

What Is the Real Prevalence of Arrhythmias in the Medicare Population?

Why selected patients deserve more proactive rhythm assessment

A Quintuple Aim Perspective | Reza Alavi, MD, MHS, MBA

Symptomatic palpitations are the visible part of the iceberg. Older adults may instead present with dizziness, weakness, exertional intolerance, unexplained falls, or no recognized symptoms. For Medicare populations with multiple chronic conditions, how much rhythm disease remains below the surface?

Early experience in value-based medical groups supports looking more systematically. These programs are finding ventricular arrhythmias, conduction disease, and supraventricular tachycardia (SVT) alongside atrial fibrillation (AF).

The central questions are how often these conditions occur, which findings matter in the patient being monitored, and what earlier recognition makes possible.

Key points

- Expand targeted, clinician-led detection in selected high-risk Medicare patients, with a defined path to clinical follow-up.
- Evaluate ventricular rhythms, heart block, and SVT in the context of the patient's underlying disease and rhythm burden.
- Measure clinical relevance, patient outcomes, harms, and affordability as programs expand.

01 Why symptoms understate the burden

Palpitations are an imperfect guide to rhythm disease. In an analysis of more than one million ambulatory ECG monitoring records, 18.3% of patients with detected arrhythmias recorded at least one symptom temporally associated with an arrhythmia. This describes symptom reporting during monitoring, rather than the sensitivity of usual care. [1] Separately, preliminary observations shared by iRhythm suggest symptom-rhythm concordance below 10%; the population and definitions require clarification before direct comparison with the published analysis. [3]

Symptoms also overlap. Fatigue or shortness of breath in a patient with heart failure, COPD, or chronic kidney disease may be attributed to a condition already on the problem list. In a patient with diabetes, dizziness or falls may prompt a different workup. Rhythm disease can be silent or difficult to distinguish from other conditions.

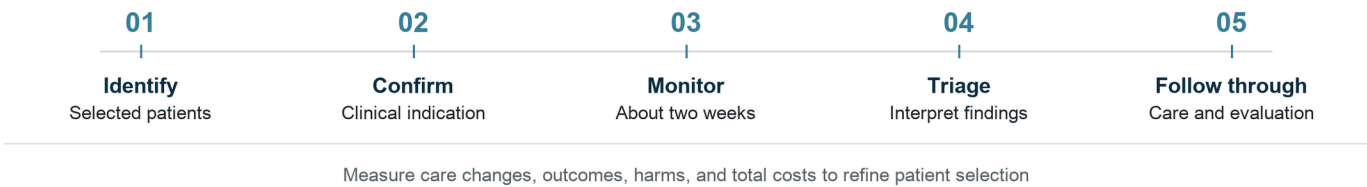
A brief ECG or short monitoring period may miss intermittent disease. Longer monitoring increases the opportunity to capture it. [2] Proactive assessment should consider both patients with no symptoms and those whose symptoms have gone unrecognized or been attributed to another condition.

What value based medical groups are beginning to do

Several value-based medical groups now identify high-risk patients for prolonged ambulatory ECG monitoring rather than waiting for classic palpitations to prompt a referral. Selection may consider age over 75, cardiovascular disease, or accumulated comorbidity, including heart failure, diabetes, COPD, and cardiovascular-kidney-metabolic disease. A clinician reviews symptoms and existing diagnoses and confirms the indication.

Population health teams identify potential candidates; the clinician orders approximately two weeks of noninvasive patch monitoring when appropriate. This may begin at a primary care encounter, annual wellness visit, or another established engagement pathway. Cardiology interpretation and triage distinguish findings that can return to primary care from those requiring further assessment or prompt intervention. A named care team must communicate results and complete the next step.

Exhibit 1 | From selected patients to clinical follow-through



A clinician-led pathway connects targeted detection to appropriate follow-up and prospective evaluation. Conceptual workflow developed by Quintuple Aim from the program approach described here.

02 Preliminary evidence from selected programs

Exhibit 2 | Preliminary signals from different sources and populations

Reported signal	Measure	Interpretation
Approximately 40%	HCC238-associated arrhythmias	Early estimate described in cross-program discussions; not a verified pooled statistic.
84.2% of 80,901 monitors	Any reported arrhythmia	One operational report from accounts designated for asymptomatic testing; median wear 13.8 days. Broad findings include SVT and short runs.

Source: unpublished partner-program materials and related discussions, February–September 2026. [3] These signals come from different sources and populations; they should not be combined into one cohort or treated as a controlled comparison. Monitors are not necessarily unique patients or newly diagnosed disease.

Separate preliminary program summaries reported AF in approximately 2–4%, second- or third-degree AV block in approximately 1–2%, and ventricular tachycardia runs of at least four beats in roughly one quarter. Ventricular yields ranged from 21.1% to 29.0% across four programs. [3]

Preliminary program experience suggests that approximately one third of patients with a newly diagnosed arrhythmia have a clinically concerning finding requiring cardiology follow-up. [3] The proportion linked to a modifiable care pathway remains under discussion; HCC classification or a rhythm finding alone does not establish treatment need.

Research partners are working toward publication. Formal results and longitudinal follow-up should clarify which patients benefit most and how earlier detection changes care.

The patient behind an NSVT finding matters

Reassurance about a few premature ventricular contractions in a healthy young person should not be applied automatically to nonsustained ventricular tachycardia (NSVT) in an older patient with coronary disease or ventricular dysfunction. The rhythms differ, as does the underlying heart.

Prior infarction, cardiomyopathy, ventricular function, symptoms, and the rhythm's duration and characteristics all influence the next clinical decision. Contemporary guidance recommends evaluating incidental NSVT in that context. [4] Some patients can be reassured after assessment; others may need imaging or evaluation for ischemic or structural disease that has not been adequately characterized.

The ventricular signal therefore warrants detailed clinical study. How many patients have reduced ejection fraction or myocardial scar? How often does further evaluation reveal previously unrecognized disease? Which findings change care? Structured evaluation can answer these questions. Program teams describe substantial experience at cardiology providers such as Heartbeat Health, including tens of thousands of rhythm findings in patients designated asymptomatic, as they refine follow-up pathways. These operational observations remain preliminary. [3]

03 Heart block and SVT have their own consequences

Second- or third-degree AV block in approximately 1–2% of a selected high-risk population can be consequential. [3] The type of block and reversible causes require review; higher-grade conduction disease may lead to medication changes or pacemaker evaluation. [5] For an older adult with unexplained syncope or falls, earlier recognition could change the next evaluation and the care offered.

SVT presents a distinct clinical and affordability problem. A national study estimated approximately 140,000 adult emergency department visits with paroxysmal SVT as the primary diagnosis in 2019; nearly one quarter resulted in hospital admission. [6] Sustained or recurrent symptomatic episodes can be distressing even when they are not immediately life-threatening.

Specific SVT diagnosis codes do not map to HCC238 or another payment HCC under the 2024 CMS-HCC model used for 2026 non-PACE Medicare Advantage risk adjustment. [7] That coding distinction does not determine whether the condition matters to patients or contributes to emergency care.

For recurrent symptomatic SVT, establishing the rhythm can support patient education, an episode-management plan, and appropriate treatment. [8] Medical groups can then evaluate whether better diagnosis and longitudinal management reduce repeat emergency visits. Brief incidental supraventricular runs require a different assessment from sustained, symptomatic SVT.

What is the cost of waiting

Detection adds visible costs for monitoring, interpretation, and follow-up. Delayed recognition is less apparent in the program budget; costs may arise later through an emergency visit, evaluation of syncope or a fall, a hip fracture, or hospital care. The question is how often earlier identification moves appropriate care into the ambulatory setting before the next event.

Risk-bearing organizations should examine the full care pathway. Affordability depends on the cost of follow-up, the utilization that changes, and which costs the organization bears. The economics may differ for a group bearing professional risk and one responsible for hospital spending.

Preliminary projections for medical groups bearing full risk estimate net savings, after deducting program costs, of approximately twice those costs. More definitive affordability outcomes are expected in 2027. [3] This is a modeled estimate; prospective evaluation must establish actual financial results.

04 Expand targeted detection while building the evidence

The next phase should broaden targeted, clinician-led detection in selected high-risk populations and incorporate evaluation from the start. Define the population, monitoring approach, and clinical response to each category of finding. Ensure that cardiology and primary care can complete necessary follow-up without creating an unmanageable burden.

Record new diagnoses separately from known disease, distinguish short rhythm findings from more concerning burden or substrate, and document actual changes in care. Follow emergency visits, hospitalizations, treatment-related harms, and total costs with an appropriate risk-matched comparison. Study results should help medical groups refine patient selection and determine when to expand.

Quintuple Aim supports more targeted detection in high-risk Medicare populations, with clinical follow-through and prospective measurement built in.

Better answers are still needed about prevalence, the significance of particular findings, and downstream outcomes. Those answers can be pursued while identifying and appropriately evaluating more patients whose rhythm disease might otherwise remain unrecognized.

Continue the conversation

Quintuple Aim welcomes discussions with medical groups and health plans developing targeted arrhythmia programs, clinical follow-up pathways, and prospective evaluation.

[Start a conversation at **quintupleaim.com/contactus**](https://quintupleaim.com/contactus)

Disclosure: Quintuple Aim provides advisory services to iRhythm Technologies, a manufacturer of ambulatory cardiac monitoring technology, and Heartbeat Health, a virtual cardiology provider operating in all 50 states.

Evidence context: AF screening trials have shown mixed clinical results; broader arrhythmia programs still require prospective evaluation of patient outcomes and harms. [9, 10]

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