VOLUME 1

RESOURCES FOR THE PRACTICING SURGEON

The Employed Surgeon

SECOND EDITION

ACS AMERICAN COLLEGE OF SURGEONS

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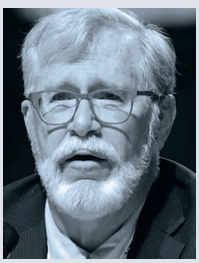

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The 2024 version updates the first edition released in 2018.

Volume 1: Resources for the Practicing Surgeon: The Employed Surgeon, Second Edition

INTRODUCTION

In the current era of consolidation in healthcare, there has been a major shift toward employment of physicians by hospital systems and corporations. Approximately 75% of surgeons are now employed by an institution—49% of surgeons are hospital employed, and 26% are employed by other corporate entities, such as private equity firms and health insurers.* There are numerous factors that may be driving this trend, including (but not limited to):

- Stagnant physician reimbursement rates relative to annual increases in hospital payments
- Substantial overhead costs and administrative burdens associated with independent practice
- High institutional demand for physicians, leading hospitals and corporations to employ surgeons and other specialists
- Market conditions and competition
- Physician demographics and lifestyle preferences

Resources for the Practicing Surgeon: The Employed Surgeon, Volume 1, Second Edition, is intended to highlight some of the important principles of navigating career opportunities and the logistical, financial, and contractual nuances associated with becoming or maintaining one's position as an employed surgeon. This primer begins with an explanation of the various types and settings of employment, a basic understanding of which is essential for any surgeon working in a hospital or corporate environment. The next parts provide practical guidance aimed at helping surgeons evaluate employment contracts and compensation models offered by hospitals and corporations. The primer concludes with tips for strategic contract negotiations, including contract templates and checklists for contracting best practices, among other tools.

Whether starting a new job or evaluating existing contractual relationships with a hospital or corporate entity, surgeons should find a wealth of detailed information within this publication to assist in navigating the current landscape of physician employment and the complexities of ensuring a surgeon's expertise is fairly and equitably measured and valued by their employer.

* Physicians Advocacy Institute and Avalere Health Physician Employment and Practice Trends Research. Specialty Edition. 2019-2022. Key Findings. Available at: https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/Specialty%20Analysis%20Key%20Findings-final.pdf?ver=u7j_0pnUKpOdsvLf1i-siA%3d%3d.

PART 1

DIMENSIONS OF EMPLOYMENT

Employment can be a broad term with many different meanings, depending on 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, and each dimension has its own unique set of challenges related to the following: (1) **employment environments**; (2) **employment types**; and (3) **transitions** to or from employment.

Employment Environments

Employment environments may vary in size, geographic location, and mission. When deciding to enter an employment contact with a hospital or institution, it is important to understand the different types of hospital environments and the employment implications associated with each environment. The choice of employment setting may affect factors such as the surgeon's work hours, practice autonomy, administrative responsibilities, and financial risks.

Across the approximately 6,120 hospitals currently operating in the US, surgeons typically find themselves in one of five common employment settings, with three relating to hospital/institutions specifically, and two others not necessarily associated with any one type of hospital/institution.[1]

- ***Major Metropolitan Tertiary Care Referral Hospitals or Academic Medical Centers:*** These are typically hospitals that have a full range of services, including pediatrics, obstetrics, general medicine, gynecology, psychiatry, and various branches of surgical specialties and subspecialties. These centers may also be linked to a medical school whose mission typically includes the teaching of medical students and physicians in training as well as conducting research. These facilities are often seeking surgeons to fill on-site coverage needs 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.

  In a payment and business environment steadily shifting toward compensation models that emphasize efficiency, a surgeon's leadership abilities to influence quality, improve patient satisfaction, and deliver increased value are important assets. Surgeons will play a vital role in helping these institutions improve quality and generate cost savings. While the surgeon will likely contribute to a solid net positive margin in their department, there will be many other service lines that will be net negative (e.g., behavioral health, pediatrics), and as such, the surgeon margin is used to offset these other critical services and keep the institution profitable. These large hospitals and institutions offer stability, but tend to be less flexible with contracts and compensation models.

- **Community Hospitals:** While these facilities have traditionally been organized as not-for-profit corporations, there are now a growing number of for-profit hospitals that are also entering the community hospital space, as large hospital corporations are taking over hospitals that were previously not-for-profit. This varies greatly by state, with more than half of community hospitals in Texas and Nevada being for-profit as of 2022.[2] State and local governments also own more than 900 community hospitals throughout the country.[3] Regardless of profit or ownership status, 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, require the expertise and reputation of skilled surgeons 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 gauge how valuable your surgical services will be to the institution. Conversely, if other entities are dominant in the market, 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 by doing research on potential competitors and asking your new potential partners about their presence in the market. Hospitals and healthcare systems operate on a close margin; with more than half experiencing negative margins relative to pre-pandemic levels in 2022 and average margins around 2.3% in 2023.[4,5] Check to see if your healthcare system is net positive and experiencing growth rather than sustaining losses.

- ***Federal or State/Local Facilities:*** *The federal government operates more than 200 healthcare institutions in the US, 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 offer opportunities for research or educational advancement.

- ***Rural And Critical Access Hospitals:*** Both rural and critical access hospitals (CAHs) provide essential health services in areas lacking other nearby options. A CAH—defined as a facility with 25 or fewer beds located more than 35 miles from another acute inpatient care facility, or more than 25 beds but are not a referral center—is a community hospital that, unlike its larger siblings, receives cost-based reimbursement under federal law.[6,7] Because of their remote locations, rural and critical access hospitals often have a difficult time recruiting surgeons, and in accepting an employment position at one 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 support will be extremely desirable for rural hospitals and CAHs. As a result, surgeons who desire to practice in such environments 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 a shortage of other local medical or surgical subspecialists (e.g., neurology, infectious disease), limited availability of blood products, and lack of dialysis, on-site radiology, and other critical care support services. Unfortunately, many rural hospitals face significant headwinds, and between 2005 and 2019, more than 150 of these facilities closed. This trend has continued with at least 9 facilities closing in 2023. The Center for Healthcare Quality and Payment Reform compiles a list of rural hospitals at risk of immediate closure due to inadequate revenue, low financial reserves, and other factors. As of January 2024, there are more than 300 facilities on this list.[8]

- ***Private Group Practices:*** In some instances, a physician or a group of physicians will form a solo or group practice, which then contracts institutions to provide services to patients in those facilities. In this scenario, the surgeon is self-employed or employed by their practice group, rather than a hospital or 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 physicians to multiple institutions in an area (such as urology, orthopaedics, vascular surgery, radiology, or anesthesiology).

Surgeons practicing within this environment must negotiate with other physicians within the organization, but are also free, to some extent, from having a purely hospital-centric focus when it comes to contract negotiations. This type of practice setting has been very effective for those surgical specialties with multiple revenue streams, such as an orthopaedic practice, 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 is less common for general surgery.

No surgeon can escape regulatory oversight completely, but the private practitioner has more authority over his or her own practice situation. The surgeon must provide services at a hospital and/or an ambulatory surgical center and these facilities will have rules for medical staff that include call coverage, licensure, board certification, and quality measurement. Even the independent surgeon will have to comply with regulations imposed by the facility. Federal, state, and private insurers will all have requirements that must be followed regardless of one's independent status.

In recent years, a growing trend is the acquisition of physician practices by private equity funds. A July 2023 report found that the number of acquisitions had grown significantly over a 10-year period, from 75 deals in 2012 to 484 in 2021, an increase of approximately 545%.[9] While practices may choose to sell to private equity for many reasons there are concerns that the loss of autonomy can lead to increased surgeon stress and burnout as well as concerns over quality and potential increased cost of care.

Employment Types

Across most of the country, surgeon employment is growing rapidly. Surgeons are aligning with hospitals or large institutions through various arrangements because both the surgeons' and the hospital's needs are changing. There is no standard type of employment arrangement for surgeons. Each option should be evaluated for the best fit for the surgeon.

- **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 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 agreements, a stock transfer restriction agreements (to ensure a hospital-friendly successor), as well as the practice entity's charter and bylaws."[10]

  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 enters into employment with 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 relative value unit 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 a graduate medical education program. These hospitals must be accredited by the Accreditation Council for Graduate Medical Education and approved by the state.

  Surgeons that chose to join an academic practice have different responsibilities than private practice and nonacademic physicians. Academic surgeons are responsible for training and mentoring resident medical students and new doctors. At some academic institutions, surgeons may play a key role in relationships with professional organizations, industry, and government. In addition, a percentage of an academic surgeon's work week may be spent conducting clinical or basic research.

  As an academic surgeon, it may also be necessary to spend time developing and evaluating training programs, designing curricula and making assessments of resident doctors, 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 questions about "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. More information on determining the value you bring to an employer and on using that knowledge in contract negotiations are available in **Parts 2** and **3** of this publication.

- ***Employment of Established Surgeon as a Contractor:*** Depending on the needs of the hospital, an established surgeon may be hired as an independent contractor, as opposed to an employee. Although contractors are not employees in the legal sense of the word, most contract employees think of themselves as being employees, as do their employers. This type of arrangement is becoming more common as hospitals or institutions see the need 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.[11] The advantage of this arrangement is that the surgeon typically retains the ability to be self-employed, still controls their professional corporation, and, under some instances, can practice outside of the independent contractor agreement (e.g., for emergency room call). Surgeons may also contract to provide services on a traditional fee-for-service basis at a contracted rate or may enter into a contractual agreement to go at risk providing bundled care for specific conditions or procedures. In the latter case it is important to have a clear understanding of the costs associated with providing care and the potential risks in order to ensure that you are contracting at the appropriate rate.

  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 because of the independent

relationship 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, insurance, retirement plans, 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.[12] 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 critical services. 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 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 (AKS), and state physician self-referral laws.

Transitional Situations To and From Employment

Today, the majority of surgeons have either transitioned to hospital employment or other formal arrangement options that align clinical and financial interests or they began their careers in an employed situation immediately upon entering practice. However, a sizeable minority of surgeons are still in private practice and for those already in employed situations, the conditions of employment often change as financial, leadership, and market competition change for a given institution or hospital. 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, and the hospital may elect to purchase the practice as a part of the employment agreement. There are significant state and federal regulatory issues unique to a hospital's purchase of a private practice, including the Stark Law, AKS, and state laws that must be considered.

  The federal Stark Law and AKS are designed to prevent the use of financial incentives to influence providers' medical decisions.[13] In addition, many

states have laws in place to prevent corporate entities from influencing medical decision-making that might negatively impact patient care. Thus, good legal representation and incorporation of expert advice is essential to avoid an inadvertent violation of a law by entering into some seemingly innocent agreements.

Physicians in private practice may choose to sell their practice for many reasons and enter into an employment agreement with a hospital. 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 (work 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 organization's care philosophy fits with the physician's practice philosophy, vision, and values.

As mentioned previously, there has been an increase in the acquisition of physician practices by private equity firms, and this trend has also extended to hospitals. As of 2024, more than 400 US hospitals are owned by such firms.[14] Ownership or acquisition of a practice or employing institution by private equity can have far reaching consequences for surgeons and their patients and therefore should be a factor considered when making employment decisions.

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. The practice value is usually the sum of tangible assets, intangible assets, and accounts receivable.[15] From the start of negotiations, the physician should have a good idea of the true value of the practice's tangible and intangible assets, including the value of property owned, accounts receivable, and the perceived value to the community and their referring doctors. A good understanding of the value of the practice, along with a practice valuation prepared by an experienced independent third party, will provide significant bargaining leverage.[15] The Stark Law also applies in the instance of a physician selling their 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. The ACS has created in-depth resources on **buying a practice** and **selling a practice** that can provide additional information.

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PART 2

UNDERSTANDING CONTRACTS

Physician employment agreements establish the legal, operational, and financial parameters of a surgeon's medical practice. This section covers some of the key components of physician employment agreements and resources from the ACS's partner, Resolve, which provides a contract review service. The following should be emphasized at the outset of this section: It is imperative that all surgeons entering an employment relationship engage the services of an experienced attorney to review the employer's proposed agreement and/or negotiate on their behalf.

Overview of Contract Sections

A basic employment contract consists of an agreement between two parties: the employer and the employee. There are eight to ten elements common to any standard employment agreement. The purpose of these elements is to specify the requirements for each of the parties, describe what circumstances cause the contract to exist, and to explicitly resolve major issues impacting employment.

The physician employment contract should describe the basic terms and agreements between the employer (i.e., the institution or practice) and the employee (i.e., the surgeon), including the term of the contract, duties and rights of the employer and employee, covenants not to compete, termination, and medical liability "tail coverage." It is critical that these and other components of the contract be included to ensure all parties understand circumstances that would put either of them in breach.

The surgeon must also ensure that all the elements of their employment agreement are memorialized in writing and signed by both the surgeon and the employer.

Many large institutions may not want to change their basic "boilerplate" contract form and language, especially if many other employees at the institution have signed the "standard contract." Some institutions may even present potential employees with a one-page contract providing links to online corporate policies for the surgeon to research on their own. In these circumstances, it is especially important that surgeons engage counsel to assist them in obtaining expert legal review.

For agreements that may be outside the scope of a standard contract, a surgeon should 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 promises made at the time of employment that were not formally memorialized in the written agreement.[1-3]

Again, when surgeons are considering accepting a position where they will be employed and are presented with a contract, they should engage the services of an attorney to assist them in understanding exactly what is in the agreement. It is imperative that the attorney selected regularly practices in the state of jurisdiction, as each state may have subtle differences in both employment and contract law. Ideally, the attorney should also have knowledge and experience with employment contracts for physicians proposed by the potential

employing entity. The primary goal of the legal review of any contract is to help the surgeon understand the various sections, provisions, and details so that there are no surprises or misunderstandings in the future.

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 with which entity they are contracted. The introductory recital statements not only describe who a surgeon's employer is, but also importantly, who is not the employer.

Terms of the Contract

It is crucial for surgeons to understand the term provisions 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 desirable and practical for their individual needs as well as experience, with points unique to *physician* contracts, and not simply employment contracts in general. Particular attention should also be paid to the time specified in the termination without cause provision.

Renewal of the Contract

Many contract agreements are valid for two to three years, which offers surgeons the opportunity to establish a productive practice and identify areas to expand their 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. At the end of the initial term, 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." Oftentimes, such a provision includes a notice of nonrenewal that can be exercised by either party, usually within 60 or 90 days. Missing the timing deadline for such provisions can result in the loss of the opportunity to renegotiate with the employer based on changes in the market value for their services.

Termination of the Contract

It is important to review the termination provisions of any employment agreement. The termination provision should clearly define the circumstances under which the surgeon may be terminated or electively terminate the contract, and under what terms or conditions the employer is permitted to terminate the surgeon's employment, either for cause or without cause.

- **Termination with cause (immediate)**: Termination with cause clauses should clearly define circumstances that result in immediate termination. Most contracts have a list of transgressions or events that will result in the immediate termination of the physician's employment. Such events may include but may not be limited to loss of license to practice medicine, loss of or failure to quality for malpractice insurance, failure to obtain hospital privileges, failure to qualify for enrollment in a federal healthcare program (e.g., Medicare,

Medicaid) commission of healthcare fraud or other criminal activity, or violation of institutional conduct policies (including drug- and alcohol-related offenses).

- **Termination with cause (with cure period)**: Situations (e.g., delinquent medical records, low productivity, poor performance on quality measures, failure to obtain or maintain board certification or loss of insurance panel status) may arise that could result in termination but may be remedied by actions taken to "cure" the infraction within a set timeframe or under specific conditions. Upon invocation of such a provision, one would be notified and instructed to take specific actions to correct the infraction and prevent termination. Time periods for resolution of these issues typically range from 30 to 60 days.
- **Termination without cause**: Contracts should also provide a pathway for either party to cancel the contract without a specific cause or reason. The timeframe, conditions for notice, and mechanisms of appeal for this type of termination should be explicitly stated in the employment contract. Conditions of notice should detail who should receive notice of termination, what form of notice is required (e.g., written, verbal), what appeals processes exist, and the length of time required 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 clearly understand any elements of the contract inherent to its termination, such as restrictive covenants, payment of malpractice tail coverage, terms for repayment of loans or advances received from the employer, and any monetary penalties associated with premature termination of the employment agreement.

Credentialing and Coterminous Provisions

It is important for surgeons to know how their credentials to practice at an institution are impacted by the terms of the employment agreement, as a surgeon's ability to practice at an institution may be dependent upon their employment. The linkage of hospital staff appointment and privileging with employment contracts is called "coterminous," and the effects of such linkage should be considered when entering into an employment agreement. One who terminates their contract may lose the right to practice at any facility associated with the former employer if the contract linked privileging to that specific institution and its affiliates by using a coterminous provision. Understanding the Recitals section regarding the structure of the healthcare organization should provide the astute surgeon with the expected facilities, affiliates, and insurance plans that may no longer be available to them when the employment agreement is terminated.

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. Though these sections may be brief, they are essential elements.

Employer Duties, Rights, and Obligations

The employment contract should clearly state the duties of the employer to include: 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 a regular employee of the institution (receives a W-2 IRS tax form), the employer should outline any benefits the surgeons will receive, such as health and disability insurance, retirement, and vacation days. This section should also outline the compensation package in comprehensive and explicit

detail, including bonuses and/or quality incentive payments available. This section may also specify an allotted lump sum for licensing fees, professional society dues, CME, technology, books, and other materials.

Employee Duties, Rights, and Obligations

The employment contract should clearly state the duties of the surgeon and the rights and obligations associated with the surgeon's position. These usually include required licensure and certification, staffing and call requirements, civic hospital duties, and required hospital privileges. Contracts may also outline clinical, teaching, research, and administrative duties that a surgeon is required to provide the institution. Most contracts will include a duty to report clause, which requires employees to notify the employer of any circumstances that may result in immediate cancellation of the contract, such as loss of medical licensure or commission of a crime. Timely and accurate maintenance of patient charts, or attendance of required staff meetings may also be specified in the contract.

Becoming Employed

Among the usual processes and procedures that must be accomplished prior to being hired are board certification, state licensure, and Drug Enforcement Administration (DEA) certification. 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.

Once licensed surgeons must then be credentialed by the healthcare facility. The credentialing process essentially verifies the documents used to support the application as listed above. The requirements for credentialing vary by state and institution and can be a rigorous process. It is important to communicate frequently with the hospital administrative staff to ensure each required item is obtained in a timely fashion.

Information needed for credentialing includes:

- Medical licenses–active and inactive
- DEA certification
- Training letters/records
- Medical school transcripts
- Proof of completion of residency and fellowship training
- References
- Background checks
- Conflict of interest forms
- Malpractice insurance/history

Application for hospital privileges begins once the credentialing process has been initiated. Privileging is the process by which the assignment of scope of practice during a surgeon's employment is determined based on their skill set, training, and certification. This process is generally reviewed by a physician leader and approved by a hospital governance committee. Privilege requests range from the ability to admit patients to the performance of specific procedures and may be differentiated based on patient age (adult, child, infant). Generally new surgeons are initially awarded probationary privileges, with a performance review scheduled several months later that will award active staff privileges. This review is often referred to as a focused professional practice evaluation. Some institutions may also require that new surgeons initially be proctored for a certain number of cases.

Concurrent with the credentialing and privileging process most employers will submit on behalf of surgeons applications to all insurance companies with which the hospital system participates to enroll in their plans. This will include both private insurance companies and government payors. This process facilitates the employer's ability to be reimbursed for the services provided. The process of insurance credentialing can be arduous and time consuming. If the employer is a private physician group, the

surgeon may share in this responsibility. Until one is credentialed by a specific payor, they may not be allowed to see patients covered by that insurance provider.

As an employed surgeon, the burden of practice management rests with the administrators of the physician group. In theory, the positive aspect of this arrangement is that it allows the surgeon to focus on patient care. However, one of the downsides of such an arrangement is that one often will not have much input on practice management decisions, even those that may directly affect one's professional and personal life.

The process of becoming an employed surgeon may be laborious but provides both the surgeon and institution the necessary opportunity to minimize unnecessary risk and exposure during the hiring process. In this regard, the goal for the new hire and the hospital is the same and there should be a large degree of collaboration throughout the process.

All issues that impact one's professional and personal life (PTO, compensation, CME, call schedule, contract questions, special provisions or equipment for specific procedures that a new surgeon may bring to the institution) should be addressed satisfactorily prior to signing the contract and the imperative nature of engaging experienced legal counsel at the outset cannot be overemphasized.

Restrictive Covenants

A restrictive covenant or non-compete agreement is a common component of an employment contract. These agreements generally limit the location a surgeon can practice for a defined time period and are often written in such a way as to be effective regardless of whether the employee or employer terminates the contract and no matter the cause for termination. [4-6]

To be sure, restrictive covenants are included in contracts to benefit the employer. A 2019 survey showed that the average general surgeon generates $2,707,317 in annual revenue.[7] If a surgeon leaves a practice to work for a competing entity, it is likely that the downstream revenues may follow the physician to the competition. Employers put in significant upfront capital to recruit surgeons. Restrictive covenants are one means by which employers seek to protect their investment.

The two main factors of a restrictive covenant are geographical restrictions, and temporal restrictions. Geographic restrictions prohibit practicing within a specified radius around the surgeon's main location of employment. However, some restrictive covenants may include all locations of practice or all locations of the employer entity within a metropolitan area. Temporal restrictions impose a set length of time that the geographic restriction can be enforced.

The applicability and enforcement of restrictive covenants is a matter of individual state contract law and vary by state. The attorney whose services are retained for review of any contract should be familiar with the allowable scope and enforceability of the covenants in the state jurisdiction where one is considering employment.

Signing an employment contract can have profound effects on a surgeon's life, both within and outside the workplace. These contracts not only determine compensation and some common benefits, but also scheduling, support staff, outside activities restrictions, personal property rights, and much more. Therefore, it is important for every surgeon to understand their contract in full and ensure the agreement supports their desired work/life balance and career goals.

The ACS has partnered with Resolve to aid surgeons in reviewing and negotiating their employment contracts, new or existing. Resolve connects each surgeon with an experienced attorney who will

take the individual's priorities into account, identify problematic contract terms, and help the surgeon through any negotiations or even negotiate on their behalf. Resolve also provides salary data for any surgical specialty and location, so surgeons know what compensation they should expect from an employer. For more information on Resolve, click here: https://www.facs.org/for-medical-professionals/practice-management/employed-surgeons/contract-review-resolve/

Because there are so many contract terms to consider, Resolve has provided a contract review guide as a free benefit to ACS members. The guide outlines the key items for surgeons to review and possibly negotiate. It can be found here: https://www.facs.org/media/j1mczwka/acs-contract-review-guide.pdf

Additional resources, including contract templates and checklists for contracting best practices, are located in the Appendix on **page 45**.

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PART 3

PERSPECTIVES ON SURGEON VALUE & COMPENSATION

This part looks at the complex issue of surgeon compensation and how to properly value the work that a surgeon does from the distinct perspectives of a health law attorney, a physician compensation data expert, and a surgeon. The first section is an in-depth review of how laws and recent regulatory changes are affecting compensation composed by Jessica L. Bailey-Wheaton, Esq., Senior Vice-President and General Counsel at Health Capital Consultants, a firm specializing in valuation of healthcare services. This section is followed by an overview of the physician compensation landscape and current trends from the perspective of Andrew Hajde, CMPE, Director of Content and Consulting at MGMA. Part 3 concludes with a look at the value a surgeon brings to the patient and employer from the surgeon's perspective, authored by Frank G. Opelka, MD, FACS, Immediate-Past Medical Director for Quality and Health Policy at the ACS and Principal Consultant at Episodes of Care Solutions, LLC.

How Surgeon Compensation Is Valued

How Institutions Value Surgeons and How Surgeons Should Value Themselves

Introduction: State of Physician Compensation

Over the last few years, the state of physician compensation has evolved, driven by the healthcare industry's focused shift to value-based care and the healthcare delivery system's flaws exposed by the COVID-19 pandemic. For example, independent physicians, overwhelmed by administrative and regulatory burdens, coupled with declining reimbursement, are having to work harder to maintain income levels, leading many to abandon independent practice for hospital or corporate employment. Additionally, the healthcare workforce is experiencing critical shortages, which necessarily impacts compensation due to the law of supply and demand.

Despite these challenges, physician compensation benchmark surveys show that physician compensation continues to trend upward, even though reimbursement is not. Physicians are also increasingly being compensated for more than just their clinical productivity. For example, physicians are being compensated for providing administrative/executive services (e.g., medical directorship, call coverage) and research services; physicians are receiving financial incentives tied to the outcomes of an entire service line/department; and physician pay is being increasingly tied to the performance of the value-based enterprise in which physician participates (e.g., the physician could be compensated for *not* doing something, so long as the value-based enterprises achieves its targeted metrics). Many of these payment mechanisms were historically disallowed by federal fraud and abuse laws. However, in 2020, the Department of Health & Human Services (HHS) published substantial regulatory revisions to those laws, allowing physicians to be compensated for

more than just their personally-performed services, paving the way for true value-based compensation models.

Federal Regulatory Considerations

As noted earlier, more and more physicians are leaving independent practice and becoming employed, which transaction (i.e., the subsequent employment) typically triggers regulatory issues. Fraud and abuse laws, specifically those related to the federal Anti-Kickback Statute (AKS) and physician self-referral laws (the Stark Law), have the greatest impact on the structure and amount of physician compensation.

The AKS and Stark Law are generally concerned with the same issue—the financial motivation behind patient referrals. However, while the AKS is broadly applied to payments between providers or suppliers in the healthcare industry and relates to any item or service that may be paid for under any federal healthcare program, the Stark Law specifically addresses the referrals from physicians to entities with which the physician has a financial relationship for the provision of defined services that are paid for by the Medicare program.[1] Additionally, while violation of the Stark Law carries only civil penalties, violation of the AKS carries both criminal and civil penalties.[2]

Anti-Kickback Statute

The AKS is a criminal and civil law that makes it a felony for any person to "knowingly and willfully" solicit or receive, or to offer or pay, any "remuneration," directly or indirectly, in exchange for the referral of a federal healthcare program beneficiary,[3]even if only one purpose of the arrangement is to offer/pay remuneration deemed illegal under the AKS.[4] Notably, a person need not have actual knowledge of the AKS or specific intent to commit a violation of the AKS for the government to prove a kickback violation, only an awareness that the conduct in question is "generally unlawful."[5,6] Further, a violation of the AKS is sufficient to state a claim under the False Claims Act (FCA).[7]

Criminal violations of the AKS are punishable by up to ten years in prison, criminal fines up to $100,000, or both, and civil violations can result in administrative penalties, including exclusion from federal healthcare programs, and civil monetary penalties plus treble damages (i.e., three times the illegal remuneration).[8] In addition, if the AKS violation triggers FCA liability, defendants can incur additional civil monetary penalties plus treble damages.[9]

Due to the broad nature of the AKS, legitimate business arrangements may appear to be prohibited.[10] As a result, AKS has a number of statutory exceptions, called "safe harbors," which set out criteria that, if met, shield an arrangement from regulatory liability, and are meant to protect transactional arrangements unlikely to result in fraud or abuse.[11] Failure to meet all of the requirements of a safe harbor does not necessarily render an arrangement illegal.[12] It should be noted that, in order for a payment to meet the requirements of many AKS safe harbors, the compensation must not exceed the range of fair market value and must be commercially reasonable.[13]

Stark Law

The Stark Law is a civil law that prohibits physicians from referring Medicare patients to entities with which the physicians or their family members have a *financial relationship* for the provision of *designated health services* (DHS), unless an exception applies.[14]

DHS includes, among other things, inpatient and outpatient hospital services.[15]

Financial relationships include:

- Direct or indirect ownership or investment interests through equity, debt, or other means; and
- Compensation arrangements, i.e., arrangements between physicians and entities involving any remuneration, directly or indirectly, in cash or in kind.[16]

Civil penalties under the Stark Law include overpayment or refund obligations, a potential civil monetary penalty of $15,000 for each service, plus treble damages, and exclusion from Medicare and Medicaid programs.[17] Further, similar to the AKS, violation of the Stark Law can also trigger a violation of the FCA.[18]

Notably, the Stark Law contains a large number of exceptions, which describe ownership interests, compensation arrangements, and forms of remuneration to which the Stark Law does not apply.[19] In order to meet the requirements of many exceptions related to compensation between physicians and other entities, compensation must:

- Not exceed the range of fair market value;
- Not take into account the volume or value of referrals generated by the compensated physician; and
- Be commercially reasonable.

Unlike the AKS safe harbors, an arrangement must fully fall within one of the exceptions in order to be shielded from enforcement of the Stark Law.[20]

Fair Market Value

Due to the regulatory considerations described earlier, employers such as hospitals often retain healthcare valuation professionals to provide an independent opinion on the fair market value of a given physician compensation arrangement in order to reduce their regulatory exposure, as federal fraud and abuse laws require physician compensation to be consistent with, or not exceed, fair market value.

The Stark Law defines fair market value as *"[t]he value in an arm's-length transaction, consistent with the general market value of the subject transaction."*[21] Additionally, general market value, as referenced in the fair market value definition, is defined *"[w]ith respect to compensation for services, [as] the compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well-informed parties that are not otherwise in a position to generate business for each other."*[22] To put it simply, a buyer (e.g., hospital) cannot pay more for physician services than anyone else in the market would; if it does, the government assumes the buyer is paying for patient referrals. It is for this reason that valuation professionals tend to lean on physician compensation surveys to determine what similar specialists are being paid. A number of organizations publish annual surveys on physician compensation and production, including but not limited to:

- Medical Group Management Association (MGMA)
- American Medical Group Association (AMGA)
- SullivanCotter

Importantly, CMS has noted in regulatory commentary and guidance that just because a physician is paid above the 75th percentile of reported compensation amounts does not mean their compensation arrangement is in jeopardy; conversely, it also means that paying a physician below the 75th percentile is not automatically safe.[23] However, if a physician is to be paid at or above these higher percentiles, the employer needs to (or have a third-party valuation professional) robustly document the reasons why it makes sense to pay this surgeon more than other similarly situated surgeons.

Commercial Reasonableness

As noted previously, not only do federal fraud and abuse laws require physician compensation to be fair market value, the entire arrangement between the surgeon and employer must be commercially reasonable. The Stark Law defines this term as follows:

> "Commercially reasonable means that the particular arrangement furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty. An arrangement may be commercially reasonable even if it does not result in profit for one or more of the parties."[24]

In general terms, the determination of whether a physician compensation arrangement is commercially reasonable is based upon the consideration of whether the parties are entering into this transaction to further their legitimate business purpose(s).

Valuing Physician Compensation

There are numerous generally accepted approaches, methods, and procedures for the valuation of healthcare related services. The three general classifications of approaches are as follows:

- **Income Approach:** Income Approach-based methods measure the present value of anticipated future economic benefits that will accrue to a party or both parties to a services arrangement.
- **Cost Approach:** The underlying theory of the Cost Approach is that a prudent willing buyer would not pay more for the services/products received than the cost of producing a substitute with the same utility. Cost Approach-based methods seek an indication of value by determining the current, or future, cost of reproducing or replacing the services/products provided or received and adds a markup for the compensation of risk assumed by the provider of the services under a services arrangement.
- **Market Approach:** The underlying theory of the Market Approach is that a prudent buyer has the ability to go to the marketplace and purchase similar services/products. Market Approach-based methodology is premised on the foundation that reported prices of comparable services/products in the marketplace provide guidance to the value of the services/products received.

The choice of approach(es) and/or method(s) depends primarily upon the purpose of the engagement and the specific characteristics of the services being appraised. As noted earlier, the Market Approach is the approach most often used in the valuation of physician compensation arrangements.

Although value-based payment models are increasing, the majority of surgeon professional payments are still based on fee-for-service. As a result, health systems and other surgeon employers have had to increasingly focus on clinical productivity compensation models for surgeons. However, the valuation of a surgeon's compensation arrangement is not just an relative value unit (RVU) exercise, wherein a dollar amount is attributed to each procedure/service and calculated. With health systems' and other providers' mission of quality, outcomes, patient access, research, and education becoming more neglected by many of the current compensation models of its employed and contracted surgeons, the development of metrics to best align incentives for clinical and nonclinical activities with institutional goals is increasingly important.

Further, due to the increasing roles that surgeons are being asked to take on (e.g., medical director, research services, meeting quality metrics), valuation professionals typically try to identify all of the economic inputs (both monetary and non-monetary) that surgeon contributes to their employer, and then determine the value of each of those inputs. Due to the novelty of some of those roles, the valuation professional must often look to proxies from other industries and other payors (e.g., Medicare) for indications as to the fair market value of such services or value-based arrangements.

What Non-Base Salary Items can Affect a Surgeon's Value?	
Excess call coverage	Relocation allowance
Supervision of advance practice clinicians (APCs)	Fringe benefits (insurance, CME, PTO, malpractice)
Medical directorship services	Joint ventures with ambulatory surgery centers
Quality incentives	Future ownership benefits, which may affect total
Signing bonus	Cash compensation

Importantly, the fair market value of a physician compensation arrangement may differ based on the employer. For example, a physician's compensation structure may differ depending on whether the employer is a hospital or private equity firm, as the Stark Law affects how hospitals can pay physicians, effectively restricting the hospital's options and how creative they can be with compensation arrangements. Additionally, the differences in the amount of compensation paid to physicians after the transaction is a significant factor for the difference in practice acquisition price between a hospital and private equity–with hospitals, physicians typically receive higher compensation than they did in private practice, while in private equity transactions, physicians receive lower compensation than they did in private practice (essentially deferred compensation), but get a payout from the sale of the practice, and a potential for a second bite of the apple in 3-to-7 years.

Conclusion

Recent regulatory revisions to the fraud and abuse laws governing compensation have finally acknowledged that: not all physicians, or compensation arrangements, are the same; compensation arrangements may have qualitative benefits that outweigh quantitative costs (i.e., profitability); and physician compensation and production surveys are only a starting point in the valuation of a compensation arrangement. These shifts in physician compensation arrangements demonstrate the need to analyze an arrangement not just from a *quantitative* perspective, but also from a *qualitative* perspective that considers the specific facts and circumstances related to the arrangement. This allows for a holistic consideration of a physician's contributions (both monetary and non-monetary) to his or her employer, and the placement of value on those contributions.

Navigating Physician Compensation: The Constant Evolution

Compensation and benefits are some of the most important considerations for physicians when evaluating a job offer. Gone are the days when salary and benefits were accepted without thorough due diligence on both sides of the relationship. Whether a physician is seeking employment at a hospital, practice, or considering a partnership or contractor role, physicians need to assess factors such as fair market value and available comparative compensation data. A comprehensive analysis of benefits should encompass relocation expenses, health and dental insurance, vision and life insurance, retirement plan contributions, vacation or paid time off, sick days, maternity/paternity leave, malpractice insurance coverage, and continuing medical education benefits. Additionally, bonuses, quality-based incentives, education or research duties, and even administrative pieces (e.g., meeting attendance and timely completion of medical records) should be factored in. It is in the best interest of physicians to understand the various compensation models and how their decisions can impact their negotiating power and eventual compensation rate.

Healthcare compensation models have dramatically changed as the industry evolves to meet the demands of consumerism, technology, and the increasing demand for care. Value-based care's rise to prominence necessitates compensation structures that align with achieving high-quality outcomes while reducing spending within carefully managed budgets.

Traditional salary and hourly models are evolving toward more innovative, blended structures incorporating metrics, incentives and equity opportunities optimized for modern multi-payer systems. Understanding the historical compensation approaches and emerging trends allows practices and organizations to attract and retain top talent while staying adaptable in a constantly changing landscape.

The dynamic nature of healthcare demands that we remain adaptive with compensation to maintain the careful balance between value and volume.

Traditional Compensation Models

Hourly Wages, Per Diem Rates, and Salaries: Historically, employed physicians working under traditional compensation models often found themselves reliant on payment structures based on hourly wages, per diem (daily) rates, or fixed salaries. While these models provided a sense of financial stability, they lacked the nuanced alignment with performance and broader healthcare goals that define most modern compensation structures.

Understanding the Relationship Between RBRVS, RVUs, and Physician Compensation

When looking at physician compensation, it's important to understand some of its foundational elements. The resource-based relative value scale (RBRVS) was introduced in the early 1990s and is now used by Medicare and many commercial health insurance payors to determine the payment amounts on thousands of medical services.[25] At the core of RBRVS is the RVU.

RVUs aim to quantify the resources involved in providing a given medical service. They have three components: physician work, practice expense, and associated malpractice costs. Each Current Procedural Terminology (CPT®) code has a value assigned to it based on those three factors.[26]

The **physician work RVU** (wRVU) component accounts for the time, technical skill and physical effort, mental effort, judgment, and psychological stress required in performing a service. wRVUs often make up more than 50%of the total RVUs for certain procedures.[27]

The **practice expense RVU** component is intended to account for clinical labor, medical supplies and equipment, and other overhead costs. Finally, the **malpractice RVU** component adjusts based on variations in professional liability insurance premiums around the country.

This total RVU aims to both quantify and foster fair and consistent reimbursements based on how demanding the various services are. Understanding RBRVS and RVUs is an important aspect of understanding how physician work and the environments in which they practice ultimately translates into compensation.

Modernizing Compensation Models: The Paradigm Shift

Many modern compensation approaches now commonly incorporate incentive-based structures tied to productivity metrics such as wRVUs as well as quality measures. Blended models that pair base pay with performance-driven bonuses and profit-sharing have emerged in recognition of physicians' multifaceted contributions to their institutions. Meanwhile, equity partnerships provide long-term retention incentives by offering ownership stakes over time.

This section will examine these innovative trends in more detail, including hybrid productivity and quality incentive plans, incorporation of nonclinical duties into compensation and other factors such as sign-on and retention bonuses and value-based care. Specialty-specific factors and personalized growth opportunities will also be explored as defining elements of the new generation of compensation plans that have been redesigned to benefit physicians and their employing organizations.

Productivity and Incentive-Based Models: In the changing world of modern employed physician compensation, a dramatic shift has occurred towards incentive and productivity-based models. Productivity bonuses, linked to wRVUs, quality metrics incentives and shared savings plans, have become integral components of contemporary agreements.[28] This evolution rewards clinical output while aligning physician incentives with the broader objectives of healthcare quality and efficiency.

- **Advantages:** Encourages physicians to boost their productivity along with quality outcomes, which supports overall healthcare goals.

- **Disadvantages:** There's a risk of prioritizing quantity over patient-centered care, so it's important to strike a balance to prevent burnout while ensuring the care patients receive is comprehensive.

Hybrid (Blended) Compensation Models: These compensation models often combine a foundational base salary with multiple incentive components, such as performance bonuses, profit-sharing arrangements, or value-based care incentives. This approach strikes a balance between financial stability and performance-driven rewards, while acknowledging more than ever the variety of contributions physicians make.

- **Advantages:** This model also encourages physicians to increase their productivity and maintain high-quality care, while offering more options to align specific incentives with the complex demands of modern-day physician work.
- **Disadvantages:** It also is at risk for prioritizing quantity over quality if a careful balance between productivity and other incentive components is not achieved.

Equity Partnerships: One modern compensation trend includes the integration of equity partnerships: offering physicians equity ownership shares over a period as part of a long-term retention strategy. This model can help to create a sense of ownership and commitment, reinforcing the idea that physicians are not just employees but are stakeholders who share in the success and growth of the organization.

- **Advantages:** It can help to create physician buy-in and shared responsibility for the success of the organization. This may also help to attract physicians who are specifically seeking a long-term partnership.
- **Disadvantages:** These models are often complex and may lead to disputes over the financial aspects of them and conflicts over strategic decision-making.

The Power of Compensation Data

Physicians should utilize accurate high-quality data sources to understand the different pay amounts based on specialty and geographic region. The ACS has partnered with the Medical Group Management Association (MGMA), Association of American Medical Colleges (AAMC), and American Medical Group Association (AMGA) to make multiple sources of data available to Fellows at a discounted rate. Other widely available salary sources, including those crowdsourced from the public, may be less accurate and are rarely used as the basis for fair market value determinations.

MGMA, for example, surveys thousands of medical groups annually to provide benchmark compensation for various specialties and roles. These survey reports account for key factors such as geography, experience level, productivity, hospital affiliations, and more.[29] When physicians compare their own credentials and responsibilities to MGMA's anonymized data, they have a clear and objective way to understand their total target compensation ranges and what they should be aiming for in negotiations with an employer. These data are also utilized by numerous leading healthcare companies that directly support physicians, such as MGMA Consulting and other top consulting and legal firms.

Leveraging data such as those available by MGMA helps physicians avoid being underpaid and provides valuable supporting evidence for discussions with potential employers.

Other Compensation Considerations

- **Specialty-Based Compensation Components:** Many modern compensation models are customized to reflect the uniqueness of each specialty field. Compensation now considers factors such as costs, revenue generation potential, and regional employment needs, ensuring alignment with the specific challenges and opportunities which are inherent to different medical specialties.

- **Consideration of Nonclinical Duties:** Newer compensation models often acknowledge the expanding roles of physicians beyond direct patient care. Bonuses tied to nonclinical activities such as administration, teaching, and research incentivize a more inclusive approach to professional responsibilities, reflecting the expanding role physicians have within the healthcare system.
- **Sign-On/Retention Bonuses:** Incentives such as sign-on and retention bonuses have become integral components of modern compensation packages. These bonuses, disbursed over time, serve as powerful tools to attract new physicians and retain seasoned practitioners, acknowledging their commitment to the organization.
- **Additional Productivity Metrics:** Some models include productivity metrics beyond RVUs. Some may now include encounter-based metrics, panel size factors, and other indicators, which can in some cases help to capture the complexity of contemporary healthcare delivery.
- **Value-Based Care (VBC) Incentives:** Employed physician compensation increasingly incorporates population health incentives to reward physicians for achieving desired clinical outcomes. Risk-based programs such as reference-based pricing, global budgeting, and capitation arrangements incentivize physicians to contribute to the health and well-being of the communities they serve.
- **Personal Growth Opportunities:** Modern employment agreements emphasize growth opportunities for the individual physician, sometimes offering partnership/equity tracks, profit-sharing arrangements, and leadership roles over time. This provides a clear path for professional advancement and reinforces the goal of a long-term collaboration between physicians and their employing institutions.
- **Benefits:** Employment agreements often include health insurance plans and participation in retirement savings plans like 401(k)s with employer matches. Paid time off (PTO) allows for vacation time, and often includes holidays and sick days. Continuing education is also offered by many employers to help physicians maintain their licensure or board certifications. Together, the benefits help to support a positive work-life balance.
- **Non-Monetary Considerations:** Flexible schedules and professional development enhance the appeal of a position beyond compensation alone. Having adaptable on-call duties and time off can help to prevent burnout. Mentorship programs and leadership roles provide long-term career growth. Other roles in education, research or community outreach can also make a position more rewarding. In some cases, perks such as loan repayment assistance and relocation packages are also offered. This flexibility and other non-monetary factors may in some cases be as appealing to a surgeon as additional wages or bonuses.

What About Base and Guaranteed Salaries?

Base salaries act as a minimum guaranteed income within a blended compensation model. Though they provide stability, base salaries typically constitute a percentage (e.g., 25%-75%) of total potential pay. Pay above the base is variable and linked to meeting performance targets or incentives. Base salaries balance reliability with reward for high achievement.

Minimum base guarantees are often provided as a minimum level of income that provides stability to physicians primarily during transitional phases, such as starting a new job. This is common in federal facilities or during the initial years of private practice. Frequently this allows the combination of the security of a base level of income along with the potential for

additional earnings based on productivity or other performance metrics. It helps to strategically attract and retain medical talent by providing a predictable income stream while allowing physicians to focus on patient care, professional development, and establishing their practice.

Guaranteed salaries provide a set level of income that does not vary based on physician performance or productivity. This helps to ensure financial stability through a prior set fixed pay amount regardless of clinical workload, revenue, or other factors.

The main differences are:

- Guaranteed salaries are based on a flat payment amount while base salaries are a minimum floor which make up a portion of the total possible compensation.
- Base salary pay will vary based on the level of productivity, quality measures or other criteria that allow bonuses or payments above the base amount. In comparison, guaranteed salaries do not fluctuate at all.
- Base salaries are often used within blended or hybrid models that include other incentives, while guaranteed salaries traditionally lack performance-linked pay. It is also common for base guaranteed salaries to only be offered for the first year or two of employment.

Here are some areas where a guaranteed salary may still be a viable option:

- **Academic or research roles:** Physicians focused primarily on academic education and clinical research may benefit more from a fixed salary that allows them to teach and perform other nonclinical duties without most of the typical pressures tied to productivity.
- **Locum tenens or interim positions:** Short-term/temporary roles often benefit from a salary when possible because it provides more stability when daily or weekly hours are not always guaranteed.
- **Federal healthcare facilities:** Salaries are often used to compensate physicians working at VA hospitals, military facilities, and Indian Health Service locations.
- **Early career physicians:** Physicians early in their careers and still establishing themselves will often have lower productivity. A guaranteed salary can provide stability during the initial ramp-up period.
- **Rural or underserved areas:** To incentivize physicians to accept difficult roles, a combination of incentives combined with a fixed compensation rate is often offered.
- **Hospital employed physician/hospitalist:** Physicians whose entire focus is hospital-based care such as in an emergency department or care for hospitalized patients in many cases prefer a salary.

Work RVUs and Physician Compensation

wRVUs are often a key factor in determining physician compensation, as they measure the complexity and effort of their services. In general, wRVU-based compensation models assign a dollar conversion factor to wRVUs, so that the earnings of a physician effectively correlate with the volume and complexity of the care provided. The following example will help to illustrate how wRVU values generated from patient encounters under a productivity-based compensation model gets translated into a base level of pay with production bonus or other incentives.

Sample wRVU Compensation Model

MGMA sample traditional wRVU compensation model		
Compensation elements	**Calculation**	**Compensation based on a primarily production/volume-based arrangement**
Physician productivity		
Physician productivity - modifier adjusted wRVUs		5,500
Base compensation		
Physician productivity - modifier adjusted wRVUs		5,500
Compensation conversion rate		$40
Productivity-based wRVU compensation	5,500 wRVUs X $40 = $220,000	$220,000
Guaranteed salary (if applicable - paid based on greater of production/guarantee)	Minimum $175,000 to be paid	$175,000
Total base compensation to be paid based on wRVUs	$220,000 > $175,000 = $220,000	$220,000
Quality compensation		
Quality metrics		$3,500
Value-based care payments (PMPM, shared savings, etc.)		$1,500
Total incentive/quality-based compensation	$3,500 + $1,500 = $5,000	$5,000
Total compensation	**$220,000 + $5,000 = $225,000**	**$225,000**

Impact of Modifiers on Compensation

Physicians also need to be aware that certain CPT® modifiers can reduce the calculated wRVU values for their compensation. For example, a modifier that indicates a procedure was bilaterally performed can reduce the wRVU value the physician receives credit for in relation to their compensation calculation. The table below demonstrates how values for various modifier codes generally impact wRVU compensation value.[30]

Administrative and Nonclinical Work

For physicians, routine administrative work like documentation and meetings are typically considered part of the regular work duties without any separate pay. However, over time these requirements and time commitments may increase, which may require periodic evaluation to make sure they are inclusive of routine versus other duties that may be tied to additional compensation.

For example, a substantial leadership role requiring significant dedicated hours, such as a medical directorship, often has distinct annual compensation tied to it.

	MODIFIER	DESCRIPTION	ADJUSTMENT RATE
SURGICAL/ PROCEDURAL MODIFIERS	22	Increased Procedural Services	Maximum of 110% of Medicare Physician Fee Schedule (MPFS)/Contracted Rate with supporting documentation
	50 OR LT, RT	Bilateral Procedure Left side (used to identify procedures performed on the left side of the body) Right side (used to identify procedures performed on the right side of the body)	150% of MPFS/Contracted Rate. Submit one line with one unit Some payers require RT, LT on same line instead of 50. Submit one line with two units. No adjustment necessary if procedure is unilateral. Append only RT or LT if unilateral procedure.
	51	Multiple Procedures	50% of MPFS/Contracted Rate for each additional procedure, unless procedure is exempt from multiple procedure logic per CCI
	52	Reduced Services	50% of MPFS/Contracted Rate
	53	Discontinued Procedure	50% of MPFS/Contracted Rate
	54	Surgical Procedure Only	70% of MPFS/Contracted Rate
	62	Two Surgeons	125% of MPFS/Contracted Rate divided by 2 for each surgeon (62.5% each)
	78	Unplanned return to the operating/procedure room by the same physician during the postoperative period	70% of MPFS/Contracted Rate
	80	Assistant Surgeon	20% of MPFS/Contracted Rate for physician 10% of MPFS/Contracted Rate for qualified surgical NPP
	81	Minimum Assistant Surgeon	20% of MPFS/Contracted Rate for physician 10% of MPFS/Contracted Rate for qualified surgical NPP
	82	Assistant Surgeon (when qualified resident surgeon not available)	20% of MPFS/Contracted Rate for physician 10% of MPFS/Contracted Rate for qualified surgical NPP
	AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	10% of MPFS/Contracted Rate for physician assistant, nurse practitioner, or clinical nurse specialist services
	SG	Ambulatory surgical center (ASC) facility service **(primary)**	100% of MPFS/Contracted Rate
	SG – 51	Ambulatory surgical center (ASC) facility service **(secondary)**	50% of Fee Schedule Allowance/Contracted Rate
	59	Distinct Procedural Services	Informational modifier impacts bundling. Reduction is based on CCI primary and subsequent procedures and contractual rate. Modifier appended to subsequent procedures with reduction per line after primary procedure. Documentation must support all billed procedures. Reduction occurs after primary procedure and must be reviewed per CCI edit to ensure modifier is allowed.

Periodic reviews should ensure that compensation arrangements continue to keep up with the demands and scope of duties for a physician. Ongoing evaluation and pay recognition for substantive administrative or executive roles such as directorships are important ways to attract qualified physicians to an organization.

Fair Market Value (FMV)

Physician compensation requires careful ongoing examination due to laws such as the Physician Self-Referral (Stark) Law, which prohibits physicians from referring Medicare or Medicaid patients to healthcare providers where they have a financial relationship, unless an exception applies. Showing that compensation is at FMV is important to meet the qualifications for exceptions. The 2021 updated physician self-referral regulations expanded exceptions for value-based arrangements, but FMV is still a requirement. Determining FMV accurately is important to avoid allegations of overcompensation used to cover up prohibited referrals. Resources such as those from MGMA and other legitimate surveys provide objective data, reflecting market rates so practices can ensure compensation arrangements withstand any scrutiny.

Education and Research

Academic physicians play an essential role in healthcare education, research, and other similar services beyond the scope of directly providing patient care. While clinical practice often still drives a base level of compensation, education and research also requires substantial investment of time from faculty or other academic physician roles.

Institutions commonly provide salaries (stipends) for academic positions based on specialty to recognize teaching obligations. However, research is also very important for advancing medicine to continuously improve treatment standards and guidelines. Many research programs heavily rely on grants and external funding. There is a balance of effort across the clinical and educational responsibilities for these roles which can vary among individual physicians.

For faculty on a tenured track, there is more focus on publishing and securing grants; the more clinical academic track prioritizes education in balance with a clinical practice presence. Both tracks require commitment to the overall academic mission of an institution.

Compensation benchmarks serve to foster transparency during negotiations and may include time that is protected and doesn't directly generate billable services. Academic positions will continue to play a very important role in the expansion of medical knowledge and improvement of patient care and outcomes.

Value Through the Eyes of a Surgeon

Determining fair compensation for a surgeon requires an understanding of the contributions and benefits they bring to their patients and their employer. This can be referred to as knowing one's value. Determining the value of a surgeon has traditionally been oversimplified to a basic measurement of productivity using RVUs, which are a system for quantifying the work and resources involved in providing medical services. RVUs are based on a variety of factors, including the time and skill required to perform a procedure, the level of training and experience of the surgeon, and the complexity of the procedure. Unfortunately, using RVUs as a proxy for determining the value of a surgeon fails to capture the multiple ways in which they contribute to a high-performing team.

Major shifts in employment patterns, evolving expectations of the new generation of surgeons, and business transformations to value-based healthcare are just some of the factors changing the ways in which the value of a surgeon are measured. Surgeons today are more commonly employed by health systems or may be self-employed with contracts to health systems or clinically integrated networks. Over the last two decades, an increasing number of surgeons have become employed within hospitals and health systems. The percentage of US physicians

employed by hospitals, health systems or corporate entities grew from 62.2% in January 2019 to 73.9% as of January 2022, according to new data from Avalere in a study sponsored by the Physicians Advocacy Institute.

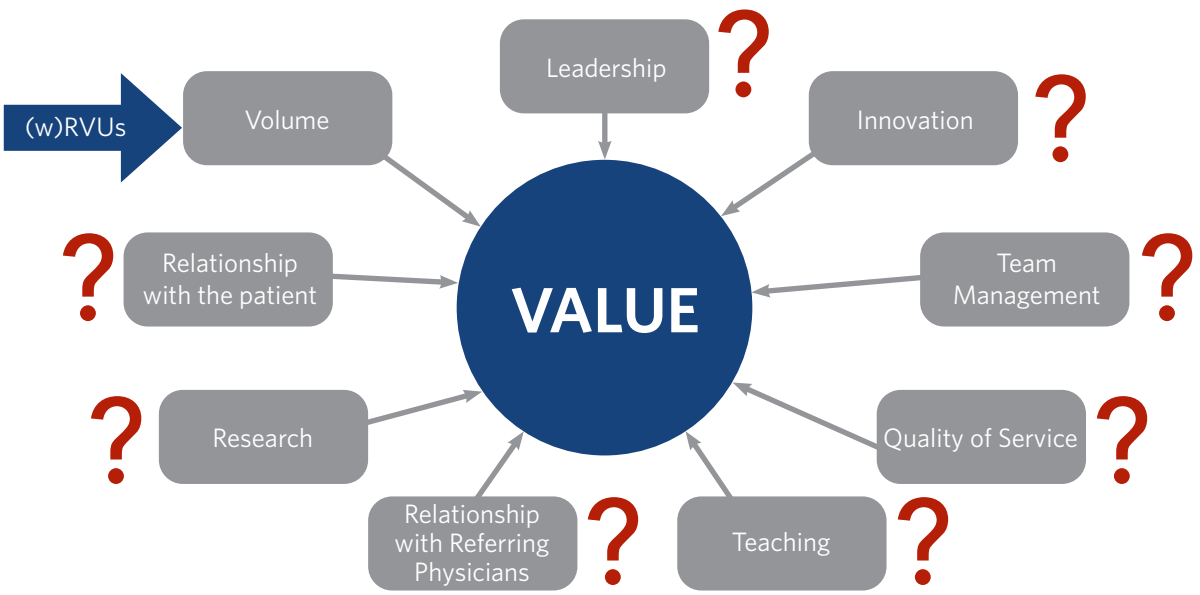
Payor contracts, once primarily focused solely on volume in a fee-for-service single transaction environment, are today increasingly moving further from single services and toward episodes of care that aggregate all services into a bundled price and assign risks related to outcomes. This transition to episodes and bundled payments is especially common for treatments and procedures with sufficient variability in resource use to provide opportunity for improved efficiency, including some surgical procedures.

Similarly, payors are incorporating additional factors into compensation determinations beyond productivity as measured by RVUs and volume as the focus shifts to value-based compensation. This means that quality and outcomes of care delivered to patients are weighed along with the volume of services provided. In this framework, surgeons are increasingly being evaluated based on factors such as patient satisfaction, complication rates, readmission rates, and adherence to evidence-based guidelines.

The following are some of the complicating factors and payment methodologies that can affect the way in which the value of a surgeon are weighed and compensated:

- **Quality Metrics:** Physicians, including surgeons, are commonly evaluated on a variety of quality metrics, such as patient satisfaction, complication rates, readmission rates, and adherence to evidence-based guidelines. When properly designed and applied, these metrics can be more meaningful to the surgical team in driving improvement and give a better picture of quality to payers and the public. These metrics can add an additional dimension to determining the value provided by the surgeon beyond the information on the volume of services available using RVUs, which are based solely on the time, intensity and resources involved in providing care.
- **Shared Savings and Risk Sharing:** Surgeons can be included on the participant list of a value-based care model such as an accountable care organization or other collaborative care model where they may share in the financial rewards or risks based on the overall performance of the healthcare system. This means that surgeons in these models may now be held financially accountable for both the cost and quality of care and have their compensation adjusted accordingly.
- **Bundled Payments:** Another form of value-based care model is the bundled payments for episodes of care, such as a joint replacement or a heart bypass surgery. Surgeons may receive a fixed payment for all of the services related to a specific procedure or condition. This means that surgeons are now being rewarded for coordinating care and achieving efficient outcomes, rather than simply performing a high volume of procedures.
- **Performance-Based Contracts:** Surgeons may enter into performance-based contracts where a portion of their compensation is tied to achieving specific quality and cost targets. This means that surgeons are now being rewarded for their ability to deliver high-quality care at a lower cost.
- **Care Coordination and Team-Based Care:** Value-based care emphasizes care coordination and team-based care, where surgeons which means that surgeons are now working more closely with other healthcare providers, such as nurses, pharmacists, and social workers. This means that surgeons are now being rewarded for their ability to work effectively as part of a team, rather than simply being a solo practitioner.

Working Hard on What?



- **Population Health Management:** Surgeons are now being involved in population health management efforts, such as preventive care and chronic disease management. This means that surgeons are now being rewarded for their ability to improve the health of a population, rather than simply providing care to individual patients.

All of the payment arrangements described in this section require additional time, effort, and expertise on the part of the surgeon and the care team beyond what is expected in a traditional fee-for-service relationship. Employers who are interested in recruiting and retaining the best surgeons and staff must offer compensation packages that recognize the surgeon is contributing much more benefit to the employer than simple RVUs alone would recognize. As portrayed in the graphic above, in addition to the volume of services, factors such as quality improvement, leadership, building and maintaining relationships with referring physicians and patients, teaching, research, recruiting and managing high-functioning teams or other tasks may all be part of the surgeon's responsibility. Health systems or other employers seek to recruit and retain the best surgeons who fit their culture and their market needs.

Fair market value (FMV) standards are based on the principles used to determine the price at which a willing buyer and a willing seller would agree to transact in an open and unrestricted market. In the context of a surgeon, FMV typically refers to the fair compensation or reimbursement for the services provided by the surgeon. Legal constraints add a note of caution for employers who must ensure that surgeon compensation arrangements fit within the regulatory environment around Stark Law and antikickback statutes related to physician services.

The FMV of a surgeon changes when a market shifts from a volume or fee-for-service market to one based on value. The market impact can depend on

factors such as cost of living, specialty shortages versus demand, procedural complexity and technical demand, clinical productivity, education and research, facilities and equipment, and experience or reputation. Since FMV is determined by the setting and the markets are transforming, this list of impact factors needs continuous updating to keep abreast with the shifting environment.

In summary, the move in markets toward value-based healthcare is changing the way that the value of a surgeon is measured. Surgeons are now being evaluated based on a variety of factors, including quality of care, cost of care, and their ability to work effectively as part of a team. This may require the employed surgeon to advocate on their own behalf when negotiating compensation and contract terms, but it is a positive change, as it is leading to a more accurate reflection of a surgeon's true value.

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PART 4

NEGOTIATION BASICS

Cathy A. Costantino, Esq.

Editor's Note: The author is writing solely in her individual capacity, not as an employee of the Federal Deposit Insurance Corporation, Georgetown Law School or Fordham Law School. She is offering negotiation advice solely as a subject matter expert, not an attorney. This chapter is not intended to provide legal advice about employment negotiations.

As surgeons increasingly become employees of organizations, institutions, and corporations, they find themselves negotiating contracts about duties, benefits, and compensation.

It is strongly recommended that surgeons consult an attorney who has experience negotiating physician employment contracts, and as appropriate, have the attorney negotiate on their behalf. This chapter provides an overview of negotiation principles and practices to guide the employee-surgeon in discussions with their attorney, and in the actual negotiation should the employee-surgeon choose to negotiate on their own behalf.

Negotiation Vitals

Elements of Negotiation: Negotiation is not haggling or selling—it is influencing. It involves elements of Behavior (what we do); Communication (how we deliver and receive information); Relationship (who are the players); and Results (why each party is there). Each negotiation has its own "culture"—timing, approach to conflict, venue and space, relationships, policies, intermediaries, power and authority, and closure rituals. All negotiations involve both process (why and how) and substance (what and when).

Taxonomy of Negotiation: The first step is Diagnosis: is the negotiation Investigatory or Deal-Making?[1] Investigatory Negotiation explores whether or not a deal is appropriate or even possible. In essence, you negotiate about whether to negotiate. If you proceed, the negotiation moves to Deal-Making: Developing Options, Mapping the Space, Identifying Zones of Possible Agreements (ZOPAs), and creating and claiming value.

Styles of Negotiation: Good negotiators are not "one-trick ponies" —they do not use the same style in each negotiation. Rather, they use the same principles and practices, but vary approach depending on the importance of Outcome (merits/results) and/or Relationship (ongoing/one-off). Possible styles are:

- ***Avoiding:*** Rate both relationship and outcome low, will avoid confrontation in negotiation
- ***Accommodating:*** Rate relationship high and outcome low, will concede/concur to get a deal
- ***Collaborating:*** Rate both relationship and outcome high, will give and take to get a deal
- ***Competing:*** Rate outcome high and relationship low; will negotiate aggressively

Principled Negotiation: This approach to negotiation focuses on parties' interests, not positions:[2]

- Separate the people from the problem
- Focus on interests (needs), not positions (wants)
- Invent options for mutual gain
- Insist on using objective criteria

The seven factors of Principled Negotiation are:

1. ***Interests:*** Identify your needs in the negotiation (salary, schedule, benefits) and rank them; do the same for the employer (timing of onboarding, oversight/supervision of others, expertise).
2. ***Alternatives:*** Calculate your BATNA (Best Alternative to a Negotiated Agreement—another offer you already have) and your WATNA (Worst Alternative to a Negotiated Agreement—having no job at all). Do the same for the employer to the best that you can. Notice that your Best or Worst Alternative is to a Negotiated Agreement, it is not your best alternative or dream outcome. This helps you decide whether to stay at the table: if your BATNA is better than their offer, walk and take your BATNA; if your WATNA is worse than their offer, stay at the table.
3. ***Options:*** Have more than one option. Prioritize them; plan your moves and design a concession strategy to give up certain options. Create "packages," but remember that once you package or link something, it is difficult to unbundle or decouple those components later.
4. ***Legitimacy:*** Provide objective criteria to support your options, such as cost of a benefit or professional membership; average salary for a particular area of surgical expertise; years of experience; collateral duties/committee memberships/teaching load. Ask the employer to do the same.
5. ***Communication:*** Who will take the lead in the negotiation: you or your attorney? If both of you are at the table, how will you interact? How formal/informal is the process: in person, written, virtual? How can you use each different communication channel to your advantage?
6. ***Relationship:*** Who do you expect to take the lead on the other side: Head of Human Resources, Vice-President of Operations, Medical Director, or another party? Do you have any pre-existing relationships with others at the institution: medical school, professional affiliation, recruitment? How important is it to preserve a long-term relationship with those with whom you will be negotiating?
7. ***Commitment:*** This is commitment to the negotiation process, not to an agreement. Each negotiation goes through six stages, explained below. Commit to the process and be patient.

Dissection of a Negotiation

The six stages of negotiation are not a linear process. Skipping the first three stages and proceeding directly to the Options stages too early will reduce your opportunity to maximize value. The stages of a negotiation are:

1. Gathering Information and Preparation

Prepare yourself and know what you truly need. Then prepare with your attorney and/or any other representatives working on your behalf. Map out the roles of all the parties: those at the table, behind the scenes, and the decision makers. Figure out who has power (can influence) and who has authority (can decide) on the other side.

Don't forget to prepare on both **process** (roles, strategies, approaches, concession plan, impasse, and closure issues) and **substance** (interests, creating and claiming value, options, aspirational value, reservation value, packages, and linkage). Know when you will walk away based on your BATNA/WATNA, and identify in advance why you will walk away (and how).

Develop an Information Management Plan: what you have, what you need, what you are willing to share, and when and what reciprocal information you will expect. Identify your "known knowns," your "known unknowns," and "unknown unknowns." Prioritize information, both yours and theirs: is the information critical/necessary, not critical but helpful, conditional on other information, or just a curiosity?

2. Identifying Interests

Map out both your interests and theirs. Ask WHY: for example, why do they have a certain timeframe for

onboarding, why do you need certain benefits. Identify conditional interests, mutually exclusive interests, and changing interests. Are there interests both parties share? Rank your interests and theirs. Don't skip this step—it can create options.

3. Developing Options

There is tension in negotiating between claiming value (most usual in an outcome-focused negotiation) and creating value (more common in a relationship-focused negotiation). Ideally, a successful negotiation is a combination of both creating and claiming; just remember to create first and not begin to claim too early in the process.

Claiming Value[2] focuses on variables we think of as objective: money, time, quantity, and risk:

- Focus on the other party's BATNA and reservation value
- Avoid making unilateral concessions (map your moves and get something in return)
- Be comfortable with silence
- Label your concessions
- Define what it means to reciprocate (both for you and the employer)
- Make contingent concessions
- Be aware of the effects of diminishing rates of concessions near the end of the process

Creating Value focuses more on interests and can be used to expand the ZOPA:

- Identify multiple interests, especially non-monetary, relationship, and future engagement
- Prioritize your interests and theirs (create a scoring system)
- Determine a range of options that meet at least some of their interests
- Negotiate in packages, add issues, use contingent offers
- Develop and execute a concession strategy

4. Narrow Options

Here, parties may become irrational, make quick (but poor) decisions not in their best interest, get impatient, or rush the process. Some strategies that can help:

- Aggregate asks (requests); disaggregate gives (concessions)
- Make conditional proposals (if/then)
- Have a pre-planned concession strategy—what to let go, why, when, and in return for what
- Avoid splitting the difference (good negotiators know how to set this up and game it)
- Watch out for cognitive biases: ego depletion, confirmation bias, agreement bias, and diminishing rates of concession near the end
- Know when to walk away and why—and stick to it!

If you are an impasse, a differential diagnosis is helpful. If you are stuck on Substance, create additional objective value, package/bundle offers, unpackage/fractionate offers, give or ask for additional information, change the risk-sharing formula or time frames, or use contingent offers.

If you are stuck on Process, you can take a break, change the pace or the tone, remove/disengage difficult parties from the table, go to a different medium (virtual, in person, written) assign "homework" to parties to get and share additional information, set deadlines, do a piecemeal deal (a short-term employment contract), or use a third party such as a mediator.

Difficult behaviors often escalate at this stage. In response, you can *model* the behavior you want, *mirror* their behavior and/or do the following: ignore, reframe, name the behavior and request a change, or pivot to another topic. Take care that you do not get caught up in their chaos or their drama.

Negotiators sometimes find it difficult to say "no." Using the Power of a Positive No[3] can be useful. Serve up a "No Sandwich": Say "yes" to something you have agreed on so far (Past); say "no" to something on the table (Present); and say "yes" to your commitment to the process (Future).

5. Closure

Leave time for this stage; it takes longer than you think. Anticipate multiple closure behaviors: *repression* (they "forget" what they agreed to); *regression* (they go "backwards" and resort to earlier proposals); *repudiation* (they withdraw offers); *reluctance* (they become "commitment-phobic"); *nibbling* ("just one more thing"); *cratering* (intentionally blowing up the deal); *gambling* (staking the entire outcome on one item); and *raising new issues for the first time.*

Don't forget to "pocket the deal" and say "yes" to each individual term. Remember that the parties must also reach agreement on the Agreement, which is the written contract. Some terms may be boilerplate and non-negotiable, so be sure to ask about these in advance so you are not surprised at the end. If negotiating on your own, it is **strongly recommended** you seek legal advice before signing any documents.

Be willing to walk away particularly if your BATNA is better than what is on the table, and if your WATNA is better than what is on the table. Explain your reason and then take your exit.

By planning and executing a deliberative, well-planned strategy and understanding the science behind the art of negotiation, you can increase your influence over the result and maximize opportunities to create and claim value.

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APPENDIX

Sample Letter of Intent

-----SAMPLE LETTER OF INTENT ----
Prepared by The Bittinger Law Firm: www.bittingerlaw.com

HEALTH SYSTEMS R US
123 ARVEEYUUS MATTER BOULEVARD
FAIR MARKET VALUE, CA 94382

Yusuf Youngun, M.D.
123 Poormans Lane
Fellows Ville, CA 94839

October 19, 2022

Dear Dr. Youngun,

Health Systems R Us (HSRU) is delighted to offer you an employment opportunity to serve HSRU patients. This letter is a formal statement of our desire to employ you, subject to licensing, credentialing, reference, vaccination status, and criminal background check. You acknowledge your intent to accept the position by signing this letter. *[analysis from Attorney Bittinger: Issue one: is this thing binding? Once you see the contract, are you locked in to the terms in here? What if there's something in the contract that impacts what is in here? See also next paragraph and the line above the signature line.]*

Once you have documented your intent to accept this position by signing and returning this letter to us, we will start to draft your agreement. Of course, not all the terms of the offer can be contained in this letter; the details will be finalized by HSRU and its legal counsel and inserted into your employment agreement.

General Outline of Terms/Specifications:

Schedule:

1. Specialty: General Surgery *[analysis from Attorney Bittinger: at what hospitals and what practice locations? This impacts work/life balance; non-compete and patient base development which impacts wRVU based compensation.]*
2. Minimum of **(35) hours 1.0 FTE** of patient contact time per calendar week, plus participation in call coverage. *[analysis from Attorney Bittinger: What about call coverage?]*

Compensation/Benefits:

1. **Guaranteed Salary.** We will guarantee a salary of Three Hundred Thousand Dollars ($300,000) per year for the initial two years. HSRU reserves the right to unilaterally modify your guaranteed salary in the event that it is no longer commercially reasonable or fair market value.

2. **Bonus**. In the event that you generate more than 6,800 wRVUs in each contract year, you will be paid an additional $50 per wRVU. *[analysis from Attorney Bittinger: We would search MGMA Data Dive to determine if this reasonable.]*

3. **Signing Bonus:** Your first paycheck will include a one-time signing bonus of Eighteen Thousand

Dollars ($18,000). You must repay it all if your employment ends within the first two years.

4. **Relocation Assistance.** We will reimburse you for your moving expenses up to $10,000, based on IRS guidelines and submission of receipts. You must repay it all if your employment ends within the first two years.
5. **Productivity**. We anticipate that you will generate 6800 wRVU's per year. *[analysis from Attorney Bittinger: this is odd language, "anticipate". Does this mean required? What happens if you don't meet the requirements? What are your compensation terms after the end of the guarantee period, in year three?]*
6. **Compensation Ceiling.** We will not pay you more than $450,00 from all sources whatsoever as fair market value.
7. **COVID-19.** You must be vaccinated against COVID.
8. **Benefits**. We offer medical, dental, vision, life, long-term care, long term disability. You may take 30 days off per year. We will pay for $2,500 in CME.

Thank you in advance for joining Health Systems R Us. We look forward to a long and robust relationship. Once you sign and return this letter, we will let you know your start date and practice location.

Sincerely,

_____
Chief of Surgery

x_____

Employment hereby accepted and agreed this ____ day of _____ 2022.

_____
Yusuf Youngun, M.D.

Employment Agreement Checklist

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"We are only as blind as we want to be." – Maya Angelou

Compensation

- ☐ Define base guarantee and guarantee period.
- ☐ What triggers an end to the guarantee period?
- ☐ Analyze wRVU or Collections thresholds needed for bonus or to maintain base.
- ☐ Check MGMA data for reasonable wRVU thresholds and $/wRVU
- ☐ Under any circumstances could the physician have to repay any compensation to the employer (a draw)?
- ☐ Does the employer pay license fees, CME, board certification, etc.? PTO? Maternity/Paternity Leave?
- ☐ Are you paid extra for call coverage? Is call shared equally? Does the contract describe ratio or frequency?
- ☐ Are they providing a sign on bonus of about 10% of your annual salary?

Insurance

- ☐ Do you have an occurrence policy or a claims made policy?
- ☐ Will you have to pay for tail insurance? Under what termination circumstances? How much might it cost?
- ☐ Is there any sovereign immunity (state government employer).

Non-compete

- ☐ What can you not do, and where can you not do it, with whom, and for how long?
- ☐ Exception for private practice?
- ☐ Trigger: applicable only if you leave without cause? Should it apply if the employer terminates for no reason?

Term & Termination

- ☐ Is your Letter of Intent binding?
- ☐ When is the contract effective, when the physician signs or starts work? If it's when the physician starts, can the employer take it away before the first day and can the physician walk away?
- ☐ How much notice is required to terminate for no cause?
- ☐ For immediate termination, are the triggers clear and non-subjective?

Negotiation Tips

- ☐ If it is not in writing in the contract, it is not enforceable. Beware side letters.
- ☐ If you don't ask, you don't get. Employers are often impressed with physicians who have a good grasp of the legal issues surrounding their employment.
- ☐ Utilize surveys (MGMA) to assess the reasonableness of the compensation.
- ☐ Think positive and be professional. Physicians invest years and thousands of dollars in getting to the point of their first employment agreement. Do not bind yourself to unreasonable terms from which you cannot escape.
- ☐ Utilize a healthcare attorney who specializes in physician employment agreements. If a potential attorney does not know what an wRVU is or doesn't know when tail insurance is required, keep searching for one who does.

MGMA Physician Employment Contracting Best Practices and Checklist

MGMA physician employment contracting best practices

- Consult with an experienced healthcare attorney before executing a physician contract.
- Verify your contract contains the required or optional contract language and terms.
- Beware of vague contract terms and understand the significance of defined contract terms.
- Utilize data/surveys, benchmarks and experts to analyze the specifics of your geographic area as it relates to contracting with and hiring a physician.
- Consider Stark Law, Anti-Kickback Statute, False Claims Act, fair market value (FMV) and any other applicable state or federal laws when hiring a physician and determining his or her compensation.
- Consider making your best offer upfront to a physician to ensure you keep up with your competition and to prevent/reduce turnover.
- Utilize a pro forma to analyze the financial impact a new physician will have on your practice for the next one to three years.
- Utilize a physician onboarding startup checklist to ensure all necessary preparations have been made as it relates to hospital/payer credentialing, licensure, etc.
- Consider whether a base guarantee should be offered and for what period of time.
- Consider all quality or value-based care incentives in addition to productivity-based incentives.
- Verify your contracting strategy complies with your overall strategic goals.
- Ensure physicians aren't working without a contract and monitor contract renewals.
- Make the contracting process as smooth and timely as possible with clear timelines.
- Make sure candidates are familiar with your organization's culture prior to them executing their contract and joining the team.
- Consider any and all outside (additional income) activities.

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Physician Employment Contract

CHECKLIST

REQUIRED CONTRACT LANGUAGE AND TERMS

- ☐ Term/dates
- ☐ Title and duties (job description and performance standards)
- ☐ Malpractice coverage and insurability
- ☐ Professional certification and licensure/educational requirements
  - Maintaining a medical license, DEA license, board certification(s) and credentialing eligibility with government/commercial insurance payers (if all are applicable)
  - Maintaining necessary hospital privileges (if applicable)
- ☐ Schedule and minimum hours worked per year (full time, part time, etc.)
- ☐ Location(s) to be covered
- ☐ On-call requirements
- ☐ Records and files
- ☐ Compensation
  - Methodology
  - Call pay
  - Directorships
  - Modifier-based adjustments
- ☐ Termination
  - For cause
  - Without cause
  - Payout in lieu of notice
  - Resignation
  - Disability
  - Death
  - Contract termination when one becomes a shareholder (if applicable)
  - Assignment of third-party reimbursement contracts (if applicable)
  - Survival of terms (If applicable)/post-termination obligations
- ☐ Confidentiality
- ☐ Medical decision making — right of a physician to exercise independent professional judgment in the care of patients
- ☐ Business opportunities and professional engagements, including an authorization to utilize the physician's information in marketing and public relations
- ☐ Representations and warranties — verify that the clinician is not bound by prior contractual or regulatory limitations, including prior malpractice claims
- ☐ Conflicts of interest/outside services
- ☐ Non-compete/restrictive covenants
  - Duration
  - Geographic radius
  - Buyout clause
- ☐ Non-solicitation provisions
- ☐ Policy adherence and behavioral standards
- ☐ Regulatory compliance
  - Structure contract terms to satisfy applicable safe harbor laws under Stark Law. Also consider requirements under the Anti-Kickback Statute, False Claims Act and fair market value (FMV)
  - State specific requirements
- ☐ Penalties for violation — confidentiality, non-solicitation, etc.
- ☐ Alternative dispute resolution — mediation or binding arbitration

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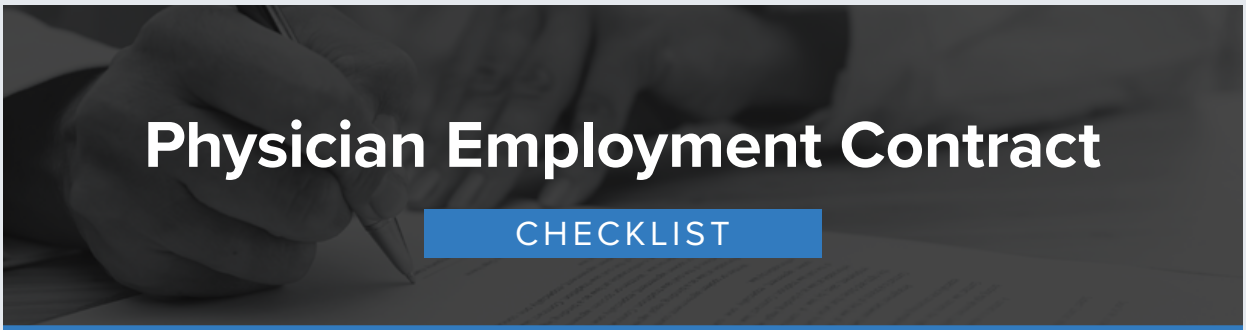

Physician Employment Contract

CHECKLIST

OPTIONAL CONTRACT LANGUAGE AND TERMS

- ☐ Title and duties (job description and performance standards)
- ☐ Benefits
  - Payment or reimbursement of liability/malpractice insurance
  - Claims-made vs. occurrence based
  - Tail coverage or prior acts coverage (if applicable)
  - Retirement plan
  - Time off (vacation, sick pay, etc.)
  - Short-/long-term disability
  - Leaves of absence
- ☐ Sign-on bonus (as well as a repayment clause if applicable)
- ☐ NPP/APP supervision payments
- ☐ Relocation expense reimbursement
- ☐ CME (travel, expenses and time off)
- ☐ Dues and subscriptions expense reimbursement (medical license, DEA license, etc.)
- ☐ Cell phone expense reimbursement
- ☐ Intellectual property
- ☐ Medical directorships
- ☐ Student loan repayment
- ☐ Research requirements
- ☐ Academic teaching requirements
- ☐ Real estate or lease guarantees
- ☐ Workers' compensation insurance (if required by state law for independent contractors)
- ☐ Indemnification for all parties against claims or losses
- ☐ Office space, supplies or personnel requirements

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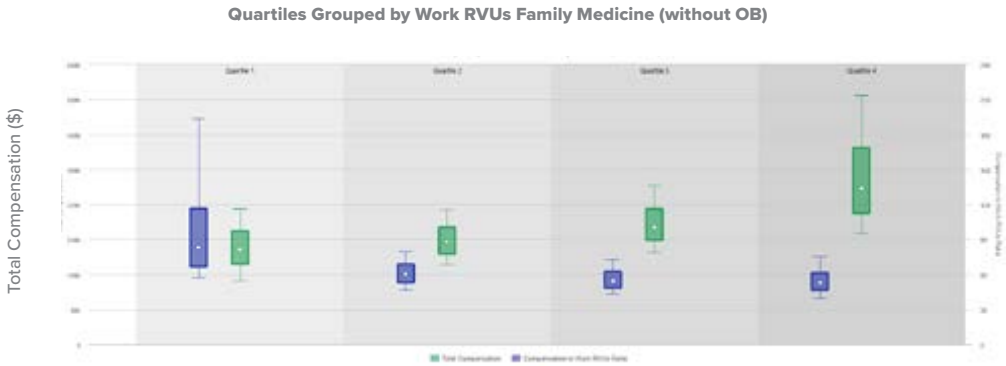
MGMA DataDive Provider Compensation

MGMA DATADIVE PROVIDER COMPENSATION

The MGMA DataDive Provider Compensation platform is one of the most comprehensive datasets in the industry, providing both hospital- and physician-owned practice data as well as compensation benchmarks for medical directorship, on-call, academic and starting salaries. The 2023 report based on 2022 data represents nearly 190,000 providers from 6,800 groups spanning 250 specialties. The MGMA DataDive Provider Compensation platform will enable you to:

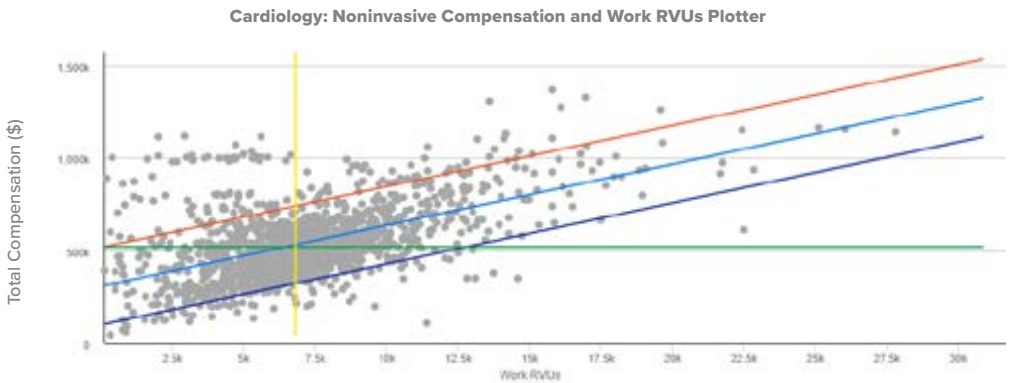
- **Attract And Retain The Highest-Quality Providers.**
  Determine the right mix of compensation, benefits and incentives to offer to ensure that your recruitment packages are competitive within the market. Retain top talent by utilizing this data to align provider performance with compensation and set realistic goals.
- **Drive more revenue through productivity.**
  Evaluate work RVUs and the median compensation to work RVU ratio to help optimize compensation based on productivity. This data set will also help you understand the effects that teaching and research have on academic faculty compensation and productivity as academic providers report less billable clinical time than non-academic providers.
- **Keep costs contained.**
  Estimate the potential effects of adding physicians and advanced practice providers to help you manage your overall compensation costs.

QUARTILE TOOL



View compensation and productivity data partitioned by highest/lowest performers and the corresponding values of up to three additional benchmarks. Data is displayed by quartile in a table and interactive graph.

PAY TO PRODUCTION PLOTTER



Understand the relationship between compensation and productivity per provider specialty on a scatter plot.

MGMA DataDive Provider Compensation (CONTINUED)

CUSTOM REPORTS & TOOLS

For the data gurus, this tool allows you to get into the weeds and search very fine data points, like specialty combinations, state combinations and five-year trends. It also lets you compare your organization's data side by side with MGMA data!

PROVIDER COMPENSATION BENCHMARKS

- ASA Units
- Bonus/Incentive
- Bonus/Incentive Payments as a Percent of Total Compensation
- Collections
- Collections to ASA Units Ratio
- Collections to Total RVUs Ratio
- Collections to Work RVUs Ratio
- Compensation to ASA Units Ratio
- Compensation to Collections Ratio
- Compensation to Encounters Ratio
- Compensation to Gross Charges Ratio
- Compensation to Total RVUs Ratio
- Compensation to Work RVUs Ratio
- Gross Charges
- Inpatient E/M Codes
- Outpatient E/M Codes
- Retirement Benefits
- Retirement Benefits as a Percent of Total Compensation
- Total Compensation
- Total Encounters
- Total Paid Time Off (PTO) Offered (in Hours)
- Total RVUs
- Total Sick Time Offered (in Hours)
- Vacation (in Hours)
- Work RVUs
- Work RVUs to Total Encounters Ratio

ACADEMIC COMPENSATION BENCHMARKS

- ASA Units
- Base Compensation
- Base Compensation as a Percent of Total Compensation
- Bonus/Incentive Amount
- Collections
- Compensation to ASA Units Ratio
- Compensation to Collections Ratio
- Compensation to Encounters Ratio
- Compensation to Gross Charges Ratio
- Compensation to Total RVUs Ratio
- Compensation to Work RVUs Ratio
- Gross Charges
- Inpatient E/M Codes
- Outpatient E/M Codes
- Retirement Benefits
- Standardized ASA Units
- Standardized Collections
- Standardized Gross Charges
- Standardized Inpatient E/M Codes
- Standardized Outpatient E/M Codes
- Standardized Total Encounters
- Standardized Total RVUs
- Standardized Work RVUs
- Total Compensation
- Total Encounters
- Total Paid Time Off (PTO) Offered (in Hours)
- Total RVUs
- Total Sick Time Offered (in Hours)
- Vacation (in Hours)
- Work RVUs

PROVIDER PLACEMENT STARTING SALARY BENCHMARKS

- Amount of CME Paid
- Amount of Signing Bonus
- Amount of Starting Bonus
- Amount Paid to Relocate
- CME Weeks Paid Time Off
- Guaranteed Compensation
- Total Paid Time Off (PTO) Offered (in Hours excluding CME)
- Total Sick Time Offered (in Hours excluding CME)
- Vacation (in Hours excluding CME)

MEDICAL DIRECTORSHIP COMPENSATION BENCHMARKS

- Annual Stipend Compensation
- Annualized Compensation
- Daily Stipend Compensation
- Deferred Compensation
- Hourly Rate Compensation
- Monthly Stipend Compensation
- Quarterly Stipend Compensation
- Total Hours Spent on Directorship per Week
- Weekly Stipend Compensation

ON-CALL COMPENSATION BENCHMARKS

- Annual On-Call Hours
- Annual Rate On-Call Compensation
- Daily On-Call Hours
- Daily Rate On-Call Compensation
- Holiday On-Call Compensation
- Hourly Rate On-Call Compensation
- Monthly On-Call Hours
- Monthly Rate On-Call Compensation
- On-Call Compensation per Procedure
- On-Call Compensation per Work RVU
- Unpaid On-Call Hours per Week
- Weekend On-Call Compensation
- Weekly On-Call Hours
- Weekly Rate On-Call Compensation

MGMA DataDive Provider Compensation (CONTINUED)

PROVIDER COMPENSATION FILTERS

- Advanced Practice Provider to Physician Ratio
- Advanced Practice Provider Specialty
- All Practices
- Compensation Plan
- Demographic Classification
- Geographic Section
- HHS Region
- Legal Organization
- Majority E/M Codes
- Minor Geographic Region
- Number of FTE Advanced Practice Providers
- Number of FTE Physicians
- Number of FTE Support Staff
- Organization Ownership
- Physician had Medical Directorship Duties
- Physician had On Call Duties
- Physician Specialty
- Physician Title
- Practice Type
- Practice was Affiliated with Accountable Care Organization
- Practice was Federally Qualified Health Center
- Practice was Patient Centered Medical Home
- Practice was Rural Health Center
- Provider FTE Category
- Provider Had Supervisory Duties
- Provider Primary Shift
- State
- Total Medical Revenue
- Type of Compensation Tax Form
- Years in Specialty

ACADEMIC COMPENSATION FILTERS

- Advanced Practice Provider to Physician Ratio
- All Practices
- Billable Clinical Activity
- Compensation Plan
- Demographic Classification
- Department Specialty
- Faculty Rank
- Geographic Section
- HHS Region
- Majority E/M Codes
- Minor Geographic Region
- Number of FTE Advanced Practice Providers
- Number of FTE Support Staff
- Number of Total FTE Faculty
- Patient Care Revenue
- Practice was Federally Qualified Health Center
- Practice was Rural Health Clinic
- Provider FTE Category
- Total Medical Revenue
- Years in Specialty

PROVIDER PLACEMENT STARTING SALARY FILTERS

- Academic Provider
- All Practices
- Demographic Classification
- Geographic Section
- HHS Placement Region
- Number of FTE Physicians
- Organization Ownership
- Placement Type
- Practice Offered Signing Bonus
- Practice Offered Starting Bonus
- Practice Required Signing Bonus Payback
- Practice Type
- Practice was Federally Qualified Health Center
- Practice was Rural Health Clinic
- Years in Specialty

MEDICAL DIRECTORSHIP COMPENSATION FILTERS

- Academic Provider
- All Practices
- Compensation Method
- Demographic Classification
- Directorship Internal or External
- Geographic Section
- Hours Spent on Directorship per Week
- Legal Organization
- Number of FTE Advanced Practice Providers
- Number of FTE Physicians
- Number of FTE Support Staff
- Organization Ownership
- Practice Type
- Practice was Federally Qualified Health Center
- Practice was Rural Health Clinic
- Total Medical Revenue
- Years in Specialty

ON-CALL COMPENSATION FILTERS

- Academic Provider
- All Practices
- Demographic Classification
- Geographic Section
- Legal Organization
- Number of FTE Advanced Practice Providers
- Number of FTE Physicians
- Number of FTE Support Staff
- Organization Ownership
- Practice Type
- Practice was Federally Qualified Health Center
- Practice was Rural Health Clinic
- Total Medical Revenue
- Type of On-Call Coverage

To learn more, visit **mgma.com/ddprovider**
or contact us based on your organization type:

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