HIGHMARK HEALTH OPTIONS

2025 Highmark Health Options West Virginia Practitioner Excellence (HHOPE) Program

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

Highmark Health Options West Virginia (HHO WV) values the important role practitioners play in serving members and improving health outcomes. In 2025, HHO WV will launch the HHOPE Program to recognize and reward providers for their dedication to high-quality member care. Participation in the Program is entirely voluntary. This resource guide will help you become familiar with the Program's quality measures, although because this is the first year the Program is in place, these specific measures cannot be assessed against any 2024 benchmark performance.

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Eligibility Criteria

The HHOPE Program is open to the following provider types:

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

For the primary PCP program, the minimum membership is five members at the entity level.

Assignment

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

Opt-In Information

In order for eligible providers to participate in the HHOPE Program, they must opt-in to the Program via their Clinical Transformation Consultant (CTC). Providers may opt-in to the Program until September 30, 2025. The HHOPE Program includes quality performance from dates of service January 1, 2025 through December 31, 2025.

By opting into the Program, the provider:

1. Acknowledges receipt of the 2025 HHOPE Provider Program Manual.
2. Agrees that they have had an opportunity to review and ask questions about the Program.
3. Understands the payment schedule, scoring methodology, and Program requirements.
4. Agrees to participate in the Program, comply with the Program requirements, and accept HHO's determination of the incentive payment.
5. Agrees, upon request from HHO, to meet with a CTC once during the first quarter to provide an education session to staff and providers, and quarterly thereafter during the Program year.
6. Understands HHO has the discretion to amend the Program term or terminate participation in the Program at any time.

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

This resource guide provides key information, helpful codes, and tips to improve your practice's Healthcare Effectiveness Data and Information Set (HEDIS®) scores. It offers examples of potential coding opportunities, but these are not exhaustive. Please note that the measures in this guide only encompass those included in the 2025 HHOPE Program.

We encourage you to review this guide carefully. We look forward to partnering with you to provide our members with excellent health care.

For questions or further information, please contact your dedicated CTC or email HHOWVPET@highmarkhealth.org.

Note: The measure descriptions and codes in this document are derived from the HEDIS® Measurement Year 2024 Volume 2 Technical Specifications/Value Set Directory. Please distribute this information to your staff as appropriate. HHO WV will continue to pay for all eligible services performed for our members.

Quality Measures Guide

Controlling High Blood Pressure (CBP)

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

Eligible Population: Members ages 18 to 85 in measurement year with a diagnosis of hypertension.

Exclusions:

1. Evidence of end-stage renal disease (ESRD) or kidney transplant.
2. Active dialysis.
3. Pregnancy during the year 2024.
4. A non-acute inpatient facility admission during 2024 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 second 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" (for example, average BP: 139/70) is eligible for use. Ranges and thresholds do not meet criteria.

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

Acceptable CPT II codes for controlled BP are listed in the table below:

Systolic Values	Diastolic Values
3074F: <130 mm Hg	**3078F:** <80 mm Hg
3075F: 130-139 mm Hg	**3079F:** 80-89 mm Hg

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 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. The provider to whom the member is assigned as of December 31, 2025 will earn the reward. Payment is made annually, by July 31, 2026.

Tips and Best Practices:

- It is critical to follow up with a member for a BP check after their initial diagnosis.
  - Schedule member's follow-up visit prior to discharging from clinic.
  - Members who have an elevated BP during an office visit in the second half of the year should be scheduled for a follow-up visit before December 31.
- If a member's initial BP reading is elevated at the start of a visit, retake the member's BP after they have had time to rest. You can take multiple readings during the same visit and use the lowest diastolic and lowest systolic to document the overall reading.
- Remind members who are nothing by mouth (NPO) for a fasting lab they should continue to take their anti-hypertensive medications with a sip of water on the morning of their appointment.
- If your office uses manual blood pressure cuffs, do not round up the BP reading.

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

Description of Measure: The percentage of members ages 18 to 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 Population: 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 age 66 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 age 66 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: The PCP must submit a CPT II code or other evidence of a controlled HbA1c of less than or equal to 9.

Acceptable CPT II codes for controlled HbA1c are listed in the table below:

CPT II Code	HbA1c Level
3044 F	Value <7
3051 F	Value ≥7 and <8
3052 F	Value ≥8 and ≤9

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 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. The provider to whom the member is assigned as of December 31, 2025 will earn the reward. Payment is made annually, by July 31, 2026.

Tips and Best Practices:

- If test result(s) are documented in the vitals section of your progress notes, please include the date of the blood draw with the result. The date of the progress notes will not count.
- Consider point of care A1c testing in the office setting, when applicable.
- Always list the date of service, result, and test together.
- Include specialist communication and lab results for testing done by endocrinologist during the measurement year.

Oral Evaluation, Dental Services (OED-CH)

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

Eligible Population:

1. Continuous enrollment for 90 days.
2. Members ages 6 months to 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). This only applies to ages 6 months to 17 years.	D1206 (with varnish) D1208 (without varnish)

Examination, Prophylaxis, and a Topical Fluoride Treatment will all need to be submitted for members ages 6 months through 20 years. The Topical Fluoride Treatment service is not required for members age 18 and older.

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

Tips and Best Practices:

- Educate patients and guardians on the importance of dental health.
- Ask about chronic special conditions impacted by dental health such as diabetes, HIV/AIDs, and pregnancy.

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

Description of Measure: Percent of members who turned 15 months old during the measurement year and who had six or more well-child visits (from birth to the child's 15-month birthday).

Eligible Population: 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 1
New Patient	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.82	age <1: 99381 age 1-4: 99382
Established Patient	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.82	age <1: 99391 age 1-4: 99392
Newborn Visit	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.82	99461

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 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. The provider to whom the member is assigned as of December 31, 2025 will earn the reward. Payment is made annually, by July 31, 2026.

Tips and Best Practices:

- Starting in 2025, wellness visits can be accepted as supplemental data, reducing the need for some chart review. Please contact your HHO WV assigned CTC to discuss clinical data exchange opportunities.
- If provider is seeing a patient for Evaluation and Management (E/M) services and all well-child visit components are completed: Attach modifier 25 or 59 to the well-child procedure code, so it is reviewed as a significant, separately identifiable procedure.
    - Modifier 25 is used to indicate a significant and separately identifiable E/M service by the same physician on the same day another procedure or service was performed.
    - Modifier 59 is used to indicate that two or more procedures were performed at the same visit, but to different sites on the body.

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

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

Eligible Population: Members who turned 30 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 two comprehensive well-child visits after the child's 15-month birthday through their 30-month birthday.

How to Submit:

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

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 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. The provider to whom the member is assigned as of December 31, 2025 will earn the reward. Payment is made annually, by July 31, 2026.

Tips and Best Practices:

- Starting in 2025, wellness visits can be accepted as supplemental data, reducing the need for some chart review. Please contact your HHO WV assigned CTC to discuss clinical data exchange opportunities.
- If provider is seeing a patient for E/M services and all well-child visit components are completed: Attach modifier 25 or 59 to the well-child procedure code so it is reviewed as a significant, separately identifiable procedure.
    - Modifier 25 is used to indicate a significant and separately identifiable E/M service by the same physician on the same day another procedure or service was performed.
    - Modifier 59 is used to indicate that two or more procedures were performed at the same visit, but to different sites on the body.

Lead Screening for Children (LSC)

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

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

Exclusions: Members who use hospice services or who die 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.

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 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. The provider to whom the member is assigned as of December 31, 2025 will earn the reward. Payment is made annually, by July 31, 2026.

Tips and Best Practices:

- The CPT code for Lead Screening is 83655.
- Date of service and result must be documented with the notation of the lead screening test.

Immunization for Adolescents – Combo 2 (IMA)

Description of Measure: Percent of adolescents who receive the required set of immunizations (listed under Adherent Member section) by their 13th birthday.

Eligible Population: Percent of adolescents who receive the required set of immunizations (listed under Adherent Member section) by their 13th birthday.

Exclusions:

1. Anaphylactic reaction to the vaccine or its components.
2. Encephalitis due to the diphtheria, tetanus, or pertussis vaccine.
3. Members in hospice or using hospice services.
4. Members who died during the measurement year.

Adherent Member: Adolescents who had all doses of the following immunizations administered in the required age ranges by their 13th birthday:

- At least one meningococcal vaccine, with a date of service on or between the member's 11th and 13th birthdays AND
- At least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, with a date of service on or between the member's 10th and 13th birthdays AND
- One of the following:
  - At least two HPV vaccines, with different dates of service at least 146 days apart on or between the member's 9th and 13th birthdays OR
  - At least three HPV vaccines, with different dates of service on or between the member's 9th and 13th birthdays

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 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. The provider to whom the member is assigned as of December 31, 2025 will earn the reward. Payment is made annually, by July 31, 2026.

Tips and Best Practices:

- A member's medical record must include:
  - A note with the name of the specific antigen and the date the vaccine was administered.
  - An immunization record from an authorized health care provider or agency–for example, a registry–including the name of the specific antigen and the date the vaccine was administered.
- Documentation that a member is up to date with all immunizations but does not include a list of the immunizations and dates they were administered, will not meet compliance.
- Documentation of physician orders (without administration), CPT codes, or billing charges will not meet compliance.

Childhood Immunization Status - Combo 10 (CIS)

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

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

Exclusions:

1. Members who had a contraindication to a childhood vaccine on or before their second birthday. Do not include laboratory claims (POS code 81).
2. Members who had any of the following on or before their second birthday: Severe combined immunodeficiency, immunodeficiency, HIV, lymphoreticular cancer, multiple myeloma, leukemia, or intussusception.
3. Members in hospice or using hospice services anytime during the measurement year.
4. Members who died during the measurement year.

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

- 4 diphtheria, tetanus, and acellular pertussis (DTaP)
- 3 polio (IPV)
- 1 measles, mumps, and rubella (MMR)
- 3 haemophilus influenza type B (HiB)
- 3 hepatitis B (HepB) - can be completed at birth (1 of 3 can be a newborn HepB vaccination)
- 1 chicken pox (VZV)
- 4 pneumococcal conjugate (PCV)
- 1 hepatitis A (HepA)
- 2 doses of the 2-dose rotavirus (RV2) or 3 doses of the 3-dose rotavirus (RV3)
- 2 influenza (flu) vaccines

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

Scoring: This measure requires an entity have a minimum of three members in the denominator to qualify to be scored. Payment may be earned via each numerator compliant member through 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. The provider to whom the member is assigned as of December 31, 2025 will earn the reward. Payment is made annually, by July 31, 2026.

Tips and Best Practices:

- A member's medical record must include:
  - A note with the name of the specific antigen and the date the vaccine was administered.
  - An immunization record from an authorized health care provider or agency–for example, a registry–including the name of the specific antigen and the date the vaccine was administered.
- Documentation that a member is up to date with all immunizations but does not include a list of the immunizations and dates they were administered, will not meet compliance.
- Documentation of physician orders (without administration), CPT codes, or billing charges will not meet compliance.
- For Hep A, Hep B, MMR, or VZV, documented history of the illness counts as numerator compliance events–but they must occur on or before a child's second birthday.
- For all 10 antigens, documented history of anaphylaxis due to the vaccine counts as numerator compliance.

General Tips and Best Practices

1. Submit applicable CPT, CPT II, and Diagnosis (ICD-10) codes via claims process for closing gaps in care for numerator compliance or excluding members from the denominator for all quality measures.
2. Starting in 2025, submit medical record evidence through the Care Gap Management Application (CGMA) for any care gaps not addressed via claims submissions.
   - Contact your HHO WV CTC for CGMA access and to arrange a demo.
3. Grant electronic medical record (EMR) access (onsite or remote) to your HHO WV CTC to assist with submission of evidence for gap closure through the CGMA.
   - Contact your HHO WV CTC for more details.
   - Provide Data Use Agreement if required by your organization.