

Practice Alert: Proposed Revision of the Federal Child and Adolescent Immunization Schedule Bypasses Established Processes

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On January 5, 2026, the US Department of Health and Human Services and the acting director of the Centers for Disease Control and Prevention announced a major revision of the federal child and adolescent immunization schedule.^{1,2} This revision circumvented the established recommendation process of the Advisory Committee on Immunization Practices (ACIP). The announcement stated that the changes were based on a “scientific assessment,” but the methodology was not described.

Soon afterward, the American Academy of Pediatrics declined to endorse the new federal recommendations and released their own child and adolescent immunization schedule, which is essentially the same as the one last endorsed by ACIP in 2024.³ The American Academy of Pediatrics’ recommendations were immediately endorsed by many other medical and public health organizations, including the American Academy of Family Physicians.⁴

WHICH RECOMMENDATIONS CHANGED?

The new recommendations separate child and adolescent vaccines into three groups: those recommended for all, those recommended for certain high-risk groups, and those to be administered only after a shared decision-making discussion (Table 1).¹

This revision shifts six vaccines (rotavirus infection, COVID-19, influenza, meningococcal ACWY, and hepatitis A and B) into an optional, case-by-case category with decisions made after a discussion with a clinician. Previously, only meningococcal B vaccine had a similar designation. No criteria are provided to explain why these additional vaccines have been moved into this category.

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Author Disclosure: Dr. Campos-Outcalt disclosed a financial relationship with CSL Seqirus. All relevant financial relationships have been mitigated. See Editor’s Note.

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The revised schedule also now recommends a single dose of human papillomavirus vaccine, instead of two doses, and does not specify the age groups for this recommendation. Notably, the US Food and Drug Administration has not approved a single-dose human papillomavirus vaccine. The World Health Organization recommends a single dose only for those 20 years or younger.⁵

A schedule that reflects the new changes was posted on the Centers for Disease Control and Prevention website but was removed on March 16, 2026, in response to a Massachusetts district court injunction that stayed the changes. Although the schedule was not endorsed by any medical organizations, it could prompt questions from patients and parents.

HOW DO THE FEDERAL GUIDELINES DEFINE SHARED DECISION-MAKING?

Before 2025, ACIP used the shared decision-making designation when a vaccine that had been approved by the US Food and Drug Administration would benefit certain individuals but be unlikely to have population-level impacts if used broadly. However, these criteria clearly do not apply to several of the newly designated vaccines (Table 2⁶⁻¹⁰). New criteria for the use of this designation have not been published, but the new schedule appears to reduce the number of routinely recommended child and adolescent vaccines while maintaining first-dollar coverage for those who choose them.

WHAT DO THE CHANGES MEAN FOR PHYSICIANS?

The federal recommendations differ significantly from those of the American Academy of Family Physicians and other major medical organizations, which has the potential to create public confusion and challenges for family physicians.

Key points to remember when discussing child and adolescent vaccines with patients, parents, and guardians:

- No vaccine was removed from the recommendation schedule.
- All of the vaccines on the previous ACIP recommendation schedule (the one currently endorsed by the American Academy of Pediatrics) have been thoroughly reviewed for safety and effectiveness and are still recommended by major medical organizations.
- Insurance coverage for vaccines has not changed. The Patient Protection and Affordable Care Act requirement for

TABLE 1

Summary of Proposed 2026 Federal Child and Adolescent Immunization Recommendations

Recommended for all	Recommended for certain high-risk groups	Shared decision-making
Diphtheria, tetanus, pertussis	Hepatitis A for those traveling internationally to areas with high or intermediate hepatitis A endemicity	Rotavirus
Polio	Hepatitis B for infants born to women with a positive or unknown hepatitis B status	Influenza
Pneumococcal infection	Dengue for those living in endemic areas who have a confirmed previous dengue infection	COVID-19
<i>Haemophilus influenzae</i> type b	Meningococcal ACWY for those with anatomic or functional asplenia or HIV infection, those traveling to hyperendemic or endemic countries, and first-year college students living in residential housing	Hepatitis A
RSV (unless mother received RSV vaccine in pregnancy)	Meningococcal B for high-risk groups (eg, those with anatomic or functional asplenia) and during outbreaks	Hepatitis B
Measles, mumps, rubella		Meningococcal ACWY
Varicella		Meningococcal B
Human papillomavirus		

Information from reference 1.

RSV = respiratory syncytial virus.

TABLE 2

Effects of Selected Vaccines on Incidence of Childhood Diseases

Vaccine	Before vaccine	After vaccine	Comments
Hepatitis B	Before universal vaccination, acute hepatitis B was reported at 8.5 cases per 100,000 people; the true incidence was likely much higher	After universal vaccination, acute cases of hepatitis B declined 75%, to 2.1 per 100,000 people	Chronic infection occurs in approximately 90% of infected infants, 30% of infected children < 5 years of age, and < 5% of infected people ≥ 5 years of age
Hepatitis A	Before the approval of the vaccines, 31% of the US population had serologic evidence of previous infection; there were an estimated 271,000 infections per year from 1980 to 1995	In 2014, there were only an estimated 200-3,000 cases of hepatitis A in the United States	Childhood hepatitis A infection is a common source of acute hepatitis A in adults, many of whom are at risk for serious outcomes
Rotavirus	Before 2006, an estimated 80% of children in the United States contracted rotavirus infection before 5 years of age, causing 410,000 physician visits, 205,000-272,000 emergency department visits, and 55,000-70,000 hospitalizations annually, with total annual direct and indirect costs of approximately \$1 billion	Rotavirus vaccines have significantly reduced the number of rotavirus infections, although the exact reduction is difficult to calculate	Although rotavirus rarely leads to death in the United States, it is a significant cause of infant mortality globally

Information from references 6-10.

first-dollar coverage for all ACIP-recommended vaccines is still in force and applies to those in the shared decision-making category. The Vaccines for Children Program will continue to include all recommended vaccines regardless of category.

- State school immunization requirements are not affected by the revisions. Family physicians should familiarize themselves with their state's requirements so they can advise patients accordingly.

- Most patients still look to and trust their personal physician when it comes to vaccine recommendations.¹¹

- Physicians should remember the impact of child immunizations on population-level outcomes. For instance, routinely administering hepatitis A and B vaccines in children reduces the risk of transmission and prevents acute and chronic hepatitis in adults.

The leadership of the US Department of Health and Human Services and Centers for Disease Control and Prevention made major changes to the federal child and adolescent immunization recommendations without clearly describing their scientific rationale. Designating previously universal vaccines as optional and based on shared decision-making could lead to a resurgence of these preventable infections and associated morbidity and mortality, not only in children but also the population as a whole. The Centers for Disease Control and Prevention website still describes the considerations and rationale for each of the original routine recommendations that have now been revised with no published justification.¹²

Editor's Note: Dr. Campos-Outcalt was the American Academy of Family Physicians' liaison to the Advisory Committee on Immunization Practices (ACIP) for 6 years, an ACIP voting member for 4 years, and a methods consultant to the ACIP for 4 years (ending in January 2025). As the editorial went to press, Dr. Campos-Outcalt disclosed a new financial relationship with CSL Seqirus. This relationship did not exist when the editorial was written and accepted for publication.

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