TriHealth
Population Health Organization

TPHO INCENTIVE MEASURE MANUAL

TPHO Adult Measures

2026

TRIHEALTH POPULATION HEALTH ORGANIZATION NETWORK

2026 TPHO Incentive Measure Manual

Updated 3/3/2026

Contents

NOTE: Target Levels were approved at the TPHO Board of Directors Meeting on March 3, 2026.

Overview

The TPHO Incentive Measure Manual is a tool to help you better understand how to be successful in population health. It serves as your guide and includes measure definitions and key actions you can take to impact the measure and, as a result, impact patient outcomes. Categories include Access to Care, Quality, Documentation and Coding, and Utilization.

Access to Care and Quality	• Access to Care: Annual Planned Visit (MA and MSSP) • Breast Cancer Screening (All Value Based patients 50-74 years) • Colorectal Cancer Screening (All Value Based patients 45-75 years) • Diabetes: A1C >9 (MA and MSSP 18-75 years) • Diabetes: A1C < 8 (Commercial and Medicaid 18-75 years) • Diabetes: KED (MA and Commercial 18-85 years) • Hypertension: BP Control (All Value Based patients 18-85 years)
Documentation and coding	• EPIC HCC Refresh • Stanson Ignore Rate Refresh
Utilization	• Outpatient ED Visits/1000 (Commercial) • Outpatient ED Visits/1000 (MA and MSSP) • Plan All-Cause Readmission (MA and MSSP)

TPHO (TPHO to TIN) Measure Weighting and Performance Level

The table below highlights weighting (%) and level of performance evaluation.

Measure Type	Weighting, Performance Level
Access to Care and Quality Measures	55%, Independent TIN or TPP Individual Provider
Documentation and Coding	30%, Independent TIN or TPP Individual Provider
Utilization	15%, POD

Guiding Principles

The following guiding principles will help you better understand the background behind each measure, and key items to keep in mind.

- These measures are crucial to perform on Value-Based contracts and will be used to determine compensation for the performance year.
- Each measure can be meaningfully impacted by primary care providers.
- Measure must be reliably measured and data accessible and actionable.
- Each measure may include any or all the following Value-Based plans:

TPHO Value-Based Contracts 2026	
▪ Aetna MA ▪ Aetna Commercial ▪ Anthem MA ▪ Anthem Commercial ▪ Buckeye Medicaid ▪ Buckeye MA ▪ Buckeye AMBetter ▪ CareSource ▪ Cigna	▪ Humana MA ▪ Humana Medicaid ▪ Medical Mutual of Ohio ▪ Medicare Shared Savings Program (MSSP) ▪ Molina Medicaid ▪ Molina MA ▪ UHC Commercial ▪ UHC PCPi MA ▪ TH Employee Health Plan (via Anthem)

- Measuring Performance
  - Data sources: Clinical (when available), claims data
  - Comparison performance: Year over year
  - Calendar Year (CY) performance: Year-to-date member months based on available data (accounting for claims lag and payors)
  - Ongoing reporting via TPHO Board and associated committees, POD, PCLT, Champions meeting and other key governance forums
  - Final data used for the incentive payment will be made available in Q1, 2028.
- Target Levels
  - Targets are on a 5-point scale.
  - Average variance between each point is between 1% and 7% points to create the 5-point scale targets.
  - Target levels are set based on historical performance, Value-Based contract targets, CMS 5 Star targets, and best in class benchmarks.
  - Target levels must be approved by TPHO Board of Directors in March 2026.
- Some measure definitions have been blended to encompass all lines of business.
- Plan enrollment (continuous enrollment and allowable gaps) considerations for the measures will fall into HEDIS (MA or Commercial or Medicaid populations), (MSSP or MSSP Enhanced populations) or both categories. If the line of business is not specified in the measure title, then continuous enrollment criteria for all populations will apply.
- Measures are based on total eligible members attributed to the provider by the payor. Payor attribution forms the baseline for incentive distribution. Please see appendix for more information on payor attribution.
- For a quality or access measure to qualify for the incentive payment, there must be at least 20 eligible patients in the denominator. If not, the weighting for that measure will be redistributed to other qualifying measures in the same domain.
- For the HCC Refresh measure, there must be at least 30 eligible diagnoses in the denominator. If not, the weighting for that measure will be redistributed equally to other qualifying measures in the domain or to other qualifying domains, if applicable.
- For the Stanson Ignore Rate Refresh measure, there must be at least 20 instances of the alert in the denominator. If not, the weighting of that measure will be redistributed equally to other qualifying measures in the domain or other qualifying domains, if applicable.

- Data source is EPIC Healthy Planet, which is derived from payor claims data and clinical data. It is acknowledged that not all clinical data from TPHO Independent EMRs will be available for inclusion in the source data used for the physician incentive plan.
- Where able, standard NCQA HEDIS measures are utilized.
- Patients cannot be removed from measures by request. Measure populations are determined by NCQA HEDIS Measure Specifications.

Annual Planned Visit (All Medicare)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target	61	64	68	71	75

- Early in the year: Use the measure not met list to identify patients who need an annual wellness visit or annual preventative visit during the calendar year.
  - If they are not scheduled during the calendar year, outreach to schedule them.
  - If they have another type of visit scheduled, consider adding on a wellness/physical or scheduling them for their wellness/physical at their next appointment.
- Throughout the year: schedule patient follow-up visits at check out.

OVERVIEW	
Definition	
The percentage of Medicare patients 20 years and older who had an annual planned visit during the measurement year. Annual Planned Visit includes an Annual Wellness Visit (G0402, G0468, G0438, G0439) or an annual preventative visit (99381 – 99387; 99391-99397) or both.	
Numerator	
Members with an annual planned visit (one of the codes specified above) during the measurement year.	
Denominator	
Medicare, including Medicare Advantage members and FFS beneficiaries attributed to the accountable care organization (i.e. MSSP, MSSP Enhanced). *Continuous Enrollment:* The measurement year. *Allowable gap:* No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.	
Exclusions	
• Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year. • Members receiving palliative care any time during the measurement year. • Members who die any time during the measurement year.	
Interpretation	Higher is better.

Breast Cancer Screening (All Value Based Patients 50-74)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target	71	74	77	80	84

- Use Gap in Care lists for outreach.
- **Review preventative care screenings & care gaps at every visit.**
- **Conduct a Breast Cancer Awareness campaign.**
- **Schedule a quarterly Mammogram van.**
- **Utilize available Breast Cancer Screening Patient Education Resources.**
- **Encourage patients to self-schedule mammograms by providing scheduling link.**

OVERVIEW

Definition
The percentage of members 50–74 years of age who were eligible for routine breast cancer screening and had a mammogram to screen for breast cancer.
Numerator
One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement period and the end of the measurement period.
Denominator
Members 52–74 years of age by the end of the measurement period who were recommended for routine breast cancer screening and also meet the criteria for participation. Include members recommended for routine breast cancer screening with any of the following criteria: • Administrative Gender of Female (AdministrativeGender code female) at any time in the member' s history. • Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the member's history. • Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period. Minus exclusions.
Exclusions

Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.

• Members who die any time during the measurement period.

• Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy:

– Bilateral mastectomy (Bilateral Mastectomy Value Set).
– Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (CPT Modifier code 50) (same procedure).
– Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral qualifier value (SNOMED CT Modifier code 51440002) (same procedure).
Note: *The " clinical" mastectomy value sets identify mastectomy; the word " clinical" refers to the data source, not to the type of mastectomy.*
– History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
– Any combination of codes from the table below that indicate a mastectomy on ***both*** the left ***and*** right side on the same date of service or on different dates of service.

Left Mastectomy (any of the following)	**Right Mastectomy (any of the following)**
Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (CPT Modifier code LT) (same procedure)	Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (CPT Modifier code RT) (same procedure)
Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) ***with*** a left-side qualifier value (SNOMED CT Modifier code 7771000) (same procedure)	Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) ***with*** a right-side qualifier value (SNOMED CT Modifier code 24028007) (same procedure)
Absence of the left breast (Absence of Left Breast Value Set). Do not include laboratory claims (claims with POS code 81)	Absence of the right breast (Absence of Right Breast Value Set). Do not include laboratory claims (claims with POS code 81)
Left unilateral mastectomy (Unilateral Mastectomy Left Value Set)	Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)

• Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) any time during the member's history through the end of the measurement period. • Medicare members 66 years of age and older by the end of the measurement period who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. – Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the monthly membership detail data file. Use the run date of the file to determine if a member had an LTI flag during the measurement period. • Members 66 years of age and older by the end of the measurement period, with frailty ***and*** advanced illness. Members must meet ***both*** frailty and advanced illness criteria to be excluded: 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS code 81). 2. **Advanced Illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). – Dispensed dementia medication (Dementia Medications List). • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS code 81).	
Interpretation	A higher rate indicates better performance.

Colorectal Cancer Screening (All Value Based Patients 45-75)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target	60	65	70	75	82

- Refer appropriate patients for colonoscopy and recommend/provide at-home alternatives for patients who decline a colonoscopy.
- Use Gap in Care lists for outreach.
- Review preventative care screenings & care gaps at every visit.
- Utilize available Colorectal Cancer Screening Patient Education Resources.

OVERVIEW

Definition
The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.
Numerator
Members with one or more screenings for colorectal cancer. Any of the following criteria: • Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement period. For administrative data, assume the required number of samples were returned, regardless of FOBT type. • Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; SNOMEDCT code 708699002) during the measurement period or the 2 years prior to the measurement period. • Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; SNOMEDCT code 841000119107) during the measurement period or the 4 years prior to the measurement period. • CT colonography (CT Colonography Value Set) during the measurement period or the 4 years prior to the measurement period. • Colonoscopy (Colonoscopy Value Set; SNOMEDCT code 851000119109) during the measurement period or the 9 years prior to the measurement period.
Denominator
Members 46–75 years as of the end of the measurement period who also meet the criteria for participation. Minus exclusions.
Exclusions

Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.

• Members who die any time during the measurement period.

• Members who had colorectal cancer (Colorectal Cancer Value Set) any time during the member's history through December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).

• Members who had a total colectomy (Total Colectomy Value Set; SNOMEDCT code 119771000119101) any time during the member's history through December 31 of the measurement period.

• Medicare members 66 years of age and older by the end of the measurement period who meet either of the following:
  – Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
  – Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the monthly membership detail data file.

Use the run date of the file to determine if a member had an LTI flag during the measurement period.

• Members 66 years of age and older by the end of the measurement period, with frailty ***and*** advanced illness. Members must meet ***both*** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement period or the year prior to the measurement period:
     – Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     – Dispensed dementia medication (Dementia Medications List).

• Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period.

• Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).

Interpretation	A higher rate indicates better performance.

Diabetes: A1C >9 (All Medicare Ages 18-75)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target	35	30	23	13	9

- Standing orders for all patients with diabetes that include HbA1c
- Use Gap in Care lists for outreach.
- Review preventative care screenings & care gaps at every visit.
- Refer to wrap around supports (pharmacy, diabetes education, care management, and/or behavioral health) for patients with out-of-range HbA1cs.
- If available, use POC A1C machine as part of rooming and/or pre-visit planning process.
- Utilize available Diabetes Patient Education Resources.

OVERVIEW

Definition

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

• Glycemic Status >9.0%.

Numerator

Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; LOINC code 97506-0) during the measurement year. Do not include CPT Category II codes (HbA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set) or from laboratory claims (claims with POS code 81). The member is numerator compliant if the most recent glycemic status assessment has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is ≤9.0%. If there are multiple glycemic status assessments on the same date, use the lowest result.

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

• *Compliant:* CPT Category II code 3046F.
• *Not compliant:* HbA1c Level Less Than or Equal To 9.0 Value Set.
Note: *A lower rate indicates better performance for this indicator (i.e., low rates of Glycemic Status >9% indicate better care).*

Denominator	

Ages: Medicare patients aged 18–75 years with diabetes (types 1 and 2) as of December 31 of the measurement year.
Continuous enrollment: The measurement year.
Allowable gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Exclusions	

Exclude members who meet any of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - Dispensed dementia medication (Dementia Medications List).

Interpretation	Lower is better.

Diabetes: A1C <8 (Commercial, Medicaid - Total for 18-75)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target	62	68	72	78	85

- Standing orders for all patients with diabetes that include HbA1c
- Use Gap in Care lists for outreach.
- Order labs ahead of visit, so A1c result is available during visit.
- If available, use POC A1C machine as part of rooming and/or pre-visit planning process
- Review preventative care screenings & care gaps at every visit.
- Refer to wrap around supports (pharmacy, diabetes education, care management, and/or behavioral health) for patients with out-of-range HbA1cs.
- Utilize available Diabetes Patient Education Resources.

OVERVIEW

Definition

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0%.

Numerator

Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; LOINC code 97506-0) during the measurement year. Do not include CPT Category II codes (HbA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set) or from laboratory claims (claims with POS code 81). The member is numerator compliant if the most recent glycemic status assessment has a result of <8.0%. The member is not numerator compliant if the result of the most recent glycemic status assessment is ≥8.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. If there are multiple glycemic status assessments on the same date of service, use the lowest result.

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

- Compliant: HbA1c Level Less Than 8.0 Value Set.
- Not compliant: HbA1c Level Greater Than or Equal To 8.0 Value Set

Denominator	

Ages: Commercial patients aged 18–75 years with diabetes (types 1 and 2) as of December 31 of the measurement year.
Continuous enrollment: The measurement year.
Allowable gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Minus exclusions.

Exclusions	

Exclude members who meet any of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - Dispensed dementia medication (Dementia Medications List).

Interpretation	Higher is better.

Diabetes KED: Kidney Health Evaluation (MA and Commercial 18-85)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target	60	65	70	75	80

- Order and request labs ahead of visits, so results are available on the day of the office visit.
- Standing orders for all diabetes patients that include
- Inform patient urine will be collected ahead of visit. Collect urine in office.
- Use Gap in Care lists for outreach.
- Review preventative care screenings & care gaps at every visit.
- For patients who are having difficulty providing a urine sample, offer water during the visit.
- If urine cannot be obtained during the office visit, instruct the patient to return to the office to provide a sample.

OVERVIEW

Definition
The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumincreatinine ratio (uACR), during the measurement year.
Numerator
Members who received ***both*** an eGFR and a uACR during the measurement year on the same or different dates of service: • At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set). • At least one uACR identified by either of the following: – ***Both*** a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) ***and*** a urine creatinine test (Urine Creatinine Lab Test Value Set) ***with*** service dates four days or less apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year. – A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set).
Denominator
The eligible population minus exclusions.

Exclusions	

Exclude members who meet any of the following criteria:

- Members with a diagnosis of ESRD (ESRD Diagnosis Value Set) any time during the member's history on or prior to December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members who had dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***both*** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - Dispensed dementia medication (Dementia Medications List).
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).

Interpretation	Higher is better.

Hypertension: BP Control (All Value Based Patients 18-85)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target	55	67	75	80	86

- If BP is persistently high in the office, encourage patient to monitor home BP. Home BPs can be used to meet measure if documented in a discrete vital sign field in the EMR.
- Recheck blood pressure if initial blood pressure >139/89
- Late in calendar year, use nurse visits and/or home BPs to collect updated BP readings
- Use Gap in Care lists for outreach.
- Review preventative care screenings & care gaps at every visit.
- Instruct patients to take blood pressure medication as prescribed prior to their office visit.
- Educate patients and team members on correct technique for measuring blood pressure.
- Leverage EMR or patient messaging to request home BP readings from patients (i.e. MyChart BP Questionnaire in Epic).
- Utilize available Hypertension Patient Education Resources .
- Implement a process for medical staff to notify provider of high BP readings.

OVERVIEW

Definition
The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
Numerator
Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement year. Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; POS code 23). The BP reading must occur *on or after* the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria). The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine compliance:

- Systolic Compliant: Systolic Less Than 140 Value Set.
- Systolic Not Compliant: CPT-CAT-II code 3077F.
- Diastolic Compliant: Diastolic Less Than 90 Value Set.
- Diastolic Not Compliant: CPT-CAT-II code 3080F.

Denominator	

18–85 years as of December 31 of the measurement year. Identify members who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set) on or between January 1 of the year prior to the measurement year and June 30 of the measurement year.

Exclusions	

Exclude members who meet any of the following criteria:

• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.

• Members who die any time during the measurement year.

• Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.

• Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).

• Members with a diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set; History of Nephrectomy or Kidney Transplant Value Set), any time during the member' s history on or prior to December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).

• Members with a procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set) any time during the member's history on or prior to December 31 of the measurement year.

• Members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).

• Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.

– Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.

• Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty *and* advanced illness. Members must meet *both* frailty and advanced illness criteria to be excluded:

1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
   – Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
   – Dispensed dementia medication (Dementia Medications List).

• Members 81 years of age and older as of December 31 of the measurement year (all product lines) with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).

Interpretation	Higher is better.

Plan All-Cause Readmission- MA and MSSP – POD

Plan All-Cause Readmission (MA, MSSP)	1	2 (Baseline)	3	4	5
TPP: PRIMARY CARE BUTLER	13.0%	12.0%	10%	9%	7%
TPP: PRIMARY CARE CENTRAL	13.2%	12.2%	10%	9%	7%
TPP: PRIMARY CARE EAST	12.9%	11.9%	10%	9%	7%
TPP: PRIMARY CARE KENWOOD	11.6%	10.6%	10%	9%	7%
TPP: PRIMARY CARE MASON	12.2%	11.2%	10%	9%	7%
TPP: PRIMARY CARE WEST - NORTH	13.0%	12.0%	10%	9%	7%
TPP: PRIMARY CARE WEST - SOUTH	12.2%	11.2%	10%	9%	7%
TPHO INDEPENDENT	13.2%	12.2%	10%	9%	7%
TPHO to TIN	13.2%	12.2%	10%	9%	7%

- Conduct a Hospital Follow Up office visit with the patient 7-10 days post discharge.
- Use Epic risk scores to identify patients who may be at increased risk for hospitalization or readmission.
- Consider Primary Care at Home for patients with high utilization patterns that have difficulty completing an office visit.
- Monitor your VBC+ patients, ensuring the patient has strong connectivity to primary care office.

OVERVIEW

Definition & importance
For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.
Numerator
At least one unplanned acute readmission for any diagnosis within 30 days of the Index Discharge Date.
Denominator
Members in the eligible population prior to exclusion of outliers. Members must be 18 and older as of the earliest Index Discharge Date. The plan population is based on members, not discharges. Count members only once in the plan population.

Exclusions	
Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.	
Interpretation	Lower is better.
Level Explanation	
Final Score baseline is Level 2, based on historical performance (July 2023 – June 2024). Levels 3-5 reflect the 2026 CMS Star Rating.	
Data Source	Claims; Expect 6-month lag.

Outpatient ED Visits/1000 – Commercial – POD

Commercial POD -ED Visits/1000	1	2	3 (Baseline)	4	5
TPP: PRIMARY CARE BUTLER	196	184	172	160	148
TPP: PRIMARY CARE CENTRAL	189	178	166	154	143
TPP: PRIMARY CARE EAST	166	156	146	136	126
TPP: PRIMARY CARE KENWOOD	158	149	139	129	120
TPP: PRIMARY CARE MASON	158	149	139	129	120
TPP: PRIMARY CARE WEST - NORTH	185	173	162	151	139
TPP: PRIMARY CARE WEST - SOUTH	194	182	170	158	146
TPHO INDEPENDENT and TPHO TIN	250	234	219	204	188
Sustained Excellence	178	168	158	149	139

- Educate on "Call Us First" principles.
- Print and/or post Call Us First flyers in the office. Include the flyer in New Patient folders.
- Use Call Us First flyers to help educate patients. Consider including Call Us First flyer in New Patient folders.
- Educate patients on the availability of clinical guidance 24/7/365.
- Ensure appointment availability for acute visit needs
- Monitor High ED Utilizer list & intervene/outreach when appropriate
- Follow up with patients (i.e. through MyChart message) after unnecessary ED visits & educate on access/care available at primary care office.
- Monitor your VBC+ patients, ensuring the patient has strong connectivitiy to primary care office
- Consider having office staff schedule directly with Priority Care or TriHealth Clinic at Walgreens if the office does not have availability for patients with acute needs
- Ensure high risk patients are triaged by a nurse using evidence-based protocols.

OVERVIEW

Definition & importance
For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year. ***Note*** *- Reducing emergency room visits is crucial in a Value-Based arrangement because it aids in managing healthcare costs while optimizing resources, enhances the quality of care by focusing on prevention and effective management of health conditions, and improves patient outcomes by reducing unnecessary hospital admissions.*
Numerator
Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify all ED visits during the measurement year using either of the following:

- An ED Visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) ***with*** an ED place of service code (POS code 23).

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set) or an observation stay (Observation Stay Value Set).

Exclude encounters with any of the following:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
- Psychiatry (Psychiatry Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set).

Denominator	
Commercial members 18 years and older as of December 31 of the measurement year.	

Exclusions	
Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.	

Level Explanation	
Final Score will be the greater of improvement over historical baseline performance (July 2023 – June 2024) or performance against the Sustained Excellence benchmark, derived from the historically highest rated POD. The purpose is to encourage year over year performance improvement while rewarding sustained excellence for historically high performing PODs who may not see significant increases year over year.	

Interpretation	Lower is better.
Data Source	Claims; Expect 6-month lag.

Outpatient ED Visits/1000 – Medicare Advantage, MSSP – POD

MA, MSSP - POD -ED Visits/1000	1	2	3 (Baseline)	4	5
TPP: PRIMARY CARE BUTLER	516	485	453	421	390
TPP: PRIMARY CARE CENTRAL	469	440	411	382	353
TPP: PRIMARY CARE EAST	418	393	367	341	316
TPP: PRIMARY CARE KENWOOD	416	391	365	339	314
TPP: PRIMARY CARE MASON	455	427	399	371	343
TPP: PRIMARY CARE WEST - NORTH	418	393	367	341	316
TPP: PRIMARY CARE WEST - SOUTH	443	416	389	362	335
TPHO INDEPENDENT and TPHO TIN	609	571	534	497	459
Sustained Excellence	467	442	416	391	365

- Educate on "Call Us First" principles.
- Print and/or post Call Us First flyers in the office. Include the flyer in New Patient folders.
- Use Call Us First flyers to help educate patients. Consider including Call Us First flyer in New Patient folders.
- Educate patients on the availability of clinical guidance 24/7/365.

- Ensure appointment availability for acute visit needs
- Monitor High ED Utilizer list & intervene/outreach when appropriate
- Follow up with patients (i.e. through MyChart message) after unnecessary ED visits & educate on access/care available at primary care office.
- Monitor your VBC+ patients, ensuring the patient has strong connectivitiy to primary care office
- Consider having office staff schedule directly with Priority Care or TriHealth Clinic at Walgreens if the office does not have availability for patients with acute needs
  - Ensure high risk patients are triaged by a nurse using evidence-based protocols.

OVERVIEW

Definition & importance
For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year. ***Note*** *- Reducing emergency room visits is crucial in a value-based arrangement because it aids in managing healthcare costs while optimizing resources, enhances the quality of care by focusing on prevention and effective management of health conditions, and improves patient outcomes by reducing unnecessary hospital admissions.*
Numerator

Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify all ED visits during the measurement year using either of the following:

- An ED Visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) ***with*** an ED place of service code (POS code 23).

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set) or an observation stay (Observation Stay Value Set).

Exclude encounters with any of the following:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
- Psychiatry (Psychiatry Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set).

Denominator	
Commercial members 18 years and older as of December 31 of the measurement year.	
Exclusions	
Members who use hospice services (Hospice Encounter Value Set; Hospice intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.	
Level Explanation	
Final Score will be the greater of improvement over historical baseline performance (July 2023 – June 2024) or performance against the Sustained Excellence benchmark, derived from the historically highest rated POD. The purpose is to encourage year over year performance improvement while rewarding sustained excellence for historically high performing PODs who may not see significant increases year over year.	
Interpretation	Lower is better.
Data Source	Claims; Expect 6-month lag.

EPIC HCC Refresh

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target	69	74	79	84	89

OVERVIEW	
Definition	
The percentage of HCC gaps that have been addressed in the measurement year for patients who have already had a qualifying encounter. Population includes Value-Based patients who had a completed visit in the last 2 years or greater than 61 years of age. Qualifying encounter types include Outpatient Follow-Up (1023), Postpartum Visit (1017), Initial Prenatal (1016), Routine Prenatal (1015), Procedure Visit (1013), Initial Consult (1011), Nursing Home Visit (304), Home Visit (302), Walk-In (2) and Office Visit (101) or Contact type = Inpatient, Surgery, Hospital Outpatient or Emergency.	
Numerator	
The number of HCC categories that have been refreshed this year.	
Denominator	
The total number of potential HCC categories that apply to the patient. *See appendix for list of v28 Categories*	
Interpretation	Higher is better.

Stanson Ignore Rate

	Maximum Ignore Rate
Target	<65%

OVERVIEW	
Definition	

Stanson Health's documentation and coding program uses AI and clinical decision support (CDS) to help healthcare providers capture accurate Hierarchical Condition Category (HCC) codes directly in the EMR, improving accuracy for complex care, ensuring accurate patient risk adjustment, and providing real-time guidance for documentation gaps.

The Ignore Rate is the total number of alerts/guidelines (depending on if there are multiple in the same alert) in the denominator and the number of guidelines/alerts ignored in the numerator.

Examples

Example 1:
Provider X received 4 HCC Stanson alerts in 1 month, each with 1 guideline. Provider accepted 2 and canceled 2 alerts. 50% ignore rate.

Example 2:
Provider X received 4 HCC Stanson alerts in 1 month. 1 of the alerts had 2 guidelines. Provider accepted 3 HCC alerts with 1 guideline and ignored the alert with 2 guidelines. 3/5 = 60% follow rate = 40% ignore rate

OPA Actions and Lockout – Education Material

Action	Description	Lockout Window
Follow	"Add Diagnosis" + "Accept"	N/A - Alert Followed
Ignore	"Do Not Add" with NO Acknowledgement Reason	24 hours
Ignore	"Cancel"	24 hours
Ignore	"Do Not Add" + "Accept"	24 hours
Override	"Do Not Add" + "Acknowledge Reason"	"Patient Doesn't have the condition" – remainder of calendar year "Other (Please Specify) – locks out the guideline for the alerted user for 1 month

Level Explanation	

In the first Performance Year of the measure, TPHO is crediting the provider for the full 5% weighting if they meet the minimum thresholds acted upon, as determined by the TPP Documentation & Coding Committee.

To achieve full credit, the provider must obtain an Ignore Rate **less than** the maximum ignore rate. Lower is better.

Appendix: Attribution Details

What is Payor Attribution?

- *Payor* identifies a provider as responsible/accountable for a patient, **based on member selection OR their own internal methodology**.
- Attribution **methodologies vary** by payor & line of business.
- Payors receive provider data through TPHO Network Operations or TriHealth Payor Enrollment/Non-Hospital Credentialing team to determine PCP availability.

Payor Methodology

"Typical*" payor methodology for assigning a patient to a provider includes:

1. **Patient selection**
2. **Claims history**
3. **Family relationship** – assign to the same provider a family member in the plan sees
4. **Quality** –high quality providers that match geo-assignment or claims diagnosis history.
5. **Location**

*****Methodologies vary by payor and line of business.*

Accountable for Care

- TPHO is financially and clinically responsible for the care of payor-attributed patients, even if the patient is not seeing the provider.
- **Our ability to earn dollars in Value-Based contracts is tied to payor-attributed patients.**

Impacts on Incentive Distribution

- Provider Incentive scores are based on performance of payor attributed patient population.
- Payor attributed patients are the basis for incentive distribution dollars.
- **The more Value-Based (VB), payor-attributed patients a provider has, the higher the earning potential is for provider incentives.**
- Payor-attributed panel will not match Epic PCP panel one-for-one.
- TPHO cannot remove a patient from a provider's payor-attributed panel.

Appendix: HCC Refresh Categories

HCC Refresh Rate - Applicable v28 Categories	
CMS-HCC 1: HIV/AIDS	CMS-HCC 226: Heart Failure, Except End-Stage and Acute
CMS-HCC 107: Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	CMS-HCC 23: Breast, Prostate, and Other Cancers and Tumors
CMS-HCC 108: Sickle Cell Disorders, Except Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero	CMS-HCC 238: Specified Heart Arrhythmias
CMS-HCC 109: Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	CMS-HCC 253: Hemiplegia/Hemiparesis
CMS-HCC 111: Hemophilia, Male	CMS-HCC 254: Monoplegia, Other Paralytic Syndromes
CMS-HCC 112: Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	CMS-HCC 264: Vascular Disease with Complications
CMS-HCC 114: Common Variable and Combined Immunodeficiencies	CMS_HCC 276: Lung Transplant Status/Complications
CMS-HCC 115: Specified Immunodeficiencies and White Blood Cell Disorders	CMS-HCC 277: Cystic Fibrosis
CMS-HCC 125: Dementia, Severe	CMS-HCC 278: Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis
CMS-HCC 126: Dementia, Moderate	CMS-HCC 279: Severe Persistent Asthma
CMS-HCC 127: Dementia, Mild or Unspecified	CMS-HCC 280: Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders
CMS-HCC 135: Drug Use with Psychotic Complications	CMS-HCC 280: Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders
CMS-HCC 136: Alcohol Use with Psychotic Complications	CMS-HCC 298: Severe Diabetic Eye Disease, Retinal Vein Occlusion, and Vitreous Hemorrhage
CMS-HCC 137: Drug Use Disorder, Moderate/Severe, or Drug Use with Non-Psychotic Complications	CMS-HCC 300: Exudative Macular Degeneration
CMS-HCC 138: Drug Use Disorder, Mild, Uncomplicated, Except Cannabis	CMS-HCC 326: Chronic Kidney Disease, Stage 5
CMS-HCC 139: Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications	CMS-HCC 327: Chronic Kidney Disease, Severe (Stage 4)

CMS-HCC 151: Schizophrenia	CMS-HCC 328: Chronic Kidney Disease, Moderate (Stage 3B)
CMS-HCC 152: Psychosis, Except Schizophrenia	CMS-HCC 329: Chronic Kidney Disease, Moderate (Stage 3, Except 3B)
CMS-HCC 153: Personality Disorders; Anorexia/Bulimia Nervosa	CMS-HCC 35: Pancreas Transplant Status
CMS-HCC 154: Bipolar Disorders without Psychosis	CMS-HCC 37: Diabetes with Chronic Complications
CMS-HCC 155: Major Depression, Moderate or Severe, without Psychosis	CMS-HCC 379: Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
CMS-HCC 17: Cancer Metastatic to Lung, Liver, Brain and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	CMS-HCC 38: Diabetes with Glycemic, Unspecified, or No Complications
CMS-HCC 18: Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid Leukemia	CMS-HCC 380: Chronic Ulcer of Skin, Except Pressure, Through to Bone or Muscle
CMS-HCC 180: Quadriplegia	CMS-HCC 382: Pressure Ulcer of Skin with Full Thickness Skin Loss
CMS-HCC 181: Paraplegia	CMS-HCC 382: Pressure Ulcer of Skin with Partial Thickness Skin Loss
CMS-HCC 182: Spinal Cord Disorders/Injuries	CMS-HCC 383: Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle
CMS-HCC 19: Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancer	CMS-HCC 397: Major Head Injury with Loss of Consciousness > 1 Hour
CMS-HCC 190: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease, Spinal Muscular Atrophy	CMS-HCC 398: Major Head Injury with Loss of Consciousness <1 Hour or Unspecified
CMS-HCC 191: Quadriplegia Cerebral Palsy	CMS-HCC 399: Major Head Injury Without Loss of Consciousness
CMS-HCC 192: Cerebral Palsy, Except Quadriplegia	CMS-HCC 409: Amputation Status, Lower Limb/Amputation Complications
CMS-HCC 193: Chronic Inflammatory Demyelinating Polyneuritis and Multifocal Motor Neuropathy	CMS-HCC 454: Stem Cell, Including Bone Marrow, Transplant Status/Complications
CMS-HCC 196: Myasthenia Gravis without (Acute) Exacerbation and Other Myoneural Disorders	CMS-HCC 463: Artificial Openings for Feeding or Elimination
CMS-HCC 197: Muscular Dystrophy	CMS-HCC 48: Morbid Obesity
CMS-HCC 198: Multiple Sclerosis	CMS-HCC 49: Specified Lysosomal Storage Disorders
CMS-HCC 199: Parkinson and Other Degenerative Disease of Basal Ganglia	CMS-HCC 50: Amyloidosis, Porphyria, and Other Specified Metabolic Disorders
CMS-HCC 20: Lung and Other Severe Cancers	CMS-HCC 51: Addison's and Cushing's Diseases, Acromegaly, and Other Specified Endocrine Disorders

CMS-HCC 200: Friedreich and Other Hereditary Ataxias; Huntington Disease	CMS-HCC 62: Liver Transplant Status/Complications
CMS-HCC 201: Seizure Disorders and Convulsions	CMS-HCC 63: Chronic Liver Failure/End-Stage Liver Disorders
CMS-HCC 21: Lymphoma and Other Cancers	CMS-HCC 64: Cirrhosis of Liver
CMS-HCC 211: Respirator Dependence/Tracheostomy Status/Complications	CMS-HCC 65: Chronic Hepatitis
CMS-HCC 213: Cardio-Respiratory Failure and Shock	CMS-HCC 77: Intestine Transplant Status/Complications
CMS-HCC 22: Colorectal, Bladder, and Other Cancers	CMS-HCC 79: Chronic Pancreatitis
CMS-HCC 221: Heart Transplant Status/Complications	CMS-HCC 80: Crohn's Disease (Regional Enteritis)
CMS-HCC 222: End-Stage Heart Failure	CMS-HCC 81: Ulcerative Colitis
CMS-HCC 223: Heart Failure with Heart Assist Device/Artificial Heart	CMS-HCC 93: Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders
CMS-HCC 224: Acute on Chronic Heart Failure	CMS-HCC 94: Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders