

Developing a compensation plan

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The mean salary for an ob-gyn in the United States, according to the Bureau of Labor Statistics, is \$239,120 annually.¹ The question is; if every physician were paid this amount as a flat salary, would access be equal across the board? Would quality? Would there be resentment among those who feel they are generating more revenue for their group or health care system or performing better than their peers making the same salary? Distributing revenue to physicians to drive productivity and thus patient access and better health outcomes is the foundation of physician compensation plans.

Physician compensation plans have certainly evolved over the years, especially as more physicians pursue employment arrangements. However, 2 foundations have not changed. First, compensation plans must be created to provide successful physician recruitment, engagement, and retention, while supporting the sustainability of the practice or health system and its mission. Second, the make-up of the compensation plan should address the following:

- Salary guarantee

- Productivity
- Value-based component
- Teaching and administration, and call stipend if appropriate

Although much attention is placed on the development of a compensation plan, the plan is best thought of as a live document designed to be modified based upon market changes and challenges. For example, a plan that emphasizes productivity may have worked well in a fee-for-service world but would not be sustainable in a highly capitated environment where care management may be more valuable to the health care system or practice than unbridled clinical activity.

Knowing the relative value and risk of each component is critical. Best practices will increase the likelihood of the compensation plan achieving its intended goals for both the physician and the organization. In a highly functioning organization, those goals should be aligned.

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An article written for the Healthcare Financial Management Association (HFMA) describes a process aimed at large medical groups but which that can also be applied to smaller groups trying to apportion revenue.²

1. Start with the basics

Benchmarks, although a very sound recommendation, must be evaluated with caution. They are often developed with unvalidated data. Salary requirements are often set by region; however, those that are necessary for a particular service to be provided may differ based upon urban or rural environments. Sometimes, these environments are in the same region. Benchmark salaries may also be in a range that is inconsistent with the group practice's viability. Benchmarks can also differ from specialty to specialty within a group, which could lead to intragroup conflicts.

2. Convene providers

In a small group it would not be unreasonable for all members to discuss the elements of the compensation plan. Elements that will be reviewed mainly revolve around the "value" portion of a compensation plan, such as quality metrics and citizenship. In a large multispecialty group practice, a balance must be weighed between sufficient representation and a group too large to effectively develop a plan. As an ob-gyn, you need to ensure your specialty is represented; this is because of the complex nature of the field, which encompasses primary, specialty, imaging, and surgical services.

3. Create guidelines and guardrails

Five principles can be adapted to any compensation development plan:

- BE FAIR AND TRANSPARENT
- USE UP-TO-DATE NATIONAL BENCHMARKS
- USE MARKET-BASED BENCHMARKS
- FOCUS ON VALUE-BASED CARE
- ENSURE THE PLAN IS FINANCIALLY SUSTAINABLE

4. Preserve the core

This step addresses the reality that 1 plan will not fit all. It is important to keep the elements of the plan defined (ie, productivity, value components) and define how each element will be apportioned in any plan. This will reduce the risk of individuals potentially defining new values above of the compensation plan.

5. Human resources and leadership communications partnerships

Nonsalary rewards must be considered when developing compensation plans. This is the case when different disciplines have different expectations such as paid time off, continuing medical education allowance, and so on. Clinicians must also appreciate the effect of their benefit package on their total compensation.

6. Implementation

This is where many details need to be addressed. If this is a new compensation plan, it must be clearly spelled out and shared with clinicians. There must be a regular flow of information concerning the clinician's performance on both productivity and value metrics.

It is a mistake to underestimate the sensitivity of clinicians to a new or revised compensation plan, and in this instance, no amount of communication could really be considered excessive.

What your compensation plan may look like

There are a limited number of ways in which to measure a physician's value and a limited number of revenue sources to make up physician compensation. Revenue sources come from payers in the form of fee-for-service payments: payment for each encounter, capitation payments or payment for the care of a population, and value payments or pay for performance premiums. Some practices may also receive stipends for providing teaching and

Once the totality of the revenue pool is understood, your practice or system will develop a plan using a defined portion of guarantee, productivity, value and stipends for teaching, administrative service, or call. Ideally, physicians will be involved in the process. An overview of the plan may be as follows²:

1 Total guaranteed salary

This is the simplest of approaches, but it requires a culture that attracts and retains highly motivated clinicians. Some clinicians may find this approach attractive, but unless there are guardrails to quickly move underperforming providers out of a practice, resentment can build and high performers may move on.

2 Total productivity

In general, productivity is measured in relative value units (RVUs), by means of which a clinician is paid a predetermined amount for each unit of clinical work they produce. The advantage of this approach is that physicians tend to be very productive and can remain payer blind when providing treatment. This model can lead to performing low-value procedures or overcoding to increase RVU production. In addition, without a value or administrative component, physicians may shy away from performing non-RVU-based activities such as quality and peer review as they do not see any personal value in their performance. Because the physician is paid for all clinical activities, they may be less sensitive to the cost of provision of care and how it affects the organization.

3 Revenue minus expenses

Physicians may be comfortable with this scheme if they have practiced in a private practice environment. It aligns them with optimizing practice operations. Physicians may seek out means of producing higher revenue, avoiding patients with a poor payer mix. Alignment with office operations, seemingly a benefit, can turn into micromanagement, with physicians interfering with those individuals who are responsible for equitable and effective office operations.

4 Base salary plus incentives

This is the most common type of compensation plan that in a perfect world will promote productivity, and thus access, while preserving alignment with other revenue sources. Ostensibly the most effective of compensation models, this plan is also the most complex, with different clinicians gaining or losing based upon the weighted percentage of each component—base salary and each portion of the plan's incentive component. High RVU producers will favor a high percentage of the incentive being based upon productivity, whereas active teachers and skilled administrators will place a higher value on citizenship and nonclinical work. The proportions can be altered depending upon practice needs, but defining and measuring nonproductivity-based elements is a much more complex task. Physician participation and buy in is likely most critical in this model.

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administration services and call pay. The key is to have not only an accurate accounting of historical values for these sources but a sense of where they may be going. This requires knowing the market (is your environment moving from fee for service to capitation and if so how quickly?) and understanding the local environment (is your health care system reevaluating teaching and administrative roles and stipends?).

Conclusion

Reliable compensation plans are imperative as health care becomes

more complex. Nobody can argue that physician engagement and performance not only drives improved health outcomes but also leads to a healthier health care system. As physicians seek employed models over private practice, participating in the creation and modification of compensation plans will drive engagement and satisfaction leading to group stability and long-term viability. Understanding your organization's compensation plan can help you optimize personal revenue. In an upcoming issue we will explore the evaluation of employment opportunities, and your understanding

of compensation models is key. ■

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The role of progesterone in miscarriage CONTINUED FROM PAGE 22

exposure to progesterone increased the risk of birth defects.²³ In an overview of birth defects reported between 1977 and 2005, 28 cases of a potential link between dydrogesterone use and congenital birth defects were reported.²⁴ The type of defects showed no specific pattern, suggesting that an association between dydrogesterone use and birth defects is unlikely. More importantly, an estimated 10 million pregnant women received dydrogesterone during this period, also supporting the safety of dydrogesterone in pregnancy. Clinical studies of progesterone use during pregnancy, both oral and vaginal, support

its tolerability and relatively minimal adverse effects.

Conclusion

Current evidence regarding the role of progesterone in early pregnancy is inconclusive. It is likely that progesterone has no role in the treatment of threatened miscarriage in women without a history of previous miscarriages. It is plausible that in cases of unexplained RPL, especially among those who present with vaginal bleeding and a history of multiple pregnancy losses, progesterone may be of benefit. Considering the apparent safety profile,

it is not surprising that many experts still recommend and administer such a treatment. Unfortunately, the evidence remains unclear, and many questions, such as the most appropriate indication, preferred dose, duration, route of administration, number needed to treat, and cost effectiveness, need further study. ■

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