



# Re-Thinking Hospital Executive Compensation: Focus on the Triple Aim



**To meet their fiduciary duty to promote optimal organizational performance, a hospital's governing board should link executive compensation to specific, well-defined performance measures. In addition to financial performance, executives' compensation metrics should address the federal government's Triple Aim of better quality of care, improved health outcomes, and enhanced efficiency.**

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**// Every system is perfectly designed to get the results it gets. //**

**— Paul Batalden, M.D.**

**The Dartmouth Institute for Health Policy and Clinical Practice**

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Volume-based reimbursement is perfectly designed to maximize the delivery of healthcare services. Payment does not depend on quality, outcomes, or efficiency. Absent proper incentives, we cannot expect much progress in achieving the Triple Aim.

But change is upon us. For example, the Medical Group Management Association's most recent annual survey of physician compensation reports a strong trend toward inclusion of quality measures as components of physicians' compensation. While the percentage of total compensation tied to quality is relatively small today, leaders expect these numbers to increase significantly in the near future.<sup>1</sup> With real money on the line, more providers' attention will turn to achieving top scores on identified performance measures.

Notably, there is little to indicate similar movement in executive compensation, even though hospitals are similarly challenged. The first comprehensive analysis of hospital executive pay-for-performance showed only a minimal relationship between executive compensation and the hospital's performance on a range of quality indicators.<sup>2</sup>

Specifically, the study showed an association between higher salaries and the hospital's size, location (urban vs. rural), and level of technological sophistication, as well as a modest relationship between compensation and patient satisfaction scores. However, no association was found between executive compensation and a hospital's scores on other measures of quality, outcomes, and efficiency.

As a key part of their fiduciary duty of care, hospital trustees are responsible for hiring the chief executive officer and evaluating and rewarding the CEO's performance. Even though the CEO exerts a significant influence on the hospital's operational agenda, the board is responsible for setting performance expectations. Few hospitals' governing bodies, however, now tie CEO compensation to anything other than meeting financial targets.

Now that clinical reimbursement is being affected by the Triple Aim, trustees must examine the CEO's performance targets to ensure they are also aligned with trending and future reimbursement models.

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<sup>1</sup> Medical Group Management Association, Physician Compensation and Production Survey: 2013 Report Based on 2012 Data.

<sup>2</sup> K.E. Joynt, MD, et al., Compensation of Chief Executive Officers at Nonprofit US Hospitals, JAMA INTERNAL MEDICINE (January 2014).

## Hospital Pay-For-Performance Programs

The starting point for this examination is an understanding of how quality of care, outcomes, and efficiency will impact hospital reimbursement. Over the last decade, the Centers for Medicare & Medicaid Services (CMS) has developed and implemented hospital pay-for-performance programs – slowly at first, but now with relative break-neck speed.

### Phase I

Medicare's first hospital pay-for-performance program was mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Under the Hospital Inpatient Quality Reporting Program (HIQR), CMS pays hospitals that successfully report designated inpatient quality measures a higher annual update to their payment rates.

The Hospital Outpatient Quality Reporting Program (HOQR) was established under the Tax Relief and Health Care Act of 2006. Hospitals that fail to submit data on measures related to the quality of care furnished by hospitals in outpatient settings are subject to a reduction in payment for outpatient services.

CMS reports the data gathered through HIQR and HOQR on its *Hospital Compare* website. This website allows consumers to select multiple hospitals and directly compare performance measure information related to heart attack, heart failure, pneumonia, surgery, and other conditions.

### Phase II

In 2013, CMS implemented two new hospital pay-for-performance programs. Under the Hospital Readmissions Reduction Program, a hospital is penalized if too many of its patients hospitalized for acute myocardial infarction, heart failure, and pneumonia are readmitted within 30 days. Starting in 2015, CMS will consider two more categories of patients – those hospitalized for chronic obstructive pulmonary disease and total hip or knee arthroplasty – in calculating a hospital's readmission penalty.

Under the Hospital Value-Based Purchasing (VBP) Program, CMS creates an incentive pool by withholding a percentage of payments made to all hospitals. The agency distributes the pool monies based on hospitals' scores on specified clinical process of care measures and patient satisfaction surveys. Low-scoring hospitals forfeit their contribution to the pool. High-scoring hospitals are paid an amount equal to their contribution plus an additional amount.

### Phase III

Starting in 2015, new patient safety and efficiency measures will be used in calculating hospital performance scores under the VBP Program. The efficiency measure, known as the Medicare Spend Per Beneficiary, totals and compares Medicare Part A and Part B payments for services provided to a Medicare beneficiary during an episode that spans from three days prior to an inpatient hospital admission through 30 days after discharge.

Also starting in 2015, CMS will implement a third hospital pay-for-performance program, the Hospital-Acquired Condition and Never Event Reduction Program (HAC Program). Hospitals scoring in the top quartile for specified hospital-acquired conditions (HACs) (e.g., catheter-associated urinary tract infection) and never events (e.g., surgery on the wrong limb) will face a one percentage point reduction in Medicare payments for all inpatient hospitalizations.

## Broader Implications

While the potential payment reductions under these three programs are not insubstantial, the influence of Medicare pay-for-performance initiatives on other healthcare stakeholders is far greater. First, commercial insurers now are following suit, implementing similar initiatives. These insurers also will use hospitals' value-based purchasing scores to make decisions on narrow network participation. Similarly, more employee health plans will incorporate incentives for individuals to seek care from providers with higher quality scores and lower cost services.

Second, hospitals' readmission rates and VBP scores – and soon data from the HAC Program – are available on the *Hospital Compare* website, as well as smart phone apps. Faced with deciding where to have surgery, a patient or family member can quickly find out which hospital in the area has the lowest readmission rate, the highest quality scores, and the lowest rate of HACs and never events. Hospitals already are incorporating their scores (and their competitors' scores) into their marketing campaigns.

All hospitals, including small suburban and rural hospitals, must navigate these new VBP waters and understand how their performance is perceived by stakeholders in their communities. Although critical access hospitals (CAHs) are not included in Medicare's pay-for-performance programs, nearly all CAHs voluntarily submit quality data to the Hospital Compare website. Thus, CAHs are likely to experience the same level of scrutiny as hospitals. Also, CMS has the authority to initiate a CAH pay-for-performance demonstration program, although it has not yet done so.

In addition to pay-for-performance programs, a hospital's quality scores also play a key role in new payment models, such as shared savings and bundled payment programs. Both the Medicare Shared Savings Program and CMS' Bundled Payment for Care Improvement Initiative, for example, require participants to meet certain quality measure scores as a condition of receiving full payment. Comparable commercial insurance programs impose similar requirements.

All of these recent developments point to the fact quality of care now has a direct and quantifiable impact on a hospital's financial health as it will impact patient, payer, and referring provider choice. The old adage "no margin, no mission" now has a corollary: "no quality, no quantity."

## Incentivizing Quality Performance

Given this intense and growing focus on healthcare quality, trustees must set high expectations for their hospital's performance on key measures. One of the most effective ways trustees communicate this message is through the CEO's compensation package.

Traditionally, CEO performance evaluations and at-risk compensation have been tied to the hospital's financial performance, such as meeting budget targets, increasing revenue, maintaining bond rating, expanding services, managing capital projects, and capturing market share. Not surprisingly, CEOs have focused on these measures of success, even at the expense of other organizational priorities.

Now trustees have the opportunity to re-direct the CEO's attention to focus more intently on leading the organization to improve quality of care, outcomes, and efficiency, as these performance measures become critical to the hospital's financial health. As a first step, trustees need to have a complete and accurate picture of the hospital's current performance on key quality measures in addition to financial metrics.

Many hospital boards now receive some sort of quality dashboard prepared by management. However, given the recent and rapid expansion of pay-for-performance programs, and the incorporation of new measures into those programs, the current dashboard may not reflect all relevant data. Trustees, therefore, should confirm with management that these dashboards have been updated appropriately.

Armed with this essential information, the board will be prepared for a substantive and meaningful discussion with the CEO regarding leadership toward quality performance. This may be accomplished most

effectively in the context of establishing criteria for at-risk compensation for the upcoming year.

With the support of a knowledgeable and objective consultant or third-party advisor, the trustees can identify key opportunities for improvement. With the CEO’s participation, the board can set expectations and corresponding financial rewards for leading quality performance. Then, on an annual basis, the board and the CEO together can evaluate progress, reward success, and recalibrate metrics for the upcoming year.

More specifically, as a matter of process, the board’s compensation committee should engage the CEO in a discussion of quality expectations and corresponding performance standards as part of its annual compensation review. Depending on the language and scope of the compensation committee’s charter, the full board should consider revising that charter

to address the committee’s responsibility to incentivize quality performance.

For tax-exempt organizations, it is crucial that the reasoning behind specific performance metrics and the at-risk compensation tied to each is thoroughly documented. This is necessary to establish the rebuttable presumption of commercial reasonableness of the CEO’s total compensation package. Establishing this presumption is critical for the hospital to withstand any challenge under the tax laws. Again, a knowledgeable consultant can help design and implement a process to ensure compliance with these requirements.

The following presents two examples of hospitals whose boards have incorporated specific quality performance measures into the criteria for CEO at-risk compensation.

Performance Measure	Percent of At-Risk Compensation
<b>Hospital A – Sole Community Hospital</b>	
Quality	40%
Reduction of HACs	20%
CMS Core Measure Improvements	5%
Reduction in Readmission Rates	15%
Service Excellence (patient satisfaction scores)	20%
People (staff turnover)	10%
Stewardship (specific financial metrics)	30%
	<b>100%</b>
<b>Hospital B – Metropolitan Safety Net Hospital</b>	
Safety and Quality (reduction of HACs)	20%
Patient Flow and Throughput (improvement in emergency room throughput)	15%
Service Excellence (patient satisfaction scores)	5%
High Performance Organization (first year staff turnover)	5%
Stewardship/Financial (net income)	25%
Discretionary (physician alignment strategic initiative)	30%
	<b>100%</b>

With the Medicare HAC Program coming on-line in 2015, both boards in the above examples chose to tie a significant percentage of their CEOs' at-risk compensation to reducing HACs. Both also selected improving patient satisfaction scores as a metric, although they assigned different percentages of compensation to this metric. Working together, the boards and CEOs of these hospitals can refine these measures over the year, as the transition from volume to value-based reimbursement accelerates.

In addition to tying CEO bonuses to quantifiable quality measures, trustees also should consider whether a portion of at-risk compensation should be based on leadership of initiatives to better position the hospital for success under new payment and delivery models. As illustrated above, Hospital B's board has tied 30% of the CEO's bonus payment to such an initiative.

Initiatives designed to improve and incent population health may include, for example, improved

hospital-physician alignment, targeted community outreach, participation in a clinically integrated network, and alliances with other hospitals and health systems. While quantifiable quality measures focus on performance within the four walls of the hospital and are key to hospital pay-for-performance programs, population health initiatives promote collaboration with other providers - also a key ingredient to success under emerging payment and delivery models such as bundled payments, shared savings, and risk-adjusted global budgets.

Again, the conversation between the CEO and the trustees to establish performance standards should address these opportunities as well as specific quality expectations. Knowledgeable trustees committed to leading the hospital in service to the community now have the opportunity to more directly participate in the process to deliver on better quality of care, improved health outcomes, and enhanced efficiency.

**To discuss how PYA can help develop an effective and compliant executive compensation package, please contact one of the following:**

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