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Bridging the Clinical-Financial Divide

How Quality and Safety Metric Realities Drive Value-Based Reimbursement

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What We'll Cover Today

Four learning objectives anchor this 75-minute session

Decode the Three CMS Programs 01

Analyze the financial mechanics, thresholds, and overlapping penalty structures of VBP, HAC, and HRRP.

Connect Outcomes to Payment 02

Evaluate how HAIs and Patient Safety Indicators directly affect base operating MS-DRG payments.

Bridge Finance and Quality 03

Identify the gaps between financial reporting and bedside execution, and how to close them.

Protect Margin Through CDI 04

Explain how documentation accuracy and risk adjustment safeguard value-based revenue.

2

POLLING QUESTION · WARM-UP

How well does your finance team understand what drives your VBP score?

- Very well — it's part of our routine reporting
- Somewhat — they know the headline, not the mechanics
- Not really — quality and finance rarely talk about this

3

Explore the CMS Quality Dashboard

Scan to interact with the prototype

Illustrative mock data • cms-quality-demo.netlify.app

4

One Set of Data, Two Very Different Lenses

The clinical-financial divide isn't a communication problem — it's a design problem

The Clinical Lens

- Optimizes for the patient in front of them, right now
- Measures success in outcomes: infection avoided, complication prevented
- Documentation is a byproduct of care, not the primary task
- Timeframe: this shift, this patient, this bed

The Financial Lens

- Optimizes for margin across the whole enrolled population
- Measures success in adjustment factors: TPS, HAC quartile, ERR
- Documentation is the primary evidence CMS pays on
- Timeframe: the performance period, the fiscal year

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THE CORE IDEA

Quality is not a clinical department. It is a line on the financial statement.

Every VBP point, every HAC quartile placement, every readmission ratio flows through the same base operating MS-DRG payment your CFO reports on.

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01

The Three CMS Programs, Broken Down

VBP · HAC Reduction · HRRP — what triggers each, how it's calculated, and what it costs

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Program 1

Hospital Value-Based Purchasing

Budget-neutral — hospitals fund their own incentive pool.

2%

of base operating DRG payments withheld & redistributed

1 How the pool works

CMS withholds 2% of every participating hospital's base operating DRG payments, then redistributes the entire amount back as value-based incentive payments — the program spends nothing extra and saves nothing extra.

2 Total Performance Score (TPS)

Built from weighted measurement domains. Each hospital earns two scores per measure — achievement (vs. all hospitals) and improvement (vs. its own baseline) — and keeps the higher of the two.

3 Payment mechanics

The net result (withhold minus earned incentive) is applied claim-by-claim as an adjustment factor to the base operating MS-DRG payment on every Medicare FFS discharge.

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Program 2

Hospital-Acquired Condition Reduction

No substantive changes made in the FY 2026 or FY 2027 IPPS rules — the mechanics you learn today hold.

1%

flat payment reduction on ALL Medicare FFS discharges

Who gets penalized

Hospitals with a Total HAC Score above the 75th percentile of all hospitals — the worst-performing quartile — nationally, every year, regardless of your own year-over-year improvement.

The six measures behind the Total HAC Score

PSI-90
Composite: patient safety & adverse events

CLABSI
Central line-associated bloodstream infection

CAUTI
Catheter-associated urinary tract infection

SSI
Colon & abdominal hysterectomy surgical site infection

MRSA
MRSA bacteremia

C. diff
Clostridioides difficile infection

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Program 3

Hospital Readmissions Reduction

Current cycle: 10/1/2025 – 9/30/2026, based on a rolling 3-year performance window.

3%

maximum penalty on Medicare payments per hospital

Six tracked conditions today

AMI | Heart Failure | Pneumonia | COPD | Hip/Knee Replacement | CABG

What's driving penalty amounts

Penalty is based on the Excess Readmission Ratio (ERR) — risk-adjusted actual vs. expected readmissions for each condition, measured over the rolling window.

Watch for FY2029: the Sepsis Readmission measure

CMS has finalized a new 30-Day Risk-Standardized Readmission measure following sepsis hospitalization. Hospitals get two years of confidential early-look reports (FY2028–FY2029) before it counts toward payment in FY2030 — start tracking sepsis readmissions now.

A hospital can be penalized under VBP, HAC, and HRRP simultaneously — these are separate, additive programs.

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Three Programs, Side by Side

Same claim, three separate ways to lose money on it

	VBP	HAC Reduction	HRRP
What triggers it	Total Performance Score across measurement domains	Landing in the worst-performing quartile nationally	Excess readmissions vs. risk-adjusted expected
How it's calculated	Achievement or improvement score, better of the two, per measure	Total HAC Score > 75th percentile of all hospitals	Excess Readmission Ratio, rolling 3-yr window, 6 conditions
Max exposure	Net of 2% withhold vs. incentive earned back	Flat 1% on all Medicare FFS discharges	Up to 3% of Medicare payments

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THE STACKING EFFECT

These penalties don't compete — they compound.

4–5%

of total Medicare reimbursement is not an uncommon combined penalty for the lowest-performing hospitals hit by all three programs at once

- VBP, HAC Reduction, and HRRP are separate statutory programs — CMS does not net them against each other
- A single hospital can appear in the worst quartile for HAC and simultaneously carry a multi-percent HRRP penalty for a completely different clinical service line
- That makes the "close-the-gap" conversation between quality and finance a recurring, not one-time, discipline

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POLLING QUESTION · CHECK YOUR ASSUMPTIONS

Which of these three programs do you think costs your organization the most?

- Hospital Value-Based Purchasing (VBP)
- HAC Reduction Program
- Hospital Readmissions Reduction Program (HRRP)
- Honestly, we've never separated them out

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02

From Bedside to Balance Sheet

Tracing one clinical event through to its financial consequence

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Tracing a Single HAI to Its Payment Impact

STEP 1
Clinical event
A patient develops a CAUTI during an inpatient stay.

→

STEP 2
NHSN reporting
Infection prevention abstracts the case and submits it to CDC's NHSN.

→

STEP 3
HAC score effect
The event feeds the CAUTI measure, moving the hospital's Total HAC Score.

→

STEP 4
Quartile placement
Enough events like this can push the hospital past the 75th percentile.

→

STEP 5
MS-DRG impact
A 1% reduction applies to every Medicare FFS discharge for the full fiscal year — not just this patient.

The takeaway: a single preventable event never stays isolated — it compounds into a system-wide, full-year payment adjustment.

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One Bad SIR, Two Separate Penalties

Illustrative example — the same CAUTI hits HAC Reduction AND the VBP Safety domain, calculated two different ways

Clinical event
A patient develops a CAUTI during an inpatient stay.

→

NHSN reporting
Infection prevention abstracts the case; the CAUTI SIR rises.

THIS EVENT NOW SPLITS INTO TWO SEPARATE CALCULATIONS

HAC REDUCTION PROGRAM — A FLAT CLIFF	VBP SAFETY DOMAIN — A CONTINUOUS DIAL
HAC score effect The CAUTI measure is 1 of 6 in the Total HAC Score; a worse SIR pulls the composite up.	**Safety domain score drops** CAUTI is 1 of 7 roughly equal measures in Safety, which is 25% of the Total Performance Score.
Quartile → flat 1% penalty Cross the 75th percentile and it's a flat 1% cut on ALL Medicare FFS discharges — all or nothing.	**TPS falls → variable net loss** Every fractional point matters continuously — no cliff, but no floor either. (Granular math next.)

The double penalty: the same CAUTI can cost you under HAC AND under VBP — two separate programs, two separate mechanics, one root cause.

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Granular: How One Zero-Point Measure Moves the VBP Score

Illustrative math, using CMS's published domain weights and scoring rules

1. **Safety is 25% of the TPS, split across 7 measures**

   CAUTI, CLABSI, C. diff, MRSA, SSI (colon/hysterectomy), PSI-90, and SEP-1 (new for FY2026) — each worth roughly 1/7 of the domain, or about 3.6% of the overall Total Performance Score.

2. **Each measure scores 0–10 points**

   CMS takes the better of achievement (vs. all hospitals) or improvement (vs. your own baseline) for every measure, per its standard methodology.

3. **One zero-point measure is enough to move the needle**

   A hospital averaging 5/10 across all 7 Safety measures has a domain score of 50. If CAUTI alone falls to 0/10, the domain score drops to about 43 — no other measure has to change.

4. **At 25% weight, that's ≈1.8 points off the overall TPS**

   (50 − 43) × 25% ≈ 1.8 points shaved off a 100-point Total Performance Score — from a single measure going to zero.

⚠ **5. From TPS points to dollars: no fixed conversion rate**

CMS converts TPS into a payment adjustment using a "linear exchange function" that resets every year based on how ALL hospitals performed nationally — so there's no fixed point-to-dollar rate. As a rough illustrative benchmark, a ~1.8-point TPS swing has translated to roughly a 0.04–0.05 percentage-point shift in net VBP payment in past program years — real money, but a fraction of the flat 1% HAC penalty.

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Documentation Is a Financial Control, Not Paperwork

Clinical documentation improvement (CDI) protects margin by protecting accuracy

Documentation accuracy → **Acuity capture** → **Protected value-based margin**

Without accurate documentation, a patient's true clinical complexity is invisible to CMS — which means the risk-adjustment models CMS uses to judge your outcomes are working against you, not with you.

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Common Gaps That Create "False" Quality Problems

The outcome may have been fine — the record just didn't say so

Undercoded comorbidities

Chronic conditions present but not documented to the specificity CMS models require, understating true patient risk.

Present-on-admission ambiguity

POA indicators missing or unclear make a pre-existing condition look hospital-acquired.

Query response lag

CDI queries to physicians go unanswered before claim submission, locking in an incomplete record.

Severity of illness understated

Vague terminology ("infection" vs. a specific organism and site) fails to capture true acuity.

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03

Bridging the Divide: The Playbook

How to build cross-functional strategies between quality and finance

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Structures That Keep Quality and Finance in the Same Room

Joint quality-finance huddles

Standing, recurring review of penalty-exposed measures with both departments at the table — not sequential handoffs.

Shared dashboards

One source of truth for VBP, HAC, and HRRP status, visible to clinical leaders and finance simultaneously.

Translated language

Clinical measures get restated in dollar terms; financial targets get restated in patient-safety terms.

Named accountability

Each penalty-exposed measure has one clinical owner and one finance partner — no diffusion of responsibility.

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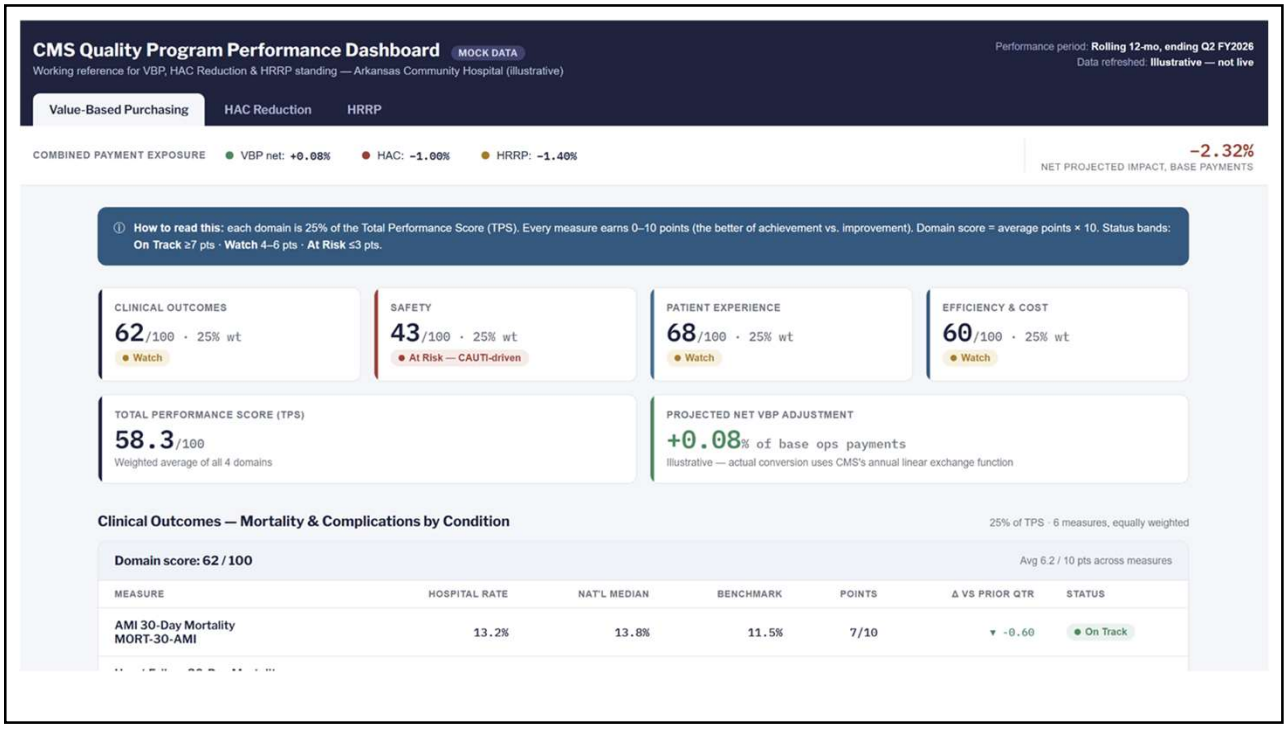

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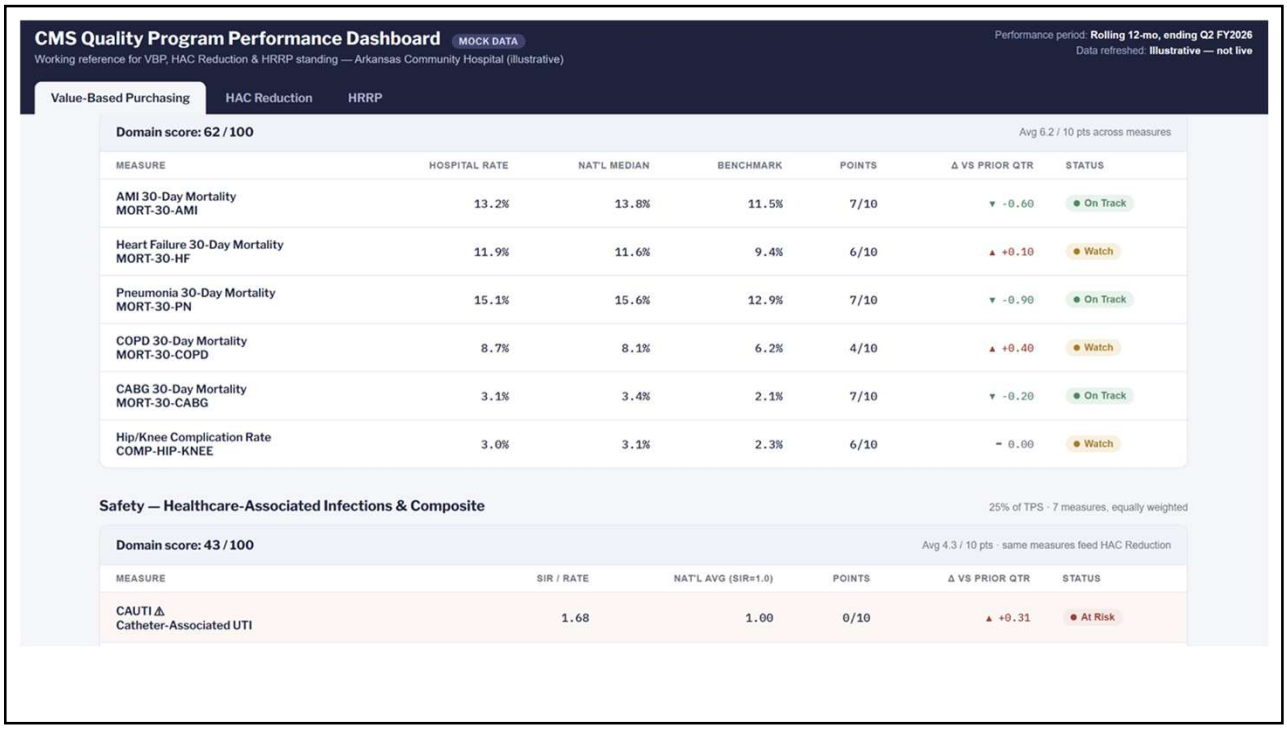
CMS Quality Program Performance Dashboard
MOCK DATA
Working reference for VBP, HAC Reduction & HRRP standing — Arkansas Community Hospital (illustrative)
Performance period: Rolling 12-mo, ending Q2 FY2026
Data refreshed: Illustrative — not live
Value-Based Purchasing
HAC Reduction
HRRP
Domain score: 62 / 100
Avg 6.2 / 10 pts across measures
MEASURE
HOSPITAL RATE
NAT'L MEDIAN
BENCHMARK
POINTS
Δ VS PRIOR QTR
STATUS
AMI 30-Day Mortality
MORT-30-AMI
13.2%
13.8%
11.5%
7/10
▼ -0.60
On Track
Heart Failure 30-Day Mortality
MORT-30-HF
11.9%
11.6%
9.4%
6/10
▲ +0.10
Watch
Pneumonia 30-Day Mortality
MORT-30-PN
15.1%
15.6%
12.9%
7/10
▼ -0.90
On Track
COPD 30-Day Mortality
MORT-30-COPD
8.7%
8.1%
6.2%
4/10
▲ +0.40
Watch
CABG 30-Day Mortality
MORT-30-CABG
3.1%
3.4%
2.1%
7/10
▼ -0.20
On Track
Hip/Knee Complication Rate
COMP-HIP-KNEE
3.0%
3.1%
2.3%
6/10
– 0.00
Watch
Safety — Healthcare-Associated Infections & Composite
25% of TPS · 7 measures, equally weighted
Domain score: 43 / 100
Avg 4.3 / 10 pts · same measures feed HAC Reduction
MEASURE
SIR / RATE
NAT'L AVG (SIR=1.0)
POINTS
Δ VS PRIOR QTR
STATUS
CAUTI ⚠
Catheter-Associated UTI
1.68
1.00
0/10
▲ +0.31
At Risk

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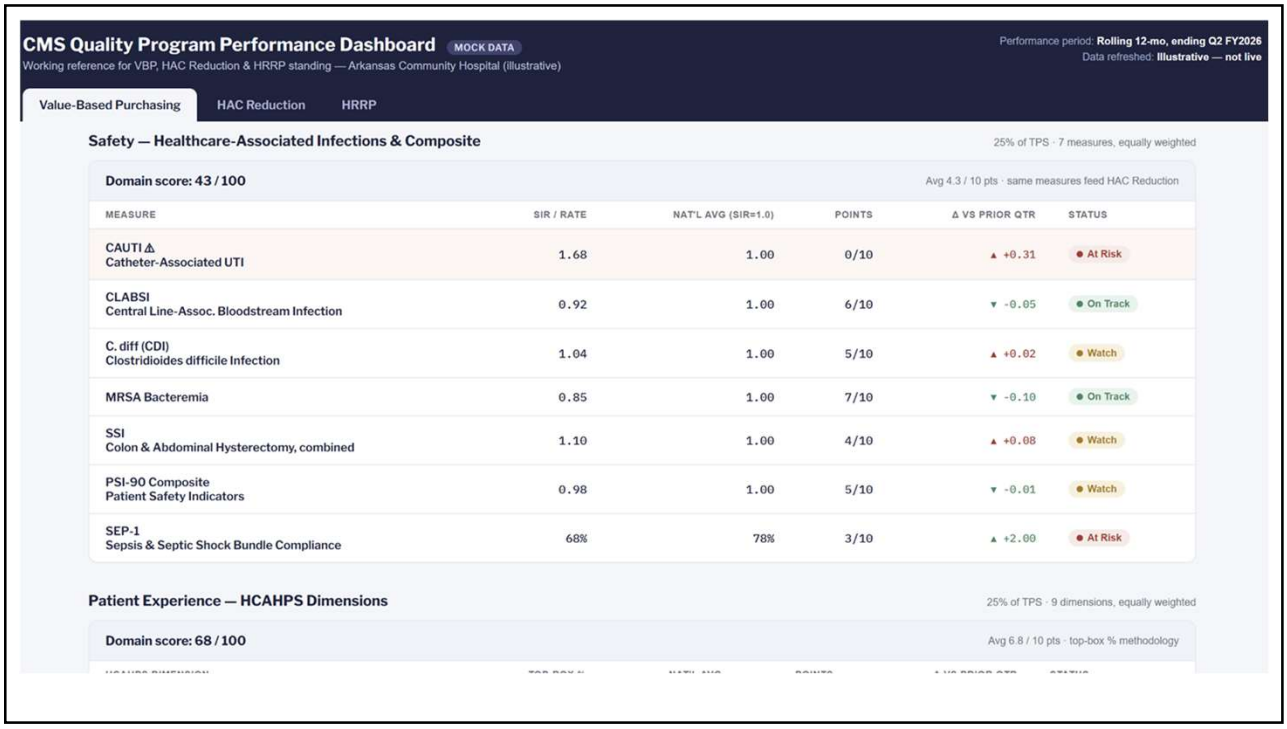
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SIR / RATE
NAT'L AVG (SIR=1.0)
POINTS
Δ VS PRIOR QTR
STATUS
CAUTI ⚠
Catheter-Associated UTI
1.68
1.00
0/10
▲ +0.31
At Risk
CLABSI
Central Line-Assoc. Bloodstream Infection
0.92
1.00
6/10
▼ -0.05
On Track
C. diff (CDI)
Clostridioides difficile Infection
1.04
1.00
5/10
▲ +0.02
Watch
MRSA Bacteremia
0.85
1.00
7/10
▼ -0.10
On Track
SSI
Colon & Abdominal Hysterectomy, combined
1.10
1.00
4/10
▲ +0.08
Watch
PSI-90 Composite
Patient Safety Indicators
0.98
1.00
5/10
▼ -0.01
Watch
SEP-1
Sepsis & Septic Shock Bundle Compliance
68%
78%
3/10
▲ +2.00
At Risk
Patient Experience — HCAHPS Dimensions
25% of TPS · 9 dimensions, equally weighted
Domain score: 68 / 100
Avg 6.8 / 10 pts · top-box % methodology

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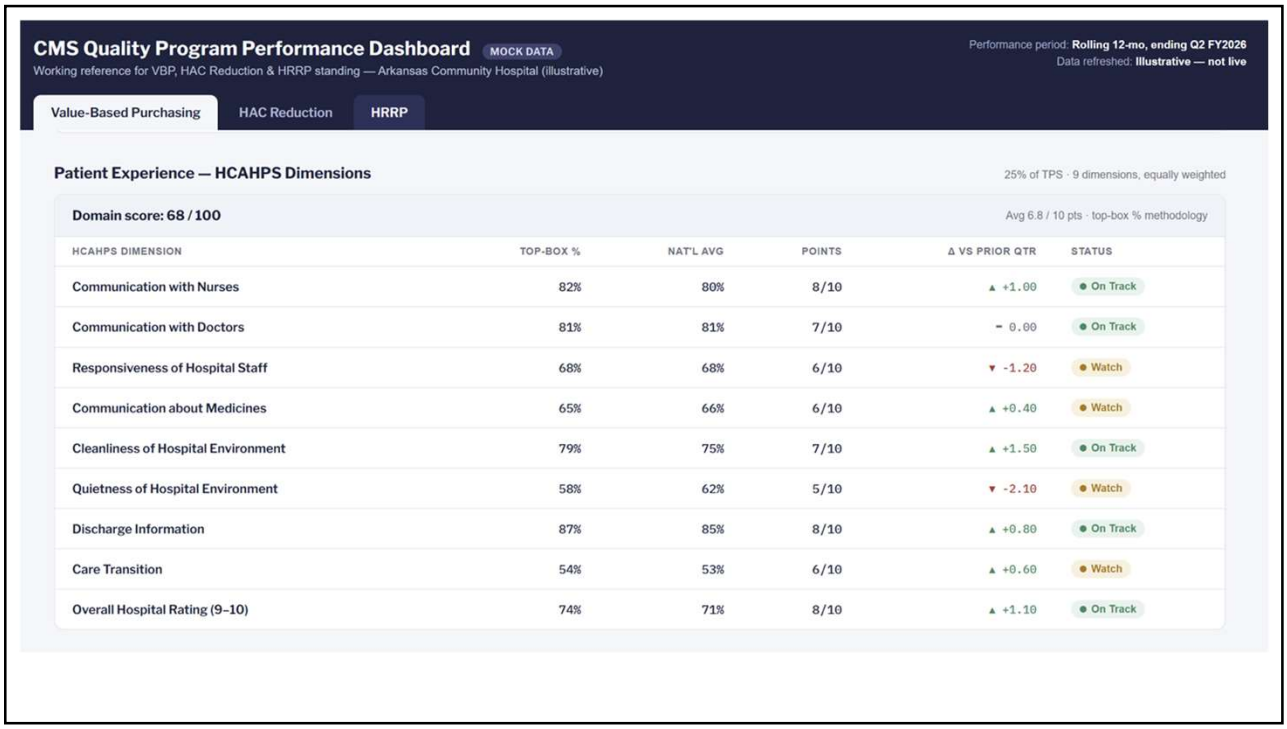
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HRRP
Patient Experience — HCAHPS Dimensions
25% of TPS · 9 dimensions, equally weighted
Domain score: 68 / 100
Avg 6.8 / 10 pts · top-box % methodology
HCAHPS DIMENSION
TOP-BOX %
NAT'L AVG
POINTS
Δ VS PRIOR QTR
STATUS
Communication with Nurses 82% 80% 8/10 ▲ +1.00 On Track
Communication with Doctors 81% 81% 7/10 – 0.00 On Track
Responsiveness of Hospital Staff 68% 68% 6/10 ▼ -1.20 Watch
Communication about Medicines 65% 66% 6/10 ▲ +0.40 Watch
Cleanliness of Hospital Environment 79% 75% 7/10 ▲ +1.50 On Track
Quietness of Hospital Environment 58% 62% 5/10 ▼ -2.10 Watch
Discharge Information 87% 85% 8/10 ▲ +0.80 On Track
Care Transition 54% 53% 6/10 ▲ +0.60 Watch
Overall Hospital Rating (9–10) 74% 71% 8/10 ▲ +1.10 On Track

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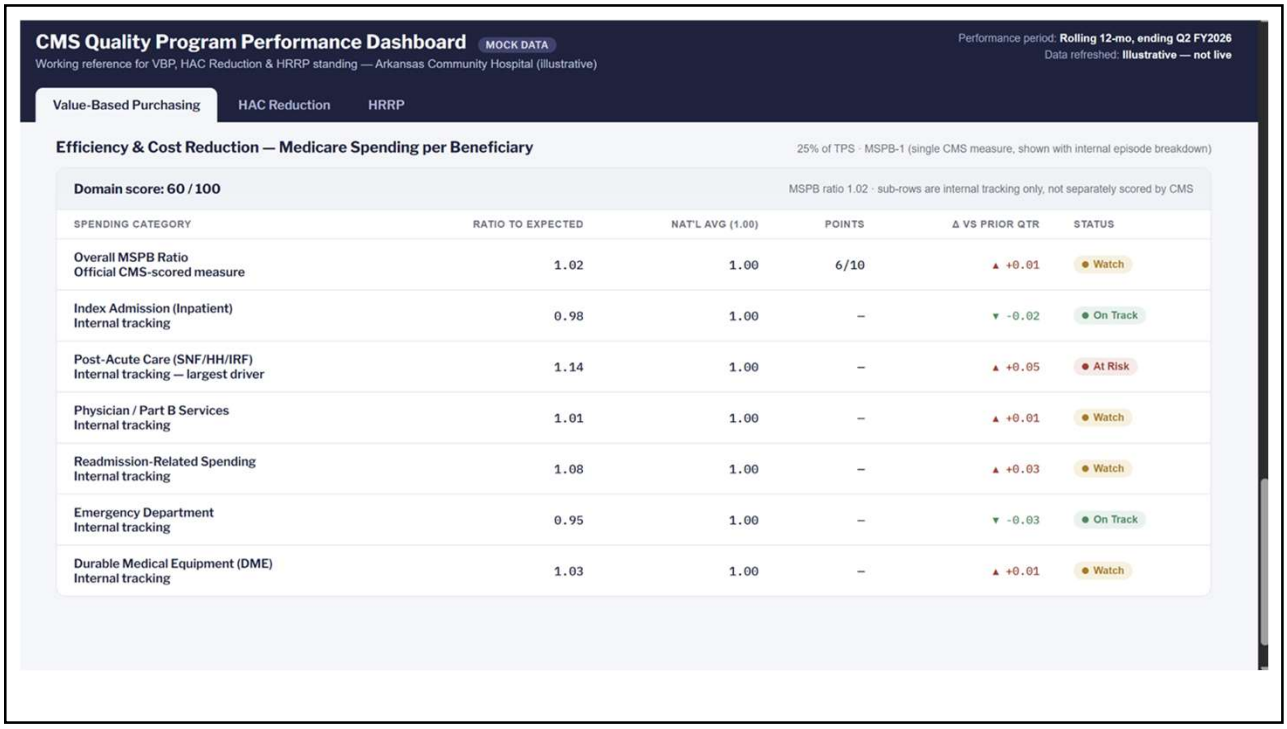
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Value-Based Purchasing
HAC Reduction
HRRP
Efficiency & Cost Reduction — Medicare Spending per Beneficiary
25% of TPS · MSPB-1 (single CMS measure, shown with internal episode breakdown)
Domain score: 60 / 100
MSPB ratio 1.02 · sub-rows are internal tracking only, not separately scored by CMS
SPENDING CATEGORY
RATIO TO EXPECTED
NAT'L AVG (1.00)
POINTS
Δ VS PRIOR QTR
STATUS
Overall MSPB Ratio
Official CMS-scored measure
1.02 1.00 6/10 ▲ +0.01 Watch
Index Admission (Inpatient)
Internal tracking
0.98 1.00 – ▼ -0.02 On Track
Post-Acute Care (SNF/HH/IRF)
Internal tracking — largest driver
1.14 1.00 – ▲ +0.05 At Risk
Physician / Part B Services
Internal tracking
1.01 1.00 – ▲ +0.01 Watch
Readmission-Related Spending
Internal tracking
1.08 1.00 – ▲ +0.03 Watch
Emergency Department
Internal tracking
0.95 1.00 – ▼ -0.03 On Track
Durable Medical Equipment (DME)
Internal tracking
1.03 1.00 – ▲ +0.01 Watch

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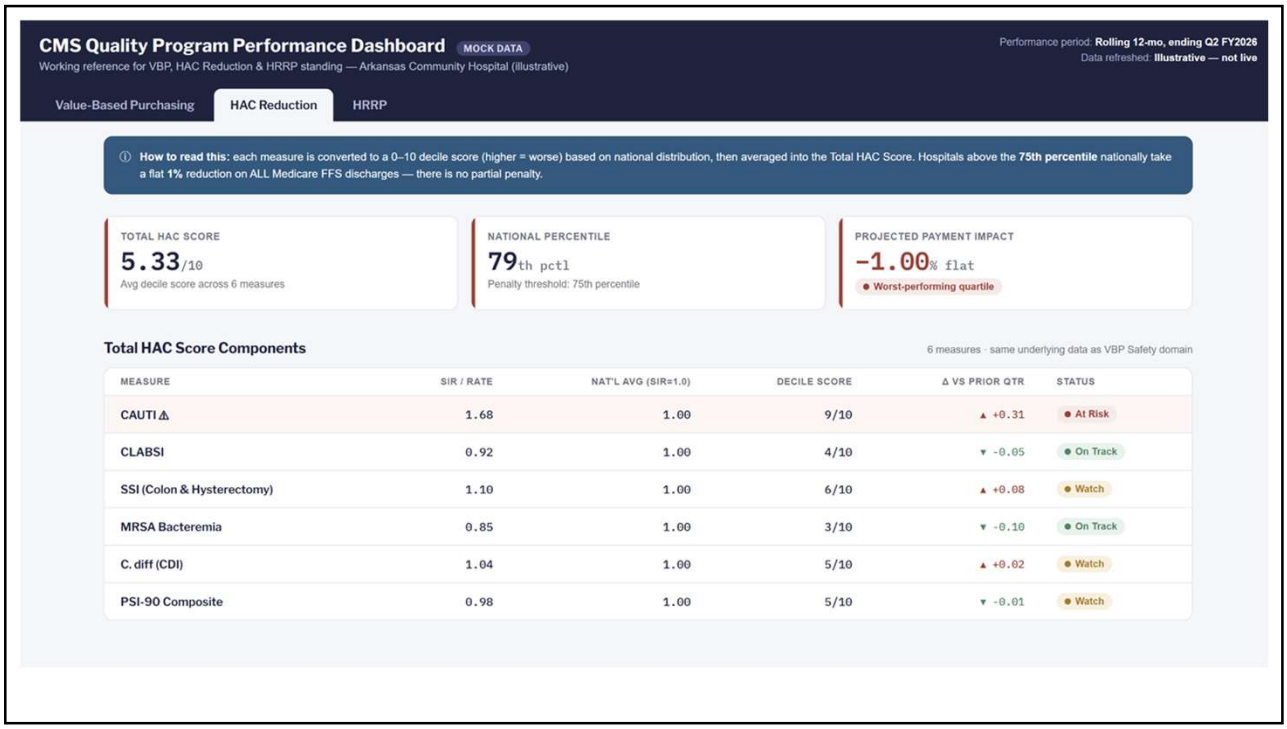
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Value-Based Purchasing
HAC Reduction
HRRP
How to read this: each measure is converted to a 0–10 decile score (higher = worse) based on national distribution, then averaged into the Total HAC Score. Hospitals above the 75th percentile nationally take a flat 1% reduction on ALL Medicare FFS discharges — there is no partial penalty.
TOTAL HAC SCORE
5.33/10
Avg decile score across 6 measures
NATIONAL PERCENTILE
79th pctl
Penalty threshold: 75th percentile
PROJECTED PAYMENT IMPACT
-1.00% flat
Worst-performing quartile
Total HAC Score Components
6 measures · same underlying data as VBP Safety domain
MEASURE | SIR / RATE | NAT'L AVG (SIR=1.0) | DECILE SCORE | Δ VS PRIOR QTR | STATUS
CAUTI ⚠ | 1.68 | 1.00 | 9/10 | ▲ +0.31 | At Risk
CLABSI | 0.92 | 1.00 | 4/10 | ▼ -0.05 | On Track
SSI (Colon & Hysterectomy) | 1.10 | 1.00 | 6/10 | ▲ +0.08 | Watch
MRSA Bacteremia | 0.85 | 1.00 | 3/10 | ▼ -0.10 | On Track
C. diff (CDI) | 1.04 | 1.00 | 5/10 | ▲ +0.02 | Watch
PSI-90 Composite | 0.98 | 1.00 | 5/10 | ▼ -0.01 | Watch

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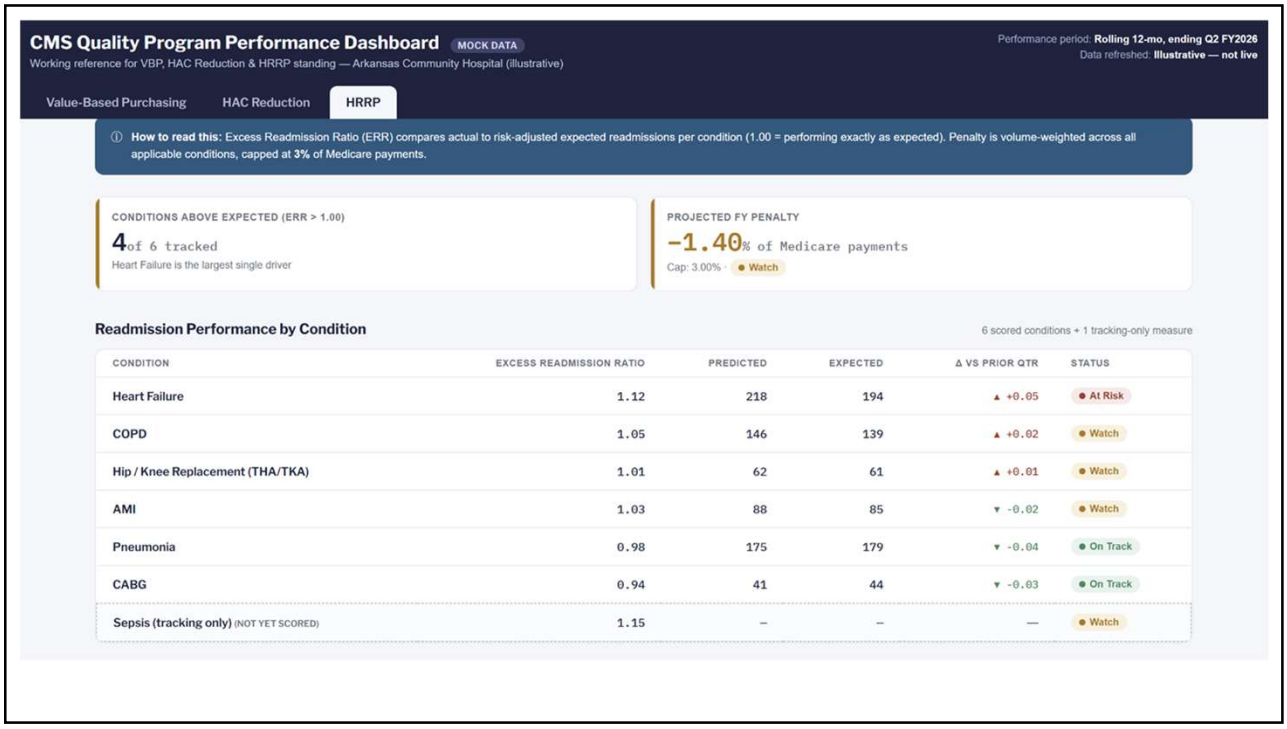
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Value-Based Purchasing
HAC Reduction
HRRP
How to read this: Excess Readmission Ratio (ERR) compares actual to risk-adjusted expected readmissions per condition (1.00 = performing exactly as expected). Penalty is volume-weighted across all applicable conditions, capped at 3% of Medicare payments.
CONDITIONS ABOVE EXPECTED (ERR > 1.00)
4 of 6 tracked
Heart Failure is the largest single driver
PROJECTED FY PENALTY
-1.40% of Medicare payments
Cap: 3.00% · Watch
Readmission Performance by Condition
6 scored conditions + 1 tracking-only measure
CONDITION | EXCESS READMISSION RATIO | PREDICTED | EXPECTED | Δ VS PRIOR QTR | STATUS
Heart Failure | 1.12 | 218 | 194 | ▲ +0.05 | At Risk
COPD | 1.05 | 146 | 139 | ▲ +0.02 | Watch
Hip / Knee Replacement (THA/TKA) | 1.01 | 62 | 61 | ▲ +0.01 | Watch
AMI | 1.03 | 88 | 85 | ▼ -0.02 | Watch
Pneumonia | 0.98 | 175 | 179 | ▼ -0.04 | On Track
CABG | 0.94 | 41 | 44 | ▼ -0.03 | On Track
Sepsis (tracking only) (NOT YET SCORED) | 1.15 | – | – | — | Watch

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A Take-Home Framework

Four steps to move your organization from reactive compliance to proactive strategy

1

ALIGN

Bring quality and finance leaders to the same table, on a standing cadence, before penalty season.

2

MEASURE

Build one shared dashboard tracking VBP, HAC, and HRRP exposure in both clinical and dollar terms.

3

TRANSLATE

Turn every clinical metric into its financial consequence, and every financial target into its clinical driver.

4

ACT

Assign named ownership to each penalty-exposed measure and close the documentation and care-process gaps.

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What You Should Walk Away With

The mechanics are learnable

VBP, HAC, and HRRP each have distinct, documented triggers and calculations — they're not a black box.

Outcomes are payments

HAIs and PSIs move the Total HAC Score, which moves the base operating MS-DRG payment, system-wide.

The gap is a design problem

Closing it takes structure — shared dashboards, translated language, named ownership — not just goodwill.

Documentation protects margin

Accurate CDI and risk adjustment are financial controls, not administrative overhead.

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Questions & Discussion

Thank you for having us today.

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