HIGHMARK WHOLECARE

2025 Highmark Wholecare Practitioner Excellence (HWPE) Program

Welcome to the Highmark Wholecare Practitioner Excellence (HWPE) Program!

At Highmark Wholecare, we value the important role that practitioners play in serving our members. Highmark Wholecare would like to welcome you to the Highmark Wholecare Practitioner Excellence (HWPE) Incentive Program. This program supports our mission to improve the health and wellness of the individuals and the communities we serve by providing access to integrated, superior health care.

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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 Wholecare's 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 and/or exclusion 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 Wholecare's medical policy.

Eligibility Criteria

Medicaid

The HWPE Program (all measures except Prenatal Care in the First Trimester and Postpartum Care) is open to the following practitioner types:

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

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 500 for both Medicare and Medicaid lines of business at the entity level. Minimum requirements for the Maternity Quality Program are 20 deliveries within the measure year.

Assignment: Member is 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.

Medicare

The HWPE Program is open to the following practitioner types:

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

Minimum panel size requirements are as follows:

- 100 Medicare members at the entity level, or
- 500 combined Medicare/Medicaid members at the entity level
- Federally Qualified Health Centers (FQHCs) are automatically eligible

If an FQHC is part of a larger entity and that entity does not have either 100 Medicare members or 500 combined Medicare/Medicaid members, only the FQHC's TIN should be eligible for HWPE.

Opt-In Information

Eligible providers who wish to participate in the 2025 HWPE Program must opt into the program via their Clinical Transformation Consultant (CTC). For an entity to be eligible for the Medicare HWPE Program, they must not currently be participating in a Shared Savings contract with Highmark Wholecare. In order for eligible providers to participate in the Maternity Quality Program, they must opt in separately from the primary HWPE Program, also via their CTC. Providers may opt-in to both programs until September 30, 2025. The 2025 HWPE Program includes quality performance from dates of service January 1, 2025, to December 31, 2025.

By opting into the program, the provider:

1. Acknowledges receipt of the 2025 Highmark Wholecare HWPE 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 Wholecare's determination of the incentive payment.
5. Agrees, upon request from Highmark Wholecare, to meet with a Clinical Transformation Consultant once during the first quarter to provide an education session to providers and staff, and quarterly thereafter during the 2025 program year.
6. Understands that Highmark Wholecare has the discretion to amend the program term and/or terminate participation in the program at any time.
7. 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 October 15 of the program year.
8. Understands of the incentive payment amount, Highmark Wholecare will require no less than 80% of the incentive payment be dispersed to the individuals whose services contributed to the achievement of outcomes incented by the provider P4P requirement(s), and that no more than 20% of those funds may be used by the provider at the TIN level for general administrative purposes. Individuals eligible to receive incentive payments include licensed and unlicensed practitioners, and clinical and support staff. Highmark Wholecare may not mandate the specific recipients or purposes of incentive funds; the recipient provider must identify the staff eligible to receive the incentive payments and allocate it to those individuals in a manner the provider determines is appropriate. Examples of permissible uses of incentive payments include supplemental salary support (i.e., bonuses); costs of attending trainings, including travel expenses; environmental enhancements; equipment to improve operations; and IT or personnel resources to assist the staff who achieved the incented outcomes.

Medicaid Quality Performance Measures and Requirements

Child & Adolescent Well-Care Visits (WCV)

Targeted Providers: PCPs

Description of Measure: Percent of members 3 to 21 years of age who had one comprehensive well-care visit with a PCP during the measurement year.

Eligible Population: Members 3 to 21 years of age by December 31, 2025.

Exclusions: There are no exclusions for this measure.

Adherent Member: Patient who has had a comprehensive well-care visit in 2025.

How to Submit:

Measure or Component	ICD-10-CM Codes	CPT Category I
Child & Adolescent Well-Care Visit Values	Z00.00, Z00.01, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z00.82, Z00.121, Z00.129, Z02.0, -Z02.71	99384, 99385, 99394, 99395

Claims submission, medical record information submitted via Highmark Wholecare's provider portal, 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 improvement over the previous year's level, (if they achieve 3, 5 or 7 percentage point improvement over 2024 performance), and benchmark percentiles (Silver or Gold respectively). Payment is calculated based on compliant members through 2025 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. Payment is made annually, by June 30, 2026.

Controlling High Blood Pressure (CBP)

Targeted Providers: PCPs

Description of Measure: Percent of members 18 to 85 years of age with a diagnosis of hypertension, whose BP was adequately controlled during the measurement year.

Eligible Population: Members ages 18 to 85 years of age in 2025 with a diagnosis of hypertension.

Exclusions: The following members will be excluded from the denominator:

1. Evidence of end-stage renal disease (ESRD) or kidney transplant
2. Active dialysis
3. Pregnancy during the year 2025
4. A non-acute inpatient facility admission during 2025 before the submission of the blood pressure measurement
5. Members in hospice or using hospice services anytime during the measurement year

Adherent Member: The member is compliant if the most recent controlled blood pressure reading on or after the 2nd hypertension diagnosis is less than 140/90 mm Hg during the measurement year. 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: The PCP must submit a member's data value electronically for the measure.* PCPs can qualify for incentive payment based on electronic submission of data values, not just CPT-II codes, indicating a controlled blood pressure reading (<140/90 mm Hg) through medical record information submitted via Highmark Wholecare's care gap management application, Health Information Exchange (HIE), provider portal and/or electronic data feeds. The 2025 Program is a bridge year, in which both electronic submission of data values and CPT-II codeswill be accepted.

*Note: This also qualifies for the Electronic Data Submission measure.

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 4, 6 or 8 percentage point improvement over 2024 performance), and benchmark percentiles (Silver or Gold respectively). Payment is calculated based on compliant members through 2025 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by June 30, 2026.

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

Targeted Providers: PCP

Description of Measure: The percentage of members 18 to 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 level during the measurement year:

- HbA1c poor control (>9.0%)

Eligible Members: Members ages 18 to 75 with diabetes (type 1 or type 2)

Exclusions: Members who use hospice services, who die any time during the measurement year, or who receive palliative care or had an encounter for palliative care. Members 66 years of age and older as of December 31 of the measurement year who either enrolled in an Institutional SNP any time during the measurement year or lived long-term in an institution any time during the measurement year. Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness.

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: PCPs can qualify for incentive payment based on electronic submission, of data values, not just CPT-II codes, indicating a glycemic status assessment (≤9.0%) through medical record information submitted via Highmark Wholecare's care gap management application, Health Information Exchange (HIE), provider portal and/or electronic data feeds.*

The PCP must submit electronic data as evidence for glycemic status assessment. The 2025 Program is a bridge year, in which both electronic submission of data values and CPT-II codes will be accepted.

*Note: This also qualifies for the Electronic Data Submission measure.

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 4, 6 or 8 percentage point improvement over 2024 performance), and benchmark percentiles (Silver or Gold respectively). Payment is calculated based on compliant members through 2025 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by June 30, 2026.

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

Targeted Providers: PCPs

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

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

Exclusions: Members who use hospice services or who die anytime during the measurement year.

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 I
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 Highmark Wholecare's 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 2024 performance), and benchmark percentiles (Silver or Gold respectively). Payment is calculated based on compliant members through 2025 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by June 30, 2026.

Asthma Medication Ratio

Targeted Providers: PCPs

Description of Measure: The percentage of members 5 to 64 years of age as of December 31 of the measurement year 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.

Eligible Population: Members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and dispensed appropriate medications, according to the HEDIS specifications at any point during the measurement year.

Exclusions: Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year: Emphysema Value Set, Other Emphysema Value Set, COPD Value Set, Obstructive Chronic Bronchitis Value Set, Chronic Respiratory Conditions Due to Fumes or Vapors Value Set, Cystic Fibrosis Value Set, Acute Respiratory Failure Value Set and members who had no asthma controller or reliever medications dispensed during the measurement year. Members in hospice or using hospice services anytime during the measurement year.

Adherent Member: Patients who had a medication ratio of 0.5 or greater during the measurement year, according to the HEDIS measure specifications.

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

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% improvement over 2024 performance). Payment is calculated based on compliant members through 2025 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by June 30, 2026.

In addition to percentage point improvement payment, providers are also eligible for a $20 per member per fill incentive (potential for $80 per member annually) for any asthma controller medication (non-rescue) eligible for a 90-day fill.

Plan All-Cause Readmissions

Targeted Providers: PCPs

Description of Measure: Members age 18 to 64 years of age who had an acute inpatient care or observation stay during the measurement year with a discharge on or between January 1 and December 1 of the measurement year, followed by a Transitional Care Management (TCM) visit.

Eligible Population: Members 18 to 64 years of age who had an acute inpatient care or observation stay during the measurement year with a discharge on or between January 1 and December 1 of the measurement year.

Exclusions: Exclude non-acute inpatient stays.

Exclude the hospital stay if a direct transfer's discharge date occurs after December 1 of the measurement year. A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Exclude hospital stays for the following reasons:

1. The member died during the stay.
2. Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.

Adherent Member: Members with a visit within seven days of discharge that has High Medical Decision Complexity (CPT 99496) and 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. Please note: Transitional Care Management Codes for the Medicaid line of business when billed by an FQHC are not eligible for claims payment. FQHCs will be rewarded for submission of the 99496 or 99495 for members with qualifying events through the HWPE program if the member is assigned to your FQHC as of December 31, 2025.

Lead Screening for Children

Targeted Providers: PCPs

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

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

Exclusions: Members in hospice or using hospice services anytime during the measurement year.

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.

Scoring: Providers can qualify for incentive payment based on submission of claims, medical record information submitted via the provider portal and/or electronic data feeds. This measure requires an entity 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 2024 performance), and benchmark percentiles (Silver or Gold respectively). Payment is calculated based on compliant members through 2025 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by June 30, 2026.

PA Performance Measures

Developmental Screening in the First 3 Years of Life

Targeted Providers: PCPs

Description of Measure: The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second or third birthday.

Eligible Population: Children who turn 1, 2 or 3 years old during the measurement year.

Adherent Member: Children who had a developmental screen on or before their first, second or third birthday.

How to Submit: Indication that the proper screening occurred will be determined by submission of CPT code 96110 up to or on their third birthday.

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 2024 performance), and benchmark percentile. Payment is calculated based on compliant members through 2025 and is paid to the PCP who was assigned to the member on the last day of that year. Payment is made annually, by June 30, 2026.

Oral Evaluation, Dental Services (OED-CH)

Targeted Providers: Dentists

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

Eligible Population:

- Continuous enrollment for 90 days per the DHS Oral Health Initiative.
- Members 6 months to 20 years of age.

Exclusions: There are no exclusions for this measure.

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

Examination, Prophylaxis, and a Topical Fluoride Treatment will all need to be submitted for members ages 6 months through 20 years of age. The Topical Fluoride Treatment service is not required for members over the age of 20 years.

Note: PCPs will not be incented for dental visits in the 2025 program.

Oral Care Service	Codes
Oral Examination Codes	D0120, D0145, D0150
Dental Prophylaxis	D1110 or D1120
Topical Application of Fluoride (with or without varnish) This only applies to ages 6 months to 17 years.	D1206 (with varnish) D1208 (without varnish)

Dental providers who partner with Highmark Wholecare to schedule a weekend (or off day) event scheduling eligible members for a visit will also be eligible for an additional incentive. The incentive will be available to the first 20 eligible providers to conduct the event in 2025. If the 20-event limit has not been reached, eligible providers may participate once per quarter from Q2 to Q4 2025. Eligible providers will need to see at least 250 Highmark Wholecare members per year, to ensure there is a large enough pool of members to schedule from. This portion of the dental program specifically would not be limited to pediatric members.

Maternity Quality Program

Prenatal Care in the First Trimester

Targeted Providers: Obstetricians

Description of Measure: Percent 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 Population: Members with deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, as determined by the HEDIS measure specifications.

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 submits a claim for prenatal care (as defined by the HEDIS specifications).

Acceptable codes for prenatal care are listed in the below table (not an all-inclusive list):

Provider can submit via claims submission, medical record information submitted via Highmark Wholecare's provider portal, and/or electronic data feeds.

Type of Code	Code
E&M Code	99201-99205-U9
FQHC must also bill	99211-99215-U9

Scoring: This measure requires an entity to have a minimum of 20 deliveries 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 2024 performance). In addition to the payout amounts for percentage point improvement, providers have the opportunity to earn top performer incentive payout, for those groups whose average peer comparison ranking the measure is 75% or higher, as illustrated in the table below:

Maternity Peer Percentile Comparison Ranking & Payment
95th
90th
85th
80th
75th

Payment is calculated based on compliant members through 2025 and is paid to the Obstetrician/Gynecologist who was responsible for the members' delivery. Payment is made annually, by June 30, 2026.

FQHC's that do not perform deliveries, but provide prenatal and postpartum care, are eligible for the percentage point improvement incentive but are not eligible for the peer percentile comparison ranking and payment.

Postpartum Care

Targeted Providers: Obstetricians

Description of Measure: Percent of members with deliveries who have had a postpartum visit within 7 to 84 days after delivery, on or before the enrollment start date, or within 42 days of enrollment in the organization.

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

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

How to Submit: The provider must submit using any of the below codes:

CPT	ICD 10 Diagnosis Code	CPTII
58300, 59430	Z39.2, Z39.1, Z01.411, Z01.419, Z01.42, Z30.430	0503F

Provider can submit via claims submission, medical record information submitted via Highmark Wholecare's provider portal, and/or electronic date feeds.

Scoring: This measure requires an entity to have a minimum of 20 deliveries 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 2024 performance). In addition to the payout amounts for percentage point improvement, providers have the opportunity to earn top performer incentive payout, for those groups whose average peer comparison ranking the measure is 75% or higher, as illustrated in the table below:

Maternity Peer Percentile Comparison Ranking & Payment
95th
90th
85th
80th
75th

Payment is calculated based on compliant members through 2025 and is paid to the Obstetrician/ Gynecologist who was responsible for the members' delivery. Payment is made annually, by June 30, 2026.

FQHC's that do not perform deliveries, but provide prenatal and postpartum care, are eligible for the percentage point improvement incentive but are not eligible for the peer percentile comparison ranking and payment.

Electronic Quality Measures

Targeted Providers: PCPs or OB/GYNs

Description of Measure:

1. Electronic Submission of data values for Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD)*
2. Electronic Submission of data values for Controlling High Blood Pressure (CBP)*
3. Electronic Submission of any measure using the Obstetrical Needs Assessment Form (ONAF)**

*Only PCPs are eligible for submission of GSD and CBP.

**Both PCPs and OB/GYNs are eligible for payment for submission of the ONAF; payment is made through claims.

How to Submit: The ONAF can either be submitted via fax or electronic submission. Members' claims will establish the data set for participant Performance and incentives based on processed adjudicated claims for the ONAF only – claims submission will not be eligible for GSD and CBP. The prenatal visit must occur in the first trimester. A visit on the day of enrollment is acceptable. Electronic data values may be submitted for both GSD and CBP, via Highmark Wholecare's care gap management application, Health Information Exchange (HIE), provider portal, and/or electronic data feeds.

Scoring: Eligible providers can only receive one payment per member per year via claims for submission of the ONAF, and one payment per member per year for submission of GSD and CBP data values (i.e. providers are eligible for payment for both GSD and CBP for the same member). All PCPs who submit an electronic glycemic status assessment or blood pressure value, regardless of value compliance, will be eligible for this additional incentive. Payments for all those compliant within 2025 are paid to the PCP who was assigned to the member on the last day of the year.

Health Equity Incentive Program

Eligible providers (PCPs) who have opted into the HWPE Incentive Program will also have the opportunity to earn improvement dollars specifically for percentage point improvement in racial disparity for Black members on their panel (minimum panel requirements of 10 members for each measure) for the following three health equity measures:

1. Well-Child Visits in the First 15 Months of Life (for measure requirements, please refer to page 10*)
2. Controlling High Blood Pressure (for measure requirements, please refer to page 8**)
3. Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD) (for measure requirements, please refer to page 9**)

Eligible providers (obstetricians/gynecologists) who have opted into the Maternity Quality Program will also have the opportunity to earn improvement dollars specifically for percentage point improvement in racial disparity for Black members on their panel (minimum requirement of 20 deliveries in the measure year) for the following two health equity measures:

1. Prenatal Care in the First Trimester*
2. Postpartum Care*

For specific program and measure requirements, please refer to the Maternity Quality Program section.

Percentage Point Improvement Rate
3%
4%
5%

Payment for percentage point improvement for these Health Equity measures will be made annually, by June 30, 2026. FQHC's that do not perform deliveries but provide prenatal and postpartum care are not eligble for this payment.

*Providers are also eligible to receive additional incentive payment $50 per numerator compliant member for this measure.

**Providers are also eligible to receive additional incentive payment $30 per numerator compliant member for this measure.

Medicare Quality Performance Measures and Requirements

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

Measure Type: Static (Not a CMS Star Measure)

Description of Measure: Percentage of 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 Population: All Medicare members age 65 years and older.

Exclusions: There are no exclusions for this measure.

Adherent Member: Patients who completed an Annual Wellness Visit or an IPPE during the measurement year.

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 2024 performance), and benchmark percentile.

Payment is calculated based on compliant members through 2025 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, 2026.

How to Submit to Highmark Wholecare:

Submit the appropriate HCPCS for the AWV/IPPE visit:

Service	Code
Initial AWV	G0438
Subsequence AWV	G0439
Initial Preventive Physical Exam (Welcome to Medicare)	G0402
Federally Qualified Healthcare Center (FQHC)	G0468

CPT codes for physical exams are also accepted as adherent for this measure.

Other:

- AWV can be completed any time during the calendar year in any setting/location.
- There is no copay when performing an AWV or IPPE by itself.
- AWV can be performed with problem/sick visit (use modifier 25) when services performed do not duplicate components already included in code G0438, G0439, G0402, or G0468. Documentation must clearly reflect the services reported as significant and separately identifiable. A copay may apply.
- 99387-Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient.
- 99397-Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, established patient.

Controlling High Blood Pressure

Measure Type: Dynamic Star Measure

Description of Measure: Percent of plan members with high blood pressure who received treatment and were able to maintain a healthy pressure.

Eligible Population: The percentage of Medicare members 18 to 85 years of age who had a diagnosis of hypertension (HTN) (denominator) and whose BP was adequately controlled (<140/90) during the measurement year (numerator).

Adherent Member: A member with the most recent blood pressure reading on or after the 2nd hypertension diagnosis during the measurement year that is resulted (appropriate CPT II codes submitted to Highmark Wholecare).

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 2024 performance), and benchmark percentile. Payment is calculated based on compliant members through 2025 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, 2026.

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.
- 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) anytime 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 Diagnosis Value Set; History of 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 to 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).

Glycemic Status Assessment for Patients with Diabetes (GSD)

Measure Type: Dynamic Star Measure

Description of Measure: The percentage of members with diabetes who received at least one glycemic status assessment or glucose management indicator during the measurement year.

Eligible Population: Diabetic members age 18 to 75 years with diabetes (types 1 and 2) whose most recent glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following level during the measurement year and who were enrolled in the plan at the end of the measurement year:

- Glycemic status ≤9.0%

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 5, 10, or 15 percentage point improvement over 2024 performance), and benchmark percentile. Payment is calculated based on compliant members through 2025 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, 2026.

Exclusions:

- Members in hospice or using hospice services any time during the measurement year.
- Members who died 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; ICD-10-CM code Z51.5) any time during the measurement year.
- 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.
- Members 66 years of age and older as of December 31 of the measurement year diagnosed with frailty and advanced illness are also excluded from this measure.

Adherent Member: The adherent member is compliant if the most recent HbA1c level is ≤9.0% (during the measurement year).

Other:

- Members are only identified as diabetic by medical claims data. The member will remain as a diabetic until Highmark Wholecare no longer receives diabetic diagnoses during the measure's two-year lookback period in claims.
- If a member has been erroneously identified as a diabetic, document in the member's medical record that the member is not diabetic.
- Claims can be corrected by contacting the diagnosing physician to submit a corrected claim with an appropriate diagnosis. If you need assistance in this process, please contact your Clinical Transformation Consultant.

Plan All-Cause Readmissions

Measure Type: Dynamic Star Measure

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

Exclusions: Exclude non-acute inpatient stays.

Exclude the hospital stay if a direct transfer's discharge date occurs after December 1 of the measurement year. A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Eligible Population: 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 January 1 and December 1 of the measurement year.

Adherent Member: Members with a visit within 7 days of discharge that has High Medical Decision Complexity (CPT 99496) and 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. Payments for all those compliant within 2025. 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, 2026.

Medication Reconciliation Post-Discharge

Measure Type: Static Star Measure

Description of Measure: The percentage of discharges from January 1 to December 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 Population: Medicare members 18 years and older as of December 31 of the measurement year with an inpatient discharge between January 1 and December 1 of the measurement year.

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).

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 2024 performance), and benchmark percentile. Payment is calculated based on compliant members through 2025 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, 2026.

How to Submit to Highmark Wholecare: Submit a claim for medication reconciliation completed and documented in the outpatient chart or via Highmark Wholecare's Care Gap Management Application (CGMA).

Program Evaluation and Scoring

Highmark Wholecare will measure provider success in the HWPE 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 HWPE 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.

Providers will also receive a scorecard that accompanies the payment with the current rate and percentile to gauge how closely the provider has performed against forecasted NCQA Quality Compass or Star Ratings.

Reporting Definitions

Medicaid

Benchmarks: Payment earned based on benchmark level attained, and number of per member care gap closures. Select measures have one benchmark level only, Gold.

- Silver Level
- Gold Level

Percentage Point Improvement: The Improvement factor may vary by measure. Improvement factor compared to a practice's prior year performance per measure.

- Oral Evaluation - Dental Services: Dentists only are eligible for this measure. This measure will have no improvement payment.

Benchmarks/Percentage Point Improvement Chart*

Primary Data Source	Measure Name	Measure Acronym	Improvement Rate			Silver	Gold
HEDIS	Child & Adolescent Well-Care Visits	WCV	3%	5%	7%	63%	69%
HEDIS	Controlling High Blood Pressure	CBP	4%	6%	8%	70%	74%
HEDIS	Glycemic Status Assessment for Patients with Diabetes >9.0%	GSD	4%	6%	8%	29%	26%
HEDIS	Well-Child Visits in the First 15 Months of Life, Six or More	W15	3%	5%	7%	73%	78%
HEDIS	Asthma Medication Ratio	AMR	3%	5%	7%	N/A	N/A
HEDIS	Lead Screening for Children	LSC	2%	4%	6%	84%	88%
PA Performance	Developmental Screening in the First 3 Years of Life	DVS	3%	5%	7%	N/A	63%
PA Performance	Oral Evaluation - Dental Services	OED-CH	N/A	N/A	N/A	N/A	N/A
HEDIS	Plan All-Cause Readmissions	PCR	N/A	N/A	N/A	N/A	N/A
HEDIS	Prenatal Care in the First Trimester	PPC-T	3%	5%	7%	N/A	N/A
HEDIS	Postpartum Care	PPC-P	3%	5%	7%	N/A	N/A

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

Maternity Peer Percentile Comparison Ranking & Payment
95th
90th
85th
80th
75th

Medicaid Health Equity Program

Providers are eligible to receive incentive payment for each numerator compliant member for Black members on their panel for the following health equity measures. Providers will also have the opportunity to earn improvement dollars specifically for percentage point improvement in racial disparity for these measures:

HEDIS Specs

Primary Data	Measure Name	Measure Acronym	Improvement Rate		
HEDIS	Well-Child Visits in the First 15 Months of Life, 6 or More*	W15	3%	4%	5%
HEDIS	Controlling High Blood Pressure*	CBP	3%	4%	5%
HEDIS	Glycemic Status Assessment for Patients with Diabetes >9.0%*	GSD	3%	4%	5%
HEDIS	Prenatal Care in the First Trimester**	PPC-T	3%	4%	5%
HEDIS	Postpartum Care**	PPC-P	3%	4%	5%

*Eligible entities must have a minimum of 10 members in the denominator to be scored.

**Eligible entities must have 20 deliveries in the measure to be scored.

Medicare

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

- 4-Star Target
- 5-Star Target

Each measure requires an entity have a minimum of 10 members in the denominator in order to qualify to be scored.

Percentage Point Improvement: The Improvement factor may vary by measure. Improvement factor compared to a practice's prior year performance per measure.

- Plan All-Cause Readmission (PCR) for the 2025 HWPE Program does not require a minimum denominator and will not have benchmark or percentage point improvement payment.

4- and 5-Star Cut-Points

Measure Class	CMS Tech Specs: Primary Data Source	Measure Name	Measure Acronym	Improvement Rate			4-Star	5-Star
Static	N/A	Annual Wellness Visit (not Stars or HEDIS measure)	AWV	3%	5%	7%	66%	79%
Static	HEDIS	Medication Reconciliation Post Discharge	MRP	3%	5%	7%	77%	88%
Dynamic	HEDIS	Glycemic Status Assessment for Patients with Diabetes	GSD	5%	10%	15%	87%	92%
Dynamic	HEDIS	Controlling High Blood Pressure	CBP	3%	5%	7%	82%	88%
Dynamic	HEDIS	Plan All-Cause Readmissions	PCR	N/A	N/A	N/A	N/A	N/A

Medicare Payment Rules

Following the completion of the 2025 HWPE Program, eligible providers will receive one payment. The only payment will be calculated in May 2026.

- 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 10 members in the denominator.
- This payment will include the combined totals of 4- and 5-star payments and percentage point improvement payments on a per compliant member basis as applicable.
- Payment is calculated based on compliant members through December 31, 2025.

Program Education and Questions

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

If you need more information, please contact your dedicated Clinical Transformation Consultant or email ProviderEngagementTeam@HighmarkWholecare.com.

Appendix

Engaging Non-adherent Patients

The following is to assist your practice with identifying, understanding, and developing strategic action plans to improve treatment compliance with your non-adherent patients.

Reasons patients do not comply with treatment:

- Denial of the problem. Many diseases and conditions, in particular, those that are asymptomatic, are easy to ignore, even when they have been diagnosed (e g. patients with diabetes or hypertension). Because symptoms don't get in the way of everyday life, it's easy for patients not to follow the prescribed treatment regimens.
- The cost of the treatment. It may or may not be covered by insurance, and the more out-of pocket cost to the patient, the less likely they will adhere.
- The difficulty of the regimen. Patients may have trouble following the directions. Any perceived inconvenience may also create a barrier to compliance. For example, taking a pill in the middle of the night, or simply opening the "child safe" bottle.
- The unpleasant outcomes or side effects of the treatment. Any perceived negative, such as an unpleasant taste of a medicine or the pain of physical therapy, may keep the patient from following through.
- Lack of trust. When patients don't buy in to the possibilities of success, they are less likely to follow through. In this case, they don't trust that adherence will really improve their health.
- Apathy. When a patient doesn't realize the importance of the treatment or doesn't care if the treatment works or not, he or she is less likely to comply.
- Previous experience. Especially in the cases of chronic or repeat conditions, patients will sometimes decide that a treatment didn't work in the past, so they are either reluctant or unwilling to try it again.
- Many patients refuse to make recommended lifestyle changes that can improve their health. Once you've figured out what's ailing the patient, the challenge is convincing him or her to follow the physician's advice. Only half of all chronically ill patients take medicines as directed, and many don't even bother to get the prescription filled, according to a World Health Organization study.

Non-adherent patient strategic action plan:

- Individual member outreach: phone calls/mailings to non-adherent patients.
- Appointment Schedule review of patients who have not been in office in a long time or excessive no-shows.
- Build easy access for referring patients.
  - Labs/tests: Advise where to go for testing and implement process for reconciling labs and tests.
  - Specialists: Keep an updated referral list of specialists in the area who are low cost/high quality.
- Develop cooperative relationships with:
  - Local pharmacies
  - Specialists
  - Hospitals where patients are admitted
- Prep chart prior for each visit. Utilize pre-visit planning form.
  - Contact patient to confirm visit date/time and remind to complete any testing as ordered.
  - Ask staff to review care gaps while rooming patients.
- Rule out significant life change events (LCE): An LCE is an event that will result in changes in coping or adapting skills for several weeks to several months. Some LCEs are:
  - Death in the family
  - Divorce
  - Legal problems
  - Change in housing
  - Hospitalization/new illness
  - Loss of primary caregiver
    - If any LCEs are identified, help the patient complete a referral for assistance external to the clinic, or through staff assistance. Be aware of community resources.
    - Convene a meeting with the patient and the treatment team to discuss the harm of skipping/shortening treatments. Implement motivational interviewing techniques.
    - Have the social worker or another staff member develop a "therapeutic alliance" with the patient.
    - Provider: Meet with patient every time he or she comes into office.
    - Attempt various techniques in patient education.
    - Be certain that the patient understands consequences of non-adherence.

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

This information is issued on behalf of Highmark Wholecare, coverage by Gateway Health Plan, which is an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare serves a Medicaid plan to Blue Shield members in 13 counties in central Pennsylvania, as well as, to Blue Cross Blue Shield members in 14 counties in western Pennsylvania. Highmark Wholecare serves Medicare Dual Special Needs plans (D-SNP) to Blue Shield members in 17 counties in northeastern Pennsylvania, 13 counties in central Pennsylvania, 5 counties in southeastern Pennsylvania, and to Blue Cross Blue Shield members in 27 counties in western Pennsylvania.