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THE EMPLOYED SURGEON

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*Inspiring Quality:
Highest Standards, Better Outcomes*



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DISCLAIMER

This research guide has been developed by the American College of Surgeons as an aid for surgeons exploring new models of practice and is intended for informational purposes only. This document does not constitute legal, accounting, business, or information systems consulting advice.



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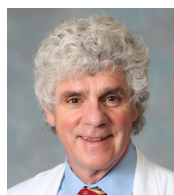
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INTRODUCTION

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INTRODUCTION

In the 1990s, with the move toward managed care and health maintenance organizations, hospitals began to purchase physician practices, especially primary care practices, in large numbers. However, these ventures, in general, were not successful due to poor design of compensation and other incentives, lack of accountability on the part of the new employees, and the assumption that the physicians would function in the same way as when they were self-employed. Most of these relationships guaranteed physician salaries with no productivity or quality-of-care metrics, and as a result, these types of arrangements failed by the start of the next decade.

In the current consolidation era of health care, there has been a renewed movement toward employment of physicians by hospitals, especially specialty physicians. According to the U.S. Bureau of Labor Statistics, hospitals account for the largest number of jobs in health care, and research by Avalere Health and the Physicians Advocacy Institute indicates the percentage of hospital-employed physicians increased by more than 63 percent between 2012 and 2016.^{1,2} As we will cover in detail below, this trend toward employment of surgeons is not just by hospitals, but also by physician groups, foundations, and other health care-related entities. As such, we will generically refer to the employer as an “institution.”

Surgeons face many challenges in today’s health care environment, particularly related to navigating job opportunities and understanding the nuances associated with employment agreements. How do surgeons choose who their employer will be? Are the terms of employment fair and equitable? How do surgeons know that they are being fairly measured and compensated for their quality and work? Does quality matter? What about experience? And, if the surgeon decides to change employers, what are the important items to consider and factor in, along with prudent steps to take?

The members of the American College of Surgeons (ACS) General Surgery Coding and Reimbursement Committee (GSCRC) represent all of the surgical specialties commonly associated with general surgery, and we work with similar committee members of other surgical organizations to provide the best advice to ACS Fellows in areas of coding, reimbursement, regulatory affairs, and practice management. It has been six years since the ACS GSCRC published the monograph “Surgeons as Institutional Employees,” and the trends toward employment of surgeons along with a corresponding reduction in private practice surgeons have continued to increase and become more widespread. Much has changed since the original publication, and yet the underlying problems and challenges remain the same.

The GSCRC has labored diligently to revamp and expand the original monograph in response to requests from Fellows and members for more help and assistance in navigating the waters of employment. Physician employment has only become more complex, with employment agreements extending to more than 20 pages in length. We hope to provide answers to the questions above as well as provide background material that will help you in this new landscape of surgeon employment. The references at the end of each chapter have been carefully chosen to provide more resources that you can look up and use when it comes time to consider or reconsider your employment situation.

Private Practice versus Employment: What’s Changed?

There are many factors that have impacted surgeons over the past 30 years, and it is over that timespan that we have witnessed a steady decrease in the number of physicians entering and working in the self-employed world.



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Change in numbers of employed surgeons. How dramatic is this trend, and how many surgeons are still in private practice? It is difficult to get a firm number due to the differences in the wide variety of medical and surgical practices. But, looking at a series of large physician surveys, it is clear that self-employed physicians have gone from the majority to the minority of practices.



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There are multiple factors driving surgeons out of private practice and into employment, such as misalignment of surgical fees relative to national inflation, increased cost and complexity of establishing and maintaining a surgical practice, and the growing number of administrative burdens placed on the surgeons and their practices by the government and commercial payors.

A recent study by the American Medical Association (AMA) showed that the percentage of self-employed physicians fell 76 percent in 1983 to 51 percent in 2014.³ Then, in a follow-up survey in 2016, physicians who owned their own practice fell below 50 percent for the first time to 47.1 percent. The year 2016 was also when the percentages of employed physicians equaled the number of physician owners (47.1 percent in both categories). A recent study by Accenture showed that the

percentage of independent physicians fell from 63 percent to 35 percent over the 16 years from 2000 to 2016.⁴ The trend is even more striking when you look at surgeons. Charles et al. analyzed AMA data in 2013 and found that 67.9 percent of surgeons were employed in 2009 compared with only 47.5 percent in 2001.⁵

Physician age. Age may be another driver of this trend. In the same AMA study, roughly 55 percent of surveyed physicians who were 55 years or older owned their practices, while only 28 percent of those under 40 years were in private practice. The Charles et al. study confirmed this, noting that 86.1 percent of general surgeons graduating after 2000 were institutionally employed. Some of this trend is likely driven by mounting debt from medical education. According to the American Association of Medical Colleges (AAMC), 75 percent of new physicians who graduated in 2017 reported leaving medical school with an average of \$190,000 in student debt (based on public and private MD-granting medical schools, including undergraduate debt), up from \$125,000 in 2000.⁶ Because young surgeons are graduating with more debt, they may be more interested in becoming employed rather than accruing more debt associated with the risk of starting an independent practice.

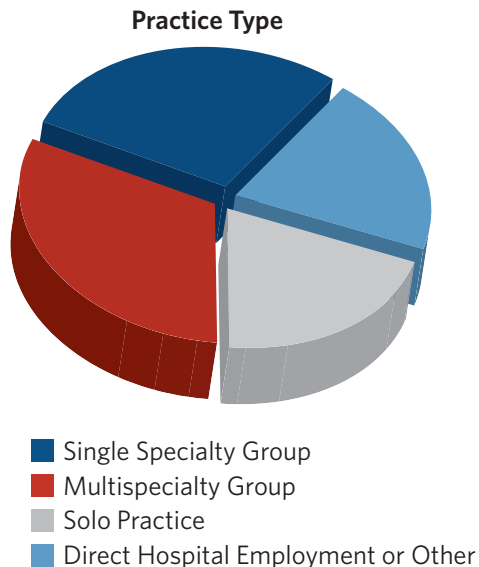
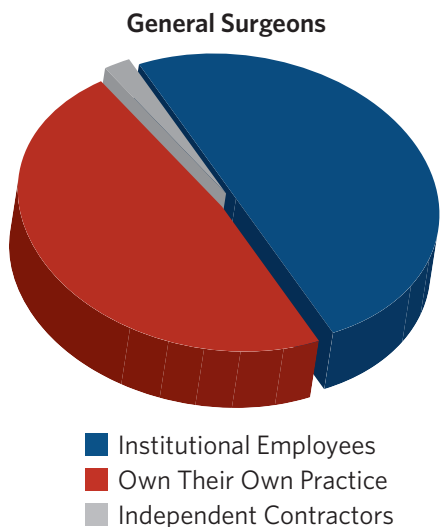
Practice size and structure. Not only has the number of self-employed physicians dropped, but the size of medical practices has increased as the solo practice physician has retired or joined other groups of physicians. Over the same time, the AMA study found that the percentage of physicians working in groups of 10 or fewer fell from 80 percent to less than 20 percent.⁷ The latest AMA Policy in Perspective study of physician practice showed more details about size of practice and ownership that may be important for surgeons. Practices with fewer than five physicians dropped to only 38 percent in 2016, while single-specialty physician practices accounted for 39 percent of physician practices.⁸ This undoubtedly



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is a result of the rise of the health care system, where physician practices are consolidated under one umbrella along with hospitals, outpatient centers, imaging, and primary care facilities.

How a practice is structured is also important, and perhaps the best way to understand structure is to consider who owns the practice. The AMA Policy in Perspective study showed that the majority (56 percent) of physicians in the U.S. work in practices that are entirely owned by physicians. Many of these practices have a combination of physicians who are true owners of the practice, those who are contract employees, and those who are true employees. Physicians who work in practices that are partially or entirely owned by hospitals have remained fairly constant at 33 percent from 2014 to 2016. This study also revealed that 50 percent of general surgeons work as institutional employees, 48 percent as owners of their practices, and 2 percent as independent contractors. When viewed from the standpoint of practice type, 31 percent of general surgeons worked in a single specialty group, 28 percent in a multispecialty group, 20 percent in solo practice, and 20 percent in some form of direct hospital employment or “other” employment situation.



Practice costs and administrative burdens. Physicians today are inundated with a growing number of administrative requirements imposed by Congress, federal and state agencies, commercial insurers, and other entities, adding unnecessary barriers to providing essential services and increasing spending on nonclinical activities. The staggering cost of electronic medical records (EMR) systems alone has been a tremendous burden for physicians. A recent study of the annual cost for an EMR for a moderate-sized practice revealed that the annual cost in 2015 was \$32,500 **per physician**, a 40 percent increase since 2009.⁹ This annual price tag doesn't take into consideration the up-front initial costs of installing the EMR on a practice's computers or the cost of training employees to use the system.

Physician reimbursement and annual inflation. Payment using the fee-for-service process has been the main method of income generated by surgeons. The primary payor has been Medicare, which uses the resource-based relative value scale (RBRVS), and over time, that method has been adapted in one form or another by most major



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To combat policies that impede surgeons' ability to provide timely and high-quality care, the ACS launched its Stop Overregulating My OR (SOMO) initiative, through which the College's Division of Advocacy and Health Policy (DAHP) highlights specific regulatory and legislative actions that should be taken to reduce administrative burdens and enable surgeons to reinvest their time and resources in patients. Under the SOMO initiative, the ACS DAHP has positioned the College at the forefront of the regulatory relief movement and has been invited by congressional and executive branch leaders to provide expert testimony on methods to reduce administrative burden and improve payment and quality measurement programs so that they work more effectively for patients and physicians. As a result of these efforts, the ACS has been successful in generating government activities—such as the removal of redundant or outdated clinical documentation requirements and the initiation of processes to make EMRs interoperable—to ease administrative requirements and align regulations with the current practice of medicine.¹⁰

commercial payors. Thus, the RBRVS relative value unit (RVU) and the conversion factor (CF) have become surrogates for the income earned by physicians. The Medicare CF has remained essentially stagnant since the RBRVS was introduced in 1992, during which time the CF was \$31 per RVU.¹¹ While surgeons briefly enjoyed an increase in the conversion factor during the years 1994 to 1997, for the following 20 years they have been paid between \$36 and \$35 per RVU.¹² During the same time period, the average inflation rate in America caused the cost of goods to increase by almost 78 percent (Figure 1, page 10).¹³

If the original Medicare CF of \$31 paid to physicians was to have kept pace with national inflation, the 2018 Medicare CF would be \$55.02 per RVU. Thus, in 2018, self-employed physicians are now earning \$24 less for each RVU produced than they would have had the Medicare CF kept pace with the Consumer Price Index (Figure 2, page 10).

A recent graph from the American Enterprise Institute shows how the cost of common goods and health care services has increased over the average inflation rate during 1997 to 2017 (Figure 3, page 11). It is no wonder that surgeons have had trouble keeping up with their expenses, year after year, as their reimbursement per RVU has been held constant, yet costs to run a practice have continued to increase, resulting on an erosion of their take-home pay.¹⁴

Increased demand by hospitals and institutions for employed surgeons. Another factor driving surgeons into employment is the willingness and/or need of those hospitals, institutions, or large practices affiliated with those entities to employ physicians. Staffing of critical areas of hospitals, on-call requirements, capture of market share, and the utility of surgeons as a mechanism to reduce costs via reduction of unnecessary or duplicative services are all known examples of why employment of surgeons benefits these institutions.¹⁵ This need to





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Figure 1. Medicare Surgical Conversion Factor vs. Consumer Price Inflation

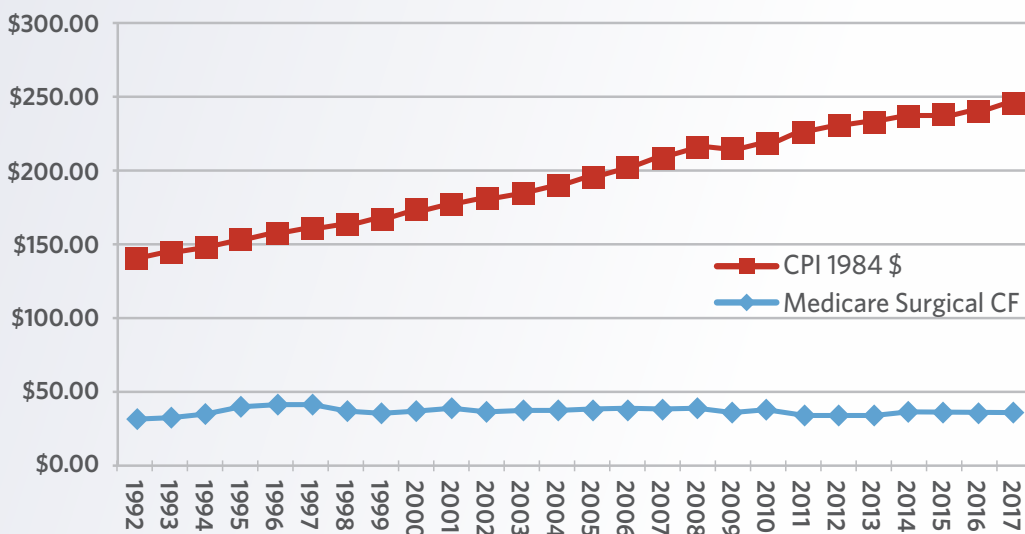
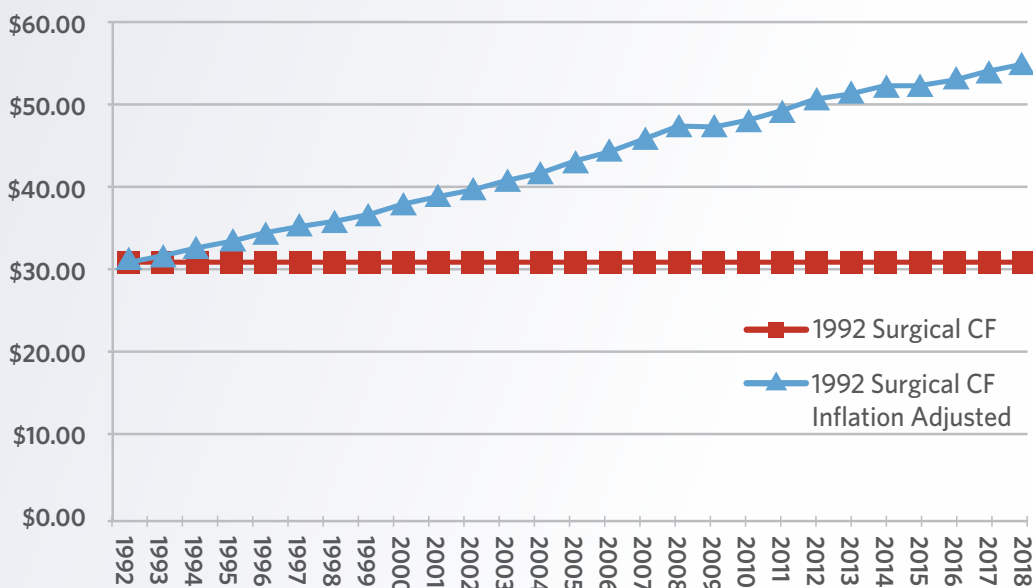


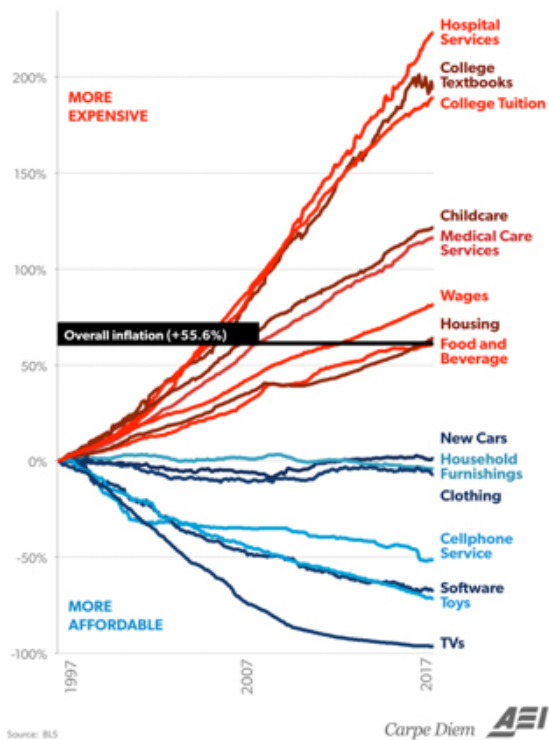
Figure 2. Comparison of 1992 Surgical Conversion Factor with Impact of Inflation





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Figure 3. Price Changes (January 1997-December 2017)



increase the numbers of employed surgeons may seem paradoxical, as most institutions lose money on the employed surgeon if **just the surgeon's income and expenses are taken into account.**¹⁶ However, when combined with the positive effect of having surgeons affiliated with an institution, there is significantly **more money**, patients, and associated revenue coming into the organization **than is lost on a surgeon.**¹⁷⁻²¹ Merritt Hawkins has produced a very nice demonstration of this effect in their 2016 survey of inpatient and outpatient revenue.²² It is clear from the existing data that hospitals are much better off by employing surgeons than dealing with

Figure 4. Physician-Generated Revenue vs. Average Salaries

Specialty	Average Revenue	Average Salary
Cardiology (Invasive)	\$2,448,136	\$525,000
Cardiology/Non-Inv.	\$1,260,971	\$291,000
Family Practice	\$1,493,518	\$198,000
Gastroenterology	\$1,422,677	\$455,000
General Surgery	\$2,169,673	\$339,000
Hematology/Oncology	\$1,688,056	\$350,000
Internal Medicine	\$1,830,200	\$207,000
Nephrology	\$712,054	\$275,000
Neurology	\$1,025,536	\$277,000
Neurosurgery	\$2,445,810	\$553,000
OB/GYN	\$1,583,209	\$276,000
Ophthalmology	\$1,035,577	\$249,000
Orthopedic Surgery	\$2,746,605	\$497,000
Otolaryngology	\$1,066,221	\$334,000
Pediatrics	\$665,972	\$195,000
Psychiatry	\$1,210,586	\$226,000
Pulmonology	\$1,191,870	\$331,000
Urology	\$1,405,659	\$412,000

the vagaries of a loose-knit group of independents, and that they are not losing money when all of the effects of employment are taken into account (Figure 4). When looking at the contribution of an employed general surgeon to a health care system, the revenue generated on the hospital side, including imaging, testing, and referrals, is tremendous and far outweighs the surgeon's salary and overhead.



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PART 1: DIMENSIONS OF EMPLOYMENT

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PART 1: DIMENSIONS OF EMPLOYMENT

Employment can be a broad term, with many different meanings, depending upon the circumstances that the surgeon finds himself or herself in. In general, there are three dimensions of surgeon employment that you should be aware of, as each dimension has its own unique set of challenges: (1) the various **employment environments**, (2) the various **employment types**, and (3) the various types of **transitions** to or from employment.

Employment Environments



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Just as there are many varied employment environments, there are just as many precautions that should be taken before joining any organization. A clear communication of expectations and diligence in reviewing both the organization and the contract prior to signing any agreement will pay benefits down the road for the employed surgeon.

Employment environments may vary in size, location, and mission. When deciding to enter an employment contract with an institution, it is important to understand the different types of institutional environments and the employment implications associated with each

environment. The choice of employment setting may affect things such as the surgeon's work hours, practice autonomy, administrative responsibilities, and financial risks.

In general, there are five types of employment settings, with three relating to hospital/institutions specifically, and two others not necessarily associated with any one type of hospital/institution.

Major metropolitan tertiary care referral hospitals or academic medical centers. These institutions typically have a full range of services, including pediatrics, obstetrics, general medicine, gynecology, psychiatry, trauma, and various branches of surgical specialties and subspecialties. They may also be linked to a medical school, and their mission often includes teaching of medical students and physicians in training and research. Many are looking for surgeons to fill on-site coverage or to develop niche markets. These types of institutions need physicians for growth in the battle to keep profit margins expanding or steady, or to grow market share. Physicians, with the proper leadership and information, can bring efficiency in product delivery and capital by reducing duplicated service lines. As health care reform expands, an institution's ability to control quality, improve patient satisfaction, and deliver increased value will prove useful in the future environment of medicine. Surgeons will play a vital role in helping these institutions improve quality and save money. While the surgeon will contribute to a solid net positive margin, there will be many other service lines that will be net negative (behavioral health, pediatrics, and so on), and so often the surgeon margin is used to shore up other areas. These large hospitals and institutions offer stability for their employees but tend to be less flexible with contracts and payment methodologies.



PART 1: DIMENSIONS OF EMPLOYMENT

Private practices. In some instances, a physician or a group of physicians will form a solo or group practice, which then contracts with hospitals or institutions, and provides services to those facilities. In this scenario, the surgeon is self-employed or employed by their practice group, rather than an institution. These practices can range from multispecialty “captive” groups or dedicated groups associated with one institution (such as a faculty group practice associated with a major teaching hospital), to a single specialty group that supplies surgical or other physician services to multiple institutions in an area (such as urology, orthopaedics, vascular surgery, radiology, or anesthesiology). In this instance, the physician must negotiate with other physicians within the organization but is also free, to some extent, from having a purely hospital-centric focus when it comes to contract negotiations. The American Academy of Orthopaedic Surgeons found that, over the past decade, a significant number of orthopaedic surgeons left the solo private practice setting and joined group practices to gain power in negotiation and market share.²⁶ This practice type has been very effective for those surgical specialties with multiple revenue streams (e.g., orthopaedics), which may offer operative care, physical therapy, pain management, and imaging all structured within the same group practice. This model has also been successful for neurosurgery, urology, and vascular surgery, but less so for general surgery.

No surgeon can escape regulatory oversight completely, but within those boundaries, the private practitioner has more authority over his or her own practice situation than the fully-employed surgeon. The surgeon must provide services at a hospital, or at least an ambulatory surgical center (ASC), which have rules for medical staff that include call coverage, licensure, board certification, and quality metrics. Even the independent surgeon will have to comply with regulations imposed by the facility. CMS, the state, and private insurers will all have requirements that must be followed regardless of one’s independent status.



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It is reasonable to ask, considering the ever-increasing regulatory burdens associated with the practice of surgery today, why anyone would ever choose to be a self-employed solo surgeon. The answer is very simple: “To be your own boss.” Consider what freedom this confers on your practice—you can tailor every detail of your office to your liking, determine your schedule, including daily office hours and vacations, select and incorporate new technologies that you believe will benefit your patients, and, just as employed surgeons engage in financial negotiations with their employer, you are free to negotiate rates with commercial insurers.

This freedom, however, comes at a price. As a solo surgeon, you assume the responsibilities the employed surgeon relinquishes to the employer, such as compliance issues, equipment maintenance, EMR and network security, insurance audits, staff training, and more. And, of course, you are responsible for the financial success of the whole enterprise, understanding that everyone’s paycheck – including yours – depends on generating referrals and balancing the costs of providing your patients with the best care based on negotiated fee schedules with private payors.

So, is the self-employed surgeon still a valid model? Of course it is, but it is a bit like asking a climber about the view from Mount Everest: It takes some work to get there, and some days it can be really cold, but the view is spectacular!



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Administrative opportunities within the federal government—including the Centers for Medicare & Medicaid Services (CMS), the Food & Drug Administration (FDA), and Health Resources and Services Administration (HRSA)—for surgeons usually require several years of clinical practice and prior leadership experience in a health care organization. Additional educational training (e.g., a Master of Business Administration (MBA) degree, Master of Public Health (MPH) degree, Juris Doctor (JD) degree) is desired to successfully compete for administrative leadership positions. Surgeons serving in this capacity have a great opportunity to effectively impact the process of care for a hospital or health care system.

The independent surgeon will be able to determine his or her own hours and vacation to a great extent and will have complete control over their staff. The surgeon can choose whether to participate in any insurance payment contract (including Medicare and Medicaid) or to remain out of network. The surgeon may opt out of many federal quality programs (sometimes because low patient volume excludes the surgeon, or volitionally with payment of a penalty). The private practitioner can also generate income from outside sources, such as consulting, locum tenens work, insurance auditing, or ownership in an ASC, without running afoul of rules from an institutional employer. In order to cover emergency services and to care for patients who may be underinsured or have no

insurance at all, private practices often contract with hospitals for call pay, which can be remunerative if well negotiated.

The private practice surgeon is a small business owner who must make business decisions. First and foremost, the surgeon must determine how they will code the services they provide and submit a patient claim for payment; practices may work with external companies that specialize in medical claims processing, or the surgeon and their staff may themselves choose to become facile in billing and coding. The surgeon must also negotiate annual payor contracts. Private practices are at a disadvantage in these negotiations, unless they offer some unique service, due to low patient volume compared with larger entities. In addition, the surgeon must establish practice protocols and manage employee health and retirement benefits. Although business management knowledge (finance, accounting, employment law, and so on) is not a prerequisite to opening a private practice, the surgeon will need to rapidly gain this knowledge—or perhaps hire an accountant with these skills—to be successful. Without a financial relationship with an institution, the private practice surgeon takes home all of their revenue, minus expenses.

Federal facilities. The federal government operates more than 200 health care institutions in the U.S., including Veterans Affairs Medical Centers, Indian Health Service facilities, and hospitals run by the Department of Defense and the Department of Health and Human Services. These types of facilities offer a secured income (although sometimes on the lower end of the pay spectrum) and work-life balance, and may provide opportunities for research and educational advancement.

Rural or critical access hospitals. These institutions have 25 or fewer beds located more than 35 miles from another acute inpatient care facility, or they have more than 25 beds but are not a referral center.²⁷ A rural critical access hospital (CAH) is a community hospital that, unlike its larger siblings, receives cost-based reimbursement under



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Not-for-profit hospitals often place great emphasis on philanthropy and employed physicians are called upon to aid in demonstrating community benefit. These activities range from speaking engagements at local businesses, health screening, and staffing health fairs.

federal law.²⁸ Because of their remote location, rural hospitals often have a difficult time recruiting surgeons, and in accepting an employment position at one of these facilities, it is important to note that the hospital may face problems with lack of coverage and support. Surgeons who can perform a full range of endoscopy services in addition to providing more standard surgical care will be extremely desirable for the rural CAH setting. As a result, surgeons who desire to practice in such an environment will have a strong negotiating position and receive a competitive salary, but must be willing to accept the limitations of the hospital and its support systems, such as not having other medical or surgical sub-specialists, interventional radiology, or advanced technology available around the clock.

Community hospitals. These hospitals are typically organized as not-for-profit corporations. Their not-for-profit status is based on their charitable purpose, and in some cases the hospital may be affiliated with a religious denomination. There are now for-profit hospitals that are also entering this “community hospital” space, as

large institutions are taking over hospitals that were previously not-for-profit. State and local governments also own nearly 1,000 community hospitals throughout the country.²⁹ Regardless of profit status or ownership, community hospitals form the backbone of American medicine and are often the largest employer in their county. One of the goals of a community hospital may be to develop a dominant position in their market area and, as a result, they need the expertise and reputation of a surgeon to draw patients to the hospital. In this environment, it will be helpful to understand the competition from other hospitals that are in the same market area to determine how valuable your surgical services will be to the institution. Conversely, if other entities are dominant in the area, it may be difficult to move market share and thus put any new surgical recruit at a disadvantage. You should not accept a position at an institution without first gauging the competitiveness of the hospital that you are considering by doing research on competitors and asking your new potential employer about this issue. Hospitals and health care systems operate on a close margin; today, a positive margin of 3 to 5 percent is excellent. Look to see if your institution is net positive and experiencing growth rather than sustaining losses.

Employment Types

As the U.S. economy continues to put more pressure on hospitals and physicians to lower costs and increase care quality, the general surgery workforce is rapidly shifting to institutional employment. There is no standard type of “employment” for surgeons, and each option should be closely evaluated by the surgeon to ensure the best fit for their wants and needs.

Full employment with a new surgeon joining other employed surgeons in a private practice. A hospital may employ or financially support a private group practice either as a wholly owned subsidiary of the hospital or its health system entity or as an affiliated practice. Typically, the “structural, operational, and, to some degree, financial



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In 21st century America, the private practice surgeon is not extinct, but they are an endangered species. These practices are usually well established by more senior surgeons who have been in private practice for their careers. It is not impossible to start a private practice, but some business acumen is necessary. Today's private practice requires a surgeon with an entrepreneurial desire.

control over the practice entity, its shareholders, and directors may then be conveyed to the hospital by means of any number of documents and agreements, including an administrative services agreement, a stock transfer restriction agreement (to ensure a hospital-friendly successor), as well as the practice entity's charter and bylaws.³⁰ The hospital does not purchase any practice assets from the group, and the practice acts in most respects much like a private practice. A surgeon entering this form of employment is employed by the private practice, a subsidiary of the hospital, but is not directly employed by the hospital. These types of financial arrangements need critical and expert input to avoid inadvertently violating federal or state laws. By the same token, good legal review of the contract arrangements on behalf of the potential new employed surgeon is essential to avoid unpleasant surprises down the road, such as a reduction in base salary or payments per RVU, or, in the event that a contract is terminated, recoupment of recruitment bonuses, student loan assistance, and so on.

Full employment with new surgeons joining other employed surgeons in an academic practice. An academic practice is one affiliated with a university that has a medical school and/or an accredited residency program. These hospitals must be accredited by the Accreditation Council for Graduate Medical Education (ACGME) and approved by their respective state boards.

Surgeons who choose to join an academic practice have different responsibilities than private practice and nonacademic physicians. Academic surgeons are responsible for training and mentoring medical students, interns, residents, and fellows. At some academic institutions, surgeons may play a key role in relations with professional organizations, industry, and government. As an academic surgeon, it may also be necessary to spend time developing and evaluating training programs, designing curricula and assessing doctors-in-training, researching and implementing innovations in the medical field, and dealing with policy and accreditation issues. Typically, there is some reduction or offset in clinical work production to help support these administrative, educational, and research roles. It is important to ask, "Who will pay for this?" during contract negotiations so that you won't end up paying for these extra jobs out of your clinical production budget or paycheck.

Employment of established surgeon as a contractor. Depending on the needs of the hospital, an established surgeon may be hired as an independent contractor, rather than a full-time employee. This type of arrangement is becoming more common as hospitals seek to align themselves with various surgical providers but want to avoid the financial investments required to purchase practices. A surgeon, as a contractor, renders services, exercises independent judgment, and is under the control of the facility for which the services are performed with respect to the result of the work, but not as to how it is accomplished.³¹ The advantage of this arrangement is that the surgeon typically retains the ability to be self-employed, still controls his or her



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professional corporation, and, under some instances, can practice outside of the independent contractor agreement (for example, emergency room call).

An independent contractor arrangement has important legal and financial ramifications that need to be considered. Agreements on fees and charges for services paid to a surgeon by the institution can pose significant fraud, abuse, and antitrust risks if such a relationship is not based upon market benchmarks. In addition, independent contractors are responsible for their own income tax. Independent contractors do not typically qualify for workers' compensation benefits and are excluded from participating in employer-sponsored benefit plans, including paid sick leave, vacations, or holidays. In the situation where a surgeon works as a part-time contractor for two or more hospitals, there are also Medicare billing regulations that must be considered. Medicare assignment rules typically prohibit a provider from billing Medicare for services performed at a location other than their own practice, and, as a result, most independent contractors will have separate provider numbers—one set for their original private practice (which they may keep active and use) and another set(s) for use by the employing institution(s), under which the hospital or institution bills for services on behalf of the surgeon.

Hospital support or stipend while remaining in private practice. In many regions, hospitals are facing increasingly scarce physician coverage for critical services.³² As a result, hospitals have created support or stipend arrangements with private practices. The goal of these arrangements is typically to ensure physician coverage of essential care. The arrangement may be very similar to the situation of a surgeon joining a group of surgeons who have support from a specific hospital. The hospital support or stipend arrangement may also look similar to a capitation model and may be created around a

specific service line. The hospital may pay the private practice surgeon(s) a set amount for each enrolled person assigned to them, per period of time, regardless of whether that person seeks care, or may pay an on-call stipend for emergency room coverage. Other variations on a theme might include additional payment for call coverage, administrative duties, and so on.

In this model, the hospital does not buy the physician's practice assets, and the surgeon(s) does not have to relinquish control of the day-to-day operations of their practice. This arrangement also has unique barriers that should be examined in relation to the federal Stark Law, anti-kickback statute, and state physician self-referral laws; these arrangements must not be seen as enhancing referrals for the private "stipended" surgeon. Caution is key in these types of arrangements, and sound legal advice is strongly encouraged.

Transitional Situations to and from Employment

Many surgeons are seeking hospital employment or other formal arrangement options that better align the surgeon's clinical and financial interests. However, as financial, leadership, and market competition change for a given institution, conditions of employment often change as well. As a result, different transitional situations can arise.

Full employment of established surgeons with purchase of established practice. A hospital may choose to directly employ a surgeon. In some cases the surgeon may have an existing private practice; the hospital may elect to purchase the practice as a part of the employment agreement. It is important to remember that there are significant fraud and abuse issues unique to a hospital's purchase of a private practice, including the Stark Law, the Anti-Kickback Statute, and state regulations that must be taken into account.



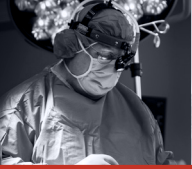
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The federal Stark Law and Anti-Kickback Statutes are designed to prevent the use of financial incentives to influence providers' medical decisions.³³ In addition, many states have policies in place to prevent corporate entities from influencing medical decision-making that might negatively impact patient care. Thus, it is essential to consult and incorporate expert legal advice when entering into agreements with hospitals to avoid any inadvertent regulatory violations.

Physicians in private practice may choose to sell their practice for many reasons and transition to an employment agreement with an institution. They may also retain their practices but function as a de-facto employee by receiving stipends/support or by entering into a professional services contract (i.e., working as a contract employee). Selling a practice can be a big endeavor. In considering the transition from private practice to hospital employment, it is important that the institution's care philosophy fits with the physician's practice philosophy, vision, and values.

Medical practice valuation, which involves assigning a dollar value to the practice, is another step in the process of selling a practice. A professional, independent party should appraise the practice value regardless of whether the physician selling is going into retirement or will continue as an employee of the buyer. As the institution acquiring the practice typically hires the third-party valuator, surgeons should ensure that the company selected by the institution has credible experience in valuating medical practices. The Stark Law also applies, in the instance of a physician selling his or her practice to an institution that will receive referrals of federally-insured patients from the physician seller. That is, the institution will be constrained in what they offer for the practice by the fair market value of the practice.

There are three general ways to value the purchase price of a practice: (1) based upon income, (2) based on value of future earnings and growth of service line revenue from the practice, and (3) based on the market value of the practice assets. Accounts receivable of the purchased practice are typically not bought by the institution, but rather, relegated to a separate custodial agreement for collection over time. In today's environment, there are minimal payments, if any, for intangibles like medical records or "goodwill" value. Pure "goodwill" payments are prohibited in general by the Stark Law, and paper charts may be viewed as more of a cost than something valuable for an institution to acquire, since there will be costs to incorporate those paper records into their EMR or to store them for retrieval. Selling your practice is more simply an asset purchase by the hospital (for example, value of ownership in an ASC, physical plant space, office equipment, other tangible values, and so on).



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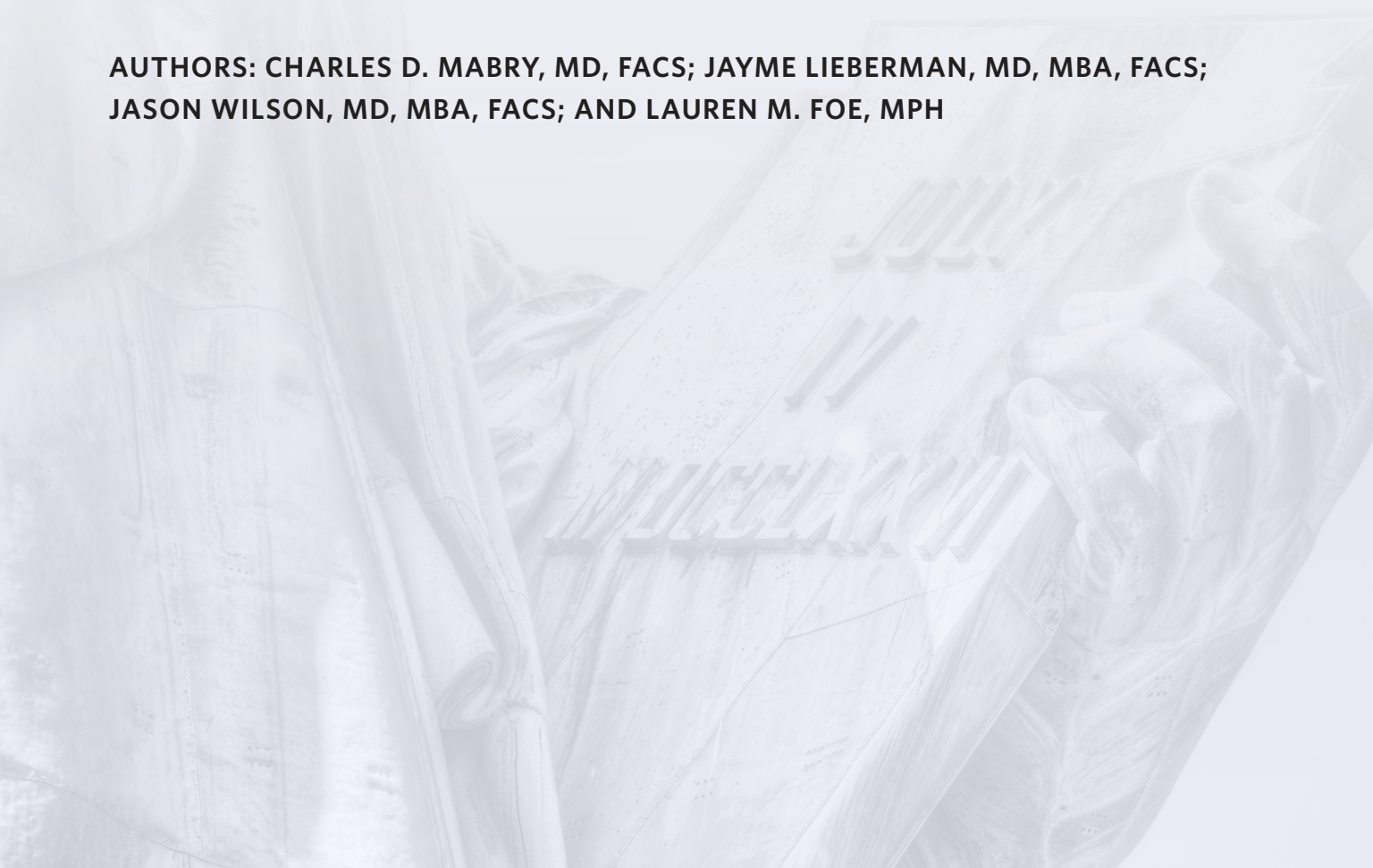




PART 2: UNDERSTANDING CONTRACTS

PART 2: UNDERSTANDING CONTRACTS

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PART 2: UNDERSTANDING CONTRACTS

Physician employment agreements play an important role in establishing the legal, operational, financial, and philosophical parameters of a surgeon's medical practice. Below, you will find a discussion of the important elements of contracts and proper negotiating tactics that will benefit surgeons entering into employment agreements with differing entities.

Overview of Contract Sections

For most types of employment situations, the basic employment contract typically boils down to an agreement between just two parties: the employer and the employee. There are typically eight to 10 elements of any standard employment contract, which are intended to spell out the requirements for each of these two parties. These elements also describe what circumstances that cause the contract to exist and/or to end so that none of the major issues impacting employment are left to the imagination of either party.^{34, 35}



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Unfortunately, some surgeons have found out that exiting a contract may prove much more difficult and costly than entering into one. Diligence on the front end by the physician signing the contract will prevent much angst on the back end.

The physician employment contract should describe many of the basic agreements between the employer (the institution or practice) and the employee (the surgeon), such as the term and termination of the contract, duties and rights of the employer and employee, covenants not to compete, and medical liability tail coverage. These main components of the contract are included to ensure all parties understand activities that would put the employee or employer in breach of the contractual agreement.

It is critical for surgeons to remember that any contract elements or other incentives discussed verbally—but not featured in the written employment contract—will likely not be enforceable should a problem within the employment relationship arise. All important terms and conditions should **always** be memorialized in a written contract signed by both the employer and employee.

However, it is not always practical to include each and every “promise” made by the employer in the formal contract, as doing so may significantly lengthen the document or stray from the typical contract format the employer extends to all employees. Many large institutions will not want to change their basic contract, especially if all other employees at the institution have signed the same standard agreement. Large institutions may present potential employees with a one page contract referencing links to online corporate policies for the surgeon to research on his or her own; legal review of these links, as well as obtaining a clear understanding of how any changes to these policies will be communicated and enforced, is critical. For example, can online content be amended with proper notice electronically? This feature alone may mean your contract can change rapidly.



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For agreements that may be outside the scope of a standard contract, a surgeon may request that a written memorandum of understanding (MOU) be established to define finer points of employment, such as research support, potential bonuses for achieving production targets, and schedules for future raises. An MOU is complementary to the contract and supports the surgeon's position in the employment relationship should any conflict arise concerning verbal promises made at the time of employment but not formally included in the contract.³⁶⁻³⁸

When surgeons are preparing for employment and are offered a contract, they should read and understand the document(s) in its entirety. All such documents should be reviewed by an attorney, certified public accountant (CPA), and/or other advisors with relevant expertise in evaluating and negotiating physician employment contracts to ensure the surgeon is entering into an agreement that is in his or her best interest. It is also important for any such advisors to be experienced in contract law within the state(s) of which you will practice medicine, as each state has different policies for the institutional employment of physicians. Importantly, the primary goal of the expert review of the contract is to help the surgeon comprehend the various sections, provisions, and details so that down the line, there are no surprises. The goal should not be to attempt to rewrite the document(s), as most institutions will have basic contracts that are relatively fixed in their major elements. Creative writing on the part of the surgeon's legal team may result in larger bills to pay, but alas, little benefit to the surgeon.

Recitals. Employment contracts often begin with a series of recitals, or introductory statements, which outline the general assumptions as to why two parties are coming together to form a contract, who the parties are, and in some cases, the underlying legal framework that affords one or both parties the ability to form a contract. While the recitals are not intended to describe the duties or rights of the parties involved, such statements are

explanatory in nature and serve to clearly identify the specific physician and employer to whom the contract applies.

Recitals may be particularly important to surgeons who choose to join a large institution, which may house multiple practices and corporations; therefore, it is essential for surgeons to understand which entity they are directly contracted with. The introductory recital statements not only describe who a surgeon's employer is, but just as importantly, who is not the surgeon's employer. This portion of the contract explains the employing entity responsible in the event of conflict or institutional changes, including institutional acquisition or bankruptcy, arise.

Term of the contract. It is crucial for surgeons to understand the term provisions (i.e., the length of time a contract is valid) of an employment contract. All contracts will be valid for a specified term, and the term should last long enough to provide security to both parties but not bind a surgeon for too long without the opportunity to renegotiate or explore new positions. It is the responsibility of each physician to evaluate their short- and long-term goals to determine a contract length that is most practical for his or her patients and practice.

Renewal of the contract. Many contract agreements are valid for up to three years, which offers surgeons the ability to establish a productive practice and identify areas to expand such practice. Surgeons typically will be offered an annual review at the conclusion of each term year, during which issues such as salary increases, production and quality bonuses, and other contract adjustments may be addressed between the surgeon and the employer. At the end of the initial term agreement, the contract will terminate, requiring a new agreement or an automatic renewal of the contract. It is critical for surgeons to know whether their contract contains an automatic renewal provision, often referred to as an "evergreen clause," as such a provision includes a notice of nonrenewal that can be exercised by either party, usually within 60 or 90 days.



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Termination of the contract. It is also important for surgeons to review the termination provisions of an employment contract. Without the ability to terminate the agreement during the contract term, surgeons may be responsible for things such as salary payments that are to be made during the course of the employment agreement. The termination provision should clearly define the circumstances under which contract termination is permitted. There are two general types of termination clauses—termination with cause and termination without cause—each of which may be enacted by the employer or employee depending on the provisions included in the contract.

- **Termination with cause (immediate).** Most contracts have a list of transgressions or critical events that will result in the immediate termination of a physician because such events render the physician unable to provide services. These immediate termination events may include, but are not limited to, loss of license to practice medicine, loss of or failure to qualify for malpractice insurance, failure to obtain hospital privileges, failure to qualify for enrollment in a federal health care program (for example, Medicare, Medicaid), commission of health care fraud or other criminal activity, or violation of institutional conduct policies (including drug- and alcohol-related offenses). Termination with cause clauses should clearly define circumstances that result in immediate termination.
- **Termination with cause (with cure period).** Situations (for example, delinquent medical records, low work production, poor performance on quality measures) may arise that could result in termination, but may be remedied or reversed if actions are taken to “cure” the infraction within a set timeframe or under specific conditions. In a termination for cause with a cure period, a surgeon may be notified and given

specific actions to correct the transgression and prevent termination. Time periods for resolution of these issues typically range from 30 to 60 days and should be outlined in the contract.

- **Termination without cause.** Contracts may also provide a pathway for either party to cancel the employment agreement without a specific cause or reason. The timeframe, conditions for notice, and mechanisms of appeal for this type of termination should be clearly stated in the contract. Conditions of notice should detail who should be notified of the termination, what form of notice is required (for example, written, verbal), what appeals processes exist, and the length of time required to pass after notice is given until termination takes effect. Traditionally, most contracts call for a written notice and will specify to whom the written notice should be delivered. Prior to giving notice to an employer, surgeons should carefully read and understand any elements of the contract that would affect contract termination, including restrictive covenants, payment of tail coverage for malpractice insurance, relinquishment of hospital privileges, methods and time periods for which loans to the organization should be paid back, and identification of any monetary penalties associated with premature termination of the employment agreement. Depending on the circumstances, some of these items may be negotiable, but if not taken into account before giving notice, this may represent a missed opportunity to negotiate a better exit. The typical notice of termination without cause is 90 days, although it may vary by institution. This clause is typically included to give both parties an easy way out of a contract if both sides are unhappy with the arrangement.



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Credentialing and coterminous provisions. It is important for surgeons to know how their credentials are affected by the terms of an employment contract—a surgeon’s ability to practice at an institution could cease to exist upon termination of employment. The linkage of hospital staff appointment and privileging with employment contracts, called “coterminous,” is a critical thing for surgeons to note and then to consider when entering into an agreement with an employer. For example, surgeons who decide to terminate their contract may lose the right to continue to practice at any facility associated with their former employer if their contract linked privileging to that specific institution and its affiliates by using a coterminous provision.

Employee and Employer Responsibilities: Duties, Rights, and Obligations

Most contracts have two separate sections that outline the duties, rights, and obligations of the employer and the employee. Once a contract is signed, the employed surgeon should understand the many facets of beginning and continuing practice.

Employer duties, rights, and obligations. The employment contract should clearly state the duties of the employer, which usually include, but may not be limited to, the financial aspects of physician work, including rights and obligations to bill, collect money, and negotiate insurance company contracts; determining fee schedules and discounts; office and personnel management; and clinical equipment and supplies. If the surgeon is fully an employee of the institution (in other words, the surgeon receives a W-2 Internal Revenue Service (IRS) tax form), the employer should outline any benefits the surgeons will receive, such as health and disability insurance, retirement, and vacation days. The employer should also outline the compensation package or plan in full detail, including any bonuses or quality incentive payments available to the surgeon. Per your contract, you

may also be allotted a lump sum to cover licensing fees, professional society dues, Continuing Medical Education (CME), technology, books, and other materials. This amount should be negotiated prior to signing the contract; however, in large physician groups, these policies may be standard and non-negotiable.

Employee duties, rights, and obligations. The employment contract should also clearly state the duties of the surgeon and the rights and obligations associated with the surgeon’s position, which usually include, but may not be limited to, required licensure and certification, staffing and call requirements, civic hospital duties, and required hospital privileges. Many contracts also outline the clinical, teaching, research, and administrative services that a surgeon is required to provide the institution, as well as the framework under which such services are provided. Most contracts will include a “duty to report” clause, requiring employees to make the employer aware of any circumstances that may result in immediate cancellation of the contract, such as loss of medical licensure or commission of a felony. “Good citizen” requirements, which include actions such as timely and accurate maintenance of patient charts and attendance of required staff meetings, may also be outlined in the employment contract.

Becoming employed. There are several steps that a surgeon must complete prior to being hired, including applying for and obtaining board certification and state licensure. These steps are usually the sole responsibility of the applicant. Depending on the state, licensure may be quite onerous, and the process should be started as soon as an agreement is reached with a practice, if not before.

Once licensed, the newly-hired surgeon will need to be credentialed by the health care facility, during which time your employer will verify the documents used to support your application. The requirements for credentialing vary by state and individual hospital. It can be a rigorous process; given the multitude of information required, the hiring hospital may assign at least one credentialing



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“liaison” to each new hire to facilitate the process. Additionally, any fees incurred during the process of credentialing and privileging are usually covered by the hospital; however, this practice varies by facility and should be stipulated in the contract. It is important to communicate frequently with your employer at this stage to ensure each item needed for credentialing is obtained in a timely fashion. Information needed for credentialing can include, but by no means is limited to:

- Medical license—active and inactive
- Drug Enforcement Administration (DEA) certification
- Training letters/records
- Medical school transcripts
- References
- Background checks
- Conflict of interest forms
- Malpractice insurance/history

Generally, it is the new hire's responsibility to submit all requested information for credentialing, which often requires some effort to ensure all documents, letters, certificates, and other materials are not only provided in a timely fashion, but are also up to date. Surgeons may store their core credentials online using the centralized platform hosted by the Federation Credentials Verification Service, which is used by multiple state medical boards to obtain verified education information for physicians applying for licensure.³⁹

Once the credentialing process has been initiated, you will be asked to apply for hospital privileges. Different from credentialing, the privileging process is the assignment of your presumed scope of practice during your employment based on your skill set, training, and certification. It is

generally reviewed by a physician leader and approved by a hospital committee. For recent graduates, it is recommended to discuss the breadth of privileges you will request with a physician leader in your new practice. Privilege requests range from the ability to admit patients to performing any procedure the new hire is trained for, and may be differentiated based on patient age (for example, adult, child, infant). While this process also varies by hospital, generally you are awarded probationary or preliminary privileges, with a review scheduled after the hire date prior to being moved to “active” status. In many hospitals, you will need to be proctored and/or mentored for a certain number of cases when you first start practice before you may be considered “active.”

Simultaneously, an application will be submitted on your behalf by the hospital to all insurance companies the institution participates with (including both government and private payors) to enroll you in their networks. This step will allow you and the hospital to be reimbursed for the services you provide. The process of insurance credentialing can take several months and is usually complete by your hire date. If, by your hire date, you are not credentialed with every payor the hospital participates with, your practice may allow you to see patients from only those insurers you are credentialed with.

Once you begin practice, you can expect a surgeon in a leadership role (chair, dean, practice lead, and so on) to set expectations for you regarding your role and responsibilities, including daily work, call schedules, office responsibilities, productivity goals, education expectations, research expectations, participation in committees (such as those for performance improvement, quality assurance, peer review, and morbidity and mortality), paid time off and CME requests, and so on. Each institution has varied policies regarding all of these issues. It is important to have clear lines of communication with your practice leaders and partners to ensure all expectations are understood and met.



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Once you begin to treat patients, Current Procedural Terminology (CPT®) codes will be submitted to insurance companies for reimbursement. Everything you do, from evaluating a new patient in the outpatient setting to a complex surgical procedure, will be assigned a code and a claim is sent to the payor for reimbursement. Generally, the practice or hospital employs coders to perform this task, but it is important to note that, ultimately, it is the surgeon's legal responsibility to ensure the correct codes are submitted. Any errors that result in improper reimbursement are the surgeon's responsibility, regardless of who actually submitted the claim. The ACS provides numerous resources, available at facs.org/advocacy/practmanagement, which can help surgeons become proficient in procedure coding and stay current in billing and documentation guidelines.

Once a code is reported and claim is submitted, monitoring of the actual amount and timing of reimbursement is the responsibility of the practice's administrative personnel. If the payment is denied, this too is usually dealt with by the practice administration. However, the physician may be asked to make an appeal of the denial, and in some circumstances, if the payment is still denied, the reduction in RVU allocations may result in loss of income.

As an employed surgeon, the burden of practice management rests with the administrators of the institution, which allows the physician to focus on patient care. Some of the daily management issues, including hiring, firing, scheduling, PTO, conflict resolution, and so on, are dealt with so as not to distract the physicians of the practice. This can be beneficial in that you do not have to deal with any of the stressors of running an effective practice; however, you will not have much input, if any, when practice management decisions are made, even if they directly affect your professional and personal life.

The process of becoming employed may be laborious but ultimately provides both the surgeon and institution the ability to minimize unnecessary risk and exposure during the hiring process. As the review of employment contracts—and all other activities required before employment may be finalized—is not a common undertaking for the individual surgeon, the hiring entity should be supportive and responsive to any questions that may arise. Issues that affect your professional and personal life (such as PTO, compensation, CME, call schedule, contract questions) should be addressed satisfactorily prior to signing the contract. As previously mentioned, many contracts at large institutions are essentially templates and are not able to be tailored to every individual request. Regardless, it is very important to understand the practice environment you are becoming involved with before final contracts are signed.

Restrictive Covenants

A restrictive covenant, also known as a non-compete agreement, is a common component of an employment contract. These agreements generally limit the location in which a surgeon can practice for a defined time period should either party decide to exit the employment agreement. Restrictive covenants are often written so they continue whether the employee or employer terminates the contract no matter the cause for termination.⁴⁰⁻⁴²

Non-compete agreements are usually included in contracts to benefit the employer. A Merritt Hawkins survey published in 2016 showed that the average general surgeon generates \$2,169,673 in annual revenue.⁴³ If a surgeon leaves a practice to work for a competing entity, it is likely that this revenue may follow the physician to the competition as well. Employers put in significant upfront capital to recruit surgeons and must be able to protect their investment; other surgeons employed by the same institution would also benefit from such restrictions, as they similarly would not wish to see a partner join a practice only to leave and become a competitor.



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There are three main factors of a restrictive covenant: scope of activity, geographical restrictions, and a time period of restrictions. The scope of activity refers to the allowed practice of medicine following termination of the existing agreement. Scope of activity should not include teaching, outside consulting, working for insurance companies, or working for a noncompeting company. Geographical restrictions prohibit practicing within a specified radius around the surgeon's main location of employment (but some may be from all locations of practice, despite distance), and the period of restrictions establish a set length of time that the agreement is in place. Some of these covenants will have an opportunity to provide compensation to the employer to nullify the terms.

One last area to pay attention to deals with restrictive covenants outside clinical or consulting work—when is it allowed, if at all? If you do consulting work on your off-work hours, does the money received belong to the institution? Do you need special permission to do outside consulting work? What about malpractice issues? If you

create intellectual property as a result of off-hours work, does the institution have a claim on ownership of that property?^{44,45}

Despite these nuances, the applicability and enforcement of these covenants is a matter of state law, which means they vary by state. In many states, restrictive covenants are enforceable as long as the geographical restrictions and time requirements are felt to be reasonable. However, whether these clauses are reasonable in terms of geography and time is going to be dependent on the individual situation and specialty.

While the ACS recognizes the intent and perceived necessity of restrictive covenants, surgeons are advised to review restrictive covenants contained in employment contracts and to negotiate mutually agreeable terms. The ACS also recommends the review of all contracts with an attorney who is familiar with local laws and precedents prior to signing any contract.



PART 2: UNDERSTANDING CONTRACTS

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PART 3: UNDERSTANDING COMPENSATION

PART 3: UNDERSTANDING COMPENSATION

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PART 3: UNDERSTANDING COMPENSATION

The compensation package is a key component of hospital recruitment and retention of physicians. Without a doubt, the amount that you are paid, the benefits you receive, and the bonuses available to you rise to the top of any list of important aspects to consider when choosing an employer.

The full package should be well defined and include moving expenses, life insurance, retirement plan contributions, vision, dental, disability, vacation, paid time off, sick days, maternity and paternity leave, and continuing medical education benefits. Keep in mind that everything is negotiable; therefore, it is very important to understand five key items when considering employment compensation:

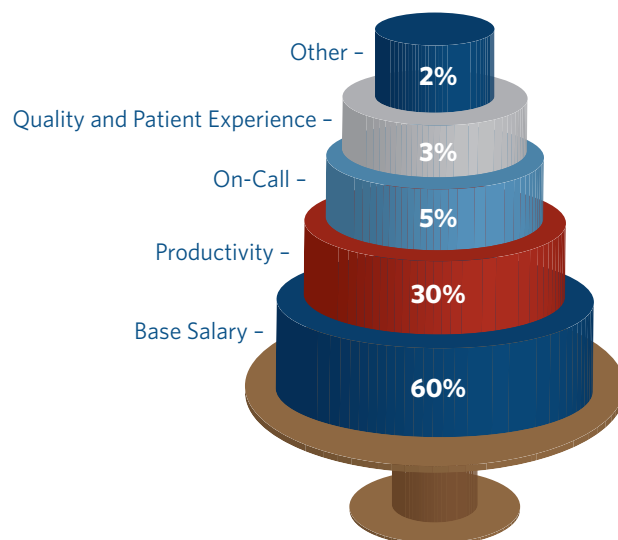
1. What is the mechanism to determine salary?
2. If the salary is formula-based, what is the formula, who calculates it, and how is it calculated?
3. How do I know if I am being paid fairly for the work that I perform? Is my work metric-based and compared with a survey?
4. If the compensation is based on other factors other than work (for example, a non-production-based salary), how are those non-work factors determined and valued?
5. What are the components of the benefit package, and what is the monetary value of those components?

Physician compensation—a layered cake. There are several compensation models available to surgeons, including guaranteed salary, base salary plus productivity bonus, RVU plus productivity bonus, productivity, and incentives/bonuses. While some models involve a straight salary, many plans being offered to surgeons today resemble a “layered cake”: a bottom layer that

is typically termed the “base” salary, which is typically a fixed amount; a second layer based on work or production; and perhaps additional layers to account for administrative, education, or research duties. Each of these layers can include a bonus component, such that if certain milestones or targets are reached for that layer, additional money is paid.⁴⁶⁻⁴⁸

Some compensation packages also add extra layers for achieving certain quality scores and “citizenship” targets (attending staff meetings, timely completion of records, helping achieve institution goals, and so on). These additional layers may be offered in the form of a financial bonus (i.e., money is awarded only if targets are achieved) or may be included in the base salary but “at risk” of not being paid if targets aren’t met. A 2018 Merritt Hawkins report noted that the majority of compensation packages featured a salary with bonus opportunities. Of the bonuses offered, most were linked to work production, while quality remains a very small component of any compensation offering (Figure 5, page 35).⁴⁹

Physician Compensation





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Figure 5. **Incentives**

Type of Incentive Offered

	Salary	Salary with Bonus	Income Guarantee	Other
2017/18	515(17%)	2,285(75%)	89(3%)	156(5%)
2016/17	723(22%)	2,359(72%)	121(4%)	84(2%)
2015/16	767(23%)	2,512(75%)	32(1%)	31(1%)
2014/15	715(23%)	2,219(71%)	124(4%)	62(2%)
2013/14	633(20%)	2,335(74%)	127(4%)	63(2%)

If salary plus production bonus, on which types of metrics was the bonus based? (of 2,285 searches offering salary plus bonus, multiple responses possible)

	RVU Based	Net Collections	Gross Billings	Patient Encounters	Quality	Other
2017/18	50%	10%	1%	4%	43%	4%
2016/17	52%	28%	6%	14%	39%	9%
2015/16	58%	22%	2%	8%	32%	8%
2014/15	57%	23%	2%	9%	23%	4%
2013/14	59%	21%	5%	11%	24%	9%

If quality factors were included in the production bonus, about what percent of physician's total compensation determined by quality?*

2017/18	2016/17	2015/16	2014/15	2013/14
8%**	4%**	6%**	5%**	3%**

*Question asked for the first time in 2017/18

**Estimates based on extrapolating how the amount of production bonus based on quality metrics would determine total compensation (family medicine only).



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Lastly, there is the frosting on the top of the compensation cake, which represents the benefit package. Most employers will offer health insurance as well as some form of retirement plan. Others will also add in life and disability insurance, stock options, and more prerequisites. It is typical that the benefit package represents between 20 and 25 percent of the total compensation but will be predictably quite different from one employer to the next.

Compensation Models

Guaranteed salary. In this model, the salary is 100 percent guaranteed regardless of productivity. This model is being offered less, as hospitals view it as a disincentive to productivity.⁵⁰ There are some situations, such as working in a federal facility, where there is a set salary in return for a set workload.

Base salary. As part of this model, there is a guaranteed base salary (in other words, the “floor” salary) offered in addition to a productivity bonus. It is important that the productivity bonus be based on objective, identifiable factors that are set in advance.⁵¹ The purpose of the base salary is to have a steady stream of income going to the surgeon, so that basic living expenses and needs can be paid for. Surgical practice can involve time away for education, vacation, training, and other administrative or institutional tasks, thus the work production during those times can decrease. Having a base salary provides a stabilizing or modulating factor to any compensation plan. Often, an initial contract will include a base salary for one to three years to act as a “floor” while the surgeon develops his or her practice.

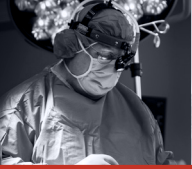
Base salaries can typically range anywhere from 25 to 75 percent of the total compensation package and are usually related to some type of national benchmark for physician payment. For employment situations in which



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How Do You Know if You’re Being Paid Fairly?

There are several sources for national compensation benchmarks, including Medical Group Management Association (MGMA), American Medical Group Association (AMGA), Association of American Medical Colleges (AAMC), and Merritt Hawkins that are all good resources to evaluate and explore. In some employment contracts (usually combined with an incentive or production bonus), the base salary is in the form of a “draw”, rather than a fixed flat amount. The “draw” is a flat amount that is paid each pay period as long as production is above a set target or level. The “draw” is adjusted down or “paid back” if production doesn’t meet expectations of a budgeted amount of work or collections. The pay back is sometimes called a “true up” exercise and occurs typically at the end of the contract year, but can occur more frequently, such as at the end of each quarter. If production is higher than expected and sustained, then the “draw” can also be increased to increase the base compensation. This allows the base salary “draw” to act a floor, but a floor that can be adjusted up or down over time, depending upon the amount of work performed.



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the salary is primarily production-based, the base salary tends to be less, with more of the salary potential moved over to the production side of the equation. For surgeons who are new to a practice, there is always a “ramp up” period, during which time the surgeon establishes their practice and builds a patient referral base. In those cases, the base salary can be 85 to 100 percent of the surgeon’s total compensation for the first year or two, and then declines in percentage as the surgeon enters their second or third year of practice, with the productivity amount increasing as the base salary decreases.

Production or work-based compensation. Not everyone works as hard as others, and in the fee-for-service world, more work on behalf of an employer usually results in more value delivered. Work performed by surgeons can be measured in many ways, such as number of surgical procedures, patient visits, dollars billed, or dollars collected. Each has some merit in the measurement of work. However, there are so many variables that affect these metrics that they are now felt to be secondary measures of work production. One of the most common incentive models is based on RVU output. In this type of arrangement, it is important to understand how your employer defines “fair and reasonable” work; numerous surveys of surgeon productivity are available, but each are nuanced and must be vetted in advance.⁵²⁻⁵⁴ Other compensation incentives can be based on percent of gross charges or percent of net collections. Note that these models will make physician payment more dependent on payor mix and effective billing systems.

The resource-based relative value scale (RBRVS) used by the Federal government for the *Medicare Physician Fee Schedule* has now eclipsed most other measures as a dependable and objective metric of physician work. While some propound that the RBRVS system will soon be replaced by newer, innovative payment models, most believe that it is here to stay as an integral component of clinical work measurement, useful for many purposes, including physician compensation.

RBRVS: The Foundation of Work-Based Compensation

Since the introduction of the RBRVS in 1992, components of this relative value scale have increasingly been used as an objective measurement of work production and have been incorporated into commercial insurers’ payment models. However, many surgeons are not familiar with the RBRVS and how the components of this system are calculated or used. It is important to ensure that any compensation model counts work fairly and, in turn, appropriately rewards the work delivered by surgeons.

The RBRVS was based upon a series of studies conducted in the late 1980s by William Hsiao, PhD, and co-workers at the Harvard School of Public Health, and was funded by the Health Care Financing Administration (HCFA), the precursor to today’s CMS. The purpose of this Harvard study was to measure the various resource components that comprise physician services, including surgical procedures, based upon CPT codes. The final product of their work was eventually used as the foundation for Medicare physician payment. This was first unveiled as the Medicare RBRVS in Section 1848 of the Omnibus Budget Reconciliation Act (OBRA), “Payment for Physicians’ Services.” CMS finalized the RBRVS method in the *Fee Schedule for Physicians’ Services Final Rule* published in November 1991. While modifications have been made along the way, the current RBRVS reflects to a great extent the original organization and structure of the physician fee schedule finalized in 1991.⁵⁵⁻⁵⁷

Current RBRVS methodology. The RBRVS has three components: work, practice expense, and malpractice insurance. These are combined to produce a total RVU, which is then multiplied by a dollar conversion factor to calculate a Medicare payment for a given service. CMS also uses geographic modifiers for each RBRVS component, called Geographic Practice Cost Indicators (GPCIs), to help offset increased costs of care in one area



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of the country from others. GPCIs are not used by private payors, since most of their fee schedules are tailored to local or state conditions and are not used transnationally.

While CMS determines the final RVU for all services covered under Medicare, organized medicine, including a strong influence from the ACS, offers advice as to what goes into each of these three components for a given CPT code. The entity that deliberates as an advisory committee to CMS is the AMA/Specialty Society RVS Update Committee (RUC). Work is measured by a series of surveys conducted by specialty societies, in which questions about time taken to perform a procedure or service, numbers of pre- and postoperative visits, hospital days required, and other patient care data are collected from practicing physicians.

Based upon the survey results provided by the specialty societies, the RUC deliberates the CPT code and compares it with the known work values of other similar procedures or services, and then votes on what it feels is a fair work value in comparison with the other established values. Importantly, the work value is relative to other work values, and thus is termed “work relative value unit” (wRVU) or alternatively termed, the relative value of work (RVW). This result is then sent to CMS as a recommendation. Practice expense (PE) and malpractice (MP) expense (sometimes referred to by CMS Professional Liability Insurance (PLI) costs are similarly collected, discussed, and the RVUs of each are sent as a recommendation to CMS by the RUC. CMS then publishes their final decision for RVW, PE, and MP units for each CPT code that has been valued in the annual *Medicare Physician Fee Schedule* rule.^{58,59}

Global periods. CPT codes are generally divided into those without a global period (in the RBRVS system they are called XXX codes) and those with a global period (bundling services that occur before, during, and after a procedure). E/M codes, laboratory tests, and radiology tests are all good examples of XXX codes. As defined by CMS, global period codes come in three major varieties:

- Zero day global (000 day, includes only the work done that day related to a procedure). Endoscopy procedures are typical examples of a 000 day global procedure.
- 10 day global (010 day, includes the day of the procedure and any related work for the next 10 days). An implanted vascular port is a typical example of a 010 day global code.
- 90 day global (090 day, includes any workup of the patient the day before the procedure, the procedure, and then postoperative-related services for 90 days afterward).
- There are some other codes—YYY (global period defined by CMS) and ZZZ (add-on codes to another CPT code that has a global period) that are infrequent and don’t materially affect the larger picture of global codes.⁶⁰

It is important to note that any professional services rendered by the surgeon during these global periods will likely result in the surgeon getting no credit for additional work output outside of the global period.



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RBRVS utility. The dollar payment made by Medicare for a CPT code is based on a formula that also takes into account the geographic variations of RVW, PE, and MP cost based on a GPCI for each value and for specific geographic areas. The total RVU is then multiplied by the Medicare conversion factor to equal a dollar amount allowed by Medicare for the performance of that CPT code. The summary formula is:

$$\text{Total RVU} = (\text{RVW} \times \text{work GPCI}) + (\text{PE RVU} \times \text{practice expense GPCI}) + (\text{MP RVU} \times \text{malpractice GPCI})$$

$$\text{\$ Payment} = \text{Total RVU} \times \text{Conversion Factor} \\ \text{(currently \$ 35.9996 for 2018)}$$

On the average, the RVW roughly accounts for 50 percent of the total RVU of a CPT code, but this percentage varies widely based upon the value embedded in the PE component. Depending upon whether a CPT code is delivered in a hospital setting or in a non-facility office setting, the PE component for a given CPT code can be either very small (the hospital is supplying equipment, not the doctor) or quite large (the doctor is supplying all of the equipment used in delivery of the CPT code). As wRVUs are very carefully measured and are intended to reflect the actual work output of a physician, and are the same in either facility or non-facility setting, they are now used more widely as a metric for work production than total RVU. Lastly, since CMS publishes the RBRVS values for each CPT code, plus the conversion factor amount in the *Federal Register* each year, these values can and are used widely by employers to help build compensation plans.⁶¹

Commercial payors have adopted the RBRVS methodology to a great extent in the calculation of their payments, based either upon a proprietary conversion factor multiplied by the CMS total RVU, or expressed as a percentage of Medicare rates (such as 125 percent of

Medicare allowable charge). For this reason, more and more institutions and practices have come to recognize and incorporate RVW values as the cornerstone of physician work production measurement.

How do RVWs determine your salary? By the same token, many institutions also use their own dollar conversion factor to calculate payment to the surgeon for the work component of their practice. You may think of your employer as the sole "insurer" to which you submit your invoices for the care you provide; the employer reimburses you based on the work component contained in the CPT codes you submit. Some employers utilize a graduate scale of dollar-per-RVW payments, based upon how much work is performed, with groupings of RVWs paying a certain amount. These are typically compared with a national benchmark for RVW production. Other contracts will use one dollar-per-RVW payment for a new surgeon fresh out of residency or fellowship, and a higher dollar-per-RVW for a surgeon with more experience. Of note, a dollar-per-RVW contract is typically unrelated to payor mix, such that surgeons can be equally compensated across the spectrum of insurance categories.

Thus, it is important to know the following facts when considering a contract that uses some version of a dollar-per-RVW methodology:

- What is the dollar-per-RVW payment for you in your contract?
- What benchmark source does the institution use for RVW production targets and dollar-per-RVW payment (for example, AAMC, MGMA, AMGA)?
- Who will do the calculation, and how will you know that all of your work has been properly accrued, valued, and accounted for?
- Are modifiers for CPT codes included in the calculation and, if so, what is their value?



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- How does the institution calculate RVW values for “unlisted” or carrier-priced CPT codes? These typically are used to describe procedures that are more complex than standard CPT codes in a given family, but by definition don’t have RVW values in the RBRVS system—therefore, under the dollar-per-RVW-based payment system, you may not receive payment for these services unless they assign a RVW value for such services. Be sure to ask about this important item when reviewing your contract.
- How often are the benchmarks for compensation, production, and dollar-per-RVW payment updated?
- Is there an offset or compensation provided for time lost due to travel to outside clinics or hospitals that require substantial driving time?
- Is there a cap on, or maximum compensation for, production?

Figure 6 features benchmarks for general surgeons, cardiovascular surgeons, and urologists for compensation, RVW production, and dollar-per-RVW payments as calculated by the MGMA. Figure 7 (page 41) lists the common modifiers used by surgeons and their impact on payment and RVW calculation. Historically, the total compensation as well as dollar-per-RVW payments

Figure 6. **Common Benchmarks for Work Production and Payment**

MGMA Metric	Specialty		
	General Surgery	Cardiovascular Surgery	Urology
	Median	Median	Median
Total Compensation*	\$415,146	\$701,219	\$450,000
RVW Production (Work RVUs)	6,569	9,634	7,664
Compensation to RVW (Work RVUs) Ratio	\$63.61	\$76.88	\$60.80

*Total compensation represents the sum of salary, bonus, call pay, research grants, and so on. Benefit package costs are not included in this number.

Data represents more than 136,000 providers in health care. Learn more about data from this dataset and several others from MGMA at mgma.com/acldata.

Source: 2018 MGMA DataDive Provider Compensation, based on 2017 data. Used with permission from MGMA, 104 Inverness Terrace East, Englewood, CO, 80112. 877-275-6462. mgma.com. Copyright 2018.



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Figure 7. **CPT Code Modifiers and Payment Adjustments**

Modifier	Description	Payment Adjustment
22	Unusual procedural services or complexity of procedure	125%
80, 81, 82	Assistant at surgery	16-25% (varies by insurer)
50 or LT and RT	Bilateral surgery	150%
51	Multiple procedure	50%
52	Reduced services	50%
53	Discontinued procedure	50%
62	Co-surgeons	62.5% for each surgeon or 125% total
66	Team surgery	33% for each team

for surgeons have steadily increased year after year; therefore, you should avoid getting locked in to a set compensation calculation for more than a year or two.^{62,63}

Basing surgeon compensation on the work performed, rather than the amount of payment received for that work, results in a much fairer system for physician reimbursement. Payment can be negatively impacted by the efficiency of an institution’s billing and collecting process, or by the payor mix that may vary from location to location. This is particularly true for those institutions that care for patients from multiple adjacent states, as can be seen by the wide variation in Medicaid payments from state to state, compared with Medicare payments. A 2016 ACS study found that, when comparing state Medicaid payments for common surgical procedures to Medicare payments for the same procedures in those

states, the difference in payment varied by up to \$150 per RVW worked. For all of these factors, we would urge institutions to avoid basing their compensation plans upon the amount paid by insurers for surgical services, in order to more fairly reimburse physicians for care that is delivered.⁶⁴

One valuable piece of information you may want to ask about when evaluating a potential employer is how much the employer’s compensation system rewards surgeons. Some employers may not share that type of information with job applicants, but you can ask your new potential partners how the current system is working, how fair they think the system is, and how their compensation has changed over the past few years.⁶⁵



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Other Layers of the Compensation Cake: Administrative, Educational, and Research Tasks

In most employment situations, surgeons are contractually obligated to complete other tasks beyond patient care. These tasks are typically divided into the following three domains: administrative, educational, and research.^{66,67}



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How to Get Credit for the Care that You Give

Surgeons should ensure complete and correct clinical documentation to appropriately reflect the true severity of a patient's illness and the expected number of resources used to take care of that patient. Patient care is the most important reason to document accurately, as the information provided in the medical chart describes how acutely sick a patient is and how much concern the surgeon has over the patient's condition. Documentation is also very important for appropriate reimbursement, quality measurement (for example, length of stay, mortality, hospital readmission, transfers to higher levels of care, surgical site infections, and so on), demonstrating compliance with regulatory requirements, and the public profiles of both the practice and the individual surgeon.

Administrative tasks. There is always a certain amount of non-clinical work that most surgeons are asked to do as working members of a medical or departmental staff. Participating in hospital committees, engaging in quality improvement activities, and promoting your employer's clinical products are all examples of such baseline work. How do you determine if your administrative work goes over the threshold of "volunteer" work into the area of "work that is reimbursed"? What if you are asked to take over the directorship of a program? Is that something that you "do for the team" gratis, or should you ask for compensation for this new responsibility? And what if your new job requires time away from clinical work to travel to outside clinics or other satellite hospitals?

Here are some things to consider when evaluating non-clinical work expectations:

- **Compare your work with your peers.** You should compare the numbers of committees you participate in, the number of hours you spend on non-clinical work, and so on to those of your surgical peers. Although everyone works different amounts of hours doing these administrative deeds, there comes a point where the hours devoted begin to negatively impact your clinical work production, and that is the point at which you should reassess whether or not your contract should take that extra non-clinical work into account.
- **Documentation of administrative work.** CMS requires hospitals to account for dollars paid to physicians, with the aim of discouraging any payment in return for referral of patients to the hospital. As a result, most hospitals will want to keep an accurate record of non-clinical work paid for, especially if the administrative work involves payment for hours worked, number of charts reviewed, numbers of meetings attended, and so on. As a result, you may be required to keep a log



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(for example, a time sheet) of your time spent, hours worked, and units of work completed for the compliance office of the hospital.⁶⁸

- **Fair compensation.** For hourly work, payment varies quite dramatically across the country. Most estimates for surgical specialties ranges from \$200 to \$300 per hour of work. You might also want to compare how much the hospital is paying for its accounting or legal services and if it has contracts for hourly services. Similarly, you can ask your colleagues how those types of professional services are priced in the area where you are planning to work. This type of comparison will give you some idea of how much the “market will bear” for fair reimbursement for chart review, meetings attended, and so on.

Some hospitals will ask you to be the “director” of a clinical effort or enterprise. This work can range from full time at one end of the spectrum, down to a few hours a week at the other extreme. At the low end, this work most likely will not be paid for, but you can use that effort to your advantage when contract negotiation time comes up—reminding the employer of how much value that you bring to the organization for this “free” work. At the other end, if you are working full time (or a set percentage, such as half time) as an administrator, there are published benchmarks for compensation for medical directors available (from such companies as MGMA) that you can use to see if you are being paid fairly. As a general guideline, most surgeons continue to practice while they also take on directorship duties, and are compensated in the range of \$50,000 to \$75,000 for that service.

- **Alternate method of calculating payment for non-clinical work.** Another way to think about non-clinical administrative work is to consider the scenario in which a surgeon’s work is 100 percent clinical, with no administrative duties. In that scenario, let’s assume that the total time per day for work is fixed, and any additional work that is non-clinical will detract from patient care. Let’s further assume that since we are calculating administrative time spent (not clinical time common for surgeons), the hours worked would be a uniform eight hours per day, five days per week, and 50 weeks per year—this gives us 2,000 hours of administrative working time per year. Now, taking a hypothetical salary of \$400,000 per year and dividing by the 2,000 hours available, we can see that the opportunity cost of taking time away from the clinical component of work “costs” \$200 per hour. Said another way, for every hour that your employer asks you to complete administrative activities (and that time is “lost”), and assuming that you don’t work overtime to make up for the lost time, you need to be compensated \$200 per hour of “lost” clinical time. See Figure 8 (page 44) for this example of an alternate method of calculation.



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Figure 8. **Alternate Method of Calculating Hourly Administrative Work**

Metric	Calculation for General Surgeon
Total clinical work salary	\$400,000
Hours worked per day	8
Days per week	5
Weeks worked per year	50
Total hours available for work	2,000
Pay equivalent per hour for “lost” clinical time	\$200.00

Educational and research tasks. Academic surgeons may be expected to provide education, conduct research, and participate in scholarly activities as determined by the institution's dean and department chair. Education and teaching stipends are determined by academic rank and specialty, and are often negotiable. Faculty will be strongly advised to solicit private, institutional, or government funding to support these efforts.

Academic institutions advance their mission in three distinct areas: service, education, and research. Operating defines surgeons. Therefore, service to patients, in the form of a surgical practice, comes intrinsically. Service is also provided to the organization (for example, school, health care organization, and so on), community (for example, outreach), and discipline (for example, surgical organizations). By nature, physicians are also educators. Teaching patients about their disease is part of treating them. However, education is more commonly focused on formal learners including medical students, residents, fellows, and so on. Although most education is provided on the ward, at the office, or in the operating room (OR), non-clinical venues, including classrooms, skills labs, or simulation centers are now common. Finally, expanding the science of surgery is a core value for academicians. A never-ending effort to answer the question “Why?” fuels these efforts.

Balancing one's efforts in each area is a challenge for even the most seasoned academic surgeon. In general, the degree to which surgeons divide their time between clinical and educational/research tasks is contingent on their interests, opportunities, and expectations of their position or “track.” Over the course of his or her career, an academic surgeon enters either the clinical or tenure track with expectations of advancing from assistant to associate professor, and eventually, professor. Faculty members in the clinical track commit to a robust clinical practice and educating learners with a modest focus on scholarly work, while tenure-track faculty members extend a greater effort on generating scholarly activity through presentations and publications and seeking research funding. Receiving tenure or a long-term clinical contract are commonly associated with promotion from assistant to associate professor and determined by institution timelines (for example, seven years).

Ultimately, an academic surgeon's goal is to allow their efforts toward each of these missions to establish themselves as an expert in the field. For example, during their first three years, in addition to achieving excellence in performing Whipple procedures, a hepatopancreatobiliary (HBP) surgeon may participate in cancer center multidisciplinary case review meetings, attend student promotion committee meetings, walk in



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the PurpleStride® to support pancreatic cancer research, outline the HPB curriculum for students on the third-year clerkship, work with residents and fellows on cadaver models, establish a clinical database of HPB procedures, and utilize large clinical databases to address and publish on current approaches to cholangiocarcinoma. Each effort links to the other and demonstrates the surgeon's focus on HPB and their impact on the institution's mission.

A common misperception suggests that academic faculty are paid to teach. However, a surgeon's salary comes from primarily two sources: clinical practice professional fees and grant funding. Other areas are also considered, including stipends for leadership positions and call pay. Through "taxes" placed on the clinical practice, institutions commonly support the academic mission and surgeons who dedicate exceptional time to non-clinical teaching, service, or early years of a research program. Although constrained with regard to what is considered a fair salary, benchmarks support transparency and diversity and reduce wage gaps.

As surgeons begin their practice or transition to new locations, it behooves them to discuss a potential startup package to support any significant amount of effort on non-clinical activities (for example, 20 percent time performing research). The surgeon's track record and anticipated role at the institution largely support the merits of this negotiation.

In the end, all surgeons pass through medical school and residency feeling they understand all of the draws on an attending surgeon's time. However, as one enters an academic practice, one quickly realizes their perception is ill-conceived. Still, the reward of impacting health policy, pulling a resident through a challenging procedure, or presenting one's thesis at the ACS Clinical Congress is exhilarating and fuels the drive to build an academic practice.

Beyond Compensation

Once you have understood the compensation mechanism within a contract vis-à-vis what will likely be based on RVW attainment, there are a number of other considerations that must be examined.

Fair market value. Fair market value (FMV) is a term that a surgeon will undoubtedly hear during a contract negotiation. Federal law will be used to set the ground rules. The Stark Law and Anti-Kickback statute do not allow for out-of-range physician salaries. CMS regulations state, "A hospital may pay you a fair market value salary as an employee or pay you fair market value for specific services rendered to the hospital as an independent contractor. However, the hospital may not offer you money, provide you free or below-market rent for your medical office, or engage in similar activities designed to influence your referral decisions."⁶⁹

FMV can be understood by:

- The services to be performed
- The method of compensation
- The amount of compensation based on a fair market value

FMV is not specifically designed to be, but in most circumstances should be, based on a blend of two or more compensation survey metrics, such as those from MGMA, Sullivan Cotter, or Merritt Hawkins.⁷⁰⁻⁷² Each of these corporations release data collated from physician groups for the 25th, 50th, 75th, and 90th percentiles for compensation and production (largely RVW-based). While these groups often charge a fee for their information, it would be well worth it to consider purchasing one dataset for an internal check against your offer. If your potential employer is only using one data set, it very well may underestimate your worth, as there is variability from one commercial vendor to another in terms of the "median" salary or RVW. Additional



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considerations for adjusting the FMV compensation could be influenced by call requirements, critical need for your specialty, or a shortage of physicians in the area.⁷³

Expected RVW availability. Other considerations regarding compensation may include: What is the expected RVW availability? Are you joining a practice that is overwhelmed with work? Are you being hired to establish a new specialty? All newly hired surgeons will believe that if they work hard they will accumulate RVWs and thus receive increased compensation. But ask yourself: Where will the RVWs come from? How competitive is the market? How many RVWs were performed by my partners? One good way to understand what will await you is to at least understand the captured market. How many referring doctors—such as primary care, gastroenterology, oncology, or cardiology physicians—are in the group who will largely refer patients to you and your surgical partners? Is there any understanding of leakage rates to other groups or to outside tertiary care centers? If you are joining a health care system, it would be important to understand if there is an insurance product that would include you and your group in a preferred network. How many captured lives are in the network? It is estimated that 30,000 such lives are needed to support the income of one general surgeon.⁷⁴

When you are joining a health care system, realize that there will necessarily be a “wall” between your practice and the workings of the hospital for the aforementioned Stark and Anti-Kickback statutes. The institution cannot directly link your salary or bonuses with how many patients you refer to the institution, or how much money that you make for them. Also understand that in most cases, your professional fees that are collected on your behalf will be less than the cost of employing you at the institution. This is a major area of concern for physicians in this new world of employment. A simple example might look something like the following: a general surgeon who bills \$1 million dollars in charges might expect to

collect \$600,000. The surgeon would then pay their overhead and take home roughly \$350,000 to \$400,000 (this figure may vary considerably depending on the fee schedule rate, regional payor contracts, and payor mix). In this scenario, it would not be unusual for the hospital to receive \$1.5 to \$2 million in gross revenue, even when accounting for direct and indirect costs. ORs are the revenue-generating engine of any hospital and, after orthopaedics, neurosurgery and cardiac surgery, general surgery is now the fourth greatest revenue-generating specialty for hospitals. See Figure 9 (page 47), which depicts the average net annual revenue generated by physicians in various specialties on behalf of their affiliated hospitals as calculated in 2016, with comparisons with data from surveys conducted in previous years.

This procedure-related revenue stream highlights why some hospitals started developing “systems” to attract more surgical cases from outlying referral areas. Many institutions note that other specialties in the system need to be subsidized since they are losses, and the surgeons’ gains are used for that purpose. So how can you leverage your worth beyond compensation? Other ways in which surgeons can achieve gains might be in preferred OR block times or hand-picked OR staff. If you are willing, you can lead a quality committee or robotics committee, or one might be able to negotiate a medical director stipend.

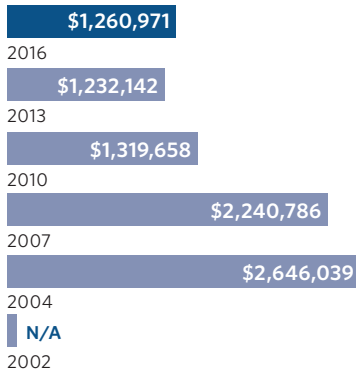
The allocation of RVW value is evolving. Most contracts will allocate RVW values based on the Medicare fee schedule and the values associated with the CPT charges submitted. The multiple procedure rule will reduce RVW values appropriately. For unlisted codes, the value will be zero, and the submitted bill will be specially constructed, and so the allocated RVW must also be negotiated by the surgeon with the institution. For complicated procedures that are creating a needed product line in the hospital, it might be prudent to allocate full RVWs for both operating surgeons and surgeon assistants.



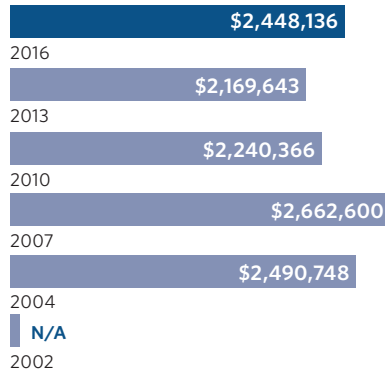
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Figure 9. **Alternate Method of Calculating Hourly Administrative Work**

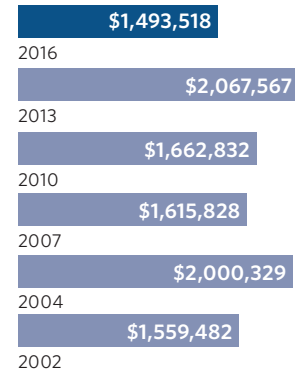
Cardiology (Non-Invasive)



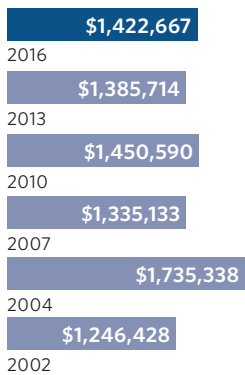
Cardiology (Invasive)



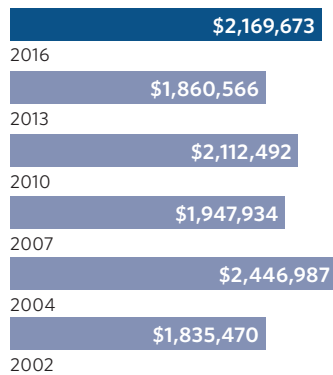
Family Practice



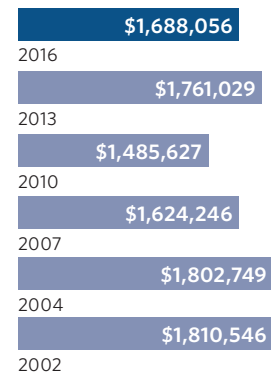
Gastroenterology



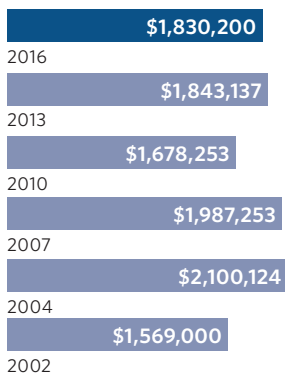
General Surgery



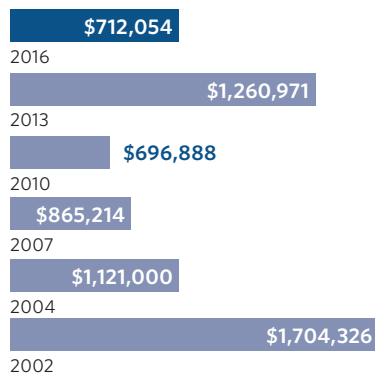
Hematology/Oncology



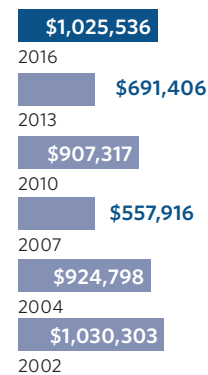
Internal Medicine



Nephrology



Neurology





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PART 4: CONTRACT NEGOTIATIONS— HOW TO GET WHAT YOU WANT

PART 4: CONTRACT NEGOTIATIONS—HOW TO GET WHAT YOU WANT

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For the employed surgeon, negotiation is typically the last item on a long checklist of things to do before starting to work. However, getting what you want in a final contract, as opposed to what is initially offered, all depends upon the art of negotiation. Negotiation comes into play not only on the initial contract, but also during contract renewal, when it may be even more important to have good negotiation skills.

Proper preparation and interprofessional communication are two components of negotiation that are perhaps the most essential. Contract negotiation is oftentimes an iterative process, and collaboration between all parties involved at the bargaining table links together those steps of ask, offer, counteroffer, and (eventually) accepting or declining a contract.

Creating a BATNA

Developing a best alternative to a negotiated agreement (BATNA) is a tried-and-true tool that you will want to know about and use to develop your skills as a successful negotiator; your BATNA is the course of action you should pursue if your negotiation reaches an impasse, and it is intended to increase your bargaining power.⁷⁵ To establish your BATNA, follow these four steps:

1. **List your alternatives.** What alternatives are available to you if the current negotiation results in a stalemate? What are your no-deal options?
2. **Evaluate your alternatives.** Examine each alternative and calculate the value of pursuing each one.
3. **Determine your BATNA.** Select a course of action that would have the highest expected value for you.
4. **Calculate your reservation value.** Now that you've established your BATNA, calculate the lowest-valued deal you are willing to accept—this is your reservation value. If the value of the final contract

offered to you is lower than your reservation value, you might consider rejecting the offer and pursuing your BATNA.⁷⁶



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At a minimum, the condition under which a mutual agreement may be made by a surgeon and his or her employer is that each party prefers such an agreement to their BATNA. When considering a contract, it is important that you develop a list of actions you might conceivably take during each step of the negotiation process, clearly express your wishes to your potential employer, closely review your potential employer's responses to your wishes, prepare counter proposals as necessary, and repeat this cycle until you have arrived at your final decision.

We offer a description, along with examples, of key points in the contract evaluation and negotiation process below.

Contract Evaluation and Negotiation Process: Preparation

It is not uncommon for an employer to wait to deliver a contract to a potential employee and require that it be finalized within just a few days, allowing the potential employee limited time to complete a thorough review of the document. This time pressure puts the physician at an immediate disadvantage in negotiating. Depending on the circumstances, it can realistically take between 30 and 60



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days to review and negotiate an employment contract. Be sure to obtain **all** documents (including any exhibits and attachments) that are referenced in the document but are separate from the contract itself. You should immediately identify the individual(s) who has been given authority by the employer to make changes to the agreement—it is critical to know who is on the other side of the negotiating table.

Obtaining legal counsel. Once you've received (or even before you've received) an employment contract, it is important to identify and engage an attorney with experience representing physicians. Communication is also critical when using legal counsel to help you evaluate and negotiate a contract. Your lawyer needs to know your expectations from them in this process.⁷⁷⁻⁸⁰

State medical societies, specialty societies, and physician colleagues may serve as valuable referral sources for skilled attorneys. One thing that is sometimes overlooked, but is nonetheless important: hire counsel licensed in the state in which you will practice. Many areas of the law involved in employment agreements are state-specific, and employment of an attorney who is unfamiliar with local and state laws may waste time and money or cause you to miss items in the contract that are critical elements to negotiate.

Here are some things to consider when identifying legal counsel who is best suited to help you review your contract:

- **Ask and compare.** When interviewing potential legal counsel, ask about their background with physician employment contracts and speak with several attorneys to compare fees and expertise. Experienced counsel should be knowledgeable about complex federal health care fraud and abuse laws; the penalties for violating those laws are severe, including criminal sanctions. They should also be familiar with the local market and have access to resources, such as compensation surveys, which can

aid them in assessing the fairness of offers made in a contract and, given a physician's bargaining power, can determine potential for fruitful negotiation.

- **Consider costs.** Don't be shy about asking for a fee schedule and the estimated cost of typical services rendered by your potential counsel. Most attorneys charge by the hour, and cost estimates may be based on an attorney's hourly rate multiplied by the time the attorney believes it will take to provide the deliverable(s) requested by the physician. Attorney hourly charges vary, particularly by geographic area, and the rate of an experienced health care lawyer can range from around \$250 to \$800 an hour. The variables that an attorney will consider when compiling an estimate for a physician seeking assistance in reviewing a contract include the length and complexity of the document, whether the terms of the agreement are favorable to the physician, and the number and type of deliverables the attorney is expected to produce.
- **Communicate needs and wants.** Clear and precise communication with your lawyer about what you need and expect from them is critical. Think about what parts of the contract are most important to you, and tell your lawyer your goals in reviewing the agreement. For example, some physicians do not expect or want to negotiate many terms of their contract, but simply want to know if the included provisions are fair or whether there is something in the document that would be concerning to the lawyer. On the other hand, some physicians seek a detailed legal review of their contract and already know that they intend to request changes to certain contract terms (for example, a restrictive covenant). Lastly, agree on the specific deliverable(s) expected from your lawyer, which will likely relate to your goals and dictate the roles that you and your counsel play during the review process. Here are some



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common hypothetical examples of deliverables that a physician might request from a lawyer, and how each example may play out:

- **Example 1:** The lawyer reviews the contract and sends an e-mail to the physician, explaining areas in the contract that are of concern and suggesting revisions to substantive terms. The physician reviews the e-mail, the physician and lawyer discuss those issues by telephone, and the physician decides whether to ask for any changes to the agreement. The attorney helps the physician draft talking points, and the physician communicates their requested changes to the employer. The employer makes changes to the contract and sends the updated document to the physician, who forwards the contract to the lawyer to confirm the changes are acceptable. If the contract is not unusually lengthy or complex, and the physician effectively communicates his or her requested changes to the employer, the lawyer could spend a total of about two to five hours reviewing the contract.
- **Example 2:** The lawyer reviews the contract, electronically marks the contract with potential changes, and provides comments and questions to the physician on the document. The physician reviews the marked contract, discusses the potential changes with the lawyer, prioritizes these changes, and, based on these conversations, the lawyer prepares a final marked copy of the contract. The physician sends the marked contract to the employer, which explains to the employer why certain changes are requested. The employer reviews the requested changes and returns the contract to the physician, indicating which changes are acceptable.

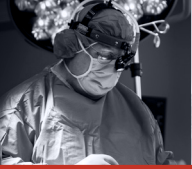
The lawyer and physician review and discuss whether to accept the contract or have further negotiations.

- **Example 3:** The lawyer reviews the contract and meets in person with the physician to provide suggestions for revisions and to develop a strategy for negotiations. The lawyer then actively negotiates the contract with the legal counsel for the employer. If the contract involves high compensation, complex payment methodologies, and will likely involve significant negotiation, it could be well worth having the lawyer actively involved in the negotiation process.

Much like a physician reviews risks of surgery or various treatment options with a patient, an attorney's job is to do the same when asked to review a contract. Some elements of contracts bring a high amount of risk, while others bring a smaller amount; just because an attorney marks up an item in an employment contract doesn't mean it's a point that a physician needs to take a hard line on in their negotiating. It's all about deciding what's most valuable and letting the institution know that it's important to you.

Contract Evaluation and Negotiation Process: Review of Terms

Even if you decide to employ legal counsel to evaluate your contract, you too should review it in detail to ensure that you understand all terms, exhibits, and attachments associated with the agreement. It is helpful to divide the contract terms into "business" terms and "legal" terms. Business terms are the contract provisions that the physician should fully understand and are the core of the arrangement—examples include your compensation, start date, locations of your practice, and how long the contract lasts. However, if terms are written in "legalese" and you cannot fully understand the language, ask your lawyer



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to explain it. Tell your lawyer if any business terms are not acceptable to you. This will reduce the time your lawyer takes to ask you about business terms, and as a result will lower your bill. Legal terms are those terms that the lawyer will need to explain to you and counsel you on whether to accept—examples include restrictive covenants, health care fraud and abuse laws and their application to the contract, Stark Laws, arbitration provisions, and liability provisions.

Contract Evaluation and Negotiation Process: Strategy for Negotiating

If you have never negotiated an employment contract before, find a mentor who can share his or her experiences. The ability to obtain your requested changes typically comes down to two things: (1) the flexibility of the employer, and (2) your leverage as a potential employee. Generally, the more the employer wants or needs you, the more leverage you have, so know your value to the employer as you enter the negotiation process. Do your homework and think of the negotiation from not just your side, but also from the side of the institution. A key component to leverage is whether you have alternative employment options if a particular employer does not accept your requests. If possible, when searching for a position, pursue multiple employers. Having several job offers means that you could be employed by a competing entity and, therefore, could have more leverage when negotiating with a particular employer. Be sure to obtain the written contracts from all potential employers sufficiently in advance so you can evaluate the best offer and contract terms, providing you with various alternatives if a particular employer refuses to agree to one or more of your requests.

If you don't have much leverage, try to find ways to increase it (for example, explain why agreeing to your requested contract changes will ultimately benefit your employer). Don't view negotiation as a win/lose proposition or an adversarial process ("if I get what I want, I win and the employer loses"). Instead, view it as a



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Having several potential offers to consider will help you better understand the employment landscape. What is common to all of the contracts is likely standard and won't easily be changed. Unique items in a given contract, however, may be more negotiable, and the absence of that item in other contracts that you are considering gives you bargaining arguments when it comes down to negotiating changes to that particular item.

way to resolve issues on both sides. This means you need to understand why the potential employer has taken a certain position, and you need to effectively communicate the reason behind your requests.

To successfully negotiate your contract, it is critical to communicate clearly what is important to you. You can't get what you don't ask for—even if you don't perceive yourself as having leverage, an employer may focus on the long-term relationship and make reasonable changes to invest in you as a physician. Talk with your lawyer about the best strategy for contract negotiations relative to your education, expertise, and experience.



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Q&A with a Surgeon: Negotiation Scenarios

Q. A surgeon is offered a contract to join a large health system with what is considered the system's "standard agreement" for the surgeon's specialty. The compensation includes references to a "fair market compensation calculation" and a resulting compensation amount that seems low. Does the surgeon have any recourse, or should it be seen as a "take it or leave it" situation?

A. There is always room for negotiation. There are multiple examples of compensation ranges under fair market value. If low compensation is challenged by the surgeon, it is very likely that it will be recognized and improved. Even the largest, most powerful health systems will negotiate when appropriate.

Q. A surgeon is concerned about the restrictive covenant included in their contract, which covers the geographic area where the surgeon may wish to practice even if they are no longer contracted with the employer. Is there any room for the surgeon to ask for this provision to be changed?

A. Yes, surgeons should not hesitate to ask for restrictive covenant terms to be revised. For example, large employers do not want their employees to leave their health system and join the competition, so instead may be willing to allow the surgeon to open or join a practice that would still send patients to the larger system in the future. In this situation, refining the restrictive covenant would be in both parties' interests.

Q. A surgeon is negotiating the "buy out" of their practice to an institution. Does this increase the worth of the surgeon in the eyes of their new employer?

A. Selling a practice will relate mainly to hard assets, and, due to Stark and Anti-Kickback laws, there is not much worth placed on patient loyalty or the surgeon's reputation in their community. Surgeons whose practices are purchased by an institution will need to negotiate their new employment contract just like any other hire.

Q. A newly-employed surgeon arrives on their first day of work and discovers that there is no guaranteed patient flow, and that the surgeon is expected to initiate all activities to increase the practice's volume. Since the surgeon's compensation is RVU-based and there is no influx of patients, what should the surgeon have done during the contract review and negotiation process to avoid sluggish remuneration?

A. It is very important that surgeons responsible for generating patient flow ensure that their employer provides a compensation floor for up to three years so that the surgeon has a stable income as they grow their practice.



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Contract Evaluation and Negotiation Process: Tips from an Attorney

Stacy Cook, JD, who has spent decades representing physicians in reviewing and negotiating employment agreements, shares common mistakes she has seen physicians make during the contract evaluation and negotiation process:

- **Not hiring legal counsel.**
- **Being afraid to ask for what you want.** If you negotiate in a professional manner, your potential employer will not think less of you. In fact, negotiation shows your potential employer that you are taking the time to ensure that you will be satisfied with the arrangement.
- **Not paying enough attention to what happens when the employee/employer part ways,** such as provisions for how either party can terminate the agreement and how much notice has to be given. When beginning a new relationship, people want to focus on the positive, but keep in mind the contract needs to address separation.
- **Relying on verbal promises** that are not in the contract or are inconsistent with the contract.
- **Not trying to negotiate at least some elements of restricted covenants.**
- **Not getting the contract from the employer soon enough,** which can reduce or eliminate your leverage.

When considering employment agreements, determine who at the employer has the authority to make decisions on contract changes. For example, at a large institution, the employer's attorney may have the authority to approve changes to terms like restrictive covenants and termination provisions, while a physician has the authority to approve changes to terms like location of practice, call schedule, and vacation. Tailor your communications and negotiations to your audience, and, if at all possible, communicate directly with the decision-makers. Some employers will say that none of the contract terms are negotiable; however, once formally asked, many will agree to make some changes.

Be strategic and maximize your position with timing. For example, if you have been recruited and your priorities are your salary, a relocation package, and call schedule, it may make sense to negotiate those terms first, and if successful, request the written contract for review. Keep in mind that while you already have achieved changes to your priority terms, you may also want to revise some of the other provisions in the contract; remember, while physician contracts are not "take it or leave it" propositions, there is often "give and take" based on employer resources and physician leverage.^{81,82} Do not commit to the position until the contract review and negotiation process is complete.



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CONCLUSION

Final Thoughts: Don't Fear the Employment Process

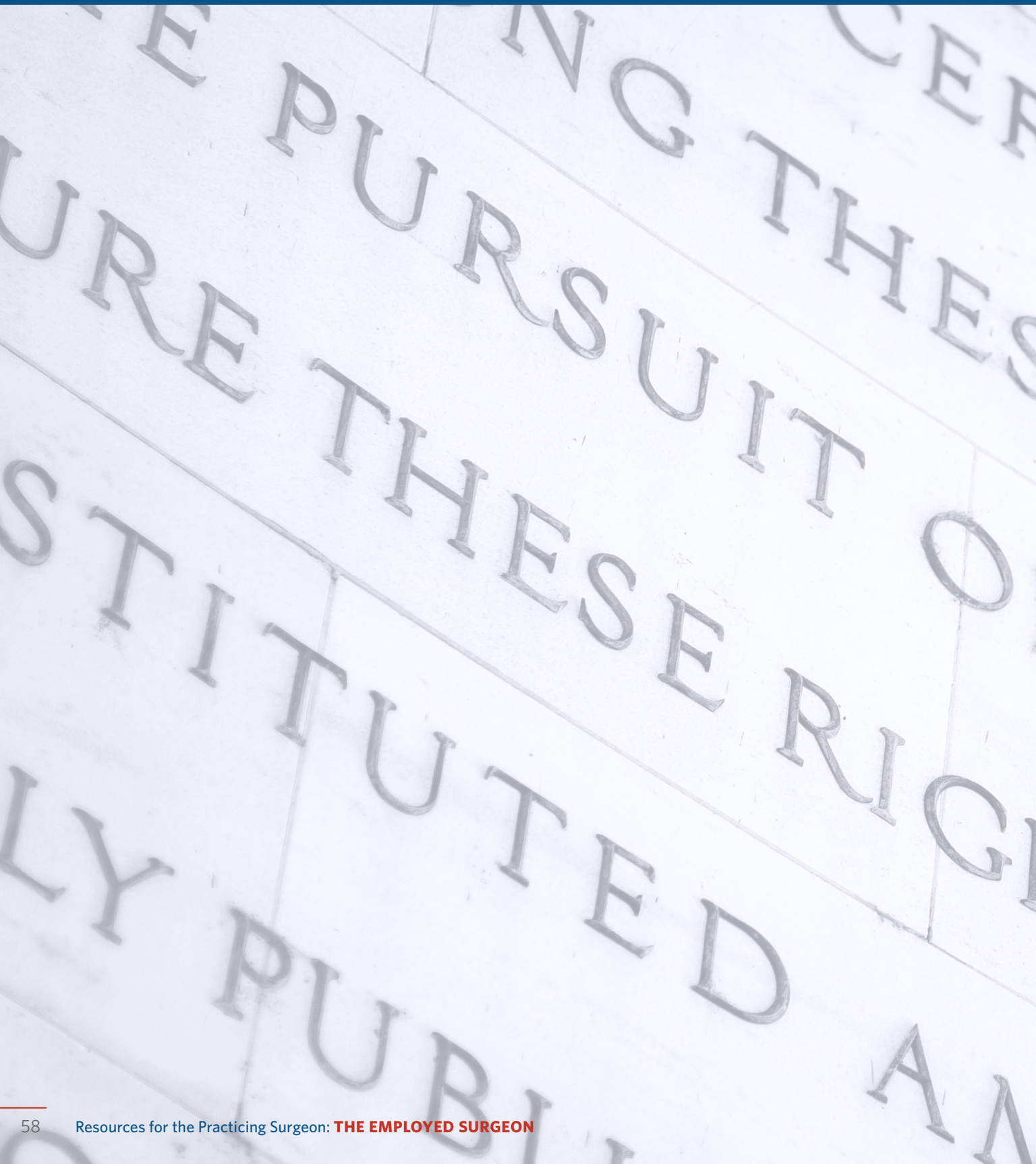
Successful hospital-surgeon integration does not just happen; rather, it is a process that will require time and research. After examining the current landscape of hospital employment of surgeons, the ACS realizes that there are a lot of options for surgeons seeking hospital employment, and there is no one-size-fits-all arrangement. We offer the following tips:

- Everything is negotiable, including salary, benefits, bonuses, staff, facilities, resources, and new physician hires.
- Ask an attorney who is familiar with employment contracts to review the contract (which should be provided initially in a modifiable format).

- Include all written and verbal agreements in the contract.
- Know your value to the hospital. Know what you bring to the table. Know why they need you.

The decision to become employed by a hospital or institution is generally complex, intensive, and critically important to the surgeon's career. While we have addressed some of the important issues when considering hospital employment, there are many other considerations to keep in mind. However, if the concepts demonstrated above are learned and utilized, the ultimate outcome is likely to be a successful alliance that protects the provider and benefits both parties by creating a trusting, sustainable partnership.







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