TriHealth
Population Health Organization

TPHO INCENTIVE MEASURE MANUAL

TPHO Pediatric Measures

2026

TRIHEALTH POPULATION HEALTH ORGANIZATION NETWORK

2026 TPP Pediatric Incentive Measure Manual

Updated 1/12/2026

Contents

Overview

The TPP Pediatric Incentive Measure Manual is a tool to help you better understand how to be successful in population health, including understanding the measures. As TPP Pediatrics moves forward in the population health journey, it will serve as your guide and include measure definitions, importance, and key actions you can take to impact the measure and, as a result, impact patient outcomes.

TPHO Incentive Summary

All TriHealth Population Health Organization network (TPHO) incentives are based on Performance Year. A Performance Year is the January through December timeframe in which our network is measured against contractual targets by payors with Value-Based agreements. After the close of each Performance Year, the TPHO distributes two payments to reward providers for their efforts in creating value for our contractual risk-based populations. The first payment, called the Advanced Payment, occurs in Q4 of the year following the Performance Year. It is based on the following:

- A projected revenue for the Performance Year minus actual TPHO expenses
- System/Provider split of remaining dollars.
- TPHO to Tax Identification Number (TIN) distribution based on Value-Based attribution.
- TriHealth G TIN (also known as TriHealth Physician Partners) allocates a portion of their distribution dollars to TPP Pediatrics.
- Pediatric providers receive a distribution based on Value-Based attribution by payor assignment.

The final reconciliation payment for the Performance Year occurs approximately 17 months after the end of the Performance Year. For example, the 2026 PY final reconciliation will occur in May 2028. This timeline allows TPHO to maximize earnings from our Value-Based agreements and ensure all dollars are in the door prior to distribution to providers.

For the final reconciliation to our network providers, the initial distribution is based on final performance against TPHO Board approved Adult incentive measures at the Tax Identification Number (TIN) level for our Independent PCPs and TriHealth employed physician groups. This also includes a reconciliation against all advance payments for that Performance Year, and the result is a final payment to close out a particular Performance Year. After that initial distribution, TPP Pediatrics receives a subset of the dollars earned by the TriHealth G (TPP) TIN.

For the final Pediatric incentive payment, Value-Based attribution sets the maximum earning potential of the payment, but actual dollars earned will be calculated by the scoring level achieved across the quality measures.

In summary, the final reconciliation payment will take into account all of the factors impacting participating TPHO providers – TPHO final revenue and expenses, Value-Based payor attributed patient

member months, scores against TPHO Board approved measures, and amounts included in the advanced payment.

Approved Measures

The TPHO Board Approved the Following Measures for 2026 Performance Year on December 6, 2025.

Access to Care	• Well Child Visits 15-30 months (Medicaid and Commercial) • Well Child Visits 3-21 years (Medicaid and Commercial)
Quality	• Childhood Immunization Status Combo 10 (Medicaid and Commercial) • Immunizations for Adolescents Combo 2 (Medicaid and Commercial) • Screening for Depression and Follow-up Plan: 12-17 (Medicaid and Commercial)

Measure Weighting and Performance Level

Each measure makes up 20% of the final score for the provider's incentive payment. If a provider does not have enough qualifying patients (minimum denominator of 20) for the measure to be a meaningful indicator of performance, the weighting for that measure will be redistributed to the remaining qualifying measures. For example, if a provider does not have at least 20 patients in the Well Child Visits 15-30 months, but 20 or more in all other measures, the remaining measures will each account for 25% of the final scoring calculation. If a provider does not have enough qualifying patients for any measure, payment will revert to payor attributed Value-Based member months only.

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 well on Value-Based contracts and will be used to determine compensation for the performance year.
- Each measure can be meaningfully impacted by Pediatric primary care providers.
- Measure must be reliable, accessible, and actionable.
- Each measure may include some or all of the following Value-Based contracts below in 2024:

Payor Populations That Can Be Included in Measures	
▪ Aetna Commercial	▪ Medical Mutual of Ohio
▪ Anthem Commercial	▪ Molina Medicaid
▪ Buckeye Medicaid	▪ UHC Commercial
▪ Buckeye AMBetter	▪ CareSource
▪ Cigna	▪ TH Employee Plan (through Anthem)
▪ Humana Medicaid	

- Measuring Performance
  - Data Sources: Clinical (when available) and claims data.

  - Calendar Year performance based on available data (accounting for claims lag and payor)
  - Ongoing reporting via key governance forums and committees.
  - Final data used for the final reconciliation incentive payment will be made available in Q1, 2028.
- Target Levels
  - Target Levels are on a 5-point scale.
  - Average variance between each level is between 8% and 13% to create the 5-point scale.
  - Target levels are set based on historical performance, Value-Based contract targets, and best in class benchmarks as published by the National Committee for Quality Assurance (NCQA). HEDIS data is collected by NCQA from health plans across the country.
  - Target levels are approved by TPHO Board of Directors in March 2026.
- Plan enrollment (continuous enrollment and allowable gaps) considerations for the measures will adhere to HEDIS standards.
- Measures are based on total eligible members attributed to the provider by the payor.
- For a 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.
- HEDIS measure specifications are confidential information of NCQA and the CPT codes are copyrighted by the AMA.
- 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.

Well Child Visits 15-30 months (Medicaid and Commercial)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target					

- Use the measure not met list to identify patients without appointments in place who need a visit. Consider use of MyChart for outreach & scheduling.
- Schedule patient's next visit before they leave current visit.
- Use Well Child Visit flyer to educate patients and families on the importance of well child visits.
- Convert sick visits to well visits when able & appropriate.
- Review last well visit date with every interaction & schedule next wellness visit date accordingly.

OVERVIEW	
Description	

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months between 15-30 months of age. The following rates are reported:

Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Numerator	

Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. Either of the following meets criteria:

- A well-care visit (Well Care Visit Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).

Do not include telehealth visits (visits billed with a code that indicates telehealth: Telehealth POS Value Set; Online Assessments Value Set; Telephone Visits Value Set).

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Denominator	

Ages: Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Continuous enrollment: 15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.
Allowable gap: No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member 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). **Anchor date:** The date when the child turns 30 months old.	
Exclusions	
Exclude members who meet either 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.	
Interpretation	Higher is better.

Well Child Visits 3-21 years old (Medicaid and Commercial)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target					

- Use the measure not met list to identify patients without appointments in place who need a visit. Consider use of MyChart for outreach and scheduling.
- Schedule patient's next visit before they leave current visit.
- Use Well Child Visit flyer to educate patients and families on the importance of well visits.
- Convert sick visits to well visits when able & appropriate.
- Review last well visit date with every interaction & schedule next wellness visit date accordingly.

OVERVIEW

Description

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Numerator

One or more well-care visits during the measurement year. Either of the following meet criteria:

- A well-care visit (Well Care Visit Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).

Do not include telehealth visits (visits billed with a code that indicates telehealth: Telehealth POS Value Set; Online Assessments Value Set; Telephone Visits Value Set).

The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

Please note that the following codes will meet the measure criteria: **99381-99385; 99391-99395; 99461**

Denominator

Ages: 3–21 years 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 continuous enrollment period. To determine continuous enrollment for a Medicaid member 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).
Anchor date: December 31 of the measurement year.

Exclusions	
Exclude members who meet either 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.	
Interpretation	Higher is better.

Immunizations for Adolescents Combo 2 (Medicaid and Commercial)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target					

- Use Ohio Childhood Registry data to supplement your visit information in Epic.
- Use Gap in Care lists for outreach.
- Review preventative care screenings & care gaps at every visit.
- Initiate discussions with patient/caregiver about HPV early (age 9).).
- Use evidence-based approaches for vaccine hesitancy discussions.
- Use available resources for patient/family education on vaccines.
- Educate all that vaccine series must be completed **by 13th birthday**, and schedule appointments accordingly.

OVERVIEW

Description
The percentage of adolescents 13 years of age who received one meningococcal vaccine on or between the member's 10th and 13th birthday, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) on or between the member's 10th and 13th birthdays and completed the human papillomavirus (HPV) vaccine series by their 13th birthday.
Numerator
Adolescents who received one meningococcal vaccine on or between the members 10th and 13th birthday, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) on or between the member's 10th and 13th birthdays and completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The HPV vaccine series is at least two HPV vaccines, at least 146 days apart, between the member's 9th and 13th birthdays *OR* at least three HPV vaccines between the member's 9th and 13th birthdays.
Denominator
Ages: Adolescents who turn 13 years of age during the measurement year. **Continuous Enrollment:** 12 months prior to the member's 13th birthday. **Allowable Gap:** No more than one gap in enrollment of up to 45 days during the 12 months prior the member's 13th birthday. **Anchor Date:** The member's 13th birthday. The initial population, 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.	
Interpretation	Higher is better.

Childhood Immunization Status Combo 10 (Medicaid and Commercial)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target					

- Use Ohio Childhood Registry data to supplement your visit information in Epic
- Use Gap in Care lists for outreach
- Use evidence-based approaches for vaccine hesitancy discussions.
- Use available resources for patient/family education on vaccines.
- Review preventative care screenings & care gaps at every visit.
- Educate all that vaccine series must be completed **by 2nd birthday**, and schedule appointments accordingly.
- Ensure there is clear documentation & visibility for patients on an alternate vaccine schedule.

OVERVIEW

Description
The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccinations by their second birthday.
Numerator
Children who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV);one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccinations by their second birthday.
Denominator
Ages: Children who turn 2 years of age during the measurement year. ***Continuous Enrollment***: 12 months prior to the child's second birthday. ***Allowable* Gap:** No more than one gap in enrollment of up to 45 days during the 12 months prior the child's second birthday. ***Anchor Date:*** The child's second birthday.
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 contraindication to a childhood vaccine on or before their second birthday. Either of the following meet criteria: – Contraindications to Childhood Vaccines Value Set. Do not include laboratory claims (claims with POS code 81). – Organ and Bone Marrow Transplants Value Set.
Interpretation	Higher is better.

Screening for Depression and Follow-up Plan: 12 -17 (Medicaid and Commercial)

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Target					

- Complete well child visits early in the year.
- Utilize gap in care lists to schedule well child visits.
- Establish a workflow for annual depression screening for patients 12 and older using a standardized, accepted screener.
- Track reliability of screening.
- Ensure screener results are entered into the EMR.
- Utilize EMR to prompt follow up after a positive screen.
- Educate all team members on criteria for a positive result.
- Schedule follow-up appointments for patients who screen positive before they leave their current appointment.
- Refer appropriate patients to Behavior Health Consultants (BHCs).
- Conduct follow up outreach for patients prescribed SSRIs to ensure pick up of medication and see how patient is doing (~2-3 weeks after visit).

OVERVIEW

Description	

The percentage of members 12 through 17 years of age who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

· *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument.

· *Follow-Up on Positive Screen.* The percentage of members who received follow-up care within 30 days of a positive depression screen finding.

Numerator	

Please note that both of the numerators below must be met to close the gap.

Numerator 1–Depression Screening
Members with a documented result for depression screening, using an appropriate age standardized instrument, performed between January 1 and December 1 of the measurement period.

Numerator 2–Follow-Up on Positive Screen
Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen:

· An outpatient, telephone, e-visit or virtual check-in follow-up visit (Follow Up Visit Value Set) with a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set).
· A depression case management encounter (Depression Case Management Encounter Value Set) that documents assessment for symptoms of depression (Symptoms of Depression Value Set) or a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set).
· A behavioral health encounter, including assessment, therapy, collaborative care or medication management (Behavioral Health Encounter Value Set).
· A diagnosis of encounter for exercise counseling (ICD-10-CM code Z71.82). Do not include laboratory claims (claims with POS code 81).
· A dispensed antidepressant medication (Antidepressant Medications List).

OR

Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Note: *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*

Denominator	

Denominator 1: Members 12 years of age and older at the start of the measurement period who also meet criteria for participation.

The initial population, minus exclusions.

Denominator 2: All members from numerator 1 with a positive depression screen finding between January 1 and December 1 of the measurement period.

Exclusions	

· Members with a history of bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) any time during the member's history through the end of the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).
· Members with depression (Depression Value Set) that starts during the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).
· 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.

Interpretation	Higher is better.

Watch Metrics – 2026 Performance Year

The following measures were approved as Watch Measures. These are measures that are important to our Value-Based contracts and care of the pediatric patient population. Data will be monitored and shared throughout Performance Year 2026, but there will be no scoring levels and the incentive payment will not use these measures in the calculation. These measures could be considered for incentives in future Performance Years.

Weight Assessment and Counseling for Nutrition and Physical Activity for Child/Adolescents: BMI Percentile Assessment (Medicaid and Commercial)

OVERVIEW

Description	
The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN during the measurement year and whose body mass index (BMI) percentile ranking was documented.	
Numerator	
Members with an outpatient visit during the measurement year who had a BMI percentile ranking documented.	
Denominator	
Ages: 3-17 years old 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. **Anchor Date: December** 31 of the measurement year.	
Exclusions	
Exclude members who have a diagnosis of pregnancy during the measurement year. Also exclude members who die or elect to use the hospice benefit (i.e., begin using hospice services) any time during the measurement year.	

Childhood Immunization: MMR (Medicaid and Commercial)

OVERVIEW

Description
The percentage of children 2 years of age who had one measles, mumps and rubella (MMR) vaccination by their second birthday.
Numerator
Children who received at least one MMR vaccination, with a date of service falling on or between the child's first and second birthdays.
Denominator
Ages: Children who turn 2 years of age during the measurement year. **Continuous Enrollment: 12 months prior to the child's second birthday.** **Allowable Gap**: No more than one gap in enrollment of up to 45 days during the 12 months prior the child's second birthday. **Anchor Date: The** child's second birthday.
Exclusions
Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The exclusion must have occurred by the child's second birthday in order to count. Examples of contraindications include anaphylactic reaction to the vaccine or its components, encephalopathy, progressive neurologic disorders, immunodeficiency, HIV, organ transplant, bone marrow transplant, leukemia, multiple myeloma, and cancers of the lymphoreticular or histiolytic tissue. Also exclude members who die or elect to use the hospice benefit (i.e., begin using hospice services) any time during the measurement year.

Asthma Medication Ratio 5-18 (Medicaid and Commercial)

OVERVIEW

Description
The percentage of members 5–18 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Numerator
The number of members who have a medication ratio of ≥0.50 during the measurement year.
Denominator
Ages: Ages 5–18 as of December 31 of the measurement year. Report the following age stratifications and a total rate: **Continuous enrollment:** The measurement year and the year prior to the measurement year. **Allowable gap:** No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. 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 during each year of continuous enrollment. **Anchor date:** December 31 of the measurement year.
Exclusions
Exclude members who met any of the following criteria: • Members who had a diagnosis that requires a different treatment approach than members with asthma (Respiratory Diseases With Different Treatment Approaches Than Asthma 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 no asthma controller or reliever medications (Asthma Controller and Reliever Medications List) dispensed during 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.

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 the payor-attributed panel.**