Members of board compensation committees are finding themselves in the spotlight as hospital chief executive compensation comes under scrutiny. National and trade media, and federal and state lawmakers are criticizing compensation levels, calling for restraints on pay and arguing that trustee compensation committees are failing to set compensation based on objective performance.

Criticism of trustee compensation committees arose from a frequently cited 2013 Harvard University study that found that CEO compensation was significantly associated with hospital teaching status, facility size, technology and patient perception of care, but not associated with quality, financial performance or community value. The article questioned whether trustees are basing CEO compensation on meaningful measures of goal achievement, especially given the magnitude of public funding hospitals receive from Medicare and Medicaid. To assess the relationship between CEO performance and compensation, the Harvard researchers

The Right Rewards for CEOs

New research suggests CEOs are compensated based on organizationwide performance

By Jean Chenoweth, Kevin Talbot and David Foster
Data Sources and Research Methods

Truven Health 100 Top Hospitals study databases were used to assess hospital performance. The databases include:

- The Centers for Medicare & Medicaid Services MEDPAR data for federal fiscal years 2011 and 2012
- CMS Hospital Compare data from 2013 for 30-day mortality and readmission rates, Core Measures and HCAHPS
- Integrated hospital-level data on total CEO compensation for 2013

The initial analysis evaluated the association between total direct compensation and the overall hospital or health system performance on our national balanced scorecard. At each level, the relevant composite performance score was used:

- Hospital level – 100 Top Hospitals balanced scorecard composite score, including financial performance
- System level – 15 Top Health Systems balanced scorecard, excluding financial performance

Subsequent analyses evaluated associations between various specific measures used in the 100 Top Hospitals or 15 Top Health Systems balanced scorecards and total compensation. We examined the distribution of hospitals by class for both 100 Top Hospitals and integrated organizations to determine that there would be sufficient volume in each class, and all analyses were adjusted for standard 100 Top Hospitals class assignment, which provides stratification on bed-size category and teaching status.

Two separate models also were conducted: one on lower-performing organizations (in the lowest 50 percent of all hospitals/health systems) and the other on higher-performing organizations (highest 50 percent) to evaluate adjusted associations between compensation and performance over two levels of performance.
Survey, which includes data on 175 executive positions and 39 manager positions from more than 1,350 facilities, also revealed that incentive opportunity is generally greater at larger hospitals and systems. Among hospitals that use incentives, opportunity levels for CEOs can range from as little as 20–30 percent of base salary at smaller organizations to 80–100 percent at larger systems.

To determine if CEO compensation is associated with a composite score of the 100 Top Hospitals national balanced scorecard, Integrated and Truven Health conducted a preliminary test. Integrated contributed total direct compensation data from 487 hospitals and 89 health systems from its compensation survey. Truven Health matched the Integrated data with the corresponding 2014 100 Top Hospital and 15 Top Health System composite scores for overall organization performance on the national balanced scorecard as well as the individual metrics. Financial data were not available for health systems.

The preliminary results of this research demonstrate that hospital and system CEOs tend to be rewarded with higher compensation for better organizationwide performance. These results were highly significant statistically. Additionally, as performance levels increased on the balanced scorecard, compensation increased in consistent increments. For example, we found that compensation increased by an average of 1.46 percent for each unit increase in 100 Top Hospitals performance percentile, and performance at the system level was associated with an average increase in compensation by 1.14 percent per unit increase in 15 Top Health Systems performance percentile [see The Study’s National Representation, below].

Additionally, these preliminary findings suggest that CEO compensation is associated with high performance on certain individual metrics within the scorecard. The analysis of individual components of the 100 Top Hospitals scorecard showed that better performance on profit from operations and expense per adjusted inpatient discharge were significantly associated with higher compensation [see Hospital and System CEO Compensation, above].

Finally, the research showed that higher-performing and lower-performing organizations compensate CEOs for better performance in similar ways. For the lowest 50 percent of hospitals, there was an increase in compensation by 2.24 percent per unit increase in scorecard perfor-
The Compensation-Performance Link: Testing the Hypothesis

The hypothesis for the CEO compensation research was that CEO total direct compensation is correlated with the 100 Top Hospitals balanced scorecard composite score. The composite score represents the performance of the hospital on all nine equally weighted measures used in the balanced scorecard. They are: (1) risk-adjusted mortality, (2) risk-adjusted complications, (3) Agency for Healthcare Research and Quality patient safety measures, (4) Centers for Medicare & Medicaid Services 30-day measures, (5) CMS Core Measures, (6) severity-adjusted lengths of stay, (7) expense per adjusted discharge, (8) profit from operations, and (9) CMS HCAHPS “Willingness to Recommend” scores.

Five of the nine measures reflect various aspects of clinical quality — inpatient outcomes, inpatient safety, post-discharge outcomes, and adherence to proxies for evidence-based medicine.

The goals of the analysis were to use Integrated survey data and the Truven Health 100 Top Hospitals study scorecard to evaluate total direct compensation, or TDC, at the system and, separately, hospital levels, to determine the association between TDC in lower-performing versus higher-performing organizations. TDC is defined as base salary plus short-term (annual) incentive payments and the annualized value of long-term incentive payments.

Focused on Performance

The results of this preliminary study strongly suggest that compensation of both hospital and system CEOs is highly aligned with objectively measured overall performance of the hospital or health system, based on 2012–2013 data. Hospital boards appeared to have weighted financial performance more strongly than other metrics in that period. Given the requirements of the Affordable Care Act to change the entire hospital business model, reduce inpatient costs dramatically and shift care to lower-cost settings, board focus on financial performance in relation to CEO compensation is understandable. For health systems, the analysis of individual metrics showed no associations. No individual metrics were statistically associated with CEO compensation. A much larger study of more than 2,000 hospitals is underway to both validate and better understand these preliminary results.

Ultimately, boards are correctly focused on meeting their obligation to review the performance of their whole organization. At the same time, they understand the imperative of financial stability during the transformation of the hospital business model.

For a copy of the Integrated Healthcare Strategies/Truven Health Analytics preliminary compensation study or the full 100 Top Hospitals or 15 Top Health Systems studies for 2014, go to www.100tophospitals.com.

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