Rewarding Better Care at Lower Cost:

Re-Designing MD Compensation in the World of Accountable Care

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Our Discussion Today

• **The Rationale:** Our imperative for re-aligning incentives

• **The Models:** An overview of Dean’s primary care and specialty value-based incentive models

• **The Lessons Learned:** Changing physician compensation is like changing culture- it takes time, patience, and lots of communication

• **A Broader View:** Trends in the Group Practice environment and predictions for the future
The Rationale

Our Imperative for Re-aligning Incentives
Non-Alignment of Incentives was transformative at Dean

[Image of The Scream by Edvard Munch]

**FFS**

**Capitated**

**FFS**

**Capitated**
Dean’s Vision and Focus

• Our Vision: “We are passionate about keeping our patients healthy, exceptional at caring for them when they are sick, and efficient in providing them with the best value and service.”

• Our Focus: Let the rest of our industry focus on Volume. We’re focusing on Value.
  – Delivering Effective Care
  – Delivering Patient-Centered Care
  – Delivering Efficient Care
We quickly learned that we can’t pay for volume in a value based world
The Models

An overview of Dean’s Primary Care and Specialty Value-Based Incentive Models
So, we began the journey toward creating a variable comp plan

Dean MD Compensation Model Transformation 2009 to 2013

- Growth
- Efficiency
- Quality
- Service
- Salary
- Production

FFS/Volume Based | Value Based

2009 | 2010 | 2011 | 2012 | 2013
In our Medical Home, the urgency for re-alignment was even greater

Dean PCMH Compensation Model Transition

Option A
Option B
Future?

Efficiency
Quality
Service
Panel Size
RVUs - 5%
RVUs
Salary

In our Medical Home, the urgency for re-alignment was even greater
Dean Physician Incentive Model 2013

Access/Growth
- Unique Patients Metric (or)
- CG-CAHPS Access Measure Individual (or)
- CG-CAHPS Access Group

Patient Satisfaction
- CG-CAHPS Overall Rating of Doctor at the individual level (or)
- CG-CAHPS Overall Rating of Doctor at the department level (or)
- Service Improvement process metric

Supplemental Goals
- Superb Service Score
- Department Budget
- Staff Satisfaction with MDs
- Total Cost of Care

Quality
- Successful attainment of quality metric as identified by benchmarks or CAVE analysis

Cost
- Successful attainment of efficient metric as identified by benchmarks or CAVE analysis
The Lessons Learned

Changing physician compensation is like changing culture; it takes time, patience, and lots of communication.
Lessons Learned along the Way

• “It’s a team effort”
  • While it takes time, and its fraught with many headaches, we encouraged the Dean Board and a committee of physicians to lead the comp re-design process (rather than management). When all that your culture knows is “pay for volume”, it takes time and effort to design an effective solutions for a value-based world.

• “Comp Re-Design Doesn’t Solve Everything”
  • The flaw of most compensation model re-designs is that they try to do too much. Remember that vision, data, peer-pressure, values, compacts, or guilt can sometimes be an effective way to bring people along.

• “Create a Balanced Scorecard”
  • If you want to reward value, the incentive plan (or other persuasion techniques) need to have balanced measures to encourage service, quality, cost, growth and production.

• “Reward Corporate, Department and Individual Performance”
Lessons Learned along the Way (continued)

• “Measure First”
  • It is most ideal to measure and report first, and link to comp second.

• “Options made the transition palatable”
  • Given the fear and anxiety associated with comp change, we created a menu of options so that there were multiple chances to receive the incentive.

• “Incentive size made the transition palatable”
  • We initially set the incentive at very small percentages, e.g. 1-2% each.

• “Low thresholds made the transition palatable”
  • We initially made the goals as achievable as possible

• “We changed the metrics, decreased the options, increased the weights, and raised the thresholds over time”
  • Once comfort with the new model set in, physicians were comfortable with more modifications.
A Broader View
Trends in the Group Practice Environment and predictions for the future
The GPIN Experience October 2012:
“If you were to identify which quadrant your group falls in as of today, which would you pick?”

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<thead>
<tr>
<th>The Value Model:</th>
<th>The Charitable Model:</th>
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<tbody>
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<td>Group’s risk-based payments are $\geq 25%$ AND Physician’s incentives for value are at least 10% of total cash compensation or greater</td>
<td>Group’s risk-based payments are $&lt;25%$ AND Physician’s incentives for value are at least 10% of total cash compensation or greater</td>
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<th>The Funky Model:</th>
<th>The Volume Model:</th>
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1% 3% 5% 90+%
Will incentive re-design be restricted to ACOs, or will it go further?
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