MHA Michigan Health & Hospital Association | Leading Healthcare

September 18, 2026

Cynthia Goss
Deputy Assistant Secretary for Planning and Evaluation
Office of the Secretary
Department of Health and Human Services

Re: Docket No. HHS-OS-2026-0332
Request for Information: Categories Used in Federal Vaccine Recommendations and the Role of Shared Clinical Decision-Making

Dear Ms. Goss:

On behalf of Michigan's 128 community hospitals, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to respond to the Department of Health and Human Services' Request for Information regarding federal vaccine recommendation categories and the role of shared clinical decision-making outlined in 2026-17250. The MHA is the statewide membership organization representing all community hospitals in Michigan. MHA represents hospitals and health systems across Michigan that administer vaccines, educate patients and families, and implement immunization policies across inpatient, outpatient, pediatric, adult, and public health settings. Membership ranges from critical access hospitals in rural areas of the Upper Peninsula to large, urban, tertiary care centers in the heart of Detroit – and everything in between. Our mission is to advance the health of individuals and communities.

MHA's overarching recommendation is straightforward: **maintain the current vaccine categories unchanged and refer to the immunization schedule endorsed by the American Academy of Pediatrics (AAP) for guidance on vaccine administration and timing.** The existing approach is widely understood by providers, effectively implemented across healthcare settings, and supported by decades of clinical evidence.

[A] Current Categories Are Not a Barrier to Vaccine Administration

[A1, A2] Providers generally do not approach immunizations through formal "routine," "risk-based," or "shared clinical decision-making" categories. Rather, clinicians make vaccination decisions based on clinical evidence and patient care considerations, including disease and exposure risk, the timing and effectiveness of immunity, patient-specific factors, and the overall benefits and risks of vaccination. **Because the existing categories do not drive clinical practice or impede vaccine implementation, MHA strongly believes the categories should not be modified.** Doing so is unlikely to improve vaccination practices, uptake, or patient outcomes; three key factors that should be contemplated prior to making changes.

In particular, the "risked-based" and "SCDM" categories introduce confusion for the general public about the strength of the recommendation, and carelessly undermine the importance of life saving vaccines. Providers also elevate the question about liability around administration of "SCDM" vaccines and wonder if, and how, they might be subject to a medical malpractice suit if documentation isn't adequate or a patient feels pressured into accepting a vaccine from this category.

[B] Do Not Create Additional Recommendation Categories

[B4] **MHA strongly opposes the creation of new recommendation categories** as it will increase complexity of care and create unnecessary confusion for patients, families, providers and payers alike.

Brian Peters, *Chief Executive Officer*
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These changes could conceivably raise questions about what populations should receive the vaccine, whether insurance coverage is available, the importance of the vaccine, and imply that it is a weaker recommendation.

Additionally, the current vaccine categories are linked to CDC schedules, ACIP recommendations, state-level requirements such as school-entry vaccination policies, provider scope-of-practice rules, and the functionality of electronic health records and immunization information systems. Thes downstream implications of such a change are wide-reaching and would require significant time, effort, and financial resources to update. **Absent a clearly defined problem or evidence that a new framework would improve patient outcomes, vaccine uptake, or provider understanding, MHA does not believe changes to the categories are warranted.** Any modifications to existing categories should be supported by a compelling evidence base and a thorough assessment of operational, regulatory, and implementation impacts and not be pursued simply for the sake of restructuring a system that is currently functioning effectively.

A designation such as "recommended, but not during infancy" would be concerning because it risks undermining decades of evidence-based vaccine scheduling specifically designed around periods of greatest disease susceptibility and optimal immune response.

[B4] Similarly, when evaluating vaccine recommendations, **HHS should prioritize the extensive body of U.S.-based clinical evidence and surveillance data that support the current schedule**. Rather than focusing heavily on practices adopted by other countries or international peer bodies, federal policy should rely on the scientific literature and evidence base that informs recommendations developed by U.S. clinical experts.

Preserve the Current Immunization Schedule

MHA believes vaccine recommendations should remain grounded in scientific evidence, disease burden, vaccine safety and effectiveness, and population health impact.

The current immunization schedules endorsed by national physician organizations, including the American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP), are widely understood and successfully implemented across healthcare settings; with vaccines overwhelmingly administered according to recommended timelines. **MHA strongly urges HHS to adopt these vaccine standards and not make changes to vaccine timing or frequency outlined therein**, absent clear and compelling evidence demonstrating improved outcomes.

[C] Use Shared Clinical Decision-Making Sparingly

MHA recognizes the value of SCDM recommendations in limited circumstances where individual patient factors affect the balance of risks and benefits, but caution against broad expansion of the SCDM category.

[C11] Hospitals and providers already face significant time pressures during patient encounters, and expanding the number of vaccines subject to SCDM could create additional administrative burden, documentation requirements, and confusion regarding vaccine coverage.

[C13] Efforts to improve understanding of the SCDM category should focus on providing clear education for healthcare providers, ensuring consistent reimbursement policies by insurers, developing clinical decision support tools, and deploying patient-facing materials that clearly articulate the limited role SCDM has.

[E] Trust and Communication

MHA agrees with HHS that public trust is fundamental to successful immunization efforts. Data shows that patients and families place significant trust in recommendations from their physicians, nurses,

pharmacists, and *local* healthcare organizations.[1] Federal vaccine recommendation frameworks should support those conversations; not complicate them.

The most effective path forward is not to create additional categories or substantially revise longstanding schedules as mentioned previously, but to improve communication regarding existing recommendations and ensure that providers have the tools necessary to explain them clearly and confidently.

Conclusion

MHA appreciates the Department's efforts to evaluate how vaccine recommendations are categorized, communicated and implemented. **MHA believes the current framework of routine, risk-based, and shared clinical decision-making recommendations generally function well and should be retained without changes.**

The existing childhood immunization schedule is widely understood, appropriately implemented, and remains an effective tool for protecting children and communities from vaccine-preventable diseases. **Thus, MHA strongly urges HHS to preserve the current timing and administration recommendations endorsed by leading provider organizations.** No modifications should be made absent clear and compelling scientific evidence demonstrating improved patient outcomes.

Thank you for the opportunity to comment. MHA remains committed to expanding access to life-saving vaccines, minimizing administrative burdens and ensuring access to evidence-based medical information for patients and families. Please contact MHA Sr. Director, Health Policy, Kelsey Ostergren at kostergren@mha.org, with additional questions.

Sincerely,

Laura Appel
Executive Vice President, Government Relations & Public Policy

[1] *Who the Public Trusts For Health Information.* KFF.