

FEATURE STORY

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anesthesia subsidies a strategic approach for financial executives

Anesthesia subsidies can erode a hospital's bottom line, but healthcare financial executives can take steps to control this expense while preserving quality.

AT A GLANCE

Healthcare financial executives should employ a systematic approach to anesthesia contract negotiations that:

- > Establishes costs and considers alternative options to reduce anesthesia expense
- > Defines expected value
- > Aligns compensation
- > Defines performance parameters
- > Establishes tracking metrics

Starting in the mid-1990s, several sweeping changes to the anesthesia landscape began to dramatically diminish the availability of providers, transforming anesthesia services from a no-cost line item to a recurring line item whose cost often dwarfs that of other large-ticket capital items on the budget. In the current challenging environment, financial executives in hospitals are seeing increasing numbers of new and escalating requests for subsidies to secure anesthesia services. In fact, 78 percent of anesthesia groups are receiving financial support, according to Karin Bierstein, JD, associate director of professional affairs for the American Society of Anesthesiologists ("Anesthesiology Practice Costs, Revenues, and Production Survey Data," *American Society of Anesthesiologists Newsletter*, April 2007).

Realizing that anesthesia care is fundamental to providing operating room (OR) services and that abruptly replacing an anesthesia group is fraught with clinical and financial risks, healthcare financial executives often feel disadvantaged in contract negotiations. However, understanding key subsidy drivers and implementing a systematic approach to anesthesia contract negotiations can help level the playing field.

How Did We Get Here?

Anesthesia subsidies in hospitals can exceed operating profit. To comprehend numbers of this magnitude, providers need to understand the three key drivers that have shaped the anesthesia market over the past decade—supply-demand imbalance, decreased productivity, and decreasing payment.

Supply-demand imbalance. The first key driver is the dramatic anesthesia provider supply-demand imbalance that developed during the 1990s. The imbalance developed due to several market forces that converged to increase demand for anesthesia providers while diluting the supply:

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- > A proliferation of surgery centers, increasing the number of anesthetizing locations^a
- > A precipitous decrease in the number of anesthesiologist and certified registered nurse anesthetist (CRNA) graduates^b
- > Increases in the number of procedures performed in surgeons' offices
- > Departure of anesthesia providers to pursue pain management

In light of the fundamental role anesthesia plays in ORs, the supply-demand imbalance led hospitals to compete for anesthesia providers to maintain OR capacity. The result has been rapidly escalating provider compensation—the key driver of anesthesia group expenses. Data from the Medical Group Management Association (MGMA) indicate that anesthesiologists' salaries rose from \$325,000 in

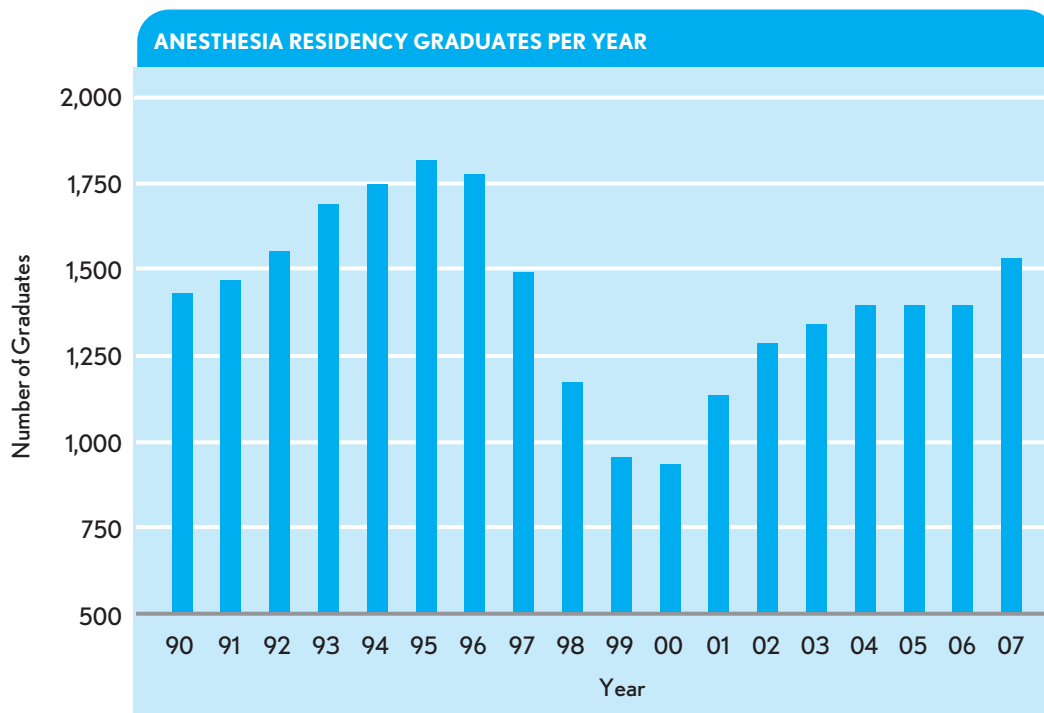
2004 to \$399,500 in 2007, an increase of more than 23 percent (*Physician Compensation and Production Survey: 2008 Report Based on 2007 Data*). And a report by Watson Wyatt Data Services notes that average salaries for CRNAs rose from \$111,000 in 2004 to \$140,000 in 2007, a 26 percent increase (*2007/2008 Survey Report on Hospital & Health Care Professional, Nursing & Allied Services Personnel Compensation*, May 1, 2007).

Decreased productivity. The second key driver is decreased productivity, which ties to the other side of the subsidy equation—the ability of anesthesia groups to collect revenue for services. Although surgical demand has increased in the United States, it has failed to keep pace with the increase in the number of ORs. Therefore, notes Bierstein in her April 2007 article, anesthesia providers, on average, are generating less revenue per staffed location, translating into lower patient service collections per provider.

Decreasing payment. The final driver is stagnant or decreasing payment. Demographics have

a. Becker, S., Verispan Market Letter/Surgery Market, August 2007.

b. Schubert, A., "2007 Anesthesiology Resident Class Sizes and Graduation Rates," *American Society of Anesthesiologists Newsletter*, December 2007.



Source: Schubert, A., "2007 Anesthesiology Resident Class Sizes and Graduation Rates," *American Society of Anesthesiologists Newsletter*, December 2007.

dictated that much of the increasing surgical volume is covered by Medicare, which reimburses anesthesia using an archaic formula that results in low rates. In fact, 76 percent of hospital CEOs now report that Medicare accounts for more than 40 percent of revenue, Stanley W. Stead, MD, CEO and founder of Stead Health Group, Inc., commented at a recent conference (“After Medicare Increases: Where Do We Go?” 2008 American Society of Anesthesiologists Conference on Practice Management, Tampa, Fla., February 2008). These numbers correlate closely with the prevalence of group subsidies referenced above.

This trend is expected to continue, with the Medicare Payment Advisory Commission projecting that total Medicare enrollees will approximately double over the next 20 years (*A Data Book: Healthcare Spending and the Medicare Program*, June 2008). With the combination of increasing labor market demand and decreasing reimbursement, anesthesia compensation has essentially become “decoupled” from patient service reimbursement. The result is a dramatic cost shift from the payer to the hospital to keep the providers at fair market compensation.

Anesthesia Subsidy Drivers

Many hospitals now support anesthesia services financially, but without working knowledge of

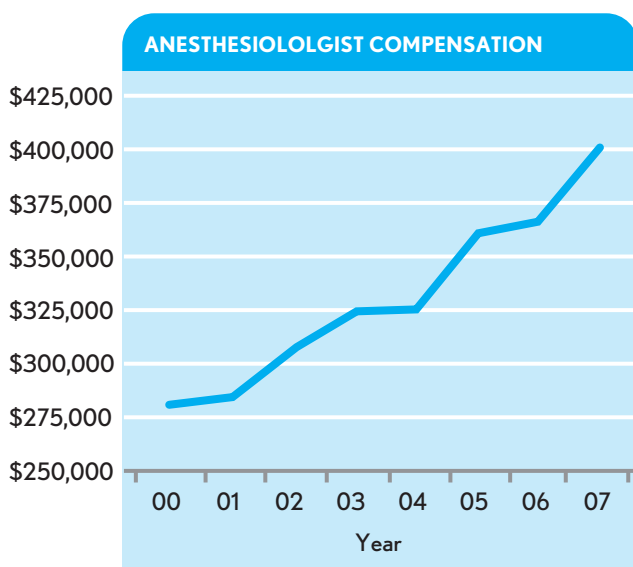
actionable drivers, financial executives may not be able to negotiate optimal contract terms. The four fundamental drivers, or four legs, of anesthesia subsidies should be addressed during negotiations:

- > Fair market value
- > Anesthetizing locations
- > Staffing matrix
- > Billing/contracting performance

Fair market value. Fair market value is determined by supply and demand forces and may be influenced by such factors as workload requirements, subspecialty expertise, and geographic location. During contract negotiations, the concept of “fair market service” for fair market compensation should be introduced. Successfully implemented, this concept creates a mechanism to align compensation with the ROI items discussed below.

Anesthetizing locations. As the primary driver of anesthesia staffing requirements, anesthetizing locations are normally controlled by the health-care organization. Surgeon demand for “7:30 starts” pressures hospital executives to open additional locations. As locations are added, utilization per staffed OR typically drops because a corresponding percentage of surgical minutes is not added simultaneously. Because anesthesia providers are required to staff the additional anesthetizing locations, each provider becomes less productive. The resulting reduction in billable minutes per anesthesia provider leads to lower net revenue per provider, which in the current environment typically translates into an escalating anesthesia subsidy. The number of anesthetizing locations is a multifactorial strategic decision, with important implications for the ability to grow caseload and market share. Nonetheless, one consideration to weigh when making this business decision is the impact on anesthesia subsidy.

Staffing matrix. The anesthesia staffing matrix used to cover required anesthetizing locations is typically created by the group. When hospital executives are unfamiliar with reasonable anesthesia staffing, they may accept staffing models



Source: 2008 MGMA Physician Compensation and Production Survey.

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without informed analysis. In fact, numerous factors affect a reasonable staffing matrix, including whether the group functions in a physician-only model or employs CRNAs, case volume and complexity, after-hours workload, and subspecialty coverage requirements. Because the addition of a single provider has a large financial impact, assistance from consultants familiar with anesthesia staffing model design is recommended in subsidized arrangements.

Billing/contracting performance. Anesthesia revenue cycle performance represents an area of substantial exposure for many facilities, because the healthcare organization in subsidized structures usually bears the risk for billing and collecting for anesthesia services. Anesthesia billing has a unique time component and uses units rather than RVUs. The acuity of the surgical case is captured by the number of “Base” units assigned to the procedure code. To the base units are added “Time” units, generally in 15-minute increments, that allow the anesthesia provider to bill for his or her actual anesthetizing time. Additionally, providers can bill for a host of modifiers that capture everything from co-morbidities to additional anesthetic procedures that can be charged. To satisfy insurer’s standards for reimbursement, each charged component must be precisely documented in accordance with a myriad of regulations that vary, depending on the staffing model, surgical procedure, and jurisdiction. Some healthcare financial executives may lack the anesthesia revenue cycle expertise needed to assess the efficacy of the collections process. Furthermore, the choice and oversight of the billing company is frequently left to the group, creating a risky disconnect between the flow of dollars and the incentive to collect those dollars.

To minimize these risks, billing performance should be tracked in any subsidized anesthesia arrangement. Properly implemented, tracking can proactively identify areas of underperformance, quantify the potential financial opportunity, and benchmark against billing key performance indicators (KPIs), such as the “actual blended unit rate” versus “expected,” which indicates

whether the billing agent is collecting in line with contract allowables. Other standard revenue cycle measures, such as days in A/R and cash factor are also as important in anesthesia billing as elsewhere. In a subsidized arrangement, the hospital should compel the group and its billing agent to report these measures on a regular basis as a condition to receive the subsidy payment. Experts in anesthesia revenue cycle can assist in creating a billing dashboard that will provide a regular snapshot of billing performance. Similarly, healthcare financial executives should insist that the group receive regular assessment and oversight of the contractual rates with payers.

Although the four legs framework is useful in assessing and identifying opportunities to reduce the cost when presented with an anesthesia subsidy request, financial executives should dig deeper to assess the value they should be seeking in ROI.

Defining the Value in Anesthesia Services

The direct expense of an anesthesia subsidy is easy to quantify. When evaluating a subsidy request or the rationale for an existing subsidy, however, management needs to recognize the value—the impact on profitability—of high-quality anesthesia care. Most subsidized models guarantee fair market value compensation, implying that all anesthesia providers and groups provide equivalent service. This is intuitively, and in reality, far from the truth, but what should hospitals use to gauge their “return” on anesthesia “investment”?

First and always most important is clinical excellence. Many large healthcare organizations now track clinical parameters to benchmark clinical quality. Such parameters typically include anesthesia-centric pay-for-performance criteria (e.g., CMS Physician Quality Reporting Initiative specific to anesthesia), but often also incorporate other metrics of clinical importance related to key components of the perioperative process, such as maintenance of normal body temperature, reduction in nausea and vomiting, and reduction in anesthesia related to critical incidents.

The impact of anesthesia providers on surgeon satisfaction is another important consideration. Surgeons weigh several key variables in determining their preferred OR venue. Anesthesia services occupy a critical role in that decision tree and are vitally important to surgeon perception of the OR environment. An anesthesia group with a positive impact on satisfaction can help improve a hospital's financial performance by driving caseload and market share growth for the hospital. Commercially available options exist to track and benchmark the KPIs that determine surgeon satisfaction with anesthesia services.

Anesthesiologists should also assume a leadership position in the OR, collaborating with surgical and facility staff to develop a data driven, functional governance and decision-making framework.^c This body should oversee OR processes, policies, and procedures, and seek continuous improvement in OR performance metrics. By requiring an anesthesia role in OR governance and tracking certain OR process-related metrics—for

example, turnover time, PACU time, and narcotic documentation—as part of an anesthesia report card, healthcare organization executives can create a mechanism to value this contribution.

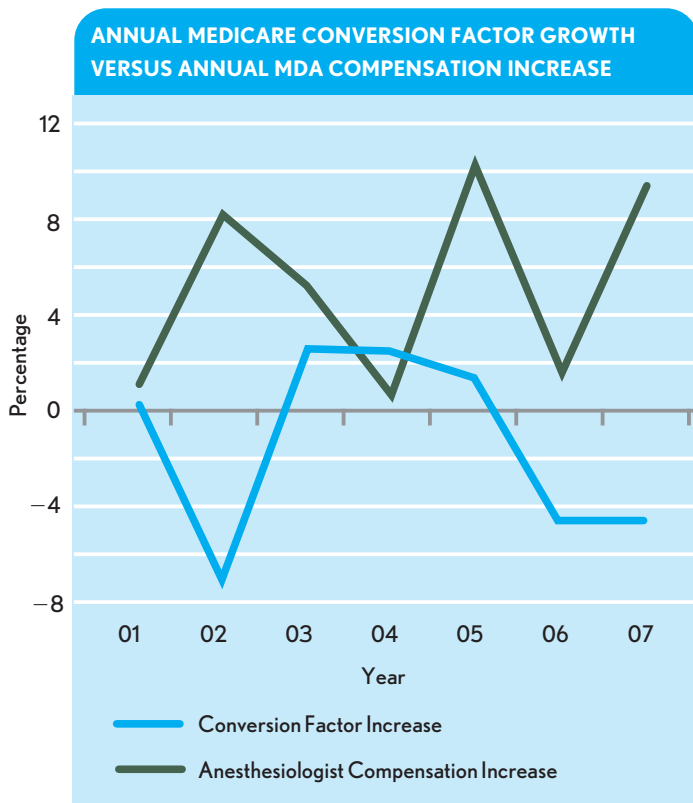
Finally, as the only group of physicians always present in the OR, anesthesiologists occupy a central position in day-to-day OR throughput and management of patient flow. They should proactively assist in patient preparation and personnel utilization, and actively communicate with OR nursing staff and surgeons. Through ongoing analysis and process improvement, anesthesia leaders should spearhead efforts to continually achieve greater safety and efficiency. Therefore, part of the anesthesia report card should relate to OR KPIs, such as prime-time utilization, on-time starts, and day of surgery cancellations. (See exhibit on page VI.)

In summary, anesthesia groups should be measured not only on what they cost, but also on the value they deliver. Healthcare financial executives should recognize their instrumental role in attracting surgical volume to the hospital through a commitment to clinical quality, efficiency, and customer service. Such deliverables should be assessed when contemplating anesthesia subsidies, because their impact on surgical volume can drive value far in excess of the subsidy itself.

**Bringing It All Together:
A Strategic Framework**

Armed with an understanding of anesthesia cost and value drivers, healthcare financial executives can coalesce these factors into a strategic approach to ensure delivery of value-added anesthesia care on the most advantageous terms.

To best position their organization for anesthesia contract discussions, financial executives should use the four legs to evaluate the steady state anesthesia deficit. They should confirm fair market value, evaluate the hospital's coverage requirements to determine if surgical volume warrants the level of service sought, and confirm that the staffing model matches coverage requirements.



Source: 2008 MGMA Physician Compensation and Production Survey and Centers for Medicare & Medicaid Services data.

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Finally, they should evaluate the anesthesia revenue cycle to ensure that all professional fees due the group are collected. The ability to analyze and understand these key drivers helps executives level the playing field during negotiations.

With the components isolated, alternatives offering potential subsidy reduction often become evident. Opportunities may include, but are not limited to, a revised staffing model, reduced anesthetizing locations, a change in billing entity, employment of providers, or even a change in provider groups. To each alternative, apply a risk/reward analysis, keeping in mind potential transition costs.

Once the required subsidy support is optimized using the four legs analysis, the challenge of developing a structure to maximize ROI can begin. The common subsidy mechanism of an income guarantee suffers from lack of aligned incentives. Without motivation to grow caseload, anesthesia providers will simply “punch the clock.” A value-based approach to subsidy structure can provide the incentive they need. With a properly designed framework, a certain portion of group compensation will be rewarded only for above-average performance. Although models are tailored to the needs of each facility or system, generally to provide adequate aligned incentives, a meaningful dollar amount should be tied to performance. For example, an appropriate subsidy guarantee baseline may need to be set at the 35th to 40th percentile of local market compensation. Remember, these levels are not necessarily below market, but are below median—which is exactly where your anesthesia group should be if it is not providing the services you value. From the baseline, build in certain performance goals that align with the organization’s mission and, if met, will allow group compensation to rise to the median or above.

c. Heslin, M., and others, “Durable Improvements in Efficiency, Safety, and Satisfaction in the Operating Room,” *Journal of the American College of Surgeons*, May 2008, pp. 1083-1089.

A systematic anesthesia contracting strategy can enable hospitals to align incentives to maximize anesthesia service return on their subsidy dollars.

Considerable thought should be devoted to specifying performance criteria. From a financial perspective, such criteria should be able to link directly to growth in surgical volume and market share. Although every healthcare organization has unique deliverables that it values, such metrics commonly fall into four general areas—clinical excellence, surgeon satisfaction, OR utilization, and OR throughput.

The focus on aligned incentives greatly elevates the need for continuous data tracking. Providers with compensation at risk will insist upon unimpeachable data. Such information may be derived from electronic records, surgical information systems, medical record review, OR personnel, or commercially available applications. Each organ-

EXAMPLE OF AN OR DASHBOARD						
Operational Metrics	Goal	Jun	May	Apr	Q1	Avg
Relationships						
Medical staff satisfaction	>95%					-
Patient satisfaction	>95%					-
Scheduling Performance						
PAT within 24 hours of schedule case time	>95%					
Case cancellation rate	<4%					
Day of surgery cancellations - anesthesia related	<1%					
First case delay rate	<10%					
Resource Utilization						
OR utilization	>70%					
Case volume	N/A					
Block utilization	>70%					
Turnaround time	<25					

ization will have unique capabilities in place for data generation. As the performance criteria are negotiated with anesthesia providers, discuss the planned metrics and the mechanism to generate the metrics. Creating ongoing data monitoring capabilities is difficult work, but doing so will strictly align anesthesia compensation with the organization’s goals. Finally, although it is not an incentive metric, tracking billing and contracting performance is recommended in all subsidized situations, because group collections are always a direct or indirect determinant of the guaranteed portion of the subsidy.

Although a detailed discussion is beyond the scope of this article, to protect their anesthesia investment and gain more control over a group of providers that is already substantially subsidized, many organizations are taking these concepts one step further and seeking to employ anesthesia providers. In today’s market, there is a strong argument and definite benefit to an employment arrangement. Through the compensation package, the hospital can align incentives to the level of individual providers, exert greater influence over scheduling, and generally promote a more team-focused environment instead of suffering through tense annual subsidy negotiations. There are, however, numerous pitfalls in a transition to and operation of an employed model. Expert advice is critical to ensure a smooth operational and cultural transition, development of an aligned compensation model, sound clinical and governance expectations, and implementation of an effective and accountable organizational structure.

Ensuring ROI

Market dynamics have conspired to place significant bargaining power in the hands of anesthesia providers, with the cost of anesthesia coverage often representing the largest single provider-

related investment for hospitals. As with any other investment, the cost must be justified by the returns. By employing a systematic strategy for addressing anesthesia contracting, hospitals can ensure incentives are aligned to maximize anesthesia service return on their subsidy dollars. By implementing the ideas presented here, executives can level the playing field in subsidy negotiations and ensure that a symbiotic and value-based relationship exists with their anesthesia providers. ●

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