2026 Highmark Health Options West Virginia Practitioner Excellence (HHOPE) Program

HIGHMARK HEALTH OPTIONS

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

Highmark Health Options West Virginia (HHO WV) values the important role practitioners play in serving members and improving health outcomes. In 2026, HHO WV will launch the HHOPE Program to recognize and reward providers for their dedication to high-quality member care. Participation in the Program is entirely voluntary. This resource guide will help you become familiar with the Program's quality measures.

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This document is intended as a guide and is not all-inclusive. The information contained within does not guarantee compliance with Highmark Health Options incentive programs. Always refer to the National Guidelines for complete coding and technical specifications. Coding may be subject to change based on National Guidelines and/or CMS updates. Examples of potential coding opportunities for metric compliance may be provided in this document. The examples provided are meant for guidance only. Listing of a code in this document does not equate to coverage under Highmark Health Options medical policy.

Novillus, Inc. is a separate company which administers their Care Gap Management Application for Highmark Health Options.

Eligibility Criteria

Medicaid

The HHOPE Program is open to the following provider types:

- Primary Care Physician (PCP)
  - Family Practice
  - Internal Medicine
  - Pediatricians
  - Certified Registered Nurse Practitioners (CRNP)
  - Physician Assistants
- Dentists (no minimum panel size required)

Minimum panel size requirements for the primary PCP program are a combined membership of five for both Medicaid and Medicare D-SNP lines of business 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 for the primary PCP program are a combined membership of five for both Medicaid and Medicare D-SNP lines of business at the entity level.

Assignment

Member is assigned to a PCP based on panel assignment. Panel assignment is month-to-month. A member may change to another provider if they are not satisfied with their current patient-practitioner relationship.

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). Providers may opt in to the Program until Sept. 30, 2026. The HHOPE Program includes quality performance from dates of service Jan. 1, 2026–Dec. 31, 2026.

By opting into the Program, the provider:

1. Acknowledges receipt of the 2026 HHOPE Provider 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 HHO's determination of the incentive payment.
5. Agrees, upon request from HHO, to meet with a CTC once during the first quarter to provide an education session to staff and providers, and quarterly thereafter during the Program year.
6. Understands HHO has the discretion to amend the Program term or terminate participation in the Program at any time.

HHO is committed to keeping providers and their staff informed about the HHOPE Program. Your primary point of contact is your HHO Clinical Transformation Consultant, who will be available to answer your questions and provide support.

This document is intended as a guide and is not all-inclusive. The information contained within does not guarantee compliance with Highmark Health Option's incentive program. Always refer to National Guidelines for complete coding and technical specifications. Coding may be subject to change based on National Guidelines and/or CMS updates. Examples of potential coding opportunities for metric compliance are provided in this document. The examples provided are meant for guidance only. Listing of a code in this document does not equate to coverage under Highmark Health Option's medical policy.

Medicaid Quality Performance Measures and Requirements

Controlling High Blood Pressure (CBP)

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

Eligible Members: Members ages 18–85 in the measurement year with a diagnosis of hypertension who meet the HEDIS criteria for Controlling Blood Pressure during the current measurement year.

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.

How to Submit: The PCP must submit a CPT II code or other evidence of a controlled BP reading of less than 140/90 mm Hg.

Provider can submit via claims submission, medical record information submitted via HHO WV's Care Gap Management Application, or electronic data feeds.

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 will earn the reward. Payment is made annually, by July 31, 2027.

Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD)

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

- HbA1c poor control (>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.

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 ≤9.0% during the measurement year.

How to Submit: The PCP must submit a CPT II code or other evidence of a controlled HbA1c of less than or equal to nine.

Provider can submit via claims submission, medical record information submitted via HHO WV's Care Gap Management Application, or electronic data feeds.

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 will earn the reward. Payment is made annually, by July 31, 2027.

Oral Evaluation, Dental Services

Description of Measure: Members ages 6 months–20 years who had at least one dental visit during the measurement year.

Eligible Members:

1. Continuous enrollment for 90 days.
2. Members ages 6 months–20 years.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: The following episodes of care occur, and the correct claims are submitted from the table below:

Oral Care Service	Codes
Oral Examination Codes	D0120, D0145, D0150
Dental Prophylaxis	D1110 or D1120
Topical Application of Fluoride (with or without varnish)	D1206 (with varnish) D1208 (without varnish)

Examination, Prophylaxis, and a Topical Fluoride Treatment will all need to be submitted for members ages 6 months–20 years.

Note: PCPs will not be incented for this measure in the 2026 program. Dentists only are eligible to earn this incentive.

W30: Well-Child Visits in the First 30 Months of Life (0–15 Months)

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 (from birth to the child's 15-month birthday).

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

Exclusions: This measure will adhere to HEDIS exclusion criteria.

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

How to Submit:

Measure or Component	ICD-10-CM Codes	CPT Category 1
New Patient	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.82	age <1: 99381 age 1–4: 99382
Established Patient	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.82	age <1: 99391 age 1–4: 99392
Newborn Visit	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.82	99461

Provider can submit via claims submission, medical record information submitted via HHO WV's Care Gap Management Application, or electronic data feeds.

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 will earn the reward. Payment is made annually, by July 31, 2027.

W30: Well-Child Visits in the First 30 Months of Life (15–30 Months)

Description of Measure: The percentage of members who turned age 30 months during the measurement year and who had two or more well-child visits (after the child's 15-month birthday through the child's 30-month birthday).

Eligible Members: Members who turned 30 months old during the measurement year.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Patient must have had two comprehensive well-child visits after the child's 15-month birthday through their 30-month birthday.

How to Submit:

Measure or Component	ICD-10-CM Codes	CPT Category 1
New Patient	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.82	age <1: 99381 age 1–4: 99382
Established Patient	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.82	age <1: 99391 age 1–4: 99392
Newborn Visit	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.82	99461

Provider can submit via claims submission, medical record information submitted via HHO WV's Care Gap Management Application, or electronic data feeds.

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 will earn the reward. Payment is made annually, by July 31, 2027.

Lead Screening for Children (LSC)

Description of Measure: The percentage of children age 2 who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Eligible Members: Children who turn 2 years old during the measurement year.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: At least one lead capillary or venous blood test on or before the child's second birthday as determined by the HEDIS specifications.

How to Submit: The CPT code for Lead Screening is 83655.

Provider can submit via claims submission, medical record information submitted via HHO WV's Care Gap Management Application, or electronic data feeds.

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 will earn the reward. Payment is made annually, by July 31, 2027.

Immunization for Adolescents – Combo 2 (IMA)

Description of Measure: The percentage of adolescents who receive the required set of immunizations (listed under Adherent Member section) by their thirteenth birthday.

Eligible Members: Percent of adolescents who receive the required set of immunizations (listed under Adherent Member section) by their thirteenth birthday. Persons who turn age 13 during the measurement year.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Adolescents who had all doses of the following immunizations administered in the required age ranges by their thirteenth birthday according to the HEDIS specification.

- At least one meningococcal vaccine, with a date of service on or between the member's tenth and thirteenth birthdays AND
- At least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, with a date of service on or between the member's tenth and thirteenth birthdays AND
- One of the following:
  - At least two HPV vaccines, with different dates of service at least 146 days apart on or between the member's ninth and thirteenth birthdays OR
  - At least three HPV vaccines, with different dates of service on or between the member's ninth and thirteenth birthdays.

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 will earn the reward. Payment is made annually, by July 31, 2027.

Childhood Immunization Status – Combo 10 (CIS)

Description of Measure: The percentage of children who receive the required set of ten immunizations (listed under Adherent Member section) by their second birthday.

Eligible Members: Children who turn 2 years old during the measurement year.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Children who had all doses of the following immunizations administered by their second birthday:

- Four diphtheria, tetanus, and acellular pertussis (DTaP)
- Three polio (IPV)
- One measles, mumps, and rubella (MMR)
- Three haemophilus influenza type B (HiB)
- Three hepatitis B (HepB)—can be completed at birth (1 of 3 can be a newborn HepB vaccination)
- One chicken pox (VZV)
- Four pneumococcal conjugate (PCV)
- One hepatitis A (HepA)
- Two doses of the two-dose rotavirus (RV2) or three doses of the three-dose rotavirus (RV3)
- Two influenza (flu) vaccines

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 will earn the reward. Payment is made annually, by July 31, 2027.

Timeliness of Prenatal Care

Description of Measure: 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 had a prenatal visit in the first trimester.

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned one time for each numerator compliant member through Dec. 31, 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 is the one who earns the reward.

Medicare Quality Performance Measures and Requirements

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

Description of Measure: 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 Medicare D-SNP members.

Exclusions: No exclusion criteria.

Adherent Member: Member who completed an Annual Wellness Visit, IPPE, or Annual Physical Exam within the measurement year.

How to Submit: Provider can submit via claims submission.

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned one time for each numerator compliant member through Dec. 31, 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 is the one who earns the reward.

Controlling High Blood Pressure (CBP)

Description of Measure: Members who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement period.

Eligible Members: Members ages 18–75 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 is 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.

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned one time for each numerator compliant member through Dec. 31, 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 is the one who earns the reward.

Breast Cancer Screening (BCS)

Description of Measure: 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 Breast Cancer Screening.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Member who had a mammogram at any time on or between Oct. 1 two years prior to the measurement period and the last day of the measurement period.

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned one time for each numerator compliant member through Dec. 31, 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 is the one who earns the reward.

Glycemic Status Assessment for Patients with Diabetes

Description of Measure: Members ages 18–75 with Diabetes Type 1 or 2 in the Glycemic Status Assessment for Patients with Diabetes measure in the current measurement year who are not currently on a Continuous Glucose Monitor and obtain a Continuous Glucose Monitor in the measurement year to help improve glycemic control.

Eligible Members: Members ages 18–75 who meet the HEDIS criteria for Glycemic Status Assessment for Patients with Diabetes.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Member is compliant if they obtain a Continuous Glucose Monitor within the measurement year.*

*Note regarding Continuous Glucose Monitor Coverage: This incentive program offers an incentive payment to the provider for placing an eligible member on a Continuous Glucose Monitor. It does not guarantee payment for the Continuous Glucose Monitor device or related services themselves. Providers must follow all Highmark Health Options benefit and authorization requirements that apply to obtaining the Continuous Glucose Monitor for the member. It is crucial to understand that this incentive does not dictate clinical decision-making; the determination of medical appropriateness for a Continuous Glucose Monitor remains solely at the discretion of the provider.

How to Submit: Submission via claims.

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned one time for each numerator compliant member through Dec. 31, 2026 and is paid to the PCP who was assigned to the member on the last day of that year, regardless of when the member moved to that provider. The provider to whom the member is assigned as of Dec. 31, 2026 is the one who earns the reward.

Program Performance and Compensation

Program Evaluation and Scoring

Highmark Health Options will measure provider success in the HHOPE Program by monitoring performance on a monthly and annual basis. The Care Gap Management Platform (CGMA) provides self-service access to your provider performance data on a monthly cadence. You can access your data at any time during the month following the reporting period. The data is refreshed monthly. The CGMA provides comprehensive reporting on your performance across all incentivized measures within the HHOPE program, as well as additional non-incentivized measures. This allows for a holistic view of your performance and outlines member-specific number compliance for each metric, along with member-specific opportunities for gaps yet to be closed.

Medicaid Payment Rules

Following the completion of the 2026 HHOPE Program, eligible providers will receive one payment. The only payment will be made by the end of July 2027.

- Providers must be opted in to be eligible for payment.
- Providers must meet the minimum membership requirements noted in the Opt-In Information section above.
- Payment is based on gap closure in each measure and is contingent upon a minimum of three members in the denominator.
- Payment is calculated based on compliant members through Dec. 31, 2026.

Medicare Payment Rules

Following the completion of the 2026 HHOPE Program, eligible providers will receive one payment. The only payment will be made by the end of July 2027.

- Providers must be opted in to be eligible for payment.
- Providers must meet the minimum membership requirements noted in the Opt-In Information section above.
- Payment is based on gap closure in each measure and is contingent upon a minimum of three members in the denominator.
- Payment is calculated based on compliant members through Dec. 31, 2026.

Program Education and Questions

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

If you need more information, please contact your dedicated Clinical Transformation Consultant or email **HHOWVPET@HighmarkHealth.org**.