

Aligning Physician/Provider Compensation Incentives for Not-for-Profit Integrated Health Systems: Art, Science, or Both?

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The fully integrated model of health system design (integrated health system or IHS) creates a potential to gain greater control over operating economics and strategy versus the more conventional community health services delivery designs.¹ In an integrated model, physicians and other licensed providers serve as a principal point of financial and economic performance.² The production of a provider's unit of clinical effort (often described as a work relative value unit or WRVU) creates a relatively predictable production chain of services utilization and resource consumption events within the IHS operating model.

If clinicians are focused on professional services unit production only, the resulting assumption is that all else (operating economics and financial performance) takes care of itself. This assumption should be questioned.

Based upon a number of internal operating dynamics and factors, the production chain model can create positive or negative operating economic effects (and related financial results) depending upon how clinicians direct their work schedules and related professional work efforts. In a simple example, two cardiologists each producing 8,000 WRVUs can create very different production chains and operating economic profiles within an IHS, based upon a range of dynamics and factors, including departmental plans, clinical subspecialty qualifications, professional interests, and incentives that derive from active internal compensation models. Provider

compensation incentives can work at cross-purposes with IHS organizational missions and strategies.

It is these dynamics that call the question of *how can and should physician compensation plan designs align incentives between physicians and the operating economics and financial performance of an IHS?* This special section examines this question from several perspectives that are intended to provide a comprehensive view of the challenges and opportunities for integrated community health systems and academic health centers.

The Question Better Defined

The production chain in a fully integrated model encompasses operating revenue and expense production profiles across a spectrum of clinical services, typically referred to as "clinical service lines." For each "average" WRVU produced by a clinician within a clinical service line, there are service demand effects created for multiple diagnostics, therapeutic, and referral services within the IHS (see **Exhibit 1** on the next page). The aggregate of these production chains can be managed to varying levels of internal and external value for the IHS.

We will examine the pros and cons of varying types and levels of incentive alignment methods operating between clinician compensation plan incentives and IHS operating economics and financial performance. The overarching question relates to the methods by which a compensation design links clinicians' behaviors to the totality of the operating, financial, strategy, and mission performance of an IHS.

For example, many productivity-based compensation plans incorporate the WRVU as the operating definition of a clinician's unit of work effort. The most simple of these designs creates an internal value for a WRVU produced (e.g., \$60 per WRVU produced by a cardiologist). Annual cash compensation paid to a cardiologist producing 8,000 WRVU is calculated by multiplying 8,000 x \$60, producing total annual cash compensation of \$480,000 (not including the accrued value of all allocated cash and non-cash benefits provided).

Key Board Takeaways

To achieve success in aligning incentives with performance in an integrated health system (IHS), physician compensation design must link clinicians' behaviors to the totality of the operating, financial, strategy, and mission performance of an IHS. The proper role of the board is to ensure that physician/provider compensation models are designed and managed to best advance the mission, goals, and objectives of the IHS.

The conversation begins with a fundamental question posed by the board: "Does our compensation plan effectively align the incentives of integrated clinicians with the goals and needs of the health system today and into the future?"

As cited above, cardiologists producing the same number of WRVUs annually can produce differing total productivity profiles for the IHS. Many compensation designs are indifferent to "downstream clinical services activities," under the theory that all WRVUs are equal. So, if clinicians are focused on professional services unit production only, the resulting assumption is that all else (operating economics and financial performance) takes care of itself. This assumption should be questioned by leaders and managers.

Connecting Cash Compensation Incentives with the Realities of Clinical Service Line Operations and Performance Incentives

IHSs exist as a portfolio of clinical service lines.³ Each plays an important role in the composition of the totality of the clinical programming and services plan. Each clinical service line is affected variously by:

- Payer mix and IHS contracting strategies
- Operating expense structures and trends
- Capital asset requirements and related and ongoing costs of capital
- Effects (and related costs of) clinical innovations

1 D.K. Zismer, "Connecting Operations, Operating Economics, and Finance for Integrated Health Systems," *Journal of Healthcare Management*, Vol. 58, No. 5, September/October 2013; pp. 314-319.

2 D.K. Zismer and F.B. Cerra, *High-Functioning, Integrated Health Systems: Governing a "Learning Organization"* (white paper), The Governance Institute, Summer 2012.

3 D.K. Zismer, "Physician Compensation in a World of Health System Consolidation and Integration," *Journal of Healthcare Management*, Vol. 58, No. 2, March/April 2013; pp. 87-91.

Exhibit 1: Considerations When Linking Cash Compensation with Clinician Behavior Potential

Opportunities for Linkage	Compensation Design Considerations
1. Gross charges (professional and related): paying based upon the IHS professional services price list or prevailing, ratable contractual adjustments.	<ul style="list-style-type: none"> • Providers somewhat insulated from varying contractual adjustment rates • Compensation affected by IHS pricing strategies • Price for same service can vary by geographic region within the IHS • Incentive to “up-charge” professional service • Services can be “bundled” per visit to create greater compensation returns
2. Work relative value units: WRVUs are “priced” and paid to providers based upon internal formulae that vary by clinical specialty or base salary may exist requiring minimum WRVU production requirement.	<ul style="list-style-type: none"> • Provider insulated from contractual adjustments • WRVU value subject to external market tests and internal equity considerations (value across clinical specialties) within the IHS
3. Payer mix: effects of system contracting strategies by clinical service line and trends over time (e.g., ongoing conversions to Medicare rates from commercial rates).	<ul style="list-style-type: none"> • Payer mix is a principal contributor to operating economics of the IHS (i.e., the effects of contractual adjustments gross charges) • Linking payer mix to provider compensation is an internal decision and not a “market effect” for IHS • Compensation question is the IHS’s philosophy on exposing clinicians to payer mix effects
4. Patient account collections (and copays): the net effects of the IHS’s abilities to efficiently and effectively convert accounts receivable to cash on patient accounts including deductibles and copays.	<ul style="list-style-type: none"> • Clinician doesn’t control the related policies, system, or processes of collecting accounts • Clinician behaviors can affect patients’ willingness to pay bills • Clinician typically doesn’t control his/her patient payer mix in the practice (an IHS philosophy) • Clinician doesn’t control service pricing or insurers’ reimbursement policies and practices and IHS contracting strategies
5. Practice-related direct costs: directs costs of operating the clinician practice including service/program staffing.	<ul style="list-style-type: none"> • Operating expense structures are variously controllable by clinicians • Clinicians’ practice styles can affect “input costs” and cost patterns • Management (not clinicians) typically control operating expense budgets
6. Total costs of care (TCOC): the aggregate, longitudinal costs associated with caring for patients with specific constellations of medical conditions requiring complex treatment processes over time.	<ul style="list-style-type: none"> • Attributing TCOC to specific clinicians requires sophisticated internal information management capabilities and subjective judgments by clinician leaders • Payers/insurers will see TCOC as increasingly important in health system contracting strategies • Clinician practice style affects TCOC • Compensation designs can affect TCOC
7. Productivity of affiliated clinicians (e.g., Advance Practice Professionals or APPs): licensed clinicians assigned to interprofessional team care for primary care and clinical specialties.	<ul style="list-style-type: none"> • APPs can be used variously within the team model • Clinical model design affects the practice styles of physicians and APPs • Compensation designs are known to affect the clinical model and their applications • A key question in compensation design is how can physicians advantage his/her compensation based upon use of APPs?
8. Patient satisfaction: as measured by survey with goals established by IHS leadership.	<ul style="list-style-type: none"> • Leadership must establish whether patient satisfaction results are expected as standard of professional practice or provides an opportunity for cash enhanced compensation • If target attainment warrants additional cash compensation, at what level?
9. Clinical outcomes/indicators: clinical indicators selected by clinical departments.	<ul style="list-style-type: none"> • Do indicators tie to organizational objectives (e.g., indicators important to payers)? • Effects on clinician patient selection (e.g., selection of patients where success is more likely)
10. Departmental financial/operations performance: cash compensation bonus potential for clinical groups/teams/depts. Attaining defined operating and financial objectives.	<ul style="list-style-type: none"> • Ensuring bonuses paid to individuals who also attained personal objectives to “qualify” for cash bonuses (e.g., productivity and quality metrics) • Interdependence of clinical depts. is considered (i.e., depts. do not sub-optimize others to their advantage) • Potential for interdepartmental relationships and morale; effects on IHS culture
11. IHS financial/operations performance: cash compensation bonus opportunities for entire clinician enterprise.	<ul style="list-style-type: none"> • Affordability of aggregate bonus to clinicians by IHS • Legal/regulatory clearance • Inclusion of clinical dept. leadership in bonus distribution decision (i.e., distribution to individual clinicians in the depts.)
12. Patient “network use” management.	<ul style="list-style-type: none"> • Direct/indirect tie linkage to “in-network” use • Degree to which clinicians use the IHS for referrals (referral retention) • Assurance of quality of care with “in-network use” • Ability of IHS to deliver appropriate access
13. Non-revenue producing requirements: strategic (such as outreach) and clinical services and organizational leadership and management.	<ul style="list-style-type: none"> • Requirements for clinicians to substitute clinical time for strategy and leadership responsibilities • Value quantification of non-revenue producing efforts • Management oversight of these activities
14. Accountability for interprofessional teams.	<ul style="list-style-type: none"> • Clinicians roles in managing teams (including effects on leaders’ personal productivity) • Distribution and management of clinical work load • Appropriateness of level of licensure, training, and experience applied to patients in care panel

- Market effects on factors such as clinician compensation ranges and rates
- Program sizing and subspecialization strategies
- Effects of competitors' strategies and tactics

For example, the factors that affect the performance of IHS orthopedics, within a given period of time, will likely differ from those that affect the performance of cardiovascular services or general pediatrics. **Exhibit 2** provides a simplified demonstration of how three clinical service lines produce very different operating economics and, ultimately, financial performance for an IHS.

A number of management-related decisions affect operating economics and financial performance of clinical service lines within IHSs, including the following factors:

- Size, scope, and subspecialization of clinical programming
- Strategy design (e.g., geographic outreach strategies)
- Emphasis of ambulatory or inpatient services
- Presence or absence of clinical research, teaching, and mentoring of medical students and post-graduate residents and fellows
- Special mission obligations (e.g., those of safety net hospitals)
- Prevailing economic effects of governmental payer programs (e.g., Medicare and Medicaid)
- Organizational costs of capital (e.g., costs related to external credit performance ratings)
- Effects of competition on operating costs, especially human capital

So, for an IHS to effectively manage the totality of its financial goals, it must effectively balance the operating economics of all clinical programs in relation to its own potential against that of all other individual programs and their economic, financial, and strategic contributions to the whole.

Now let's crosswalk this concept to compensation design, looking specifically at the cardiovascular services example in **Exhibit 3**.

Three initial observations regarding operating examples and financial performance of the principal component parts of the cardiovascular service line are obvious: 1) professional services (i.e., blended reimbursements for physician services) produce an operations professional loss

Exhibit 2: Operating Economics Produced per WRVU for Three Clinical Service Lines within an IHS

Specialty	Physician FTE in IHS	Net Revenue per Average WRVU	Direct Expense per Average WRVU	Contribution Margin per Average WRVU	Net Margin per Average WRVU
Primary Care	56.3	\$308	\$232	\$77	\$(3)
Cardiology	18.6	\$647	\$440	\$207	\$73
Orthopedics	16	\$553	\$352	\$201	\$61

Notes:

1. All results reported per WRVU produced for an IHS service line assuming all provider WRVU production at the median of national standards. Results presented assume all accounted revenues and expenses for the designated service line (all inpatient, outpatient, and professional services).
2. "Net Revenue" is defined as "operating net revenue" (i.e., gross charges minus contractual adjustments).
3. "Direct Expense" is defined as all direct care-related expenses accounted across the designated service line.
4. "Contribution Margin" is defined as all net operating revenue for the clinical service line minus all related and accounted direct operating expense for the service line.
5. "Net Margin" is defined as contribution margin for the service line minus all accounted indirect expenses allocated to the service line.
6. All per-WRVU financial values are rounded to the nearest dollar.

Exhibit 3: Operating Economics for Cardiology Service Lines within an IHS: A "per-WRVU" Analysis

	Net Operating Revenue	Direct Operating Expense	Indirect Expense	Net Operating Margin
Professional Fees*	\$103	\$154	\$39	(\$90)
Outpatient Services*	\$244	\$120	\$38	\$87
Inpatient Services*	\$272	\$166	\$57	\$49
Totals	\$619	\$440	\$134	\$45

*Per average WRVU.

Payer Mix Assumptions

(If all WRVU clinical activity was dedicated to a single payer class)

	All Medicare	All Medicaid	All Commercial
Total Operating Revenue per WRVU	\$461	\$390	\$1,099

Notes:

1. All assumptions are based upon a simulated IHS with a blended payer mix and all providers operating at median productivity. All cardiology subspecialties are blended to create a mean per-cardiologist performance for an integrated cardiology service line within an IHS, providing a full range of cardiovascular clinical services (professional fees, outpatient services, and inpatient services).
2. Revenues, expenses, and margins are accounted based upon industry standards for clinical service lines within IHSs.
3. Payer mix assumptions (per category) were taken from the blended-rate case example.
4. Blended average ratio of cardiologist subspecialty FTEs within the sample practice were constructed from IHS examples used to build a simulated service line.

"per unit of effort produced"; 2) contribution margin and net operating margin for inpatient and outpatient services varies with outpatient services providing greater net operating margin potential; and 3) payer mix affects financial performance to a substantial extent.

So, compensation plan designs for cardiologists must encompass and fairly consider a range of operating economics, financial characteristics, and related incentives. Three models for IHS compensation design are described below.

Model #1

All senior-level cardiologists are paid a salary at the same level, with an equal bonus opportunity payable as a percentage of total salary. Bonuses are based upon performance of the integrated cardiology service line. Junior-level physicians are paid a flat salary per year with increases available per year on a five-year progression to attained senior-level status.

With model #1, there is an active philosophy of team care and shared responsibility for departmental performance. Financial incentives are driven largely by market compensation rates, as well as the performance of the cardiovascular service line overall. Given the subspecialty nature of the composite clinical subspecialty services profile, it is assumed that a comprehensive, subspecialized array and scope of clinical services and programming is provided. Physicians are affected by incentives that favor the performance of the whole, with recognition of requirements for individualized performance expectations.

Model #2

The cardiology department is compensated, in the aggregate, based upon number of total WRVUs produced, multiplied by an IHS-determined internal value that meets applicable fair market tests.⁴ Physicians in the department, at their election, choose to share the aggregate cash compensation pool on an equal share basis for all cardiologists with a minimum of four years experience with the group (for employment in the first three years, cardiologists are paid a salary with individual productivity targets available). If departmental financial and operating targets are met, the value of all WRVUs produced can be increased by 10 percent. All quality-of-care targets must be met to qualify for the bonus opportunity.

With model #2, the cardiologists have an incentive for clinical unit productivity, collaboration toward shared goals, accountability for quality and patient satisfaction, and the mentoring and management of new physicians in the group. Incentives

⁴ The IRS prohibits 501(c)(3) tax-exempt entities from operating other than for charitable purposes, and prohibits compensation payments to employed physicians in excess of fair market value. Fair market value (FMV) is generally defined as value paid according to an “arm’s length” transaction (agreement); one that is consistent with demonstrated and documented market value paid under similar conditions and circumstances.

Exhibit 4: The Aggregate Operating Economics and Financial Performance for 22 Clinical Specialties Caring for a Hypothetical Population of 100,000 from an IHS Structure

Description (IHS Simulation):
N=22 clinical specialties, producing 1.39 million WRVUs,
from 209 physician FTEs caring for a defined population of 100,000

Net Operating Revenue	\$682,267,493
Direct Operating Expense	\$468,468,030
Contribution Margin	\$213,799,455
Indirect Expenses	\$182,921,860
Net Operation Margin	\$30,877,595 (4.5%)
Net Revenue PMPM	\$568.56

Notes:

1. A fully formed and functioning IHS delivering primary, secondary, and tertiary care is likely to offer more than 22 physician specialties; this example is not intended to cover the full complement.
2. The simulation assumes all physicians operate at median productivity levels that are not likely to be accurate and reliable in practice, over time.
3. The simulation assumes the 100,000 population identified receives all care from the IHS for the clinical services identified.
4. The simulation assumes a payer mix typical of a large metropolitan area served.
5. The simulation identifies net operating revenues as gross charges minus contractual adjustments.

also exist for innovation in interprofessional team care and economic “leverage” of the clinical care models applied.

Model #3

Physicians are compensated on an individual productivity model with a common value per unit of effort produced (e.g., common value paid per WRVU produced).

Under this model, there is no theoretical cap on individual physician earning potential. Physicians are not exposed to payer mix contractual adjustment differences or operating expense structures of the service line. Physicians are either advantaged or disadvantaged by the earning potential of their own clinical subspecialty (e.g., interventional cardiologists have greater earning potential over general non-procedural cardiologists operating under this model, and physicians are free to develop self-stylized practice models to best advantage their individual cash earnings targets).

Based upon the three compensation model designs presented, it is clear that each can have different effects on operating economics and financial performance of the clinical department. Thus, compensation plan designs matter in the operating economic and financial performance of “the whole”—each clinical department and the IHS overall.

Returning to the Production and Value Chain Paradigm

As stated, for virtually every WRVU produced by a practicing clinician in an IHS, other units of clinical activity are produced, which bear upon operating revenues and expense performance of the IHS (see **Exhibit 4**).

These economic productivity profiles are affected by:

- Clinical specialty or subspecialty
- Clinical program assignments (e.g., a cardiologist assigned to a heart failure management program versus an alternative programmatic assignment)
- Provider experience, training, and professional interests
- Existence (or absence) of clinical pathways and protocols as promulgated by the IHS
- Clinical profiles of individual patients treated
- Management/leadership model of the departmental home of the clinician, including operating philosophy and culture of that clinical home (e.g., clinicians are free to self-stylize personal practice patterns, or the “collective we” operates as an integrated team)
- The IHS’s approach to management and financial data transparency—especially reporting on how practice styles and patterns vary across peers, affecting the operating economics and financial performance of the IHS

Based upon these factors, the total production and value chain of an individual clinician can vary significantly as compared with others practicing within the same specialty. Many times there are good reasons for observed variances, meaning the variances are expected and consistent with organizational or clinical service line strategy and best-practice care models (including expected contributions of individual clinicians to clinical models). However, variances may not always be productive for the IHS—provider compensation incentives can work at cross-purposes with IHS organizational missions and strategies.

What Should Be Included in a Compensation Design?

In theory, there are a great number of opportunities, models, and methods to align operating economic, financial, and clinical care outcomes incentives between clinicians and the IHS:

- WRVU production targets and value paid per unit produced
- Utilization of IHS clinical resources and services (e.g., referrals to other providers, diagnostic services, hospital days, outpatient therapeutics)
- Total costs of care⁵
- Clinical outcomes produced
- Applications of accepted clinical pathways and patient-centered care protocols
- Patient satisfaction
- Clinical department performance (measured variously)
- Behaviors of practicing clinicians
- Performance of the IHS overall (measured variously)

Exhibit 5: Compensation Plans for Health Systems with/without Academic Health Services

Integrated Community Health Systems:	Without Academic Health Services	With Academic Health Services
Clinical care productivity-related requirements exist at the individual provider levels	√	√
Need for collaboration among providers across system services components	√	√
Need to recruit and retain top talent	√	√
Need to ensure compensation plans are assessed as fair and equitable among providers based upon work and outcomes required	√	√
Non-cash benefits are fair and equitable (including the value of tenure for academic faculty)	√	√
Management of total costs of care based upon terms of third-party payer agreements	√	√
Defined roles, responsibilities, and accountabilities of clinical department/division leaders, including related compensation incentives	√	√

The related questions of principal importance are:

1. What factors are productive and counterproductive to align?
2. How many factors are manageable within a compensation plan design?
3. Which factors should have financial incentives attached (vs. non-financial performance evaluation opportunities evaluated by an assigned clinical leader)?
4. How should factors affecting cash compensation (incentives) be valued and applied to clinician compensation?

Philosophies on where and how to link and align cash compensation incentives vary within IHSs. Philosophy drives design and design influences clinician behaviors. Clinicians will frequently report, “We work our pay plans.” The big question is whether “working the pay plan” sufficiently and

productively aligns the goals and objectives of clinicians with those required for the performance success of the organization?

Compensation design philosophy also drives considerations regarding the mechanics of how cash compensation is managed. As with almost any array of incentives that affect human behaviors at work, there is the potential for unintended consequences (good and bad). **Exhibit 5** provides an array of such design considerations gathered from “the field.” A summary of experience with each is provided.

The big question is whether “working the pay plan” sufficiently and productively aligns the goals and objectives of clinicians with those required for the performance success of the organization?



⁵ Here, total costs of care is defined as total costs consumed by individuals who are identified as having a profile of clinical conditions affected by one or several related and intervening factors over a specified period of time.

Exhibit 6: Continuum of Compensation Design Philosophies

Philosophy A

The best design simulates how the incentives of “private practice” affect clinician compensation, including all inherent risks and rewards; a simulation of the “real world” (i.e., physicians being fully exposed to the vagaries of changing marketplace).

Variations on Themes

Philosophy B

Clinicians are employees as are all others; they should be fully insulated from the vagaries of healthcare market dynamics and changing economic policies and regulations, and all dynamics they can't directly control. Physicians should not be exposed to that which they can't control.

Simplified, compensation design philosophies exist on a continuum. The range of philosophies can be described as one from the simplistic to the complex (see **Exhibit 6**).

As is the case with most management decisions, adherence to extreme positions on any operating philosophy or management theory can be counterproductive. The best answers often lie somewhere in between. But, getting the organizational philosophy clear is important because all else follows: incentives design, managerial mechanics, organizational behaviors, and performance results.

Culture and Leading Professionals

When forming cash compensation design philosophy, there is a need to determine whether clinician behaviors are principally managed by cash incentives or the culture, influence, and direction of leaders, colleagues, and peers. IHSs, especially those in early stages of development, often search for the “magic” formula that doesn't require influencing the behaviors of physicians. As IHSs mature, most come to realize that mechanical formulae don't lead or manage people—leaders and managers do. So, the “big deal” in compensation philosophy is creating a design that strikes a healthy balance between the mechanics of a formula and behavioral management requirements derived from effective leadership.

One test of the potential for striking such a successful balance is to look at the

job descriptions of clinician leaders. These must include the presence of clear responsibilities for the behaviors of clinicians working within clinics or clinical programs where the cash compensation designs and incentives apply. These position descriptions should clearly describe how leaders interact with clinicians to evaluate, coach, and influence the professional behaviors of clinicians working in their areas of responsibility.

Position descriptions of leaders (especially identified clinician leaders) should provide clarity on how the responsibilities and accountabilities of the positions tie to the broader approach to the leadership and management of the IHS, including the relationship ties of the goals and objectives of individual clinical departments (or divisions) to the greater physician/provider enterprise within the IHS and, ultimately, to the performance and success of the IHS overall.

Job description language must be explicit regarding goals and the interdependence of

the clinical services, programs, and related obligations and accountabilities of the individual physician/provider working within the IHS. Such language also makes clear the responsibilities and accountabilities not provided for within the compensation design, including the implied covenants between the individual physicians/providers and the IHS.

The Role of IHS Governance in Compensation Plan Design

A strong argument can be made for an IHS governing body to stay out of the design and management of physician/provider compensation plans. However, a stronger argument can be made for proper involvement of IHS governance to the point of ensuring that physician/provider compensation models are designed and managed to best advance the mission, goals, and objectives of the IHS.

To this end, routine management reporting of IHS performance to the board should include both objective and subjective evaluations of the overall effectiveness of the physician/provider compensation plan set in the context of the IHS's mission, values, and goals.

How Does This Apply to Clinicians in Academic Health Centers?

The compensation design philosophy and models presented above are applicable to both community-based integrated health systems as well as academic health systems. The related question addressed here is: “Are the goals and objectives of academic health systems so different from those of community-based health systems that clinician compensation plan designs must, by design, be very different?” To answer that question, let's briefly explore how academic and community-based health systems are similar and different (see Exhibit 5) from each other to understand what factors might be necessary to best align providers with health system goals.



In general, the most successful academic health systems (AHSs) achieve alignment between the research, education, and clinical missions so there is synergy between and across all missions, as well as shared responsibility for the investments and performance of each. That interplay between the missions introduces additional factors that must be considered in establishing physician incentives, even for those solely related to clinical activity.

The incentives necessary to achieve the experience, cost, or outcomes in clinical care are arguably the same for all integrated health systems. Some believe the motives for physicians in AHSs may be more tilted towards research to the disadvantage of clinical care. In fact, there is much evidence the best medical schools, as ranked by Blue Ridge,⁶ are often aligned with the best hospitals. Indeed, the concordance between medical school stature and the best hospitals in the *U.S. News* rankings is notable. Mechanisms for motivating clinicians and providing the environment in which to excel in clinical care delivery are essential in AHSs. In fact, the need to generate margins in the AHS clinical enterprise is even more critical given the need to support underfunded research and medical education from the various clinical revenue streams. Linking clinical compensation incentives to broad system goals is as reasonable with an AHS as with a community health system.

What considerations must be evaluated for the differences inherent in the AHS? The need to generate margins, a constant in both academic and community systems, can be even greater in AHSs that must generate the financial support necessary for ongoing investments in research as well as underfunded education and research activities. This would suggest an even greater need for efficient use of all resources.

Recruitment and retention in AHSs also introduces additional considerations. For highly specialized physicians, whether the specialization is clinical care or research, the market may be national or international. Moreover, compensation profiles generated by local market dynamics bear upon compensation plans for AHSs. So a broad understanding of both the priorities of the highly skilled clinicians and the benefits to the health system must be attained.

While many of the potential metrics are similar to those of physicians in a community system, additional factors such as generating new clinical market share or new research funding may be incented.

While it is critical that the clinical goals and incentives for providers in an AHS are aligned and leveraged, consideration must also be given to aligning the performance of the research and education missions to achieve true differentiation for the AHS within a competitive market. For the sake of demonstration, at one extreme is a community health system with a university name on it—but without ownership or integration of the academic mission. At the other extreme is complete alignment between the clinical and academic missions—functionally and structurally, a fully integrated model. While many systems exist along this continuum, the greatest leverage of the academic mission—both to achieve business goals as well as to serve the community—is likely to occur with greater alignment and structural integration.

An Illustrative Case Example

Community Health System (CHS) is a large, community-based health system with regional reach and a multi-state and international referral draw for specific, complex clinical cases. The CHS model integrates employed, community service-focused physicians with an owned and controlled academic health center (AHC), which includes a medical school and broad research mission funded by a range of public and private research grants.

CHS competes in a “crowded” marketplace with worthy competitors. On the academic medicine “side of the house,” there are internal and external competitors for at least 90 percent of the clinical care and programing provided.

CHS operates under a unified governing board (with employed physicians and leaders from the community services medical enterprise and the AHC, including the dean of the affiliated medical school and the CEO of the AHC physician practice plan) and a singular, unified senior management team. The CHS board recognizes that it

should not be about the business of designing the compensation plan for clinical providers under the IHS’s corporate umbrella. However, it believes it is responsible for defining the principles of the “universal” physician/provider compensation plan (i.e., principles that span plan designs for physician/providers employed to provide community-based care and those who serve the mission of the AHC component of the IHS). The theory is:

“Principles of the compensation plan serve the mission, vision, values, and required strategies of the IHS and leadership must create operative designs that effectively harmonize the incentives of the healthcare delivery policies and processes with the required goals and objectives of the whole.”

As a consequence of the implied mandate, CHS governance promulgates the following set of principles to guide compensation design across the various (and varying) operational components and sites of the IHS. The operating incentives of all active compensation plans must:

1. Ensure that the health and healthcare needs of patients are foremost and are well served above all else.
2. Patients are served by known and accepted, evidence-based clinical best practices as vetted by the best, most reliable clinical research with internal peer review and acceptance by the



6 Blue Ridge Institute for Medical Research, NIH Funding to U.S. Medical Schools, 2006–2014.

organization's best-qualified clinical experts.

3. Total costs of care are well considered in the care planning and care plans for all patients.
4. The potential for the financial gain of individual clinical practitioners is never placed above the best interests of the health and well-being of patients and others served.
5. The patient services productivity of clinical services providers is designed consistent with the best interest of patients and where reasonable, the best interests of CHS, including interests that further the long-term viability of the organization.
6. The professional behaviors of practicing clinical professionals are overseen by an authorized peer(s) in a position of leadership authority who has as an assigned responsibility for the welfare of patients as well as the organization.
7. Senior leadership of the IHS believes that the active physician/provider compensation plan of the IHS can be successfully implemented to serve the guiding principles as defined.
8. The compensation of leaders and managers who operate the mission-guided services of the IHS is well aligned with the comprehensive mission and mission plan of the organization.
9. The research and teaching goals of the IHS are advanced and are sustainable.

These nine principles serve as examples of how an important connection is made between the responsibilities of governance of an IHS and the design and operations of a compensation design for an IHS, including those that span a strategy of community health services delivery and academic medicine.

What Might the Future Hold for IHS Clinician Compensation Plans?

If it is safe to assume that “pay plans” will continue to influence the behaviors of humans in the work setting for as long as humans are at work, then IHSs will likely be in a constant state of developing compensation plans for employed clinicians. As such, it's useful to look ahead in an attempt to identify the issues and dynamics that may define or at least influence

compensation designs for future IHSs, including potential market disruptors:

1. Technological advances, (e.g., hand-held health status monitors and related devices), telehealth, self-care, and virtual care.
2. Genomics and the opportunities to customize prescriptive care plans, including preventive care plans tailored to individualized health risk profiles.
3. Moving from fee-for-service to value-based payer reimbursement schemes. With these, IHSs assume financial risk for defined populations, by contract with third-party payers.⁷
4. The “Watson Effect”: computer-designed care plans; the eventual ability of supercomputers to map evidence-based, best-practice pathways to care planning and clinical pathway prescriptions.
5. Interprofessional team care models.⁸
6. Effective interaction and collaboration of clinicians and clinical programs within an IHS.
7. Health insurance plans that create incentives for “narrow network” clinical behaviors by clinicians and patients (i.e., incentives to retain care within a defined “system of care”).
8. Physicians' interests in the security of employment relationships; the attraction from independent practice to the planned and managed “system” of care delivery and health management employment opportunities.
9. A need to encourage the ongoing development of professionals within organizations; creating an environment that supports professional development along a career path; providing benefits of career development and a tangible, valued benefit of the IHS.

7 D.K. Zismer, “How Might a Reforming U.S. Healthcare Marketplace Threaten Balance Sheet Liquidity for Community Health Systems?,” *Journal of Healthcare Management*, Vol. 58, No. 3, May/June 2013 (pp. 168–172); and D.K. Zismer and C. Beith, “Free Cash Flow Productivity and Its Connections to U.S. Health System Financial Performance and Strategy in Current and Future Markets: A ‘Macro View’ of a Potentially Systemic Problem,” The Governance Institute, February 2014.

8 D.K. Zismer, “An Argument for the Integration of Healthcare Management with Public Health Practice,” *Journal of Healthcare Management*, Vol. 58, No. 4, July/August 2013; pp. 253–257.

Conclusion

As IHS design and function matures in the U.S., so should the compensation models for physicians and other clinical service providers who practice within them. IHSs will come to understand that the incentives set in motion by their compensation plans drive the behaviors of those operating under them. As such, the incentives at play affect the performance of the whole.

The ultimate goal in the design of provider compensation models is their ability to effectively serve temporal business plans while ensuring the longer-term reputations and sustainability of the organization; especially goals related to health services quality, value, customer service, and the ongoing pursuit of optimized best clinical practice and care.

Physician/provider compensation designs and plan management are fundamental to the ongoing mission and viability of any and every integrated health system. IHS leaders and boards must be mindful of how physician/provider compensation plan design and management affects the “greater whole” and the “greater good” of the organization. IHS boards are encouraged to test operating provider compensation plans against the sample principles offered above to begin the dialogue between the board and senior leadership.

The conversation begins with a fundamental question posed by the board: “Does our compensation plan effectively align the incentives of integrated clinicians with the goals and needs of the health system today and into the future?” ●

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