2026 Highmark Health Options Practitioner Excellence (HHOPE) Program

HIGHMARK HEALTH OPTIONS

HIGHMARK

Welcome to the Highmark Health Options Practitioner Excellence (HHOPE) Program!

At Highmark Health Options/Highmark Blue Cross Blue Shield (hereafter "Highmark"), we value the important role that practitioners play in serving our members. We would like to welcome you to the Highmark Health Options Practitioner Excellence (HHOPE) Incentive Program. This program supports our efforts to improve the health and wellness of individuals and the communities we serve by providing access to superior health care.

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Program Overview

Highmark and our network of providers work together to give high quality health care to those who need it most: adults and children eligible for Medicaid and D-SNP, freeing our members to be their best.

Eligibility Criteria

Medicaid

The Highmark Health Options Practitioner Excellence Program (HHOPE, aka "Program") is open to the following provider types (all measures except Timeliness of Prenatal Care and Postpartum Care):

- Primary Care Physician (PCP)
  - Family Practice
  - Internal Medicine
  - Pediatricians
  - Certified Registered Nurse Practitioners (CRNP)
  - Physician Assistants

The Maternity Quality Program (consisting of the Prenatal Care in the First Trimester and Postpartum Care measures) is open to the following practitioner types:

- Obstetricians/Gynecologists

Minimum panel size requirements for the primary PCP Program are a combined membership of 100 for both Medicare and Medicaid lines of business at the entity level. Minimum requirements for the Maternity Quality Program are 20 live deliveries within the measure year.

Assignment: Members are assigned to a PCP based on panel assignment. Panel assignment is month-to-month. A member may change to another PCP should a satisfactory patient-practitioner relationship not develop. The Maternity Quality Program attributes members to the OB/GYN responsible for the members' delivery.

HHOPE Program uses Entity-level scoring:

- If a provider terminates their relationship with the Entity during the Program period, the program will reflect the fluctuation in the numerator/denominator and assigned members at the Entity level upon the provider change being completed.
- If a provider joins an Entity during the Program period, the program will reflect the fluctuation in the numerator/denominator and assigned members at the Entity level upon the provider change being completed.
- Payment of an incentive, if applicable, is made at the Entity level.

Medicare

The HHOPE Program is open to the following practitioner types:

- Primary Care Physician (PCP)
  - Family Practice
  - Internal Medicine
  - Pediatricians
  - Certified Registered Nurse Practitioners (CRNP)
  - Physician Assistants

Minimum panel size requirements are as follows:

- 100 combined Medicare/Medicaid members at the Entity level.

Assignment: Members are assigned to a PCP based on panel assignment. Panel assignment is month-to-month. A member may change to another PCP should a satisfactory patient-practitioner relationship not develop.

HHOPE Program uses Entity-level scoring:

- If a provider terminates their relationship with the Entity during the Program period, the program will reflect the fluctuation in the numerator/denominator and assigned members at the Entity level upon the provider change being completed.
- If a provider joins an Entity during the Program period, the program will reflect the fluctuation in the numerator/denominator and assigned members at the Entity level upon the provider change being completed.
- Payment of an incentive, if applicable, is made at the Entity level.

Exclusion

Providers who are participating in a Shared Savings contract with Highmark are not eligible to participate in the HHOPE Medicaid Program.

Opt-In Information

Eligible providers who wish to participate in the 2026 HHOPE Program must opt in to the program via their Clinical Transformation Consultant (CTC). For an entity to be eligible for the Medicaid HHOPE Program, they must not currently be participating in a Shared Savings contract with Highmark. In order for eligible providers to participate in the Maternity Quality Program, they must opt in separately from the primary HHOPE Program, also via their CTC. Providers may opt in to both programs until Sept. 30, 2026. The 2026 HHOPE Program includes quality performance from dates of service Jan. 1–Dec. 31, 2026.

By opting into the Program, the provider:

1. Acknowledges receipt of the 2026 HHOPE Program Manual.
2. Agrees that they have had an opportunity to review and ask questions about the program.
3. Understands the payment schedule, scoring methodology, and program requirements.
4. Agrees to participate in the program, comply with the program requirements, and accept Highmark determination of the incentive payment.
5. Agrees, upon request from Highmark, to meet with a Clinical Transformation Consultant at least once during the first quarter to provide an education session to providers and staff, and at minimum, quarterly, thereafter during the 2026 program year.
6. Understands that Highmark has the discretion to amend the program term and/or terminate participation in the program at any time.
7. Entities and Practitioners shall provide, free of charge, requested medical records or other documentation for the purposes of reporting to external agencies, such as the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and Centers for Medicare and Medicaid Services (CMS). Refusal to comply with such above noted requests may jeopardize Program eligibility and reimbursement.
   - When feasible, the Entity and/or Practitioner shall enter into a Data Exchange Agreement.
   - When feasible, the Entity and/or Practitioner shall provide remote Electronic Medical Record (EMR) access to Highmark.
8. Understands program benchmarks are subject to change contingent on the release of the new Quality Compass Benchmarks, with the potential for benchmark changes up to Oct. 15 of the program year.

Medicaid Quality Performance Measures and Requirements

Glycemic Status Assessment for Patients with Diabetes (GSD)

Targeted Providers: PCPs

Description of Measure: The percentage of members ages 18–75 with diabetes (types 1 and 2) whose most recent glycemic status (HbA1c or GMI) was at the following level during the measurement year:

- Glycemic Status <8.0%

Eligible Members: Members ages 18–75 with diabetes (type 1 or type 2) who meet the HEDIS criteria for Glycemic Status Assessment for Patients with Diabetes.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: The adherent member is compliant if the most recent glycemic status assessment has a result of <8.0% during the measurement year.

How to Submit: PCPs can qualify for incentive payment based on claims submission by reporting CPT II codes, electronically submitting data values that indicate the most recent glycemic status assessment (HbA1c or GMI) through medical record information submitted via Care Gap Management Application, provider portal, and/or electronic data feeds.

Scoring: This measure requires an entity to have a minimum of 10 members in the denominator in order to qualify to be scored. Payment is based on improvement over the previous year's level, (if they achieve 3, 5, or 7 percentage point improvement over 2025 performance), and/or benchmark percentiles (Silver or Gold, respectively). Payment is calculated based on compliant members through 2026 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually by July 31, 2027.

Cervical Cancer Screening (CCS)

Targeted Providers: PCPs

Description of Measure: The percentage of members ages 21–64 who were recommended for a routine cervical cancer screening and were screened for cervical cancer.

Eligible Members: Members ages 21–64 who meet the HEDIS criteria for Cervical Cancer Screening.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: The adherent member is compliant if they meet one of the following criteria recommended for routine cervical cancer screening:

- Cervical cytology performed within the last three years.
- Members ages 30–64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.
- Members ages 30–64 who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting performed within the last five years.

How to Submit: PCPs can qualify for incentive payment based on claims submission, medical record information submitted via Care Gap Management Application, provider portal, and/or electronic data feeds.

Scoring: This measure requires an entity to have a minimum of 10 members in the denominator in order to qualify to be scored. Payment is based on improvement over the previous year's level, (if they achieve 3, 5, or 7 percentage point improvement over 2025 performance), and/or benchmark percentiles (Silver or Gold, respectively). Payment is calculated based on compliant members through 2026 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually by July 31, 2027.

Breast Cancer Screening (BCS)

Targeted Providers: PCPs

Description of Measure: The percentage of members ages 40–74 who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

Eligible Members: Members ages 40–74 who meet the HEDIS criteria for Cancer Screening.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: The adherent member is compliant if they had a mammogram any time on or between Oct.1, two years prior to the measurement year and the last day of the measurement period (Dec. 31, 2026).

How to Submit: PCPs can qualify for incentive payment based on claims submission, medical record information submitted via Care Gap Management Application, provider portal, and/or electronic data feeds.

Scoring: This measure requires an entity to have a minimum of 10 members in the denominator in order to qualify to be scored. Payment is based on improvement over the previous year's level, (if they achieve 2, 4, or 6 percentage point improvement over 2025 performance), and/or benchmark percentiles (Silver or Gold respectively). Payment is calculated based on compliant members through 2026 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually by July 31, 2027.

Controlling Blood Pressure (CBP)

Targeted Providers: PCPs

Description of Measure: The percentage of members ages 18–85 with a diagnosis of hypertension, whose blood pressure was adequately controlled (<140/90 mm HG) during the measurement year.

Eligible Population: Members ages 18–85 in 2026 with a diagnosis of hypertension who meet the HEDIS criteria for Controlling High Blood Pressure.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: The member is compliant if the most recent controlled blood pressure reading on or after the second hypertension diagnosis is less than 140/90 mm Hg during the measurement year.*

*Note: BP readings taken by the member are eligible for use in reporting. BP documented as an "average BP" (e.g., average BP: 139/70) is eligible for use. Ranges and thresholds do not meet criteria.

How to Submit: PCPs can qualify for incentive payment based on claims submission, medical record information submitted via Care Gap Management Application, provider portal, and/or electronic data feeds.

Scoring: This measure requires an entity to have a minimum of 10 members in the denominator in order to qualify to be scored. Payment is based on improvement over the previous year's level, (if they achieve 3, 5, or 7 percentage point improvement over 2025 performance), and/or benchmark percentiles (Silver or Gold respectively). Payment is calculated based on compliant members through 2026 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually by July 31, 2027.

Well-Child Visits in the First 15 Months of Life, Six or More (W15)

Targeted Providers: PCPs

Description of Measure: The percentage of members who turned age 15 months during the measurement year and who had six or more well-child visits.

Eligible Members: Members who turned age 15 months during the measurement year.

Exclusions: This measure will adhere to HEDIS exclusion criteria for Well-Child Visits in the First 15 Months measure.

Adherent Member: Patient must have had six comprehensive well-child visits by their 15-month birthday.

How to Submit: Provider can submit via claims submission, medical record information submitted via Care Gap Management Application, and/or electronic data feeds.

Scoring: This measure requires an entity to have a minimum of 10 members in the denominator in order to qualify to be scored. Payment is based on achievement of benchmark percentiles (Silver or Gold, respectively). Payment is calculated based on compliant members through 2026 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by July 31, 2027.

Child and Adolescent Well-Care Visits (WCV)

Targeted Providers: PCPs

Description of Measure: The percentage of members ages 3–21 who had one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.

Eligible Members: Members ages 3–21 by Dec. 31, 2026.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Patient who had a comprehensive well-care visit in 2026.

How to Submit: Provider can submit via claims submission, medical record information submitted via Care Gap Management Application, and/or electronic data feeds.

Scoring: This measure requires an entity to have a minimum of 10 members in the denominator in order to qualify to be scored. Payment is based on achievement of benchmark percentiles (Silver or Gold, respectively). Payment is calculated based on compliant members through 2026 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by July 31, 2027.

Plan All-Cause Readmissions (PCR)

Targeted Providers: PCPs

Description of Measure: Members ages 18–64 who had an acute inpatient care or observation stay during the measurement year with a discharge on or between Jan. 1–Dec. 1 of the measurement year, followed by a Transitional Care Management (TCM) visit.

Eligible Members: Members ages 18–64 who had an acute inpatient care or observation stay during the measurement year with a discharge on or between Jan. 1–Dec. 1 of the measurement year.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Members with a visit within seven days of discharge that has High Medical Decision Complexity (CPT 99496) or members with a visit within 14 days of discharge that has Moderate Medical Decision Complexity (CPT 99495).

How to Submit: This measure is captured through claims submission only.

Scoring: This measure does not have a minimum denominator requirement. Payment is calculated based on members compliant within 2026. A higher widget incentive payment will be awarded for members with a visit within seven days of discharge (High Medical Decision Complexity, CPT 99496) compared to those with a visit within 14 days of discharge (Moderate Medical Decision Complexity, CPT 99495). Payment is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by July 31, 2027.

Maternity Quality Program

Timeliness of Prenatal Care (PPC: TOPC)

Targeted Providers: Obstetricians

Description of Measure: The percentage of members with deliveries who have had a prenatal visit within the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.

Eligible Members: Members with deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year, as determined by the HEDIS measure specifications.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Member who has had a prenatal visit within the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.

How to Submit: Provider can submit via claims submission, medical record information submitted via Care Gap Management Application, provider portal, and/or electronic data feeds.

Scoring: This measure requires an entity to have a minimum of 20 live birth deliveries in the denominator in order to qualify to be scored. Payment is based on achieving benchmark (Silver or Gold, respectively). Payment is calculated based on compliant members through 2026 and is paid to the Obstetrician/Gynecologist who was responsible for the members' delivery. Payment is made annually, by July 31, 2027.

Postpartum Care (PPC: POST)

Targeted Providers: Obstetricians

Description of Measure: The percentage of members with deliveries who have had a postpartum visit on or between 7–84 days after delivery.

Eligible Members: Members with deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year, as determined by the HEDIS measure specifications.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Member who has postpartum care (as defined by the HEDIS measure specifications) on or between 7–84 days after delivery.

How to Submit: Provider can submit via claims submission, medical record information submitted via Care Gap Management Application, provider portal, and/or electronic data feeds.

Scoring: This measure requires an entity to have a minimum of 20 live birth deliveries in the denominator in order to qualify to be scored. Payment is based on achieving benchmark (Silver or Gold, respectively). Payment is calculated based on compliant members through 2026 and is paid to the Obstetrician/Gynecologist who was responsible for the members' delivery. Payment is made annually, by July 31, 2027.

Medicare D-SNP Quality Performance Measures and Requirements

Glycemic Status Assessment for Patients With Diabetes (GSD)

Targeted Provider: PCPs

Description of Measure: Members between ages 18–75 with diabetes (types 1 and 2) whose most recent glycemic status (HbA1c or GMI) was at the following level during the measurement year:

- Glycemic Status ≤9.0%

Eligible Members: Members ages 18–75 with diabetes (type 1 or type 2) who meet the HEDIS criteria for Glycemic Status Assessment for Patients with Diabetes. Each member in the denominator falls into one of the following tiers:

- **Tier 1: Previously Compliant Members**
  - Members who were compliant with the Glycemic Status Assessment measure at the end of 2025 and are in the eligible denominator for 2026.
- **Tier 2: Previously Non-Compliant or New Members**
  - Members who were not compliant with the Glycemic Status Assessment measure at the end of 2025 and are in the eligible denominator for 2026 or are new to the denominator in 2026.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member:

- **Tier 1:** The member is adherent if the most recent glycemic status assessment has a result of <9% during the measurement year.
- **Tier 2:** The member is adherent if the most recent glycemic status assessment has a result of <9% during the measurement year.

How to Submit: PCPs can qualify for incentive payment based on claims submission by reporting CPT II codes, electronically submitting data values that indicate the most recent glycemic status assessment (HbA1c or GMI) through medical record information submitted via Care Gap Management Application, provider portal, and/or electronic data feeds.

Scoring: Providers will be eligible for incentive payments based on their performance across two distinct tiers. Each member in the denominator falls into one of these tiers. Payment is calculated based on compliant members through 2026 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by July 31, 2027.

For Highmark Health Options Duals (HMO SNP) members, providers can only receive one payment per member per year for the HHOPE Glycemic Status Assessment Measure. These members will not be eligible for the HHOPE D-SNP GSD payment if the provider earns payment under the 2026 Medicaid HHOPE Program for the same member and measure opportunity.

Controlling Blood Pressure (CBP)

Targeted Provider: PCPs

Description of Measure: Members ages 18–75 with a diagnosis of Hypertension who meet the HEDIS criteria for Controlling High Blood Pressure, whose BP was adequately controlled (<140/90) during the measurement year.

Eligible Members: Members ages 18–75 with a diagnosis of Hypertension who meet the HEDIS criteria for Controlling High Blood Pressure. Each member in the denominator falls into one of the following tiers:

- **Tier 1: Previously Compliant Members**
  - Members who were compliant with the Controlling Blood Pressure measure at the end of 2025 and are in the eligible denominator for 2026.
- **Tier 2: Previously Non-Compliant or New Members**
  - Members who were not compliant with the Controlling Blood Pressure measure at the end of 2025 and are in the eligible denominator for 2026 or are new to the denominator in 2026.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member:

- **Tier 1:** The member is adherent if the most recent blood pressure reading has a result of <140/90 during the measurement year.
- **Tier 2:** The member is adherent if the most recent blood pressure reading has a result of <140/90 during the measurement year.

How to Submit: PCPs can qualify for incentive payment based on electronic submission of data values, not just CPT-II codes via claims submission, indicating a controlled blood pressure reading (<140/90 mm Hg) through medical record information submitted via Care Gap Management Application, provider portal, and/or electronic data feeds.

Scoring: Providers will be eligible for incentive payments based on their performance across two distinct tiers. Each member in the denominator falls into one of these tiers. Payment is calculated based on compliant members through 2026 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by July 31, 2027.

For Highmark Health Options Duals (HMO SNP) members, providers can only receive one payment per member per year for the HHOPE Controlling High Blood Pressure Measure. These members will not be eligible for the HHOPE D-SNP CBP payment if the provider earns payment under the 2026 Medicaid HHOPE Program for the same member and measure opportunity.

Transitions of Care: Medication Reconciliation Post Discharge (TRC)

Targeted Provider: PCPs

Description of Measure: The percentage of discharges from Jan. 1–Dec. 1 of the measurement year for members for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

Eligible Members: Medicare members ages 18 and older as of Dec. 31 of the measurement year with an inpatient discharge between Jan. 1–Dec. 1 of the measurement year.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, or registered nurse on the date of discharge through 30 days after discharge (31 total days).

How to Submit: Submit a claim for medication reconciliation completed and documented in the outpatient chart or via Care Gap Management Application, provider portal, and/or electronic data feeds.

Scoring: Payment is based on achieving benchmark (Silver or Gold, respectively). Payment is calculated based on compliant members through 2026 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by July 31, 2027.

Annual Wellness Visit (AWV), Annual Physical Exam, Initial Preventative Exam (IPPE)

Targeted Provider: PCPs

Description of Measure: Medicare members who had an Annual Wellness Visit (AWV) during the measurement year, or Initial Preventive Physical Exam (IPPE) or Annual Physical Exam within the first 12 months of enrollment in the Medicare product.

Eligible Members: All D-SNP members. Each member in the denominator falls into one of the following tiers:

- **Tier 1: Previously Compliant Members**
  - Members who were compliant with the Annual Wellness Visit measure at the end of 2025 and are in the eligible denominator for 2026.
- **Tier 2: Previously Non-Compliant or New Members**
  - Members who were not compliant with the Annual Wellness Visit measure at the end of 2025 and are in the eligible denominator for 2026 or are new to the denominator in 2026.

Exclusions: There are no exclusions for this measure.

Adherent Member:

- **Tier 1:** The member is adherent if they complete an Annual Wellness Exam, Initial Preventative Physician Exam, or Annual Physical Exam during the measurement year.
- **Tier 2:** The member is adherent if they complete an Annual Wellness Exam, Initial Preventative Physician Exam, or Annual Physical Exam during the measurement year.

How to Submit: This measure is closed via claims submission.

Scoring: Payment is earned by achieving benchmark based on member compliance as of Dec. 31, 2026. Each measure tier is scored separately. Payment is issued only for year-end compliant members. One payment per member per year regardless of tier. Payment is calculated based on compliant members through 2026 and is paid to the PCP who was assigned to the member on the last day of the year. Payment is made annually, by July 31, 2027.

Plan All-Cause Readmissions (PCR)

Targeted Providers: PCPs

Description of Measure: Medicare members ages 18 and older who had an acute inpatient care or observation stay during the measurement year with a discharge on or between Jan. 1–Dec. 1 of the measurement year followed by a Transitional Care Management (TCM) visit.

Eligible Members: Medicare members ages 18 and older who had a qualifying acute inpatient care or observation stay during the measurement year with a discharge on or between Jan. 1–Dec. 1 of the measurement year.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Members with a visit within seven days of discharge that has High Medical Decision Complexity (CPT 99496) or members with a visit within 14 days of discharge that has Moderate Medical Decision Complexity (CPT 99495).

How to Submit: This measure is captured through claims submission.

Scoring: This measure does not have a minimum denominator requirement. Payment is calculated based on members compliant within 2026. A higher widget incentive payment will be awarded for members with a visit within seven days of discharge (High Medical Decision Complexity, CPT 99496) compared to those with a visit within 14 days of discharge (Moderate Medical Decision Complexity, CPT 99495). Payment is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by July 31, 2027.

Medication Adherence for Diabetes Medications (MAD)

Targeted Providers: PCPs

Description of Measure: Members ages 18 or older as of Dec. 31 of the measurement year with a second fill diabetes medication within the measurement period. The goal is for the member to convert to an extended-day supply from a current 30–83-day supply of diabetes medication. An additional objective is for the member to demonstrate adherence by filling their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication, which would qualify for a bonus.

Eligible Members: Members ages 18 or older as of Dec. 31 of the measurement year qualify for this measure if they have a second fill of diabetes medication within the measurement period and their last fill in 2025 was not an extended-day supply of diabetes medication.

Exclusions: This measure will adhere to CMS STAR exclusion criteria which include exclusion for one or more prescriptions for insulin.

Adherent Member: A member is considered adherent if they fill and pick up an eligible 84–100-day medication supply. Payment for such members is earned through two distinct pathways, with a higher incentive payment awarded for members who fill and pick up the eligible 84–100-day medication supply by May 31, 2026:

- **Tier 1:** The member fills and picks up the eligible 84–100-day medication supply by May 31, 2026.
- **Tier 2:** The member fills and picks up the eligible 84–100-day medication supply on or after June 1, 2026.
- **Year-End Adherence Bonus:** Providers can earn an additional incentive for members who convert to an 84–100-day extended supply and are compliant with the Medication Adherence measure year-end.

How to Submit: This data is only captured via a pharmacy claim.

Scoring: Payment is calculated based on member conversions as of Dec. 31, 2026. Each conversion measure is scored separately. Providers are eligible to earn one incentive per member per program year for conversions based on the pickup date, irrespective of Medication Adherence measure compliance. An additional bonus will be paid for members who convert to an extended-day supply and are compliant with the Medication Adherence for Diabetes measure by year-end. The incentive payment will be made to the PCP to whom the member is assigned on Dec. 31, 2026, regardless of the assignment date during the year. Payment will be made annually, by July 31, 2027.

Medication Adherence for Cholesterol (Statins) (MAC)

Targeted Providers: PCPs

Description of Measure: Members ages 18 or older as of Dec. 31 of the measurement year with a second fill of statin cholesterol medication within the measurement period. The goal is for the member to convert to an extended-day supply from a current 30–89-day supply of statin cholesterol medication. An additional objective is for the member to demonstrate adherence by filling their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication, which would qualify for a bonus.

Eligible Members: Members ages 18 or older as of Dec. 31 of the measurement year qualify for this measure if they have a second fill of statin cholesterol medication within the measurement period and their last fill in 2025 was not an extended-day supply of statin cholesterol medication.

Exclusions: This measure will adhere to CMS STAR exclusion criteria.

Adherent Member: A member is considered adherent if they fill and pick up an eligible 90- or 100-day medication supply. Payment for such members is earned through two distinct pathways, with a higher incentive payment awarded for members who fill and pick up the eligible 90- or 100-day medication supply by May 31, 2026:

- **Tier 1:** The member fills and picks up the eligible 90- or 100-day medication supply by May 31, 2026.
- **Tier 2:** The member fills and picks up the eligible 90- or 100-day medication supply on or after June 1, 2026.
- **Year-End Adherence Bonus:** Providers can earn an additional incentive for members who convert to a 90- or 100-day extended supply and are compliant with the Medication Adherence measure year-end.

How to Submit: This data is only captured via a pharmacy claim.

Scoring: Payment is calculated based on member conversions as of Dec. 31, 2026. Each conversion measure is scored separately. Providers are eligible to earn one incentive per member per program year for conversions based on the pickup date, irrespective of Medication Adherence measure compliance. An additional bonus will be paid for members who convert to an extended-day supply and are compliant with the Medication Adherence for Cholesterol measure by year-end. The incentive payment will be made to the PCP to whom the member is assigned on Dec. 31, 2026, regardless of the assignment date during the year. Payment will be made annually, by July 31, 2027.

Medication Adherence for Hypertension (RAS antagonists) (MAH)

Targeted Providers: PCPs

Description of Measure: Members ages 18 or older as of Dec. 31 of the measurement year with a second fill of blood pressure medication (RAS antagonist) within the measurement period. The goal is for the member to convert to an extended-day supply from a current 30–89-day supply of hypertension medication. An additional objective is for the member to demonstrate adherence by filling their prescription often enough to cover 80% or more of the time they supposed to be taking the medication, which would qualify for a bonus.

Eligible Members: Members ages 18 or older as of Dec. 31 of the measurement year qualify for this measure if they have a second fill of blood pressure medication (RAS antagonist) within the measurement period and their last fill in 2025 was not an extended-day supply of hypertension medications.

Exclusions: This measure will adhere to CMS STAR exclusion criteria.

Adherent Member: A member is considered adherent if they fill and pick up an eligible 90- or 100-day medication supply. Payment for such members is earned through two distinct pathways, with a higher incentive payment awarded for members who fill and pick up the eligible 90- or 100-day medication supply by May 31, 2026:

- **Tier 1:** The member fills and picks up the eligible 90- or 100-day medication supply by May 31, 2026.
- **Tier 2:** The member fills and picks up the eligible 90- or 100-day medication supply on or after June 1, 2026.
- **Year-End Adherence Bonus:** Providers can earn an additional incentive for members who convert to a 90- or 100-day extended supply and are compliant with the Medication Adherence measure year-end.

How to Submit: This data is only captured via a pharmacy claim.

Scoring: Payment is calculated based on member conversions as of Dec. 31, 2026. Each conversion measure is scored separately. Providers are eligible to earn one incentive per member per program year for conversions based on the pickup date, irrespective of Medication Adherence measure compliance. An additional bonus will be paid for members who convert to an extended-day supply and are compliant with the Medication Adherence for Hypertension measure by year-end. The incentive payment will be made to the PCP to whom the member is assigned on Dec. 31, 2026, regardless of the assignment date during the year. Payment will be made annually, by July 31, 2027.

Reporting Definitions

Medicaid

Benchmarks: Payment earned based on benchmark level attained, and number of per member care gap closures.

- Silver Level
- Gold Level

Percentage Point Improvement: The Improvement factor may vary by measure. Improvement factor compared to an entity's performance per measure. Select measures do not qualify for improvement.

Benchmarks/Percentage Point Improvement Chart*

Primary Data Source	Measure Name	Measure Acronym	Improvement Rate			Silver	Gold
HEDIS	Glycemic Status Assessment for Patients with Diabetes	GSD	3%	5%	7%	62.6%	65%
HEDIS	Cervical Cancer Screening	CCS	3%	5%	7%	64.1%	68.2%
HEDIS	Breast Cancer Screening	BCS	2%	4%	6%	59.9%	61.4%
HEDIS	Controlling High Blood Pressure	CBP	3%	5%	7%	73.3%	77.4%
HEDIS	Well-Child in the First 15 Months of Life, Six or More	W15	N/A	N/A	N/A	65%	66.6%
HEDIS	Child and Adolescent Well-Care Visits	WCV	N/A	N/A	N/A	61.2%	63.5%
HEDIS	Plan All-Cause Readmissions	PCR	N/A	N/A	N/A	N/A	N/A
HEDIS	Timeliness of Prenatal Care	PPC: TOPC	N/A	N/A	N/A	90.6%	93%
HEDIS	Postpartum Care	PPC: POST	N/A	N/A	N/A	86.2%	89.3%

*Benchmarks are subject to change contingent on release of new Quality Compass Benchmarks.

Medicare

For 2026, the program introduces an evolved measure scoring approach that moves beyond benchmark attainment. This new structure focuses on measure-specific benchmarks, percentage point improvement, and individual per-member incentive payments to drive enhanced member health outcomes.

Primary Data Source	Measure Name	Measure Acronym	4-Star Target	5-Star Target	Other Benchmarks
N/A	Annual Wellness Visit (not Stars or HEDIS measure)	AWV	N/A	N/A	**Tier 1 Benchmark:** 75% **Tier 2 Benchmark:** 35% Payments based on benchmark achievement. Each measure Tier 1 and Tier 2 scored separately.
HEDIS	Medication Reconciliation Post-Discharge	MRP	81%	90%	**Benchmark:** Payments based on achieving benchmark (4-Star/5-Star respectively).
HEDIS	Glycemic Status Assessment for Patients with Diabetes	GSD	N/A	N/A	**Tiered Member Compliance:** Payments based on individual member compliance in Tier 1 or Tier 2.
HEDIS	Controlling High Blood Pressure	CBP	N/A	N/A	**Tiered Member Compliance:** Payments based on individual member compliance in Tier 1 or Tier 2.
HEDIS	Plan All-Cause Readmissions	PCR	N/A	N/A	**Visit-based Payments:** CPT 99495 within 14 days and CPT 99496 within seven days. No minimum denominator.
STAR	Medication Adherence for Hypertension (RAS antagonists)	MAH	N/A	N/A	**Conversion Payments:** May be eligible for additional bonus for year-end adherence.
STAR	Medication Adherence for Diabetes Medications	MAD	N/A	N/A	**Conversion Payments:** May be eligible for additional bonus for year-end adherence.
STAR	Medication Adherence for Cholesterol (Statins)	MAC	N/A	N/A	**Conversion Payments:** May be eligible for additional bonus for year-end adherence.

*Benchmarks are subject to change contingent on release of new Quality Compass Benchmarks.

Program Payment Rules

Following the completion of the 2026 HHOPE Program, eligible providers will receive one payment for each program component. The only payment will be calculated in July 2027.

- Provider must be opted in by Sept. 30, 2026, to be eligible for payment.
- Provider must meet minimum membership requirements noted in the Opt-In information section.
- Payment for gap closure in each measure is contingent upon meeting the minimum denominator requirements as noted throughout this guide. Failure to meet these minimums will result in no payment for that specific measure.
- Payment is calculated based on compliant members through Dec. 31, 2026.
- The provider to whom the member is assigned as of Dec. 31, 2026, is the one who earns the reward.
- If an entity terminates from the Program before Dec. 31 of the program year, the entity is not eligible for the HHOPE payment.
- Payments will be dispersed by July 31, 2027, after a final review of all 2026 information and to allow for the three-month claims run-out period.
- If a member is a Highmark Health Options Duals (HMO SNP) member, providers can only receive one payment per member per year for the HHOPE Controlling High Blood Pressure and Glycemic Status Assessment Measure. This member will not be eligible for the HHOPE D-SNP CBP and GSD payment if the provider earns payment under the 2026 Medicaid HHOPE Program for the same member and measure opportunity.

Program Education and Questions

Highmark is committed to ensuring providers and their staff are notified and educated on our HHOPE Program and incentives. The Highmark Clinical Transformation Consultants (CTCs) will provide face-to-face training with network providers throughout Highmark's service area.

If you need more information, please contact your dedicated Clinical Transformation Consultant or email at **DePET@Highmark.com**.