

SURGEONS

AS INSTITUTIONAL EMPLOYEES:

A STRATEGIC LOOK AT THE DIMENSIONS OF
SURGEONS AS EMPLOYEES OF HOSPITALS



DIVISION OF ADVOCACY AND HEALTH POLICY

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DISCLAIMER

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



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INTRODUCTION

In the 1990s, with the move toward managed care and health maintenance organizations, hospitals began to purchase physician practices, especially primary care practices, in large numbers. However, these ventures, in general, were not successful due to poor incentive compensation design, lack of accountability on the part of the new employees, and the assumption that the physicians would function the same as when they were self-employed. Most of these relationships guaranteed physician salaries with no productivity or quality-of-care metrics, and as a result, these types of arrangements failed by the start of the next decade.¹ Consequently, it is now very rare to see an arrangement with compensation guaranteed, without some type of measure of productivity and/or quality.

Recently, there has been a renewed movement toward employment of physicians by hospitals, especially specialty physicians. According to the American Hospital Association (AHA), hospitals now support one in nine jobs in the United States.² The American Medical Association (AMA) stated, “the number of physicians and dentists employed full time by community hospitals went up from 62,152 in 1998 to 91,282 in 2010.”³

What factors are driving this trend?

- Hospitals are trying to build targeted specialty services to increase market share and revenue.
- Younger physicians are seeking a different work/life balance.
- Reimbursement rates based upon the Medicare conversion factor for physicians and surgeons have been essentially stagnant for the past decade.
- In the meantime, for practicing surgeons, overhead costs have continued to grow during that same decade.⁴
- Adding to this financial insult for surgeons is now the need to implement costly health information technology systems that make it even more difficult for many physicians to afford to remain in independent practice.⁵

- Lastly, the creation of accountable care organizations and more risk-based payment approaches also fuel the push toward hospital-based employment, as institutions try to align the interests of both hospital and surgeon-provider.

As the economy continues to put pressure on hospitals and physicians to lower cost and increase quality, hospitals increasingly need physicians for growth in the battle to keep margins expanding or even holding. Physicians bring efficiency in product delivery and capital efficiencies by reducing duplicated service lines. The hospital’s ability to control quality and monitor patient satisfaction will prove useful in the future environment of health care.

The American College of Surgeons (ACS) has developed this research guide to provide valuable information that surgeons will find useful when considering institutional or hospital-based employment. In the context of this research guide, employment is used in the larger sense to include a wide spectrum of employment options, ranging from traditional full employment to surgeons working as locum tenens or contract employees of a hospital. Similarly, hospital is used in a sense to mean any healthcare facility ranging from small community hospital, to a large hospital institution located in multiple states. This research guide will also give an overview of the potential benefits and pitfalls of leaving private practice and entering employment as well as provide suggestions on selling a practice.

Initially, it is important to be aware of your state and federal employment laws. Currently, five states (California, Colorado, Iowa, Ohio, and Texas) clearly prohibit hospitals from employing physicians. It is important to understand your state laws regarding the employment of physicians at hospitals. Even in those states that clearly prohibit hospitals from employing physicians there are exceptions. The Office of the Inspector General (OIG) stated that in California “the prohibition does not apply to clinics operated by university medical schools or public hospitals. In Iowa, Colorado, and Ohio, teaching hospitals may hire faculty as well as residents and interns for education purposes. In Texas, public hospitals may employ physicians directly.”⁶

This research guide is organized to consider three dimensions of surgeon employment, as each dimension has its own unique set of challenges: (1) the various hospital employment environments; (2) the various hospital employment types; and (3) the various types of transitions to or from employment. In addition, this research guide also discusses contracting issues related to employment.



DIMENSION 1: TYPES OF HOSPITAL/INSTITUTION ENVIRONMENTS

The hospital environment may vary in size, location, and mission. When deciding to enter an employment contract 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 things such as the surgeon's work hours, practice autonomy, administrative responsibilities, and financial risks.

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

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, and various branches of surgery and psychiatry. They might also be linked to a medical school and their mission may be based on the teaching of medical students and physicians in training and research. They are typically looking for surgeons to fill on-site coverage or to develop niche markets. These types of institutions need physicians for growth in the battle to keep profit margins expanding or steady. Physicians, with the proper leadership and information, can bring efficiency in product delivery and capital efficiencies by reducing duplicated service lines. As health care reform expands, an institution's ability to control quality, improve patient satisfaction, and deliver increased value will prove useful in the future environment of health care.

Not-for-profit community hospitals

These are typically hospitals organized as a not-for-profit corporation. Their not-for-profit status is based on their charitable purpose, and in some cases, the hospital may be affiliated with a religious denomination. This type of hospital forms the backbone of American medicine and is often

the largest employer in their county. One of its goals may be to develop a dominant position in its market area and, as a result, it needs the expertise and reputation of a surgeon to draw patients to the hospital.⁷ In this environment it will be helpful to understand the competition from other hospitals in the same market area in order to gauge how valuable 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 the new physician at a disadvantage.

Rural or critical access hospitals

These are typically hospitals with 50 or fewer beds located more than 30 miles from another acute inpatient care facility, or more than 50 beds but are not a referral center.⁸ A rural critical access hospital is a community hospital that receives cost-based reimbursement under federal law.⁹ As a general rule, rural hospitals have a difficult time recruiting enough surgeons because of their remote location. 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. As a result, surgeons who desire such a practice environment will have a strong negotiating position. Surgeons who will perform a full range of endoscopy in addition to providing surgical support will be extremely desirable for these types of settings.

Large group practice

In some instances, groups of physicians will form a group practice, which then contracts with one or several hospitals or institutions, providing services to those facilities. These groups can range from multispecialty "captive" 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 surgeons or physicians to multiple institutions in an area (such as vascular surgery, radiology, or anesthesiology). In this instance, the surgeon must negotiate with other physicians within the organization, but is also free to some extent or another from having a purely hospital-centric focus when it comes to contract negotiations.

Small group practice

There are still many practices in America that employ surgeons via a corporation composed of surgeons. Although we tend to think of those arrangements as being in private practice, the surgeons nonetheless are employees of a corporation and, as such, have some of the same issues involved with being an employee of even the largest corporations.



DIMENSION 2: TYPES OF HOSPITAL/INSTITUTION EMPLOYMENT

Across most of the country, hospital employment is growing rapidly. Surgeons are aligning with hospitals through various arrangements because both their and the hospital's needs are changing. It is important to note that 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 surgeons 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.¹⁰ 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 agreement, a stock transfer restriction agreement (to ensure a hospital-friendly successor), as well as the practice entity's charter and bylaws."¹¹ 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. Similar to the example above, these types of financial arrangements need critical and expert input to avoid inadvertently violating federal or state laws.

Full employment with new surgeons joining other employed surgeons in an academic practice

An academic practice is one affiliated with a university that has a medical school and/or an accredited residency program. These hospitals must be accredited by the Accreditation Council for Graduate Medical Education and approved by the state.

Surgeons that choose 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 relations with professional organizations, industry, and government. In addition, a percentage of an academic surgeon's work week will be spent conducting clinical 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.

Full employment of established surgeons with purchase of established practice

A hospital may choose to directly employ a surgeon. In some cases the surgeon may have an existing private practice; the hospital may 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, anti-kickback statute, and state laws that must be taken into account.

The federal Stark Law and anti-kickback statute are designed to prevent the use of financial incentives to influence providers' medical decisions.¹² 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.



Employment of an 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. 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.¹³ The advantage of this arrangement is that the surgeon typically retains the ability to once again become self-employed, still controls his or her professional corporation, and, under some instances, can practice outside of the independent contractor agreement.

An independent contractor arrangement has important legal and financial ramifications that need to be considered, similar to those arrangements mentioned above. Agreements on fees and charges for services have the potential to pose significant fraud, abuse, and antitrust risks because of the independent relationship. 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 and taking sick leave or paid vacations and holidays. There are also Medicare billing regulations that must be considered. Medicare assignment rules typically prohibit a provider from billing Medicare for services

performed by another provider, 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 for use by the employing institution, 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.¹⁴ 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 example above 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.

In this model the hospital does not buy the physician's practice assets and the surgeon(s) does not have to relinquish control of the day-to-day operations of his or her practice. This arrangement also has unique barriers that should be examined in relation to the federal Stark Law, anti-kickback statute, and state physician self-referral laws.





DIMENSION 3: TYPES OF TRANSITIONAL SITUATIONS

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

Private practice to employment

Physicians in private practice may choose to sell their practice for many reasons and enter 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 YOUR PRACTICE

Selling a practice can be a complicated endeavor. In considering the transition from private practice to hospital employment, it is important that the organization's care philosophy fit with the physician's practice philosophy, vision, and values.

Medical practice valuation, which involves assigning a dollar value to the practice, is another step in the process of selling a practice. A professional, independent party should appraise the practice value regardless of whether the physician selling is going into retirement or will continue as an employee of the buyer. 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 his or her 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.¹⁶

There are three general ways to value the purchase price for a practice: (1) based upon income; (2) based on value to the organization of future earnings and growth of service line revenue from the practice; and (3) based on cost or worth of the practice assets. Accounts receivable of the purchased practice are typically not purchased but rather relegated to a separate custodial agreement for collection over time. In today's environment, there are minimal payments if any for intangibles like medical records or "goodwill" value. Selling your practice is more simply an asset purchase by the hospital (for example, value of ownership in an ASC, physical plant space, office equipment, other tangible values, and so on).

REPURCHASE PROVISIONS

Physicians in private practice may be reluctant to sell their practice to a hospital when entering employment without a provision for repurchasing if the employment relationship does not go well.

Under a repurchasing provision the physician will have the opportunity to repurchase the assets of the practice from the hospital. However, the hospital will often require a certain timeframe following the hospital's purchase of the practice before the provision can be triggered.¹⁷ When

considering a repurchase provision it is important to consider who has the rights to accounts receivable for services prior to repurchase, who will employ nonphysician personnel, who will assume practice office leases, and how electronic billing and medical record information will be transitioned.¹⁸

Employed surgeons renegotiating their contract

Contract renegotiation typically occurs two to five years after the initial employment contract. However, some employment contracts include an automatic renewal provision (often referred to as an "Evergreen Clause"). It is pertinent to know whether your contract contains such a clause. After the initial contract term, a contract may automatically renew for another full term of two to five years without resigning. Furthermore, contracts that include an automatic renewal provision typically include a notice of nonrenewal provision that can be exercised by either party, generally 60 or 90 days. The notice of nonrenewal can be an important negotiating point.

For surgeons renegotiating their contract it is important to know what drives the hospital's ability to sustain itself and the role the surgeon plays in the success of the hospital. Being aware of these interdependencies will be valuable during contract renegotiation.



For example, typically, a specialist will show an initial loss to the hospital of \$100k–\$200k on the practice side. It is pertinent that the surgeon understand his or her own productivity, compensation, and overhead. Often the hospital will displace practice overhead to balance losses elsewhere (service fees, hardware fees, software fees, and so on). Surgeons need know their hospital side worth in terms of contribution to the margin, referrals to in-network physicians (for example, radiation oncology, gastrointestinal, intensive care unit physicians, and so on), and revenue down the road in terms of ancillaries (for example, imaging, labs, and so on). Additionally, surgeons who are able to positively impact quality metrics, length of stay, readmission rates, and customer satisfaction surveys will have added worth to their institution. There are different resources that may be helpful in assessing and understanding one's value to the institution, with respect to productivity and salary.

The Medical Group Management Association publishes a benchmark survey report that includes data across multiple indicators, including specialty, geographic region, practice setting, years in specialty, and method of compensation.¹⁹ These reports may be helpful in equipping one's self during contract renegotiation. In short, remember the mantra "Value equals quality divided by cost." The surgeon of today needs to know what his or her quality metrics are and how those outcomes are cost effectively attained. Positive patient feedback and top-notch customer satisfaction also add to your negotiating worth.

Employed surgeons moving to a new hospital/institution

In some instances, the surgeon finds him or herself in a position of either needing to move, or wanting to move. Depending upon the circumstances of need for relocation, there are several important items that should be considered. In some cases, the surgeon needs to relocate because the renegotiation process has not worked well, the situation in their current environment is untenable, and relocation appears to be the best and most viable option to take. In this instance, the surgeon should review their contract very carefully, and should involve legal counsel in that process, in order to understand all of the consequences and considerations of unwinding the current arrangement. Typically, those items include considering noncompete clauses, loan repayment, reconciliation of accounts receivable, and splitting of costs of tail coverage for malpractice insurance, among others. In some cases, the new hospital will pay some or all of these disengagement costs, while in other cases, the surgeon will have to bear the brunt of these expenses. Thus, good legal review and preparation, prior to disassociating from a hospital just makes good sense and will prevent future regrets.

Residents or surgeons finishing fellowship: Choosing a practice

For surgical residents or Fellows preparing to enter practice, choosing a practice may seem like a daunting task, especially since practice opportunities are multifaceted and

range from private practice, academic practice, or hospital employment. Careful planning should go into which practice option best fits the surgical resident's or Fellow's needs.

Many key considerations are necessary to decide on a practice type, as discussed above. However, residents and surgeons seeking their first position might encounter circumstances requiring increased flexibility on salary, vacation, and geographic location.

Unlike more seasoned surgeons, the resident or Fellow will have little or no productivity data or quality metrics with which to negotiate, and it will be important to provide employers with information beyond just having passed the boards. Bringing additional skills and knowledge to the table such as involvement beyond clinical care will be an important component of initial negotiations.

The ACS has developed a practice management series for residents and young surgeons. The series is designed to educate and equip residents and young surgeons who have recently started practice with the knowledge to manage their personal surgical future with a focus on issues such as: how to select a career in private practice I and II; coding for surgical residents I and II; surgical financial management reports I; surgical financial management reports II, organizing a surgical practice, and understanding insurance processing; accumulation planning, goal planning, and risk management; negotiation; and changing the liability equation.²⁰



UNDERSTANDING AND NEGOTIATING YOUR EMPLOYMENT CONTRACT

Physician employment agreements play an important role in establishing the legal, operational, financial, and philosophical parameters of a physician's medical practice. All contracts should be reviewed by an attorney experienced in contract law and within the state of which you will practice medicine. Each state has different laws on hospital employment of physicians.



GENERAL EMPLOYMENT CONTRACT PROVISIONS

The contract should state many of the basics, including the term and termination of the contract, duties of the surgeon, covenants not to compete, and medical liability tail coverage.

Term and termination

It is critical to include term and termination provisions in every contract. The contract will be valid for a specified term, usually one to three years. At the end of the initial agreement, the contract will terminate, requiring a new agreement, or an automatic renewal provision may be included. It is pertinent to know whether your contract contains such a provision because typically automatic renewal provisions include a notice of nonrenewal that can be exercised by either party, generally 60 or 90 days.²¹

It is also important to include a termination provision. Without the ability to terminate the contract during the term, the surgeon may be responsible for things such as salary payments that are to be made during the term.²² The termination provision should clearly define the circumstances under which the surgeon or practice may be terminated or terminate the contract early. There are two types of termination clauses: termination with cause and termination without cause.

Termination with cause typically includes, but is not limited to: loss of license to practice medicine, loss of or failure to obtain a required board certification, committing health care fraud or other criminal activity, suspension, or failure to qualify for enrollment in a federal health care program (for example, Medicare), loss of or failure to qualify for medical liability coverage, or failure to obtain hospital privileges.

Termination without cause needs to be closely reviewed. This clause should be specific and have a mechanism for appeal. In general,

it may require that two-thirds of the board validate the termination or provide an appeals process to a panel of physicians (presumably your peers) in order to settle the appeal. However, you need to be able to terminate for breach and this should be specifically laid out (in which case, a restrictive covenant/noncompete clause should not apply). Additionally, the surgeon may need to terminate without cause (it is likely that restrictive covenant would continue to apply).

Duties of the surgeon

The agreement should clearly state the duties of the position. These usually include, but may not be limited to: required licensure and certification, staffing requirements, call requirements, teaching, research, administrative and civic hospital duties, and required hospital privileges, where appropriate. Having the duties clearly stated will become important when compensation is determined. It is also important to note, this may be an addendum and will contain a clause that it can be changed from time to time, so read it carefully.

Duties of the practice

The agreement should clearly state the duties of the practice. These usually include, but may not be limited to: office space, equipment and supplies, utilities and support services, personnel, malpractice insurance, and delegation of duties to outside vendors. Having the duties clearly stated will become important when setting up the office environment. Expectations can be realized if they are delineated up front. Other items to consider in negotiation are as to who pays licensing fees and professional membership dues.

Outside activities

The American Medical Association (AMA) suggests that it is important to read any clauses governing outside activities, including those done on personal time. This could make a difference in who receives royalties from creative or scientific endeavors.²³ Certain nonpatient care fees that may be medically related and performed on your own time should be retained by the surgeon and also be outside the compensation calculation. Seminar honorariums and expert witness litigation fees are examples of this type of remuneration. Understanding your options and what can and cannot be done will be very important on the front end of any negotiation or contracting opportunity.

Additional consideration for academic employment

Academic surgeons may be expected to provide education, conduct research, and participate in scholarly activities as determined by the dean and department chair. Also, the surgeon is expected to practice clinical medicine.

Education and teaching stipends are determined by academic rank and specialty and are negotiable. Other revenue may be generated by private, intramural, or government grants. All inpatient and outpatient activities are charged accordingly.



GENERAL EMPLOYMENT CONTRACT PROVISIONS (cont.)

Covenants to not compete/restrictive covenant

Covenants to not compete (restrictive covenant) are agreements that prevent competition against the employer. The three main factors of restrictive covenants are: scope of activity, range of activity, and period of restrictions.

Scope of activity: Restriction on practicing your specialty or specific procedures. The ACS suggests that scope of activity should not include teaching, working for insurance companies, or working in a noncompeting company.

Range of activity: Prohibiting practice within a certain radius from a location. A covenant that is too restrictive could mean that the only way a physician can change jobs is to move away from the region. The ACS suggests that range of activity should not prevent you from relocating within the same area.²⁴

Period of restrictions: A set length of time in which you cannot compete.

Any restrictive covenant that interferes with the uninterrupted delivery of qualified surgical care to patients is considered unethical. Restrictive covenants should be specific with regard to:

1. The defined geographic area.
2. The duration of the restrictive covenant.
3. The presence of a restrictive covenant clause in subsequent contract renewals.

While the ACS recognizes the intent and the perceived necessity of restrictive covenants, surgeons are advised to review restrictive covenants contained in proposed contracts and to negotiate mutually agreeable terms. The ACS also recommends the review of all contracts with an attorney who is familiar with local laws and precedents prior to signing any contract.²⁵

Medical liability tail

At one time, the tail cost would be paid by the hospital. However, many hospitals are now shifting this cost, in full, to the surgeon. It is important to know what the medical liability tail provision is in your contract, as this can be a large expense. Contracts may state the following: "The tail will be paid by the surgeon if he resigns voluntarily, or is terminated with cause, but it will be paid by the hospital if the physician is terminated involuntarily and without cause."²⁶ This provision should clearly specify the allocation of medical liability tail in the event of any termination.





COMPENSATION AND BENEFITS

Salary, benefits, and bonuses are a key component of hospital recruitment and retention of physicians. The full benefit package should be well defined and include moving expenses, life insurance, retirement plan contributions, vision, dental, disability, vacation, paid time off, sick days, maternity and paternity leave, and continuing medical education benefits. Keep in mind that everything is negotiable.

Salary

As discussed above, federal and state regulations have a significant impact on compensation agreements. The Stark Law limits compensation and other financial arrangements between physicians and other provider entities. However, there are still opportunities for surgeons to negotiate a fair and reasonable compensation arrangement. There are several salary models, including: guaranteed salary, base salary plus productivity bonus, Relative Value Unit (RVU) plus productivity bonus, productivity, and incentives/bonuses.

A typical current incentive model is based on work RVUs (wRVUs). In this type of arrangement, it is important to understand “fair and reasonable” and how your hospital is defining these terms. Numerous surveys are available but each have nuanced differences and must be vetted in advance. Other compensation incentives can be based on percent of gross charges or percent of net collections. Note that these models will make physician compensation increasingly dependent on payer mix and effective billing systems.

GUARANTEED SALARY

In this model the salary is 100 percent guaranteed regardless of productivity. This model is being offered less, as hospitals view it as a disincentive to productivity.²⁷

BASE SALARY PLUS PRODUCTIVITY BONUS:

As part of this model there is a guaranteed base salary, and there is a productivity bonus. It is important

that the productivity bonus be based on objective, identifiable factors that are set in advance.²⁸

RVU PLUS PRODUCTIVITY BONUS

RVUs (and in particular wRVUs) reflect the relative level of time, skill, training, and intensity required of a physician to provide a given service. “RVUs, therefore, are a good method for calculating the volume of work or effort expended by a physician in treating patients. A well patient visit, for example, would be assigned a lower RVU than an invasive surgical procedure.”²⁹ In connection with the RVUs there are typically productivity and quality measures used to determine the overall compensation and productivity.³⁰

Because of the use of RVUs in employed physician compensation, it is important that surgeons working in employment arrangements continue to be experts in coding. This will help to ensure the accuracy of RVU allocations. Many surgeons working in employment situations are under the misperception that coding becomes the sole responsibility of the employer. While employers might offer staff assistance in coding, it is important to know that no person is better situated than the surgeon to know what service was performed, and therefore, which codes should be submitted. It is imperative that employed surgeons continue educational efforts at accurate coding and to follow physician coding updates.

PRODUCTIVITY

This model bases compensation solely on physician productivity and there is no base salary. It is essential

that the terms of the productivity calculation be based on objective and identifiable factors.

INCENTIVES/BONUSES

Incentive-based bonus compensation may also be a component, typically based on productivity. If productivity is the driving factor for bonus compensation, productivity should be well defined. Incentives can also be set up for each added component. For example, teaching could have metrics for a certain number of lectures or grand rounds. Research and academic institutions may incentivize publications and presentations. An incentive may be set around administrative duties geared toward promoting committee involvement.

Benefits

The typical package of benefits may include health insurance, malpractice insurance, dues, licenses, journals, and Continuing Medical Education (CME) costs. In addition, the benefit package should include vacation and continuing medical education time off. Typically, there is also allotted sick time.³¹

However, benefits are always negotiable. Surgeons should negotiate dollars for coverage of CME, professional society memberships and annual meetings, maintenance of certification, and ongoing participation in local, regional, and national organizations. These additional benefits will be critical to enhancing quality and the institution or practice should support these endeavors or at minimum provide protected time (not vacation) for such meetings.



CONCLUSION

Much has been learned about physician employment during the past 20 years, including the fact that physician employment generally increases in response to economic and other market forces.³² The ACS expects that as reimbursement rates continue to stay stagnant, as alternative payment models geared toward care coordination networks are implemented, and as overhead costs continue to rise, the number of hospitals seeking to employ surgeons and the surgeons seeking hospital employment will continue to increase.

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

1. Everything is negotiable, including salary, benefits, bonuses, staff, facilities, resources, and new physician hires.
2. Ask an attorney who is familiar with employment contracts to review the contract (which should be provided initially in a modifiable format).
3. Include all written and verbal agreements in the contract.
4. Know your worth to the hospital. Know what you bring to the table. Know why they need you.

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

The ACS will continue developing resources for Fellows to address the needs in each of these areas.



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