



ARTICLE

Cardiovascular ASC Reimbursement Changes: Not the New Ortho

In 2019, the Centers for Medicare & Medicaid Services (CMS) began to transition reimbursement for a number of cardiovascular (CV) procedures, including many cardiac catheterization and vascular interventions, to the ambulatory surgery center (ASC) setting. The goal? Lower the cost of care and create greater cost savings for patients by moving the procedures to a lower-cost environment.

Examples of procedures now reimbursed in an ASC or office-based environment include percutaneous coronary interventions (PCIs), coronary angiography, and peripheral vascular.¹ These procedures now reimbursed outside the hospital account for a material percentage of volume currently conducted in many hospital-based cardiac catheterization labs (cath labs).

These changes in CV reimbursement were preceded by similar changes in orthopedic surgery, with a focus on relocating total joint replacements to lower-cost settings, starting with knee replacements and then moving to hip replacements. In the case of orthopedics, the change resulted in a significant shift of volume—in some cases very rapidly—to ASCs. This shift has been further driven by independent orthopedics groups looking to take advantage of physician-owned or joint-ventured ASCs, often with private equity acting as a capital partner and catalyst.

It is anticipated that 40% to 60% of joint replacement cases may move to the outpatient or ASC setting, depending on the joint site.² This shift has resulted in some savings for payers, employers, and patients. In a number of cases, it has also led to material losses for health systems.

While we expect the migration of CV cases to the ambulatory setting to accelerate in the coming years, the degree, pace, and nature of the shift is likely to differ from what has occurred to date in orthopedics. The reasons are a combination of factors unique to CV—first and foremost, quality and safety concerns. In addition, the nature of CV care (including the more emergent nature of the specialty, how patients seek care, and how cardiologists are organized) is fundamentally different from ortho care.

Many of these hurdles will likely dampen the shift of cardiac procedures out of the hospital, as well as circumscribe opportunities for investment in cardiac-focused ASCs,

necessitating more scrutiny of potential targets. However, they have not diminished the level of investor interest in this area as investors continue to test new hypotheses for investment in an adult CV market with spend exceeding \$320 billion.³

Why is CV Different?

1. Requirements for Patient Triage Can Be Operationally Challenging

Clinical trials (such as C-Port E) have demonstrated that cardiac cath procedures, including certain PCIs, can be done without cardiac surgery backup.⁴ But the risk of potential complications with these procedures remains if patients are not properly evaluated for the procedures. When performing these interventions in a free-standing facility, transfer protocols and emergency procedures need to be put in place. Case selection is important to ensure the patient is a good candidate for the procedure in an outpatient setting, both in terms of avoiding complications and ensuring that a second follow-up interventional cath procedure isn't needed in an inpatient setting.

While similar considerations exist in orthopedics as well (with complications including site infections and blood clotting issues), the potential complications in cardiac cath (such as bleeding or damage to the artery and heart or areas where the insertion occurs) can be very serious and have to be planned for. A further consideration for the performing cardiologist is a matter of logistics—most interventional cardiologists will still have to perform some catheterizations in a hospital-based lab, making it not only time consuming and inefficient to rotate between sites but challenging for them to fill an entire day. The cardiologist may also prefer to conduct the procedures in a hospital-based environment where they have backup in case of complications.

2. The Majority of Cardiologists Are Employed

Currently, an estimated 70% to 87% of cardiologists nationwide are employed or contracted by health systems.⁵ Comparatively, only 33% of orthopedic practices are owned by hospitals or health systems.⁶ This is important because health systems exert a high degree of control around how, and in what settings, their employed cardiologists practice.

Without permission from their employer, many employed cardiologists are prohibited from participating in outside clinical ventures, such as joint-ventured (JV'd) cath labs and ASCs. Moreover, absent any forcing competition or market disruption, health systems likely will be slow to transition CV cases to ASCs due to lower reimbursement for these cases, high capital costs that duplicate existing operating infrastructure, and logistical challenges related to interventionalists covering multiple sites.

3. Cardiologists Are Reliant on Health Systems

In many markets, cardiologists are more reliant on their health system partners than specialists in orthopedics and other procedure-based specialties due to the high proportion of CV referrals originating from the emergency room (ER) or direct from primary care. In fact, in most cardiology practices, most new patients are generated from hospital ER visits when the patients present with emergent cardiac issues, such as acute myocardial infarctions (AMIs).

In markets where health systems have large bases of employed primary care providers, the health systems can influence, at least in part, where patients are directed for cardiology services. This is similar to GI, but very different from orthopedics, which is typically more successful with self-referrals. This means that even for an independent cardiology group, it can be difficult to establish a new ASC that may disrupt the group's relationship with its aligned health system partner, putting at risk current referral relationships.

4. Certificate of Need Requirements Constrain Cardiac ASC Growth

Many states have certificate of need (CON) requirements that limit the ability to add or build new clinical services without state regulatory authorization. Rules are particularly stringent for the addition of cardiac catheterization—more so than would apply to a general ASC with a focus on joint replacements.

Of the 35 states with CON laws, 23 states plus the District of Columbia require ASCs to apply for CON.⁷ Further, 13 states have regulations prohibiting cardiac catheterizations in freestanding clinics.⁸ This again increases the reliance on health system partners and the hurdles to building new ASCs, particularly if they are physician owned or joint ventured.

Furthermore, the equipment needed for cardiac catheterization comes at a high price (often several million dollars). Dedicated, trained staff also are required to aid in performing procedures. These barriers have limited the number of CV-dedicated ASCs that have been developed to date, as compared to ortho and GI, as an example. As of 2020, there were 106 CV-focused ASCs, compared to more than 1,500 that are specific to GI or orthopedics.⁹

Opportunities Remain for PE Investment in CV

Untapped opportunities exist for potential private equity investors, but they require specific circumstances for a higher probability of return on investment. Investment theses likely need to focus on taking advantage of alternative payment models (e.g., bundled payments) and careful screening of potential acquisition targets. Investors need to understand how procedural work can be conducted in an ASC setting, given local CON requirements and market dynamics.

Unlike the playbook typically deployed by orthopedic or ophthalmology platforms (which can largely be executed independent of in-market health systems), CV will require a more deliberate and likely collaborative approach to health system relationships, considering CON requirements and the nature of CV referral relationships. Recognizing the greater interdependency between cardiologist and health system, an opportunity exists to think creatively about partnering with health systems even beyond ASC JVs. Potential opportunities include revisiting how CV physicians are employed and other economic alignment vehicles, such as co-management arrangements that help health systems and private groups jointly manage the CV service line.

As a Health System, What Should My Priorities Be?

For health systems, think carefully about how these changes in reimbursement might impact the organization's current delivery model based on CON requirements,

dependence on independent cardiologists, existence of JV'd cath labs currently in the market, and private equity activity occurring in adjacent services. For many, this may be a game of wait and see. For others, the situation might serve as a catalyst to assess a value-based care strategy in CV services or to consider how to better align with independent cardiology or vascular surgery practices.



Next Intelligence

KEY TAKEAWAYS

- **Cardiology is gaining a lot of attention as a potential new frontier for investors.** This is driven by CMS transitioning a number of cardiac procedures (including many cardiac catheterization and vascular interventions) to being reimbursed in an ASC setting.
- **Cardiology will likely follow a different playbook compared to orthopedics** because of a combination of factors related to physician employment, referral patterns, reliance on health systems, quality/safety concerns, and levels of investment required.
- **While cardiology will be different from orthopedics, private equity investors are still showing a lot of interest.** Investments in CV will have to consider the role of the health system.
- **Health systems should evaluate the potential impact of these reimbursement changes** and consider revisiting their CV strategy to ensure the system is well positioned to navigate through these changes.

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⁹ [Medicare Payment Advisory Commission, March 2022 Report to Congress](#)

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