2026 Highmark Wholecare Practitioner Excellence (HWPE) Program

HIGHMARK WHOLECARE

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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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 Practitioners (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. This entity-level approach applies to all program scoring. 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 Practitioners (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.
- This entity-level approach applies to all program scoring.

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 2026 HWPE Program must opt into the program via their Clinical Transformation Consultant (CTC). 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 Sept. 30, 2026. The 2026 HWPE 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 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 2026 program year.
6. Understands that Highmark Wholecare has the discretion to amend the program measures, 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 Oct. 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.

Introduction to the Pediatric Benchmark Bundle

Highmark Wholecare's Pediatric Benchmark Bundle is designed to promote comprehensive, high-quality care for our pediatric members. To earn incentives within this bundle, providers must demonstrate benchmark achievement across multiple related measures, fostering a comprehensive approach to patient care.

The specific measures included in the Pediatric Benchmark Bundle are:

- Child and Adolescent Well-Care Visits (Total)
- Well-Child Visits in the First 15 Months of Life (six or more)
- Lead Screening
- Developmental Screening

Achievement Tiers: The Pediatric Benchmark Bundle features two achievement tiers: Gold and Silver. To be eligible for any incentive payment, providers must achieve the benchmark on all four measures within the bundle and meet the minimum denominator requirement in each.

- **Gold Tier:** This tier represents the highest level of performance. To qualify for the Gold Tier payment, providers must achieve the Gold benchmark in all four measures.
- **Silver Tier:** This tier offers an alternative pathway for rewarding providers. To qualify for the Silver Tier payment, providers must achieve at least the Silver benchmark or the Gold benchmark where Silver is not available in all four measures. This means a combination of Silver or Gold benchmark achievement across all measures would result in qualifying for the Silver Tier.

How Qualification Works: To qualify for either the Gold or Silver Bundle, providers must meet the minimum benchmark in all four measures and meet the minimum denominator requirement in each. If a provider achieves the Gold benchmark in all four measures, they qualify for the Gold Tier. If a provider achieves at least the Silver benchmark in all four measures (which could include some Gold achievements), they qualify for the Silver Tier. If even one measure falls below the Silver benchmark, the provider will not qualify for any payment within this bundle.

Example Scenario: Consider a provider entity evaluated on the Pediatric Benchmark Bundle. Their results are as follows:

- **Child and Adolescent Well-Care Visits (Total):** Achieved Silver Benchmark
- **Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months Age Band:** Achieved Silver Benchmark
- **Developmental Screening:** Achieved Gold Benchmark
- **Lead Screening:** Achieved Silver Benchmark

In this example, because the provider entity achieved at least the Silver benchmark in all four measures, they qualify for the Silver Pediatric Bundle Tier. Payment is calculated based on compliant members through the performance year 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 of the performance year is the one who earns the reward. Payments are made annually, following a final data review for the entire performance year.

Medicaid Quality Performance Measures and Requirements

Child & Adolescent Well-Care Visits (WCV)

Targeted Providers: PCPs

Description of Measure: Percent 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 between 3–21 years of age by Dec. 31, 2026.

Exclusions: This measure will adhere to the HEDIS exclusion criteria.

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

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 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 earned through two distinct pathways:

1. Improvement over the previous year's level (achieving 4, 6, or 8 percentage point improvement over 2025 performance), and/or
2. Benchmark achievement (Silver or Gold, respectively) for the Child and Adolescent Well-Care Visits measure to qualify for payment related to the Pediatric Benchmark Bundle.

This measure is part of a larger, interdependent Pediatric Benchmark Bundle, which includes: Child and Adolescent Well-Care Visits (Total), Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months Age Band, Developmental Screening, and Lead Screening. To be eligible for the incentive payment associated with the bundle, providers must achieve the Gold or Silver tier on all four measures within the bundle and meet the minimum denominator requirement for each. See the **Introduction to the Pediatric Benchmark Bundle** for additional details.

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, regardless of when the member moved to that provider. Payment is made annually, by June 30, 2027.

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

Targeted Providers: PCPs

Description of Measure: Percent 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.

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 earned through two distinct pathways:

1. Improvement over the previous year's level (achieving 3, 5, or 7 percentage point improvement over 2025 performance), and/or
2. Benchmark achievement (Silver or Gold, respectively) for the Well-Child Visits in the First 15 Months of Life measure to qualify for payment related to the Pediatric Benchmark Bundle.

This measure is part of a larger, interdependent Pediatric Benchmark Bundle, which includes: Child and Adolescent Well-Care Visits (Total), Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months Age Band, Developmental Screening, and Lead Screening. To be eligible for the incentive payment associated with the bundle, providers must achieve the Gold or Silver tier on all four measures within the bundle and meet the minimum denominator requirement for each. See the **Introduction to the Pediatric Benchmark Bundle** for additional details.

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 June 30, 2027.

Lead Screening for Children (LSC)

Targeted Providers: PCPs

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 age 2 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. Providers 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 have a minimum of 10 members in the denominator in order to qualify to be scored. Payment is earned through two distinct pathways:

1. Improvement over the previous year's level (achieving 2, 4, or 6 percentage point improvement over 2025 performance), and/or
2. Benchmark achievement (Silver or Gold, respectively) for the Lead Screening measure to qualify for payment related to the Pediatric Benchmark Bundle.

This measure is part of a larger, interdependent Pediatric Benchmark Bundle, which includes: Child and Adolescent Well-Care Visits (Total), Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months Age Band, Developmental Screening, and Lead Screening. To be eligible for the incentive payment associated with the bundle, providers must achieve the Gold or Silver tier on all four measures within the bundle and meet the minimum denominator requirement for each. See the **Introduction to the Pediatric Benchmark Bundle** for additional details.

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 June 30, 2027.

Developmental Screening in the First 3 Years of Life (DEV-CH)

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 Members: Children who turn age 1, 2, or 3 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 earned through benchmark achievement for the Developmental Screening measure to qualify for payment related to the Pediatric Benchmark Bundle.

This measure is part of a larger, interdependent Pediatric Benchmark Bundle, which includes: Child and Adolescent Well-Care Visits (Total), Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months Age Band, Developmental Screening, and Lead Screening. To be eligible for the incentive payment associated with the bundle, providers must achieve the Gold or Silver tier on all four measures within the bundle and meet the minimum denominator requirement for each. See the **Introduction to the Pediatric Benchmark Bundle** for additional details.

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 June 30, 2027.

Controlling High Blood Pressure (CBP)

Targeted Providers: PCPs

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

Eligible Members: Members ages 18–85 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 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, provider portal, and/or electronic data feeds.

*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 2025 performance), and 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 June 30, 2027.

Glycemic Status Assessment for Patients with Diabetes >9.0% (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 (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. 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 Highmark Wholecare's Care Gap Management Application, provider portal, and/or electronic data feeds.*

*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. 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 June 30, 2027.

Asthma Medication Ratio (AMR)

Targeted Providers: PCPs

Description of Measure: Members ages 5–64 as of Dec. 31 of the measurement year who were identified as having persistent asthma and dispensed a 90-day fill of appropriate medications, according to the 2025 HEDIS specifications at any point during the measurement year.

Eligible Members: Members ages 5–64 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. Due to its retirement as a HEDIS measure for MY 2026, this measure will become a PAPM that utilizes the MY 2025 specifications for determining eligible members.

Exclusions: This measure will adhere to HEDIS exclusion criteria.

Adherent Member: Patients who received a 90-day fill of an eligible asthma controller medication (non-rescue) during the measurement year.

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

Scoring: This measure does not have a minimum denominator requirement. Payment is calculated based on members with an eligible 90-day fill (potential for four annually per member) through 2026 and is paid to the PCP who was assigned to the member as of Dec. 31, 2026, regardless of when the member moved to that provider. Payment is made annually, by June 30, 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. 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 Dec. 31, 2026.

Scoring: This measure does not have a minimum denominator requirement. Payment is calculated based on compliant members through 2026. The provider to whom the member is assigned as of Dec. 31, 2026, is the one who earns the reward. Payment is made annually, by June 30, 2027, after a final data review for all of 2026.

Oral Evaluation, Dental Services (OED)

Targeted Providers: Dentists

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

Eligible Members:

- Continuous enrollment for 90 days per the DHS Oral Health Initiative.
- Members ages 6 months–20 years.

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:

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. 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 2026 program.

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 2026. If the 20-event limit has not been reached, eligible providers may participate once per quarter from Q2 to Q4 2026. 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.

Introduction to the Maternity Benchmark Bundle

Highmark Wholecare's Maternity Benchmark Bundle is designed to recognize and reward providers for delivering comprehensive care throughout the critical stages of pregnancy and postpartum for Wholecare members. To earn incentives within this bundle, providers must demonstrate benchmark achievements across both maternity measures.

The specific measures included in the Maternity Benchmark Bundle are:

- Prenatal Care in the First Trimester
- Postpartum Care

Achievement Tiers: The Maternity Benchmark Bundle features two achievement tiers:

- Gold
- Silver

How Qualification Works: To qualify for any incentive payment, providers must achieve the benchmark for both measures within the bundle and meet the minimum denominator requirement in each. If benchmarks are achieved for both measures in the bundle, the provider will earn the measure value payout for each specific measure achieved. However, if the benchmark is not achieved for both measures, the provider will not qualify for any payment within this bundle, and no benchmark payment will be issued.

Example Scenario: Consider a provider entity evaluated on the Maternity Benchmark Bundle. Their results are as follows:

- **Prenatal Care in the First Trimester:** Achieved Silver Benchmark
- **Postpartum Care:** Achieved Gold Benchmark

In this example, because the provider entity achieved at least the silver benchmark in both measures, they qualify for the Maternity Benchmark Bundle. In this scenario, the entity would earn the specific measure value payout associated with the achievement level for each individual measure.

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 June 30, 2027. FQHC's that do not perform deliveries, are not eligible for the Maternity Benchmark Bundle incentive.

Maternity Quality Program

Prenatal Care in the First Trimester (PPC-T)

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.

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):

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

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 20 deliveries in the denominator in order to qualify to be scored. Payment is earned through two distinct pathways:

1. Improvement over the previous year's level (achieving 3, 5, or 7 percentage point improvement over 2025 performance), and/or
2. Benchmark achievement (Silver or Gold, respectively) for the Prenatal Care in the First Trimester measure to qualify for payment related to the Maternity Benchmark Bundle.

This measure is part of a larger, interdependent Maternity Benchmark Bundle, which includes: Prenatal Care in the First Trimester and Postpartum Care. To be eligible for the incentive payment associated with the bundle, providers must achieve the Gold or Silver tier on both measures within the bundle and meet the minimum denominator requirement for each. See the **Introduction to the Maternity Benchmark Bundle** for additional details.

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 June 30, 2027. 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 Maternity Benchmark Bundle and payment.

Postpartum Care (PPC-P)

Targeted Providers: Obstetricians

Description of Measure: Percent 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 according to the HEDIS measure specifications.

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: 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 Care Gap Management Application, 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 earned through two distinct pathways:

1. Improvement over the previous year's level (achieving 3, 5, or 7 percentage point improvement over 2025 performance), and/or
2. Benchmark achievement (Silver or Gold, respectively) for the Postpartum Care measure to qualify for payment related to the Maternity Benchmark Bundle.

This measure is part of a larger, interdependent Maternity Benchmark Bundle, which includes: Prenatal Care in the First Trimester and Postpartum Care. To be eligible for the incentive payment associated with the bundle, providers must achieve the Gold or Silver tier on both measures within the bundle and meet the minimum denominator requirement for each. See the **Introduction to the Maternity Benchmark Bundle** for additional details.

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 June 30, 2027. 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 Maternity Benchmark Bundle 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).**
4. Electronic Submission of the Obstetrical Needs Assessment Form for members in the HEDIS Timeliness of Prenatal Care denominator during the current measurement year — must include the members' MA ID number.***

*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.

***Only OB/GYNs are eligible for electronic submission of the ONAF; payment is made through the HWPE Program.

How to Submit: Electronic data values may be submitted for both GSD and CBP, via Highmark Wholecare's Care Gap Management Application, provider portal, and/or electronic data feeds (1 & 2). ONAF (3) 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 (3). The prenatal visit must occur in the first trimester; a visit on the day of enrollment is acceptable (3)**. Claims submission will not be eligible for GSD, CBP, and electronic submissions of the ONAF which must include the members MA ID number (4)***.

Scoring: Eligible providers can only receive one payment per member per year via claims for submission of the ONAF (3), and one payment per member per year for submission of ONAF (4), 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 2026 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 and Hispanic/Latino 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 13**[*])
3. Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD) (for measure requirements, please refer to **page 14**[*])

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 and Hispanic/Latino 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, 2027. FQHC's that do not perform deliveries but provide prenatal and postpartum care are not eligible for this payment.

[*]For all five health equity measures, the Black and Hispanic/Latino member populations will be scored independently to determine percentage point improvement in racial disparity. This means that for each measure, improvement for Black members will be assessed separately from improvement for Hispanic/Latino members.

Medicare Quality Performance Measures and Requirements

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

Targeted Providers: 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 Medicare 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 data is only captured via claims submission.

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 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 that year. Payment is made annually, by June 30, 2027.

Controlling High Blood Pressure (CBP)

Targeted Providers: PCPs

Description of Measure: Members ages 18–85 with a diagnosis of hypertension, whose BP was adequately controlled during the measurement year.

Eligible Members: Members ages 18–85 with a diagnosis of Hypertension who meet the HEDIS criteria for Controlling 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 High 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 claims submission by reporting CPT II codes, electronically submitting data values that indicate the most recent blood pressure through 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. 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 June 30, 2027.

Glycemic Status Assessment for Patients with Diabetes (GSD)

Targeted Providers: 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 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. 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 June 30, 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. A higher 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 June 30, 2027.

Medication Reconciliation Post-Discharge (MRP)

Targeted Providers: 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 Highmark Wholecare's Care Gap Management Application (CGMA).

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 benchmark percentile. 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 June 30, 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 June 30, 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 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 includes 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 a 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 June 30, 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 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 June 30, 2027.

Reporting Definitions

Medicaid

Benchmarks: Payment earned based on benchmark level attained, and number of per member care gap closures. Some measures are part of a bundle and may be interdependent on other measures. Please refer to the bundle introductions for additional information on the Pediatric Benchmark Bundle and the Maternity Benchmark Bundle. Select measures have one benchmark level only, Gold.

- Silver Level
- Gold Level

Note: Measures that are part of a benchmark bundle will be indicated with ** next to the Measure Name in the full measure chart.

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 benchmark or improvement payment.
- **Glycemic Status Assessment for Patients with Diabetes:** This measure will not have a benchmark or percentage point improvement. This measure will have a tier incentive structure for 2026.
- **Developmental Screening in the First Three Years of Life:** This measure will have no improvement.
- **Plan All-Cause Readmission:** This measures will not have a benchmark or percentage point improvement payment.
- **Asthma Medication Ratio:** This measure will not have a benchmark or percentage point 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	4%	6%	8%	65%	71%
HEDIS	Controlling High Blood Pressure	CBP	4%	6%	8%	74%	78%
HEDIS	Glycemic Status Assessment for Patients with Diabetes >9.0%	GSD	N/A	N/A	N/A	N/A	N/A
HEDIS	Well-Child Visits in the First 15 Months of Life, Six or More**	W15	3%	5%	7%	70%	75%
HEDIS	Asthma Medication Ratio	AMR	N/A	N/A	N/A	N/A	N/A
HEDIS	Lead Screening for Children**	LSC	2%	4%	6%	79%	82%
CMS Core Set	Developmental Screening in the First 3 Years of Life**	DEV-CH	N/A	N/A	N/A	N/A	78%
PA Performance	Oral Evaluation, Dental Services	OED	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%	91%	93%
HEDIS	Postpartum Care**	PPC-P	3%	5%	7%	87%	90%

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

**As part of a benchmark bundle, these measures are interdependent with other measures within the bundle. To be eligible for the incentive payment associated with a bundle payment, providers must achieve the benchmark on all measures included in the benchmark bundle.

Medicaid Health Equity Program

Providers are eligible to earn percentage point improvement dollars in racial disparity for each numerator compliant member for Black and Hispanic/Latino members (populations scored separately by measure) on their panel for the following health equity measures.

HEDIS Specs

Primary Data Source	Measure Name	Measure Acronym	Improvement Rate		
HEDIS	Well-Child Visits in the First 15 Months of Life, Six 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

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.

Minimum Denominator Requirement for Scoring: Most measures require an entity to have a minimum of 10 members in the denominator in order to qualify to be scored and eligible for incentive payments.

Benchmark, Targets, and Incentive Triggers

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%
HEDIS	Medication Reconciliation Post Discharge	MRP	81%	90%	**Improvement:** 3%, 5%, 7% percentage point improvement over 2025 performance.
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 antagonist)	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.

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.

Payment Rules

Following the completion of the 2026 HWPE Program, eligible providers will receive one payment for each program component (Medicaid, Maternity, and Medicare). Payment will be issued in June 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 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.
- This payment will include the combined totals of 4- and 5-star and Silver and Gold benchmark payments, percentage point improvement payments, incentive tier payments, benchmark bundles, benchmark attainment, and widget payments, as applicable, on a per compliant member basis, all subject to the scoring guidelines by 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 provider who earns the reward. The delivering OBGYN will earn the reward for the Maternity Program measures.
- If an entity terminates from the program before Dec. 31 of the program year, the entity is not eligible for the HWPE payment.
- Payments will be dispersed by June 30, 2027, after a final review of all 2026 data and to allow for the three-months claims run-out period.

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 **HWC_ProviderEngagementTeam@highmark.com**.

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. The Healthcare Effectiveness Data and Information Set (HEDIS®) and Star Ratings Technical Notes area widely used sets of health care performance measures in the United States. Refer to these documents for information on how to improve clinical quality care and performance on the HEDIS/Star measures outlined. 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 Wholecare's medical policy.

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

This information is issued on behalf of Gateway Health Plan, Inc. d/b/a Highmark Wholecare, an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare provides Medicaid coverage for Blue Shield in 14 counties in central PA and Blue Cross Blue Shield in 14 counties in western PA. Highmark Wholecare provides Medicare Dual-Eligible Special Needs Plans (HMO D-SNP) for Blue Shield in 17 counties in northeastern PA, 13 counties in central PA, 5 counties in southeastern PA, and for Blue Cross Blue Shield in 27 counties in western PA.

Highmark Wholecare offers HMO plans with a Medicare Contract. Enrollment in these plans depends on contract renewal.