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Does CEO Compensation at Non-Profit Hospitals Need to be Tied to Quality Metrics?

Since the advent of healthcare reform and the transition from a fee-for-service to a pay-for-performance marketplace, hospital performance in various quality metrics has been laboring under increasing levels of scrutiny. Refer to the Health Capital Topics series on *"Infection Control and Never Events,"* appearing in issues released in May 2013 through August 2013.[1] Many of the quality metrics being evaluated under the Patient Protection and Affordable Care Act (ACA) scrutinize efficacy and quality of clinical care, putting the work of physicians; nurses; other clinicians; and, quality departments under a microscope. Despite this growing trend, the issue of whether executive-level, including Chief Executive Officer (CEO), compensation relates to quality performance has largely been ignored during healthcare reform implementation. However, the public availability of hospital CEO compensation data,[2] and a recent publication in the Journal of the American Medical Association (JAMA) sheds more light on compensation for CEOs of non-profit hospitals, with the latter analyzing how compensation is associated with various healthcare outcome measures.[3]

The JAMA study, published online on October 14, 2013, analyzed non-profit hospital CEO compensation data from 2009 to determine whether it was linked with certain organizational factors; performance measures; technological capabilities; community outreach; or, patient outcomes.[4] The authors found that the average CEO compensation was $595,781, with those managing more beds; multiple campuses; urban locations; teaching hospitals; and, facilities with a lower proportion of Medicare beneficiaries and poor patients, having significantly higher compensation.[5] Of interest, the study found a significant association between higher CEO compensation rates and increasing technological capabilities and patient satisfaction, but no association was found with community benefit; hospital financial performance; or, typical quality indicators, i.e., process quality, risk-adjusted mortality, and readmission rates.[6]

While the JAMA study is one of the first to explicitly note the lack of association between non-profit hospital CEO compensation with quality metrics, the lack of fiscal accountability in non-profit C-suites is not a novel problem. In April 2013, the IRS released the final report on a multi-year project analyzing financial practices of non-profit colleges and universities and found that entity presidents achieved an annual average compensation of $623,267 and approximately 50% of executive retirement plans had compliance issues, resulting in over $1 million in adjustments.[7] This report was discussed more fully in a September 2013 issue of Health Capital Topics.[8]

In addition to the spotlight the IRS placed on non-profit higher education institutions, non-profit hospitals are not far behind. The May 2013 issue of Health Capital Topics examined one example of exorbitant compensation in a tax-exempt medical center associated with a university, as well as a new IRS proposed rule to ensure that charitable hospitals were adequately meeting community needs.[9]

As both the trends of pay-for-performance and prosecution of fraud and abuse in the healthcare system continue to expand within the context of healthcare reform, the idea of tying C-suite compensation or incentives to quality process and patient outcome metrics will likely grow as well. Of note though, despite government and public focus on increasing patient quality of care, hospitals have found that increasing publicity regarding patient amenities, as opposed to quality performance, has a bigger effect on the entity's bottom line. This dependence on consumer perception may impede efforts to move quality metrics as incentivized projects, as discussed in an October 2013 Health Capital Topics article.[10] Despite this challenge, healthcare providers; hospitals; and, healthcare executives must find a way to maintain the bottom line and patient satisfaction scores while simultaneously improving performance in various quality and efficiency metrics under healthcare reform.

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[1] "An Overview of Infection Control and Patient Safety in the Era of 'Never Events'", By Health Capital Consultants, Health Capital Topics, Vol. 6, No. 5, May 2013; "Regulatory and Reimbursement Penalties for 'No Pay' Events", By Health Capital Consultants, Health Capital Topics, Vol. 6, No. 6, June 2013; "Data Metrics for 'No Pay' Events: How Accurate is it?", By Health Capital Consultants, Health Capital Topics, Vol. 6, No. 7, July 2013; "The Future of Patient Safety for Healthcare Stakeholders", By Health Capital Consultants, Health Capital Topics, Vol. 6, No. 7, August 2013

[2] "*GuideStar Nonprofit Compensation Report*: The Most Comprehensive Analysis Available", GuideStar USA, Inc., 2013, http://www.guidestar.org/rxg/products/nonprofit-compensation-solutions/guidestar-nonprofit-compensation-report.aspx (Accessed 11/3/13)

[3] "Compensation of Chief Executive Officers at Nonprofit US Hospitals", By Joynt et al., 2013, JAMA Internal Medicine, October 14, 2013 (Online publication; Accessed 11/3/13)

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[4] *Ibid*, Joynt et al., 2013, p. E2
[5] *Ibid*, Joynt et al., 2013, p. E4
[6] *Ibid*, Joynt et al., 2013, p. E4-E5
[7] "Colleges and Universities Compliance Report: Final Report", By the IRS, April 25, 2013, pp. 16, 20-21
[8] "IRS Finds Extensive Non-Compliance Among Tax-Exempt Colleges and University", By Health Capital Consultants, Health Capital Topics, Vol. 6, Issue 9, September 2013
[9] "IRS Proposes Requirements to Make Charitable Hospitals more 'Charitable'", By Health Capital Consultants, Health Capital Topics, Vol. 6, Issue 5, May 2013
[10] "Turning Hospitals into Hotels: How Increasing Amenities Could Sacrifice Quality", By Health Capital Consultants, Health Capital Topics, Vol. 6, No. 10, October 2013

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