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Cardiology products

Cardiology spending trends continue to reflect growth in structural heart and electrophysiology technologies. Structural heart remained the largest cardiology spend category, while electrophysiology experienced the most significant increase in relative share, driven by adoption of pulsed field ablation (PFA) and next-generation mapping and ablation platforms.

Spending patterns suggest increasing emphasis on procedure-based cardiovascular technologies, while more established categories such as cardiac rhythm management continue to represent a significant portion of spend despite slower relative growth within this physician preference items (PPI) category. Together, these trends highlight the ongoing influence of innovation and evolving treatment approaches on cardiology purchasing patterns.

Top 15 cardiology spend categories*

Rank	Product spend category	Portion of spend (%), summer 2026	Portion of spend (%), winter 2026[a]	Percentage point change[b]
1	Structural heart	19.0	18.8	+0.2 ↑
2	Electrophysiology products	18.0	16.4	+1.6 ↑
3	Cardiac rhythm management	13.3	14.2	−0.9 ↓
4	Peripheral vascular products	12.1	12.4	−0.3 ↓
5	Coronary vascular products and accessories	6.5	6.6	−0.1 ↓
6	Endoluminal grafts	5.3	5.8	−0.5 ↓
7	Ventricular assist devices	5.3	5.4	−0.1 ↓
8	Neurointerventional products and accessories	4.1	4.3	−0.2 ↓
9	Hemodynamic monitoring	3.7	3.7	—
10	Surgical heart valves	2.2	2.3	−0.1 ↓
11	Vascular closure devices	2.2	2.2	—
12	Vascular coils	2.1	2.1	—
13	Perfusion equipment and disposables	1.5	1.4	+0.1 ↑
14	Intravascular imaging	1.2	1.2	—
15	Vascular grafts	1.1	1.1	—

Source: Automated Data Submission, all client spend, by Vizient spend category. February 2025–January 2026.
*Categories have been refined in collaboration with Vizient subject matter experts to provide more granular product-level detail.
[a] Previously ranked in the winter 2026 Outlook with data analyzed from August 2024–July 2025
[b] Arrows indicate increase (↑) or decrease (↓) since the winter 2026 edition.

Category movements

Increases in spend

- **Electrophysiology products (+1.6%):** Electrophysiology experienced the most significant proportional growth this analysis cycle, driven by accelerating adoption of PFA and next-generation mapping and ablation platforms. Growth reflects both increasing atrial fibrillation (AF) procedure volumes and conversion from legacy technologies, with many programs developing capacity for higher procedural throughput for AF ablation due to improved procedural efficiencies with PFA. This increased throughput isn't universal, however, as it requires optimized workflows in anesthesia and post-operative recovery in addition to shorter procedure times. Advanced PFA catheters and mapping systems contribute to higher procedural costs. As PFA adoption expands, continued variation in product selection and pricing is expected, reinforcing the need for strong physician alignment and disciplined contracting strategy.

- **Structural heart (+0.2%):** Structural heart remains the largest cardiology spend category, with continued growth driven by expansion of transcatheter valve procedures and emerging technologies. Changes in clinical indications and coverage requirements—such as the ongoing Centers for Medicare & Medicaid Services transcatheter aortic valve replacement (TAVR) coverage review—may influence patient eligibility, program requirements, and procedural growth. Supplier concentration and infrastructure requirements continue to localize these procedures within specialized centers, with implications for pricing leverage and long-term contracting strategy.

  Aortic regurgitation devices represent an emerging structural heart segment with high-cost implications. JenaValve's Trilogy system received U.S. Food and Drug Administration premarket approval for symptomatic severe aortic regurgitation in patients at high or greater surgical risk, expanding transcatheter treatment options within a historically limited market segment. Ongoing acquisition and investment activity—including the Federal Trade Commission's challenge to Edwards Lifesciences' proposed acquisition of JenaValve and Boston Scientific's strategic investment in MiRus and re-entry into the TAVR market—further reflects continued competition, innovation, and evolving market dynamics within structural heart technologies.

Decreases in spend

- **Cardiac rhythm management (–0.9%):** Cardiac rhythm management declined in relative share of spend, reflecting slower growth compared with higher-innovation categories rather than reduced demand. Longer battery life, stable implant volumes, and reduced replacement frequency continue to moderate spend growth. While innovation persists in areas such as leadless pacing and device connectivity, the category remains driven by replacement-cycle dynamics, contributing to a relative shift in spend toward emerging, procedure-based technologies. Leadless pacing and conduction system pacing continue to be areas of high interest and high physician preference.

Cardiovascular care at a crossroads: New technologies and shifting care settings demand governance before growth

Coronary drug-coated balloons (DCBs), renal denervation (RDN), and the push to move cardiovascular procedures into ambulatory surgery centers (ASCs) share a common challenge: The infrastructure to govern them responsibly hasn't kept pace with the interest in adopting them. Without deliberate case-level controls, service line alignment, and scenario-based planning, health systems risk eroding margins, losing procedural volume, and missing the clinical and financial upside these innovations can deliver.

Coronary drug-coated balloons and renal denervation

Coronary DCBs and RDN have moved beyond the purely investigational stage and may be poised for broader adoption, but their spend management implications are different. DCBs require case-level discipline due to the cost difference relative to drug eluting stents (DES), the need for adjunctive product use for vessel preparation, and total procedural cost. RDN requires program-level discipline because successful adoption depends on a hypertension pathway that can identify appropriate patients, keep them engaged, support complete documentation, and generate consistent referral volume.

Coronary drug-coated balloons

Coronary DCBs are currently a targeted strategy for percutaneous coronary intervention, with U.S. use limited to in-stent restenosis (ISR). The only **FDA-approved coronary DCB is paclitaxel-coated**, and its approved indication is ISR in previously treated coronary lesions after appropriate vessel preparation. While that approval was important, both for the clinical need and the ability to bring the coronary DCB to the market, it's only the first coronary clinical use case to be approved. Sirolimus-coated balloons are emerging as the next major category, with recent clinical trials reporting non-inferiority compared with DES in both ISR and de novo coronary interventions. This matters for planning because coronary DCB utilization could expand beyond today's narrower ISR use case if future FDA approvals broaden the treatable patient population.

For health systems, the near-term risk is uncontrolled variation. DCBs cost more than DES, although the CMS Transitional Pass-Through Payment (TPT) can at least temporarily mitigate much of the impact on procedural margin. Total case cost can rise further when physicians use additional imaging or vessel-preparation tools to support the procedure such as atherectomy or cutting balloons, but the same considerations also often apply to DES. Since DCBs don't provide the same structural support as a stent, appropriate case selection and lesion preparation are central to both outcomes and financial value. The **FDA labeling** specifically ties use to appropriate vessel preparation.

Health systems should partner with physicians to plan local DCB use criteria before volumes grow and indications expand. Those criteria should clarify appropriate ISR scenarios, when DES remains preferred, what documentation should support DCB selection, and which adjunctive tools are reasonable for different lesion types. Supply chain and value analysis teams also should regularly review DCB metrics by indication, physician, lesion type, adjunctive product use, total case cost, and outcomes. This gives hospitals a practical way to support appropriate adoption while identifying patterns that may erode margins without improving care.

Renal denervation for uncontrolled hypertension

RDN is better understood as a hypertension program opportunity than as a standalone procedural technology. **CMS coverage** and TPT payments create a pathway for RDN, but it also raises the operational bar for patient selection, longitudinal hypertension management, medication optimization, documentation, and follow-up. CMS also requires **facilities performing RDN** to have a hypertension program that includes a hypertension clinician with longitudinal patient management responsibility, a hypertension navigator, and access to relevant specialties. For health systems, this means RDN adoption will depend on how reliably the organization can move appropriate patients through the hypertension pathway, not simply whether the procedure is available.

For hospitals that want RDN to succeed clinically, operationally, and financially, the priority is to make the

hypertension pathway consistent and patient-friendly over the continuum of care. A strong **RDN program** should operationalize that pathway across the full hypertension care team by defining referral triggers, ownership of medication management and follow-up, handoffs between primary care and specialists, patient education, documentation, and post-procedure monitoring. Without that structure, RDN can become dependent on inconsistent one-off referrals, and patients may be lost during the workup before they're ever evaluated for the procedure. This level of coordination supports appropriate volume, reduces patient leakage, and gives the program a stronger foundation for outcomes, documentation, reimbursement execution, and long-term viability.

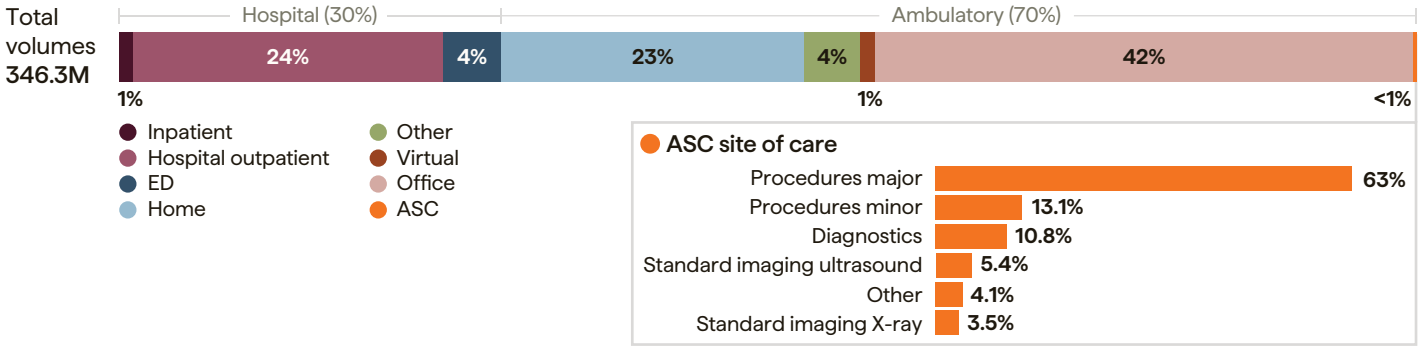
That same infrastructure also is important for reimbursement, because coverage doesn't eliminate payment complexity. RDN is covered by Medicare only when CMS coverage criteria are met and when the procedure is furnished in the context of a CMS-approved Coverage with Evidence Development study. The procedure also uses **Category III CPT** codes for unilateral and bilateral treatment, making early coordination with coding, prior authorization, documentation, and revenue cycle important while payment processes continue to mature across Medicare contractors and commercial payers.

Together, these technologies illustrate how cardiovascular innovation demands new approaches to clinical, operational, and financial decision-making.

Cardiovascular procedures: Evolving site-of-care dynamics and ASC opportunity

Expansion of ASC capabilities in cardiovascular care remains a high-interest but early-stage trend. As illustrated in **Figure 1**, ASC volume currently represents less than 1% of cardiovascular procedures, with most care continuing to occur in hospital outpatient departments due to patient acuity, regulatory requirements, infrastructure needs, and the limited national footprint of cardiovascular ASCs.

Figure 1. Hospital-based vs ambulatory volumes, cardiovascular service line group, U.S. market, 2025



Note: Analysis excludes 0–17 age group. All other site-of-care detail includes clinic, hospice, OP rehab, public clinic, rural clinic, skilled nursing facility, urgent care. ASC = ambulatory surgery center. Sources: Proprietary Vizient All-Payer Claims Data Set; IQVIA; Vizient Analysis, 2025.

Despite limited current volume, cardiovascular ASCs represent a targeted growth opportunity, particularly for diagnostic services and select low-acuity procedures where site-of-care flexibility may improve patient access. Recent CMS approval of catheter ablation in the ASC setting has accelerated interest, particularly among electrophysiologists and physician-owned ASC models. However, it remains unclear how this interest will translate into actual procedural volume shift.

For health systems, the strategic issue is not simply whether cardiovascular procedures can move to ASCs, but which cases may shift, who captures the economics, and how the organization manages the resulting operational complexity. Movement of routine or higher-margin procedures into ASC environments could leave hospital outpatient departments with a more complex case mix, while also creating new challenges related to supply chain visibility, device standardization, quality reporting, staffing, and governance across multiple sites of care.

From a PPI perspective, the implications are less about changes in total demand and more about where demand is captured and under what economic structure. As procedures move into ASC and office-based environments, purchasing may occur outside traditional hospital

contracting channels, reducing visibility into utilization and potentially altering pricing dynamics. Cardiovascular procedures remain highly device-intensive, and margins in ambulatory settings are particularly sensitive to implant, catheter, and consumable costs.

Organizations should evaluate cardiovascular ASC strategies through a scenario-based planning process that includes proceduralists, medical cardiologists, imaging leaders, anesthesia, nursing, finance, supply chain, and operations. Scenario planning should assess no-shift, limited-shift, and accelerated-shift models, including the impact on access, hospital outpatient margins, workforce requirements, quality oversight, device contracting, and capital investment. For some organizations, the better investment may be improving campus-based procedural efficiency, turnaround times, and unit costs rather than building or expanding a new ASC platform.

Ultimately, cardiovascular ASC adoption will depend on more than policy changes. Growth will require alignment across physicians, procedural selection, infrastructure, reimbursement, quality oversight, and supply chain strategy. The core question for leaders is whether ASC expansion creates meaningful access and enterprise value or primarily redistributes profitable volume away from the hospital outpatient setting.

Learn more about how these category movements connect to broader trends by visiting the **Spend Management Outlook**.