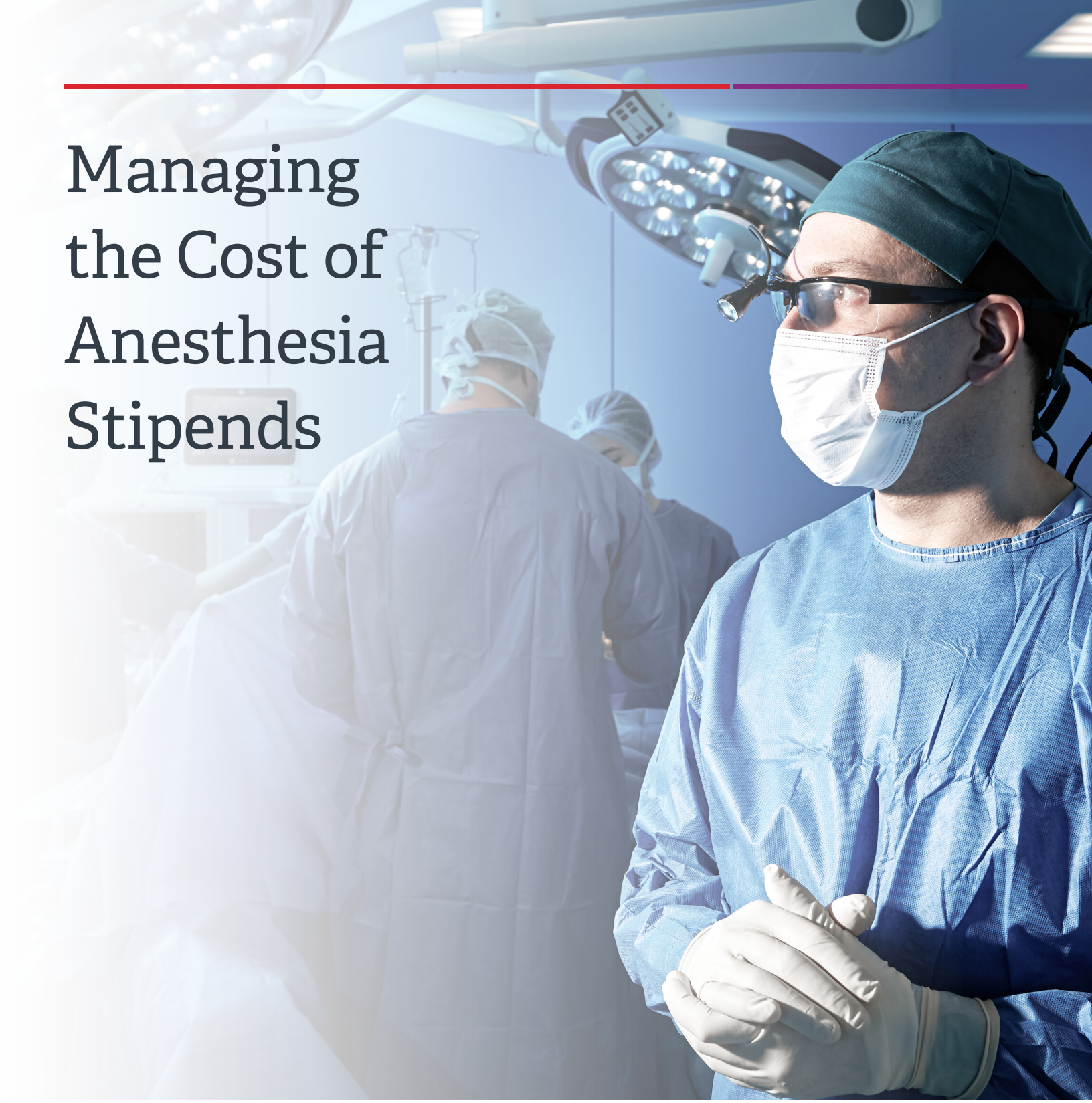
Managing the Cost of Anesthesia Stipends



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As we have discussed previously, we are witnessing a sharp increase in hospitals having to pay large amounts of financial support to their anesthesiologists. These payments typically come about through a series of events such as the following:

- Increasing market rates for anesthesiologist and certified registered nurse anesthetist (CRNA) compensation outstrip the anesthesia group's ability to generate revenue.
- Providers leave the group for greener pastures (which they can do very easily in their specialty), and replacements can't be recruited at a price the group can afford.
- The group quickly becomes unstable, and soon the hospital is faced with the prospect of inadequate anesthesia coverage.

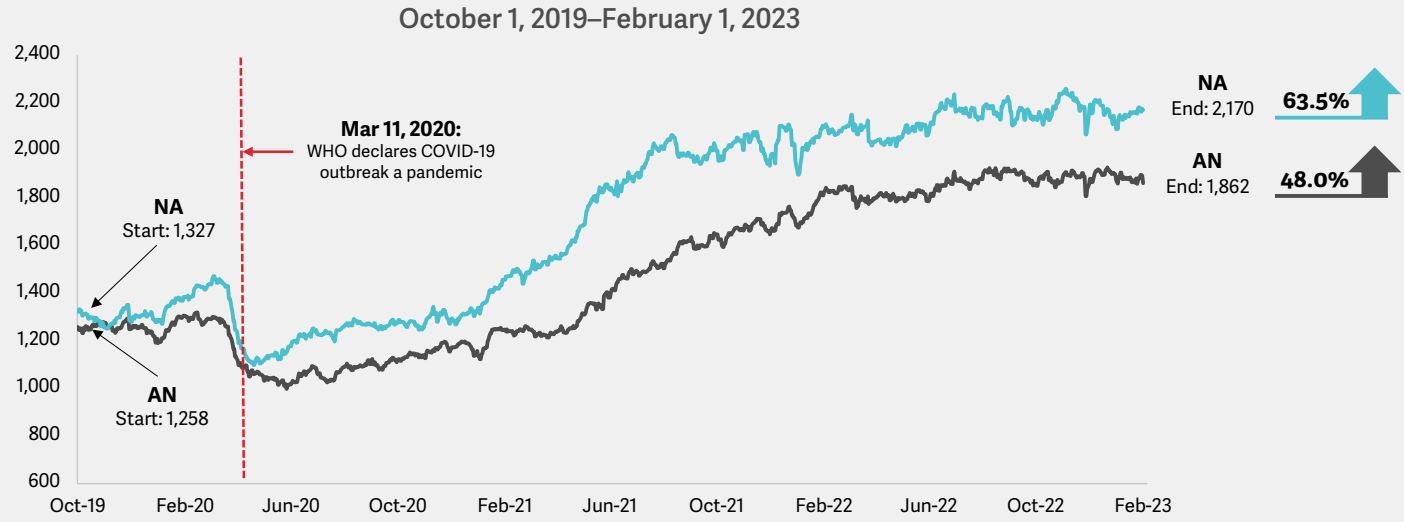
We have also offered some pointers to hospitals on how to deal with the situation when it arises.

However, these stipends will likely only grow in the future, and maintaining an adequately staffed anesthesia department will remain a chronic challenge. In this article, we dig deeper into the underlying reasons why this is the case and offer advice on how to manage the situation on a continual, rather than an episodic, basis. Recent experience has demonstrated that ongoing, proactive management is necessary because negotiating an anesthesia stipend is often not a "one and done" affair. Many of our clients have negotiated contracts only to find that within a year or so, the situation has changed and they must return to the negotiating table to address yet another increase in financial support.

RISING ANESTHESIA COMPENSATION LEVELS

Compensation levels for anesthesiologists and CRNAs are rising rapidly, as any provider in the field will tell you. To some extent this is evidenced by survey data, but these surveys always lag behind the market by one to two years and are still somewhat skewed by the effects of the pandemic. A more vivid illustration of what is currently happening can be seen in the rapidly increasing number of posted job offers (figure 1).

FIGURE 1: NON-RECRUITING AGENCY JOB POSTING TRENDS FOR ANESTHESIOLOGISTS (AN) AND NURSE ANESTHETISTS (NA)



Source: www.GasWork.com an anesthesia employment resources, October 16, 2018–February 1, 2023

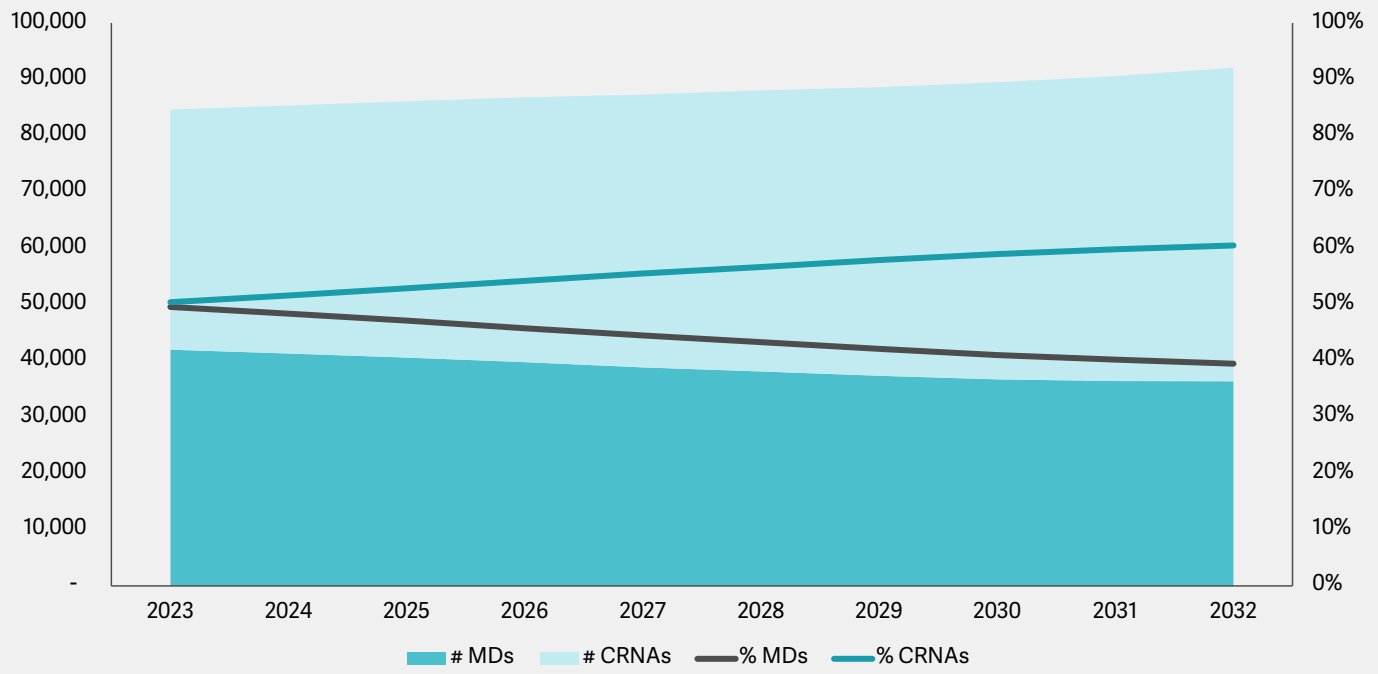
As with any good or service, the price for anesthesia providers is a function of supply and demand, and there are major forces at play with both.

Beginning with supply, there simply are not enough anesthesia providers in the market. This is not a new problem.[1,2,3] As a group, anesthesiologists are older than physicians in almost every other specialty, and by all indications they are retiring faster than new anesthesiologists are joining the workforce.

CRNA programs have alleviated the shortage of anesthesiologists somewhat and are now producing graduates at a faster pace than anesthesia residencies. While this helps, it also alters the mix of anesthesia providers in the market, which has significant staffing implications for hospitals (figure 2).

[1] "The Shortage of Anesthesiologists: An Unwelcome Lesson for Other Medical Specialties" (October 2001), Mayo Clinic Proceedings.
[2] "Is There a Shortage of Anesthesia Providers in the United States?" (2010), RAND Health, RAND Corporation.
[3] "Are We Facing an Anesthesiologist Shortage?" (January 2022), ASA Monitor, American Society of Anesthesiologists.

FIGURE 2: PROJECTED ANESTHESIA PROVIDER DEMOGRAPHICS



Declining numbers of anesthesiologists and increasing numbers of CRNAs will result in a very different mix of providers in the coming years. Currently there are roughly equal numbers of each; however, in the foreseeable future there will be more of a 60/40 split.

As for demand, the aging of the US general population is driving up the utilization of procedures requiring anesthesia. There is also the phenomenon of more anesthesia being provided at various locations outside of the main hospital OR, which creates inefficiencies (for anesthesia at least) and further increases the need for anesthesia providers.

Obviously, with demand increasing and supply fixed or decreasing, the price will only go up. Moreover, when the good or service in question satisfies an important need and there are no viable substitutes, the price tends to go up dramatically; anesthesia is a perfect example. Just like gasoline prices in late 2022, a relatively minor disruption in supply sends prices skyrocketing, and buyers have little alternative but to absorb the cost. Unlike gasoline, however, we predict that it will take years for anesthesiologist supply to realign with demand.

THE HOSPITAL PAYS THE COST

At this point you may be asking, "so how does this become the hospital's problem? After all, the patients and the payers are the buyers, so wouldn't they bear the burden of this?" Unfortunately for hospitals, both patients and payers are insulated from these market dynamics.

In years past, patients were more likely to bear the burden of high anesthesia costs. Many anesthesia groups chose a strategy of not contracting with payers and instead balance billing their patients;

the No Surprises Act put an end to that in 2022. The act also established an out-of-network rate-setting methodology that was very slanted in favor of payers. This has effectively negated anesthesiologists' ability to use contract termination as a negotiation tactic, seriously undermining their ability to obtain better rates. As a result, payers get the benefit of keeping the anesthesiologists in their network, and at low rates.

However, since the hospital cannot survive without anesthesia, it often finds itself with no alternative but to make a major financial commitment to supporting its anesthesia providers.

LONG-TERM PROGNOSIS

For the reasons just described, we expect that hospitals will struggle to keep their anesthesia departments fully staffed for years to come. In time, the solution may come as more people, lured by attractive salary levels, choose to enter the field of anesthesia. But that is a very long-term prospect at best, and may not materialize at all if the number of anesthesia residents does not increase. In the interim, we offer some specific observations.

The cost and availability of anesthesia providers will remain a challenge.

Because market rates for anesthesia providers are being driven by long-term trends that will not be reversed any time soon, these rates will continue to climb for the foreseeable future. Even at higher levels of funding, availability of anesthesia support will continue to be a challenge. To stay ahead of the curve, a hospital would need to pay top dollar for anesthesia coverage continuously—a very expensive approach that few, if any, organizations will be able to pursue. For the vast majority, it will feel like constantly playing catch-up.

Anesthesia collections will stagnate or decline.

As we discussed, anesthesia groups are now at a decided disadvantage in negotiating with payers. We don't envision this letting up any time soon, because the payers now have the upper hand thanks to federal legislation. In fact, we have seen in some markets that payers are explicitly pursuing a strategy of terminating or not renewing contracts with hospital-based physicians specifically so they can force providers out of network to obtain more favorable rates. This only makes the need for hospital financial support more acute.

OR utilization and provider mix will need to be managed more closely.

Anesthesiologists frequently claim that their staffing needs are inflated because the hospital requires them to cover more anesthetizing locations than are actually needed. Hospital leadership often agrees but cites challenges with surgeon satisfaction, the need for surge capacity, etc. This is nothing new, but as the cost of excess capacity (not just for anesthesia but for hospital staff as well) continues to rise, efficiency will become a more urgent priority.

Likewise, there will be additional pressure to ensure all anesthesia providers are practicing at the top of their license. This may mean using unsupervised CRNAs in cases where previously the CRNA would have been supervised by an anesthesiologist; utilizing physician-supervised CRNAs in cases that previously were anesthesiologist-only; and/or having anesthesiologists supervise a greater number of CRNAs concurrently. The higher economic stakes, coupled with the aforementioned changes in the mix of providers in the marketplace, will necessitate making some adjustments in how ORs and other anesthetizing locations are staffed.

HOW TO MANAGE IT

As we have said, the cost of sustaining anesthesia coverage has gotten much higher. At the same time, the likelihood of not having anesthesia, and the rapidity with which that scenario can emerge, are now much higher as well. Hospitals need to accept that anesthesia is going to be an ongoing struggle, and that revisiting it only in a state of crisis isn't a viable strategy.

Anesthesia has become a critical resource that will have to be managed much more actively than most hospitals are accustomed to. The following are three key components of making that happen.

Have a contractual arrangement that provides flexibility.

A typical anesthesia services agreement is for three years or more. Given the volatility in the market, it is unlikely that a contract of that duration will make it to the end of its term without requiring modification. Too often, when negotiating an anesthesia services agreement, the parties settle on an amount of financial support and then write that figure into the contract without any context. Later, when it comes time to revisit that amount, the parties cannot remember or agree on how it was originally was determined, so the negotiation must begin again from scratch.

Instead, the arrangement should be constructed so that the hospital's coverage requirements are clearly spelled out, with a clear methodology for translating that into financial support. Typically this means quantifying the hospital's coverage requirements in terms of the number of anesthesia provider FTEs needed. The market rate per FTE can be established, and financial support is based on the shortfall between the group's collections and the funding needed to sustain those FTEs. This way, guidelines are established for recalculating financial support when the facts on the ground change.

Build a governance structure.

A properly constructed contract should be supported by an ongoing governance structure involving operational leaders, anesthesia leaders, and potentially surgery leaders. In some instances, we advise clients to include language saying that the two parties will revisit financial support every quarter or every six months. In other instances, that's not frequent enough, and monthly oversight meetings need to occur. This is not simply for purposes of determining financial support requirements but also for ensuring that operational and patient quality/safety issues are addressed.

In determining the number of anesthesia providers needed, the governance body should address questions such as:

- What is the normal expectation for CRNA and anesthesiologist vacation time?
- How many hours should a typical workweek involve?
- How often should anesthesiologists be on call, and when should the call require time off on the day of and/or the day prior?
- How many CRNAs should an anesthesiologist supervise concurrently, and under which conditions?
- Should there be different expectations (and potentially pay structures) among CRNAs based on their ability to operate with less supervision?
- How should patient acuity be factored into the above decisions?

Create a dashboard for monitoring performance.

The governance structure should run the department "by the numbers" with clear expectations around productivity, work hours, operating efficiency, etc. This provides advance warning when things are getting off track and takes a lot of the emotion out of the situation when either party believes adjustments need to be made.

Dashboard metrics for anesthesia oversight:

- Average hours worked per FTE per year
- Number of calls per month
- CRNA-to-anesthesiologist ratio for locations using supervised CRNAs
- Overall CRNA-to-anesthesiologist ratio (including physician-only locations)
- ASA units per FTE
- Utilization ratios in the ORs and other anesthetizing locations
- Case volumes by type
- Quality and safety measures

Consider alternative relationships.

Some hospitals have considered employing their anesthesiologists as a means of bringing the situation under control. While this may make sense in certain circumstances, it is not a panacea and could create more problems than it solves by giving the hospital yet another thing to manage.

An alternative may be to outsource the service to a national anesthesia management company. These companies can bring more robust capabilities than an independent anesthesia group, but that must be weighed against the uncertainties of bringing an outside party into this essential clinical service.

Finally, more closely affiliated structures such as a PHO may alleviate some of the hospital's financial burden by bringing the anesthesiologists under the umbrella of a contracting entity that can negotiate better rates with payers than the anesthesiologists can alone.

MAKING THE MOST OF A DIFFICULT SITUATION

We recognize that for hospital administrators, the evermore difficult challenge to maintain anesthesia coverage is one that most do not welcome and may prefer not to think about. It involves significant additional cost just to sustain operations, which is a rather unsatisfying prospect. However, those that take a proactive approach will find that doing so produces much less turmoil and greater predictability than a strategy of avoidance.

The silver lining in all of this may be that it provides the necessary impetus for hospitals to enhance their discipline around the utilization of critical resources that have always been important, and now are absolutely critical to success.

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the Author

DAVE WOFFORD
Principal

DWofford@ecgmc.com

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