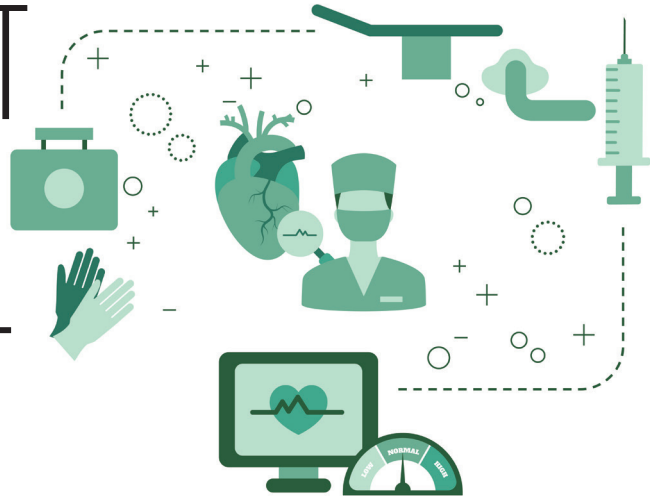
KEY CONSIDERATIONS FOR YOUR NEXT ANESTHESIA ARRANGEMENT



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It is essential for practice leaders of anesthesia groups and hospital CEOs and CFOs to clearly define the terms of any anesthesia coverage arrangement. When terms are not clearly defined, both parties can feel short changed, leading to dissatisfaction and potential disruptions in service. When setting up coverage arrangements, it is important to clearly define two key terms: resources used and services covered. This clarification is crucial for a successful coverage arrangement.

THE RESOURCES PROVIDED MATTER

At first glance, defining the necessary resources sounds simple enough; however, despite many attempts, it can still result in ambiguity. One common approach is simply specifying the number of providers, which may sound good but can pose several challenges.

The type of provider matters. Defining the number of providers is helpful, but the type of provider used makes a significant difference in the services they can provide and the associated costs. Services provided by anesthesiologists, certified registered nurse anesthetists (CRNA) and anesthesiologist assistants (AA) are not the same, nor are their associated costs. Solely employing anesthesiologists incurs higher costs than using a care team model. While an anesthesiologists-only model may be the best fit depending on the required scope and services, it comes with a cost.

Historically, a practice may have exclusively staffed anesthesiologists but over time starts integrating CRNAs into the provider pool. If the practice maintains the requisite number of providers under the agreement, they fulfill their contractual obligations. However, the financial aspects of the arrangement have changed. This is illustrated in Table 1 based on median total compensation for these providers established in the *2023 MGMA DataDive Provider Compensation* report.

TABLE 1. COMPENSATION DIFFERENCES

Provider type	MGMA median total compensation
Anesthesiologists	$498,954
CRNAs	$214,589
Difference	$284,365

Initially, the annual resource costs for anesthesiologist coverage may be almost $500,000. However, substituting CRNAs for anesthesiologists impacts these resource

costs. If the practice is being subsidized by a facility under a revenue guarantee or a stipend agreement and the agreement specifies "providers" without detailing the resource costs, the facility might be paying more than necessary. This discrepancy arises from the facility covering expenses beyond what is justified by the actual resource costs.

Another practice may have historically employed a care team model. Due to a highly competitive market for CRNAs, the practice failed to maintain CRNA staffing and is now relying on physicians for services previously performed by CRNAs. Consequently, the practice wants a subsidy increase to cover these increased costs. If the agreement simply mentions the number of providers without clarifying their role within a care team, transitioning to a different provider type may not be sufficient to trigger a subsidy adjustment without renegotiating the entire agreement.

The practice may decide to recruit AAs. Given the demand for CRNAs and their desire to practice to the full extent of their license, a practice may transition to AAs to provide some coverage that was previously performed by CRNAs. Unlike CRNAs, AAs must always be supervised by physicians — except in a care team model, in which CRNAs are also supervised by physicians. A practice has the option to transition from CRNAs to using AAs for certain services, which could possibly result in cost savings for coverage.

How providers are counted matters. Even if the type of provider is clear, it is important to know whether the number is based on head counts or FTEs. For eight sites of service operating five days a week, a care team model might require two physicians and eight CRNAs daily. However, to ensure adequate staffing to cover vacation and CME, the practice would need more providers on their payroll.

THE DEGREE OF SERVICES COVERED MATTERS

Defining the services to be covered can also be problematic. For example, specifying only the hours of coverage may suffice for an ambulatory surgery center (ASC) that is open eight hours a day, five days a week, but for a hospital, more detail is necessary. Even stating "24/7 coverage" is not enough — clarification is needed on whether it is in-house coverage or on-call coverage. If there is a misunderstanding between parties about the type of coverage, neither will be happy.

Defining the level of coverage matters. The resource costs of in-house and on-call coverage are very different. Due to high demand of anesthesia services, both parties are motivated to ensure the coverage is efficiently staffed. Anesthesia practices aim to minimize unnecessary on-site hours for providers, considering they are often already overworked and stretched thin. Facilities seek efficient staffing to cut costs, given declining reimbursements and increased subsidy requests in the current market.

Defining the hours matters. It is important to distinguish between site coverage hours and staffing coverage hours. Site coverage might not include supervision hours within a care team model. Additionally, for high-volume L&D facilities, a single site may require more than one provider, despite being counted as just one site.

Defining the services matters. In addition to specifying in-house or on-call coverage and clarifying the staffing, it is important to specify whether coverage is based on sites of service or specific service lines. Stating the number of concurrent coverage sites is helpful, especially when providers float or cover various non-OR sites based on daily demand. This approach optimizes resource utilization during periods of low volume, avoiding the need for a full-time provider every weekday. Indicating the number of concurrent sites rather than all covered service lines accurately reflects the required provider coverage.

Alternatively, specifying coverage for critical areas like cardiac or trauma cases can ensure resource availability, but it may also increase costs if dedicated coverage isn't warranted by the volumes. Having a primary provider on-call with a back-up can cut costs while maintaining adequate coverage, particularly in facilities with lower volumes.

Terminology matters. It is also important to clarify seemingly clear terminology, such as "flexing," which can have different meanings. Some perceive it as adding coverage day by day or as needed, while others use it when referring to increasing coverage on a more long-term basis. The distinction matters for coverage and cost. Agreements that include an opportunity for as-needed coverage provide more flexibility but usually at a higher cost, unlike long-term coverage expansions, which demand recruitment and more notice. Each scenario has its own unique challenges in today's anesthesia market. A practice may be able to commit to one type of "flexing" but not the other, making it critical to clarify the type of flexing needed.

Labor costs are the primary driver for coverage services. Clarifying these in an anesthesia arrangement ensures both parties understand coverage expectations and can allocate resources effectively, laying the foundation for a successful arrangement. ■

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