Modern Healthcare Special Feature

Added incentive

Pay packages increasingly linked to executive performance

Melanie Evans

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Compensation levels for senior executives -- as well as governing boards' willingness to make that compensation dependent on the executives' performance -- increased in 2006, again, according to *Modern Healthcare*'s annual survey of not-for-profit hospital and health system pay packages.

See the 2006 executive compensation charts.

The magazine's 26th annual survey of compensation for top-level, not-for-profit healthcare executives found strong gains in salary, bonuses and benefits. Meanwhile, incentive plans that link executive pay to financial, quality or strategic goals also increased in 2006 from the previous year among not-for-profit hospitals and health systems, the survey found, which is perhaps evidence of heightened sensitivity among governing boards to regulators' scrutiny of executive compensation practices at tax-exempt healthcare institutions.

Customized data from Chicago-based Sullivan, Cotter and Associates used in the survey is based on compensation information on dozens of C-suite and top management job categories. In total, Sullivan Cotter's 2006 survey includes data for 178 executive, professional and management job categories from 874 organizations: 669 hospitals and 205 health systems. That's up from 855 organizations in 2005 -- 670 hospitals and 185 health systems.

Data provided for *Modern Healthcare*'s survey include responses from only those hospitals and health systems that participated in both 2005 and 2006. This year's results found median overall cash compensation for chief executive officers rose at faster rates than last year across the board among hospitals and health systems of all sizes, with one exception: Free-standing hospitals with annual revenue of less than $200 million saw median CEO compensation increase by 2.5%, identical to last year's increase.

This year's big winners appear to be CEOs at system-owned hospitals. CEOs at small system-owned hospitals reported an 8.2% boost in median compensation for 2006, compared with a drop of 3.1% a year earlier. For large system-owned hospitals, with more than $200 million in revenue, median CEO compensation rose 12.6% compared with a 0.5% increase in 2005.

Gains in total cash compensation for CEOs in 2006 surpassed increases in their base pay -- with the exception of free-standing hospitals -- which may indicate rising payouts from incentive plans, says Tom Pavlik, a managing principal for Sullivan

Cotter. The firm's preliminary 2006 data show 86% of hospitals and 76% of systems surveyed included short-term incentives in executives' compensation, compared with 81% and 74% in 2005. "We continue to see the use of annual incentive plans," Pavlik says. Judging from the survey results, "The plans this year were being paid out."

Beyond traditional financial targets, hospitals and health systems most frequently report patient satisfaction, clinical outcomes and employee satisfaction as measures linked to executives' bonuses.

"I can say that, in my experience, tax-exempt organizations are definitely placing greater emphasis on performance measures," says Ralph DeJong, a Chicago healthcare attorney with McDermott, Will & Emery, in an e-mail. "And they are skewing total pay to reflect the greater demand for achieving organization-specific performance measures."

The shift comes as the Internal Revenue Service and the Government Accountability Office continue to dig into tax-exempt hospitals' compensation of top executives, including a recent IRS "soft audit" mailed to tax-exempt hospitals that sought, among other things, information on who sets compensation and how boards evaluate competitive salaries, bonuses and perks.

"There's a lot of sensitivity to compensation value and transparency," says Kenneth Graham, who will become CEO of 379-bed El Camino Hospital, Mountain View, Calif., on Aug. 7 after 12 years as head of 251-bed Overlake Hospital Medical Center, Bellevue, Wash. Graham's experience underscores how boards have responded to regulators' recent pressure to change compensation. Overlake formally adopted a policy this year prohibiting loans to board members or executives, he says. Meanwhile, Graham's new employer tweaked his compensation as incoming CEO to eliminate some perks, such as a car allowance or company cell phone, though the board also reduced the amount of his pay dependent on performance to 30% from 40%. Recent IRS inquiries into not-for-profits have uncovered poor disclosure of benefits such as loans and club memberships.

Graham doesn't see scrutiny of not-for-profit executive compensation levels waning anytime soon, he says. And he wonders if the move toward compensation disclosure will spread from the C-suite to midlevel managers, as was the case with conflict-of-interest disclosures, he says. "I think it's going to be a subject for quite a while."

By the numbers

For CEOs at system-owned hospitals, 2006 was a very good year. For all such hospitals, regardless of size -- of which 238 were included in this year's compensation report -- CEOs' median total cash compensation rose 11.9% to $363,700 from $325,200 a year earlier.

For the 62 free-standing hospitals included in this year's comparison, median total cash compensation for CEOs rose 4.3% to $417,400 from $400,000 in 2005. Among

the 121 health systems included in this year's report, CEOs' median compensation rose 6.8% to $800,000 from $749,200 the previous year.

The entire C-suite made healthy gains in total cash compensation for 2006. Among hospital executives -- notably the CEO, chief operating officer, chief medical officer, chief financial officer and chief information officer -- half saw an 8% or higher gain in median total cash compensation. In C-suite positions at health systems -- which also include a chief network officer and a chief privacy officer -- half of the executives reported a 7.1% or higher increase in median total cash compensation.

Among all titles included in *Modern Healthcare*'s report, chief network officers saw the largest gain in median cash compensation, 17.3%, or $361,500 in 2006, up from $308,100 a year earlier. However, the job category garnered just eight responses. At hospitals, both free-standing and system-owned, COOs saw the largest gains, 13.9%, for a median cash compensation of $252,600 in 2006 compared with $221,900 a year earlier.

Other top executives also fared well. Health system CFOs saw a 7.6% increase in median total cash compensation, to $409,600 in 2006 from $380,700 in 2005. Hospital CFOs reported $212,400 in median total cash compensation in 2006, up 11.5% from $190,500 a year earlier.

In 2006, median base pay -- which excludes bonuses, perks and benefits -- rose 7.8% and 5.4% for CEOs at health systems and free-standing hospitals, respectively. CEOs at system-owned hospitals saw a 4.1% median salary increase, according to figures compiled by Sullivan Cotter. In 2006, half of health system CEOs surveyed earned more than $646,600 in pay, while half of surveyed CEOs from free-standing hospitals earned more than $390,000 and half of CEOs of hospitals owned by a system earned more than $291,100.

Tying pay to nonfinancial performance isn't a science, as one Ohio hospital's experience demonstrates. In June 2004, Cincinnati Children's Hospital Medical Center overhauled its incentives to put a greater emphasis on nonfinancial goals. Previously, incentive pay was divided equally between financial and nonfinancial targets. After the switch, achieving financial goals accounted for 30% of executives' bonus with the remaining 70% linked to nonfinancial goals, including improved quality, access to care and efficiency.

It took two years before the 413-bed hospital came up with "clean and aligned and defined and upfront" measures for quality incentives, says Uma Kotagal, Cincinnati Children's vice president for quality and transformation, and director of health policy and clinical effectiveness.

Even now, Kotagal and Cincinnati Children's President and CEO James Anderson admit the quality incentive goals -- of which there are 99 for 2006 -- aren't ideal. "Some are not useful," Anderson says. "Some were hatched from a good idea that we weren't really able to translate into a measure that drove results."

For example, the hospital abandoned its goal to increase the percentage of surgeries finished on schedule. Instead, the hospital relies on an additional measure to improve efficiency in its operating rooms: the percentage of surgeries that start on time. Tracking both was redundant. By boosting the number of surgeries that start on schedule, officials believe operating room and related teams will address any snags that prolong surgeries, Anderson says.

"That's the nuance," Kotagal says. Goals must clearly improve care, patient satisfaction or provider efficiency. "If you don't, you lost credibility." Collecting largely irrelevant data undermines efforts to promote patient safety. "The quality folks have to measure the right things."

Cincinnati Children's officials are working to winnow the 99 quality measures into a shorter list of indicators, Anderson says, and executive pay incentives will change accordingly.