Should You Flip the Anesthesia Business Model?

BY MARK F. WEISS, JD
The Mark F. Weiss Law Firm, Dallas, TX, Los Angeles and Santa Barbara, CA

It's not like we need an actual study to tell us that physicians across many specialties, including anesthesiology, are working harder but that earnings are not keeping pace. The simple way to say this is "more work, less pay." (Some say that the simplest way to say this is "burnout.")

Frankly, if that's your anesthesia group's business reality, then it doesn't much matter if everyone else or no one else is suffering from the same ills. Either you complain about it, suck it up or take the road less travelled and do something about it.

FIRST, SOME DATA

But for those who need a study, the Kauffman Hall consulting firm conducted one. They report that physician full-time equivalent (FTE) productivity measured in units increased 12% in the second quarter of 2025, over the second quarter of 2023. However, physician compensation per FTE increased only by 6% over the same time period.[1]

Projecting this unsightly trend into even the near future, if payer rates, both governmental and commercial, continue to decline, and if the ranks of the uninsured grow, physicians will suffer a further degradation in income.

It will become an instantiation of the Red Queen's warning in Lewis Carroll's *Through the Looking Glass*:

> *"Now, here, you see, it takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!"*

THE RELATIVELY QUICK AND EASY PATCHES

For anesthesiologists and their groups' leaders, there are some easily identifiable and achievable interventions for the work/pay gap.

Unfortunately, they are in the nature of palliatives. Although the healthcare chattering class is singularly focused on them, they don't guarantee much more than a slight extension of your business's half-life.

I'm speaking of initiatives such as aggressive negotiation for facility financial support, direct-to-employer, regularly renegotiating payor contracts, weighing out-of-network alternatives and exploring smart staffing models.

Note that I'm *not* saying that these patches don't have value, after all, a large part of my work with anesthesia groups across the country is focused on these matters, but that their value is somewhat akin to a "doughnut" spare tire or a can of Fix-a-Flat: They'll successfully get you on the road again, but not all the way from, say, Portland, Oregon to Portland, Maine.

Instead, I'm arguing that at some point the delta between your practice's collections and its costs of operation, including its largest category of expense, staff compensation, might become too large to fix via subsidy, the hospital or other facility, like many, might go bankrupt or be merged out of existence, or *your* usefulness to the facility might end.

It's trite to say that these efforts are like rearranging the deck chairs on the Titanic, but the reason the analogy has become trite is that it's true.

1 https://www.kaufmanhall.com/news/physicians-and-advanced-practice-providers-working-more-ever

Continued on page 20

Should You Flip the Anesthesia Business Model?

Continued from page 19

ASKING THE BIGGER QUESTION

Holding fast to the Titanic analogy, what if instead of rearranging the deck chairs, you ask whether you're on the right ship?

In other words, what if the prevailing anesthesia business model is upside down?

The Prevailing Business Model

Let's define what I mean by the anesthesia business model.

First, to get it out of the way, let's address what I'm *not* talking about.

I am *not* speaking of the hospital or health system *employment* structure, because it doesn't involve an anesthesia group at all, just, in some minority of cases, something that looks like one. Note that no *actual* employment is required; a "group on paper" controlled by a hospital or health system, whether via a so-called "friendly physician" or via wide, but illusory, ownership (i.e., no real equity) falls into the same pot.

Neither am I speaking of the situation in which a group or even a confederation of individual physicians has agreed to become captive to a management structure, whether it's called an management service organization (MSO), a physician practice management company or otherwise. In these management structures, business decision-making has been transferred to the parent entity. Of course, the parent entity could explore the alternative thinking that I'll describe below.

Instead, the prevalent model *that I am describing* is based upon the following required elements:

- The hospital controls access to the relationship. In other words, the hospital "permits" the group and its professionals to provide anesthesia services at its facility, generally pursuant to an exclusive contract.
- The anesthesia group exists and operates independently of the hospital at which it provides services.[2]
- In this model, groups were historically reliant upon collections for their gross income. That said, many can no longer operate without some form of financial support from the hospital. There are many ways to structure those financial arrangements, but, save for the most foolish, they all amount to cash infusions from the hospital in one form or another.

Thinking Outside of the George Box

The late George Box, the prominent British statistician, said that "all models are wrong, but some are useful."

I'd go one step further and add that some models *were* once useful but no longer are.

How's the "reliant on Medicare," or even the "reliant on commercial payors," model working out for you? They're choking what they'll pay you via rate reductions, payment delays and flat-out denials. Yet your expenses, especially the compensation paid to your physicians and other staff, keep going up.

For how long will the temporary fixes touched on above work? None of them do much, if anything, to fix the decay, the increasing uselessness, of the model itself.

Although many believe that hospital financial support is a long-term solution, the length of a contract's term,[3] and the hospital's ability to leverage you off of it, are tied to the fact that the prevalent model brands you as the supplicant. *But what if you're not?*

BOARDING THE RIGHT SHIP: ALTERNATIVE MODELS

There are multiple other business models for anesthesiologists and their groups to consider. They're not the prevalent model because most groups and most individuals fear doing anything outside of what's prevalent, of what's perceived as "safe."[4]

After all, they are following "best practices," falling for the ruse that the term actually means the *best* practice, when what it really means is copying everyone else, a race in which being first and last are the same thing.

Note that alternative models, whether those discussed below or others, are not all-or-nothing, yes-or-no, or in-or-out.

2 For convenience, I am using the word "hospital" to refer to any location at which the group provides services.
3 See the contract's termination provision, e.g., 90 days' without notice, not the "Term" provision (e.g., 3 years).
4 This perception does not necessarily comport with reality.

Anesthesia groups, as well individual anesthesiologists or small subsets of an existing group, can test out alternative models on the side, while still keeping one foot, or just one toe, in prevalent model practice.

Modeling the Migration of Office-Based Physicians Out of Employment

Some of our clients have drawn on the lessons of office-based physicians who faced similar dilemmas at an earlier point in time.

For example, we've modeled the work done with orthopedic surgeons who fell for the fallacy of hospital employment. We extricated those physicians from their circumstances and enabled them to start their own practices, often creating their own systems of multiple practice locations, surgical facilities and ancillary services.

There are multiple ways to translate that model into anesthesiology terms. One is the move into outside-of-facility practice, some examples being ketamine and other infusion clinics, mobile anesthesia practices and physician's office-based practices. Another is the move to out-of-network practice, whether or not at out-of-network facilities.

Reversing the RFP Reverse Auction Model

Several years ago, anesthesia business education focused heavily on responding to requests for proposal, i.e., RFPs.

Today, there's such a shortage of anesthesiologists and CRNAs that it's difficult to find anyone to respond to an RFP. Threats of replacing an incumbent contracted anesthesia group by issuing an RFP, are hollow.

But the leverage created by the staffing shortage opens the door to another strategy, one that I describe as "reversing the reverse auction," for that is what an RFP is, a reverse auction. Let me explain.

A normal auction, actually referred to as a "forward auction," involves a single seller and multiple buyers. That's the sort of auction with which most people are familiar, from fine art auctions at Sotheby's, to collector car auctions by Mecum to live auctions at elementary school fundraisers. The single seller attempts to pit multiple buyers against one another in order to obtain the highest price.

An RFP for anesthesia service is an auction, too. It's a reverse auction in which the party "buying" the services, i.e., the hospital, attracts multiple "sellers," i.e., anesthesia groups, pitting them against one another to provide the broadest scope of services for the lowest subsidy; in other words, in total, the lowest price.

Given the fantastic leverage that providers of anesthesia services now enjoy, the forward auction strategy involves pitting multiple facilities against one another for your group's services. Will this work in the middle of a large metropolitan area? Maybe, maybe not. But the cost to explore your answer is relatively low.

For naysayers, this strategy is essentially the same as that played out by large physician practice management companies and, outside of healthcare, businesses from Amazon to Volkswagen dealers.

A FEW MORE WORDS

The above are a few of the models that run counter to that prevalent in anesthesia business.

There are others, some of which bear little relationship to what anesthesia group leaders and chatterati might conceive. That's what makes them highly strategic and very profitable.

Most anesthesia group leaders are afraid to go there, which makes it all the better for those who aren't.

MARK F. WEISS, JD

Mark F. Weiss, JD, is an attorney specializing in the business and legal issues affecting anesthesia groups and healthcare facilities on a national basis, practicing at The Mark F. Weiss Law Firm, with offices in Dallas, Texas and Los Angeles and Santa Barbara, California. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine. He can be reached by email at **markweiss@weisspc.com**.