

ASC Subsidies – The New Normal:

Trends in Anesthesia Financial Support

for Ambulatory Surgery Centers

BY HOWARD GREENFIELD, MD

Co-Founder and Principal, Enhance Healthcare Consulting, Aventura, FL

INTRODUCTION

Until recently, in addition to the certainty of death and taxes, there were a few virtual certainties – other than the need for anesthesia financial support from hospitals, and no need from ambulatory surgery centers (ASCs). While the former holds true more than ever, the latter has been turned 180 degrees just in the last 2–3 years. Factors contributing to this trend include provider compensation increases, reimbursement challenges, historically poor utilization in ASCs, and an ongoing shift in ASC case mix. This article will look at the trends we see in financial negotiations with surgery centers and describe the approach we feel that anesthesia groups should utilize to ensure adequate support to maintain a viable, sustainable ASC practice.



WHAT'S CHANGED

Such a dramatic shift in the ASC market norm has been caused by a “perfect storm” of key market dynamics. Coming out of COVID, there has been a well-documented supply shortage relative to demand for anesthesia providers. This has led to a meaningful

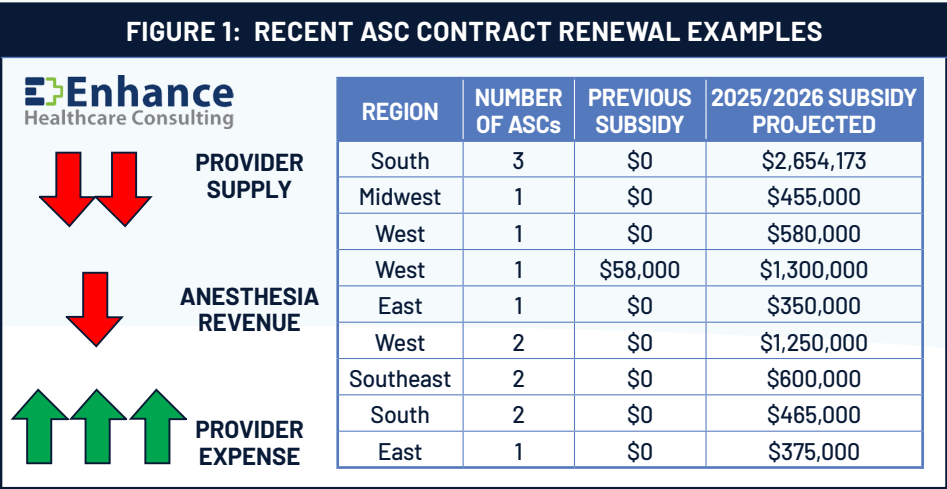
Continued on page 2

INSIDE THIS ISSUE:

ASC Subsidies – The New Normal: Trends in Anesthesia Financial Support for Ambulatory Surgery Centers	1
Choosing the Right Anesthesia Compensation System: A Strategic Framework for Independent Physician Groups	5
Solving the Mystery of Billing for CPT® 01996	8
THE GREAT SURGICAL MIGRATION: How Distributed Surgical Networks Will Redefine Anesthesia	11
Friendly PC Models: Now Is the Time for a Thoughtful Compliance Review	15
Hazards On The Horizon: Reviewing The Emerging Threats To Anesthesia Practices	18
Professional Events	20

ASC Subsidies – The New Normal

Continued from page 1



increase in compensation, far outstripping the rate of wage and cost inflation in other areas of the economy. Thus, more anesthesia revenue is required to support fair market value compensation for anesthesiologists, CRNAs, and AAs at each center. At the same time, reimbursement has been under pressure. Readers are aware of the longstanding (and worsening) underpayment for anesthesia services by government payers, with among the lowest percentage of payment relative to commercial of any specialty. In recent years, commercial payers have joined the party, putting downward pressure on in-network rates, reducing reimbursement for CRNA-only services, and denying payment for modifiers. Superimposed on an aging population that gradually skews the payer mix to government, the net effect is dwindling reimbursement per billed ASA unit.

Reimbursement pressure is being exacerbated by the evolving mix of cases performed in ASCs. For example, total joint replacements, once exclusively

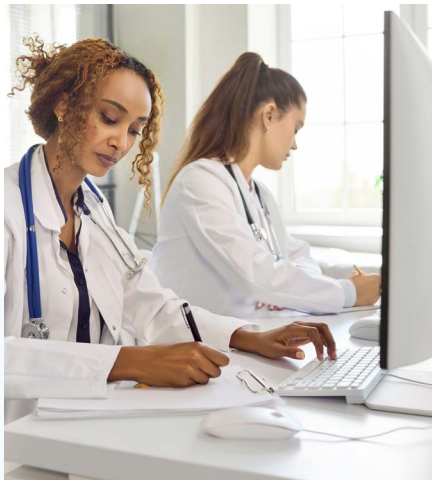
performed in hospitals, have moved in large numbers to surgery centers. The “inpatient only” list of surgical procedures is being reduced each year significantly and is planned to be phased out by 2028. The result is an ongoing migration of complex cases in orthopedics, neurosurgery, cardiology, and other specialties. The impact on anesthesia groups is not only increased clinical complexity, but also a shift toward a heavier government payer mix in surgery centers, further driving down reimbursement per unit.

An increasing number of surgical centers now feature corporate or hospital ownership. Adding corporate-hospital ownership to surgical center leadership teams alongside the traditional physician owners introduces a different management perspective. These individuals are accustomed to the nearly ubiquitous financial support at hospitals, and (although often begrudgingly) understand that anesthesia coverage is a necessary investment to drive surgical volume – the financial lifeblood of an ASC.

However, unlike hospitals, surgical centers almost all have some surgeon ownership. This dynamic complicates financial support negotiations, as the surgeons – who often have had “unlimited” anesthesia access at their ASC – push back significantly against payment to guarantee compensation for anesthesiologists and anesthesiologists while they often don’t have similar guarantees themselves.

STATISTICS

Anesthesia financial trends in ASCs have been studied extensively. An analysis by VMG showed that the percentage of ASCs paying subsidies increased from 28% in 2024 to 44% in 2025. The same analysis found that anesthesia cost/coverage was the most prominent financial concern of ASC administrators. Our experience is significantly different. Currently, we see over 75% of ASCs requiring anesthesia financial support nationwide; See **Figure 1** for Recent ASC Contract Renewal Examples.



ASC RESPONSES

Securing safe and reliable anesthesia coverage for their facilities has suddenly become a major focus for ASC administrators and owners. Approaches have varied but are generally designed to mitigate the expense side of anesthesia service delivery.

Historically, in the days of no anesthesia subsidies, ASCs focused on offering easy surgeon access and maximizing first-case starts to attract cases. This approach often comes at the expense of overall room and anesthesia utilization. Now, with the newfound need for substantial anesthesia support, many centers have been forced to optimize utilization of anesthesia-staffed time, reducing FTEs and anesthesia program expense. Technology and predictive analytics can support scheduling optimization if it is installed in the center. Nonetheless, striking this balance has been painful for many centers and surgeons, but staffing a very expensive anesthetizing location for a few hours of surgery each day is no longer viable.

Financial pressure has also increased the scrutiny of anesthesia staffing models at ASCs. This has led some centers to move to CRNA-only models. As case complexity increases, this option requires a careful balance between cost and clinical expertise of the onsite providers. Some ASCs have decided to move to anesthesia provider employment in response to the market pressures. While this option can secure dedicated anesthesia capacity at the facility, it does nothing to change fair market compensation or the number of providers required to cover a given set of anesthetizing hours. In our experience,

employment of anesthesia services by ASCs costs at least as much, and often more than a similar coverage model by an independent group.

Floating support models based on utilization, or cases per staffed location, are being used by some administrators. They often attempt to create a flexible pool of providers to match case volume and insert volume or utilization as a proxy for anesthesia professional fees. In our opinion, there are two challenges with this approach:

- »» The ability to change staffed locations on short notice is difficult, as providers want to have locked-in and guaranteed shifts in advance.
- »» The use of caseload or utilization as a revenue proxy does not account for the ability to generate ASA units (variable case length), or the dramatic impact of payer mix on net collectible revenue.

A final strategy worth noting is the transition of appropriate cases to conscious sedation. Given the challenge of accessing anesthesia capacity, some ASCs are looking to move cases such as cataracts or routine endoscopy to nurse-administered conscious sedation. This approach reduces anesthesia needs but increases the expertise and expectations of nursing staff and – especially in endoscopy – is associated with reduced patient satisfaction and longer recovery times.

Depending on how severe the anesthesia shortage and associated costs are in any local market, expect to see some or all of these models arriving in your town soon!

ANESTHESIA GROUP APPROACHES TO ASC CONTRACTING

For groups, the process of ASC contracting has changed dramatically in the past few years. While historically these arrangements usually provided a stable, profitable book of business without any financial support, that is no longer true. Therefore, groups now need to protect their financial viability in surgical center arrangements as they have long done in hospital contracts.



When we work with groups covering ASCs, we recommend building a staffing model and pro forma in the same way this is done for hospitals. We must make sure to allocate full local fair market compensation, allocate for benefits and vacation, and allocate reasonable ratios of anesthesiologists to anesthetists for the case types and complexity at the center.

Given the sharp scrutiny of anesthesia staffing, groups should work with facilities to maximize leverage and minimize costs. This should be done by balancing clinical needs such as

ASC Subsidies – The New Normal

Continued from page 5

availability and expertise for regional blocks, and throughput needs such as availability to pre-op patients in advance – against the overall expense to provide the service. For example, a facility performing high-volume joint replacements will benefit from available anesthesiologists (or anesthesiologists) to provide pain blocks and not delay cases. Conversely, a cataract room can often be covered by a CRNA alone, without a decrease in service or quality. It should be noted that the coverage model may be able to vary if the caseload, case type, and complexity have a known variability by day of week.

In the event the providers are not required to take call at an affiliated local hospital, compensation may be slightly adjusted down to account for this, but we do see the gap between ASC and hospital total compensation narrowing in most markets. Each group should have

extensive knowledge of the competitive landscape locally and must reflect this in the models.

Ultimately, the staffing model and associated cost assumptions should be incorporated into a pro forma for anesthesia coverage and presented to ASC leadership to support a sustainable financial arrangement. Groups should remain prepared to modify staffing when the center can appropriately reduce the required coverage footprint. However, when projected costs exceed known or anticipated collections, the group should seek financial support. Several structures may be appropriate, ranging from a per-click payment model—calculated by hour, day, or week, with the ASC billing for anesthesia services—to a traditional revenue guarantee. In our experience, a number of approaches can be effective. The essential objective is to develop an accurate staffing model



and pro forma that enables the group to recruit and retain providers while maintaining an appropriate profit margin and a sustainable business. Ideally, the model should be sufficiently flexible to reflect staffing requirements, collection performance, and changes in local fair market compensation.

This contract structure will allow you to add “not losing your group’s financial viability due to an ASC,” alongside death and taxes, to the list of items you can be certain of in life!



**HOWARD
GREENFIELD, MD**

Howard Greenfield, MD, is a board-certified anesthesiologist and co-founder of Enhance Healthcare Consulting. A graduate of Temple University School of Medicine, he completed his anesthesiology training at Jackson Memorial Hospital/University of Miami.

Dr. Greenfield has extensive clinical, operational, and executive experience in anesthesia and perioperative services. He previously served as Chief of Anesthesia at Memorial Regional Hospital and was one of the founding partners of Sheridan Healthcare, which grew into one of the nation’s leading physician-services organizations. Dr. Greenfield later co-founded Enhance Healthcare Consulting with Robert Stiefel, MD. Together, they bring decades of

national experience advising hospitals, health systems, ambulatory surgery centers, and anesthesia practices. Their work includes structuring and negotiating anesthesia service agreements, evaluating staffing and financial support requirements, optimizing revenue-cycle performance, and implementing operating room and perioperative improvement initiatives. Drs. Greenfield and Stiefel have advised anesthesia practices nationwide on evaluating strategic alternatives and anesthesia subsidy negotiations.

Connect with Enhance Healthcare Consulting on www.linkedin.com/company/enhancehealthcareconsulting or learn more at www.enhancehc.com