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Owner Tony Smith:
Payer Data Analyst
Area PQN VII / TACO
Applicability Privia Health - Corporate Site Only

Care Coordination

1. Purpose:

Provide a description of the ACO's Care Coordination Program as required by the Medicare Shared Savings Program Final Rule.

2. Scope:

The Accountable Care Organization, Ltd. and Participants and provider/suppliers in the Medicare Shared Savings Program.

3. Policy:

It is the policy of the ACO to maintain a care coordination program to meet the needs of the ACO population, including but not limited to chronic disease management, transition of care and high, rising and low risk management programs for beneficiaries attributed to the ACO.

4. Procedure:

- A. The ACO will provide providers and suppliers care coordination support through various mechanisms which can consist of, but are not limited to:
 - **Care Management:** Clinical nursing support for chronic care management, proactive patient engagement and facilitating transitions of care.
 - **Clinical Decision Support:** Evidence based medicine decision trees at the point of care within the EMR.

- **Admission Discharge and Transfer:** Connect with vendors that provide notifications of inpatient admission and discharge, along with transfers of care from SNF and home health providers.
 - **24/7 Care Advice Line:** A mechanism for patients to have 24/7 support access to a nurse to address any urgent issues after hours.
 - **Virtual Health Clinic:** Beneficiaries will have the capability to schedule appointments on demand with a virtual health clinician.
 - **Health Information Exchange:** Technology that allows for the exchange of clinical notes from other places of care, allowing for a complete clinical record and coordination of care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers both inside and outside of the ACO.
 - **Collaborative Care Management:** Integrated behavioral health services for patients with identified behavioral conditions.
 - **Remote Patient Monitoring:** Devices or technology to monitor patients health status and alert care teams as needed.
- B. The ACO will provide meaningful data to identify high-quality, low cost post acute care providers. At the discretion of the board a narrow network may be defined.
- C. The ACO may use care management as a tool to customize care for its highest risk patients to ensure the unique needs of each beneficiary are met. For example:
- Collaborative care management
 - Chronic care management
 - Medication adherence education and reminders
- D. The ACO will collect information on Social Determinants of Health (SDOH) and use that info to identify needed community resources.
- E. Use of Enabling Technologies. The ACO encourages and promotes the use of enabling technologies for improving care coordination for beneficiaries. Enabling Technologies may include one or more of the following:
- Electronic health records and other health IT tools
 - Telehealth services, including remote monitoring
 - 3rd Party clinical decision support tools at the point of care
 - Electronic exchange of health information
 - Other electronic tools to engage beneficiaries in their care
- F. **Use of Certified EHR Technologies.** The ACO and its Participants are required to use Certified Electronic Health Record Technology (CEHRT) as that term is defined under 42 CFR § 414.1305, in a manner sufficient to meet the applicable requirements of 42 CFR § 414.1415(a)(1)(i).
- Any Participants not meeting these requirements must qualify for and, where necessary, receive approval of an appropriate exception. Documentation of the exception and, if necessary, its approval must be provided to the ACO within 30 days of receipt.

- G. The ACO utilizes reports developed in accordance with the ACO’s Internal Reporting on Cost and Quality Metrics Policy to identify high-risk and multiple chronic condition beneficiaries. These reports also allow the ACO to identify additional target populations that would benefit from the individualized care plans provided during care coordination, and the additional assistance of available community resources.
 - Beneficiaries will only be excluded from care coordination if they decline to participate or are unable to be contacted.
 - The ACO shall not use data to avoid at-risk beneficiaries. Use of data is for identification of those beneficiaries who are most in need of care coordination services, and who are most likely to benefit from those services. Care Coordination activities are not denied based on a beneficiary's classification as "at-risk".
- H. The ACO does not require Beneficiaries to be referred within the ACO or to any other provider or supplier.
 - Exception: Referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement to the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if:
 - The beneficiary expresses a preference for a different provider, practitioner or supplier; or
 - The referral is not in the beneficiary’s best medical interests in the judgment of the referring party.
- I. The ACO continually reviews and identifies partners with long-term and post-acute care providers, both inside and outside the ACO, to improve care coordination and clinical collaboration for assigned beneficiaries.
- J. Enforcement. ACO Participants and Provider/Suppliers are required to follow all applicable ACO policies. Failure to comply with ACO processes, including cooperation in Beneficiary Engagement and Care Coordination activities, will result in remedial and/or disciplinary actions as appropriate in accordance with the ACO’s [Corrective and/or Disciplinary Action Policy](#).

Approval Signatures

Step Description	Approver	Date
PQN Leadership #1	Nico Salas: AVP, Non-Platform Operations	04/2026
Compliance Review	Policy Admin	04/2026
Approver 1	Tony Smith: Payer Data Analyst	04/2026
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