From Prehistory to Avoiding Post-History: Anesthesia Group Stipends

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Growing up in Los Angeles, one of my favorite places to visit was La Brea Tar pits, the death-trap in watering hole clothing that became the sticky final resting place of thousands of now extinct creatures including my favorite, the saber-toothed tiger, genus Smilodon.

Smilodon, depending on species, ranged in size from 120 to 620 pounds, and was strongly built with well-developed forelimbs and gigantically long upper canines, essentially "tooth knives" evolved for killing.

But despite their status as near perfect, apex predators which enabled them to turn bison and camels into lunch, around 10,000 years ago they simply disappeared. They no longer fit into the evolutionary plan and were wiped off the board. Gone. Dead. Extinct.

And yet, they live on in a sense, their skulls a form of fascination for children and adults alike, and yes, as an analogy for you and for other anesthesia group leaders.

Simply put, your job as a leader is to prevent your group from stepping into the sticky pit of extinction.

Today, as my friend John put it, "[is] a great time to be an anesthesiologist"—fantastic compensation, the ability to easily relocate, part time work and so on. Just like it was once a great time to be a sabertoothed tiger.

But for an anesthesia group *qua* group, as was the case for the genus Smilodon, the times are far more dangerous.

MORE TIME TRAVEL TO THE LESS DISTANT PAST

Anesthesia groups emerged from the primordial sea of solo anesthesiologists in the late 1970s and 1980s, fueled by the need to integrate on a business level to meet coverage demands, and more importantly, antitrust (i.e., price fixing) concerns related to the need to contract with emerging managed care payors.

Prior to that time, anesthesiologists were independent practitioners bound together only by mutual membership on the medical staff. There were no financial ties among them, or between them and the hospital. Many went kicking and screaming from the status of unicellular business organisms to that of shareholders or partners within an anesthesia group.

As those early groups contracted with hospitals for coverage, aside from small administrative fees related to medical director-type services, their patient care services were as free to the hospital as were the services delivered by any other sort of physician with medical staff privileges, from allergists to vascular surgeons.

Concurrent with the maturing of the anesthesia group model, managed care expanded, the number of hospitals proliferated, and ambulatory surgery centers emerged from another sort of primordial sea—an ambulatory surgery center (ASC) is essentially an outpatient OR plus waiting room plus pre-op plus post-op that developed legs and walked out of the hospital.

Depending on the area of the country, the late 1980s into the early 2000s saw significant waves of gaps between the expense of fielding a team of anesthesiologists, and, increasingly, CRNAs, compared to incoming collections (the "Income-Expense Gap™")—resulting in waves of negotiation for hospital financial support, especially for those groups that understood how to negotiate.

TODAY

Since the COVID-19 pandemic, the trends that propelled previous episodes of the Income-Expense Gap™ and the accompanying waves of hospital financial support have intensified, with added fuel from demographic changes, both on the provider and the patient sides, and from political meddling in the market.

In general terms, the demographic issues have resulted in a significant shortage of anesthesiologists as well as CRNAs.

In respect of anesthesiologists, the percentage of those over 55 years of age remains significant, and many groups have suffered from a large number of retirements. This was exacerbated by the COVID-19 crisis, during which many older anesthesiologists decided it was time to turn in the scrubs.

Other older anesthesiologists have opted to remain, but many are interested in working part time, or in positions not involving call obligations. At the same time, many younger anesthesiologists have sought "quality of life" positions, in which their druthers map nearly completely onto that of their significantly older colleagues.

On the training side, the bureaucratic reduction in the number of anesthesia residency slots in the mid-1990s, and the longer lasting signal sent to medical students about the attractiveness of the specialty, created a long-term shortage of anesthesiologists. As to CRNAs, the more recent morphing of master's degree programs into longer, doctorate-level programs impacted the number of new anesthetists entering the labor pool.

At the same time, the tidal wave of aging baby boomers has pushed up the demand for care.

Although hospitals and entire health systems have experienced financial challenges, some resulting in bankruptcy and their own demise, the number of anesthetizing locations, when considering both acute care hospitals and ambulatory surgery centers, has increased.

Simply put, there's more work and not enough providers, with the result being lifted directly from Econ 101: higher compensation demands.

In simpler times, real or imagined, some of the pressure would be taken off through negotiations for increased anesthesia reimbursement from insurance carriers and managed care payers.

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However, the federal No Surprises Act (NSA) and state counterparts slammed that door shut and played a significant role in creating the current crisis. What was sold to the public by politicians as a shield against so-called "surprise medical bills" was actually a sword to be wielded by payors in slashing reimbursement against the threat of network exclusion. Payors regularly take the position that if an anesthesia group will not take a cut in reimbursement, despite all the evidence of overall inflation and the outsized increase in provider compensation demands, they will toss them out of network and into NSA hell.

The overall result is an increasing financial crisis within many anesthesia groups, both large and small: They struggle to retain their staff because offers of higher compensation lure physicians and CRNAs away. They struggle to recruit new staff because of a similar inability to meet the market. The morale of remaining group members begins to tank due to increasing workload—there's just as much overall work but fewer colleagues

to do it, leading to even more under-compensated work for each remaining physician/CRNA. The outcome is an accelerating downward spiral toward the sticky tar pit of group extinction.

AVOIDING POST-HISTORY

To dispense with a question that's crossed countless anesthesia group leaders' minds, and always comes back to bite, it is impossible to borrow one's way out of this foundational problem.

A business with costs (i.e., the cost of fielding a team of anesthesiologists and/or CRNAs) continuously exceeding its income cannot afford to bear those costs plus the cost of new bank, or even hospital, debt.

Of course, that's not to say that an anesthesia group, like any other business, shouldn't have more than a deposit relationship with a bank—the availability of a line of credit to cover short-term needs. Just don't ever believe that borrowing as a short-term solution to solve a short-term problem is of any value in respect of solving a long-term problem, that is, of the Income-Expense Gap™.

Accordingly, we're back to where we started in terms of another, this time tsunami-sized, wave of need for financial support from hospitals, and this time even from ASCs, in order for groups to remain viable.

WHAT!? NEGOTIATING FOR FINANCIAL SUPPORT ISN'T "NEGOTIATING FOR FINANCIAL SUPPORT"

Even though the need for financial support might be the impetus for negotiation with a facility, especially in the case of a hospital, it's not close to the universe of what will be negotiated in order to obtain it.

That's because financial support from any facility is an integral part of the multiple elements of an exclusive contract and can't be separated from them. Accordingly, although legal counsel will engage consultants with the necessary credentials to quantify the Income-Expense Gap™ and determine fair market value, the issues are far more complex than that.

For example, financial support is intrinsically linked to coverage, and that means that coverage must be "locked in" in concert with support (or you will create a very common, yet easily avoidable problem). What causes that "lock" to unlock, and at whose behest? What are the consequences? How can a properly negotiated agreement "stretch" with changes in coverage?

Many provisions of the facility agreement, including those pertaining to financial support, also relate to, impact, or are impacted by, a group's other agreements, both internal and external. In some cases, those agreements must be modified simultaneously.

For example, it's impossible to separate the terms of any exclusive contract from the terms by which the group owners relate to one another via the

shareholders agreement/partnership agreement. Similarly, it's impossible to separate the terms of any exclusive contract from the way the group relates to its professional staff through its various professional services (employment/independent contractor) agreements. Contractual mismatches can doom a group.

Last, because hospital financial support implicates the federal Anti-Kickback Statute and its state counterparts, as well as, potentially, depending upon the range of services a group provides, Stark, and, as to non-profit facilities, issues of private remuneration/preservation of their tax-exempt status, it's extremely important that valuation consultants be engaged through legal counsel to protect communication and valuation work product to the fullest extent possible.

Preparing for and negotiating for stipend support in the context of a new or renewed agreement with a facility is complicated and time-consuming. But for many anesthesia groups, it's required. Don't create additional problems for your group by approaching it in an ad hoc or haphazard manner or by directly embarking on valuation studies, the result of which will be to put your group into a sticky situation, perhaps one as grave as suffered by the sabertoothed tiger.

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