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Negotiating a Hospital Anesthesia Financial Support Agreement

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SUMMARY

Most anesthesia groups need to create or update agreements with the hospitals they serve. There are many ways to approach this sensitive task. The author recommends a financial support agreement based on utilization. I further recommend that the supporting calculations be done based on billed minutes (or total billed units) with values determined based on industry benchmarks. This logical approach is easily tracked and administered and minimizes the risk of the anesthesia practice having to open its books to the hospital.

Of course, any negotiation for financial support comes with risks. At the most basic level, the greater the financial support request, the higher the likelihood the hospital will want to exert control. Plus, with larger d mands, the hospital is incented to look for alternative anesthesia providers.

With those risks fully in mind, we believe the approach described in this paper provides the best way for an anesthesia practice to approach this complex negotiation. This paper provides examples of the important calculations and a complete spreadsheet with all of the calculations is available upon request.

AT A GLANCE:

- Financial support agreements may be necessary, but carry risks.
- A utilization-based agreement is recommended and described in detail.
- Industry benchmarks should be used, not practice-specific numbers.
- Examples of all important calculations are shown and a companion spreadsheet is available.

BACKGROUND

> "In a darkened office, late into the evening, the hospital administrator sits quietly, and ponders a career question: "Should I or should I not replace this anesthesia group?"
>
> To the surprise and dismay of anesthesiologists across the country, this question is being asked and answered. Anesthesiologists are losing their exclusive contracts to provide service. They are losing their independence as owners of multi-million dollar businesses. And they are becoming employees of hospitals, large mega-groups, or publicly owned corporations."[1]

So began the article in the May 2008 ASA Newsletter dealing with the dangers facing small to medium sized anesthesia groups. Anesthesia groups are facing challenges on multiple fronts. There are demands for increased coverage from their hospitals. There are downward pressures on reimbursement for rendered services. Separately, but equally troubling, private equity is moving into the business of anesthesia.

Faced with the challenges of decreasing reimbursement, requests for increased coverage not necessarily supported by increased levels of utilization, and rising personnel costs, anesthesia groups have turned to the hospital for financial support.

[1] ASA Newsletter, May 2008 Small to Medium-Sized Groups are Endangered p. 31.

There are a number of financial support mechanisms that can be negotiated with the hospital administration. Examples are agreements that can cover the cost of increased coverage less any increased utilization. Another type is a guarantee of physician W2 income and benefits. No doubt, there are others.

This article will review activities associated with the development of an agreement based upon utilization.

FINANCIAL SUPPORT BASED ON UTILIZATION

In June 2004, September 2004, and June 2007, the ASA published a series of articles regarding O.R. utilization. These articles were designed to help an anesthesia practice determine a utilization level that would allow the group to function without financial support from the hospital.

(Note: In these articles, utilization refers only to utilization for surgical cases in the O.R. The delivery of Obstetrical Anesthesia services ought not to be considered when determining the efficiency of the O.R.)

The author feels that a surgical utilization rate in the range of 75% throughout the O.R.'s, during the prime hours (i.e., 7:30 a.m. – 5:30 p.m.) with a reasonable payor mix and reasonable turnover time should, but not necessarily absolutely guarantee, that the anesthesia practice will have sufficient revenue to:

- → Cover the costs of the physician owners;
- → Employee nurse anesthetists; and
- → Cover associated business costs, such as billing and practice management.

I would define a "reasonable payor mix" as Medicare and Medicaid (and sometimes Worker's Comp) Gross Charges at 40% or less. "Reasonable turnover time" should not exceed, on average, more than 15 – 20 minutes per case.

Given the above, utilization rate can roughly be defined with the following formula:

$$\frac{\text{REPORTED ANESTHESIA TIME + TURNOVER TIME}}{\text{SCHEDULED O.R. TIME + OVERTIME}}$$

Consider the following simple example:

O.R.	SCHEDULED TIME	TOTAL SCHEDULED HOURS
#1	7:30 – 3:30	8
#2	7:30 – 3:30	8
#3	7:30 – 5:30	10
	26 HOURS OR 1,560 MINUTES	

Billed Anesthesia minutes: 824 minutes
Total Turnover Time: 120 minutes
Total Utilized Minutes: 944 minutes

944 minutes / 1,560 minutes = 60.5% utilization rate

It has been my experience that a utilization rate of 60.5% is insufficient to cover the costs of anesthesia staffing. Therefore, the anesthesia group may be faced with approaching the hospital with this information and discuss ways to either A) reduce the level of coverage required, or B) provide financial support that would cover the cost of the underutilization.

The following spreadsheet and example will assist the group in their discussions with the hospital on the number of rooms they may need to reach 75% utilization.

O.R. UTILIZATION BASED ON ANESTHESIA BILLING DATA
INPUT TABLE

								Enter OR Hour-Blocks				
Start Date / End Date			Holidays Within Time Frame	% After-Hour Week-End	Room Turnover Time	Total Cases For Period	Total Minutes For Period	8 Hr Rms	10 Hr Rms	12 Hr Rms	Ideal Room Utilization	Total OR's
Month	Day	Year										
1	1	2011	8									
12	31	2011										
Hospital OR Variation												
7:00 a.m. - 5:30 p.m.				0.00%	15	7,767	824,500	5	4	0	75%	9
7:00 a.m. - 5:30 p.m.				0.00%	15	7,767	824,500	5	5	0	75%	10
7:00 a.m. - 5:30 p.m.				**0.00%**	**15**	**7,767**	**824,500**	**7**	**4**	**0**	**75%**	**11**

Total OR WeekDays	Total Available OR Hours	OR Utilization Percent	OR's Unused 100% Utilization	OR's Unused At Ideal	Average Hours Per Case	Daily Extra Cases At Ideal	Potential Billable OR Hours
252	20,160	**74.98%**	2.25	0.00	1.77	0	3
252	22,680	**66.37%**	3.36	1.15	1.77	3	1,512
252	**24,192**	**61.96%**	**4.18**	**1.91**	**1.77**	**5**	**2,430**

(This spreadsheet along with more detailed instructions regarding its use is available by request from AHS.)

Important note: Total Cases are unique surgical procedures and their associated time. Cases would not include blocks for post-operative pain, monitoring procedures, such as A-Lines, CVP, P.S. modifiers, etc.

This example assumes an O.R. suite with 9 rooms. Utilization is a healthy 74.98%. The hospital wishes to expand O.R. capacity to 11 rooms with seven rooms running for eight hours and four rooms running for ten hours.

The Room Turnover Time is based upon the average for all types of procedures. Turnover after a long heart or spine case would obviously be longer than after an appendectomy or T&A's. The figure of 15

minutes is what the group and hospital jointly decide is the average for all cases.

(The present configuration is shown in **red**. The new proposed configuration is shown in **purple**.)

CALCULATING THE COST OF THE FINANCIAL SUPPORT REQUEST

Assume the following:

1. As noted above, the spreadsheet represents a 9 O.R. hospital with utilization at 74.98%. At present, the group does not receive support from the hospital for coverage.
2. The hospital requests that the anesthesia group retain additional personnel to cover two additional rooms per day;
3. Anesthesia services are provided by the team approach with physicians generally directing CRNAs at a ratio of 1:3 or 1:4; and
4. The hospital cannot guarantee that they will have additional cases to fill these rooms.

Point #4 above is an issue. Expansion by two rooms as requested by the hospital without any increase in volume will drop utilization down to about 62%. This means that anesthesia staff (and hospital staff, for that matter) will be generating costs for a percentage of the day without generating any corresponding revenue.

So, what should be done? Well, the anesthesia group meets with their Practice Manager. After a review, it is determined that 2.5 additional CRNAs will need to be hired. They also feel that they will need to increase physician FTE's by .5.

Using MGMA data, they determine the cost as follows:

.5 MD FTE	$275,000 (This include salary, insurances, taxes, etc.)
2.2 CRNA FTE's	$370,000 ($185K CRNA FTE costs, includes salary, benefits, taxes, etc.)

Total cost for the new coverage equals $645,000.

How should the financial support request be presented? We will consider two options. They are as follows:

1. The hospital will guarantee that collections increase by the cost of the increased coverage By the amount that it does not, the hospital makes up the difference.
2. The additional number of billed minutes (or it can include total billed units) are calculated prior to the increase and a value is assigned to them based upon the cost of additional coverage.

I personally do not recommend use of Option #1. Why?

- → The group would need to "open" up its financial books to the hospital;
- → The hospital would want to examine billing methods and collections;
- → They could potentially determine salary and benefit levels being paid to the physician owners and then challenge whether or not they were being "overpaid". Being "overpaid" would provide arguments that the requested stipend was too much;
- → The hospital might challenge how much time off the physicians received. They could state that the requested increase in physician coverage was unwarranted if the present physicians would work more weeks during the year;

→ And other reasons.

Compared to the above, the use of Option #2 is, for me, far more viable. Why?

→ The financial support is based upon utilization and MGMA FTE cost data. This would limit the pressure and reasons to open up the books for a review of income, billing and collections;

→ The increase from the agreed upon base line utilization level of 75% can be easily tracked by both the hospital and the group;

→ The system allows for varying levels of support based upon increases in utilization. If utilization eventually reaches the goal (in this case 75%), then the financial supportnecessary would be reduced to $0.00.

Let's going to look at the same table again and project how many cases and minutes would be needed to attain a utilization of 75% for 11 rooms instead of 9 rooms. We start off with the original configuration of 9 rooms, move it to 10 rooms, and then to 11 rooms. In the 11 rooms configuration the number of cases and billed minutes needed to reach an equivalent utilization rate is easily seen.

O.R. UTILIZATION BASED ON ANESTHESIA BILLING DATA
INPUT TABLE

								Enter OR Hour-Blocks				
Start Date / End Date			Holidays Within Time Frame	% After-Hour Week-End	Room Turnover Time	Total Cases For Period	Total Minutes For Period	8 Hr Rms	10 Hr Rms	12 Hr Rms	Ideal Room Utilization	Total OR's
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7:00 a.m. - 5:00 p.m.				0.00%	15	7,767	824,500	5	5	0	**75%**	10
7:00 a.m. - 5:00 p.m.				**0.00%**	**15**	**9,367**	**992,500**	**7**	**4**	**0**	**75%**	**11**

Total OR WeekDays	Total Available OR Hours	OR Utilization Percent	OR's Unused 100% Utilization	OR's Unused At Ideal	Average Hours Per Case	Daily Extra Cases At Ideal	Potential Billable OR Hours
252	20,160	**74.98%**	2.25	0.00	1.77	0	3
252	22,680	**66.37%**	3.36	1.15	1.77	3	1,512
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Note: In the above example,

Average Base Units Per Case = 5.78 Units
Average Time Units Per Case = 7.07 Units

Total Units Per Case = 12.85 Units

To reach 75% utilization, case volume and total minutes would have to increase as follows:

Cases: 1,600
Minutes: 168,000 (11,200 Time Units in 15 minute increments)

Important point: Remember, we are tracking the "prime hours" for providing surgical services in the facility. In this case, it is from 7:00 p.m. – 5:00 p.m.

Interesting note: 800 cases per year per room. Broken down to weekdays the O.R. is in operation, less holidays, would equal to about 3.2 cases per new room per day.
(52 weeks * 5 days = 260 O.R. week days less 8 holidays = 252 days. 800/252 = ~3.2)

So, how should the group present the proposal for financial support? There are two ways we are going to review. They are:

1. Utilizing Total Cases;
2. Utilizing Total Billed Anesthesia Units (TBAU's).

Each system is similar and the system for developing the cost is the same. However the group, the hospital administration, or both may prefer one methodology over the other as providing the most easily tracked and therefore viable method of determining the actual level of financial support.

TOTAL CASE METHODOLOGY

Present Yearly Cases	Monthly Cases		
7,767	647		
Cost of New Personnel	**New Cases Needed**	**New Cases Monthly**	**Average per Case**
$645,000	1,600	133	$403.13

The Utilization Spreadsheet shows that the group needs to bill 9,367 Cases annually or approximately 780 cases monthly (9,367 / 12 = 780) so that utilization will equal about 75%.

Therefore, the proposal would be as follows:

Monthly, Total Cases billed during prime hours less than 780 cases would be reimbursed by the hospital to the group in the amount of $403.13.

Here is how it would work. Assume that the group provided anesthesia during prime time for 692 cases during the first month of the new contract. The support would flow as follows:

Cases Needed to reach 75% Util.	780
Actual Cases Performed	692
Shortfall	88
Support / Case	$403.13
Total Invoice	$35,475.44

The hospital might ask how the support would be handled if cases exceeded the total number needed per month. This is a concern since the O.R. weekdays vary from month to month. Also, what would happen if total cases drop below the previous average of 647 cases?

Negotiation options might include:

- → When cases exceed total additional needed of 133, then no invoice will be forwarded and there will be a "true up" every three months or half year.
- → If cases drop below 647, then the total amount invoiced would be limited to 133 cases multiplied by the $403.13 or $53,616.29. However, in that event, when the "true up" took place, the actual cases for which anesthesia provided service would be utilized, not the base of 647.

FINANCIAL SUPPORT BASED UPON TOTAL BILLED ANESTHESIA UNITS

An alternate way to calculate a financial support request would utilize Total Billed Anesthesia Units (TBAU) instead of Billed Time Units (BTU). As you are well aware, the complexity of the surgical intervention impacts the valuation of the base component of the procedure. An extreme example would be the base value of a heart procedure might be 20 whereas the base unit value of a PE Tube procedure would be 4 base units plus approximately 2 time units.

Again it should be noted that TBAUs should be based upon the base value of each procedure and the associated time units for those procedures. They should not include blocks for postoperative pain, monitoring procedures, such as A-Lines, CVP, P.S. modifiers, etc.

These variances can impact the amount of financial assistance that the hospital will need to provide.

Please review the following two tables with data taken from the Utilization Spreadsheet above.

As noted above in the Utilization Spreadsheet, the complexity of the hypothetical group's mix of cases was as follows:

Average Base Units Per Procedure = 5.78 Units
Average Time Units Per Procedure = 7.07 Units
Total Base + Time Units Per Procedure = 12.85 Units

- → Table 1: Base Units & Time Units needed to approximately equal a utilization level of 75% with the new coverage requirements. (Important note: This assumes that all new cases

will have the same average base units + time units as historical averages.)

→ Table 2: Base Units & Time Units where utilization was approximately 75% prior to the hospital's request for an expansion of services.

TABLE 1 - NEW LEVELS

Total Cases Annually	9,367
Total Base Units (5.78 / Case)	54,141
Total Minutes	992,500
Total Time Units (7.07 / Case)	66,167

Total Units Annually	120,308
Annually Increase	20,448
Monthly Increase	1,704

Avg Base Per Case	5.78
Avg Per Case	7.06
Avg Units Per Case	12.84

Total Cases & Units Needed to meet utilization levels of approximately 75%

(Note: .02 unit variance per case due to rounding)

Total Cases Annually	7,767
Total Base Units (5.78 / Case)	44,893
Total Minutes	824,500
Total Time Units (7.07 / Case)	54,967

Total Units Annually	99,860

Avg Base Per Case	5.78
Avg Per Case	7.08
Avg Units Per Case	12.86

Total Cases & Units Needed prior to the request for additional room coverage

(Note: .02 unit variance per case due to rounding)

As you can see, the hospital would need to add sufficient cases so that annually the group could bill 120,308 Total Anesthesia Units during prime time (7:00 a.m. – 5:00 p.m.)

The associated FTE cost of the new personnel per TBAU is shown below:

Cost of new Personnel	$645,000
Total Additional Units	20,448
Avg. Per Unit	**$31.54**

Invoices for hospital support would be calculated by

→ Calculating the number of billed units during the prime time hours
→ Invoicing the hospital at $31.54 per unit for any shortfall

A CAUTIONARY NOTE

The "New Levels" assume that the mix of surgical cases for the new business the hospital attracts will remain the same. *However, what would happen if the hospital recruited a pediatric group which tended to perform a large number of cases with shorter times and base units than the traditional average?* In this event, utilizing the Total Case Methodology would not necessarily cover the cost of the additional coverage needed.

The following example will demonstrate this. We are going to again assume the following:

- → The same shortfall of 88 cases, and;
- → Average units per case for which anesthesia provided services during the prime hours declined by a little over 1 unit per case.

TABLE 1 - AVG. UNITS / CASE STAYS THE SAME

Cases Needed	780
Previous Total Units Case / Avg	12.85
Total Units Needed	10,023
Cases for the month	692
Average Units per case	12.85
Total Units	8,892
Total Units Needed	10,023
Actual Total Units Billed	8,892
Shortfall	1,131
Value of Unit	$31.54
Invoice to Hospital	$35,665.43

TABLE 1 - AVG. UNITS / CASE FALLS BY 1 UNIT

Cases Needed	780
Previous Total Units Case / Avg	12.85
Total Units Needed	10,023
Cases for the month	692
Average Units per case	11.85
Total Units	8,200
Total Units Needed	10,023
Actual Total Units Billed	8,200
Shortfall	1,823
Value of Unit	$31.54
Invoice to Hospital	**$57,491.11**

As you can see, if the total average units per case remained the same (Table 1), the invoice would be the same. If the average units per case declined, then the invoice would be impacted accordingly. Conversely, if the new business that the hospital hopes to recruit is of a mix and complexity that would increase average billed units per case, then the group might want to consider using the Total Case Methodology.

In conclusion, whether or not the methods we've described are utilized, or some other way is found to ask the hospital for support (if it is determined that it is needed), I would like to share these cautionary thoughts:

In this hypothetical situation, prior to the request for additional room coverage and the subsequent negotiations for covering the increased cost, the group itself, or more specifically the owners of the practice, absorbed the cost of downward variances in units per case. And they had also absorbed the cost associated with degrading payor mixes. Conversely, they **also** benefited from improvements in the volume and/or payor mix.

These variances in revenue are natural components of owning multi-million dollar enterprises. When another corporate entity, in this case the hospital, begins underwriting the risks associated with owning a business, then at some point, the hospital will begin to exercise inappropriate levels of control on the group.

Sometimes the underwriting becomes significant, totaling many hundreds of thousands of dollars. Eventually, those controls will equate to ownership. Note what the ASA Newsletter Article mentioned at the beginning of this article stated:

> " At a certain point and at a certain dollar level, the hospital may perceive the demands of the anesthesiologists to be excessive for the services the group is providing or which it has been asked to provide. Some dismayed anesthesiologists discover, too late, that another group of anesthesiologists are willing and capable of providing quality service at less than what they might have been demanding. Or, even worse, the hospital may consider managing the group's coverage and expense via employment, or by utilizing an outside practice management company."

I hope this material can provide some thoughts or ideas that can be utilized in the event your group finds it necessary to enter into discussions with your hospital for financial assistance.

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Mr. Monea has over 20 years of anesthesia management experience. He currently manages several anesthesia practices in Kentucky and Ohio and is a regular published author and paid speaker to the ASA and MGMA AAA.