Why Anesthesia Groups Lose ASC Contracts

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Why do Anesthesia groups lose their ASC contracts?

Contract loss is rarely about "bad anesthesia"

- It's usually comes down to 3 things:
  - Predictability
  - Throughput
  - Trust

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The ASC Perspective

- ASCs operate on **thin margins**
  - Cases/day x margin/case – staffing/overhead = what matters
- Anesthesia is a **throughput enabler**
  - Enabler of efficiency (FCOTS, TOT, PACU throughput)
  - Impacts case selection, case cancellations
- And a **cost center**
  - Highest per minute staffing cost for an ASC

Administrators value **predictability, reliability, and partnership**

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Five Risk Domains

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Regulatory: Credentialing & Coverage

Regulatory & Compliance

- Lapsed licenses, DEA, or board certification
- Incomplete payer credentialing
- Failure to meet **state ASC or CMS Conditions for Coverage**
  - Governing body oversight
  - Quality program participation
  - Infection Control
  - Emergency Preparedness

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Compliance: Anesthesia Evaluation, Documentation & Supervision

Regulatory & Compliance

- Pre-anesthesia assessment
  - Who, when, and how complete
- Poor documentation
  - Medical direction/supervision
  - Missing elements (e.g., ASA PS, airway details, plan, etc.)
  - Inconsistent time stamps
  - No post-anesthesia eval
- Noncompliance with anesthesia staffing ratios and supervision requirements

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Quality: Events & Outcomes That Matter

Quality & Patient Safety

- Unplanned transfers/admissions
- Unplanned hospital visits within 24-72h
- PACU complications or delays
- Failure to participate in external reporting, QI or peer review

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Safety: Complications, Culture & Transparency

Quality & Patient Safety

How you "show up" after an adverse event matters

- Transparency vs. Defensiveness and poor communication
- Leadership/participation in structured review (RCAs), Engagement in Morbidity & Mortality process
- Visible changes/improvements (policies, protocols, training)

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Efficiency: First Case On-Time Starts

Efficiency & Throughput

- Anesthesia-controlled drivers:
  - Late arrivals/pre-op readiness
  - Inconsistent pre-op optimization (BP/glucose/OSA/anticaog/GLP-1)
  - Inefficient regional anesthesia workflows
  - Missing meds/anes. equipment
- FCOTS failures cascade
  - Following cases delayed, surgeon frustration, staff overtime, patient dissatisfaction, compressed turnovers → increased safety risk
- Don't play the blame game

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Throughput: Turnover & Flow

Efficiency & Throughput

PACU is where inefficiency becomes visible

Anesthesia-controlled drivers of extended PACU LOS:

- Inadequate Treatment for Pain
- PONY Prophylaxis
- Slow emergence patterns
- Discharge criteria standardization
- Lack of staffing flexibility during peak times

Efficiency is not speed—it's ***predictable flow***

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Risk: Subsidies & Staffing Models

Financial Alignment

The number one financial driver of replacement: ASC concludes the coverage model is inefficient or overpriced.

- Most relevant metrics:
  - Cost per anesthetizing location hour
  - Predictability of staffing
- Common mismatch patterns:
  - Overstaffing early day, understaffing at peak
  - Rigid staffing with poor flex ("we can't add anyone when cases run over")
  - Coverage that forces expensive overtime or agency staffing
- Financial trust collapses when:
  - Subsidy demands appear without warning
  - "Coverage gaps" require the ASC to scramble

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Risk: Billing, Compliance & Value

Financial Alignment

- Billing and Compliance - ASCs do not want to inherit your audit risk
  - Billing risks (Medical direction documentation mismatches, inconsistent time documentation, upcoding)
  - "Documentation isn't paperwork, it's contract protection"
- Value
  - Lack of clarity around billing performance
  - Poor commercial contracting
  - High write-offs or denials
  - No demonstration of value beyond staffing

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Risk: Behavior & Reliability

Professionalism & Relationships

- ASCs are relationship-driven ecosystems:
  - Surgeons often have ownership/influence
  - Staff turnover is expensive and personal
- Common contract-killers:
  - Disruptive behavior (toward staff, surgeons, patients) - **The fastest way to lose a contract:** "one bad actor" + leadership unwillingness to address it.
  - Chronic lateness, last-minute call-outs
  - "Policy Wars" in pre-op (inconsistent thresholds; arguing in front of patients)

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Risk: Leadership Vacuum

Professionalism & Relationships

- ASCs expect Anesthesia to lead:
  - Quality & Safety
  - Infection Prevention
  - Emergency Preparedness
  - Sedation policy
- When anesthesia leadership is invisible:
  - Others define the problems
  - Anesthesia becomes a commodity
- Be proactive - not reactive

If you're not at the table, you're on the menu.

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Early Warning Signs of Contract Risk

- Increased administrator micromanagement (e.g., coverage schedules)
- Requests for OR Efficiency Improvement Projects. (FCOTS, TOT)
- Dashboards that isolate anesthesia delay codes
- Requests for "benchmarking" data
- Being left out of discussions with surgeons, nursing, admin
- Market comparison and/or RFP discussions

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How to Stay Contract-Secure

- Think like an ASC partner, not a vendor
- Invest in **visibility, reliability, and improvement**
- Be the group they can't imagine replacing

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How to Stay Contract-Secure

REGULATORY & COMPLIANCE	QUALITY & PATIENT SAFETY	EFFICIENCY & THROUGHPUT	FINANCIAL ALIGNMENT	PROFESSIONALISM & RELATIONSHIPS
• 100% credentialing accuracy • Template-driven documentation aligned with ASA expectations • Survey readiness: know ASC CfCs basics	• Own the metrics the ASC is judged on (hospital visits/unplanned transfers) • Run event huddles • Lead/ participate in visible QI initiatives	• FCOTS: set a shared goal (~90%), define exclusions • Same-day cancellations: work toward <2% • PACU throughput: reduce outliers; align pathways (PONV, pain, regional)	• No surprise subsidies • Monthly value reports • Staffing flexibility	• "No drama" culture • Rapid remediation • Visible leadership presence

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Case Vignettes

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Case #1: "It Wasn't the Late Start… Until It Was"

What Anesthesia Thought

- Delays are **multifactorial**
- Surgeons arrive late
- Patients not prepped on time
- Anesthesia clinically ready when called
- FCOTS is a *shared problem*, not ours alone
- No safety issues → no real risk

What the ASC Saw

- FCOTS stuck at ~**80%**
- "Anesthesia not ready" = most common delay code
- Afternoon spillover → **staff overtime**
- Surgeon frustration escalating quietly
- Requests for "benchmarking" and "improvement plan"
- **Perception: anesthesia = unreliable bottleneck**

Contract risk is driven by perception of reliability, not by fault attribution.
Refusing to own operational metrics accelerates replacement.

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Case #2: "The Transfer That Changed Everything"

- ***What Anesthesia Thought***
- Rare, unavoidable physiologic response
- Patient ultimately did well
- No deviation from standard care
- PACU managed appropriately
- Not worth escalating—noise, not signal

- ***What the ASC Saw***
- **Unplanned hospital transfer**
- Family complaint filed
- Appears in **claims-based quality data**
- Surveyors ask about:
  - patient selection
  - anesthesia evaluation
  - PACU escalation criteria
- No proactive anesthesia communication
- **Perception: anesthesia = regulatory & reputational risk**

In ASCs, rare events carry disproportionate weight.
Silence after an event is interpreted as lack of accountability.

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Case Vignette #3: "The Survey Finding that Wouldn't Go Away"

What Anesthesia Thought

- Minor documentation issue
- Surveyor was being overly detailed
- No patient harm occurred
- "We've always done it this way"
- Issue is **facility-owned**, not anesthesia-owned
- Fix it later—low urgency

What the ASC Saw

- Repeat anesthesia-related survey finding
- Citations tied to:
  - pre-anesthesia evaluation timing
  - missing or inconsistent anesthesia documentation
  - unclear medical direction language
- Required **Plan of Correction** submitted
- Follow-up survey scheduled
- Risk of:
  - payment delays
  - increased scrutiny
  - reputational damage
- **Perception: anesthesia = compliance liability**

Regulatory risk is not about harm—it's about confidence.
Repeat findings signal loss of control, and ASCs replace risk, not people.

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Guiding the future of patient care

?

Questions?

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CRASH
Guiding the future of patient care

Analyze key financial and performance metrics needed to make a winning bid when asked to submit an RFP for coverage of an existing ASC

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Framing the RFP: What the ASC Is *Really* Asking

It's Rarely Just about cost*

- It's usually comes down to 4 things:
  - Can you Staff Reliably?
  - Can you operate efficiently?
  - Can you grow with us?
  - Can you do this with a sustainable cost?

CRASH

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Core financial Metrics

You need to understand how you will get paid in **this** ASC

- Payor Mix
- Average Case length
- Case Mix by specialty
- OR Utilization Rates
  - Prime Time Utilization

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What are we really solving for?

At a simplistic level we provide coverage

- Ultimately you are trying to figure out what will be the net collections per anesthetizing (coverage) hour

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Payor Mix Sensitivity

Even small shifts in payor mix can destabilize an ASC and the anesthesia group. What you need to know

- % Commercial (and which contracts)
- % Government
- % Workers Comp
- % Out of network risk

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Units Per Case & Case Duration

Case count is not nearly as important as **units x time**

- Ultimately you are trying to figure out what will be the net collections per anesthetizing (coverage) hour
- Base units per specialty (CPT/volume list would be ideal, but may not be willing to share)
- Average Case Time per specialty

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The high risk scenario

Low volume + Guaranteed Coverage + Long open hours

- Idle Time= Lost revenue

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What is your cost Structure?

Not accounting for fully loaded provider cost is the most common failure point for an anesthesia group

- Salary/hourly wage
- Benefits
- Employer payroll costs
- Malpractice
- CME/Credentialing/Licensing/Recruitment

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The End Equation

Net Collections/hour – Fully Loaded cost/hour=??

- What to consider if it's Positive?
- What to do if it's negative?

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Awesome! It's positive

Downside and Upside Risk Modeling- Sensitivity Analysis

- Volume Changes (+/- 10%, 20%)
- Payer mix changes
- Payer Contracting Changes
- Case Mix changes (focus on highest/lowest revenue/hr)

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We are getting a negative margin/hour, what are we doing wrong?

We are entering an interesting time in anesthesiology

- Costs (compensation) continues to increase
- Reimbursement continues to decline
- Demand > Supply for anesthesia providers?

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Subsidy to staff an ASC? Are you insane?

What used to be considered impossible is now slowly starting to become reality

- While not yet the norm, the % of ASC's having to provide some form of anesthesia subsidy is increasing. Has been reported as high as 40% (Beckers)

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What does Chat GPT have to say?

(entertainment purposes only)

Here's the prompt I gave it

- "I run an ASC and my anesthesia group says they need a subsidy, how do I prove them wrong?"

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"Here's some helpful headlines I made up to help"

(entertainment purposes only)

- Oversupply of Anesthesiologists Forces ASCs to Introduce Waitlists for Jobs
- Anesthesia Oversupply Unlocks Bold New Concept: Paying Less
- Executives Confirm: There Are Now More Anesthesia Providers Than Cases
- CRNAs Reportedly Competing for Shifts Using Rock-Paper-Scissors
- ASCs Explore Rotating Anesthesia Sabbaticals to Manage Excess Coverage
- Excess Anesthesia Supply Creates Once-in-a-Generation Margin Opportunity

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True Subsidy vs. "Insurance"

Depends on how close you are to covering costs

- If calculations show true negative operating margin a true subsidy is likely required
- If its close, or if can become negative "easily" a contract with an "insurance" clause may be warranted

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*What if you can't provide coverage without a subsidy?**

Some options of how to structure it

- Fixed Daily subsidy
- Per Room daily subsidy
- Volume based subsidy
- Hybrid (fixed base + volume)

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One approach

Minimum cases/minutes per month

- We use this in a limited specialty ASC
- Minimum cases/room/month
- Example: 6 OR's open for 20 days= 120 room days
  - 3 cases/room/day= **360 cases/month**
  - Allows facility and surgeons flexibility, but gives us a backstop if volume changes significantly

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Summary

- The ASC world is shifting for anesthesia. What was once considered a guaranteed positive margin environment is slowly eroding
- Understanding the importance of being able to accurately evaluate net revenue vs. true cost structure when assessing or putting together a contract is of paramount importance
- While not the norm yet, subsidies for coverage are becoming more common
- While case volume is shifting toward the ASC environment, the anesthesia economics are putting a bit of a wrench in the works.
- Honest, transparent, and collaborative relationships are going to be extremely important as this evolves

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Developing Culture in the ASC

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February 24, 2026

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Disclosures

- No relevant financial relationships

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Goals and Objectives

- Identify changes affecting the future practice landscape of ambulatory surgery
- Determine key elements that contribute to a positive and cohesive culture in high-performing teams
- Differentiate between process and culture, translating their impact to the ASC setting

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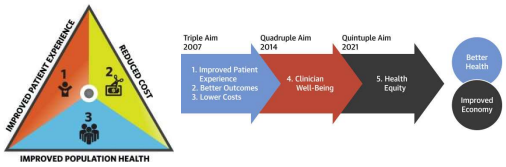
IHI Quintuple Aim of Healthcare



Nundy S, et al. JAMA. 2022;327(6):521-522

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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Safety of Inpatient Health Care

David W. Bates, M.D., David M. Levine, M.D., M.P.H., Hojat Salmasian, M.D., Ph.D., M.P.H., Ania Syrowatka, Ph.D., David M. Shahian, M.D., Stuart Lipsitz, Sc.D., Jonathan P. Zebrowski, M.D., M.H.Q.S., Laura C. Myers, M.D., M.P.H., Merranda S. Logan, M.D., M.P.H., Christopher G. Roy, M.D., M.P.H., Christine Iannaccone, M.P.H., Michelle L. Frits, B.A., Lynn A. Volk, M.H.S., Sevan Dulgarian, B.S., B.A., Mary G. Amato, Pharm.D., M.P.H., Heba H. Edrees, Pharm.D., Luke Sato, M.D., Patricia Folcarelli, Ph.D., R.N., Jonathan S. Einbinder, M.D., M.P.H., Mark E. Reynolds, B.A., and Elizabeth Mort, M.D., M.P.H.

"Adverse events were identified in nearly one in four admissions, and approximately one fourth of the events were preventable."

- Adverse drug events (39%)
- Surgical or other procedural events (30.4%)
- Patient-care events associated with nursing (15%)
- Healthcare associated infections (11.9%)

Bates DW, et al. N Engl J Med 2023;388:142-53

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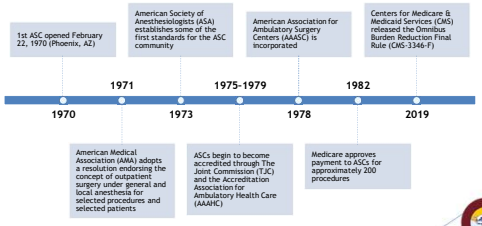
ASC Timeline



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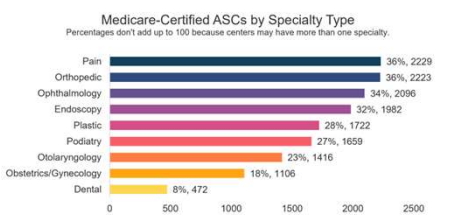
The ASC as a Focused Factory



https://www.ascassociation.org/asca/about-ascs/surgery-centers

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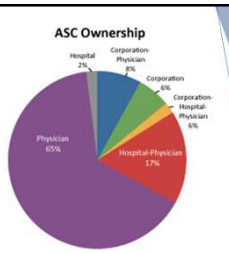
ASC Ownership Models



- Physician-Owned
- Joint Venture: Physicians + Management Company
- Joint Venture: Physicians + Hospital
- Joint Venture: Physicians + Hospital + Management Company
- Hospital-Owned with Physician Co-Management

J Spine Surg 2019;5(2):5195-5203
https://www.ascassociation.org/advancingsurgicalcare/aboutascs/industryoverview/a positivetrendinhealthcare

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ASA Statement on Ambulatory Anesthesia and Surgery I

- ASA Standards, Guidelines, and Policies should be adhered to in all settings
- A licensed physician should be in attendance in the facility until the patient is discharged from anesthesia care
- At a minimum, all settings should have a reliable source of oxygen, suction, resuscitation equipment and emergency drugs
- The facility must have a governing body that assumes full legal responsibility for its operational policies
- Qualified personnel and equipment should be on hand to manage emergencies
- Must have well defined policies and procedures for the immediate transfer of patients
- The facility must maintain and annually review a disaster/emergency preparedness plan
- Physicians providing medical care in the facility should assume responsibility for credentials review, delineation of privileges, quality assurance, and peer review

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ASA Statement on Ambulatory Anesthesia and Surgery II

- Minimal patient care should include:
  - Preoperative instructions and preparation
  - Appropriate pre-anesthesia evaluation, examination, and plan by an anesthesiologist
  - Preoperative studies and consultations as medically indicated
  - Discharge of the patient from anesthesia care is the responsibility of the anesthesiologist or other qualified physician
  - Patients who receive other than unsupplemented local anesthesia must be discharged with a responsible adult
  - Written postoperative and follow-up care instructions
  - Accurate, confidential, and current medical records

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2026 Hospital Outpatient Prospective Payment System (OPPS) and ASC Final Rule (CMS-1834-FC)

- Phasing out inpatient-only list (removed 285 procedures) and expanding ASC covered procedures (added 289 procedures)
- Outpatient payment rates to increase by 2.6% for hospitals that meet quality-reporting requirements
- Hospital Price Transparency Policy Changes
  - Hospitals required to post actual, consumer-friendly prices — not estimates
  - When a payer-specific negotiated charge is based on a percentage or algorithm, hospitals will be required to encode the median allowed amount and the 10th and 90th percentile allowed amount in dollars
- Access to Non-Opioid Treatments for Pain Relief (5 drugs, 11 devices)
- Ambulatory Surgical Center Quality Reporting (ASCQR) Program
  - ASCs that fail to submit required data on quality measures as specified by CMS receive a 2% reduction to their annual payment rate update

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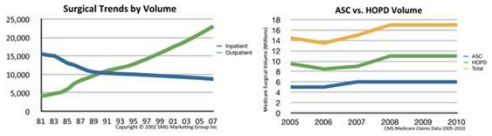
Why This Matters Now



- Rapid migration of complex procedures to ASCs
- Higher patient acuity with tighter margins for error
- Workforce strain, burnout, and turnover risks

J Spine Surg 2019;5(2):S195-S203

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How Systems Are Preparing

- Emphasis on strengthening pre-procedure screening and optimization
- Ensure clinical judgement is not overridden by convenience
- Ensure payer coverage decisions account for patient-specific factors beyond the procedure type
- Improve patient education and guidance re: day-surgery expectations
- Modernize data collection and analysis for appropriate care coordination
- Building strong internal governance structures

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The ASC Reality

- Fast pace with high turnover pressure and rapid throughput
- Surgeon-driven variability
- Limited buffers and/or backup resources
- Lean staffing
- Compressed timelines for decision-making
- Dependence on trust, anticipation, and reliability
- **Failures are often <u>cultural</u> before they are technical**

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What is Culture?

- Shared values that translate into daily actions
- Defined by how we behave and perform when no one is watching
- Can either amplify (positive culture) or erode (negative culture) performance
- Reinforced through what leaders tolerate, reward, and model

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Process vs. Culture

- Process
  - Checklists
  - Policies
  - Schedules
  - Metrics
- Culture
  - Shared accountability
  - Psychological safety and open reporting
  - Respect for time
  - Ownership of outcomes

Does process drive culture?
Or does culture drive process?

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Why Culture Drives Outcomes

- Processes provide structure → Culture determines adherence
- Weak culture → Variability, conflict and safety drift
- Strong culture → Fewer workarounds and one-offs
- Relationships are the key → Neither process nor culture programs work in isolation

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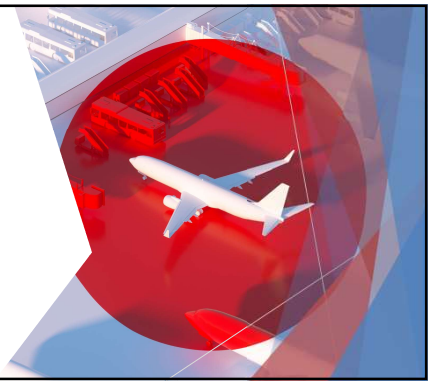
Pillars of High-Performing Teams

- Trust & psychological safety
- Role clarity & accountability
- Prompt & effective communication
- Continuous improvement & growth mindset
- Examples:
  - Toyota Production System
  - Navy SEALs
  - Aviation
  - **Anesthesiology?**



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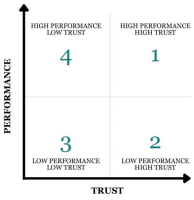

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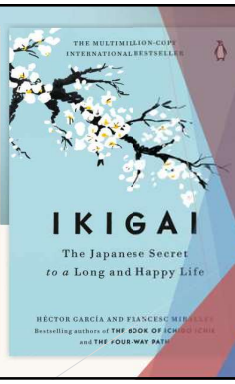

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Culture and Access

- Stable and efficient teams create capacity
- Trust enables flexible staffing models
- Reduced turnover times preserves access
- Reliable screening process and patient education as a cultural signal
- **Examples**: Multidisciplinary PAT/scheduling processes, collaborative Epic Secure Chat discussions

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Culture and Flow

- FCOTS = shared value
- Case length accuracy = respect for downstream teams
- Reduction in same day cancellations = fewer surprises → smoother throughput
- Fewer delays = greater patient satisfaction
- **Examples**: Monthly Performance Scorecards for Surgeons, efficient teams communicate proactively = afternoon flex for flipped 2nd rooms

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Culture and Quality

- Standardized screening and patient selection
- Willingness to say "no" → "Right Case, Right Space"
- Culture supports clinical judgment over production pressure
- Culture influences vigilance and situational awareness
- Team behaviors affect outcomes
- Safety culture must be visible, accountability-driven and reinforced
- **Examples**: RL Review, Preference Guides, ASC Patient Selection Criteria, ASC-specific Education and QI initiatives

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Culture and Growth Mindset

- Scalable culture supports expansion
- Proficiency and reliability across sites
- Ongoing competency development and staff training
- Emergency preparedness with simulation and scenario-based learning
- Training and readiness for higher-acuity outpatient care
- Peer review and QI initiatives
- **Examples**: Quarterly Perioperative Simulation, Nursing Journal Club, Monthly Anesthesia Education

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Measuring Culture in the ASC

- Staff engagement surveys
- KPIs
- Safety event reporting and unanticipated transfer trends
- Staff turnover and absenteeism
- Patient experience and likelihood to recommend feedback

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Data, Feedback, and Transparency

- Share performance metrics
- Close the loop on reported concerns
- Use data to reinforce learning, not blame
- Education prevents downstream failures
- Teams should expect variability and be proactive rather than reactive
- Clear medical and operational leadership roles
- Shared accountability
- Standard expectations across the ASC network

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Leadership as the Cultural Multiplier

- **Leadership sets tone, priorities, and psychological safety**
  - Visibility and approachability
  - Consistent messaging
  - Modeling interdisciplinary respect reduces friction
- **Culture reflects what leaders tolerate**
  - Swift response to safety and respect issues
- **Informal leadership is as impactful as formal titles**
  - **Model desired behaviors daily**
- **Help people understand their role in "co-owning" the problem and actively participating in the solution**
  - Dependent on people first; reinforce respect for people
  - Focus on the environment and process for areas of improvement

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Culture change happens through small acts done well every single day.

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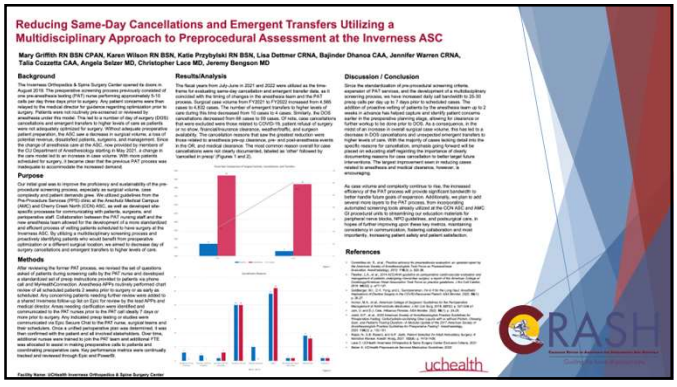

Reducing Same-Day Cancellations and Emergent Transfers Utilizing a Multidisciplinary Approach to Preprocedural Assessment at the Inverness ASC

Mary Griffith RN BSN CPAN, Karen Wilson RN BSN, Katie Przybylski RN BSN, Lisa Dettmer CRNA, Bajinder Dhanoa CAA, Jennifer Warren CRNA, Talia Cozzetta CAA, Angela Selzer MD, Christopher Lace MD, Jeremy Bengson MD

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Weathering the Storm: A Multidisciplinary Approach to Sustaining Case Volume During a Critical Fluid Shortage at an Orthopedic ASC

Jeremy Bengson, M.D.
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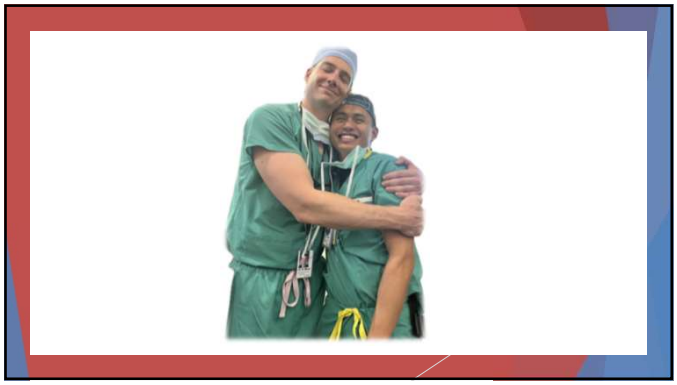

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