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CMS WISeR Model: What Anesthesiologists and Compliance Leaders Need to Know in 2026

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The Centers for Medicare & Medicaid Services (CMS) is implementing the **Wasteful and Inappropriate Service Reduction (WISeR) Model**, a new Innovation Center demonstration that began January 1, 2026, and will run through December 31, 2031. The model introduces a technology-enabled prior authorization and pre-payment review process in original Medicare fee-for-service (FFS), targeting selected services with historically high variation or inappropriate utilization.

The WISeR model will certainly affect anesthesiology and pain practices. Under this new model, it means that pre-approval will be required for 14 procedures:

- Lumbar decompression
- Knee scopes
- Lesion of nerve tracts
- Vagus nerve stims
- Phrenic nerve stims
- Spinal cord stims
- Incontinence devices
- Sacral nerve stims
- Impotence procedures
- Kypho/vertebroplasty
- ESIs
- Cervical fusions
- Hypoglossal nerve stims
- Skin substitutes/wounds

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WISeR PRE-APPROVAL PROCESS

The WISeR pre-approval request has 27 data elements. Anesthesia providers must attest to meeting the local coverage determination (LCD)/ national coverage determination (NCD) requirements. Medicare will either issue an affirmation of the attestation or "non-affirmation" (i.e., denial) of the attestation. If a non-affirmation is issued, Medicare will explain why. The anesthesia provider can then resubmit a new attestation/request for pre-approval/affirmation.

If you don't get pre-approval, each claim will be manually audited before payment to verify that the surgeon met the LCD requirements. If the requirements are not met by the surgeon, payment will be denied for both the surgical procedure and the anesthesia procedure.

WISeR ANESTHESIA-SPECIFIC PROBLEM

As you can see, under the WISeR model, payment denial will be based on the surgeon/pain physician meeting LCD requirements. Anesthesia has no control over that. LCDs can be onerous with many requirements. To make matters worse, many of the surgeons probably will not even be aware of WISeR, which means the surgeon probably won't meet the LCD requirements, probably won't get preapproval, which would result in the denial of payment—both the surgeon's claim and the anesthesia provider's claim.

WHY WISeR MATTERS TO ANESTHESIOLOGISTS

While anesthesia professional services are not the primary target, WISeR directly affects **interventional pain and spine procedures** including:

- Epidural steroid injections
- Cervical fusion procedures
- Percutaneous vertebral augmentation
- Lumbar decompression services

These services already face high scrutiny under LCDs and targeted probe-and-educate (TPE) audits; WISeR effectively adds another compliance checkpoint upstream in the revenue cycle.

WHAT THE WISeR MODEL DOES

WISeR combines **AI-supported workflows with clinician oversight** to review requests for designated Medicare services and reduce unnecessary care. Key compliance-relevant design elements include: (1) Prior authorization or pre-payment review required for selected services in original Medicare; (2) AI-assisted review with human clinical validation required for adverse determinations; (3) No change to Medicare coverage policies or appeals rights, meaning traditional LCD/NCD standards still govern medical necessity; (4) Time-bound decisions generally within approximately 72 hours (48 hours expedited).

CMS emphasizes that the model is designed to improve efficiency rather than simply increase denials, with performance-based contractor payment tied to accuracy and timeliness.

WHERE IT APPLIES

CMS selected six states for initial implementation:

- New Jersey (Novitas MAC)
- Oklahoma (Novitas MAC)
- Texas (Novitas MAC)
- Arizona (Noridian MAC)
- Washington (Noridian MAC)
- Ohio (CGS MAC)

Although geographically limited, anesthesiology groups/providers with multi-state operations should anticipate workflow standardization across regions.

COMPLIANCE AND OPERATIONAL IMPLICATIONS

1. Documentation Standards Will Tighten
Expect more rigorous scrutiny of failed conservative therapy documentation,

imaging correlation, functional impairment evidence, and procedure specific LCD criteria alignment. Incomplete documentation will likely lead to delayed approvals, pre-payment review or denials.

2. Workflow Changes Across the Revenue Cycle
Compliance-focused practices should prepare for integrated clinical/RCM workflows, additional front-end staffing or automation, and appeals tracking for WISeR determinations. Because payment hinges on authorization outcomes, pre-service controls become essential.

3. AI Oversight = New Audit Risk
Although CMS requires clinician validation for denials, stakeholders have raised concerns regarding algorithm transparency and bias. From a compliance standpoint, practices should treat WISeR determinations similarly to recovery audit contractor (RAC) or universal payment identification code (UPIC) findings—subject to tracking, trending and corrective action plans.

PRACTICAL STEPS FOR ANESTHESIA COMPLIANCE PROGRAMS

To mitigate risk and operational disruption, it is recommended that anesthesiology groups and compliance programs: (1) strengthen medical necessity infrastructure by aligning templates to LCD/NCD language and standardizing documentation prompts for pain procedures; (2) enhance pre-service governance by implementing authorization dashboards and monitoring turnaround time and approval rates; (3) strategically track denials via trending by procedure, provider, and diagnosis, and escalate patterns to compliance committees; and (4) educate clinicians and coders by reinforcing LCD-based documentation and providing feedback loops tied to denial outcomes.

POLICY OUTLOOK

Early analysis suggests WISeR's initial spending impact may be modest due to its limited scope, but expansion could significantly increase its influence across Part B services. For anesthesiology, WISeR signals continued CMS emphasis on utilization management, data analytics and upstream compliance controls—particularly in interventional pain.

CONCLUSION

The CMS WISeR Model represents a meaningful shift toward **technology-driven utilization oversight in Medicare FFS**. For anesthesia providers and compliance leaders, success will depend on proactive workflow alignment, strengthened documentation practices and close monitoring of emerging denial trends. Early preparation will be key as CMS evaluates whether the model should expand nationally.

Sources

1. CMS Innovation Center. *WISeR Model Overview.*
2. Kaiser Family Foundation (KFF). *Examining the Potential Impact of Medicare's New WISeR Model.*
3. American Society of Regional Anesthesia (ASRA). *CMS Provides More Details on WISeR Prior Authorization Model.*
4. Georgetown University Center on Health Insurance Reforms. *New CMS WISeR Model Revives Concerns of Prior Authorization and AI.*

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ISN'T IT TIME? A Call for an Anesthesia Industry Network Dedicated to Objective Standards, Benchmarks and a Common Business Framework

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ABSTRACT

The anesthesia industry is navigating one of the most consequential periods in its history. A workforce crisis of historic proportions, a rapid and disruptive surge in non-OR anesthesia (NORA), unsustainable financial pressures on hospitals and anesthesia groups alike, and a near-total absence of objective, shared benchmarks have created conditions that demand a coordinated industry response. Yet the field lacks a single network, body or forum specifically dedicated to advancing the business, economic and operational performance of anesthesia as a specialty. This article argues the time has arrived—perhaps long past arrived—for the anesthesia community and its hospital/health system partners to create such a network: a professionally governed, data-informed organization committed to producing the objective standards, benchmarks, vocabulary and shared intelligence the industry urgently needs.

I. A SPECIALTY AT A CROSSROADS

Ask any hospital CFO, anesthesia group medical director or health system administrator what keeps them up at night, and the answer increasingly centers on the economics of anesthesia. It is not on surgical volume and not on nursing shortages—though those issues are real—but rather on anesthesia: its cost, its availability and the growing difficulty of negotiating an equitable arrangement that works for everyone at the table.

This is not a local phenomenon. Across the country, in community hospitals and academic medical centers, in freestanding ambulatory surgery centers and large integrated health systems, the same pressures are converging simultaneously. The workforce pipeline has not kept pace with demand. The sites requiring anesthesia have multiplied far faster than the providers available to serve them. Reimbursement has been compressed by federal policy. And the financial support that hospitals provide to anesthesia groups—the subsidy, stipend or deficit payment that makes many programs operationally viable—has risen from an average of $2–4 million annually to levels approaching or exceeding $12 million, a dramatic shift that has occurred in less than two years.

The data are sobering. Before COVID-19, approximately 35% of facilities reported anesthesia staffing shortages. Within two years of the pandemic's onset, that figure had more than doubled to 78%.[1] Fifteen percent of the active ASA physician workforce has retired since COVID.[2] Of those who remain, more than 57% are age 55 or older.[3] Replacing each departing physician requires between 1.4 and 1.7 full-time equivalents—not because of incompetence, but because of the permanent generational shift in how younger providers balance

[1] Abouleish AE, Pomerantz P, Peterson MD, et al. Closing the Chasm: Understanding and Addressing the Anesthesia Workforce Supply and Demand Imbalance. Anesthesiology. 2024;141(2):238–249. doi:10.1097/ALN.0000000000005052. Source for pre- and post-pandemic staffing shortage rates (35% rising to 78%); physician workforce demographics; supply-demand dynamics.
[2] Johnson R, Scott SJ, Semo JJ. Requesting Compensation for Undercompensated Services: Three Industry Perspectives. ADVANCE Annual Meeting Presentation. January 31, 2025. Source for: 15% ASA workforce retirement since COVID; 57%+ physicians age 55+; 1.4–1.7 FTE replacement ratio; generational workforce expectations; subsidy escalation to $12M; facility crisis case examples.
[3] Ibid. (Johnson, Scott & Semo, ADVANCE 2025).

professional and personal life.[4] Simultaneously, non-OR anesthesia cases have grown from roughly 20% to more than 35% of all anesthesia volume and are projected to exceed 50% of cases in acute care hospitals before 2030.[5]

> *"The anesthesia subsidy that averaged $2–4 million a few years ago is now approaching or exceeding $12 million in many markets—yet both sides of the negotiating table lack the objective benchmarks to evaluate these arrangements fairly."*

Despite these pressures, the anesthesia industry (including pain management services) operates without the shared institutional infrastructure that some other complex, high-stakes specialties take for granted. There is no dedicated network for exchanging economic intelligence. There are no consensus-driven, specialty-specific benchmarks for compensation, subsidy levels or productivity. There is no forum in which hospitals, groups, academic centers, ambulatory providers and clinicians can come together as peers to define what "fair" looks like. Without these things, every negotiation begins from scratch, every contract is contested based on anecdote rather than evidence and every stakeholder is disadvantaged by the absence of a shared framework.

Isn't it time for the anesthesia community to build the infrastructure it has long lacked?

II. THE WORKFORCE CRISIS: SCALE, SCOPE AND DURATION

Any serious conversation about the anesthesia industry must begin with workforce, because workforce is the governing constraint on every other variable. You cannot negotiate a reasonable subsidy without understanding what it truly costs to staff a program. You cannot design a NORA strategy without knowing where your providers are being deployed and how efficiently. You cannot plan without an honest accounting of the supply and demand imbalance that will define the next decade.

The supply side of the equation has been structurally disrupted in ways that will take years to repair. Training pipelines were interrupted during the pandemic. A generation of anesthesiologists who might have worked several more years elected to retire rather than endure the operational chaos of pandemic-era practice. The conversion of CRNA programs to doctoral-level education temporarily reduced the graduation pipeline. The remaining workforce is aging out at a rate that incoming classes of new providers simply cannot match. While anesthesia is not the great driver of economic sustainability, it is the enabler. These collective supply constraints will be catastrophic to the "have nots" in the industry and force already bleak decision making into worse long-term choices. The demand side has grown in parallel.

An aging U.S. population with an increasing burden of chronic illness requires more procedures.[6] Hospitals continue to expand service offerings, often without the strategic discipline to evaluate whether the anesthesia resources required are actually available or affordable.[7] NORA cases, which are structurally less efficient than OR cases—requiring the same provider mobilization and documentation burden for lower per-case revenue—now represent a major and growing share of total workload.[8] The locum tenens market, which in some markets has become the de facto solution instead of existing to bridge supply gaps, carries premium labor rates that compound the financial pressure on both sides of the table.

What is perhaps most striking about this crisis is how unevenly it is understood. Clinicians and administrators within the specialty have a granular, lived sense of the pressure. Hospital executives at the system level—particularly those who built their careers before the current environment emerged—are often operating from outdated mental models. The executive whose instinct is to say "just hire more CRNAs" or "we

[4] Ibid. (Johnson, Scott & Semo, ADVANCE 2025).
[5] Medaxion. 5 Ways to Limit NORA Impact on OR Coverage. OR Manager White Paper, 2024–2025. Source for NORA growth from ~20% to 35%+; projection to exceed 50% in acute care by 2030; NORA operational and safety characteristics; data capture gaps in EMRs; impact on OR utilization reporting.
[6] Ibid. (Johnson, Scott & Semo, ADVANCE 2025).
[7] Ibid. (Johnson, Scott & Semo, ADVANCE 2025).
[8] Ibid. (Medaxion OR Manager White Paper). For NORA scheduling characteristics, absence of centralized leadership, anesthesia utilization inefficiency in non-OR settings, and resource allocation implications of simultaneous OR and NORA demand.

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didn't pay subsidies at my last hospital" is not acting in bad faith; they are simply operating without current, objective, shared data.

III. NORA: THE FASTEST-GROWING CHALLENGE NOBODY PLANNED FOR

Non-OR anesthesia deserves particular attention, not only because of its growth rate, but because it represents a category of operational complexity most facilities are genuinely unprepared to manage. Unlike the operating room—where decades of infrastructure, governance, scheduling systems and leadership structures have been developed—NORA has expanded organically, procedure by procedure, department by department, without a corresponding investment in management capability.

The consequences are predictable and documented. NORA cases are distributed throughout the hospital in physically distributed locations where anesthesia providers are infrequent visitors rather than integrated members of a care team. Scheduling is often paper-based or informal. Data capture in the EMR is incomplete, which means that when NORA volume is excluded from OR utilization metrics—as it typically is—performance reports overstate efficiency and mask the true cost burden of the anesthesia service line.[9] Clinically, the risks are real: patients undergoing NORA procedures have higher rates of severe adverse events than those in the OR, and in a substantial proportion of documented claims, the care was deemed preventable.[10]

For OR managers, the operational impact is direct and daily. Every anesthesia provider pulled toward a NORA location is unavailable for surgical cases. Delays, cancellations and OR closures attributed to anesthesia shortages frequently have unmanaged NORA demand as a contributing or primary cause. However, as the data connecting NORA activity to OR performance is typically absent, the causal relationship remains invisible to administrators making resource allocation decisions.

Managing NORA well requires data systems, leadership structures, scheduling infrastructure and staffing models specifically designed for non-OR settings. Purpose-built anesthesia information platforms—such as Medaxion's *Anesthesia Manager*—can provide the real-time visibility previously unavailable, capturing case volume, location, acuity and staffing deployment across both OR and NORA settings in ways that hospital EMRs cannot.[11] But data systems alone cannot ensure effective management and governance of optimized scheduling. What the industry needs are shared standards for how NORA should be led, staffed, measured and reported. No such standards currently exist in any widely accepted form.

> *"NORA cases now represent more than 35% of all anesthesia volume—yet most facilities have no organized NORA leadership, no acuity-adjusted staffing model, and no data infrastructure accurate enough to manage it effectively."*

IV. THE FINANCIAL RECKONING: NEGOTIATING WITHOUT A MAP

At the center of the current anesthesia crisis is a financial negotiation that

[9] Ibid. (Medaxion OR Manager White Paper).
[10] Ibid. (Medaxion OR Manager White Paper).
[11] Ibid. (Medaxion OR Manager White Paper).

has grown vastly more consequential without a corresponding development of the tools, benchmarks or frameworks needed to conduct it well. The subsidy negotiation—in which an anesthesia group asks a hospital for financial support to close the gap between clinical revenue and the true cost of providing contracted services—has become one of the highest-stakes conversations in healthcare operations.

The numbers are no longer marginal. Across many markets, organizations that were paying $2–4 million annually are now receiving ask amounts of $10, $12 or $15 million.[12] These increases are not arbitrary. They reflect the convergence of compressed commercial reimbursement from the No Surprises Act, rising anesthesia labor costs in a constrained market, the structural inefficiency of NORA and the true cost of providing on-call coverage that prior generations largely absorbed without compensation. The ask is real. The need is genuine.[13]

The problem is not the ask itself. The problem is the absence of any shared, objective framework for evaluating said requests. Hospital executives are asked to approve expenditures of this magnitude without access to industry-wide benchmarks for what constitutes a reasonable subsidy, an appropriate compensation level or a fair staffing ratio for their facility type and case mix. Anesthesia groups present their own financial data, which is accurate but inevitably framed in their interest. Both sides may hire consultants who add genuine expertise, but who bring their own client relationships and perspectives to the analysis. The result can be penny-wise financial decisions that create compounding, long-term business issues for the very delivery of care.

The industry does not have consistent, accessible objective data sources that are unbiased, absent agendas and free from partisan groups advocating a particular point of view. National compensation surveys exist, but they are generalized, they lag the market by a year or more, and they are not calibrated to the specific variables—facility type, payer mix, NORA load, coverage model, call burden—that drive the actual cost of a given program. In their absence, negotiations are conducted based on what each side believes, what each has heard happened elsewhere, and what each can will to fruition. The survival of the fittest in negotiations does not mean wellness for collective stakeholders.

The results are well-documented: programs where the hospital holds leverage produce outcomes that undercompensate anesthesia and generate the workforce instability that makes programs unsustainable. Programs where anesthesia holds leverage produce subsidy levels straining hospital budgets and inviting adversarial responses—RFP, insourcing, corporate replacement—that typically disrupt clinical operations far more than they reduce costs.[14] Neither outcome serves patients, institutions or the specialty.

V. THE VOCABULARY PROBLEM: AN INDUSTRY WITHOUT A COMMON LANGUAGE

Before there can be shared benchmarks, there must be shared definitions. The anesthesia industry, for all its clinical sophistication, has not yet achieved consensus on the business vocabulary that underpins every negotiation, every contract and every performance conversation.

Consider the word "subsidy" or more appropriately "stipend." In common usage, subsidy carries a connotation of largesse—a gift from the hospital to a group that cannot support itself. An anesthesia stipend—the financial support required to close the gap between an anesthesia group's net clinical revenue and the verifiable cost of providing contracted services at fair market staffing and compensation levels. Either use stipend or define "anesthesia subsidy"—the reciprocal service delivery obligation—is materially different from the informal usage, and the difference matters enormously at the negotiating table.

[12] Ibid. (Johnson, Scott & Semo, ADVANCE 2025).
[13] Johnson, Scott & Semo, ADVANCE 2025 (op. cit.). For the No Surprises Act's effect on commercial reimbursement compression; rising labor cost data; and the operational and legal dynamics of subsidy negotiations under financial pressure.
[14] Trinity Health Advisors. Anesthesia Service Line Insourcing. Operational overview, 2024–2025. Source for context on hospital insourcing decisions, data-driven governance during employment model transitions, and the operational management challenges that accompany adversarial program changes.

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As well, consider "fair market value" in the context of physician and advanced practice provider (APP) compensation. Most participants treat fair market value (FMV) as if it were a single number (e.g., the median) derivable from published survey data. It is not. Fair market value for anesthesia compensation requires contextual analysis adjusted for the employment model, coverage model, call burden, NORA load, payer mix and regional supply/demand dynamics. An FMV determination that does not account for these variables is not defensible; and, in a regulatory context, an indefensible FMV determination carries, at best, meaningful legal risk and, at worse, unintended behavior and consequences.

The same applies to productivity measurement. Is a provider who generates fewer billable time units because they carry a disproportionate share of call obligations, NORA coverage and medical direction responsibilities less productive than a peer working exclusively in the efficient OR? Any honest answer requires a composite metric accounting for all dimensions of contribution and no such standard metric exists in common use. The absence of agreed vocabulary enables bad outcomes, because it allows each party to define key terms in whatever way supports their position.

VI. WHAT EXISTS TODAY—AND WHAT IS MISSING

The anesthesia field is not without professional infrastructure. The American Society of Anesthesiologists provides clinical guidance, advocacy and educational programming of significant depth and quality. The AANA serves nurse anesthetists with similar breadth. Specialty-specific quality improvement networks—including the Anesthesia Quality Institute and the Michigan Anesthesiology Quality Collaborative—have made meaningful contributions to patient safety and outcomes measurement.

What these organizations do not do—and arguably should not be expected to do—is address the business, economic and operational dimensions of anesthesia practice with the depth and specificity the current environment requires. Their missions are rightly focused on clinical quality, patient safety and professional advocacy. A CFO evaluating whether a $12 million subsidy request is reasonable, an anesthesia medical director building a defensible compensation analysis or a hospital administrator designing a NORA staffing model—none of these stakeholders can go to an existing body, extract the necessary data or better yet operate an application that can produce an unbiased management report.

National consulting firms, specialist attorneys and individual advisors fill some of the gap and many do so with genuine expertise. But consulting relationships are bilateral by definition—they produce intelligence for paying clients, not public goods for the field. The anesthesia industry needs something qualitatively different: a shared platform where benchmarks and standards are produced collectively through a rigorous and transparent process, and made available to the whole community.

> *"The clinical quality infrastructure of anesthesia is well-developed. The business and economic infrastructure—the benchmarks, vocabulary, standards and shared intelligence that every stakeholder needs—simply does not yet exist."*

VII. A NETWORK BUILT FOR THIS MOMENT

What the anesthesia industry needs is a dedicated network—an anesthesia management network—specifically designed to address the business, economic and operational dimensions of practice. Not a lobbying organization, but the data could help in the activities of lobbying. Not a clinical quality body, but acknowledgement and inclusion of clinical data where appropriate. Not a consulting firm, but the community of consultants that wish to support organizations with accurate, unbiased data and in-depth services. Vendors of anesthesia services that have

professional experience and expertise would be welcome. In summary: a professionally governed, membership-based and inclusive network dedicated to producing the shared intelligence and frameworks that the industry currently lacks.

The design of such a network matters as much as its existence. Several principles should govern it:

Independence and Objectivity Above All

- The network's value depends entirely on the credibility of its outputs. Hospitals, anesthesia groups, vendors, consultants and clinicians all have legitimate interests in anesthesia economics—and all those interests deserve representation. The governance structure should reflect that balance, and the processes by which benchmarks and standards are developed should be transparent enough to withstand scrutiny from every member constituency.

Anesthesia Group Management Applications Available to Network Members

- Many organizations are swimming in too much industry data and drowning in its complexity. The network should support and operate management applications that can source these networks or other databases for reporting purposes. In some cases, could operate real-time management tools such as APP shift optimization to member organizations: (a) anesthesia groups and their client facilities and (b) organizations that employ anesthesia providers—with real

time dashboards. The application should be robust enough to assist with understanding both economic drivers and to correlate those to clinical events.

Grounded in Real Data

- The network's outputs must be grounded in data and direct information, not indirect survey data alone. The field needs access to transactional-level case data reflecting actual operational patterns across diverse facility types, geographic markets and payer environments. Purpose-built anesthesia information platforms—such as Medaxion's *Anesthesia Manager*—which aggregate millions of case records across hundreds of facilities, represent exactly the kind of data infrastructure that rigorous benchmarking requires, provided appropriate governance and data-use agreements are in place.[15] The network should establish clear methodological standards for how data is analyzed and reported, allowing for stakeholders to acknowledge that "in God we trust, all others bring data."

Broad and Balanced Representation

- The network should encompass the full range of stakeholders whose decisions shape anesthesia economics: hospital and health system executives, ASC administrators, anesthesia group leaders, independent consultants, legal and compliance professionals, finance representatives and clinicians. Anesthesia economics is a multi-party problem that can only be addressed through multi-party participation. A body representing only one constituency will produce outputs that only one constituency trusts.

Clinical Integrity Through a Medical Advisor

- Anesthesiology is a medical specialty practiced by physicians and advanced practice clinicians, subject to professional and regulatory standards that have direct implications for business decisions. The network should include a medical advisor—a licensed physician of standing in the anesthesia community—whose role is to provide clinical and scientific oversight, approve any research activities and maintain the evidence-based integrity of the network's published work.

Complementary to Existing Infrastructure

- The network should be designed explicitly to complement the existing professional and quality infrastructure of anesthesia—not to compete with or duplicate it. The ASA (AQI and various committees), AANA, and similar bodies do important work that the business network should support. However,

[15] Ibid. (Medaxion OR Manager White Paper).

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the network's specific mandate—produce business, economic and operational standards utilizing direct access to millions of anesthesia records—would be sufficiently distinct that a well-designed and educationally focused organization could fill the gap and complement the work of existing institutions.

VIII. WHAT A NETWORK SHOULD PRODUCE

A network of this kind, properly constituted and resourced, should be capable of producing outputs across several interconnected dimensions. Taken together, these outputs would give every stakeholder in the industry access to a shared framework for making and defending decisions .... for the first time.

- **Compensation benchmarks and commentary:** Contextualized analyses accounting for employment model, coverage requirements, call burden, NORA load and local market conditions—with the methodological commentary needed to apply benchmarks and appropriate productivity metrics defensibly in specific situations, not use overly generalized, outdated and statistically flawed survey medians.
- **Subsidy, stipend and deficit standards:** Consensus definitions of what constitutes a fair and reasonable stipend (subsidy) or department budget deficit, grounded in a shared understanding of how anesthesia program costs are calculated and benchmarked against comparable facilities nationwide.
- **Staffing and coverage model frameworks:** Evidence-based frameworks based on historical and future data for how anesthesia programs should be staffed across OR and NORA settings, calibrated to different facility types, case mixes and service requirements. Fill an existing need for studies on the amount and type of call (e.g., beeper vs in-house) that anesthesia practitioners typically provide and/or should provide.[16]
- **NORA management standards:** Leadership structures, scheduling approaches, data capture standards and acuity-adjusted staffing models specifically designed for non-OR anesthesia settings—none of which currently exist in widely accepted form.
- **Operational performance benchmarks:** OR utilization, case throughput, flip room efficiency and turnaround standards calculated using NORA-adjusted methodology that prevents distortion of performance data when NORA volume is excluded.
- **Common industry vocabulary:** Agreed definitions for the key business and operational terms—subsidy, fair market value, productivity, coverage model, medical direction and others—that underpin every negotiation and contract in the field.
- **Knowledge sharing and education:** Regular forums, published case studies and structured programming through which members exchange practical intelligence on workforce planning, NORA governance, contract strategy and operational leadership—grounded in real data rather than anecdote.
- **Research and peer-reviewed publications:** Studies utilizing real-world clinical and operational data, overseen by a medical advisor, that advance the field's collective understanding of the economic and operational dynamics shaping anesthesia practice.

None of these outputs are currently produced by any existing body in a form that is broadly accessible, and grounded in the kind of multi-facility, multi-market data that would make them credible across constituency lines. The gap is real, the need is urgent and its costs are borne every day by every stakeholder in the industry.

[16] Johnson R. How Much Call is Too Much? Communiqué (Anesthesia Business Consultants). Spring 2018. Available at: https://www.anesthesiallc.com/news-events/99-communique/past-issues/spring-2018/1114-how-much-call-is-too-much. Source for call burden data by facility type; beeper vs. in-house call patterns; relationship between call obligations and anesthesia provider compensation and staffing models.

IX. THE COST OF CONTINUED INACTION

The costs of operating without shared benchmarks and standards are not abstract. They are paid in the specific currency of disruption: contracts that collapse because neither party can agree on what "fair" looks like; RFP processes launched in frustration that produce institutional upheaval without the savings anticipated; insourcing initiatives undertaken without the data infrastructure or operational expertise to succeed; locum tenens costs that compound because programs cannot recruit permanently into environments where compensation norms are actively contested.

The publicly documented cases of anesthesia program breakdowns across the country—facilities that have lost their entire anesthesia teams, OR throughput that is permanently thwarted due to lack of enabling anesthesia availability, systems that have spent tens of millions of dollars in crisis response, communities whose patients have faced access disruptions for months—share a common characteristic: they reached the point of crisis before any party had the data, the vocabulary or the framework to intervene constructively.[17] [18]

The anesthesia industry is at an inflection point. The workforce will not replenish itself on the old timeline. NORA will not stop growing. Subsidies will not return to 2019 levels. The No Surprises Act will not be repealed. These are the structural conditions within which the field will operate for the foreseeable future. The question is not whether those conditions demand a more

sophisticated institutional response—they clearly do. The question is whether the industry will build that response proactively or wait until the next wave of program failures makes the cost of inaction undeniable.

X. A CALL TO THE INDUSTRY

The creation of an anesthesia management network is not a complex proposition. It does not require legislation, regulatory approval or resolution of any fundamental disagreement about how anesthesia should be practiced. It requires only that the stakeholders who have the most to gain from shared intelligence—and the most to lose from its continued absence—recognize that collective action is in their common interest.

Hospital executives who are tired of negotiating without access to objective benchmarks that would allow them to evaluate what they are being asked to pay—they have every reason to participate. Anesthesia group leaders who are tired of being viewed with suspicion when they present data that supports their own position, and who would benefit from the credibility that comes with an independent, consensus-driven standard—they have every reason to participate. Clinicians who believe that anesthesiology's value as a medical specialty is systematically underrepresented in the business frameworks that govern their contracts and compensation—they have every reason to participate. ASC administrators, independent consultants, legal and compliance professionals and industry vendors who serve this field and understand that its dysfunction is ultimately their problem too—they all have reason to participate.

A network of this kind could be membership-based and self-sustaining, with broad fees calibrated to ensure academic medical centers, training programs, individual clinicians and organizations providing substantive data contributions can participate regardless of institutional resources. The goal is not exclusivity; it is breadth of representation and depth of shared commitment to the health of the specialty.

[17] Ibid. (Johnson, Scott & Semo, ADVANCE 2025).
[18] Ibid. (Trinity Health Advisors, 2024–2025).

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The network this article describes is not a utopian vision. It is a pragmatic response to well-documented problems that have grown severe enough to demand a structural solution. The analytical tools exist. The data infrastructure is emerging. The expertise is distributed throughout the field. What has been missing is the organizing vehicle—a network with a clear mandate, credible governance and the commitment to produce outputs that serve the whole community rather than any single constituency within it.

The anesthesia industry has navigated remarkable transformations before: the development of the anesthesia care team model, the expansion of ambulatory surgery, the integration of digital information systems into perioperative care. In each case, the specialty's ability to adapt was strengthened by the development of shared frameworks that gave every stakeholder a common reference point. The current moment calls for exactly that kind of collective intelligence—applied not to clinical technique but to the business, economic and operational realities that will determine whether anesthesia programs across the country remain viable, equitable and sustainable for the patients who depend on them.

> *"The time to build shared infrastructure is before the crisis forces it. The anesthesia industry has the expertise, the data and the collective interest to act. The only thing missing is the decision to begin."*

Isn't it time?

About This Paper

This position paper was prepared to advance industry dialogue about the need for a dedicated anesthesia business and economic network. It draws on published peer-reviewed research, industry conference presentations and operational white papers from across the anesthesia field. It does not represent the official position of any professional society, health system or commercial entity. References are provided as footnotes throughout the text. This paper is intended as a contribution to a conversation the industry needs to have—and to the decision to begin having it in an organized, constructive and data-driven way.

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Robert Johnson, RCPT, MBA, is a seasoned healthcare executive with deep expertise in hospital operations, hospital-based physician services and anesthesia business development. His career began at Johns Hopkins, where he advanced from anesthesia technician and perfusionist to administrator for the Department of Anesthesiology and Critical Care Medicine. He subsequently held senior leadership roles across both academic and for-profit healthcare, including Johns Hopkins, Baylor College of Medicine, Duke University Hospital, and UPMC. Early in his career, he co-founded and helped launch with Michael DeBakey, MD, ***The Health Channel***, a pioneering satellite-delivered medical education service. Mr. Johnson has led business development and integration efforts for several national anesthesia organizations, including Anesthesia Partners, Premier Anesthesia, and Sheridan (now Envision). He served as corporate vice president of hospital-based physician services at HCA, where he directed contracting and employment operations across its 180-hospital system with a concentrated focus on anesthesia services. Prior to joining Medaxion, Johnson provided strategic advisory services to anesthesia groups, hospitals and health systems, including HCA, Bon Secours Mercy, Universal Health Services, Piedmont, Ardent, Advocate and others. At Medaxion, he contributes expert guidance to the development of enterprise-wide anesthesia management tools for national anesthesia groups and health systems and is leading the creation of the anesthesia management network: an industry-wide information and benchmarking resource. He can be reached at **bob.johnson@medaxion.com**.

Analyzing Anesthesia Subsidies

BY JOSEPHINE BALLARD, MS
Executive Vice President of Practice Management, Coronis Health, Jackson, MI

On the surface, anesthesia support agreements seem simple:

Collections – Provider Compensation – Operating Expenses = Financial Support Required.

In practice, however, determining whether that support level is appropriate—or whether a contract is quietly underperforming—is far more complex. For anesthesia groups, subsidy performance is influenced by a wide array of moving targets: variability in revenue, case volume, payer mix, operating room utilization, staffing models, provider compensation and even employment classification. Together, these factors create significant volatility, making anesthesia one of the most challenging hospital service lines to validate financially.

REVENUE VARIABILITY AND CONTRACT ASSUMPTIONS

Most anesthesia support arrangements are built on projected revenue tied to expected case volume, acuity (units per case) and payer mix. Even minor yet sustained deviations from these baseline assumptions can materially alter actual revenue performance. Any consistent shift in case volume, case mix, acuity, payer mix or OR utilization can impact subsidy adequacy far more quickly than a contract may anticipate. For this reason, it is essential that support agreements include clear language allowing financial adjustments when real-world conditions deviate materially from original projections. Without this flexibility, support structures can fall out of alignment long before the contract term ends.

CASH VS. ACCRUAL ACCOUNTING AND CONTRACT ALIGNMENT

Another often-overlooked complication is how revenue is measured. Contract performance can differ substantially depending on whether revenue is calculated on a cash basis (when payment is received) or an accrual basis (date of service). This issue becomes even more pronounced when the agreement follows a fiscal year that does not match the anesthesia group's internal calendar-year reporting. Many practices operate on a cash basis and track financials January through December; if the contract is written using accrual accounting on a different cycle, internal statements cannot reliably evaluate contract performance. The challenge becomes even more complex when "true-up" or look-back provisions extend financial reconciliation months beyond the contract year.

MULTI-SITE PRACTICES AND THE NEED FOR LOCATION-LEVEL VISIBILITY

For practices covering multiple facilities, site-specific profit-and-loss reporting is essential. Evaluating performance on a consolidated basis may mask underperforming locations, misaligned staffing models or inadequate support arrangements. In many situations, one site may be unknowingly subsidizing losses at another. Without granular financial visibility, these issues can persist indefinitely—and may only surface once losses become significant.

STAFFING VOLATILITY

Staffing shortages have added yet another layer of complexity to anesthesia subsidy management. Support agreements are typically based on a defined staffing model that aligns with the service expectations of the facility. But market pressures often force practices to deploy whichever provider types are available, rather than the most economical mix. This may result in physician-heavy staffing due to CRNA shortages, suboptimal care team ratios or shifts toward QZ billing models when physicians are unavailable—each of which can push expenses beyond what the contract assumed. Without diligent monitoring, groups may not realize that a contract has drifted into material underperformance.

PROVIDER COST ESCALATION AND EMPLOYMENT CLASSIFICATION

One of the fastest-changing elements of anesthesia economics is the rising cost of providers and the growing complexity of employment classifications. Traditional assumptions about full-time staffing are now increasingly outdated. It is common

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to see fragmented schedules, partial-day staffing and multiple individuals combining to cover what once represented a single FTE. Compensation structures also vary widely across full-time W-2 employees, part-time providers, hourly 1099 contractors and agency or locum clinicians—whose hourly rates may far exceed those of employed staff.

Without an integrated electronic scheduling platform tied directly to payroll, accurately tracking provider utilization and true staffing costs, especially across multiple sites, is extremely difficult. This lack of visibility can obscure contract misalignment until it becomes financially significant.

UTILIZATION CHALLENGES

One of the most significant ways for both the anesthesia group and the facility to minimize negative financial impact is to be aligned with utilization. Often facilities are motivated to schedule as many cases as possible in a day to meet the needs of the surgeons. In theory, more cases equal more revenue for the facility, the surgeon and the anesthesiologist. Unfortunately, the simple concept of more cases and more revenue does not translate to more profit for anesthesia. Due to the staffing challenges noted above, opening more rooms without using the full operating hours of the day will actually result in greater staffing challenges and the need to use more expensive labor for the anesthesiology team. Opening more rooms for morning cases, but not achieving optimal utilization for the full operating hours, will result in nonbillable anesthesia time that needs to be subsidized by the facility thus eliminating any profit hoped to be gained by the additional case volume.

As much as possible, the anesthesia group will work to meet the schedule of the facility and the surgeons but that comes at a cost. The more that can be done to keep the daily needs consistent provides the anesthesia team an opportunity to predict provider schedules in advance and work to optimize the use of the least expensive staffing model.

CONCLUSION

Evaluating anesthesia subsidy performance goes far beyond a straightforward revenue-minus-expense equation. It requires disciplined accounting alignment, flexible contract structures that adapt to real-world conditions, true site-specific financial visibility and precise tracking of staffing utilization. Only when these elements work together can organizations accurately assess subsidy adequacy and maintain financially sustainable anesthesia coverage.

As important as the metrics are in a contract, the relationship/partnership with hospital administration cannot be overlooked. Regularly scheduled structured meetings with the hospital should occur on a monthly or quarterly basis and should include transparent reporting and joint evaluation of all key contract metrics. Additionally, it is important for anesthesia departments to work in tandem with the hospital stakeholders to meet financial, quality and service line goals; both parties need to be aligned and work as a true partnership. In today's environment, characterized by workforce shortages and reimbursement pressures, both parties must remain adaptable and willing to rethink traditional operating models.

Without the right systems, safeguards and a truly collaborative partnership in place, both anesthesia groups and healthcare facilities risk operating under agreements that no longer align with clinical demand, workforce realities or long-term financial viability.

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Effective Governance:

Building A Foundation For Independence

BY SHENA J. SCOTT, MBA, FACMPE
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Thinking of all the factors that are critical to ensuring your practice's ability to retain its independence, strong governance is high on the list. Without it, your practice may lack direction, the ability to manage its own members, make timely decisions and/or effectively communicate with facility partners. Decisions may contradict each other, or be undermined by people or behaviors, and staying current with the times may become impossible. All of these are threats to a group's ability to stay independent.

So how do you create an effective governance structure? To some extent, it depends on the size of the group. Clearly a ten-member group has different challenges and needs than a two-hundred-physician group. The latter is likely spread across multiple facilities and geographic regions, making communication and engagement more challenging. But members of larger groups are also more likely to have accepted that everybody cannot be involved in every decision, to have developed a defined governance structure and succession policy and determined the best ways to engage members.

Smaller groups may be more likely to try and involve every physician in every decision. This ceases to become practical once group size gets into the double digits, if not before. Yet, we still see groups of thirty or forty physicians clinging to the notion that "I am an owner and therefore I have a right to weigh in on (or, in some cases, obstruct) every decision." This is highly problematic and can easily lead to the demise of the group. These groups cannot make timely decisions, people on the outside become frustrated because they do not know who the leaders are, and the leaders themselves become frustrated with "spinning their wheels" without the ability to make decisions or move forward.

To counteract, it is not uncommon for a benevolent dictator to emerge in these groups, someone who is fundamentally trusted by most (at least initially) and can communicate with facility leadership to get things done. This can be a welcome relief after the chaos of a group that is run too democratically. The problem is that it rarely continues because, no matter how benevolent and trustworthy the leader is, people start to become suspicious of his or her actions and efforts ensue to undermine his/her decisions, if not the leader him/herself.

One common structure to emerge when initially thinking about developing a more formal governance structure is constituency-based representation. Most groups have some type of formal or informal "divisions" or "sub-groups," whether aligned by sub-specialty, healthcare system, facility, age or work style. Clearly, for a governance structure to be effective, it is important for each of these constituencies to have a voice and to feel a connection to the leaders. While it is tempting to structure the model to ensure that each of the constituencies has representation, one problem with that is that people who are elected to represent a particular constituency may feel compelled to frame their opinions in consideration of what is best for that constituency, rather than the entire group. A classic example of this might be a division along the lines of sub-specialty. Perhaps the group needs to make some changes to its compensation to better facilitate recruitment. But a certain faction of the group is opposed to the change because they have an advantage under the current

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system. Under a constituency model, a representative of that faction might feel compelled to oppose the change because it was not in the best interest of his/her constituents even if s/he agreed that facilitating recruitment would be in the best interest of the group overall.

Another issue with constituency models is that they may not bring forth the best, or most interested, candidates. Perhaps Constituency A has three qualified candidates, while Constituency B only has one interested person who really is not a good leader and Constituency C has nobody interested at all. Under a constituency model, each constituency might have to bring forth a representative, meaning Constituency A would have to choose between its three good candidates, while Constituency C would have to scramble to find someone who really did not want to do it and Constituency B might bring forth its sub-optimal candidate.

Under a competency-based model, candidates are elected at large based upon their ability to fill an agreed upon list of needed competencies, as well as their ability to represent different constituencies within the group. For example, perhaps Candidate A is a young, female cardiac anesthesiologist who works primarily at Facility B and has a strong background in strategic planning through her community service work. While her strategic planning experience could bring value to the board, she would also be able to relate to, and communicate the perspectives of, multiple factions within the group (cardiac anesthesia, Facility B, younger generation, female and, perhaps, young parent) without being beholden to defend the specific interests of any of them. While understanding constituency perspectives is necessary, it is critically important that the members of the governing body wear their "group" hat in making decisions. Having a competency-based structure facilitates this. One thing that needs to be considered under this structure is the fact that candidates from smaller facilities within a larger group may be at a disadvantage in garnering enough votes to get elected. For this reason, many groups create a nominating or governance committee to vet candidates and make recommendations for a slate.

People often ask how large a board should be. Research shows that smaller boards are more productive, with five to seven members considered the ideal size. The smaller end of this is best for most groups, although larger groups may need as many as seven to ensure all bases are covered and smaller groups may need as few as three. If there are only eight owners, a board of five would be too many. Odd numbers are generally considered better for tie-breaking purposes, although most boards try to come to a greater consensus than a single vote majority.

One thing that is important to consider when thinking about governance is the different types of governance that must be addressed: clinical, operational and strategic. Typically, clinical governance is handled by the medical directors and/or department chair. Having a body of representatives dedicated to managing clinical issues takes this off the plate of the board and frees them to focus on strategy. Likewise, having a strong management team (typically composed of at least one non-physician administrator in a dyad with a physician president) to manage the operational side of the practice and report to the board monthly or quarterly helps keep the board out of the weeds. While the board is responsible for oversight, its primary purpose is strategic; so, it is important to try and clear its focus for that. In an ideal world, the board chair should be someone different from the president as these are two important, yet distinct, roles. The board chair should be responsible for leading the board, while the president is responsible for leading the practice. One frequent governance mistake we see is trying to put all these functions under one single governing body. In these instances, that body inevitably becomes overwhelmed by the more pressing clinical and management issues at the expense of making time for strategy and higher-level corporate governance.

Even smaller organizations should consider developing a robust committee structure to engage more people, provide leadership training for the future, and spread out the workload. At a minimum, consider creating a finance committee, a compensation committee and a recruiting committee. Larger organizations may want a governance committee to vet candidates and consider succession planning. Another benefit of having committees is that it allows people to tap into their strongest skill set. For example, someone might not have the interpersonal skills to be the President and interact with the hospital C-suite, but s/he may have significant financial acumen and be a great leader for the finance committee. If you are going to develop a committee structure, it is important for them to be empowered. Otherwise, people will quickly lose interest and consider it a waste of their time.

Creating this structure allows people to find their place to be involved and frees the board to do its most important job: determine the strategic direction of the group and keep the ship moving in the right direction. The board, board chair, clinical chair and president all need to be empowered to perform their functions. With an established election process, with appropriate term limits and succession plan in place to ensure continuity (for example, terms should be staggered and there should be a structure for automatic advancement from vice-chair to chair and vice president to president), there will be options for turnover in leadership if the group is unhappy with performance.

But, during their term, leaders need the latitude to function and make decisions (a governance manual can outline the scope of their authority and when, and with whom, they need to confer) without their hands tied or needing a full group vote on every issue. Certainly, larger issues may require a group vote, particularly in a smaller group, but the more you are able to delegate authority, the smoother the process will be.

And having a smooth process is essential in being able to make important decisions that will propel the group forward and facilitate independence. Groups who are unable to do this are often perceived as weak or disorganized by people on the outside and they may find themselves unable to maintain adequate staff or manage a problem physician. In these instances, the facility may seek a stronger partner that is able to move with the times and make the right decisions on a timely basis.

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Shena J. Scott, MBA, FACMPE, founder and CEO of Scott Healthcare Consulting, Inc., has been actively involved in anesthesia practice administration for over 30 years. She has spent the last six years consulting with over 100 anesthesia practices and hospitals across the country in many areas of practice improvement, most often assisting them with hospital contract negotiations, strategic planning and governance. She spent the first 22 years of her career as the executive director of a mid-sized anesthesia practice in Melbourne, FL. In 2013, she led that practice through a merger with five other practices in three different specialties to form Brevard Physician Associates, a 200+ provider group that provides all of the anesthesia, emergency medicine and radiology services to the largest integrated delivery system in Brevard County, Florida. Ms. Scott is a former chair of the MGMA Board of Directors, president of the MGMA Anesthesia Administration Assembly, and a current member of the ASA Committee on Practice Management. She is a frequent lecturer at ASA Practice Management, AIABPM, MGMA and other conferences. She can be reached at **scotthealthcareconsulting@gmail.com**.

Key Strategic Thinking for Anesthesia Practices

BY JODY LOCKE, MA
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The world of anesthesia is in a constant state of evolution because American healthcare is in such a constant state of flux. Practices come and go more rapidly than ever before. What used to be practices dedicated to providing anesthesia to surgical and obstetric patients at a given facility now find their scope expanding to a much wider variety of clinical services at a variety of venues. The key strategic question practices must address is whether they should maintain their independence and continue to anticipate changing market demands or sell out to the hospital or another anesthesia practice. Never has there been so much corporate activity merger and practice consolidation activity.

THE GROWTH OR SELL-OUT QUESTION

The first question every anesthesia practice should ask is how much control it has over the factors that determine providers' income and lifestyle. Is the practice in control or at effect of payor mix, scope of service requirements, clinical volume, coverage and call requirements and administration expectations? If the practice is well managed, and if it enjoys a strong relationship with administration, it probably has a good opportunity to maintain its independence and explore market opportunities. If not, it would probably make sense to explore other alternatives. Practices that need excessive subsidies to remain viable may find hospital employment a viable option because it will shift the burden of financial viability to the hospital. Practices in very competitive markets may find a merger with a stronger practice the best strategy for ongoing success based on the assumption that bigger is better when it comes to maintaining a favorable market position. It should come as no surprise that many practices across the country have chosen this option. An ever-growing percentage of anesthesia providers are now employed by mega-groups of 100 or more providers.

How does an anesthesia practice know whether it is on a positive path to success or in denial about its imminent demise? Experienced practice management consultants like to perform a SWOT analysis with the management team. It is a particularly useful tool that every practice should use on a regular basis. An honest and careful examination of each of the four elements can shed light on areas requiring attention and significant refinement. The basic objective is to turn weaknesses to strengths and threats to opportunities.

Strengths are aspects of the practice that enhance its relationship with its customers. Many features of a practice may be its true strengths such as the quality and experience of its providers, the focus and diligence of its management team, the effectiveness of its billing solution and its overall relationship with administration.

Weaknesses can be subtle and deceiving. As service organizations, anesthesia practices are only as good as the quality of service they provide. In the current environment it is not enough to have consistent clinical outcomes. Anesthesia practices are expected to be corporate players who are always enhancing the reputation of the facility. The most important factor today is customer service. An increasing number of hospitals now use independent agencies to score anesthesia customer service.

Opportunities may be internal or external. Some practices are asked to expand their scope of services to include services such as stroke management, ICU or neonatology. Other opportunities such as surgery centers and endo centers may represent new challenges.

Threats are ever present but need to be clearly identified and assessed. The

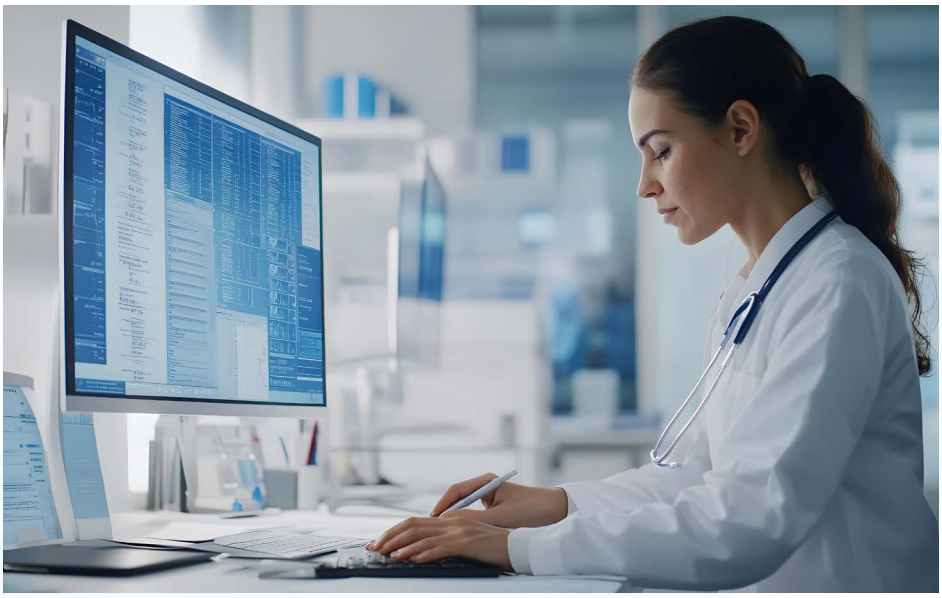
most common and annoying threat to an anesthesia practice is the RFP, the request for proposal, which is the administration's way of assessing its options.

Anesthesia practice is a business and must be treated as such. Businesses need a clear plan and disciplined management to be successful. They must always be focused on maintaining the confidence of their employees and their customers. Three aspects are critical: accountability, collaboration and innovation. Whenever a practice is considering its options, it should always start with a careful review of its strengths, weaknesses opportunities and market threats. A weak ship will never survive a big storm.

WHAT ARE THE BEST OPPORTUNITIES?

It is always useful to establish the objective of the practice's business. The biggest challenge facing most anesthesia practices today is generating enough revenue to cover the cost of providing the services it is contractually obligated to provide with its customers. Because of this it is best to pursue the most profitable opportunities.

The basic formula for determining profitability is to subtract the cost of a service from the revenue potential. The profitability of an anesthesia practice would be the total collections posted plus any stipend payments minus cost of provider payroll and business expenses. While such a calculation is relevant as an overall assessment of practice profitability it would not be particularly relevant for the evaluation of specific business situations such as profitability



by lines of business. There are a variety of ways to further refine the profitability analysis such as per hour or per day. Most practices find analysis of profitability per clinical day most useful especially in the evaluation of opportunities for expansion.

COST PER LOCATION DAY

To determine the average cost per location day it is especially useful to coordinate with the practice accountant. There are two pieces of information necessary: the average total gross compensation for each class of provider, physician and CRNA and the number of days each provider works per year. This model is based on a standard day, typically 10 hours. The objective here is to determine the average cost of each clinical day's provider cost. Obviously, some days are much shorter while others are longer. The point is how much the practice must dedicate for each day staffed. This is a generic template. Each practice should adjust the variable factors based on specific practice experience.

REVENUE PER LOCATION DAY

The billing staff can provide the data elements necessary for this calculation. It is most useful if specific data is provided for each line of business or clinical location you wish to analyze. This combination of elements is selected so that the analysis will highlight what is unique about each line of business such as the average case time and the average acuity of care, as measured in base units per case. It is also to identify any revenue from flat fee services separately billed.

There are many ways to calculate the average yield per unit billed. We typically base this on historical data that is at least six months old, otherwise known as date of service data (DOS). Sometimes it might be necessary to base this calculation on expected data.

Successful practices perform this profitability assessment for each line of business and clinical venue. It is especially useful to perform this for each surgicenter.

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Key Strategic Thinking for Anesthesia Practices

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WHAT ARE THE MOST SIGNIFICANT THREATS?

Market changes can threaten even the most serious anesthesia practice. Hospital mergers and consolidation can undermine even the most well-thought-out strategic plan. When a hospital closes its anesthesia practice loses a contract and must either shut down or find a new contract. Hospital mergers can have the same impact especially when the new hospital has its own preferred anesthesia solution. Anesthesia practices also find out occasionally that the administration they had been working with for years simply decided to find a new anesthesia solution. As a general rule, the higher the subsidy a facility must pay, the greater the risk for the anesthesia practice.

Changing administrators can also prove to be a serious threat. New administrators often have their own way of viewing and interpreting the relationship with the anesthesia practice. More often than not, such administrators chose to employe the anesthesia providers.

OPTIMIZING PRACTICE PROFITABILITY

The goal of every anesthesia practice must be optimum profitability. As we have discussed, there are five variables in the profitability calculation.

1. Ensuring that the practice is collecting every dollar to which it is legally entitled, which requires a close working relationship with the billing staff and consistent monitoring of all appropriate management reports.
2. Reasonable financial support from practice facilities that allows the practice to recruit and retail a qualified team of providers to meet the customers' service requirements.
3. Effective staffing with a staffing model that allows for adequate coverage and ideal customer service.

4. Competitive provider compensation that enhances provider commitment to the mission and values of the practice.
5. Rigorous expense management that enhances the revenue potential for provider compensation.

Given the dynamic nature of American medicine effective monitoring and management of each of the five variables listed above. This requires disciplined budgeting and the willingness to effect strategic changes when things change. To this end, it is especially important to monitor the profitability of each line of business and the willingness to cancel any unprofitable commitments.

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Hidden Pitfalls in Physician Employment Agreements: What Practitioners Should Negotiate Before Signing

BY CHRISTOPER J. RYAN, ESQ.
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Recently, anesthesiology has been at the center of consolidation, private equity investment and hospital-driven employment models. Many practitioners have joined large groups, consolidated health systems or management companies using employment forms that employers often present as non-negotiable. In reality, employers likely draft these forms to protect their own interests.

The stakes in anesthesia are high compared with some other specialties. The practice depends on circumstances beyond your control, such as facility contracts, OR block management, payer dynamics and team-based models involving CRNAs and APPs. A poorly drafted agreement can expose you to risk for decisions you cannot control.

This article highlights hidden pitfalls that practitioners should recognize and negotiate *before* signing. It focuses on a handful of clauses that determine what you get paid, how hard you work, what happens if things go wrong and how easily you can move on if they do.

I. COMPENSATION, CALL COVERAGE AND WORKLOAD EXPECTATIONS

Most anesthesia contracts define compensation in terms that sound straightforward: a base salary and perhaps a productivity or quality component. The fine print can tell a different story. A common pitfall is a guaranteed salary that lasts only for the first year or two. After that, your income may depend heavily on productivity thresholds. Without data on historical OR volume, payer mix and case assignment methods, you may never reach those thresholds.

Signing bonuses, relocation assistance and loan repayment add another layer of risk. These incentives often carry repayment obligations if you leave before a specified date. The trap arises when the contract defines that deadline broadly. For example, repayment may be triggered even if the employer terminates you without cause or if you resign because the employer breached the agreement. Practitioners should negotiate for pro-rated forgiveness over time. They should also seek carve-outs that prevent clawback when the employer, not the practitioner, ended the relationship.

In anesthesia, call coverage is often where standard contract language hides the most risk. Agreements that require participation in reasonable call or call as determined by the practice, without specifying frequency, type or compensation, invite problems. Such language allows the employer to expand your obligations unilaterally.

Another issue is who controls the call schedule and what happens if the underlying facility contract changes. If your group picks up additional hospitals or ASCs, you may suddenly cover more sites and more call without agreeing to any formal change to your agreement. Negotiating specific guardrails can prevent these surprises. Examples include maximum call shifts per month, limits on consecutive in-house nights, and a requirement that material changes to call duties trigger renegotiation or additional compensation.

Administrative and leadership tasks are another area where practitioners face surprises. Quality committees, OR governance meetings, scheduling oversight and medical directorship roles all take time. If the contract folds these responsibilities into your regular duties without separate compensation or a reduced clinical load, you may regret not negotiating before signing.

II. MALPRACTICE INSURANCE: CLAIMS-MADE, OCCURRENCE AND TAIL

Malpractice insurance is one of the most misunderstood parts of a physician employment agreement. Occurrence

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coverage responds to claims arising from care provided during the policy period, regardless of when the claim is filed. Claims-made coverage, by contrast, only responds to claims made during the policy period.

The type of policy matters because it determines whether you will need tail coverage when the relationship ends. Tail coverage extends a claims-made policy to cover claims reported after the policy ends for care rendered while it was in effect. A common trap is an agreement that simply states the employer will provide malpractice insurance without specifying whether it is claims-made or occurrence. A practitioner who assumes all coverage is the same may discover at departure that the policy is claims-made and that tail coverage is expensive. Given the long latency for some claims and the potential severity of anesthesia-related events, ambiguity does not work in your favor. Often, if the policy is claims-made, practitioners can negotiate for the employer to pay for tail coverage when the employment relationship ends.

Even when the contract addresses malpractice coverage and tail, practitioners should examine policy limits and how those limits are structured. The contract may state only that you will be covered under the employer's policy without specifying per-claim and aggregate limits. In that case, you may share a limit with the entire group across multiple locations. The appropriate amount of coverage may also vary depending on your state's laws.

III. RESTRICTIVE COVENANTS AND POST-EMPLOYMENT RESTRICTIONS

Non-compete provisions are the most common type of restrictive covenant. Some states ban them entirely, but most do not. Employers sometimes frame these provisions as a standard requirement of joining an anesthesia group or hospital. Practitioners should pay close attention to three things: the types of services covered, the duration after employment ends, and the geographic scope. Geography deserves particular scrutiny because the potential pitfall is not obvious. Some agreements define the restricted area by reference to every facility where the employer provides services. In a multi-hospital system or regional practice, that restriction could lock you out of an entire metropolitan area.

Agreements without a formal non-compete may still contain broad non-solicitation provisions. These can restrict you from treating any patient you cared for during your employment, even if that patient independently seeks you out at a new facility. They can also limit your ability to recruit colleagues or administrative staff you worked with. These provisions can prevent you from building a new practice or joining a competing group in the same market.

IV. TERMINATION AND INDEMNIFICATION: HOW THE RELATIONSHIP CAN END AND WHO PAYS

Employment agreements typically allow either party to terminate without cause on written notice, often 60 to 180 days. On its face, mutual no-cause termination appears fair. Either side can exit the relationship if it no longer works. But the details frequently favor the employer. The contract may allow the employer to terminate on short notice while tying your bonuses, loan forgiveness or vesting to longer periods. That structure gives the group the power to cut off benefits while still holding you to restrictive covenants.

Another frequent problem arises when the group's facility contract is at risk. Some agreements allow the employer to terminate physicians without cause, on minimal notice, if a hospital or ASC contract is lost or materially changed. If that happens, you might find yourself unemployed, still bound by a non-compete and potentially responsible for tail coverage or repayment of incentives.

This can occur even though the change had nothing to do with your performance. Negotiate for longer notice periods, pro-rated forgiveness of incentives and clear rules about who bears costs triggered by employer-initiated termination or loss of facility contracts.

Termination for cause provisions often use broad language. Common examples include failure to meet professional standards, conduct deemed detrimental to the employer or actions not in the employer's best interests. These standards can be highly subjective. They give the group significant discretion to label disagreements over scheduling, supervision or quality initiatives as cause for termination. A for-cause termination often triggers the harshest consequences. Practitioners should ensure that for-cause termination is limited to objective measures such as loss of licensing or exclusion from federal payment programs. Practitioners should also negotiate for notice and an opportunity to cure before the employer can terminate for cause.

Indemnification clauses determine who pays when things go wrong. Billing errors, malpractice claims and government investigations are common. In some contracts, the employer requires the practitioner to indemnify and hold the group harmless for losses related to the practitioner's services. That language, combined with employer-controlled billing and coding, can shift risk entirely to the provider. Where employers insist on indemnification, practitioners should limit the obligation to losses caused by intentional misconduct or gross negligence.

V. INTEGRATION CLAUSES AND UNWRITTEN PROMISES

Almost every employment agreement contains an integration or merger clause. These clauses often appear as routine language near the end of the agreement. An integration clause states that the written contract is the complete and final agreement between the parties and supersedes all prior negotiations and understandings. For practitioners recruited with informal assurances about call, optimistic compensation projections and promises about vacation time, this clause eliminates those assurances. Once you sign, only the written contract matters. Promises made during the interview or at a recruitment dinner are irrelevant.

This is where many providers fall into a trap. They rely on verbal statements that the non-compete is never enforced or that call will only be once a month. Then they discover the written contract says something different. Integration clauses prevent either party from later claiming the written contract does not control. Courts routinely enforce the written contract over unwritten assurances. The guiding principle is simple: if it matters to you, it needs to be in the agreement.

VI. PRACTICAL STRATEGIES FOR NEGOTIATING BEFORE YOU SIGN

Most providers hesitate to negotiate. Many say they lack bargaining power. This is often untrue. Employers need qualified candidates as much as candidates need good employers. The goal is not to fight over every clause. Instead, identify and address the issues that matter most and affect your risk. Counsel who routinely review anesthesia contracts can help you spot pitfalls and propose reasonable fixes.

Physician employment agreements are complex and carry significant long-term consequences. The clauses discussed above are areas where standard language can quietly shift risk to the practitioner or cause problems after the relationship ends. The time to identify and address these issues is before you sign, not after a dispute arises. A careful review of your agreement is one of the most important steps you can take at the outset of any employment relationship.

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Professional Events

DATE	EVENT	LOCATION	CONTACT INFO
April 18-22, 2026	AIABPM National show: Advanced Institute for Anesthesia Billing & Practice Management 26	Gila River Wild Horse Pass Resort & Casino Chandler, AZ	Advanced Institute for Anesthesia Billing and Practice Management – The Premier Meeting for Anesthesia Practice Leaders
August 21-25, 2026	AANA 26: American Association of Nurse Anesthetists Annual Congress	Thomas M. Menino Convention & Exhibition Center Boston, MA	AANA | Annual Congress
August 28-30, 2026	2026 Great Lakes Anesthesiology Meeting (GLAM)	Swissôtel Chicago, IL	Wisconsin Society of Anesthesiologists - Great Lakes Anesthesiology Meeting (GLAM)
October 16-20, 2026	ASA Annual 26: American Society of Anesthesiologists Annual Conference	San Diego Convention Center San Diego, CA	ANESTHESIOLOGY 2026 | American Society of Anesthesiologists (ASA)

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