Modern Healthcare | SURVEY

THE ONLY HEALTHCARE BUSINESS NEWS WEEKLY | AUGUST 8, 2016

EXECUTIVE COMPENSATION

Pay for performance takes on new meaning

By Joseph Conn

Value-based care has settled into the C-suites of the nation's hospitals and health systems.

And as executives' compensation continues to soar, more is coming from performance-based payment models that aren't just linked to individual efforts and outcomes, but also the efforts of their organizations.

Year-over-year increases in median total cash compensation for the top 10 C-suite positions ranged from a high of 15.3% for chief information officers at all hospitals to a low of 0.3% for chief medical officers at stand-alone hospitals, according to Modern Healthcare's 36th annual Executive Compensation Survey. Across all 17 of the hospital executive titles in the survey, C-suite and below, the median increase in 2016 was 4.6%. The survey covers 1,213 organizations, up 3% from 2015.

GETTY IMAGES

Presidents and CEOs of stand-alone hospitals saw their median total compensation jump 10% this year. Executives of hospitals owned by a parent organization rose by a more modest 2.2%. These top leaders at stand-alone hospitals earned an average of $716,300.

This year's average total compensation for a health system president/CEO is just over $1.2 million.

For health systems, increases in median total cash compensation for the top executive positions surveyed ranged from a high of 9.1% for chief operating officers to a low of 2.6% for CMOs. The midpoint of their range was 5.7%.

The median increase across all 34 job titles at the health systems surveyed was 5.9%. The median increase for presidents and CEOs of health systems was 3.9%. For the largest systems by revenue ($1 billion or more), the average total compensation for a president/CEO was nearly $1.5 million.

It was the second straight year that C-suite positions took home raises in this range and closer to the pre-recession annual raises that ran about 6% to 8%. It's a leap from 2014, when increases were around 2%.

Growth and consolidation are among the key drivers of pay hikes this year, said Tom Pavlik, managing principal at Sullivan, Cotter and Associates, the compensation consulting firm that has supplied data for Modern Healthcare's survey since 2003.

EXECUTIVE COMPENSATION SURVEY

Executive compensation by organization size

Key titles by organization revenue, ranked by average total cash compensation, 2016 ($ in thousands)

TITLE (NUMBER SURVEYED)	MEDIAN BASE 2016	MEDIAN BASE 2015	MEDIAN BASE % CHANGE	MEDIAN TOTAL CASH COMPENSATION 2016	MEDIAN TOTAL CASH COMPENSATION 2015	MEDIAN TOTAL CASH COMPENSATION % CHANGE	AVERAGE TOTAL CASH COMPENSATION 2016	AVERAGE TOTAL CASH COMPENSATION 2015	AVERAGE TOTAL CASH COMPENSATION % CHANGE
HOSPITALS WITH NET REVENUE LESS THAN $300 MILLION									
President and CEO, stand-alone hospital (36)	$460.0	$463.4	(0.7%)	$565.6	$513.9	10.1%	$551.9	$525.7	5.0%
President and CEO, system-owned hospital (346)	314.1	308.2	1.9	396.7	390.6	1.6	413.2	397.3	4.0
Chief medical officer, system-owned hospital (73)	312.0	309.3	0.9	350.0	343.5	1.9	361.1	347.4	3.9
Chief financial officer, stand-alone hospital (35)	300.0	282.3	6.3	344.8	310.0	11.2	326.8	306.2	6.7
Chief financial officer, system-owned hospital (172)	200.2	195.0	2.6	246.1	231.5	6.3	254.7	246.7	3.3
Chief operating officer, system-owned hospital (126)	194.3	195.5	(0.6)	238.8	231.3	3.2	249.6	246.1	1.4
HOSPITALS WITH NET REVENUE OF $300 MILLION OR MORE									
President and CEO, stand-alone hospital (21)	$754.3	$739.5	2.0%	$932.9	$895.5	4.2%	$998.3	$967.0	3.2%
President and CEO, system-owned hospital (191)	443.7	433.5	2.4	593.6	545.0	8.9	616.8	589.6	4.6
Chief medical officer, system-owned hospital (94)	359.3	352.4	2.0	422.2	406.5	3.9	430.8	407.7	5.7
Chief operating officer, system-owned hospital (88)	273.8	272.1	0.6	323.8	323.6	0.1	365.0	350.6	4.1
Chief financial officer, system-owned hospital (107)	265.3	261.6	1.4	332.1	318.0	4.4	337.0	324.3	3.9
SYSTEMS WITH NET REVENUE LESS THAN $1 BILLION									
President and CEO (103)	$676.3	$647.0	4.5%	$800.0	$745.4	7.3%	$821.0	$752.7	9.1%
Chief operating officer (43)	445.0	427.6	4.1	510.0	472.3	8.0	523.2	476.5	9.8
Chief medical officer (64)	397.7	385.5	3.2	452.5	428.6	5.6	466.6	445.8	4.7
Chief financial officer (87)	391.4	378.8	3.3	443.7	411.0	8.0	449.8	421.3	6.8
SYSTEMS WITH NET REVENUE OF $1 BILLION OR MORE									
President and CEO (168)	$1,000.0	$975.0	2.6%	$1,328.0	$1,235.0	7.5%	$1,483.4	$1,422.1	4.3%
Chief operating officer (98)	617.5	589.3	4.8	759.2	706.4	7.5	926.8	852.6	8.7
Chief financial officer (148)	547.8	517.4	5.9	665.0	638.8	4.1	759.4	720.2	5.4
Chief medical officer (108)	504.6	493.8	2.2	621.1	597.2	4.0	689.4	660.5	4.4

Note: Data are from a constant sample. All numbers rounded.

Source: Sullivan, Cotter and Associates

EXECUTIVE COMPENSATION SURVEY

Executive compensation—healthcare systems

Ranked by average total cash compensation, 2016 ($ in thousands)

	MEDIAN						AVERAGE		
	BASE			TOTAL CASH COMPENSATION			TOTAL CASH COMPENSATION		
TITLE (NUMBER SURVEYED)	2016	2015	% CHANGE	2016	2015	% CHANGE	2016	2015	% CHANGE
TOP CORPORATE EXECUTIVES									
President and CEO (271)	$850.7	$800.0	6.3%	$1,032.1	$993.5	3.9%	$1,231.7	$1,167.6	5.5%
Chief operating officer (141)	566.5	532.8	6.3	670.1	614.2	9.1	$803.7	$737.9	8.9
Chief administrative officer (48)	489.6	466.8	4.9	603.4	558.6	8.0	$653.2	$611.7	6.8
Chief financial officer (235)	481.9	461.7	4.4	591.9	548.5	7.9	$644.8	$609.5	5.8
Chief medical officer (172)	465.8	446.5	4.3	564.5	550.0	2.6	$606.5	$580.6	4.4
Chief strategy officer (63)	391.4	369.2	6.0	475.9	450.0	5.7	$555.1	$510.6	8.7
Chief information officer (176)	370.6	350.8	5.7	425.1	397.5	6.9	$462.5	$437.0	5.8
Chief nursing officer (154)	304.5	300.7	1.3	345.6	331.0	4.4	$359.2	$343.7	4.5
Compliance executive (98)	240.9	229.7	4.9	265.3	257.8	2.9	$280.8	$268.5	4.6
TOP CORPORATE DEPARTMENT EXECUTIVES									
Legal services executive (general counsel) (161)	$403.7	$387.1	4.3%	$471.6	$443.7	6.3%	$524.2	$489.8	7.0%
Clinical research executive (29)	334.3	324.3	3.1	388.1	374.4	3.6	$471.4	$456.8	3.2
Quality and patient safety executive (39)	388.1	376.8	3.0	464.6	437.1	6.3	$453.6	$435.7	4.1
Human resources executive (196)	330.2	310.0	6.5	385.7	354.4	8.8	$419.7	$395.1	6.2
Business development executive (48)	297.0	294.8	0.7	364.6	336.4	8.4	$386.7	$363.7	6.3
Managed-care executive (54)	288.8	272.4	6.0	329.1	323.9	1.6	$375.7	$360.4	4.2
Medical informatics executive (61)	301.1	292.5	2.9	348.7	335.9	3.8	$365.7	$351.1	4.1
Physician practices management executive (31)	259.1	250.9	3.3	302.9	281.9	7.5	$358.6	$350.0	2.4
Communications executive (27)	240.7	227.6	5.7	272.7	265.9	2.5	$340.8	$327.8	4.0
Ambulatory care executive (37)	282.2	268.3	5.2	312.1	293.3	6.4	$338.5	$325.4	4.0
Mission services executive (27)	206.8	199.7	3.5	245.8	225.3	9.1	$337.7	$316.8	3.7
Foundation/fund development executive (109)	258.0	251.2	2.7	300.0	283.1	6.0	$335.8	$323.7	6.6
Marketing executive (82)	256.8	250.0	2.7	298.8	273.9	9.1	$333.0	$308.1	6.0
Supply chain management executive (62)	270.0	258.9	4.3	311.0	301.0	3.3	$329.5	$310.8	8.1
Revenue cycle executive (74)	259.1	250.0	3.6	295.8	282.2	4.8	$323.1	$301.3	7.2
Professional services executive (43)	246.1	243.5	1.1	295.3	280.0	5.5	$317.9	$296.3	5.5
Planning executive (35)	254.6	252.0	1.0	316.7	269.2	17.7	$317.3	$299.1	6.1
Government relations executive (77)	250.0	242.9	2.9	300.0	282.6	6.2	$316.8	$300.3	3.2
Support services executive (29)	230.0	221.9	3.6	264.5	241.8	9.4	$311.8	$296.9	5.0
Facilities planning/construction executive (42)	246.9	239.5	3.1	273.5	259.1	5.6	$308.4	$298.9	7.3
Internal audit executive (30)	220.9	215.0	2.8	279.4	270.6	3.3	$302.5	$287.9	5.1
Risk management executive (35)	226.5	222.1	2.0	272.7	237.5	14.8	$299.5	$278.0	4.5
Facilities executive (51)	240.0	234.7	2.3	261.4	250.0	4.6	$297.7	$284.8	7.7
Home health executive (29)	226.7	216.6	4.6	269.5	255.0	5.7	$286.8	$269.9	6.2
Pharmacy executive (41)	235.5	226.6	3.9	267.7	261.6	2.3	$283.9	$268.9	5.6

Note: Data are from a constant sample. All figures rounded.

Source: Sullivan, Cotter and Associates

EXECUTIVE COMPENSATION SURVEY

Executive compensation—hospitals

Selected titles, ranked by average total cash compensation, 2016 ($ in thousands)

TITLE (NUMBER SURVEYED)	MEDIAN BASE 2016	MEDIAN BASE 2015	MEDIAN BASE % CHANGE	MEDIAN TOTAL CASH COMPENSATION 2016	MEDIAN TOTAL CASH COMPENSATION 2015	MEDIAN TOTAL CASH COMPENSATION % CHANGE	AVERAGE TOTAL CASH COMPENSATION 2016	AVERAGE TOTAL CASH COMPENSATION 2015	AVERAGE TOTAL CASH COMPENSATION % CHANGE
C-SUITE EXECUTIVES									
President and CEO, stand-alone hospital (57)	$530.0	$525.0	1.0%	$658.0	$598.4	10.0%	$716.3	$688.2	4.1%
President and CEO, system-owned hospital (537)	361.1	352.2	2.5	450.4	440.9	2.2	485.6	465.7	4.3
Chief operating officer, stand-alone hospital (30)	364.4	364.4	0.0	407.4	398.1	2.3	425.6	429.0	(0.8)
Chief medical officer, stand-alone hospital (31)	354.2	345.5	2.5	390.4	389.3	0.3	422.9	411.5	2.8
Chief medical officer, system-owned hospital (167)	336.3	327.5	2.7	395.5	369.2	7.1	400.3	381.4	5.0
Chief financial officer, stand-alone hospital (53)	324.4	310.0	4.6	361.0	340.3	6.1	390.3	371.9	4.9
Chief information officer* (41)	263.9	253.0	4.3	306.0	265.3	15.3	308.9	295.4	4.6
Chief operating officer, system-owned hospital (214)	220.1	214.7	2.5	276.2	263.8	4.7	297.1	289.1	2.8
Chief financial officer, system-owned hospital (279)	224.0	215.0	4.2	272.8	265.6	2.7	286.3	276.5	3.5
Chief nursing officer* (462)	202.0	195.8	3.2	240.1	236.4	1.6	247.5	239.2	3.5
OTHER TOP EXECUTIVES									
Legal services executive, general counsel (29)	$279.4	$259.6	7.6%	$297.8	$292.6	1.8%	$361.6	$335.1	7.9%
Foundation/fund development executive (55)	216.7	207.2	4.6	250.6	234.7	6.8	277.1	259.1	7.0
Human resources executive (118)	206.4	194.7	6.0	243.0	217.6	11.7	253.8	233.5	8.7
Business development executive (52)	202.6	190.2	6.5	228.5	208.0	9.8	242.7	226.6	7.1
Professional services executive (60)	186.5	188.5	(1.1)	214.1	214.3	(0.1)	232.6	222.4	4.6
Marketing executive (28)	196.7	185.9	5.8	207.6	198.5	4.6	231.0	217.5	6.2
Mission services executive (25)	151.9	150.3	1.1	184.5	180.3	2.3	190.5	178.0	7.0

Note: Data are from a constant sample. All numbers rounded.

*Average of compensation for this title in all settings.

Source: Sullivan, Cotter and Associates

"We're seeing more variability, with (more) compensation at risk," he said.

The emphasis on population health and risk management along with the push to move patients out of hospitals and into ambulatory care has placed chief information officers, who are responsible for the systems that track a hospital's success, into the spotlight.

"You're seeing roles change as the industry changes," Pavlik said.

Marc Probst, veteran Intermountain Healthcare system CIO, said he wasn't shocked by the double-digit pay hikes some of his health IT peers received, although, he conceded he did not receive one that large.

"I think you have an interesting divergence with the role of CIO right now," Probst said. There is one kind of CIO role that's highly technical, an executive who is running the IT systems, managing cybersecurity and the physical assets that come with information systems. This person also manages the data.

And then there's the CIO who applies technology while developing an organizational strategy.

Not every organization has a strategic CIO and that kind of CIO is going to see greater salary growth, Probst said.

Many executives this year, as in recent years, have pushed to cut costs by consolidating.

"The big are getting bigger," Pavlik said. The median revenue growth for a large healthcare system was 13%, a greater rate than that for the industry overall. "If they've integrated and become twice the size, the compensation follows as well," he said.

Turnover also affects pay, Pavlik said. "If they want a seasoned person as chief financial officer, they may have to pay more."

Of the 51 executive positions in the survey for both hospitals and health systems, only hospital professional services executives, the people responsible for diagnostic, laboratory and pharmacy services, behavioral health and rehabilitation, had median total compensation lower this year than the year before (down 0.1%).

They and CMOs at stand-alone hospitals were the only executives whose median increases didn't beat the rate of inflation, based on the Consumer Price Index, measured at 1.1% by the U.S. Commerce Department.

By comparison, the midpoint of healthcare executives' median total cash compensation last year was a full percentage point higher than healthcare inflation measured by the Milliman index and 4.6 percentage points higher than the current rate of inflation.

"When I look at executive comp, the striking thing is that it just always goes up," said Dr. Roy Poses, clinical associate professor of medicine at Brown University and president of the Foundation for Integrity and Responsibility in Medicine.

Executive pay continues to rise despite a desire to control healthcare costs, he said. "And it goes up regardless of performance."

A lack of transparency in the salary-setting process is a problem, particularly with not-for-profit systems, said Princeton University health economist Uwe Reinhardt, who has served on boards of directors of both for-profit and not-for-profit healthcare organizations.

Most for-profit boards receive a report from a compensation committee and it's fairly open, Reinhardt said. But with not-for-profits, "I've never in all my years seen the executive committee share the compensation information with the (full) board."

Reinhardt says we're reaching a tipping point. Healthcare costs, including those for physician and executive compensation, can't keep rising indefinitely above the incomes of the patients who ultimately foot the bill, he said.

From 2002 to 2016, total healthcare costs for a household of four on average rose 7.6% every year, rising from $9,235 to $25,826, said Dan Munro, who tracks the Milliman Index of these costs.

"At some point there will be a limit, when the bottom half of the nation's income distribution will be cleaned out by the healthcare sector," Reinhardt said.

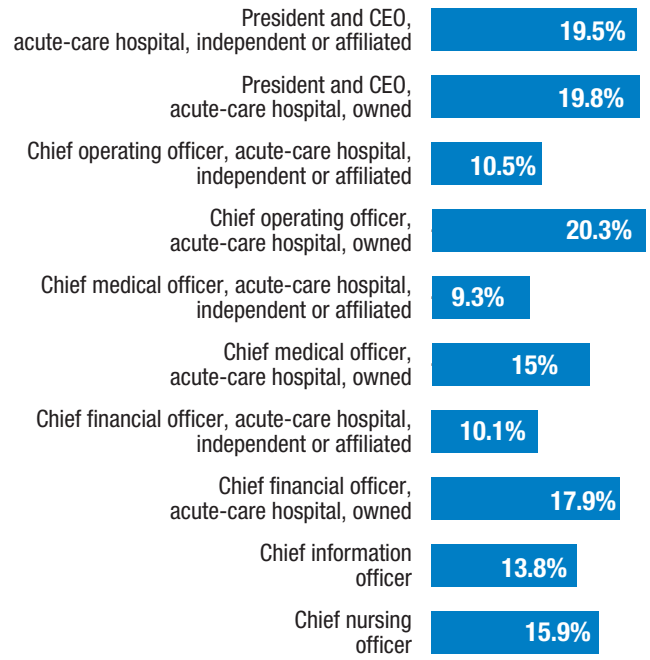
A noticeable trend in the compensation data this year was the substantial increase in the percentage of executive pay attributable to short-term incentives (cash payments within one year) calculated from the Sullivan Cotter data by subtracting base pay from total

Paying for performance

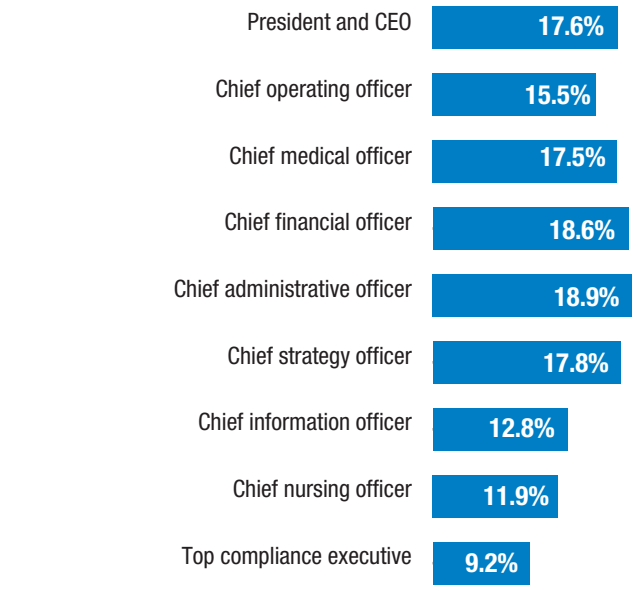
C-suite healthcare executives see a growing portion of their paychecks devoted to performance-based incentives

Other 2016 compensation as percentage of total compensation

ALL HOSPITALS: Top corporate executives*



ALL SYSTEMS: Top corporate executives*



*Analyzed for "other compensation."
Based on percentage of median total cash compensation.

Sources: Modern Healthcare's 36th Annual Survey of Executive Compensation, Sullivan, Cotter and Associates

compensation. Organizations base those incentives on some combination of quality, safety and patient experience or satisfaction, which is typically done by a third party, and financial performance, which is based on financial statements, said Meg Garrison, managing director of Sullivan Cotter's Atlanta office.

According to a Modern Healthcare analysis, this "other compensation" as a percentage of median total cash compensation increased in this year's survey over last year's for all nine of the top C-suite titles for health systems and eight of the top 10 executive positions at hospitals. The median increase in other compensation was 16.6% for health systems titles and 17.4% for hospital positions.

Incentives are typically offered in ranges, with a minimum threshold for receiving some payment, a maximum payment amount, and a target payment in between. This year, "the payouts were typically around the target level," Garrison said.

That's likely the result of more active involvement by the people who set executive compensation in selecting the performance metrics and setting the goals around those, she added.

Most organizations are going to focus on quality metrics that show them performing below peers or industry norms. Payers, including Medicare, influence the need to improve.

"There's certainly discussion among our clients and compensation committees about which ones have more impact than others," Garrison said. But the metrics that make up value-based payments are often the ones included in the compensation of executives.

Intermountain's Probst said that only about 20% of his incentive pay is based on meeting goals set for his performance alone. "Most of my 'other comp' is highly aligned with the organization's success," he said.

For example, Intermountain is about halfway through the rollout of a new Cerner Corp. electronic health record system. But incentive payments for the project are to be paid out to members of the entire healthcare organization, not only the IT department.

Another example of a longer-term incentive, payable after three to five years if goals are met, would be a payment for successful integrating operations after a merger or acquisition. A majority (58%) of large health systems use these incentives, but smaller systems and hospitals are beginning to adopt them as well, Pavlik said. With smaller hospitals, the percentage with long-term executive incentive programs drops below 10%.

Not-for-profits are still adjusting to 2009 IRS rule changes that required disclosures about executive compensation and possible conflicts of interest for board members. The IRS was trying to compare organizations and better understand their governance, said Alexander Yaffe, CEO of Yaffe & Co., a compensation consultant who works with clients in healthcare and at not-for-profit colleges and universities.

Yaffe's white paper *The Expanding Role of the Compensation Committee*, published by the American Hospital Association's Center for Healthcare Governance, predicts healthcare organizations must be even more transparent in a world of value-based payments. The IRS is asking not-for-profits to have independent boards that use appropriate data to compare compensation levels for similar positions in peer organizations. Their process for compensating executives must also be well-documented.

The IRS feels a well-governed organization will be a more compliant one, he said. "It's a decent theory, at least."

More planning is something industry experts would like to see within hospitals and health systems overall.

Healthcare organizations could do a much better job grooming future leaders, laments Dr. Frank Byrne, a former president and board member of two hospitals as well as other not-for-profit and for-profit companies.

"One of the things that drive compensation increases is poor succession planning," Byrne said. "I'm hoping with the formation of these larger systems, more attention will be paid to developing bench strength."

Healthcare organizations might consider being less risk-averse when promoting into C-suite positions, Byrne said. "Many of the searches I see, they're recruiting someone who already has done the job, which I think is a mistake," that drives up cost. "They should be looking at a mix of experience and people with new ideas." ●