirds have elevated LDL-C levels. The Family Heart Database®, which includes medical claims from 340+ million people (2012–2023), representing over half the U.S. population each year, demonstrated that 72%—over 27.5 million Americans--were above the LDL-C threshold.[10] These numbers underscore the urgent need for a national measurement strategy.

Of the 38 million Americans who have the highest risk of heart disease, **72% never reach recommended LDL cholesterol levels.**

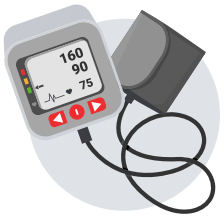
The United States' guidelines already recommend regular lipid screening for children, adolescents and adults. Yet CMS quality measures for older adults with ASCVD omit LDL-C testing altogether. This leaves patients unaware of their cholesterol levels and potentially untreated for a major cardiovascular risk factor. Adoption of the newly announced threshold of an LDL-C at or below 70 mg/dL for people with ASCVD would mark substantial progress.[11]

Sustained LDL-C reduction improves outcomes across all patient populations.[12] Regular measurement enables earlier intervention, guides both lifestyle and pharmacologic therapy and reduces the risk of recurrent events.

Lessons from Blood Pressure and A1C:

WHY CHOLESTEROL NEEDS A GOAL

Quality measures are most effective when they track not only whether treatment is prescribed, but also whether patients reach evidence-based thresholds that reduce risk. For conditions like hypertension and diabetes, NCQA and CMS quality measures already emphasize outcome-based goals.



Blood pressure

National measures require clinicians to track whether patients with hypertension achieve a blood pressure below 140/90 mmHg. This clear benchmark both guides treatment and allows clinicians to be held accountable for ensuring patients' blood pressure is under control. This, in turn, may prevent severe cardiac events such as heart attack or stroke.

Diabetes (A1C)

Similarly, for patients with diabetes, CMS and NCQA measure whether individuals maintain a hemoglobin A1C below 8%. This threshold is important to monitor, as elevated blood sugar may lead to cardiovascular disease, neuropathy and kidney failure. This threshold also provides a quantifiable target for both clinicians and patients, encouraging active management and timely intervention.

These known metrics illustrate how measurable goals can drive improvements in care. Yet in cholesterol management, quality measures lack a defined target. Current measures assume cholesterol is "controlled" if a patient is prescribed a statin, regardless of whether LDL-C levels improve. However, as data from the Family Heart Foundation indicates, control of LDL-C to desirable levels in people with ASCVD is infrequently being achieved.[13] This gap undermines accountability; patients and their health care teams need a goal, similar to the metrics patients with diabetes and high blood pressure have, to better guide management of their LDL-cholesterol.

By following the example set in hypertension and diabetes—and by incorporating guidance from trusted medical societies—cholesterol care can finally move from process-based measures to outcome-based accountability.

POLICY RECOMMENDATIONS

Following the ACC/AHA issuance of specific LDL-cholesterol goals, there must be alignment on the recommendations provided and the delivery of guidance-based care. A single LDL-C target for all patients with ASCVD, for example, would simplify the guidelines and better facilitate their adoption. Having different targets of <70 and <55 mg/dL, separated by a mere 15 mg/dL, risks confusion and may be unnecessary. When it comes to LDL-C, lower for longer is better. Alignment between clinical recommendations and national quality standards would ensure patients receive care consistent with best practices and global norms.

To best address the United States' cardiovascular crisis, policymakers, clinicians and health care institutions should:

- Embrace NCQA and CMS quality measure guidelines that include a framework of measurement for patients' LDL-cholesterol.
- Incorporate outcome-based measurement, not just process metrics, by tracking whether LDL-C reaches evidence-based goals.
- Implement a treat-to-target approach, establishing LDL-C benchmarks (e.g., below 70 mg/dL for secondary prevention) to align practice with national guidelines.
- Ensure patients understand LDL-cholesterol goals. The Family Heart Foundation found that the absence of symptoms for high cholesterol translates to both a lack of urgency to lower LDL-C and a misunderstanding of treatment options.

Only 28% of patients surveyed understood that taking a lipid-lowering therapy would lower the risk of heart attack or stroke.[14]

CONCLUSION

Managing cholesterol is central to reversing America's cardiovascular crisis. The current quality measure—statin prescription alone—is too blunt an instrument. By requiring LDL-C testing and returning to achievement of defined goals, NCQA and CMS can transform care delivery, reduce recurrent cardiac events and save lives.

Precise, outcome-based measures will empower patients and their health care teams and enhance health system accountability to facilitate meaningful progress in cardiovascular health.

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