Clinical Guideline: Attention-Deficit/Hyperactivity Disorder (Children and Adolescents)

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1. Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) (Source: HEDIS® MY 2026 Vol. 2, Technical Specifications)	The percentage of persons newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: *Initiation Phase.* The percentage of persons 6–12 years of age with a prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. *Continuation and Maintenance (C&M) Phase.* The percentage of persons 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.
References	**Reference Link**
AAP Practice Guideline: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-	Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

Deficit/Hyperactivity Disorder in Children and Adolescents (2019)	

Clinical Guideline: Adult Preventative Guidelines (21 & Over)

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
Added: Clinical Indicators: Adult Immunization Status - Added the COVID-19 indicator for adults 65 and older. This indicator is in first-year status for measurement year 2026. **Removed: Reference:** Center for Disease Control and Prevention Recommended Adult Immunization Schedule, for Ages 19 Years and Older – replaced with AAFP guidelines. **Added: Reference:** American Association of Family Physicians, Adult Immunization Schedule, for Ages 19 Years and Older Regarding This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1. **Breast Cancer Screening** (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *BCS-E*)	The percentage of members 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.
2. **Cervical Cancer Screening** (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *CCS-E*)	The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria: • Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. • Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
3. **Chlamydia Screening** (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *CHL*)	The percentage of members 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement year.

Adult Immunization Status (Source: HEDIS Measurement Year 2026, Vol. 2, Technical Specifications-AIS-E)	The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, pneumococcal and hepatitis B.
5. **Documented Assessment After Mammogram** (Source: HEDIS Measurement Year 2026, Vol. 2., Technical Specifications DBM-E)	The percentage of episodes of mammograms documented in the form of a BI-RADS assessment within 14 days of the mammogram for members 40-74 years of age
Adults' Access to Preventive/Ambulatory Health Services (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications – *AAP*)	The percentage of members 20 years and older as of December 31 who had an ambulatory or preventive care visit. Medicaid members who had an ambulatory or preventive care visit during the measurement year.
Reference	**Reference Link**
American Association of Family Physicians, Recommended Adult Immunization Schedule, for Ages 19 Years and Older (2026)	AAFP Recommended Adult Immunization Schedule
U.S. Preventive Task Force Recommendations Adult Preventive Health Care Schedule (2022)	U.S. Preventive Task Force Recommendations Adult Preventive Health Care Schedule
U.S. Preventive Services Task Force Final Recommendations Statement Breast Cancer: Screening (2024)	U.S. Preventive Services Task Force Final Recommendations Statement Breast Cancer: Screening
U.S. Preventive Services Task Force Final Recommendations Statement Cervical Cancer Screening (2018)	U.S. Preventive Services Task Force Final Recommendations Statement Cervical Cancer Screening
U.S. Preventive Services Task Force Final Recommendations Statement Chlamydia and Gonorrhea: Screening (2018)	U.S. Preventive Services Task Force Final Recommendations Statement Chlamydia and Gonorrhea: Screening

Clinical Indicator	Ages 21-39	Ages 40-49	Ages 50-64	Ages 65+
Assessing Tobacco Use	Every Visit	Every Visit	Every Visit	Every Visit
Advising Smokers to Quit	At least annually	At least annually	At least Annually	At least Annually
Assess Drug/Alcohol Use	Annually	Annually	Annually	Annually
Depression Screening	Annually	Annually	Annually	Annually
Assess STD Risk	Annually	Annually	Annually	Annually
Assessment of Functional Status				Annually
Assessment of Fall Risk			Annually if high risk	Annually
Pain Assessment				Annually
Medication Review	Every Visit	Every Visit	Every Visit	Every Visit
Advance Care Planning	Annually	Annually	Annually	Annually
Discussion of Aspirin Prophylaxis	High Risk	If high risk: Men-annually Women-post menopausal	Annually if high risk	Annually if high risk
Preventive Screening Evaluation	Every Visit	Every Visit	Every Visit	Every Visit
Blood Pressure	Every Visit	Every Visit	Every Visit	Every Visit
Cervical Cancer Screening (PAP)	At a minimum every three years, more frequently if in a high-risk group. When combined with HPV contesting, once every 5 years for women ≥ 30 years.	At a minimum every three years, more frequently if in a high-risk group. When combined with HPV contesting, once every 5 years for women ≥ 30 years.	At a minimum every three years, more if in a high-risk group. When combined with HPV contesting, once every 5 years for women ≥ 30 years.	Women: High-risk
HPV	Women: ≥ age 30 every 5 years, more frequently if in a high-risk group	Women: ≥ age 30 every 5 years, more frequently if in a high-risk group	Women: ≥ age 30 every 5 years, more frequently if in a high-risk group	Women high-risk
Mammogram		Women, if high risk: May benefit from screening in their 40's	Women: every 2 years	Women every 2 years until the age of 75
Abdominal Aortic Aneurysm Screening				Men aged 65 to 75 who have ever smokes (One-time screening)
Chlamydia Screening	Women: annually to age 24 & with Pregnancy	If high-risk	If high-risk	
Discuss Prostate Cancer Screening		Annually	Annually	Annually

Colorectal Cancer screening by any of the following methods: Fecal occult blood (high sensitivity) or			Annually	Annually until age 75
Fecal Immunochemical Test-DNA or			Every 3 years	Every 3 years until age 75
Sigmoidoscopy or			Every 5 years	Every 5 years until age 75
Colonoscopy			Every 10 years	Every 10 years until age 75
Vision, Hearing	Every 5 years, Diabetics Annually	Every 5 years, Diabetics Annually	Every 5 years, Diabetics Annually	Every 5 years, Diabetics Annually
Lipid Profile	Men ≥ 20: every 5 years unless high-risk	Men: every 5 years unless high-risk Women ≥ age 45: every 5 years unless high risk	Every 5 years unless high risk	If not checked previously
Obesity Screening (BMI)	Every visit	Every visit	Every visit	Every visit
Domestic Violence	Annually	Annually	Annually	Annually
Osteoporosis Screening	BMD testing if postmenopausal woman who is at increased risk of osteoporosis	BMD testing if postmenopausal woman who is at increased risk of osteoporosis	BMD testing if postmenopausal woman who is at increased risk of osteoporosis	At age 65, provide BMD testing if not previously tested. Evidence is lacking about optimal intervals for repeated screening
Hepatitis C Screening	At least once if high risk	At least once if high risk	One time screening for those aged 50-64	One time screening for those aged 65-70
HIV screening	At least once or annually if high-risk	At least once or annually if high-risk	At least once or annually if high-risk	At least once or annually if high-risk
Bladder Control/Incontinence				Annually
Diabetes screening w/out prior diagnosis – HbA1C		At least once or annually if at risk	At least once or annually if at risk	At least once or annually if

				at risk until age 70
Diabetes screening w/prior diagnosis – HbA1C, dilated retinal examination, and microalbumin/nephropathy testing	At least once annually	At least once annually	At least once annually	At least once annually
Wellness Visit or Physical	Annually	Annually	Annually	Annually

1 Use CAGE screening. C: “Have you ever felt you ought to Cut down on drinking?” A: “Have people Annoyed you by criticizing your drinking?” G: “Have you ever felt bad or Guilty about your drinking?” E: “Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye opener)?

2 Screening questions are: “Over the past month have you felt down, depressed or hopeless” and “Over the past month have you felt little interest or pleasure in doing things.” 3 Aspirin prophylaxis high risk-diabetes, elevated cholesterol levels, low levels of HDL cholesterol, elevated blood pressure, family history and smoking.

4 Discontinuation of cervical cancer screening in older women is appropriate, provided women have had adequate recent screening with normal Pap results. Screening is recommended in older women who have not been previously screened, when information about previous screening is unavailable or when screening is unlikely to have been done in the past. Recommendations from various organizations differ in how often the Pap screen should be done. The general recommendation is to screen every 2-3 years after 3 years of being sexually active but not later than age 21. Women ages 30-64 may only need to be screened every 5 years if the Pap test is done in combination with HPV testing.

5 Although the United States Preventive Services Task Force found insufficient evidence to recommend for or against screening, other organizations endorsed routine screening along with Pap tests for women age 30 and older.

6 There is controversy over how often and at what age the mammograms should be done. Various agencies recommend starting annual screening at age 40 for all women, other agencies say to start at age 50. The included recommendation is based off of current United States Preventive Services Task Force guidelines. The United States Preventive Services Task Force also suggests that screening starting at age 40 may benefit high risk women.

7 United States Preventive Services Task Force

8 Chlamydia screening high risk – Prevalence is higher in the following populations: unmarried women, African American race, prior history of STD, having new or multiple sex partners, having cervical ectopy using barrier contraceptives inconsistently, and partners having multiple partners who engage in high-risk behavior.

9 The American Urological Association recommends shared decision making with men on the use of PSA for screening. Men ages 40-54 at high risk and men at average risk ages 55-69 with a life expectancy > 10 years who decide to include PSA should have routine screening every two years. PSA screening is not recommended for men ages 70+.

10 United States Preventive Services Task Force recommends against routine screening for colorectal cancer in adults 76-85. There may be considerations that support colorectal cancer screening in an individual patient.

11Lipid disorder high risk – diabetes, history of cardiovascular disease before age 50 in male relatives or age 60 in female relatives, history suggestive of familial hyperlipidemia, multiple coronary heart disease risk factors and people who have lipid levels close to those warranting treatment.

12Assess BMI and waist circumference at every visit during which weight is measured. Use 5As: Ask if patient is ready to make a change. Advise in a clear, specific and tailored manner. Assess level of obesity and co morbidities. Assist by providing necessary tools and support. Arrange contact with other providers who can provide a team approach.

13 At each visit ask: “Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone?” “Are you in a relationship with a person who physically hurts you?” “Has anyone forced you to have sexual activities that make you feel uncomfortable?”

14Men and women ages 40-70 years who have at least one risk factor should be screened at least once annually. Risk factors include a BMI > 25, history of smoking, or a prior abnormal A1C. Abnormal A1C tests should receive follow-up within 3-6 months. 15Microalbumin/ nephropathy testing should occur annually if results are negative. Positive results should receive follow-up testing within 3-6 months

Clinical Guideline: Chronic Obstructive Pulmonary Disease

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
No Changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicator	**Description of Indicator**
1. **Pharmacotherapy Management of COPD Exacerbation** (Source: HEDIS® Measurement Year (MY) 2026 Vol. 2, Technical Specifications- *PCE*)	Percentage of COPD exacerbations for members 40 years and older who had an acute inpatient discharge or ED visit *(any claims for COPD)* between January 1-November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported: • Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event • Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event **Note:** The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual
Reference	**Reference Link**
Global Initiative for Chronic Obstructive Lung Disease – GOLD (2025)	Global Initiative for Chronic Obstructive Lung Disease – GOLD
AAFP COPD: Clinical Guidance and Practice Resources (2025)	AAFP COPD: Clinical Guidance and Practice Resources

Clinical Guideline: Cystic Fibrosis

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, (HEDIS ® Measurement Year (MY) 2026 Vol. 2, Technical Specifications - WCC)	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of the following during the measurement year: BMI percentile documentation* Counseling for nutrition Counseling for physical activity *Because BMI norms for youth vary with age and gendersex, this measure measures BMI percentile rather than an absolute BMI value.
2. Outpatient visit with pulmonologist in the past 12 months.	Number of individuals with at least one outpatient visit with a pulmonologist in the past 12 months.
3. Annual Flu Shot	Annual flu vaccine
4. Pneumococcal Vaccine	Up-to-date on pneumococcal vaccine.
References	**Reference Link**
Clinical Care Guidelines, Cystic Fibrosis Foundation (2023)	Clinical Care Guidelines
Chronic Medications to Maintain Lung Health, Cystic Fibrosis Foundation (2021)	Chronic Medications to Maintain Lung Health
Age Specific Care, Cystic Fibrosis Foundation (2023)	Age Specific Care

Clinical Guideline: Pediatric Preventive/EPSDT/Lead Screening - Birth to 21 Years Old

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Well Child Visits in the First 30 Months of Life

Changes for 2026	
Updated: References: DHS MA Bulletin # 99-25-05 PA DHS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule, updated for 2025. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1. Well-Child Visits in the First 30 Months of Life (Source: HEDIS® Measurement Year (MY) 2026 Vol. 2, Technical Specifications – W30)	The percentage of members who had the following number of well-child visits with a PCP during their last 15 months. The following rates are reported: Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.
2. EPSDT EPSDT Visits Medicaid EPSDT Reporting Medicaid.gov	EPSDT Description The percentage of members who complete a visit in each periodicity. Eligibility occurs when the member is enrolled for 90 days. An EPSDT is identified by the use of a Well Visit Value Set (99381-99382 or 99391 -99392) with an appended EP modifier and appropriate diagnosis codes.
References	**Reference Link**
Medicaid.gov Keeping America Healthy - Early and Periodic Screening, Diagnostic, and Treatment (2026)	Medicaid.gov Keeping America Healthy - Early and Periodic Screening, Diagnostic, and Treatment

EPSDT in Medicaid (2021)	EPSDT in Medicaid

DHS MA Bulletin # 99-25-05 DHS Early and Periodic Screening, Diagnosis and Treatment Schedule (2025)	DHS MA Bulletin # 99-25-05 PA DHS Early and Periodic Screening, Diagnosis and Treatment Schedule

Child and Adolescent Well-Care Visits

Changes for 2026	
Updated: References: DHS MA Bulletin # 99-25-05 PA DHS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule, updated for 2025. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1.**Child and Adolescent Well-Care Visits** (Source: HEDIS® Measurement Year 2026 Vol. 2, Technical Specifications - *WCV*)	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
2. **EPSDT** EPSDT Visits Medicaid EPSDT Reporting Medicaid.gov	The percentage of members who complete a visit in each periodicity. Eligibility occurs when the member is enrolled for 90 days. An EPSDT is identified by the use of a Well Visit Value Set (99381-99382 or 99391 -99392) with an appended EP modifier and appropriate diagnosis codes.
References	**Reference Link**

Medicaid.gov Keeping America Healthy - Early and Periodic Screening, Diagnostic, and Treatment (2026)	Medicaid.gov Keeping America Healthy - Early and Periodic Screening, Diagnostic, and Treatment
Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements (2024)	Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements
DHS MA Bulletin # 99-25-05 PA DHS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule (2025)	Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule

Child and Adolescent Immunization

Changes for 2026
Updated: References: DHS MA Bulletin # 99-25-05 PA DHS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule, updated for 2025. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care

Clinical Indicators	**Description of the indicator**
1. Pennsylvania EPSDT Periodicity Schedule	• EPSDT follows the CDC and ACIP Guidelines • EPSDT tracks all HEDIS Measures, and School Vaccine Requirements from age's birth through 20 years.

2. Pennsylvania Department of Health School Requirements - School Vaccination Requirements	KINDERGARDEN (all grade school students) • 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 4th birthday) • 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)** • 2 doses of measles, mumps, rubella (MMR) • 3 doses of hepatitis B • 2 doses of varicella (chickenpox) or evidence of immunity *Usually given as DTP or DTaP or DT or Td ** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose FOR ATTENDANCE IN 7TH GRADE: In addition to all other required grade school immunizations: • 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade. • 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade. Note: If a child gains entrance to school in any succeeding year, the same immunizations are required on the first day. FOR ATTENDANCE IN 12TH GRADE: In addition to all other required grade school immunizations: One dose of meningococcal conjugate vaccine (MCV) on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the 12th grade dose.

References	**Reference Link**
CDC Recommended Child and Adolescent Immunization Schedule ages 18 Years or Younger (2025)	CDC Recommended Child and Adolescent Immunization Schedule ages 18 Years or Younger

ACIP Vaccine-Specific Recommendations (2025)	ACIP Vaccine-Specific Recommendations
Department of Human Services (DHS) Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule (2025)	Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule
School Vaccination Requirements for Attendance in Pennsylvania Schools (2025)	School Vaccination Requirements for Attendance in Pennsylvania Schools

Developmental Screening

Changes for 2026	
Updated: References: DHS MA Bulletin # 99-25-05 PA DHS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule, updated for 2025. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1. **Developmental Screening in the First Three Years of Life** (Source: PA EQRO Measurement Year (MY) 2026, Technical Specifications - DEV)	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. Four rates, one for each age group and a combined rate are to be calculated and reported. Four rates, one for each age group and a combined rate are to be calculated and reported • Children in the eligible population who turned 1 during the measurement year. • Children in the eligible population who turned 2 during the measurement year. • Children in the eligible population who turned 3 during the measurement year.

	• Combined Rate Children should receive Structured Developmental Screenings during the following visits: ○ 9-11 Month Visit and ○ 18 Month Visit and ○ 30 Month Visit Children Should receive a Structured Autism Screening during the following visits: ○ 18 Month Visit and ○ 24 Month Visit Children who have a positive screening should be referred for further evaluation and diagnosis without delay. Children must also be referred to their local Early Intervention Services. This can be done either directly through the office contacts or via CONNECT.
2. **Pennsylvania EPSDT Periodicity Schedule**	Number of children who receive the Developmental Screening at ages listed above prior to the member turning age 2 years 9 months
References	**Reference Link**
DHS EPSDT Program Periodicity Schedule (2025)	DHS EPSDT Program Periodicity Schedule
PA Department of Education Early Learning Early Intervention (2026)	PA Department of Education Early Learning Intervention
AAP Screening Technical Assistance & Resource Center (2025)	AAP Screening Technical Assistance & Resource Center

Lead Testing

Changes for 2026
Updated: References: DHS MA Bulletin # 99-25-05 PA DHS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule, updated for 2025. **Updated: References:** Lead Testing Guidelines Form, updated with the Highmark site link. **Updated: References:** Environmental Lead Investigation Form, updated with the Highmark site link.

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Clinical Indicators	**Description of the indicator**
1. **HEDIS Measure Name Lead Screening in Children** (Source: HEDIS® Measurement Year 2026 Technical Specifications – *LSC*)	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. All children enrolled in Medicaid are required to have 2 lead tests. ○ Test 1 at 9-11 Months ○ Test 2 at 24 Months ○ Children who enroll in Medicaid after 24 months of age and not previously having had a lead test should receive a catch up lead test. ○ All refugee infants and children ages 0-16 should be tested for Lead. For children who are refugees, children should be re-tested 3 to 6 months post resettlement regardless of initial BLL result, and all children aged 6 months to 6 years should be provided with a daily pediatric multivitamin with iron.
References	**Reference Link**
Lead Testing Guidelines Form (2026)	Lead Testing Guidelines Form
Environmental Lead Investigation Form (2025)	Environmental Lead Investigation Form
Immigrant and Refugee Health (2026)	Immigrant and Refugee Health
Medicaid.gov Lead Screening (2026)	Medicaid.gov Lead Screening
American Academy of Pediatrics, AAP Blood Lead Levels Among Resettled Refugee Children in Select US States 2010-2014 (2019)	AAP Blood Lead Levels Among Resettled Refugee Children in Select US States 2010-2014
PA DOH Lead Poisoning (2026)	PA DOH Lead Poisoning
PA DOH Childhood Blood Lead Act (2023)	PA DOH Childhood Blood Lead Act
DHS EPSDT Program Periodicity Schedule (2025)	DHS EPSDT Program Periodicity Schedule

Handling of Elevated Blood Lead Levels

Changes for 2026
Updated: References: Environmental Lead Investigation Form, updated with the Highmark site link.

This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care

Clinical Indicators	**Description of the indicator**
1. **State Regulatory Requirement EPSDT**	• Children who have a blood lead level of ≥3.5µg/dL need to receive follow up per Pennsylvania Guidelines. • Children who had an initial value ≥3.5µg/dL through capillary screening should have results confirmed with blood drawn by venipuncture. The CDC has a recommended schedule for obtaining a confirmatory venous sample. The higher the blood lead level on the capillary screening the more urgent the need for confirmatory testing. • Children who had an initial value of ≥3.5µg/dL through venipuncture should follow the CDC guidelines for follow-up blood lead testing as frequency is based on initial blood lead level. • Siblings in the home should also receive lead testing, even if previous tests showed that their lead levels were within normal limits. • Children with a venous elevated blood lead levels should be referred to Early Intervention or DART for tracking services. This can be through the CONNECT Helpline at 1-800-692-7288 • Children with a venous elevated blood lead levels should receive additional developmental screenings by their PCP to ensure that the member is achieving developmental milestones on time. • Children with a venous elevated blood lead level should be referred for an Environmental Lead Investigation on the first elevated venous lead level.
References	**Reference Link**
Environmental Lead Investigation Form (2025)	Environmental Lead Investigation Form
About Childhood Lead Poisoning Prevention (2025)	About Childhood Lead Poisoning Prevention
CDC Recommended Actions Based on Blood Lead Level (2025)	CDC Recommended Actions Based on Blood Lead Level

CDC Childhood Lead Poisoning Prevention-Scientific Publications (2026)	CDC Childhood Lead Poisoning Prevention-Scientific Publications

Clinical Guideline: Healthy Weight Management for Children and Adolescents

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026.	
Updated: References: PA Department of Human Services (DHS) - MA Bulletin MAB20230913 Updates to Childhood Nutrition and Weight Management Services – updated for 2023 This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (HEDIS® Measurement Year (MY) 2026 Vol. 2, Technical Specifications - WCC)	1. The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of the following during the measurement year: BMI percentile documentation* Counseling for nutrition Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure measures BMI percentile rather than an absolute BMI value
References	**Reference Link**
PA Department of Human Services (DHS) - MA Bulletin MAB20230913 Updates to Childhood Nutrition and Weight Management Services (2023)	Updates to Childhood Nutrition and Weight Management Services
AACE/ACE Comprehensive Clinical Practice Guidelines for Medical Care of Patients with Obesity (2016)	AACE/ACE Comprehensive Clinical Practice Guidelines for Medical Care of Patients with Obesity
JCEM – Pediatric Obesity – Assessment, Treatment and Prevention: An Endocrine Society Clinical Practice Guideline (2017)	JCEM – Pediatric Obesity – Assessment, Treatment and Prevention: An Endocrine Society Clinical Practice Guideline

Prevention of Pediatric Overweight and Obesity: Position of the Academy of Nutrition and Dietetics Based on an Umbrella Review of Systematic Reviews (2022)	Prevention of Pediatric Overweight and Obesity: Position of the Academy of Nutrition and Dietetics Based on an Umbrella Review of Systematic Reviews
High Body Mass Index in Children and Adolescents: Interventions (2024)	High Body Mass Index in Children and Adolescents: Interventions
American Academy of Pediatrics Clinical Practice Guidelines for the Evaluation and Treatment of Children and Adolescents with Obesity (2023)	American Academy of Pediatrics Clinical Practice Guidelines for the Evaluation and Treatment of Children and Adolescents with Obesity

Clinical Guideline: Healthy Weight Management

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
Updated: References: American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE) Clinical Practice Guidelines for Comprehensive Medical Care of Patients with Obesity – updated for 2025. **Updated: References:** USDA Dietary Guidelines updated for 2025-2030 This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1.**Obesity rates for adults in Pennsylvania by ethnicity***: • White 32.7% • Black 44.6% • Hispanic 34.1% • Multiracial, non-Hispanic 44.9% • Asian, non-Hispanic 10.6% * 2023 CDC BRFSS BMI data	**Statistical Data:** Age group: 18 years and older • Racial/ethnic groups are mutually exclusive. Percentages are weighted to reflect population characteristics. • An adult who has a BMI between 25 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. • Data based on the Behavioral Risk Factor Surveillance System, an ongoing, state-based, random-digit-dialed telephone survey of non-institutionalized civilian adults aged 18 years and older. Information about the BRFSS is available at http://www.cdc.gov/brfss/index.html. • Release date represents the date figures were accessed.

2. Reduce the proportion of adults with obesity	**Healthy People 2030 Objective:** Target: 36.0 percent **Numerator** Number of adults aged 20 years and over with a body mass index (BMI) equal to or greater than 30.0 **Denominator** Number of adults aged 20 years and over

References	**Reference Link**
Centers for Disease Control and Prevention (CDC) – Overweight and Obesity (2024)	Centers for Disease Control and Prevention (CDC) – Overweight and Obesity
Healthy People 2030 Reduce the portion of Adults with Obesity (2020)	Healthy People 2030 Reduce the portion of Adults with Obesity
American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE) Clinical Practice Guidelines for Comprehensive Medical Care of Patients with Obesity 2025 UPDATE (2025)	American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE) Clinical Practice Guidelines for Comprehensive Medical Care of Patients with Obesity
Evidence Analysis Library Adult Weight Management Guideline 2021-2022 (2022)	Evidence Analysis Library Adult Weight Management Guideline 2021-2022
2025-2030 USDA Dietary Guidelines for Americans (2025)	2025-2030 USDA Dietary Guidelines for Americans
NIH Overweight and Obesity Treatment (2022)	NIH Overweight and Obesity Treatment

Clinical Guideline: Heart Failure, MI, CAD, IVD and Cholesterol Management

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
Removed: Clinical Indicator: Statin Therapy for Patients with Cardiovascular Disease (SPC)- retired. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1. Persistence of Beta-Blocker Treatment after a Heart Attack (PBH) (Source: HEDIS® MY 2026, Vol. 2, Technical Specifications)	The percentage of people 18 years of age and older during the measurement period who were hospitalized and discharged from July 1 of the year prior to the measurement period to June 30 of the measurement period with a diagnosis of AMI and who received persistent beta-blocker treatment for 180 days (6 months) after discharge.
Reference	**Reference Link**
American College of Cardiology/American Heart Association, Task Force on Clinical Practice Guidelines (2019)	American College of Cardiology/American Heart Association, Task Force on Clinical Practice Guidelines
Journal of the American College of Cardiology, Treatment of Blood Cholesterol (2018)	Journal of the American College of Cardiology, Treatment of Blood Cholesterol
AHA Guideline on the Management of Blood Cholesterol: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines (2018)	AHA Guideline on the Management of Blood Cholesterol: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines
Guideline for the Management of Heart Failure (2022)	Guideline for the Management of Heart Failure
Coronary Artery Disease Prevention (2023)	Coronary Artery Disease Prevention
Addressing Social Determinants of Health in the Care of Patients with Heart Failure: A Scientific Statement from the American Heart Association (2020)	Addressing Social Determinants of Health in the Care of Patients with Heart Failure: A Scientific Statement from the American Heart Association
Guideline for the Evaluation and Diagnosis of Chest Pain (2021)	Guideline for the Evaluation and Diagnosis of Chest Pain

Clinical Guideline: Palliative Care

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1. Care for Older Adults-Medication Review (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *COA*)	Either of the following meets criteria: • Both of the following during the same visit during the measurement year where the provider type is a prescribing practitioner or clinical pharmacist. Do not include codes with a modifier. At least one medication review The presence of a medication list in the medical record • Transitional care management services during the measurement year. *Do not include services provided in an acute inpatient setting*
2.Care for Older Adults-Functional Status Assessment (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *COA*)	At least one functional status assessment during the measurement year, as documented through either administrative data or medical record review.
References	**Reference Link**
National Coalition for Hospice and Palliative Care (NCHP), National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care (2018)	National Coalition for Hospice and Palliative Care Clinical Practice Guidelines for Quality Palliative Care

Clinical Guideline: Pediatric Preventative Dental Care

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
Updated: Reference: PA DHS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule, updated for 2025. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1. Oral Evaluation, Dental Services (Source HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *OED*) **This measure has been included in and/or adapted for HEDIS with the permission of the Dental Quality Alliance (DQA) and American Dental Association (ADA). © 2023 DQA on behalf of ADA, all rights reserved.*	The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year. Under 21 years as of December 31 of the measurement year.

2. Topical Fluoride for Children (Source HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - TFC) **This measure has been included in and/or adapted for HEDIS with the permission of the Dental Quality Alliance (DQA) and American Dental Association (ADA). © 2023 DQA on behalf of ADA, all rights reserved.*	The percentage of members 1–4 years of age who received at least two fluoride varnish applications during the measurement year. 1–4 years as of December 31 of the measurement year.
References	**Reference Link**
Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents (2022)	Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents
DHS MA Bulletin # 99-25-05 PA DHS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Schedule (2025)	PA DHS Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Schedule

AGE	6-12 Months	12-24 Months	2-6 Years	6- 12 Years	12 Years and Older
Clinical Indicators					
Clinical Oral Examination[1]	✓	✓	✓	✓	✓
Assess Oral growth and development[2]	✓	✓	✓	✓	✓
Caries-risk assessment[3]	✓	✓	✓	✓	✓

Radiographic Assessment[4]	✓	✓	✓	✓	✓
Prophylaxis and Topical fluoride[3,4]	✓	✓	✓	✓	✓
Fluoride supplementation[5]	✓	✓	✓	✓	✓
Anticipatory guidance/counseling[6]	✓	✓	✓	✓	✓
Oral hygiene counseling[3,7]	**Parent**	**Parent**	**Patient/Parent**	**Patient/Parent**	**Patient**
Dietary counseling[3,8]	✓	✓	✓	✓	✓
Counseling for nonnutritive habits[9]	✓	✓	✓	✓	✓
Injury prevention and safety counseling [10]	✓	✓	✓	✓	✓
Assess speech and language development[11]	✓	✓	✓		
Assessment developing occlusion[12]			✓	✓	✓
Assessment for pit and fissure sealants[13]			✓	✓	✓
Periodontal-risk assessment [14]			✓	✓	✓
Counseling for tobacco, vaping, and substance misuse				✓	✓
Counseling for human papilloma virus/vaccine				✓	✓
Counseling for intraoral/perioral piercings				✓	✓
Assessment of third molars					✓
Transition to adult dental care					✓

[1] First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology injuries.
[2] By clinical examination.
[3] Must be repeated regularly and frequently to maximize effectiveness.
[4] Timing, types and frequency determined by child's history, clinical findings and susceptibility to oral disease.
[5] Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
[6] Appropriate discussion and counseling should be an integral part of each visit for care.
[7] Initially, responsibility of parent, as child matures, jointly with parent; then, when indicated, only child.
[8] Every appointment, initially to discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity. Monitor body mass index beginning at age two

[9] At first, discuss the need for nonnutritive sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or deleterious effect on the dentofacial complex occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism

[10] Initially pacifiers, car seats, play objects, electric cords; secondhand smoke; when learning to walk; with sports and routine playing, including the importance of mouthguards; then motor vehicles and high-speed activities.

[11] Observation for age-appropriate speech articulation and fluency as well as achieving receptive and expressive language milestones.

[12] Identify: transverse, vertical, and sagittal growth patterns; asymmetry; occlusal disharmonies; functional status including temporomandibular joint dysfunction; esthetic influences on self-image and emotional development.

[13] For caries susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

[14] Periodontal probing should be added to the risk-assessment process after the eruption of the first permanent molars.

Clinical Guideline: Prescribing Opioids for Chronic Pain

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
No Changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1. Use of Opioid at High Dosage (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *HDO*)	The percentage of members 18 years and older who received prescribed opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year. ***Note:*** *A lower rate indicates a better performance*.
2. Use of Opioids from Multiple Providers (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *UOP*)* **Adapted with financial support from CMS and with permission from the measure developer, Pharmacy Quality Alliance (PQA).*	The percentage of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year, who received opioids from multiple providers. Three rates are reported. 1. **Multiple prescribers** defined as the percentage of members receiving prescriptions for opioids from four or more different prescribers during the measurement year 2. **Multiple pharmacies** defined as the percentage of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year. 3. **Multiple prescribers and multiple pharmacies** defined as percentage of members receiving prescriptions for opioids from 4 or more different prescribers **and** 4 or more different pharmacies during the measurement year. (i.e., the proportion of member who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates). ***Note:*** *A lower rate indicates a better performance for all three rates*.

3. Continued Opioid Use (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - COU)* ***Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS) and with permission from the measure developer, Minnesota Department of Human Services.*	The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported: The percentage of members with at least 15 days of prescription opioids in a 30-day period. The percentage of members with at least 31 days of prescription opioids in a 62-day period. ***Note:*** *A lower rate indicates better performance.*

References	**Reference Link**
CDC Guideline for Prescribing Opioid for Chronic Pain (2022)	CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR
CDC's Efforts to Prevent Overdoses and Substance Use-Related Harms (2024)	CDC's Efforts to Prevent Overdoses and Substance Use-Related Harms
FDA Identifies Harm Reported from Sudden Discontinuation of Opioid Pain Medicines (2019)	FDA Identifies Harm Reported from Sudden Discontinuation of Opioid Pain Medicines
NEJM: No Shortcuts to Safer Opioid Prescribing (2019)	NEJM: No Shortcuts to Safer Opioid Prescribing

Clinical Guideline: Prevention, Detection, Evaluation, and Treatment of High Blood Pressure

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
Updated: References: Journal of the American College of Cardiology, Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adult: Updated for 2025. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1.Controlling High Blood Pressure (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications) *CBP*	Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (BP was <140/90 mm Hg) during the measurement year.
2. Blood Pressure Control for Patients with Hypertension (Source: HEDIS Measurement Year (MY) 2026, Vol. 2., Technical Specifications *(BPC-E)*	The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose most recent BP was <140/90 mm Hg during the measurement period.
References	**Reference Link**
Journal of the American College of Cardiology, Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (2025)	Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults
American College of Cardiology/American Heart Association, Guideline on the Primary Prevention of Cardiovascular Disease: Executive Summary (2019)	ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines

Guideline-Driven Management of Hypertension: An Evidence-Based Update (2021)	Guideline-Driven Management of Hypertension: An Evidence-Based Update

Clinical Guideline: Routine and High Risk Prenatal and Postpartum Care

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
Updated: Clinical Indicator: Prenatal Depression Screening and Follow-Up - Added the PROMIS Emotional Distress instrument to the depression screening instruments for adults. **Updated: Clinical Indicator:** Postpartum Depression Screening and Follow-Up - Added the PROMIS Emotional Distress instrument to the depression screening instruments for adults. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1.Timeliness of Prenatal Care (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *PPC*)	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
2.Postpartum Care (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *PPC*)	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
3.Prenatal Immunization Status (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *PRS-E*)	The percentage of deliveries in the Measurement Period in which women had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

4.Prenatal Depression Screening and Follow-Up (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *PND-E*)	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. *Depression Screening*: The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. *Follow-Up on Positive Screen*: The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.
5.Postpartum Depression Screening and Follow-Up (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications -*PDS-E*)	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. *Depression Screening:* The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. *Follow-Up on Positive Screen:* The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.
References	**Reference Link**
American College of Obstetricians and Gynecologists (2024)	American College of Obstetricians and Gynecologists
Cleveland Clinic Journal of Medicine, Maternal Asthma: Management Strategies (2017)	Cleveland Clinic Journal of Medicine, Maternal Asthma: Management Strategies
Clinical Guidance for the Integration of the Findings of the Chronic Hypertension and Pregnancy (CHAP) Study (2022)	Clinical Guidance for the Integration of the Findings of the Chronic Hypertension and Pregnancy (CHAP) Study
American College of Allergy, Pregnancy and Asthma (2023)	American College of Allergy, Pregnancy and Asthma
CDC Activities: Improving Maternal Mental Health Care (2024)	CDC Activities: Improving Maternal Mental Health Care

Clinical Guideline: Sickle Cell Disease

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1.Receipt of seasonal flu shot	Percentage of enrollees diagnosed with Sickle Cell disease who received the flu shot. (total and by race/ethnicity breakdown)
2.Receipt of meningococcal vaccination	Percentage of enrollees diagnosed with Sickle Cell disease who received the meningococcal vaccination (quadrivalent meningococcal conjugate vaccine) starting age 2-10 years, then every 5 years after)
3.Outpatient visit in the past 12 months	Percentage of enrollees diagnosed with Sickle Cell disease with at least one outpatient visit in the past 12 months.
4.Retinal Exams	Percentage of enrollees diagnosed with Sickle Cell disease who received retinal eye exams.
4.ED Visits for Pain Management	Percentage of enrollees diagnosed with Sickle Cell disease who had ED Visits for Pain Management.
5.Adherence to Antibiotic Prophylaxis	Percentage of enrollees diagnosed with Sickle Cell disease who are adherent with Antibiotic Prophylaxis.
References	**Reference Link**
National Institutes of Health, National Heart, Lung, and Blood Institute (NHLBI) Sickle Cell Disease (2025)	Sickle Cell Disease
Evidence-Based Management of Sickle Cell Disease: Expert Panel Report (2014)	Evidence-Based Management of Sickle Cell Disease: Expert Panel Report
National Library of Medicine, Quality of Care Indicators for Children with Sickle Cell Disease (2011)	Quality of Care Indicators for Children with Sickle Cell Disease

American Society of Hematology (ASH) Clinical Practice Guidelines on Sickle Cell Disease (2026)	Clinical Practice Guidelines on Sickle Cell Disease
American College of Emergency Physicians, Emergency Department Sickle Cell Care Coalition (2026)	Emergency Department Sickle Cell Care Coalition

Clinical Guideline: The Treatment of Patients with Substance Use Disorders

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1.Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence (AOD) Treatment (Source: HEDIS® Measurement Year (MY) 2026 Vol. 2, Technical Specifications*, IET*)	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: *Initiation of SUD Treatment*. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. *Engagement of SUD Treatment.* The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
2.Follow-Up After Emergency Department Visit for Substance Use (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications, *FUA*) **Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was*	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).	The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
References	**Reference Link**
VA/DoD Clinical Practice Guidelines, Management of Substance Use Disorder, (2021)	Management of Patients with Substance Use Disorders
APA Practice Guideline for The Pharmacological Treatment of Patients with Alcohol Use Disorder (2018)	APA Practice Guideline for The Pharmacological Treatment of Patients with Alcohol Use Disorder
National Institute on Drug Abuse (NIDA) Principles of Drug Addiction Treatment (2023).	National Institute on Drug Abuse (NIDA) Principles of Drug Addiction Treatment
Dartmouth-Hitchcock Knowledge Map, Unhealthy Alcohol and Drug Use – Adult Primary Care (2017)	Dartmouth-Hitchcock Knowledge Map, Unhealthy Alcohol and Drug Use – Adult Primary Care
Dartmouth-Hitchcock Unhealthy Alcohol and Drug Use (2021)	Dartmouth-Hitchcock Unhealthy Alcohol and Drug Use
ASAM National Practice Guideline for treatment of Stimulant Use Disorder (2026)	National Practice Guideline for Stimulant Use Disorder
American Society of Addiction Medical (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder (2024)	American Society of Addiction Medical (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder
American Society of Addiction Medical (ASAM) Clinical Practice Guideline on Alcohol Withdrawal Management (2026)	American Society of Addiction Medical (ASAM) Clinical Practice Guideline on Alcohol Withdrawal Management

Clinical Guideline: The Diagnosis and Management of Asthma

Line of Business: PA Medicare Assured

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
Added: Clinical Indicator: Follow-Up After Acute and Urgent Care Visits for Asthma **Removed: Clinical Indicator:** Asthma Medication Ratio – Retired. **Removed: Clinical Indicator:** Asthma in Younger Adults Admission Rate – Retired. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1. **Follow-Up After Acute and Urgent Care Visits for Asthma** (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications, AAF-E)	The percentage of persons 5-64 years of age with an urgent care visit, acute inpatient discharge, observation stay discharge or ED visit with a diagnosis of asthma that had a corresponding outpatient follow-up visit with a diagnosis of asthma within 30 days.
References	**Reference Link**
National Heart Lung and Blood Institute (NHLBI), National Asthma Education and Prevention Program (NAEP) (2020)	National Heart Lung and Blood Institute (NHLBI), National Asthma Education and Prevention Program (NAEP)

Clinical Guideline: The Management of Diabetes

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026.

Changes for 2026	
No Changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicator	**Description of Indicator**
1. Glycemic Status Assessment for Patients with Diabetes (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications, GSD)	The percentage of members 18–75 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 levels during the measurement year: • Glycemic Status <8.0%. • Glycemic Status >9.0%. Note: Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.
2.Eye Exam for Patients with Diabetes (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications, *EED*)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam performed.
3.Blood Pressure Control for Patients with Diabetes (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications, *BPD*)	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
4.Statin Therapy for Patients with Diabetes (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications, *SPD*)	The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

	1. *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year 2. *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.
5. Kidney Health Evaluation for Patients with Diabetes (Source: HEDIS Measurement Year 2026, Technical Specifications, Vol. 2., KED) *This measure was developed by NCQA with input from the National Kidney Foundation	The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation defined by and estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.
Reference	**Reference Link**
American Diabetes Association, Standards of Medical Care (2024)	American Diabetes Association, Standards of Medical Care
Management of Hyperglycemia in Type 2 Diabetes (2022)	Management of Hyperglycemia in Type 2 Diabetes
American Optometric Association, Eye Care of The Patient with Diabetes Mellitus (2019)	American Optometric Association, Eye Care of The Patient with Diabetes Mellitus
AHA Comprehensive Management of Cardiovascular Risk Factors for Adults with Type 2 Diabetes: A Scientific Statement from the American Heart Association (2022)	AHA Comprehensive Management of Cardiovascular Risk Factors for Adults with Type 2 Diabetes: A Scientific Statement from the American Heart Association
Mayo Clinic Proceedings: Innovations, Quality, and Outcomes. Fulfillment and Validity of the Kidney Health Evaluation Measure for People with Diabetes. (2023)	Mayo Clinic Proceedings: Innovations, Quality, and Outcomes. Fulfillment and Validity of the Kidney Health Evaluation Measure for People with Diabetes.

Clinical Guideline: The Management of Major Depression in Adults in Primary Care

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
Updated: Clinical Indicator: Added the PROMIS Emotional Distress—Depression—Short Form instrument to the list of depression screening instruments for adults 18+ years of age. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1. Depression Screening and Follow-Up for Adolescents and Adults (Source: HEDIS Measurement Year (MY) 2026 Vol 2., Technical Specifications, DSF-E)	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument. • Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of a positive depressions screen finding.
References	**Reference Link**
Mayo Clinic: Depression (Major Depressive Disorder) (2023)	Mayo Clinic: Depression (Major Depressive Disorder)
Multiple Chronic Conditions, Depression Guidelines (2025)	Multiple Chronic Conditions, Depression Guidelines
American Psychological Association Psychotherapy and Pharmacotherapy for Treating Depression (2019)	American Psychological Association Psychotherapy and Pharmacotherapy for Treating Depression

Clinical Guideline: The Treatment of Schizophrenia in Children & Adolescents

Line of Business: PA Medicaid

Date of QI/UM Committee Review and Adoption: May 20th, 2026

Changes for 2026	
Added: References: Mayo Clinic: Childhood Schizophrenia (2026) This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1.Metabolic Monitoring for Children and Adolescents on Antipsychotics (Source: HEDIS® Measurement Year (MY) 2026, Volume 2 Technical Specifications, *APM*)	The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: The percentage of children and adolescents on antipsychotics who received blood glucose testing. The percentage of children and adolescents on antipsychotics who received cholesterol testing. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.
References	**Reference Link**
Journal of the American Academy of Child & Adolescent Psychiatry (JAACAP) "Practice Parameters for the Assessment and Treatment of Children and Adolescents with Schizophrenia" (2013)	Journal of the American Academy of Child & Adolescent Psychiatry (JAACAP) "Practice Parameters for the Assessment and Treatment of Children and Adolescents with Schizophrenia"
Childhood Onset Schizophrenia Treatment and Management (2019)	Childhood Onset Schizophrenia Treatment and Management
Mayo Clinic: Childhood Schizophrenia (2026)	Mayo Clinic: Childhood Schizophrenia