Anesthesia Finances in the Age of COVID-19

PART 2 – Impact of Common Early Responses

Robert Stiefel, MD, Principal, Enhance Healthcare Consulting

The good old days of February and early March are a distant memory. In Part 1 of Anesthesia Finances in the Age of COVID-19 we described the dramatic impact a projected (and increasingly realistic) 80% decrease in anesthesia group professional revenue would have on anesthesia financials with a fully supported staffing model. In a fixed subsidy the impact was up to an 87% decrease in partner physician compensation while in a revenue guarantee, using our assumptions, the hospital subsidy increased up to 66% from baseline.

Realistically, most anesthesia groups (regardless of their size) and hospitals are not going to be able to absorb such a significant financial hit for long. Most facilities have significantly reduced the number of anesthetizing locations as elective cases have disappeared, and many previous subsidy support levels have been dramatically reduced or eliminated. We are aware of one large hospital system that has already asked many of their anesthesia groups to take a 50% subsidy reduction for the next 90 days and one smaller anesthesia group that has agreed to reduce their subsidy by the same percentage (20%) the hospital reduces it's employed surgeon's compensation.

Our objective for this installment of our series is to model the impact of several examples of these changes on anesthesia group finances. As we did previously, in order to demonstrate the impact in various scenarios, our example will use 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.

To highlight the impact of changes, we will use a revenue guarantee model showing the impact of reducing subsidy supported anesthetizing locations by 50% from 10 to 5 (although many of our clients report a 60-80% reduction in rooms in use), and then adding a reduction in supported compensation for all anesthesia providers by 50%.

Summarized in Table 1 below, the BC-19 (Before COVID-19) section shows the arrangement at steady state, all 10 operating rooms are running, anesthesia revenue is at the projected steady state ($250,000/mo) and compensation is at Fair Market Value levels for all providers.

Staffing		BC -19 (Before COVID-19)				
MD's	CRNA/AA's	Monthly Revenue	Monthly Subsidy	Total Revenue	Implied Annual MD Comp	Implied Annual CRNA/AA Comp
12	0	250,000	315,000	565,000	540,000	250,000
8	7	250,000	280,831	530,831	540,000	250,000
5	12	250,000	249,996	499,996	540,000	250,000

TABLE 1 : *Financial Model Baseline - Before COVID-19*

In the DC-19 (During COVID-19) analysis shown in Table 2, all of which maintain the initial monthly group overhead ($25,000/mo. in all scenarios), we see the cumulative impact of the cost cutting measures as compared to the baseline modeled in Table 1.

In scenarios 1 through 3, in Table 2 below, the impact of the 50% reduction in anesthetizing locations results in a monthly subsidy which is minimally changed from that seen before the impact of the virus. This is because the savings resulting from reduced provider FTE's required for the reduced staffed locations comes close to offsetting the $200,000 reduction in monthly revenue. It is only when we superimpose a 50% reduction in provider compensation in scenarios 4 through 6 that the hospital can meaningfully reduce the overall subsidy spend. In these models, where both the staffed locations and provider compensation are reduced by 50%, we see the calculated facility support decrease approximately 50% from baseline.

		DC (During Corona)							
	Scenario	**MD's**	**CRNA/ AA's**	**Monthly Revenue**	**Monthly Subsidy**	**Total Revenue**	**Implied Annual MD Comp**	**Implied Annual CRNA/AA Comp**	**Subsidy Structure**
Rev Guarantee Reduce Locations 50%	1	7	0	50,000	**290,000**	340,000	540,000	250,000	Rev Guarantee
	2	5	4	50,000	**283,332**	333,332	540,000	250,000	Rev Guarantee
	3	4	6	50,000	**279,998**	329,998	540,000	250,000	Rev Guarantee
Rev Guarantee Reduced Locations and Comp 50%	4	7	0	50,000	**132,500**	182,500	**270,000**	**125,000**	Rev Guarantee
	5	5	4	50,000	**129,164**	179,164	**270,000**	**125,000**	Rev Guarantee
	6	4	6	50,000	**127,496**	177,496	**270,000**	**125,000**	Rev Guarantee

TABLE 2: *Financial Model of Interventions During COVID-19*

We want to be clear that the examples here are designed for demonstration purposes only and cannot be applied directly to any specific facility. Other options to reduce the overall spend certainly exist and our models are only designed to directionally show the impact of two common approaches we have seen. There are numerous anesthesia support models and certainly the details (coverage and call requirements, subspecialty coverage, leverage of mid-level providers etc.), and the financial impact of various maneuvers, will vary within each arrangement. However, the key point here is that in any stable, balanced anesthesia subsidy, a sudden, dramatic reduction in revenue will require drastic steps to mitigate. Given the sudden and devastating impact of Covid-19 on all aspects of healthcare, facilities and

groups will need to take some measures to “share the pain” because every aspect of the system is undergoing a massive stress test. It won’t be easy for any of us and will only worsen as the duration of the elective case moratorium continues.

In the current “During COVID-19 Phase”, the good old days appear a distant memory. Both personally and professionally our lives have been turned upside down. We suddenly live in a world of social distancing, stay at home orders and online schooling that was unimaginable just over a month ago. Professionally, elective surgical cases have gone away, providers are being terminated or furloughed, and revenue will begin to fall off a cliff in April making groups of all sizes possible bankruptcy candidates.

However, we will get through this and eventually create a new normal. In time, we will all emerge from our COVID-19 cocoons and elective cases will start up, likely with pent up demand. We believe that decisions made during this “During COVID-19” phase will have a huge impact on the ability to absorb the ramp up on the other side. Working together, we will navigate the short-term pain with an eye on intermediate and long-term gains in caseload, market share and ultimately profitability.

In Part 3 of this series, we will model the potential financial impact of our various scenarios on facilities as they scramble to meet surgical demand in an AC-19 (After COVID-19) world.