Anesthesia Finances in the Age of COVID-19

PART 1 – Impact of Maintaining Existing Subsidy Structures

Robert Stiefel, MD, Principal, Enhance Healthcare Consulting

Remember the good old days? Remember when OR's were full and you needed to back up a Brinks truck to recruit an anesthesiologist, CRNA or AA? Remember when everyone was concerned with OR growth, market share and meeting quality and performance metrics? Ah, the good old days of February.

How things have changed in a few short weeks as a result of the 2019 Coronavirus (COVID-19) pandemic! Anesthesia providers are now being furloughed or laid off, some being asked to provide services in ICU's or Emergency Departments, while elective surgical procedures, a significant source of revenue, have effectively come to a halt in most US hospitals and Ambulatory Surgery Centers. While the impact may pale in comparison to industries such as airlines, cruise lines and hospitality, it has nonetheless been, and will continue to be, a cataclysmic operational and financial change for the anesthesia delivery model in the US.

Greater than 80% of US hospitals who contract with an independent anesthesia group support Fair Market Value compensation through subsidy payments or compensation for services to those groups. These subsidies are typically negotiated based on steady state or projected group expenses and professional fee revenue. In advance of the agreement the parties will carefully negotiate the number of anesthetizing locations, FTE providers, overhead and calculate expected revenue collection. In a typical 3-year contract, the subsidy arrangement works well for both parties if the revenue and expenses stay within a reasonable range (usually 5% or 10%) of projections.

Subsides may be structured in many ways, the most common being fixed stipends and revenue guarantees. Each structure has pros and cons, but in a sudden financial upheaval like we are experiencing, where surgical cases and corresponding anesthesia revenue grind to a halt, one party or the other will be significantly harmed depending on the structure chosen. We will use a simplified, theoretical anesthesia group to highlight the stark financial differences between each subsidy model and to show the dramatic impact of different anesthesia staffing models on partner physician compensation.

In Table 1, we model a group staffing 10 locations, with three distinct staffing models. One is all MD, one is a "mixed" care team model and the third is a "heavy" care team model with an anesthetist in each staffed location. The staffing for these models in Table 1 are 12 MD/0 CRNA/AA, 8 MD/7 CRNA/AA and 5 MD/12 CRNA/AA, respectively. In the BC-19 era (Before COVID-19), the projected and actual revenue are the same, thus the subsidy is the same for identical staffing models under a fixed or a revenue guarantee model. In this BC-19 era, the partner physicians would expect to make the same total compensation in each of the six scenarios. As would be expected, as the use of mid-level provider leverage increases, the overall subsidy diminishes slightly.

				BC-19 (Before COVID-19)				
	Scenario	**MD's**	**CRNA/AA's**	**Monthly Revenue**	**Monthly Subsidy**	**Total Revenue**	**Implied Annualized MD Comp**	**Subsidy Structure**
Fixed Subsidy	1	12	0	250,000	315,000	565,000	540,000	Fixed
Baseline	2	8	7	250,000	280,831	530,831	540,000	Fixed
Locations	3	5	12	250,000	249,996	499,996	540,000	Fixed
Rev Guarantee	4	12	0	250,000	315,000	565,000	540,000	Rev Guarantee
Baseline	5	8	7	250,000	280,831	530,831	540,000	Rev Guarantee
Locations	6	5	12	250,000	249,996	499,996	540,000	Rev Guarantee

TABLE 1: *Sample Staffing and Subsidy Model Before COVID-19*

For our DC-19 (During COVID-19) time period model shown in Table 2 we assume that the requirement to staff all 10 anesthetizing locations remains. Although the locations may not be open due to loss of elective procedures, the assumption is that the facility continues the same level of subsidy support which was in place prior to the virus. However, due to loss of significant elective surgical volume, we show a decrease in collections from payers and patients of 80%, or from $250,000 to $50,000 per month.

With the assumptions above, the DC-19 phase is characterized by substantial differences in physician compensation based upon the subsidy support and mid-level leverage in place. As seen in Table 2, assuming all group physicians are partners and share equally in profit/loss and assuming that mid-level provider compensation is paid in full, if a fixed subsidy model is in place, the All-MD, mixed and heavy models will result in annualized partner physician compensation of $344,167, $246,247 and $69,990 respectively. Conversely, in an open-ended revenue guarantee (no cap), all of the providers compensation will be protected, but the hospital subsidy will increase by $200,000 per month in each staffing model to make up for lost surgical volume and corresponding anesthesia revenue.

				DC-19 (During COVID-19)				
	Scenario	**MD's**	**CRNA/AA's**	**Monthly Revenue**	**Monthly Subsidy**	**Total Revenue**	**Implied Annualized MD Comp**	**Subsidy Structure**
Fixed Subsidy Baseline Locations	1	12	0	50,000	315,000	365,000	**344,167**	Fixed
	2	8	7	50,000	280,831	330,831	**246,247**	Fixed
	3	5	12	50,000	249,996	299,996	**69,990**	Fixed
Rev Guarantee Baseline Locations	4	12	0	50,000	**515,000**	565,000	540,000	Rev Guarantee
	5	8	7	50,000	**480,831**	530,831	540,000	Rev Guarantee
	6	5	12	50,000	**449,996**	499,996	540,000	Rev Guarantee

TABLE 2: *Sample Staffing and Subsidy Model During COVID-19*

While each facility and anesthesia provider group must assess their own situation, simply maintaining the support mechanism in place prior to COVID-19 will be very expensive for one party or the other. In our most highly leveraged model with a fixed subsidy, and the assumptions as described, our hypothetical physician partners will see their total compensation reduced by 87% (from $540,000 to $69,990 per year). On the other hand, in a revenue guarantee with no cap, the highly leveraged model shows a $200,000 increase in required hospital subsidy per month, representing a 66.6% increase. All of this in an environment where hospital finances are under siege on all fronts trying to deal with the needs of their communities to battle the virus.

Bottom line, COVID-19 is a massive stress test for anesthesia group financials. Depending on the type of support model, that stress test may be on the group and its partners or on the hospital as a component of a much larger financial stress test. Unfortunately, many hospitals and groups are not equipped to absorb the respective financial hit for very long at all – often only for a matter of weeks. Clearly, maintaining the existing contractual support model will often have unsustainable financial implications for many anesthesia arrangements, which will worsen as the elective case shutdown continues.

If current models are unsustainable, what happens next? Already, we have seen groups threaten bankruptcy, furlough physicians and anesthetists, and ask to become hospital employees. Many hospitals and large health systems have proposed a dramatic reduction in subsidy support dollars.

In part 2 of this series, we will model several potential interim responses and discuss the financial and operational implications.

EHC consultants with expertise in anesthesia financials and operations are available now to help you plan for the After COVID-19 period.
Please call or email us to discuss how we can help you formulate short and long-term plans.
Email: info@enhancehc.com Phone: (954) 242-1296

Enhance
Healthcare Consulting