



Anesthesia Finances in the Age of COVID-19

PART 3 – Impact of Responses on Post Virus Performance

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In [Part 1](#) and [Part 2](#) of Anesthesia Finances in the Age of COVID-19, we described the impact a projected 80% decrease in anesthesia group professional revenue would have on anesthesia financials in three distinct scenarios. First with a fully supported anesthesia staffing model (impact of both a flat subsidy and revenue guarantee); second with a 50% reduction in staffed anesthetizing locations; and third, in addition to the reduced locations, a superimposed 50% reduction in provider compensation levels. While our focus in the previous models was on the immediate financial impact on both contracted entities, this installment will attempt to analyze the impact on facility finances in the first few months after the virus threat has stabilized to the point where elective surgical cases are able to resume.

Depending on a wide variety of factors including the percentage of elective cases prior to the shutdown, service line mix, payer mix, and baseline subsidy structure, each hospital will have unique implications and responses “During the COVID-19 (“DC-19”)” crisis. Clearly the path taken during the crisis will impact the position of a healthcare system to accommodate a return of surgical volume, which may include an overshoot due to pent up demand. We cannot hope to analyze each situation but endeavor to model directionally the impact of DC-19 actions on the ability of anesthesia provider groups to respond operationally after the elective case moratorium is lifted and the financial impact on the associated facility. To best illustrate, we will use the most heavily leveraged revenue guarantee model from Parts 1 and 2 and assume significant pent up surgical demand.

The DC-19 modeled staffing, supported locations, and implied monthly subsidies (see Parts 1 and 2 for details) are seen in the “During COVID-19” shaded section of Table 1. For the current analysis key assumptions are as follows:

- The After COVID-19 (“AC-19”) section shows the impact for the 2 months after elective surgical cases resume
- The During COVID-19 period lasts 3 months
- In scenarios 1 and 2 where full compensation was supported for all anesthesia providers, the facility has anesthesia staff available to run the number of supported locations (10 and 5 respectively) for the AC-19 period
- In scenario 3 where 5 locations were supported at 50% compensation, enough providers for only 3 locations remain in the AC-19 period
- It is assumed that average demand for surgical cases is elevated in the AC-19 period, thus cases per staffed location increase (from 66/month baseline to 100/month)
- Surgical contribution margin is calculated at \$2,000 per case
- “Net Facility Impact” for the 2-month AC period is calculated as the total contribution margin reduced by the total subsidy paid in the 3-month DC period

Scenario		DURING COVID-19			AFTER COVID-19			
		MD's	CRNA/AA's	Monthly Subsidy During COVID-19	Max Locations for 2 months AC	Max Cases for 2 Months AC	Surgical Contribution Margin (for 2 months)	Net Facility Impact (for 2 months)
1	Maintain 10 Locations and Full Comp	5	12	\$ 449,996	10	2000	\$ 4,000,000	\$ 2,650,012
2	Reduce to 5 Locations	4	6	\$ 279,998	5	1000	\$ 2,000,000	\$ 1,160,006
3	Reduce to 5 Locations and Reduce Comp 50%	4	6	\$ 127,496	3	600	\$ 1,200,000	\$ 817,512

TABLE 1: Financial Performance After COVID-19

Results highlight the potential impact of reduced support for anesthesia services in the short term (DC-19 period) leaving the facility unable to accommodate the surgical demand after the crisis resolves. In our hypothetical examples, the subsidy paid over a 3-month period in scenarios 1, 2 and 3 are approximately \$1,350,000; \$850,000 and \$400,000 respectively. Clearly, a meaningful reduction in immediate spending, however using our assumptions, these short-term savings come at a steep cost when elective surgical volume returns. As financial support diminishes in the DC-19 period, fewer anesthesia providers are in place and able to hit the ground running when case volume returns. This results in an inability to accommodate lucrative OR and NORA volume in the AC-19 period. The net contribution over the 2-month AC-19 period, accounting for the total subsidy paid, shows over a 3-fold increase from scenario 3 to 1 and over a 2-fold increase from scenario 2 to 1.

We want to be clear that the examples here are designed for demonstration purposes only and cannot be applied directly to every facility. We have made assumptions on several points which will surely deviate from the actual outcome as we recover from the current crisis. The duration of the COVID-19 shutdown, modeled as a 3-month period in our example, is unknown at this time. A shorter shutdown would actually result in a larger benefit for scenario 1 as compared to other scenarios (less total subsidy spend with the same calculated contribution margin). It is also possible that surgical demand will ramp up slower than expected, and that a sustained 50% increase above baseline caseload per anesthetizing location may not be realized. The availability for recruitment of “disenfranchised anesthesia providers” whose baseline compensation was not supported during the elective case moratorium is a true unknown. There will certainly be providers who perceive they were not supported adequately by their group or hospital system, but will they be willing to move to new situations in large numbers, or will they eventually settle back into their previous practices? If providers can be rapidly recruited (or perhaps re-recruited to their previous practice) for the AC-19 period, the number of anesthetizing locations available to support surgical cases may be reached quickly and mitigate the loss of case capacity assumed in our model.

Nonetheless, our key point here is that support of anesthesia providers during the current crisis will likely have important implications as surgical volume recovers. If our examples and assumptions are directionally correct, the return on investment of supporting anesthesia provider groups will have a positive net financial impact by the time elective case volume stabilizes. As we have acknowledged previously in this series, in light of the sudden and devastating impact of COVID-19, all healthcare organizations will need to take some measures to “share the pain” because every aspect of the system is undergoing a massive stress test. However, those facilities and health systems who are willing (and financially able given the tsunami of short-term issues they face) to significantly support their anesthesia service, will likely be better positioned when the elective case moratorium is lifted.

An important assumption which supports our “AC-19 analysis” is a pent-up demand of surgical cases and the ability to achieve volumes 50% higher than baseline for several months. This assumption will be impacted by a number of variables which we believe warrant a more detailed discussion. In Part 4 of this series, we will discuss these variables and attempt to assess the impact on facilities and decision making as we emerge into an After COVID-19 world.

EHC consultants with expertise in anesthesia financials and operations are available now to help you plan for the After COVID-19 period.

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