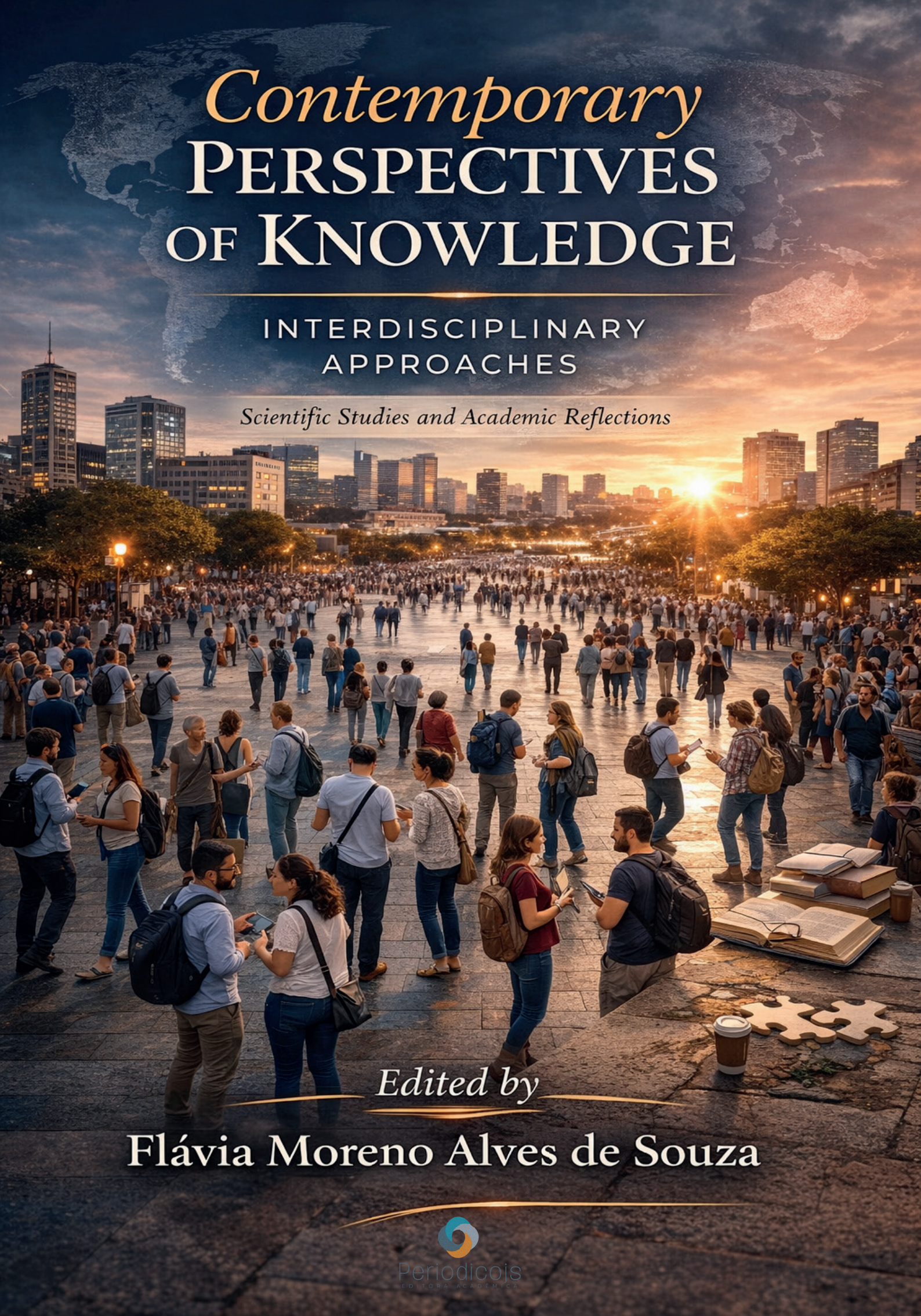




Contemporary PERSPECTIVES OF KNOWLEDGE

INTERDISCIPLINARY
APPROACHES

Scientific Studies and Academic Reflections

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Graphic Design, Layout and Cover

Academic Publisher Periodicojs

Language

Portuguese and English

International Cataloging-in-Publication Data (CIP)

(Brazilian Book Chamber, SP, Brazil)

C761	Contemporary Perspectives of Knowledge: Interdisciplinary Approaches/ Flávia Moreno Alves de Souza (org) – João Pessoa: Periodicojs publisher, 2026. E-book: il. color. Includes bibliography ISBN: 978-65-6010-196-8 1. Free themes. I. Souza, Flávia Moreno Alves. II. Title
CDD 370	

Prepared by Dayse de França Barbosa CRB 15-553

Index for systematic catalog:

Indexes for systematic catalog:

1. Education: 370

Work without funding from public or private bodies.

The published works have been submitted to peer review and evaluation (double-blind), with respective acceptance letters in the publisher's system.

The work is the result of studies and research from the Interdisciplinary Studies in Human Sciences section of the Humanities in Perspective book collection.



Filipe Lins dos Santos
President and Senior Editor of Periodicojs

CNPJ: 39.865.437/0001-23

Rua Josias Lopes Braga, n. 437, Bancários, João Pessoa - PB - Brazil
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Chapter 22

INTEGRATING CMS COMPLIANCE, OPERATIONAL EXCELLENCE, AND WORKFORCE DEVELOPMENT IN UNITED STATES HEALTHCARE ORGANIZATIONS



INTEGRATING CMS COMPLIANCE, OPERATIONAL EXCELLENCE, AND WORKFORCE DEVELOPMENT IN UNITED STATES HEALTHCARE ORGANIZATIONS

Lupércio de Castro Pedra¹

Abstract: This chapter examines how regulatory compliance with the Centers for Medicare & Medicaid Services (CMS), the transition to value-based payment models (Value-Based Care), workforce development, continuous process improvement, and manager capacity-building are articulated as interdependent dimensions of healthcare organization management in the United States. It is argued that these five dimensions, treated in isolation in current managerial practice, produce suboptimal results, and that their deliberate integration constitutes a competitive advantage and a condition for institutional sustainability in the current regulatory and payment environment.

Keywords: CMS compliance; Value-based care; Healthcare workforce; Continuous improvement; Healthcare leadership.

Learning Objectives

By the end of this chapter, the reader should be able to:

- Describe the regulatory architecture of hospital compliance with CMS, including the Conditions of Participation and the seven elements of the OIG compliance program;
- Distinguish the main CMS value-based payment programs — including Medicare Advantage Star Ratings — and their regulatory status in 2026;
- Explain how the healthcare workforce crisis conditions the viability of regulatory compliance

¹ Bachelor's degree in Business Administration from the Federal University of Juiz de Fora (UFJF), MBA in Financial Management: Controllershship and Auditing, from the Getúlio Vargas Foundation - FGV.



and value-based performance;

- Apply concepts of continuous improvement (Lean, Six Sigma, DMAIC) and high-reliability organizations to operational problems in healthcare;
- Critically evaluate — not merely describe — healthcare leadership competency models and the evidence (including null findings) regarding their impact on organizational performance;
- Critically discuss the academic controversies surrounding CMS’s main value-based programs.

Glossary of Acronyms

Acronym	Meaning
ACHE	American College of Healthcare Executives — professional association of U.S. healthcare executives
ACO	Accountable Care Organization — a group of providers held accountable for the cost and quality of care for a population
CMS	Centers for Medicare & Medicaid Services — the federal agency that administers Medicare and Medicaid
CoP	Condition of Participation — a minimum health/safety requirement for participation in Medicare/Medicaid
DMAIC	Define-Measure-Analyze-Improve-Control — the structured Six Sigma cycle
FACHE	Fellow of the American College of Healthcare Executives — ACHE’s healthcare executive certification
GCPG	General Compliance Program Guidance — general compliance program guidance issued by the OIG/HHS
HAC	Hospital-Acquired Condition — a condition acquired during a hospital stay
HRO	High Reliability Organization
HRRP	Hospital Readmissions Reduction Program
MIPS	Merit-based Incentive Payment System — the QPP’s merit-based payment system
MSSP	Medicare Shared Savings Program
NCHL	National Center for Healthcare Leadership — a reference organization for healthcare leadership competency models
OIG	Office of Inspector General — the HHS oversight body
QAPI	Quality Assessment and Performance Improvement — the performance assessment and improvement program required by CMS
QPP	Quality Payment Program — the quality payment program that encompasses MIPS



VBC	Value-Based Care
VBP	Value-Based Purchasing — a CMS hospital program

Introduction

Healthcare organizations in the United States operate under one of the most complex regulatory and payment environments in the world. On one hand, compliance with the rules of the Centers for Medicare & Medicaid Services (CMS) — which spans everything from the Conditions of Participation (CoPs) applicable to hospitals to the myriad of federal fraud and abuse laws — is a condition of eligibility for receiving Medicare and Medicaid reimbursements, on which the financial viability of the vast majority of American hospitals depends. On the other hand, the design of federal payments itself has, over the past decade and a half, migrated from a predominantly volume-based model (fee-for-service) toward arrangements that condition a significant portion of hospital and physician revenue on performance in quality, safety, and total cost of care — what has come to be called Value-Based Care (VBC).

These two regulatory vectors do not operate in an organizational vacuum. Their successful implementation depends directly on the workforce's capacity to execute clinical and administrative processes consistently, on the maturity of continuous improvement systems capable of translating regulatory goals into real operational change, and on the technical and behavioral competence of the managers responsible for leading this transformation. This chapter argues that CMS compliance, Value-Based Care, workforce development, continuous improvement, and manager capacity-building are not five parallel agendas, but five faces of the same integrated management challenge — although, as will be seen in Section 7, this integration remains, in the literature and in practice, more of a normative aspiration than an institutionalized and tested model.

The structure of the chapter follows the five proposed axes: Section 2 examines the architecture of regulatory compliance with CMS; Section 3 discusses the evolution and functioning



of the main value-based payment programs, including their controversies; Section 4 addresses the structural healthcare workforce crisis; Section 5 covers continuous improvement methodologies and high-reliability organizations; Section 6 discusses competency models for manager capacity-building, including empirical evidence on their real impact; Section 7 proposes an integrative model of these five dimensions; and Section 8 presents an illustrative hypothetical application, followed by review questions and closing remarks.

CMS Compliance

Regulatory architecture: Conditions of Participation and QAPI

The foundation of hospital compliance with CMS is set out in Title 42 of the Code of Federal Regulations, Part 482 (42 CFR Part 482), which establishes the Conditions of Participation (CoPs) — the minimum health and safety requirements that hospitals must meet to participate in the Medicare and Medicaid programs (ECFR, 2026; CMS, 2026). The CoPs cover areas as diverse as medical and nursing services, pharmacy, infection control, emergency services, patient rights, medical records, and the physical environment. Among these requirements, the Quality Assessment and Performance Improvement (QAPI) program stands out, requiring hospitals to maintain and demonstrate, through evidence auditable by CMS, an ongoing program capable of producing measurable improvement in outcome indicators and in the reduction of medical errors (ECFR, 2026).

Hospitals with “deemed status” — that is, accredited by organizations such as The Joint Commission, HFAP, CIHQ, or DNV Healthcare — remain subject to the same CoPs, compliance with which is verified through thousands of annual surveys conducted by CMS, most of them unannounced, with the Physical Environment category (42 CFR §482.41) accounting for the largest proportion of deficiencies cited nationally according to industry surveys (OXMAINT, 2026) — a finding that, although derived from a commercial source rather than official CMS-consolidated statistics, is consistent with the emphasis the CoPs themselves place on building and equipment maintenance.



It is important to note that the academic literature on the real impact of hospital accreditation on care quality is more cautious than commercial compliance rhetoric tends to suggest: a systematic review of 76 empirical studies, following PRISMA guidelines, found a consistently positive effect of accreditation on safety culture, process measures, and efficiency, but no clear relationship with patient and staff satisfaction, 30-day readmission, and inconsistent results regarding mortality and healthcare-associated infections (HUSSEIN et al., 2021) — a nuance rarely mentioned in market-facing compliance materials.

The seven elements of the Compliance Program (OIG General Compliance Program Guidance)

Alongside the CoPs, which regulate care operations, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) published, in November 2023, the General Compliance Program Guidance (GCPG) — a reference document, voluntary and non-binding in nature, but which has become established as the primary federal benchmark for building and evaluating healthcare compliance programs (OIG/HHS, 2023). The GCPG structures the compliance program around seven core elements, summarized in Table 1.

Table 1 — The seven elements of the compliance program according to the General Compliance Program Guidance (OIG/HHS, 2023)

Element (GCPG/OIG)	Brief description	Example of operationalization
1. Written policies and procedures	A code of conduct and policies defining expected behavior in billing, referrals, and privacy.	Compliance manual reviewed annually; code of conduct signed by 100% of the workforce.
2. Compliance oversight structure	A compliance officer with real authority and direct reporting to the board.	Compliance Officer with a seat in board meetings; multidisciplinary compliance committee.
3. Training and education	Periodic, mandatory training on regulatory risks.	Annual training on the Anti-Kickback Statute, the Stark Law, and HIPAA for the entire workforce.



4. Open lines of communication	Confidential, non-retaliatory channels for reporting suspected non-compliance.	Anonymous hotline; formal non-retaliation policy.
5. Risk-based auditing and monitoring	Periodic verification of high-risk areas (billing, OIG exclusions).	Monthly checks against the OIG List of Excluded Individuals and Entities (LEIE) and GSA debarment lists.
6. Consistent enforcement of standards	Proportional consequences for violations and incentives for good compliance performance.	Disciplinary matrix applied consistently, regardless of the employee's position.
7. Prompt response and corrective action	Swift investigation of identified deviations and correction of the root cause.	Self-disclosure and repayment of improper payments within the 60-day rule (False Claims Act).

Source: prepared by the author based on OIG/HHS (2023) and Accountable HQ (2026).

The way OIG evaluates compliance programs has evolved significantly: federal prosecutors now examine not only the program's formal existence, but its actual functionality — whether the compliance officer holds real authority, whether training effectively reaches the entire workforce, whether auditing proactively identifies problems, and whether corrective actions address root causes. Programs that constitute mere “paper compliance” offer limited legal protection; robust, operational programs can mean the difference between a civil resolution and a criminal prosecution (OIG/HHS, 2023).

Key fraud and abuse laws

The legal framework underpinning CMS/OIG enforcement includes, among other rules: the False Claims Act (31 U.S.C. §§ 3729-3733), which prohibits the submission of false claims to the federal government and whose “60-day rule” — set out in CMS's final rule on overpayments (42 CFR § 401.305) — requires that identified overpayments be self-disclosed and repaid within that period, on penalty of the omission constituting a reverse false claim; the Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)), which prohibits paying remuneration in exchange for referrals of patients covered by



federal programs; the Stark Law (42 U.S.C. § 1395nn), which restricts physician referrals to entities with which the physician has a financial relationship; the Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a); and HIPAA, which governs the privacy and security of health information. Compliance with these rules requires, in operational practice, periodic — generally monthly — checks against the OIG List of Excluded Individuals and Entities (LEIE), the General Services Administration’s (GSA) debarment list, and state Medicaid sanction databases.

Organizational implications

Reading these requirements together reveals a central point for this chapter: CMS compliance is, for the most part, not an isolated legal problem solved by a compliance department operating separately — it is, rather, a matter of day-to-day operational execution (building maintenance, clinical documentation, staff training, monitoring of quality indicators) that depends directly on the workforce’s capacity and on the maturity of the organization’s continuous improvement systems. This finding is the first connecting thread of the integration proposed in Section 7.

Value-Based Care (VBC)

From volume-based to value-based reimbursement

Historically, Medicare reimbursed hospitals and physicians primarily by volume of services provided (fee-for-service), a model criticized for incentivizing quantity over quality and efficiency. Since the 2010s, CMS has been implementing a growing set of programs that condition a portion of reimbursement on performance in quality, safety, patient experience, and total cost of care. CMS formally identifies these as its “Value-Based Programs”: Hospital Value-Based Purchasing (VBP),



the Hospital Readmissions Reduction Program (HRRP), the Value Modifier, the Hospital-Acquired Condition (HAC) Reduction Program, in addition to equivalent programs for home health and long-term care institutions (CMS, 2026).

Accountable Care Organization models: MSSP and ACO REACH

The Medicare Shared Savings Program (MSSP), in effect since 2012, is Medicare's largest alternative payment model, having generated more than US\$ 35 billion in gross savings over its history (ALEDADÉ, 2026). Under the final rule of the Medicare Physician Fee Schedule for 2026, ACOs will be able to remain for up to five performance years in the BASIC track of one-sided risk for agreements starting in 2027 onward, after which they must migrate to two-sided risk models (MEDBRIDGE, 2025). At the same time, the ACO REACH model had its termination announced in December 2025, effective at the end of 2026; in its place, the CMS Innovation Center will launch the Long-term Enhanced ACO Design (LEAD) Model, a ten-year initiative expected to begin in 2027 (ALEDADÉ, 2026). In 2025, more than 900 Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals participated in ACO REACH (PENN STATE PORH, 2025).

Hospital value-based programs: VBP, HRRP, and the HAC Reduction Program

The Hospital VBP Program adjusts payments under the Inpatient Prospective Payment System (IPPS) — affecting approximately 3,100 hospitals — based on a Total Performance Score calculated from quality, safety, and patient experience domains (CMS, 2026). The HRRP penalizes hospitals for excess readmissions in tracer conditions, and the HAC Reduction Program reduces payment by 1% for hospitals in the worst-performing safety quartile.



MIPS/QPP: the incentive architecture for physicians in 2026

For eligible physicians and groups outside alternative payment models, the main value mechanism is the Merit-based Incentive Payment System (MIPS). CMS's final rule for the 2026 performance year signals stabilization: the performance threshold remains at 75 points through at least 2028, category weights are unchanged (Quality 30%, Cost 30%, Promoting Interoperability 25%, Improvement Activities 15%), and payment adjustments of up to $\pm 9\%$ (ECQI RESOURCE CENTER, 2025; MDINTERACTIVE, 2025). There are 187 quality measures available for 2026, with six new MIPS Value Pathways (MVPs) (ECQI RESOURCE CENTER, 2025).

Medicare Advantage: Star Ratings and the Quality Bonus Program

No discussion of Value-Based Care in the United States is complete without Medicare Advantage (MA), a modality that already covers about half of Medicare beneficiaries — approximately 35 million people in 2026 (KFF, 2026). CMS annually assigns each MA contract a rating of one to five stars (Star Rating), calculated from a weighted average of performance across roughly 40 quality measures, capturing health outcomes, beneficiary experience, and access to care and medications (AARP, 2026; CMS, 2026). Contracts that reach four stars or more qualify for the Quality Bonus Program (QBP), whose projected federal spending exceeds US\$ 13 billion in 2026 alone, with 68% of MA beneficiaries in bonus-eligible plans (KFF, 2026).

2026 was a particularly turbulent year for the program: the national average score fell from 3.92 to 3.65 stars in the initial October 2025 release (BECKER'S PAYER ISSUES, 2025), leading insurers such as Clover Health to sue CMS, alleging the use of illegitimate metrics; the agency subsequently voluntarily recalculated 2026 ratings following a court ruling, raising bonuses for major insurers such as UnitedHealth and Aetna (AXIOS, 2026). CMS also finalized a methodological overhaul of the Star Ratings system that, according to estimates, is expected to direct billions of additional dollars to



insurers over the next decade (HEALTHCARE DIVE, 2026).

Table 2 summarizes the main value-based programs discussed in this section.

Table 2 — Main CMS Value-Based Care programs and their status in 2026

Program	Unit of analysis	Incentive mechanism	Status in 2026
Hospital Value-Based Purchasing (VBP)	Hospitals (IPPS)	Payment adjustment based on a Total Performance Score in quality, safety, and patient experience	Consolidated program, with annual reports (Baseline and Percentage Payment Summary Reports)
Hospital Readmissions Reduction Program (HRRP)	Hospitals (IPPS)	Penalty for excess readmissions in tracer conditions	In effect; subject to academic controversy regarding disproportionate penalization of safety-net hospitals (see 3.7)
Hospital-Acquired Condition (HAC) Reduction Program	Hospitals (IPPS)	1% payment reduction for hospitals in the worst-performing safety quartile	In effect, with growing focus on healthcare-associated infections
Medicare Shared Savings Program (MSSP)	ACOs (provider groups)	Savings/loss sharing against a total-cost benchmark	Medicare's largest alternative payment model; more than US\$ 35 billion in gross savings since 2012
ACO REACH	High-risk ACOs	Partial/full capitation and greater shared financial risk	Termination scheduled for the end of 2026; replaced by the LEAD model starting in 2027
Merit-based Incentive Payment System (MIPS)	Eligible physicians and groups	Payment adjustment (up to $\pm 9\%$) based on scoring in Quality, Cost, Interoperability, and Improvement Activities	75-point threshold maintained through 2028; 187 quality measures in the 2026 performance year
Medicare Advantage Star Ratings / Quality Bonus Program (QBP)	Medicare Advantage plans (contracts)	Payment bonus (rebate) for contracts with 4 stars or more, calculated on roughly 40 quality measures	Projected federal spending above US\$ 13 billion in 2026; methodology under strong legal challenge and MedPAC review (see 3.7)

Source: prepared by the author based on CMS (2026), Aledade (2026), Medbridge (2025), Penn State PORH (2025), eCQI Resource Center (2025), and KFF (2026).

Operational and financial implications



Reading these programs together reveals that Value-Based Care is not a single program, but a mosaic of incentive mechanisms with distinct units of analysis, time windows, and degrees of financial risk — requiring healthcare organizations to have the analytical capacity to navigate multiple programs simultaneously, often with overlapping but not identical metrics. The transition from ACO REACH to the LEAD model illustrates how the regulatory instability of payment innovation models is, in itself, a management challenge that requires organizational leadership to have continuous strategic replanning capacity.

Critical counterpoints: value-based programs under scrutiny

A technically serious chapter must not uncritically reproduce CMS’s institutional narrative about its own programs. Regarding the HRRP, a study published in BMC Health Services Research found that, between 2009 and 2016, the frequency of readmission penalties was systematically higher among safety-net hospitals — 72% of these hospitals were penalized in all four years post-implementation of the program, compared to 59% of other hospitals — which reinforces concerns that the program’s risk-adjustment model does not adequately capture socioeconomic factors associated with higher readmission risk, penalizing hospitals that serve more vulnerable populations for characteristics largely outside their direct control (BANERJEE et al., 2022). This is a tension directly relevant to rural and community hospitals, a central theme of this author’s previous work on hospital financial sustainability.

Regarding Medicare Advantage, the Medicare Payment Advisory Commission (MedPAC) — an advisory commission to the U.S. Congress — estimates that payments to MA plans will exceed, in 2026, the costs that traditional Medicare would incur to serve the same beneficiaries by approximately US\$ 76 billion, which has fueled proposals, including from think tanks aligned with different political spectrums, to eliminate or substantially reform the Quality Bonus Program itself (AXIOS, 2026).



It is also worth noting that the Quality Bonus Program itself is not budget-neutral — unlike other traditional Medicare value-based programs, in which bonuses for high performance are offset by penalties for low performance — which means its cost falls directly on the federal budget, with no automatic offsetting mechanism (AARP, 2026).

These counterpoints do not invalidate the general logic of Value-Based Care, but they indicate that its concrete implementation involves unresolved distributive and methodological disputes — between hospitals with different care profiles, in the case of the HRRP, and between traditional Medicare and Medicare Advantage, in the case of MA. Healthcare organization managers must understand these programs not merely as technical targets to be optimized, but as arenas of evolving regulatory dispute.

Workforce Development and Professional Capacity-Building

A structural, not cyclical, crisis

The 2026 Health Care Workforce Scan, published by the American Hospital Association (AHA), describes a sector “in motion” facing structural pressures: rising labor and supply costs, inflation, high interest rates, an aging population with increasing care complexity, and a workforce still burdened by years of pandemic-era strain (AHA, 2025a). The report projects that, at the current rate of four healthcare workers per elderly person, this ratio will fall to 2.9 workers per elderly person over the next five years (AHA, 2025b).

Category-specific projections reinforce the severity of the situation: the National Center for Health Workforce Analysis projects a shortfall of more than 78,000 registered nurses by the end of 2025, and the American College of Physicians projects a shortage of up to 85,000 physicians by 2036 (HELLOSYNEX, 2026). Rural and underserved communities face the most acute shortages (AHA, 2025a).



Organizational response strategies

Faced with this situation, hospitals and health systems have been investing in: (i) career pathways, apprenticeship programs, and partnerships with educational institutions (“grow-your-own strategies”); (ii) expanding the scope of practice of Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs), with evidence published in JAMA of outcomes equivalent to physicians in appropriate clinical contexts; (iii) internal flexible staffing models — internal float pools, internal staffing agencies, and predictive scheduling; and (iv) outsourcing of non-clinical functions (HEALTH CATALYST, 2025; AHA, 2025a).

The workforce as a condition for compliance and value

It is essential to note that workforce development is not a parallel agenda to regulatory compliance or Value-Based Care performance: it is its operational precondition. The Conditions of Participation require nursing and clinical service staffing levels compatible with the hospital’s care complexity; performance in the safety domains of the Hospital VBP and the HAC Reduction Program depends directly on staff stability; and operating under shared-risk models such as the MSSP presupposes population health management teams that, in many rural hospitals, do not yet exist at adequate scale.

Continuous Improvement: Lean, Six Sigma, and High-Reliability Organizations

Methodological foundations

Continuous Quality Improvement (CQI) constitutes the operational mechanism through which healthcare organizations translate regulatory requirements (such as CMS’s own QAPI) and value goals into real process change. Two methodologies, originating in industrial manufacturing,



have become established as the main CQI tools in healthcare: Lean, focused on eliminating waste, and Six Sigma, oriented toward reducing variation through the Define-Measure-Analyze-Improve-Control (DMAIC) cycle (STATPEARLS, 2024).

Evidence of impact

A review of the application of Six Sigma and Lean in surgery identified measurable improvement in more than 88% of the studies analyzed, with the authors themselves noting that this percentage may reflect publication bias (STATPEARLS, 2023). A study with 251 respondents from twelve Malaysian hospitals accredited by the Malaysian Society for Quality in Health found that Lean and Six Sigma initiatives positively and significantly impact continuous quality improvement, and that top management support is a central determinant of this relationship (AHMED et al., 2023) — a finding that directly reconnects continuous improvement to the manager capacity-building discussed in Section 6. An Italian study developed and validated a specific scale to assess public hospitals' readiness to adopt Lean Six Sigma, recognizing that this readiness varies according to regional and governance factors (ROSA et al., 2024).

Safety culture and high-reliability organizations

In addition to structured process-improvement methodologies, the concept of the High Reliability Organization (HRO), developed by Weick and Sutcliffe (2015) based on the study of organizations that operate consistently safely in high-risk environments (such as aircraft carriers, air traffic control, and hospital emergency units), has guided patient safety initiatives in American hospitals. The authors identify five principles of the “mindful organization”: preoccupation with failure (even minor), reluctance to simplify interpretations of adverse events, sensitivity to day-to-day operations, commitment to organizational resilience, and deference to technical expertise, regardless



of the hierarchical position of whoever holds it (WEICK; SUTCLIFFE, 2015). Adoption of these principles connects directly with CMS’s QAPI requirements (Section 2.1) and with the safety domains of the Hospital VBP and the HAC Reduction Program (Section 3.3), reinforcing that continuous improvement, regulatory compliance, and value-based performance share the same underlying operational infrastructure.

Manager Training and Development

Competency models for healthcare leadership

The capacity-building of healthcare managers in the United States is largely structured by competency models developed by professional associations. The American College of Healthcare Executives (ACHE) has maintained, since 2023, competencies organized into domains such as Communication and Relationship Management, Leadership, Healthcare System Knowledge, Business Skills and Knowledge, and Professionalism, derived from research conducted by the associations of the Healthcare Leadership Alliance (ACHE, the American Association of Physician Leadership, the American Organization for Nursing Leadership, HFMA, HIMSS, and MGMA) (PEIRCE COLLEGE, 2024). At the same time, the National Center for Healthcare Leadership (NCHL) developed the Health Leadership Competency Model™, organized into three domains — Transformation, Execution, and People (ICAN, 2025). Table 3 summarizes the main domains of these two models.

Table 3 — Competency domains of the ACHE and NCHL models

Model / Domain	Central focus
ACHE — Communication and Relationship Management	Ability to articulate vision, negotiate, and build trust with clinical and administrative teams.
ACHE — Leadership	Self-awareness, change management, and development of other leaders.
ACHE — Healthcare System Knowledge	Understanding of financing, regulation (including CMS), and industry dynamics.



ACHE — Business Skills and Knowledge	Finance, operations, human resource management, and information technology.
ACHE — Professionalism	Ethics, accountability, and commitment to excellence in care.
NCHL — Transformation	Strategic vision, innovation, analytical thinking, and leadership of organizational change.
NCHL — Execution	Performance management, accountability, and process management.
NCHL — People	Talent development, relationship management, and interpersonal communication.

Source: prepared by the author based on ACHE (2023), Peirce College (2024), and iCAN (2025).

Certification and continuing education

ACHE maintains a voluntary certification program — the Board Certification in Healthcare Management — which grants approved executives the title of Fellow (FACHE), requiring academic training beyond the bachelor’s degree, minimum experience in management positions, and an ongoing commitment to continuing education (ACHE, 2024). Maintaining certification requires 36 hours of continuing education per cycle (ACHE, 2023).

From individual competency to organizational capacity: what the evidence actually shows

Contrary to what a purely descriptive reading of the ACHE and NCHL models might suggest, the empirical evidence available on the real impact of manager certification on hospital performance is scarce and, when it exists, not necessarily favorable to the narrative that certified individual competence automatically translates into superior organizational performance. A study published in the journal *Healthcare* (MDPI), the first of its kind according to the authors themselves, specifically examined whether Texas hospitals led by executives trained in healthcare administration master’s programs accredited by the Commission on Accreditation of Healthcare Management Education (CAHME) and



affiliated with ACHE showed better financial and quality performance — including the Hospital VBP Program’s own Total Performance Score discussed in Section 3.3. The result was a null finding: no statistically significant effect of the training program’s CAHME accreditation or of ACHE affiliation was found on the cost, quality, and access outcomes analyzed (BROOKS et al., 2021).

This null finding should not be read as evidence that credentials and competency models are irrelevant, but as an important methodological warning: the relationship between certified individual competency and organizational performance is likely mediated by variables that competency models, by themselves, do not capture — governance structure, organizational culture, information systems maturity, and, as discussed in Section 5.2, the degree of effective top management support for continuous improvement initiatives. This chapter, therefore, does not endorse the premise that merely obtaining credentials such as the FACHE guarantees better institutional performance; rather, it positions manager capacity-building as a necessary, but clearly not sufficient, condition for the integration proposed in Section 7.

An Integrative Model: The Author’s Proposal

The previous sections treated CMS Compliance, Value-Based Care, workforce development, continuous improvement, and manager capacity-building as analytically distinct axes. It must be made clear, however — in the same line of methodological caution adopted in this author’s previous work on hospital financial sustainability — that the integration proposed in this section constitutes a theoretical construct by the author, grounded in an articulated reading of the reviewed literature, and not an empirically tested conclusion from any of the sources cited in this chapter. None of the studies or documents mobilized here simultaneously and jointly measures the performance of a single healthcare organization across the five proposed axes. The null finding discussed in Section 6.3 itself reinforces the need for this caution: if even the link between individual certification and organizational performance is not well established in the literature, the integration of five entire axes is, all the more



so, a working hypothesis.

With that caveat made, it is proposed that the five axes relate according to the following logic. CMS compliance (Section 2) defines the non-negotiable regulatory floor for operations. Value-Based Care (Section 3) shifts the economic incentive beyond that floor, rewarding superior performance — but depends, for its execution, on the same data systems, processes, and organizational culture required by regulatory compliance. The workforce (Section 4) is the executing resource for both agendas. Continuous improvement (Section 5) provides the methodological infrastructure that translates regulatory requirements and value goals into measurable process change. And manager capacity-building (Section 6) acts as a cross-cutting enabling factor — with the empirical caveat that this capacity-building, on its own, is no guarantee of results, requiring articulation with organizational governance, culture, and systems.

This proposed integration remains, it bears repeating, a working hypothesis. Its validation would require future studies that simultaneously measure compliance indicators, performance in value-based programs, workforce indicators, continuous improvement maturity, and leadership certification level within the same sample of organizations — a study which, as far as the research conducted for this chapter could verify, does not yet exist in the literature.

Illustrative Application (Hypothetical Scenario)

To make the integration proposal of Section 7 more concrete, a composite hypothetical scenario is presented below — not corresponding to any real organization — for exclusively didactic purposes.

Consider a hypothetical 120-bed community hospital, a participant in the MSSP and subject to the Hospital VBP Program and the HRRP. An unannounced CMS survey identifies “Condition”-level deficiencies in the Physical Environment category. The root-cause investigation reveals that preventive equipment maintenance had been postponed for months due to a prolonged vacancy in the



maintenance manager position — a direct reflection of the workforce shortage described in Section 4. The corrective response required by the seventh element of the GCPG (Table 1) includes not only immediate physical remediation, but a review of the recruitment program for operational support positions.

At the same time, the hypothetical hospital identifies, through its continuous improvement program, a readmission rate above the HRRP benchmark for heart failure patients — a situation that, in light of the critical counterpoint in Section 3.7, requires heightened attention if the hospital serves a high proportion of low-income patients, given the risk that social factors not captured by the program's risk adjustment explain part of the observed performance. A Lean Six Sigma project, structured according to the DMAIC cycle, maps the hospital discharge process and identifies failures in the transition of outpatient care. Leadership of the project by a FACHE-certified manager is identified, in this illustrative scenario, as a factor that enables the implementation of the changes — an illustration that, in light of Section 6.3, should be read as a pedagogical example, not as an empirical generalization about the effect of certification.

This scenario, although hypothetical, illustrates the central argument of this chapter: a single non-compliance event and a single value-based performance indicator prove, in practice, to be symptoms of the same underlying root cause, reinforcing that the five axes of this chapter can rarely be managed in a truly independent way.

Review and Discussion Questions

- Explain why most deficiencies identified in CMS surveys are concentrated in the Physical Environment category, and relate this finding to the workforce problem discussed in Section 4.
- Compare the incentive mechanisms of the MSSP, ACO REACH/LEAD, and MIPS. Why does the regulatory instability of some of these models represent a management challenge distinct from the challenge posed by their technical complexity?
- According to Banerjee et al. (2022), safety-net hospitals are penalized more frequently under the HRRP. Discuss whether this indicates a problem in the program's design, a real quality-of-



care problem in these hospitals, or both — and how you would substantiate your answer.

- Does the null finding of the study published in Healthcare (2021) on CAHME/ACHE certification and hospital performance contradict the integration proposal in Section 7? Justify your answer considering the difference between a “necessary condition” and a “sufficient condition.”

- Using the hypothetical scenario in Section 8 as a starting point, redesign the sequence of managerial decisions assuming the hospital does NOT have a structured continuous improvement program. Which of the chapter’s five dimensions would be most affected?

Closing Remarks

This chapter examined five central dimensions of healthcare organization management in the United States — CMS compliance, Value-Based Care, workforce development, continuous improvement, and manager capacity-building — based on current regulatory, technical, and academic literature, including critical counterpoints to programs often presented only descriptively in market literature. An effort was made to keep clear the boundary between what the literature actually documents and what constitutes the author’s interpretive proposal.

As a central practical implication, it is argued that healthcare organizations — particularly rural and community hospitals — benefit from treating regulatory compliance, value-based performance, workforce planning, continuous improvement, and leadership development as a single portfolio of managerial investment. As a limitation, it is acknowledged that this integrative proposal lacks direct empirical testing — and that even partial links in this chain, such as the effect of manager certification on organizational performance, lack robust evidence in the current literature, constituting more of a research agenda than an established conclusion.

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