

ASC Subsidies – The New Normal:

Trends in Anesthesia Financial Support

for Ambulatory Surgery Centers

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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

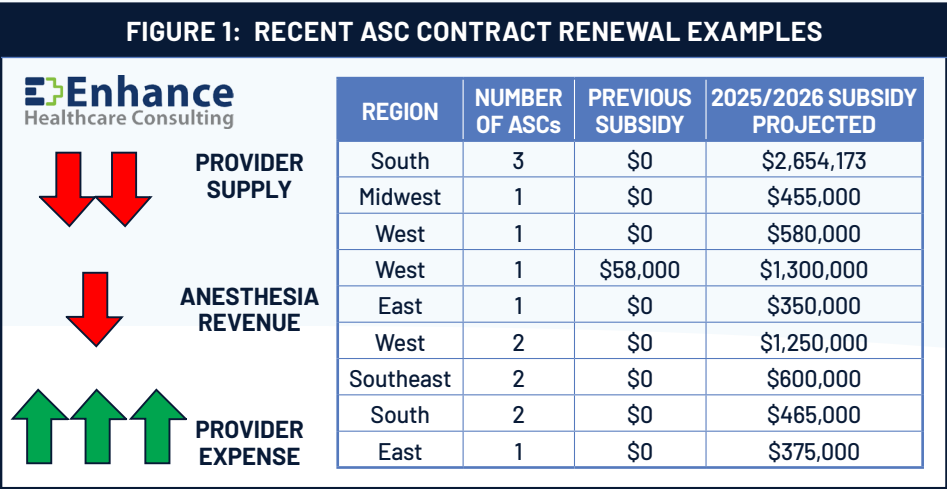
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increase in compensation, far outstripping the rate of wage and cost inflation in other areas of the economy. Thus, more anesthesia revenue is required to support fair market value compensation for anesthesiologists, CRNAs, and AAs at each center. 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

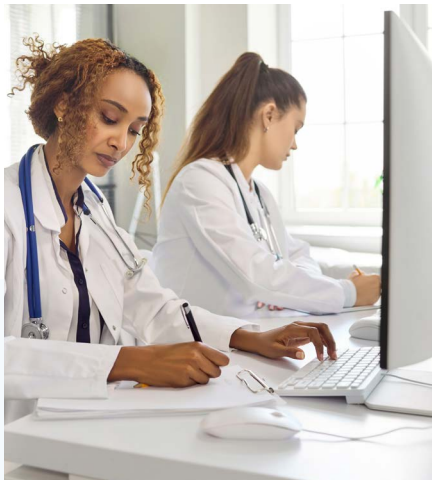
performed in hospitals, have moved in large numbers to surgery centers. The “inpatient only” list of surgical procedures is being reduced each year significantly and is planned to be phased out by 2028. The result is an ongoing migration of complex cases in orthopedics, neurosurgery, cardiology, and 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 anesthesiologists 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

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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!



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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

Choosing the Right Anesthesia Compensation System: A Strategic Framework for Independent Physician Groups

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INTRODUCTION

Few decisions have a greater impact on an anesthesia practice than its physician compensation system. While reimbursement, staffing, hospital contracts, and operating room efficiency often dominate strategic discussions, the compensation model quietly influences nearly every aspect of a group's performance. It shapes physician behavior, affects recruitment and retention, determines perceptions of fairness, and ultimately defines the culture of the organization.

Yet compensation discussions are frequently among the most difficult conversations physician groups have. They involve deeply held beliefs about equity, professionalism, productivity, and the value of different types of work. Senior partners may prioritize stability and shared responsibility, while younger physicians often seek transparency, predictable income, and recognition for individual effort. Hospital expectations continue to evolve, demanding broader physician engagement in quality improvement, perioperative leadership, and operational performance. Meanwhile, declining reimbursement and increasing labor costs require groups to carefully manage increasingly limited financial resources.

Against this backdrop, many anesthesia groups ask a deceptively simple question: "What is the best compensation model?"

The reality is that no universally superior model exists. Every compensation system rewards certain behaviors while discouraging others. There are quite a few compensation systems, but they can be categorized into 3 main methodologies.

1. Equal Share Compensation
2. Productivity Based Compensation
3. Hybrid Compensation Model

Equal share systems foster collaboration but may frustrate exceptionally productive physicians. Productivity-based models encourage efficiency but can unintentionally discourage teamwork. Hybrid systems attempt to balance competing priorities but introduce greater complexity.

The most successful physician groups recognize that compensation is not simply an accounting exercise. It is a strategic management tool.

A well-designed compensation system should accomplish several objectives simultaneously:

- » Promote behaviors that advance the group's mission.



- » Provide fair recognition of clinical and non-clinical contributions.
- » Support financial sustainability.
- » Strengthen physician engagement and retention.
- » Enhance recruitment competitiveness.
- » Align physician incentives with hospital and patient needs.

When viewed through this broader lens, compensation becomes less about dividing income and more about building an organization capable of succeeding in an increasingly complex healthcare environment.

This paper reviews the principal physician compensation models used in independent anesthesia practices, examines the incentives each creates, discusses common implementation challenges, and offers a structured

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framework for selecting or redesigning a compensation system that aligns with an organization's long-term strategic goals.

COMPENSATION MATTERS MORE THAN MOST GROUPS REALIZE

Compensation systems communicate organizational priorities more clearly than mission statements.

Every payment methodology answers an implicit question: "What does this group truly value?"

If physicians are compensated solely on productivity, the organization signals that clinical production is the highest priority. If all partners receive identical compensation regardless of workload, the message becomes one of shared responsibility and collective success. When leadership activities, committee work, teaching, quality improvement, or mentoring receive explicit recognition, physicians understand that these contributions are essential to the organization's mission rather than optional volunteer activities.

Over time, physicians naturally adjust their behavior to align with these incentives. This phenomenon is not unique to medicine; it reflects a fundamental principle of organizational behavior. People tend to devote greater effort to activities that are measured and rewarded, while responsibilities that receive little recognition often become secondary priorities.



For anesthesia practices, this dynamic is particularly important because physicians contribute value in many different ways. Clinical production remains the economic engine of the practice, but the organization's long-term success also depends on numerous activities that generate little or no direct revenue. Examples include scheduling optimization, quality improvement initiatives, mentoring new physicians, recruiting candidates, negotiating with hospitals, and participating in administrative leadership.

If these activities are consistently undervalued, they often become concentrated among a small group of physicians, increasing the risk of burnout and leadership succession challenges. Conversely, if compensation places insufficient emphasis on clinical productivity, highly productive physicians may perceive the system as inequitable and reduce discretionary effort or seek opportunities elsewhere.

An effective compensation system therefore seeks balance rather than perfection. It recognizes that physician contributions are multidimensional and that organizational success depends

upon rewarding a portfolio of behaviors rather than a single performance metric.

THE STRATEGIC OBJECTIVES OF PHYSICIAN COMPENSATION

Before evaluating specific compensation formulas, physician groups should first establish the strategic objectives the system is intended to achieve.

Although every organization has unique priorities, most compensation systems seek to advance five broad goals.

1. Financial Sustainability

The compensation model must be economically viable under a variety of reimbursement scenarios. A system that performs well during periods of strong hospital support may become unsustainable if subsidies decline or payer mix changes. Compensation design should therefore account for the long-term financial health of the organization rather than simply maximizing current physician income.

2. Fairness

Fairness does not necessarily mean equality.

Rather, physicians generally perceive compensation as fair when differences in income correspond to meaningful differences in contribution, responsibility, or workload. Transparency in how compensation decisions are made is often as important as the absolute dollar amounts involved. Groups that clearly articulate the rationale

behind compensation decisions tend to experience greater trust and fewer internal conflicts.

3. Behavioral Alignment

Every compensation model creates incentives.

The critical question is whether those incentives support the organization's strategic goals. Groups should intentionally reward behaviors that improve patient care, operational performance, physician engagement, and long-term organizational health rather than relying on assumptions that these behaviors will occur voluntarily.

4. Recruitment and Retention

The labor market for anesthesiologists has changed dramatically over the past decade. Candidates increasingly compare compensation models in addition to salary levels. Predictability, transparency, work-life balance, and perceived fairness often influence recruiting success as much as compensation itself. A model that consistently frustrates new physicians may undermine recruitment regardless of income levels.

5. Organizational Culture

Culture develops through repeated organizational decisions, and

compensation is among the most visible of those decisions.

Groups that emphasize collective responsibility frequently adopt compensation systems that minimize income disparities. Organizations seeking entrepreneurial growth may intentionally reward innovation and individual productivity. Neither philosophy is inherently superior, but compensation should reinforce rather than contradict the culture leadership hopes to create.

DESIGNING COMPENSATION AROUND ORGANIZATIONAL STRATEGY

A common mistake is to begin compensation redesign by debating formulas.

Should physicians be paid according to ASA units? Clinical hours? Collections? Equal shares?

These questions, while important, are secondary.

The more important discussion concerns organizational strategy.

Imagine two independent anesthesia groups of similar size.

The first group enjoys a long-standing exclusive hospital contract, stable physician staffing, and relatively consistent clinical assignments. Leadership views teamwork and long-term stability as its greatest competitive advantages. For this organization, an equal-share or lightly modified equal-share system may reinforce the behaviors that have already contributed to its success.

The second group operates across multiple hospitals and ambulatory surgery centers with highly variable case complexity, significant subspecialization, and frequent physician recruitment challenges. Individual workloads differ substantially, leadership responsibilities are extensive, and operational flexibility is essential. A hybrid compensation model that explicitly recognizes productivity, leadership, call burden, and quality initiatives may better support this organization's strategic needs.

Both groups may achieve excellent outcomes despite using very different compensation methodologies because each system aligns with its underlying organizational strategy.

The lesson is straightforward: compensation models should be selected to support the practice the group wishes to become, not merely to reflect the practice it has historically been.



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Solving the Mystery of Billing for CPT® 01996

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Before access to the internet was readily available, I remember reaching out to the American Society of Anesthesiologists® (ASA) regarding documentation requirements for CPT® 01996. Although the description of the code seemed straightforward enough, as “Daily hospital management of epidural or subarachnoid continuous drug administration,” the code description is not a clear requirement of what management means, what the service entails, or what type of documentation is expected to report a code for “daily hospital management.” Interestingly enough, the ASA did not have any documentation requirements and, as we discussed, physicians are responsible for determining their own documentation. Of course, this includes non-physicians, such as Certified Registered Nurse Anesthetists (CRNAs), Advanced Registered Nurse Practitioners (ARNPs), Certified Anesthesia Assistants (CAAs), or other anesthesia physician extenders as long as the state laws, facility’s Delineation of Privileges, and malpractice coverage allows. If these issues are addressed, physician extenders are described many different ways — as Qualified Healthcare Professionals (QHP), qualified nonphysician anesthetists, or qualified Non-Physician Practitioners (NPPs), which will be used for this article as the acronyms are numerous and not all inclusive!

Documentation requirements and billing regulations are not typically part of the training received in medical school, so my best advice is to be available to your coder or coders and to document the

“Five ‘W’s”: Who, What, When, Where, and Why explained as follows:

Who provided the service? When there is more than one anesthesia provider in a group, in order to bill the service one must know **who** performed the service. It is also important to understand that by virtue of signing the documentation, the physician or NPP is attesting to the fact that everything contained in their signed documentation accurately describes and supports the service provided.

What service was provided? The “**what**” is a coder’s clue for how medical services will be reported. Keep in mind that most coders do not have clinical backgrounds and depend on documentation to guide the way. For this specific code, documentation must support daily *hospital* management of epidural or subarachnoid *continuous* drug administration. As patients may be sent home with an acute pain catheter, 01996 is automatically excluded as the patient is no longer in the hospital. This procedure is also limited to *epidural* and *subarachnoid* continuous catheters. As described by the New York School of Regional Anesthesia® (NYSORA), “Before administering medications through the epidural catheter, subarachnoid, intravascular, and subdural placement should be ruled out” and coders may see terms such as “continuous catheter” or “bolus” or “test dose” in the documentation for the initial catheter. According to the Cleveland Clinic, epidural catheters are



placed in the epidural space (between the dura mater of the spinal cord and bones of the vertebral column), whereas a subarachnoid catheter is placed on a deeper level (between the arachnoid mater and pia mater). Therefore, CPT® 01996 is not reported for daily hospital management of other types of continuous catheters, such as CPT® codes 64416 (brachial plexus), 64446 (sciatic), or 64448 (femoral). Being available or open to answering coder questions is a plus!

When was the service provided? According to Chapter 2 of the National Correct Coding Initiative (NCCI) Revision Date (Medicare): 1/1/2026, “Management of epidural or subarachnoid drug administration (CPT code 01996) is separately payable on dates of service after surgery but not on the date of surgery.” Documentation of the date and time supports **when** the patient was seen and confirms the patient was seen the following day and how much time spent with the patient. When time is documented during the visit, coders familiar with anesthesia coding rules understand the documented time should

not be overlapping with any concurrent anesthesia cases.

Where was the service provided?

Services must be provided in a hospital and CPT® 01996 cannot be reported until the day after surgery. These visits are usually performed in the patient's room, rather than an operating room (OR) or post anesthesia care unit (PACU). As most patients' rooms are not in the immediate area of the OR or PACU, anesthesiologists who are actively medically directing surgical anesthesia cases are not typically assigned to provide daily management care for these patients.

Why was the service provided? The NCCI, along with recommendations from the ASA, provide explanations to guide clinical staff to proper documentation for these services. The ASA's *Statement on Reporting Postoperative Pain Procedures in Conjunction with Anesthesia* describes conditions that apply to the initial catheter, without outlining documentation expectations for CPT® 01996. However, their recommendations for the initial catheter were updated in 2025 and indicate as follows:

"One method for describing that the primary purpose for the block is to provide post-operative analgesia is to dictate or record details about the procedure in a separate document in the medical record from the anesthetic record. When documenting, it is important to discuss that:

1. The surgeon requested the provision of postoperative analgesia by the anesthesiologists. Some payers may require the specific documentation of this request

by both the surgeon and/or the anesthesiologist.

2. The patient participated in the discussion regarding the most appropriate plan for post-operative analgesia.
3. Distinct informed consent must be performed for the planned postoperative pain management intervention, including providing the patient with specific information about the risks and benefits of the proposed therapy."

Having good initial documentation that follows the above ASA recommendations, along with the "Five W's" of Who, What, When, Where, and Why, are an excellent starting point. Your group may choose to create a template to help guide clinical staff toward these five areas of documentation, although one must use caution not to lead or direct the documentation. It is also a good idea to leave room on the form for comments or free-hand notes. While there are some areas of consistency, documentation must be specific to each patient encounter and, regardless of how many encounters with the patient on a daily basis, this code is limited to once per day. According to NCCI Chapter 2, "If the only service provided is management of epidural/subarachnoid drug administration, then an E&M service shall not be reported in addition to CPT code 01996. Payment for management of epidural/subarachnoid drug administration is limited to one unit of service per postoperative day regardless of the number of visits necessary to manage the catheter per postoperative day (CPT definition). While an anesthesiologist or nonmedically directed CRNA may be able to report this service, only one payment will be made

per day." While the NCCI only mentions an anesthesiologist or a "nonmedically directed CRNA," remember that state laws, facility privileges, malpractice insurers, and payers may also allow NPPs to provide these services.

Additional questions often asked are "how many days can we bill" and "can we bill the day the catheter is removed?" These questions lead us back to the code itself and coders and billers should be aware there are limitations which are usually defined by payer policies to determine how many days are covered. When the catheter is placed, there is an expectation that it will also be removed, which is typically included in the work value of the code. There may be exceptions, depending on the documentation and circumstances. The number of days will depend on how the patient is responding to the treatment and what treatment is medically necessary for each particular patient. Reporting CPT® 01996 may be limited to a specific number of days, without an appeal or determination of medical necessity. For example, Asuris Northwest Health limits coverage to three days by policy although good documentation may allow one to exceed their policy limits. Knowing where resources are located and providing them to your clinical staff is half the battle! The other half is reviewing the documentation from time to time to ensure payers would consider these services are well documented and accurately represent the service provided.

Much of this important information and more is published and available on CMS Anesthesiologist Information Center, last updated July 1, 2026.

Solving the Mystery of Billing for CPT® 01996

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If you are not familiar with this resource, a link is provided. There is also a link to *Documentation and Resources 080426*, my YouTube video providing documentation resources for anesthesia and pain management. Checklists are provided by Novitas and Noridian, although the requirements are not exclusive to 01996, and Coronis shares the following documentation requirements with their clients.

Documentation requirements supporting 01996:

- »» Details regarding the patient's level of pain and subsequent relief

- »» Medication plan
- »» Exam of placement site
- »» Any side effects
- »» Catheter status — (example if being removed during that visit— a note such as "catheter removed", "catheter removed tip intact", etc. Should be present. If the catheter is not being removed during visit — a note in the plan such as "continue catheter", "continue epidural", etc. should be present)
- »» Provider signature
- »» Date of service

Armed with these resources, your clinical staff has solid guidance for documentation to support 01996.

Resources:

American Society of Anesthesiologists (October 15, 2025) *Statement on Reporting Postoperative Pain Procedures in Conjunction with Anesthesia*
<https://www.asahq.org/standards-and-practice-parameters/statement-on-reporting-postoperative-pain-procedures-in-conjunction-with-anesthesia>

Asuris Northwest Health (March 2026) *Anesthesia Reimbursement & Services Reporting, Policy No: 102*
<https://www.asuris.com/provider/library/policies-guidelines/reimbursement-policy/anesthesia-reimbursement-services-reporting>

Centers for Medicare and Medicaid Services (2026) *Chapter 2, NCCI Medicare Policy Manual*
<https://www.cms.gov/files/document/02-chapter2-ncci-medicare-policy-manual-2026-final.pdf>

Centers for Medicare and Medicaid Services, *Chapter 12, Medicare Claims Processing Manual*
<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf>

Cleveland Clinic (January 2022) *Meninges (Medically Reviewed)*
<https://my.clevelandclinic.org/health/articles/22266-meninges>

Kelly's Anesthesia tips, (August 2026) *Documentation and Resources 080426*
<https://youtu.be/1G8xcCXV014>

New York School of Regional Anesthesia. *Epidural Anesthesia and Analgesia*
<https://www.nysora.com/topics/abdomen/epidural-anesthesia-analgesia/>



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Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPMA, CPC, CPC-I, has over 41 years of experience in anesthesia coding and billing and has been speaking about anesthesia issues nationally since 2002. She has a master's degree in business administration, is a certified auditor, coder and instructor through the American Academy of Professional Coders. Kelly is an advanced coding specialist through the Board of Medical Specialty and served as

lead advisor for their anesthesia board. Kelly also serves as a practice management and reimbursement consultant for the American Society of Anesthesiologists. She is a certified health care auditor and has owned her own consulting company, specializing in anesthesia, Perfect Office Solutions, Inc., since November 2001. She can be reached at kelly@perfectofficesolutions.com www.perfectofficesolutions.com

THE GREAT SURGICAL MIGRATION: How Distributed Surgical Networks Will Redefine Anesthesia

BY KENDALL R. LUTZ

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For most of modern medicine, surgery has revolved around the hospital.

The operating rooms were there. The equipment was there. The specialists were there. And anesthesia practices were built around that infrastructure.

That model is already changing.

Surgical care is steadily migrating beyond the traditional hospital operating room into ambulatory surgery centers (ASCs), hospital outpatient departments, specialty procedural facilities and office-based surgical suites. Procedures that once required the resources of a hospital are increasingly being performed safely and efficiently in lower-cost settings.

But describing this simply as the growth of ASCs misses the larger transformation.

What is emerging is a **Distributed Surgical Network**: an interconnected system of hospitals, ASCs and specialized procedural facilities in which cases are directed to the setting best suited to their clinical complexity, resource requirements and economics.

By 2035, the question may no longer be whether a case belongs in a hospital or an ASC.

The question will be: **Where within the surgical network should this patient be treated?**

And wherever surgery goes, anesthesia must go with it.



THE HOSPITAL BECOMES THE HIGH-ACUITY HUB

The Great Surgical Migration does not mean the disappearance of hospitals. It means their role changes.

Hospitals will increasingly concentrate on the patients and procedures that truly require hospital-level resources: trauma, major emergencies, highly acute patients, intensive-care-dependent procedures, complex surgery and cases requiring extensive multidisciplinary support.

Meanwhile, procedures that can safely migrate outward will continue to do so.

Advances in minimally invasive surgery, regional anesthesia, multimodal pain management, surgical technology and postoperative monitoring have steadily expanded the range of patients and procedures appropriate for outpatient care.

There is also a powerful economic incentive.

ASCs generally operate with lower facility costs and less infrastructure than hospitals. Medicare, commercial insurers, employers and health systems therefore have compelling reasons to direct appropriate surgical volume toward lower-cost sites of service.

The result will not simply be more ASCs.

It will be a **redistribution of surgical volume and acuity across an increasingly diverse network of facilities.**

WHEN CARDIAC CASES MOVE, THE BOUNDARIES HAVE CHANGED

Perhaps nothing demonstrates the potential extent of this migration better than cardiovascular care.

Cardiac catheterization and electrophysiology procedures have already expanded beyond the traditional hospital environment, while advances in technology, patient selection and clinical protocols continue to push the outpatient boundary.

That should command the attention of anesthesia leaders.

Cardiac anesthesia has historically been among the services most closely associated with the hospital. If increasingly complex cardiovascular

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THE GREAT SURGICAL MIGRATION

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procedures can move into specialized outpatient environments, the specialties driving ASC growth tomorrow may look very different from those that built the ASC industry yesterday.

Orthopedics, GI and ophthalmology helped establish the ASC model.

The next phase could involve increasingly complex spine, cardiovascular and other higher-acuity procedures that would have been difficult to imagine outside a hospital not long ago.

The question is no longer whether surgical migration will continue.

It is **how far it can go**.

NOT EVERYTHING WILL MIGRATE

There are obvious limits.

Obstetric anesthesia is perhaps the clearest example.

Babies do not schedule themselves for Tuesday at 9:30.

Labor and delivery require around-the-clock anesthesia availability, immediate emergency response and access to hospital resources for both maternal and neonatal complications.

Trauma, transplant, emergency surgery and many highly complex procedures will similarly remain hospital-centered.

The future, therefore, is not outpatient surgery replacing hospital surgery.

It is a **redistribution of surgical acuity**.

The hospital becomes the high-acuity

anchor of a much larger surgical ecosystem.

THE DISTRIBUTED SURGICAL NETWORK

Consider what a health system might look like in 2035.

Its flagship hospital handles trauma, complex cardiac surgery, high-risk obstetrics and its sickest patients.

Several ASCs perform orthopedics, spine, general surgery, ophthalmology, GI and urology.

A cardiovascular facility performs selected cardiac and electrophysiology procedures.

Other specialty centers handle pain management, interventional radiology and additional procedural services.

Office-based suites perform dental, plastic surgery and other appropriate procedures.

Patients move throughout this network according to clinical need, available resources and cost rather than automatically being routed to the hospital because that is where surgery has traditionally occurred.

These sites may have different addresses, operating structures and reimbursement models.

Operationally, however, they increasingly function as **one surgical enterprise**.

That is the Distributed Surgical Network.

And it creates a fundamentally different challenge for anesthesia.

ANESTHESIA MUST BECOME A NETWORK, TOO

The traditional anesthesia practice was often built around one primary hospital contract.

The anesthesia organization of the future may need to cover an entire surgical network.

The same organization could be responsible for anesthesia at a tertiary hospital, several ASCs, an endoscopy center, a cardiovascular facility and multiple office-based locations.



That creates challenges that simply do not exist when the practice revolves around one hospital.

Credentialing must work across facilities. Staffing must respond to surgical demand across locations, providers must have the appropriate privileges and competencies for different sites and case types and quality metrics must follow providers and patients across settings.

Scheduling must account not only for how many operating rooms are running, but **where they are running**.

A provider shortage at one ASC may exist at the same moment another location finishes early. A hospital may have

unused anesthesia capacity while an affiliated outpatient facility struggles to open another room.

Managing those locations independently wastes one of the most scarce resources in perioperative medicine: anesthesia capacity.

The successful anesthesia organization of the future will therefore have to think less like a hospital department and more like an **enterprise perioperative organization**.

THE ECONOMICS MUST MIGRATE WITH THE CASES

There is another complication. Moving a surgical case does not simply move the patient. It changes the economics surrounding the case.

A procedure performed at a hospital may generate a very different reimbursement profile when performed at an ASC or office-based facility. Facility reimbursement changes. Staffing requirements may change. Payer mix, case duration, medical-direction models and operating costs all affect the economics of providing anesthesia.

And this creates an important disconnect.

Payers and health systems can realize substantial savings when appropriate procedures migrate from higher-cost hospital settings into ASCs.

But the anesthesia required to make that migration possible does not automatically share in those savings.

In many cases, anesthesia continues to be reimbursed under the same underlying professional payment methodology even though the anesthesia organization is being asked to support an increasingly fragmented and operationally complex network.

That should become part of the contracting conversation.

If moving cases into an ASC reduces the total cost of care for a commercial payer, there is a legitimate economic argument for recognizing the anesthesia infrastructure necessary to make that lower-cost site of service work.

The value of anesthesia in this environment is not limited to administering an anesthetic.

It includes maintaining the provider capacity that allows cases to migrate safely in the first place.

FROM REVENUE CYCLE TO ENTERPRISE INTELLIGENCE

This transformation also changes the value of anesthesia revenue-cycle data. Traditional revenue-cycle management asks important questions:

- >>> Did we capture the case?
- >>> Was it coded correctly?
- >>> Did we bill it correctly?
- >>> Did the payer reimburse it appropriately?

Those questions remain essential. But a Distributed Surgical Network requires another layer of intelligence.

- >>> Where are cases moving?
- >>> Which facilities are growing?
- >>> Which service lines are profitable?
- >>> Where is anesthesia capacity being underutilized?
- >>> Which payer contracts make certain sites economically viable?
- >>> Where are staffing costs increasing faster than reimbursement?
- >>> Could surgical volume be shifted to another location without compromising patient care?
- >>> At that point, revenue-cycle data stops being simply billing data.

It becomes **enterprise intelligence**.

Anesthesia organizations and their management partners sit on an extraordinary amount of information about surgical volume, payer behavior, procedure mix, operating-room utilization, staffing and reimbursement.

The opportunity is to connect those data points and use them to help manage the surgical enterprise itself.

TECHNOLOGY BECOMES THE COORDINATION LAYER

A Distributed Surgical Network becomes increasingly difficult to manage using spreadsheets, phone calls and historical reports.

Predictive analytics and artificial intelligence will eventually become part of the coordination layer.

Imagine an anesthesia leadership team able to see tomorrow's surgical schedule across an entire health system.

It can identify where rooms are likely to run late. It can anticipate staffing gaps.

It knows which providers are credentialed at each location. It can recognize cancellation patterns.

It can compare staffing costs with expected reimbursement. It can identify unused anesthesia capacity elsewhere in the network.

Eventually, systems may recommend where providers should be deployed, where additional rooms can be opened and where surgical volume could be shifted to improve throughput.

The anesthesia organization is no longer simply reacting to tomorrow's schedule. It is helping **optimize the network**.

THE GREAT SURGICAL MIGRATION

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A DIFFERENT VALUE PROPOSITION FOR ANESTHESIA

For decades, one of the most consequential questions for an anesthesia practice was:

Who has the anesthesia contract at the hospital? The Great Surgical Migration changes the question.

As surgical volume becomes distributed across multiple settings, health systems will increasingly need anesthesia partners capable of supporting the entire continuum.

The more important question may become: **Who can manage anesthesia across our entire surgical network?** That represents a significant change in the value proposition.

Anesthesia is uniquely positioned for this role because it touches nearly every procedural specialty and nearly every

surgical location. Few other clinical services have such broad visibility across the perioperative enterprise.

The organizations that can combine clinical coverage, staffing, revenue-cycle expertise, operational data and predictive analytics may become something much more valuable than anesthesia vendors.

They can become strategic partners in managing surgical capacity.

THE GREAT SURGICAL MIGRATION HAS ALREADY BEGUN

By 2035, one of the defining changes in surgery may not be a new robot, a new drug or even a new procedure. It may be **where surgery happens**.

Cases will continue moving toward the safest, most efficient and most economical setting capable of performing them.

Hospitals will increasingly concentrate on acuity.

ASCs and specialized procedural facilities will absorb more surgical volume.

And health systems will begin thinking less about individual facilities and more about the performance of the **Distributed Surgical Network** connecting them.

For anesthesia organizations, following surgical volume will not be enough.

The opportunity is to help determine where that volume should go, how anesthesia resources should be deployed and how the entire network can operate more efficiently.

The anesthesia organizations that recognize this shift early will not simply survive the Great Surgical Migration.

They will help build the infrastructure that makes it possible.



KENDALL R. LUTZ

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Friendly PC Models: Now Is the Time for a Thoughtful Compliance Review

BY KATE HICKNER

Partner, Taft Stettinius & Hollister LLP, Cleveland, OH

Friendly professional corporation (PC) models continue to proliferate. This is especially true with the increasing prevalence of healthcare private equity acquisitions and the rapid expansion of the cash-based telehealth industry. You may have also heard these models referred to as “friendly physician,” “captive PC” or “management services organization (MSO)” models.

Friendly PC models are used to permit non-physicians to indirectly invest in physician practices when the state law prohibits non-physicians from directly investing. In general, a friendly physician model involves a professional entity that is owned by one or more licensed physicians, and an MSO, owned in whole, or in part, by nonphysicians.

Friendly PC models exist as a result of the patchwork of corporate practice of medicine (CPOM) requirements across the country. In most CPOM states, non-physicians may not own an entity that employs or contracts with physicians to provide professional medical services. In these states, the entity that provides professional medical services generally must be owned and controlled by licensed physicians.

The CPOM doctrine is intended to protect the independent medical judgment of physicians—and, with it, the sanctity of the physician-patient relationship. Many argue that doing so is in the best interest of both patients and licensed professionals. Others

argue that the requirements are antiquated and fail to account for the realities of today’s healthcare delivery environment.

States have adopted a wide variety of approaches to their respective CPOM laws. Many CPOM states require that physician-owned entities providing professional medical services be organized as professional entities that satisfy state-specific organizational requirements. Other states require that agreements between MSOs and the entities providing professional medical services include—or omit—specific terms. Some states actively enforce their CPOM requirements; others are less stringent. The states whose laws apply generally include those where the entities are organized, where the providers are licensed and where the patients are located. Compliance therefore must be assessed on a state-by-state basis.

Each friendly PC model must be structured in a manner that is defensible under all applicable laws, including the federal and state anti-kickback prohibitions, state fee-splitting laws and state corporate practice of medicine requirements. Failure to comply can result in corporate and individual criminal and civil liability, fines and penalties, rescission of contracts, overpayment liability, loss of licensure and other adverse consequences, depending on the states at issue and the underlying circumstances. For these reasons, friendly PC models often focus on corporate separateness, the proper flow of funds, permissible compensation methodologies,



the way the business is held out to patients and the public more generally, robust management or administrative services agreements, a determination that the fees paid to the MSO are within the range of fair market value, and other safeguards.

The model also needs to be reevaluated from a compliance perspective frequently, as states continue to promulgate and revise CPOM requirements and related guidance. That is especially true in Oregon and California, both of which have recently enacted legislation bolstering their corporate practice of medicine requirements and tightening restrictions on friendly PC structures.

Oregon’s Senate Bill 951, enacted in 2025 and amended by House Bill 3410, adds significant restrictions for MSOs and the professional entities they manage. Its MSO ownership, control and governance restrictions apply beginning January 1, 2026, to arrangements formed on or after June 9, 2025, and beginning January 1, 2029, to preexisting arrangements. Among other requirements, the law imposes

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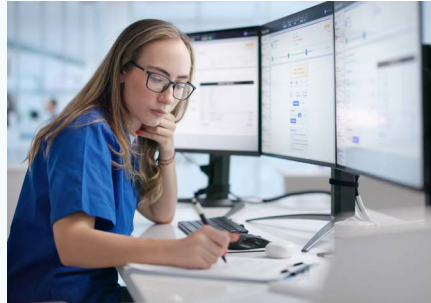
Friendly PC Models

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detailed and nuanced restrictions on the ownership, control and governance of the MSOs and professional entities involved in friendly PC models, including a prohibition on “de facto control” over hiring and termination, staffing levels, compensation, clinical standards, billing policies, advertising, pricing and third-party payer contracting. It also imposes limitations upon restrictive covenants such as noncompete, nondisclosure and non-disparagement agreements.

The law and guidance in California are also developing quickly. In *Art Center Holdings, Inc. v. WCE CA Art, LLC*, a California trial court held that the continuity agreement in that case, which permitted the MSO to have wide discretion to cause the transfer of physician ownership of the professional entity to another licensed individual, was a violation of the California CPOM doctrine. Briefly stated, because the physician could be removed at any time, he had no real independence and was required to defer to the MSO in order to retain his position. The case is currently on appeal before the California Court of Appeal. The appeal warrants close attention.

The California Attorney General has also entered settlements during 2026 that provide guidance to friendly PCs that are or will be subject to California law. During May 2026, the Attorney General announced a settlement with Aspen Dental Management, Inc. resolving corporate practice of dentistry claims. Aspen agreed to pay \$2 million in civil penalties and \$300,000 in patient restitution. The terms bar the MSO from replacing practice owners with another of the MSO's choosing; from owning the property of the dental practice; from setting management fees based on practice revenue, sales or profits; and from enforcing noncompete



provisions restricting where clinicians may work. Aspen must also register with the Dental Board of California as an advertising and referral service and identify the practice owner in its advertising. During June 2026, the California Attorney General announced a settlement with Carbon Health Technologies, Inc., its affiliated medical groups and its co-founder and former chief executive officer. Carbon Health agreed to pay \$4.4 million in penalties, Mr. Bali agreed to pay \$100,000, and the company agreed to restructure so that the MSO no longer controls clinical decision making. Based upon the settlement, it is clear that the California Attorney General does not believe that any of the following should be present in a friendly PC model: (a) the MSO serving as the exclusive lender to the PC, (b) the MSO having the power to unilaterally remove the physician owner at any time, (c) management agreements giving the MSO complete authority over hiring, firing, advertising, billing and other key activities, or (d) having the MSO or non-licensed individuals involved in clinical matters.

Separately, hedge funds and private equity groups need to be cognizant of two new California laws. California Senate Bill 351 took effect on January 1, 2026. It codifies core CPOM principles and expressly restricts private equity groups and hedge funds that manage physician and dental practices from interfering with clinical

decision-making. A companion law, Assembly Bill 1415, also effective January 1, 2026, extends healthcare transaction reporting obligations to private equity groups, hedge funds and management services organizations.

Given the changing regulatory requirements and enforcement environment, now is the time for every friendly PC model to reevaluate its compliance with applicable state law. The following areas deserve particular attention:

- » **Confirm Corporate Separateness.** Friendly PC models should review their corporate organizational chart, the flow of funds within the structure and the relationships among the entities, licensed professionals and patients to confirm that the model is operating as intended. Corporate organizational charts and schematics are very helpful for purposes of these discussions. If the legitimacy of the structure were questioned, would the MSO's and the professional entity's bank accounts, bookkeeping, financials and tax returns be consistent with the CPOM requirements and the governing agreements? Are vendor agreements signed by the correct entities? Are the signatories to those agreements authorized to sign on behalf of the entity?
- » **Meaningful Independence.** In CPOM states, physicians must have meaningful independence and control over the professional entity and the provision of professional services. The focus is on substance over form. The parties should review governing documents, continuity planning agreements, management and administrative

services agreements, employment or professional services agreements and standard operating procedures. Does the physician owner control the hiring and firing of clinical staff, the medical records, clinical protocols and policies, payor contracting, coding and billing, the purchase of equipment and the selection of vendors involved in clinical services? If the physician owner's independence, control and involvement are challenged in the future, how would the MSO and the PC defend the arrangement? Has the organization developed and maintained written documentation evidencing that the physician has been involved in such clinical decisions?

- »» **Defensible Continuity Planning Agreements.** The review should carefully consider the applicable continuity planning agreement under applicable state law. In California, for example, a continuity planning agreement should not permit the MSO to unilaterally remove the physician owner at any time. One approach is a friendly PC structure with multiple physician owners, which ensures continuity upon a physician's departure. Another is to permit the MSO to require a transfer of the physician's ownership only upon certain defined events—for example, retirement, death or disability, loss of professional license, excluded provider status or

bankruptcy—which provisions are generally more defensible.

- »» **Clear and Correct Messaging.** The friendly PC model should review websites, online postings, marketing materials, patient intake forms and terms and conditions to ensure that its communications are consistent with the friendly PC structure. Do both internal and external communications make clear that professional services are provided by the professional entity itself and not by the MSO? Patients should understand which entity is providing their care.
- »» **Obtain Valuation of Management Fee.** Under federal and state fee-splitting, kickback and self-referral laws, it is generally imperative that compensation paid by the professional entity to the MSO be commercially reasonable and within the range of fair market value (as defined in the federal healthcare programs). An outside valuation from an independent, qualified and experienced healthcare valuation consultant is typically not required, but obtaining one is highly recommended, as it can significantly mitigate risk. If a friendly PC model has not obtained an outside valuation of the compensation under its management agreement, how has the organization made a reasonable, good faith determination of fair market value internally? Did it use market comparables, historical financials or budgets during the review? In the event of a challenge,

how will the parties demonstrate good intent? Has the issue of fair market value been reviewed each year on a prospective basis, and was sufficient documentation of that process placed in the file?

- »» **Confirm Permissibility of Compensation Methodology.** It does not work for the MSO to simply sweep the account of the professional entity. The compensation methodology for determining the fee paid to the MSO must be defensible under federal and state law. Percentage-based fees often engender risk and, in some states, are treated as impermissible fee splitting; New York, for example, generally treats compensation measured as a percentage of practice revenue as prohibited fee splitting. In general, a flat fee or cost-plus structure set in advance and changed not more than once a year is the better approach.
- »» **Stay Current.** The law in this area continues to develop, and it is imperative to stay abreast of current developments. Each friendly PC model should be regularly reviewed for compliance with state CPOM requirements. It is a good idea to meet with your healthcare attorney periodically as part of your annual compliance review to discuss changes in the law, the current state of your organization's compliance and ways to mitigate legal risk. What is the best way for your compliance officer and leadership team to stay current?



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Hazards On The Horizon: Reviewing The Emerging Threats To Anesthesia Practices

BY JUSTIN VAUGHN, MDIV

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It is a very real risk. Aging landmines from a bygone era dot the fields, jungles and deserts of a thousand battlefields, now silent. While dormant and undetected—and lying just beneath the surface—they are by no means inert. Uncounted years after their covert concealment, innocent passersby continue to step on these hidden hazards, losing limbs and lives in the process.

One never knows what lies out there a little farther down the road. It helps, however, to get the assessment of an assembly of experts in any given field of inquiry. When it comes to emerging threats facing the practice of anesthesia, *Becker's ASC Review* recently sought out the expertise of those who actually practice within the specialty, getting their insights on possible future threats. From their interviews, one can piece together a picture of what may be facing anesthesia groups in the days ahead.

FLAGGING REIMBURSEMENT

Mo Azam, MD, head of innovation at U.S. Anesthesia Partners in Dallas, maintains that one of the biggest threats to anesthesia stability is similar to that facing the rest of the healthcare industry; and, here, we're talking about appropriate reimbursement. And who within the medical community can argue with that sentiment? He argues that Medicare payments for anesthesia "have

effectively remained flat for decades when adjusted for inflation, leaving many practices providing services below the cost of care." He further asserts that "Medicare is stuck where it was 30 years ago, on an inflation-adjusted basis."

In support of this argument, one need look no further than the most recent 2027 Medicare Physician Fee Schedule proposed rule, which outlines, among other things, reimbursement rates that the Centers for Medicare & Medicaid Services has planned for the coming year. In that proposed rule, both the anesthesia conversion factor and the non-anesthesia (RBRVS) conversion factor have been reduced from the 2026 rates. Congress may step in, as they occasionally have in the past, to mitigate the cuts; but, there is no guarantee.

There is good reason, then, for the genuine concern now being expressed among many in the specialty concerning the long-term financial stability and viability of the average anesthesia practice. There are many contributors to this concern, in addition to conversion rate volatility and the already meager reimbursement rates for federal health plans. Groups must also contend with new pitfalls presented by commercial payers, as well as the looming provider shortage crisis. These very real hazards to healthcare providers are further examined below.

PAYER TACTICS

Commercial health plans are our friends. They are our comrades in arms and only want what's best for providers and patients alike. If this were only true. Sadly, there is a growing inventory of evidence that this is not the case—at least where it concerns a handful of premier payers.

Antonio Hernandez Conte, MD, Past-President of the California Society of Anesthesiologists has said that "the escalating aggressive behavior by health insurance carriers to place profits over patient care is a serious threat to access." He asserts that the latest tactic is to financially penalize hospitals and ASCs that do not use physicians who participate on "in-network" panels. "This tactic is designed to force physicians to sign in-network contracts that are meant to lower physician reimbursement."

Dr. Conte notes that "the resultant effect for anesthesia practices is that hospitals will be forced to provide additional revenue to anesthesiologists to make up for the deteriorating third-party payer reimbursement, which does not match market costs for anesthesia services."

That's a problem. When given the choice to either participate with a payer or lose your contract with the facility, many

anesthesia groups will find themselves between the proverbial rock and hard place.

PROVIDER SHORTAGES

Many anesthesia groups and anesthesia departments have been feeling the pinch for some time now when it comes to adequate staffing. The ability to recruit and retain anesthesiologists and anesthesiologists is becoming more difficult as the Medicare and overall population grow and the availability of these providers becomes limited. Dr. Azam, referenced above, holds that “on the workforce side, the threat is the lack of clinical training sites, stagnant slots and funding for graduate medical education.”

Adam Chaucer, CRNA, owner of Trident Anesthesia in the Dallas-Fort Worth area, echoed Dr. Azam’s concerns. He noted the following:

Demand for anesthesia services is rising due to factors such as an aging population, increased surgical volume and growth in outpatient procedures. At the same time, workforce shortages are expected as many providers near retirement, potentially creating a shortfall of thousands within the next five to 10 years. This combination could widen staffing gaps, delay surgeries and reduce available services.

In that same vein, Garo Derparseghian, MD, an anesthesiologist in Montebello, California, believes that the greatest threat to anesthesia stability is the thought that you can use software to dictate anesthesia staffing needs, based on what cases are scheduled, in advance. “Anesthesia requires continuous staffing and standby readiness, not case-by-case deployment. Combined with a permanent shift toward workforce predictability, underestimating the cost of reliable coverage leads to burnout, turnover and rising subsidy pressure.”

SEEKING SOLUTIONS

While the interviewees did not provide solutions to every problem outlined above, there were a few suggestions that addressed the recruiting/retaining problem in particular. For example, Dr. Azam’s practice has sought to ameliorate the provider shortage issue in their Dallas-area facilities through beefed-up training programs, as he outlines below:

My practice has approached this dilemma by implementing innovative solutions to train residents, CRNAs and CAAs. These include bold new collaborations with academic institutions and the formation of several of our own residency programs.

Jacob Schaff, MD, Division Chief of Cardiac Anesthesiology at White Plains Hospital in New York, believes that “departments that build differentiated employment tracks will retain talent. Those that don’t will continue losing providers to contract work, regardless of how high their baseline compensation is.” In other words, providing flexibility in work schedules should be part of the overall strategy for attracting and keeping valued anesthesia team members.

So, there is much work to be done to avoid the threats that lie ahead. Some possible solutions have already been identified; it will be up to the greater anesthesia community and their representatives to find and implement others. Pushing back on bad behavior by certain payers is one approach. Providers can work with their medical societies or contact their state insurance commissioner to apply pressure on commercial insurers to rescind onerous policies. Make your voices heard in the halls of Congress concerning untenable reimbursement rates for federal healthcare programs. These strategies have been successful in recent history.

With dedication and determination, these hazards can be removed—one landmine at a time.



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Professional Events

DATE	EVENT	LOCATION	CONTACT INFO
October 15-16, 2026	Society for Pediatric Anesthesia (SPA) 2026 Annual Meeting	Hilton San Diego Bayfront San Diego, CA	https://pedsanesthesia.org/exhibitor-information/annual-meeting/
October 16-20, 2026	ASA Annual 26: American Society of Anesthesiologists Annual Conference	San Diego Convention Center San Diego, CA	https://www.asahq.org/ annualmeeting
December 11-14, 2026	80th PostGraduate Assembly in Anesthesiology (PGA)	Marriott Marquis New York City, NY	https://www.nyssa-pga.org/ events/80th-postgraduate-assembly- in-anesthesiology-pga/
January 22-24, 2027	American Society of Anesthesiologists Advance 2027	Gaylord National Resort and Convention Center Washington D.C.	https://www.asahq.org/advance

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