Anesthesia Subsidies

Putting it all on the table!

Hospitals are experiencing a dramatic increase in requests for financial support of their anesthesia service providers, a situation which has been exacerbated by the pandemic. The Enhance Healthcare database, which contains over 120 hospitals, shows the average subsidy per anesthetizing location skyrocket to $185,000 for contracts signed in the last 3 years, a dramatic 30% increase from the $132,000 per anesthetizing location the 3 years prior. This frequently puts total hospital subsidies in the millions or tens of millions of dollars in annual subsidy, enough to meaningfully impact the facility bottom line.

The factors that affect anesthesia subsidies include:

1. Fair Market Value Compensation
2. Required Staffed Anesthetizing Locations
3. Anesthesia Staffing Model
4. Anesthesia Revenue Cycle Performance.

Armed with an understanding of the key drivers of anesthesia subsidies, hospitals and anesthesia groups should be better equipped to proceed with data driven negotiations. Both sides must acknowledge that the relationship between a facility and its anesthesia partners is mutually dependent. A hospital cannot remain viable without anesthesia services. Anesthesia groups cannot function without the cases brought by a facility's surgical staff. Establishing this perspective early on will help to address each of these factors.

While support of anesthesia services is often impactful to the bottom line, when both parties utilize a data driven framework and create an aligned support structure, a stronger partnership is created.

Anesthesia Subsidies provides a framework on how each of these factors affect the amount of anesthesia financial support required. These factors are also considered the "Four Legs" of anesthesia subsidies. Each factor should be isolated and analyzed as subsidies are being negotiated.

Fair Value Market Compensation

Fair market value for anesthesia provider compensation is determined by supply and demand. We have access to numerous internal and external surveys of anesthesia compensation that we use to conduct commercial reasonableness assessments. These surveys offer guidance and parameters based on national and local markets. These surveys don't all look at the same parameters which in turn create a wide range of average payments. It also creates a tendency for stakeholders to cherry pick the surveys that support their argument.

Furthermore, job requirements of anesthesiologists are far from similar. At the simplest level, positions at Surgery Centers with no night or weekend responsibilities differ dramatically from hospital-based positions, yet providers at both practice settings are included in broad surveys. Drilling down further, considering only hospital-based anesthesiologists, there is dramatic variation in allocated vacation, frequency of call, subspecialty care required, staffing model used, and case complexity and acuity.

Enhance Healthcare's consultants are experts when it comes to analyzing metrics. We use national survey databases and large proprietary datasets such as our EHCData to match compensation to the unique challenges of each facility. Our experts utilize numerous metrics such as ASA units per Anesthesiologist, subsidy per anesthetizing location and productivity per provider to support compensation requirements.

While Enhance Healthcare is not licensed to perform FMV evaluations we always take them into consideration during discussions with our clients.

Required Staffed Anesthetizing Locations

The second key driver of Anesthesia Subsidies is Required Staffed Anesthetizing Locations**.** That is the number of locations anesthesia is expected to cover by day of the week and time of day. It is the primary basis for anesthesia staffing and is determined by the facility or healthcare system.

Typically, hospital executives respond to the challenge of retaining talented surgeons and proceduralists in a competitive market by offering first case starts and flexible booking times, resulting in a need for additional late anesthetizing locations. In both the OR and NORA sites (Endoscopy, Cath Lab, IR), adding locations, increasing late afternoon OR time, and adding subspecialty (cardiac, trauma) call requirements without increasing the number of surgical minutes leads to decreased utilization of expensive anesthesia resources. Decreased provider productivity leads to less total revenue collected by the anesthesia group, which directly results in a higher anesthesia subsidy.

Determining the number of anesthetizing locations is a complex and multifactorial business decision and should not be viewed simply through the lens of anesthesia financial support. Hospital executives and OR nursing leadership should consider actual block utilization in the OR and NORA, perioperative inefficiencies, and the competitive market of the facility. “Build it and they will come” may be a valid and profitable long-term strategy, however expecting to increase capacity by overstating anesthesia availability will be costly.

Anesthesia Staffing Model

While OR and NORA coverage requirements are typically under the purview of the hospital, it is up to the anesthesia provider group to determine how the locations will be staffed. Whether the group functions as an anesthesiologist-only model, Anesthesia Care Team, or a CRNA-only model, several factors must be taken into consideration when designing a staffing matrix. These include call obligations, comfort level of the surgical staff, and the complexity and subspecialty mix of cases.

Many decision-makers assume the use of CRNAs, or AAs will dramatically decrease the required anesthesia support. The reality of incorporating CRNA/AAs into the staffing model are far more nuanced and subsidy levels can range depending on factors such as medical direction, call requirements, shift lengths and total hours worked. An expert review of the proposed staffing matrix is recommended in any subsidized arrangement to assess the impact of adding each type of provider and the specific details of required coverage.

Anesthesia Revenue Cycle Performance

Anesthesia Revenue Cycle Performance does not receive enough attention before or during contract negotiations between the hospital and the anesthesia provider. Hospitals that are subsidizing anesthesia groups are either directly or indirectly responsible for the group's total revenue collections. In an uncapped revenue guarantee, the hospital is responsible for making up every dollar that is not collected. In flat subsidy arrangements, which may be negotiated every few years, the actual revenue reported by the provider group is often not understood or even challenged.

We recommend that the hospital C-Suite track the entire revenue cycle on an ongoing basis in any subsidized arrangement. By implementing the proper tracking system, hospital leadership can identify areas of underperformance, quantify potential revenue opportunities, and benchmark against standard billing performance metrics.

Enhance Healthcare's anesthesia experts are equipped with the knowledge to develop a dashboard of anesthesia-specific revenue cycle Key Performance Indicators which can be tracked monthly. These metrics create benchmarks and follow average discretionary payer contract rates (along with local/national benchmarks) to proactively determine any drop-off in performance.