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Medicare payment change will shift lucrative heart procedures out of the hospital

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Dr. L. Keith Routh does a follow-up exam on Winnie Marie Jones in his cardiology group's ASC.

Last month, Winnie Marie Jones underwent a heart catheterization procedure in which three stents were placed in her coronary arteries to open blockages.

Unlike her husband, Robert, who had a cardiac stent procedure several years ago, Winnie didn't go to the hospital for the surgery. The 70-year-old Medicare patient had it done in a free-standing ambulatory surgery center, Medfinity

Plano, located about 15 minutes from where she lives in Garland, Texas. She was back home less than five hours after the procedure started.

“It was so smooth,” she marveled. “We parked right in front. I didn’t have to wait. The procedure started around 8:30 in the morning, and I was home by 1 in the afternoon. And the staff was supergreat.”

In January, Medicare started paying for six types of percutaneous coronary intervention, or PCI, procedures, also known as angioplasties, which it previously paid for only in inpatient or hospital outpatient settings. The CMS reimburses ASCs about 40% less for these services than it pays for hospital outpatient care. In fiscal 2018, it covered more than 150,000 of these procedures at a cost of about $1 billion in facility fees alone, according to CMS data.

The CMS rule allowing ASCs to perform these lucrative PCI procedures, finalized last November, is widely expected to speed the migration of cardiovascular procedures out of hospitals and into the ambulatory sites. In addition, the agency has asked for public comment on whether it should pay for 14 more codes for higher-risk coronary intervention procedures in ASCs.

Some commercial insurers already are covering both diagnostic and interventional catheterizations in ASCs for non-Medicare patients in states where it is permitted.

The Medicare payment policy change has spurred a rush by ambulatory surgery companies, independent cardiology groups, some hospitals, private equity investors and insurers to enter into or expand their ambulatory cardiovascular business. Cardiology groups and ASCs specializing in cardiovascular care say they’re being swamped with acquisition and joint venture offers.

“We see this as a big opportunity,” said Dr. Dan Murrey, chief medical officer of Optum-owned Surgical Care Affiliates, which operates 210 ASCs around the country, some as joint ventures with hospitals. “With Medicare opening up interventional cardiology, that provides a critical mass of procedures and makes it easier for interventional cardiologists to make the shift to ASCs.”

Texas is host to a lot of activity. “Every major health system in the Dallas area has asked us if we’re interested in selling our ASC, but we’re not,” said Dr. Rick Snyder, whose cardiology group HeartPlace co-owns two Medfinity ASCs with National Cardiovascular Providers. His group did 23 PCIs on

Medicare patients in January and February. “They see where the market is going.”

If a significant share of these procedures move out of the hospital as expected, hospitals will be hard hit financially. That blow would come on top of the likely migration of many other lucrative procedures to ASCs, including total knee replacements, which the CMS also approved in ASCs starting Jan. 1.

Experts say hospitals will have to think hard about whether to try to keep these services in the hospital or develop an ambulatory strategy for cardiovascular services, which account for about 20% of total Medicare spending.

For many hospitals, “this is not an exciting opportunity,” said Julie Bass, a senior consultant for cardiovascular services at the Advisory Board. “The reimbursement is lower, and folks are trying to figure out how that fits into the bottom line. Do they build new relationships to retain outpatient revenue from those services?”

AVERAGE ANNUAL NET REVENUE PER AFFILIATED HOSPITAL

($ in millions) by physician type

Cardiovascular surgery $3.70

Cardiology (invasive) 3.48

Neurosurgery 3.44

Orthopedic surgery 3.29

Gastroenterology 2.97

Hematology/oncology 2.86

General surgery 2.71

Internal medicine 2.67

Pulmonology 2.36

Cardiology (non-invasive) 2.31

Urology 2.16

Family medicine 2.11

Neurology 2.05

Obstetrics/gynecology 2.02

Otolaryngology 1.94

Psychiatry 1.82

Nephrology 1.79

Pediatrics 1.61

Note: Physicians include primary care and specialists.

Source: Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey

Stakes could be great

One big hurdle is that at least half the states, including California, currently don't allow cardiac catheterization procedures in ambulatory surgery centers. Many observers foresee a state-by-state political fight over whether to ease those restrictions.

While big financial interests are involved, those debates are likely to be publicly framed around quality and safety issues. In addition, there are concerns about whether cardiologists with ownership interests in ASCs will have incentives to do inappropriate or unnecessary procedures.

In its final rule, the CMS estimated that if 5% of coronary intervention procedures shift from hospital outpatient labs to ASCs in 2020, Medicare would save $20 million, and beneficiaries would save $5 million in out-of-pocket costs. But some experts say the stakes are much larger, predicting far more non-acute PCIs will shift to ASCs—from one-fifth to half or more.

A year earlier, the CMS allowed Medicare payment in ASCs for 12 diagnostic catheterization codes. Takeup was limited, however, because cardiologists were reluctant to perform an invasive diagnostic procedure if they couldn't get paid for treating any coronary lesions they found.

In fiscal 2018, before the CMS approved those diagnostic procedures in ASCs, Medicare paid for about 524,000 procedures under those 12 codes, for a total expenditure of $812 million, according to CMS data. With the CMS now

paying for PCIs in the ambulatory setting, the volume of both diagnostic and interventional angioplasties in ASCs is likely to grow rapidly, experts say.

That makes investment in ambulatory angioplasty facilities—and participation by interventional cardiologists—much more viable and attractive.

Watershed moment

Improvements in procedural technique also have made doing angioplasties in ASCs more viable, particularly a switch to inserting the catheter through the wrist rather than the groin. That makes same-day discharge easier on patients.

“Medicare approving heart stenting in ASCs was a watershed moment,” said Marc Toth, vice president of cardiovascular services for Atlas Healthcare Partners, which is working with Banner Health to develop ASCs to provide cardiac catheterization services in Arizona. “It has set off a huge wave of momentum for cardiovascular outmigration.”

Banner is planning to open its first ambulatory surgery center with a cardiac cath lab next year as part of its new hospital campus in Chandler, said Joan Thiel, Banner’s vice president for ambulatory services. It’s also exploring ASC opportunities with cardiology groups all around metropolitan Phoenix, including offering its employed cardiologists the opportunity to be co-investors in ASCs. Thiel said that Banner’s leadership expects their approach will pass scrutiny related to anti-kickback laws.

“Care is migrating out from the hospital, and we want to be proactive,” Thiel said. “This is an opportunity to differentiate ourselves in the minds of consumers, physicians and payers.”

Opposition

But other hospital systems are digging in to protect their exclusive right in many states to provide diagnostic and interventional heart catheterization procedures. The American Hospital Association strongly opposed the new Medicare payment policy.

“It’s been a lucrative business for hospitals, and some are holding on as long as they can to hospital-based payment status,” said Susan Heck, senior vice president at Corazon, a consulting practice focusing on cardiovascular, neuroscience and orthopedics programs.

Battles are shaping up in California, Michigan, Ohio, Pennsylvania and other states over proposals to ease state rules restricting delivery of heart catheterization procedures in ASCs. Hospital associations in those states say they haven't taken a position on the issue because they have members on both sides. "Hospital associations will try to fight it in each state," Toth said. "They won't roll over and play dead. That's because most health systems don't have a strategy to deal with this outmigration of cardiovascular services."

Opponents, including the AHA, argue that PCI procedures in ambulatory surgery centers are unsafe, and that they should only be performed in the hospital setting where there is on-site surgical backup and intensive care available in case of emergency.

Many states bar ASCs from performing procedures involving major blood vessels, though that's often ill-defined.

The CMS and medical experts acknowledge that cardiologists need to select Medicare patients conservatively for these procedures in ASCs. That's because there's limited experience doing PCIs on patients outside the hospital setting, Medicare patients are older and tend to be sicker, and quality and safety requirements for ASCs vary by state.

In its final rule, the CMS said the majority of Medicare beneficiaries may not be suitable candidates to receive these procedures in ASCs due to age and comorbidities, but that it wanted to ensure access to these services in a lower-cost setting.

It cited expert consensus, including support from the American College of Cardiology, that these procedures could be safely performed in ASCs on appropriately selected patients. Studies have found PCIs done in hospital settings have rates of mortality or serious complications of about 1%. There are no publicly available data on outcomes in ASCs.

Outcomes questions

In its letter supporting the CMS payment change, the Society for Cardiovascular Angiography & Interventions urged the CMS to require ASCs to report their PCI outcomes to an established cardiology registry to monitor quality of care. The group asked the agency for a meeting to discuss its quality concerns, which SCAI said has not yet taken place.

Some ASC operators say they will voluntarily participate in registries such as the American College of Cardiology's CathPCI Registry, and that they already are tracking their outcomes closely.

"We have rigorous data collection on patient safety and quality," said Murrey of Surgical Care Affiliates, whose facilities up to now have done only diagnostic coronary catheter procedures. "It's necessary to build a track record in these facilities. We'll start with the simplest cases before expanding into the broader population."

A limited number of ASCs around the country have experience performing diagnostic and interventional cardiac catheterization procedures on commercially insured, non-Medicare patients.

Several major insurers including Aetna, Cigna and UnitedHealthcare have covered these services in ASCs and physician-owned office-based labs in some markets, attracted by the much lower rates than in hospital outpatient cath labs.

"We knew the CMS change was on the horizon and we built up our ability to do" PCIs, said Amanda Stanley, administrator of Advanced Surgical & Research Solutions, an ASC in Oklahoma City owned by an independent cardiology group called the Cardiovascular Health Clinic. "We've seen no different outcomes from our hospital outpatient cases."

Her center has done PCIs on about 300 commercially insured patients over the past two years, and on about 20 Medicare patients so far this year, she added. The cardiologists in her group believe that as many as 70% of their Medicare patients would be appropriate candidates for having their coronary stent procedures done in the ASC.

Cardiologists and ASC operators say that for Medicare patients, the shift of non-acute PCIs to ASCs is likely to happen gradually.

"When stenting starts in ASCs, people will be extremely cautious to not try to do anything that would be risky," said Dr. Usman Baber, incoming director of the cardiac catheterization lab at OU Medical Center in Oklahoma City. "If you have just one or two complications in your new ASC, you've created a massive problem for yourself."

Still, some providers may be a little more aggressive in patient selection.

Gerald Davis of Garland, Texas, who soon will turn 90, was one of the first Medicare patients to get a PCI in an ambulatory setting. In early February, Davis went with his wife Mary to Medfinity Plano, where he had stents implanted in two blocked arteries by Dr. L. Keith Routh. A week or so before that, he had a replacement pacemaker implanted at that facility.

In early March, he went to the hospital for an aortic valve replacement. His wife said he suffered a stroke in the past, and that his heart problems have caused a lot of other medical problems.

In an interview prior to his valve replacement procedure, Davis, who spoke in a whispery voice and whose wife described him as “fragile,” said he liked the ambulatory surgery center because it was more convenient than going to the hospital.

He stressed that he and his wife were able to park right out front, rather than having to valet park.

Snyder, Routh’s partner in the cardiology group that co-owns Medfinity, said Davis was an appropriate patient for having a PCI in the ambulatory setting. If Davis were excessively frail, he said, the hospital wouldn’t have scheduled him for the valve replacement procedure at the hospital.

“There is no formal guideline or consensus document out yet regarding which combination of patient characteristics would present too much risk” in an ASC, Snyder said. “Judgment is key here, and the ‘eyeball test’ and a formal frailty score are important. I have never met this patient so I cannot apply the eyeball test.”

While declining to comment on the Davis case, OU’s Baber voiced a contrarian take on the likely volume of PCIs moving out of the hospital. He argued that only a relatively small number of patients are appropriate.

Coming from Mount Sinai Hospital’s busy cardiac cath lab in New York City, he sees the epidemiology shifting and stenting candidates increasingly skewing older and sicker with more complex comorbid conditions. He believes most need a hospital’s surgical backup.

“My assumption is the proportion of patients eligible for this will be quite narrow,” he said. “As of right now, I don’t see this having a major major impact on how we practice interventional cardiology.”

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Banner, AdventHealth among the few partnering with docs on ASCs

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Getty Images

Medicare's decision to reimburse ambulatory surgery centers for certain cardiovascular procedures has invited a flurry of deals and partnerships.

To take advantage of Medicare's new payment rule, ambulatory surgery companies, independent cardiology groups, and some hospital systems are racing to assemble capital and physicians to develop ambulatory sites for providing angioplasties and other cardiovascular services.

The harder piece may be finding available interventional cardiologists, when an estimated 80% of cardiologists already are employed by hospitals.

Phoenix-based Banner Health is addressing that challenge by offering both its employed and independent cardiologists an opportunity to invest in ambulatory surgery sites as a joint venture with the system. That's a new business option for cardiologists that's long been available to surgeons.

"It's good they have this opportunity to invest in centers where they practice," said Joan Thiel, Banner's vice president of ambulatory services. "It makes them highly engaged in quality and cost-effectiveness and aligns everyone's incentives."

The investing doctors will have to perform at least 30% of their cases in the ASC to fall within the federal government's safe-harbor guidelines and avoid scrutiny under the anti-kickback and Stark laws. Medicare generally pays physicians the same professional fee in hospital outpatient and ASC settings.

While many hospitals are holding back because Medicare pays about 40% less for heart catheterization procedures in ASCs than in hospital outpatient cath labs, Banner is embracing the shift.

Banner plans to have ambulatory sites for cardiovascular procedures throughout the Phoenix area, with the first one opening next year. Thiel said the lower-cost sites will be a good fit for managed-care contracts.

AdventHealth in Florida is another hospital system planning to jump into ambulatory cardiovascular services. It currently shares ownership with cardiologist groups in an ASC near The Villages, a giant retirement community in central Florida.

Advent will be working with multispecialty ASCs to open a number of cath labs as early as this summer, with the likelihood that up to 50% of all its angioplasties will be done in ambulatory settings in the near future, said Gordon Wesley, executive director of Advent's Cardiovascular Institute. The system will consider outright acquisitions, strategic partnerships and joint ventures with its own employed cardiologists.

It will cost anywhere from $400,000 to $1 million to equip those existing ASCs to perform coronary stent procedures, he said.

“We shouldn’t just sit in the hospital and hope folks will come to us,” Wesley said. “If we don’t build it, others will.”

In response to the new Medicare policy, two multistate ambulatory surgery companies say they’re scouting for hospital and cardiology partners in expanding their cardiovascular business, which includes electrophysiology procedures and catheterizations to open blood vessels in the legs.

Dr. Dan Murrey, chief medical officer of Optum-owned Surgical Care Affiliates, said health system participation will vary market by market—about half of its 210 facilities are partnerships with hospitals. The company currently is eyeing California, Missouri and South Dakota. “Hospitals in some markets get that we need to make this shift to lower-cost settings, and in other markets not,” he said.

It’s also necessary to make interventional cardiologists feel clinically comfortable doing cases in ambulatory settings, and showing them that it’s economically viable. “Physician acceptance is the biggest issue,” Murrey said. “It typically starts with a handful of physician champions who want to provide more convenience and lower costs for patients.”

Kelly Bemis, chief clinical officer at Fresenius-owned National Cardiovascular Partners, said her company would welcome hospital investment in opening new ASCs. Twenty of its 22 facilities currently do cardiovascular work.

But she’s not optimistic in the short term. The company currently has only one hospital partner—Methodist Health System—in three ambulatory sites in the Houston area. “We aren’t seeing any uptick in interest from hospitals,” she said. “My gut says hospitals would like to keep those cases in their outpatient labs.”

Hospitals may be quietly mulling their ambulatory cardiovascular strategies, but some observers warn they may find themselves outflanked by competitors if they don’t act soon.

Larry Sobal, CEO of the Heart and Vascular Institute of Wisconsin in Appleton, a cardiology group that broke away from ThedaCare last year, said he’s talked with all three local hospital systems about investing in a cardiovascular ASC but hasn’t received any firm commitments yet. He’s also talked with private equity investors and other physician groups.

“The hospitals are not very excited about this because they’re reluctant to give up the higher reimbursement,” Sobal said. “But they may look around town and see multiple other ASCs owned exclusively by independent physician practices and say this is the one they want to be involved in.”