



Origination 04/2026  
Last Approved 04/2026  
Effective 04/2026  
Last Revised 04/2026  
Next Review 04/2027

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

## Reporting on Cost and Quality Metrics

### 1. Purpose:

Provide details around the ACO's processes for internally reporting on cost and quality metrics to ensure success in the Medicare Shared Savings Program.

### 2. Scope:

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

### 3. Definitions:

- ACO Activities- Activities related to promoting accountability for the quality, cost, and overall care for a population of attributed Medicare Fee-For-Service Beneficiaries, including managing and coordinating care, encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery; or carrying out any other obligation or duty of the ACO under the Medicare Shared Savings Program.
- ACO Participant- An entity identified by a Medicare-enrolled billing TIN through which one or more ACO providers/suppliers bill Medicare, that alone or together with one or more other ACO participants compose an ACO, and that is included on the list of ACO participants that is required under 42 C.F.R. § 425.118.
- ACO Provider/Supplier- An individual or entity that: (1) is a provider or supplier under Medicare regulations; (2) is enrolled in Medicare; (3) bills for items and services furnished to Medicare fee-for-service beneficiaries during the agreement period under a Medicare billing number assigned to the TIN of an ACO participant; and (4) is included on the list of ACO providers/

suppliers that is required under 42 C.F.R. §425.118.

- ACO Related Individual - ACO officers, directors, employees, ACO Participant, ACO Provider/Supplier, or any other individual or entity providing functions or services related to ACO Activities.

## 4. Policy:

It is the policy of the ACO to maintain an infrastructure for reporting and management of quality and cost metrics to improve beneficiary outcomes and monitor the performance of ACO Participants and Provider/Suppliers as required by Section [425.112](#) of the Medicare Shared Savings Program Final Rule.

## 5. Procedure:

- A. The ACO's Governing Body is charged with reviewing and updating the ACO's infrastructure for internal reporting of quality and cost metrics.
- B. The ACO utilizes standardized, nationally recognized performance measures to assess cost and quality performance. The ACO utilizes internal reports on cost and quality metrics to identify target populations that would benefit from care coordination and individualized care plans, as described in the ACO's Care Coordination Policy. Minimum performance thresholds for each critical cost and quality metric are established and Evidence Based Medical Guidelines are approved by the Governing Body as a benchmark for performance.
- C. The ACO's Governing Body reviews reports as appropriate and makes suggestions based on the clinical and operational goals of the ACO, ACO progress in achieving cost and quality metrics, and CMS requirements.
- D. Recommendations for performance measures and Evidence Based Medical Guidelines may be recommended to the Governing Body by any ACO Related Individual.
- E. The ACO reviews providers performance and provides support to encourage beneficiary engagement. Based on cost and quality report findings, the ACO uses provider leadership such as the ACO Medical Director, the ACO Governing Body and ACO Administrative teams, to follow up with clinicians who require intervention and recognition.
- F. Reports are provided monthly and/or quarterly which allows clinical and administrative leaders to review data on a consistent basis. Reports are created by the analytics team and stored in a secure platform to limit access to only individuals required to review the reports. The reports consist of:
  - G. Quarterly cost and utilization reports at the ACO and individual physician level.
  - H. Monthly reports that list attributed beneficiaries with multiple chronic conditions and their outstanding quality care gaps.
    - I. The ACO shall not use data to avoid at-risk beneficiaries. Data is used to identify opportunities for the ACO to meet the goals of improved health, improved quality and lower costs.
  - J. Quality Reporting. The ACO shall completely and accurately report quality measures for each Performance Year. Participants are required to cooperate in quality measure reporting.
    1. In the event that ACO is unable to complete Quality Reporting due to an Extreme and Unforeseen Circumstance (EUC), the ACO may seek an EUC Exception through the Quality Payment Program (QPP).

2. The ACO is responsible for procuring a CMS-approved vendor to conduct the CAHPS or other patient experience survey. Results are transmitted to CMS by a date and in a form and manner established by CMS.
- K. Enforcement. ACO Participants and Provider/Suppliers are required to follow all applicable ACO policies. Failure to comply with ACO processes, including cooperation with the care coordination program and evidence based medicine initiatives, 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
	Tony Smith: Payer Data Analyst	04/2026