

Freestanding Ambulatory Surgery Centers: A New Strategy for Cardiovascular Services?

By Christine McIntyre

With the advent of the Affordable Care Act and the move to value-based care, hospitals and healthcare systems are facing stiff competition from freestanding ambulatory service sites, especially those that offer outpatient imaging, physician-office-based procedures, and ambulatory surgery. Gaining in popularity across the country, Ambulatory Surgery Centers (ASCs) provide operational and economic efficiencies, allowing for very competitive pricing, ease of patient access, and increased opportunities for physician engagement. As such, Corazon believes hospitals and healthcare systems should consider strategies for how to capitalize on this trend – especially in the cardiovascular service line.

More than 35.8 million outpatient surgical procedures are performed annually in hospital outpatient departments (HOPD) and in freestanding ASCs nationwide.¹ As of 2017, more than half of all outpatient surgeries were performed in an ASC.² Looking ahead, there's no doubt ASCs can expect steady growth through this year and beyond. There are over 6,100 ASCs in the US, and approximately 5,500 are Medicare-certified. Based on responses from a recent report from HealthCare Appraisers and the Ambulatory Surgery Center Association, 53% percent of respondents reported planning to purchase one to five ASCs or interest in an ASC in the next 12 months.

Table 1. Final Additions to the List of ASC-Covered Surgical Procedures for Calendar Year 2019. ⁴	
Calendar Year 2019 CPT Code	Calendar Year 2019 Long Descriptor
93451	Right heart catheterization, including measurement(s) of oxygen saturation and cardiac output, when performed.
93452	Left heart catheterization, including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed.
93453	Combined right and left heart catheterization, including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed.
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation.
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography.
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization.
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization.
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed.
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography.
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed.
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography.

The Centers for Medicare & Medicaid Services’ (CMS) final 2019 payment rule revised the definition of “surgery,” which resulted in the addition of 12 cardiac catheterization procedures (Table 1) to the Medicare ASC payable list, specifically for vascular, electrophysiology, and diagnostic cardiac cath procedures.¹

This move in cardiovascular (CV) procedure reimbursement is expected to continue with more leveling of volume between the hospital and the outpatient ambulatory care settings, particularly if elective PCI follows. And, CMS is not the only payor permitting cardiac procedure performance in the ASC setting. With appropriate state licensure and payor agreements, several private payors, such as United Healthcare, Cigna, and Humana already allow coronary stenting in the ASC setting.

Technological advances have led to increased volume for ASCs in orthopedics, gastroenterology, ophthalmology, pain management, and spine, as well as improving the safety of these procedures in the outpatient setting. Today, the shift to OP services is also influenced by technology, but to a greater extent by the need to lower

cost and improve convenient access to care for both payors and patients. With CV procedural advances, such as radial access, closure devices, and the adoption of same-day discharge programs, the addition of cardiac catheterization procedures for ASCs may be the impetus for many cardiovascular programs to reevaluate their outpatient strategy for the cardiovascular outpatient migration to an ASC.

ASCs have a distinct set of requirements that necessitates thorough analysis as well as expertise and guidance. Providers stepping into this setting of care need to be vigilant about their program development to ensure compliance with the highly regulated program requirements from CMS and other payers as well as the significant capital outlay for an ASC. Corazon advocates a sound business planning process to weigh the volume, revenue, capacity, and physician engagement impact of your strategy—all very important elements to consider so that the transition of appropriate cases occurs without negative impact on clinical outcomes, program financials, or operational efficiency. Table 2 provides some of the benefits and risks of an ASC, and the business implications to consider.

Table 2. Benefits and Risks of an Ambulatory Surgical Center (ASC).	
ASC Benefits	ASC Risks
<ul style="list-style-type: none"> Appeals to healthcare consumer's desire for easy access and more convenient location to receive care without an inpatient admission. 	<ul style="list-style-type: none"> ASCs are subject to state, federal, and also voluntary regulation, along with accreditation standards: <ul style="list-style-type: none"> 46 states require ASCs to be licensed under state law; 28/46 states require third-party accreditation for licensure; 25 states have Certificate of Need laws requiring ASCs demonstrate a need for the new service and construction, potentially resulting in significant delays.
<ul style="list-style-type: none"> Lower-cost option that appeals to payors and consumers with high-deductible plans (ASC administrators will be prepared to market their service and deliver the message of potential savings opportunities for health plans). 	<ul style="list-style-type: none"> ASCs must be certified by CMS to participate, limiting the scope of procedures to: <ul style="list-style-type: none"> Elective procedures with short anesthesia and operating times; Surgical services not requiring inpatient hospitalization (cannot extend past 24 hours); Dedicated space during operating hours, including space within a hospital or critical access hospital outpatient surgery center.
<ul style="list-style-type: none"> Entry into new markets: expanding into new geographies to capture new revenue streams will generate new sources of growth for procedural care. 	<ul style="list-style-type: none"> Due to the heavy regulatory costs and quality reporting, strong volume and physician alignment is essential to offset the cost of equipment and services. <ul style="list-style-type: none"> Innovative, experienced partners, such as joint ventures with physicians, require sound business planning to weigh the volume and revenue impact for the organization.
<ul style="list-style-type: none"> Improves access for all patients by transitioning approved, elective CV procedures, such as pacemakers, peripheral arterial (PAD) angiography, and elective diagnostic cath/same-day discharge procedures from the inpatient setting to the ASC; backfill with high-acuity, high-revenue cases to improve access for inpatient procedures, reduce length of stay, and increase case mix index. 	
<ul style="list-style-type: none"> Greater alignment with physicians: Physician entrepreneurs were early adopters with orthopedics and spine, but over 70% of cardiologists are employed; ASCs will need to demonstrate a value proposition in order to facilitate partnerships with CV proceduralists.⁵ 	

With CMS’ support of the safety and efficacy of diagnostic catheterizations in the ASC setting, the potential for PCI approval in the ASC can be reasonable within the next two to four years. When this occurs, the advantages for the payor, the patient, and the interventionalist could change the paradigm in CV Services. Within the next five years, some experts predict that hospital-based cath labs will focus on urgent inpatient procedures and myocardial ischemia patients, leaving the ASCs to play a much greater role in CV services for elective coronary intervention and other cardiac cases.

ASCs may be the next step in the value transition, provide a better patient experience for cardiovascular patients, and may represent a strong strategic alternative for cardiovascular service lines (CVSL) to consider for the future. Given this evolving landscape administrators need to perform an internal readiness assessment to determine whether their programs are prepared for this transition. Key considerations will relate to clinical staffing, employed physician contracts, operational metrics, appropriation of newly vacated space for other procedure types and, of course, the financial impact.

These considerations as well as the distinct set of regulatory and operational components will require thoughtful and thorough analysis. Corazon recommends a gap assessment as a first step, especially in regards to overall CV service line strategy and future preparedness. A specific market-based analysis of important service line inpatient and outpatient strategies will strengthen the success of the cardiac program components and of the organization overall.

References

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