STATEMENTS OF POLICY

Title 31—INSURANCE

INSURANCE DEPARTMENT

DEPARTMENT OF HEALTH

[31 PA. CODE CHS. 152 AND 301]

Health Maintenance Organizations and Preferred Provider Organizations

The Insurance Department and Department of Health (Departments) jointly adopt the statements of policy in Annex A and Annex B. These statements of policy outline the standards to be used by the Departments in reviewing filings for group specific community rating by Health Maintenance Organizations (HMOs), point-of-service products and Preferred Provider Organization (PPO) products with primary care gatekeeper requirements.

A point-of-service product is an HMO product that includes an option for the use of out-of-network providers. Choice of an out-of-network provider by the member results in out of pocket expenses to the member for deductibles, coinsurance and other limitations traditionally found in indemnity health insurance plans. This type of product may appeal to employer groups who are interested in the HMO product but do not want to restrict their employes' freedom of choice of provider to the extent required by a traditional HMO.

Group specific community rating will permit HMOs to vary their rates by group. This may appeal to employer groups who want more rate flexibility than permitted by current community rating requirements.

A PPO with a primary care gatekeeper would require an enrollee to obtain approval for treatment from a preselected primary care physician in order to receive a higher reimbursement level for expenses incurred. This may appeal to employer groups who are interested in limited managed care programs with broad freedom of choice of provider for employes and maximum rate flexibility.

Each of these managed care features may currently be in use in other states. HMOs and PPOs have approached the Departments for approval of these features for use in this Commonwealth. In April, 1991, the Departments issued a joint draft of a statement of policy addressing these three features. This draft proposed conditions under which these features might be considered for approval and sought comments from interested parties, including HMOs, PPOs, nonprofit insurers, commercial insurers, industry trade associations and employers.

Adoption of the statements of policy will improve the managed care marketplace for consumers by enhancing competition, consumer choice and cost containment. Adoption will also serve to improve the quality of filings for this type of product because of the publication of standards to be used by the Departments in the review of filings submitted by the managed care industry.

Purpose

The purpose of these statements of policy is to inform interested parties of the standards used by the Insurance Department and the Department of Health in the review of point-of-service products, group specific community rating and PPO primary care gatekeeper products.

These statements of policy will expedite the offering of these new products to Commonwealth consumers and enhance managed care competition in this Commonwealth.

While the Departments now interpret the HMO and PPO Acts to permit the offering of these products/features, they also recognize the need for reasonable limitations and oversight of each product offering.

In the case of point-of-service products, the Departments believe that the primary business of an HMO should remain providing and financing basic health care services through the HMO's own organized health service delivery system and primary care physician network.

Therefore, the statement of policy addresses the following issues:

1) Member usage of nonparticipating providers.

2) Increased financial risk associated with payment of indemnity claims.

3) Protection of continuity of care.

4) Assurance of adequate disclosure of limitations and conditions.

In the case of group specific community rating, the Insurance Department recognizes the lack of experience of the HMO industry in the use of this rating methodology. To be consistent with the Federal government, the Insurance Department has chosen the methodology proposed by the Health Care Financing Administration for use in this Commonwealth. Modifications to the Federally proposed methodology were made to be consistent with the intent to place reasonable limits on the use of this rating methodology to protect the financial solvency of HMOs and Pennsylvania consumers.

In the case of PPOs with primary care gatekeeper requirements, significant quality of care issues arise primarily due to a reduction of access to care. The use of primary care gatekeepers by PPOs creates arrangements or provisions which may lead to under treatment or poor quality care. The statement of policy establishes a delivery system and quality of care oversight standard equivalent to that currently in place for HMOs.

Form and Effect

These statements of policy provide guidance regarding the standards to be used by the Departments in the review of point-of-service products, group specific community rating by HMOs and PPO products with primary care gatekeeper requirements. These statements of policy do not constitute a rule or regulation entitled to the force and effect of law.

Fiscal Impact and Paperwork Requirements

HMOs offering point-of-service products and using group specific community rating will be assuming increased financial risk beyond that currently associated with HMO operations in this Commonwealth. To protect consumers, HMOs that wish to offer these products and use these rating methodologies must meet higher finan-

For details relating to fiscal notes see the box at the bottom of the first page of the **Proposed Rulemaking** heading of the *Pennsylvania Bulletin*.

cial reserving requirements. Because of the increased potential for quality of care problems with PPOs that require use of primary care gatekeepers, appropriate quality of care monitoring is necessary.

The changes to product offerings as a result of these statements of policy will allow the industry to meet the demands of employers or unions, or both, for these new features. This should also lead to increased membership in managed care programs. Any increased cost in implementing and regulating these changes should be outweighed by the overall savings that should be realized by consumers in their health care costs. There will be less time necessary for an HMO or PPO to research the Department's standards prior to developing and submitting a product filing. Additionally, there should be a corresponding reduction in time required by the Department's staff persons in reviewing the product submissions. However, necessary delivery system and quality of care oversight of gatekeeper PPO products will substantially increase the workload of the Department of Health.

Further Information

Persons desiring more information regarding these statements or policy should contact Arthur J. Sconing, Supervisor, Division of HMOs/PPOs, Accident and Health Bureau, Insurance Department, Room 1311, Strawberry Square, Harrisburg, Pa. 17120, (717) 787-7701 or Stephen Male, Director, Bureau of Health Financing and Program Development, Department of Health, Room 1026 Health and Welfare Building, P. O. Box 90, Harrisburg, Pa. 17108, (717) 787-5193.

Effective Date

This statement of policy is effective immediately upon publication in the *Pennsylvania Bulletin*.

(*Editor's Note*: Title 31 (Insurance) is amended by adding two statements of policy. The first statement of policy is added at §§ 301.201—301.204 as set forth in Annex A. The second statement of policy is added at §§ 152.101—152.105 as set forth in Annex B. Interested parties also may wish to refer to the Department of Health HMO regulations found at 28 Pa. Code Chapter 9).

CONSTANCE B. FOSTER,
Insurance Commissioner
CARL F. FONASH,
Acting Secretary of Health

Fiscal Note: 11-98. No fiscal impact; (8) recommends adoption. This statement of policy will not increase costs to the Insurance Department. It may require a redistribution of existing administrative responsibilities within the Department of Health to provide the necessary oversight of gatekeeper PPO products.

Annex A

TITLE 31. INSURANCE

PART X. HEALTH MAINTENANCE ORGANIZATIONS

CHAPTER 301. HEALTH MAINTENANCE ORGANIZATIONS

Subchapter G. POINT-OF-SERVICE PRODUCTS GROUP SPECIFIC COMMUNITY RATING—STATEMENT OF POLICY

Sec.
301.201. General.
301.202. Financial requirements-point-of-service products.
301.203. Filing requirements.
301.204. Group specific community rating for HMOs.

§ 301.201. General.

An HMO point-of-service product filing or a group specific community rating filing complying with standards in this chapter is acceptable.

§ 301.202. Financial requirements-point-of-service products.

(a) *Minimum net worth compliance.*

(1) HMOs offering point-of-service products will be assuming additional indemnity-type financial risk. To adequately protect HMO members enrolled in point-of-service products and to ensure HMO ability to pay indemnity claims for covered services rendered by out-of-network providers, each HMO desiring to offer a point-of-service product shall first present satisfactory evidence of having a minimum net worth of the highest of $1.5 million of 2% of premiums, or an amount equal to the sum of 3 months uncovered health care expenditures as reported on the most recent financial statement filed with the Insurance Department. The evidence shall be presented to the Insurance Department's Bureau of Licensing and Financial Analysis, Office of the Regulation of Companies.

(2) Upon satisfactory compliance with this requirement, an HMO may then make an appropriate program filing with the Department's Office of Rate and Policy Regulation, Division of HMOs/PPOs and to the Bureau of Health Financing and Program Development of the Health Department.

(b) *Adequate reserving requirements.*

(1) An important component of financial integrity of a point-of-service product is the ability of an HMO to monitor adequately incurred but not reported claims (IBNR) and adequately reserve for the liabilities.

(2) An HMO receiving approval to offer a point-of-service product shall establish and maintain specified reserves for uncovered expenditures—that is, expenditures owed to nonparticipating providers not having contracts with the HMO which includes NAIC/NAHMOR financial hold harmless language—greater than the most recent 3 months of out-of-network (swing out) claims paid.

(3) Each HMO gaining approval to offer a point-of-service product shall submit to the Department's Bureau of Licensing and Financial Analysis on a quarterly basis evidence that it has met this requirement and established sufficient reserves.

(4) The Department and the Department of Health (the Departments) may suspend the HMO's authority to enroll additional members in point-of-service products if it fails to maintain the minimum net worth requirements as set forth in subsections (a) and this subsection. Failure of the HMO to correct a reserve deficiency promptly may result in withdrawal of its authority to offer a point-of-service product.

(c) *Limits on out-of-network usage/expenses.*

(1) It is the Department's interpretation of the act that, while HMOs may be permitted to offer point-of-service products, the primary business of an HMO should remain the provision and financing of basic health services through the HMO's organized health services delivery system centered around each member's voluntarily selected primary care physician (PCP).

(2) Therefore, the Departments are establishing a 10% target limit for out-of-plan usage.

(3) The 10% target limit shall be calculated as follows for each reporting period:

Total point-of-service out of network claims incurred by the HMO for the reporting period.
Divided by:

Total of all claims incurred by the HMO for the reporting period.
Equals:
The target percentage

(i) The target percentage shall be calculated and reported to the Departments on a quarterly basis.

(ii) If the target percentage exceeds 10%. The HMO shall include with its submission of the target percentage calculation:

(A) An explanation of why and how out-of-plan utilization has exceeded 10%.

(B) What steps will be taken during the following reporting period to bring out-of-plan utilization to within the target percentage.

(iii) The Departments may suspend the HMO from enrolling additional members in the point-of-service product if the target percentage exceeds 10% for more than 3 consecutive quarters.

(iv) The Departments will compare reported estimated expenditures with actual expenditures. Variations between estimated and actual expenditures may result in suspension of the HMO's authority to offer a point-of-service product.

§ 301.203. Filing requirements.

(a) Along with the submission of adequate reserving methodology, an HMO shall submit a formal product filing to the Division of HMOs/PPOs of the Department and the Bureau of Health Financing and Program Development of the Department of Health.

(b) HMOs will be permitted to offer a point-of-service product subject to the following conditions.

(1) Filing requirements—all products:

(i) Two copies shall be submitted to each Department.

(ii) The filing shall include an appropriate rate filing.

(iii) The filing should contain incentives for HMO members to utilize basic HMO services, stay within the HMO panel of participating providers, and utilize the services of designated primary care physicians. Minimum requirements for indemnity reimbursement for out-of-network claims should be:

(A) Minimum deductible of $250 per individual/$500 per family per calendar year.

(B) Minimum coinsurance of 20%.

(C) Total out-of-pocket expenses for use of nonnetwork providers should be in the following ranges:

(I) Individual annual out-of-pocket expense, excluding calendar year deductible: minimum—$2,000; maximum—$5,000.

(II) Family annual out-of-pocket expense, excluding calendar year deductible: minimum—$4,000; maximum—$10,000.

(III) The lifetime maximum for point-of-service out-of-network claims per person shall be at least $250,000.

(iv) Clear and adequate disclosure is an absolute necessity because of the complexity of the point-of-service product and great potential for enrollees to misunderstand it. The evidence of coverage shall contain adequate disclosure of coverage limitations and conditions, including member liability for deductibles, copayments and differences between the HMO's UCR reimbursement and actual charges of out-of-network providers.

(v) Primary care services shall only be reimbursable within the HMO network when rendered at or by direction of the member's primary care physician. Primary care services shall be services which the primary care physician is requested to provide under the provisions of the contract with the HMO.

(vi) An HMO may require precertification of out-of-network nonemergency hospital admissions.

(vii) Emergency coverage shall be provided under provisions of the basic HMO coverage without application of out-of-network deductibles or coinsurance.

(viii) The filing shall include an explanation of how the HMO will meet its continuity of care requirements under the act and 28 Pa. Code (relating to Health and Safety).

(ix) The HMO shall require that either the member's PCP or the HMO itself issue a claim form or other notice for use by the member in claiming reimbursement for out-of-network care. The claim form or other notice shall be submitted for review and approval of the Departments and the Department of Health. The claim form or notice shall require the signature of the member and contain adequate disclosure that the member understands that by voluntarily seeking care out-of-network the member is assuming substantial financial liability for the care, and that the care if provided within the HMO network would be provided at a much lower out-of-pocket expense to the member.

(x) The HMO is responsible for furnishing claims information to the primary care physician concerning the member's usage of out-of-network health services. The objective of this requirement is to provide critical information to the patient's primary care physician so that when the member returns in-network, the PCP has adequate knowledge to maintain continuity of care.

(xi) Other methods to accomplish the objective in subparagraph (x) may be proposed in the filing and will be reviewed on a case by case basis.

(xii) An information system shall be included by which the HMO will track the claims payments by PCP for out-of-network services. The HMO shall commit itself to monitoring out-of-network usage and to promptly investigate any PCP practice whose enrolled members are utilizing substantially higher levels of out-of-network care than average. Therefore, written policies and procedures shall be included in the filing to ensure that PCPs are not subtlety or otherwise encouraging members to use out-of-network providers.

(xiii) The filing shall describe in detail the HMO's claims payment system. This description shall include staffing for paying out-of-network indemnity claims and capability for establishing adequate tracking, estimation and reserving for incurred but not reported claims.

(xiv) The HMO's data/information system shall be capable of paying out-of-network claims in a timely manner, tracking incurred but not reported expenses, adequately forecasting projections, calculating the 10% limit, adequately interfacing between membership and eligibility files and between the HMO's systems and those of an applicable affiliated insurer, and generating required Department reports.

(iv) Nongroup conversions are not required to include a point-of-service benefit.

(v) Approvals for point-of-service products will be subject to a 1-year probationary period during which time the HMO will have to establish a track record of successfully administering a point-of-service product. During the 1-year probationary period, enrollment in the point-of-service may not exceed 5% of the HMO's private sector enrollment.

(b) Additional filing requirements for products in which the out-of-network indemnity benefits are to be underwritten by an HMO affiliated insurer, which is any carrier other than the HMO itself proposing to supplement the HMO's standard coverage by providing out-of-network benefits are:

(1) The filing shall be made by the HMO.

(2) The filing shall include:

(i) Copies of the previously approved group contract and certificate.

(ii) Copies of amendments necessary or desirable thereto to integrate the services to be provided by the HMO and paid for by the affiliate insurer.

(iii) Copies of the affiliated insurers group master contract and certificate.

(iv) Enrollment material and enrollee literature.

(v) The certificates and enrollee literature that adequately explain how the program will operate.

(vi) A copy of the contract between the HMO and affiliated insurer detailing their respective responsibilities and obligations in offering a point-of-service product.

(3) The HMO shall include in its rate filing the rate level justification and a demonstration of how the out-of-network indemnity benefits to be provided by the affiliated insurer will impact on the HMO's rates and underlying utilization assumptions.

(4) To lessen confusion on the part of members, out-of-network claims shall be initially filed with the HMO. Additionally, the member point of contact regarding out-of-network benefits shall always be with the HMO.

(5) Grievances, including those concerning coverage or claim denial under the out-of-network benefit program, shall be subject to and decided by the HMO's approved grievance system and procedures.

(6) The affiliated insurer and joint product shall comply with this subchapter except for the financial reserving requirements of § 301.202(b) (relating to financial requirements—point-of-service products).

(7) The HMO is responsible for utilization management activities, not the affiliated insurer.

§ 301.204. Group specific community rating for HMOs.

(a) HMOs will be permitted by the Department to use group specific community rating subject to the methodology in the proposed regulations published by the Health Care Financing Administration in *Federal Register*, Vol. 56, Number 133 at page 31597, July 11, 1991 (to be codified at 42 CFR 417.104(b)(2)(ii)) or in a final adopted regulation if there is a change in this section.

(b) In addition to the Federal standards, an HMO shall also meet the following conditions to use group specific community rating in this Commonwealth:

(1) The HMO shall demonstrate that it has the capability to capture claims data on a group specific basis.

(2) Group specific community rating will only be applicable to groups that have an enrollment in the HMO of at least 250 employes for the most current 12-month period. An HMO may set the minimum size requirement at a higher level than 250 enrolled employes. The minimum size requirement applies to each HMO product sold to the group.

(3) Once an HMO elects to use group specific community rating, it shall use the method for all groups that meet the minimum size requirement established by that HMO and approved by the Department.

(4) The HMO shall have covered the group for at least 36 consecutive months.

Annex B

TITLE 31. INSURANCE

PART VIII. MISCELLANEOUS PROVISIONS

CHAPTER 152. PREFERRED PROVIDER ORGANIZATIONS

PRIMARY CARE GATEKEEPER PPO PRODUCTS—STATEMENT OF POLICY

Sec
152.101 Scope.
152.102 Definitions.
152.103 HMO and PPO differentiation.
152.104 Filing requirements.
152.105 Delivery system and quality of care oversight.

§ 152.101. Scope.

A PPO product filing by an approved PPO complying with this chapter is acceptable. A preferred provider agreement filing by a nonprofit hospital corporation or a nonprofit professional health service plan corporation, or both, otherwise complying with 40 Pa.C.S. Chapters 61 or 63, or both (relating to rules of evidence; juvenile matters) and complying with this chapter is acceptable.

§ 152.102. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Gatekeeper product—A product offered by a PPO which requires an enrollee to preselect a particular primary care physician from among a list of participating primary care physicians, and to receive from the physician, as a condition for receipt of a higher level of benefits or reimbursement level, or both, referrals for nonemergency specialty, hospital and other services.

ERISA-exempt PPO—A PPO which, in accordance with § 152.3(d) (relating to content of an application for approval), has submitted and received joint Department and Department of Health approval of an ERISA-exemption certificate.

HMO—Health maintenance organization.

PPO—Preferred provider organization.

Passive gatekeeper product. A product offered by a PPO which does not require an enrollee to preselect a particular primary care physician, but requires, as a condition for receipt of a higher level of benefits or reimbursement level, or both, that an enrollee receive care from or a referral from a participating preferred primary care physician. The products are permissible if their restrictions are adequately disclosed to enrollees and receive appropriate approval of the Department. However, since they do not lock enrollees into use of a particular primary care physician, they are not subject to

§§ 152.101, 152.103—152.105 and this section (relating to primary care gatekeeper PPO products—statement of policy).

§ 152.103. HMO and PPO differentiation.

(a) *General.* Under the time provisions of § 152.8 (relating to compliance with Health Maintenance Organization Act (40 P. S. §§ 1551—1567)), the Secretary of Health will determine when a PPO is engaging in the business of an HMO and required to seek licensure as such. The use of a primary care gatekeeper is a feature associated with HMOs, and is a required feature, under Department of Health HMO regulations at 28 Pa. Code Chapter 9 (relating to health maintenance organizations) of licensed HMOs. A PPO using a primary care gatekeeper feature, otherwise meeting the standards of this chapter, will not be considered an HMO by the Secretary or be required to obtain an HMO certificate of authority prior to commencement of operations if it meets the following standards:

(1) Preferred primary care physicians are reimbursed solely on a fee-for-service basis.

(2) Preferred primary care physicians are not at financial risk for the provision for health service utilization to enrollees through use of risk incentive withhold pools or other means of financial reward for utilization control.

(3) The PPO is not an exclusive provider organization.

(b) *Exception.* A PPO will be permitted to utilize primary care gatekeepers which are capitated or at financial risk, or both, if the primary care gatekeeper services are being offered under a subcontract between the PPO and an affiliated licensed HMO, if:

(1) The provisions of the subcontract are acceptable to the Departments and the Department of Health.

(2) The HMO's quality assurance systems, and similar consumer protection measures are extended to the PPO enrollees in a manner found acceptable by the Department of Health.

§ 152.104. Filing requirements.

(a) A PPO desiring to offer a gatekeeper product shall submit a formal product filing to the Division of HMOs/PPOs of the Department and the Bureau of Health Financing and Program Development of the Department of Health. Two copies shall be filed with each Department and shall include:

(1) The group master policy, certificate and enrollee literature. Adequate primary care benefits shall be provided when an enrollee seeks care from the enrollee's primary care physician. Copayments may not be so high as to act as a barrier to an enrollee's use of the primary care physician.

(2) Initial rates and rating methodology.

(3) Copies of preferred provider contracts, which should contain features required by the Department of Health in HMO contracts, including:

(i) NAIC/National Association of HMO Regulators enrollee hold harmless language.

(ii) A provision for a preferred provider to participate in activities of and abide by the decisions of the PPO's quality assurance and utilization review committee.

(iii) A provision for a preferred provider to cooperate [illegible] and abide by the decisions of the PPO's enrollee

(iv) A provision for the preferred provider to abide by PPO rules and regulations for preferred providers, including those regarding hospital privileges, credentialing, in-office reviews and similar rules.

(v) A provision for the provider to provide the PPO and the Department of Health with access to enrollee medical records for the purposes of quality oversight and grievance resolution.

(vi) A provision for immediate termination of participation and preferred status if the provider is found to be harming patients.

(4) Provisions of the proposed quality assurance and utilization review systems, including staffing and professional qualifications of the medical director, quality assurance, utilization review and provider relations staff.

(5) A description of the proposed grievance system.

(6) A description of the PPO's ability to collect data and meet the annual and quarterly reporting requirements of the Department of Health.

(7) A copy of a notice form to be used when an enrollee seeks care without first obtaining a referral from the enrollee's primary care physician, adequately disclosing the benefit or reimbursement advantages, or both, of seeking care by or through the enrollee's primary care physician.

(b) As is the usual and customary practice of the Department and the Department of Health, the filing will be approved by joint approval letter, and no final approval action will be taken by either Department until both Departments complete their review and find the application to be acceptable.

§ 152.105. Delivery system and quality of care oversight.

(a) The use of a gatekeeper product by a PPO restricts enrollee freedom of provider choice and is an arrangement which may lead to undertreatment or poor quality care, since enrollee access to specialty and other needed care is restricted. Gatekeeper PPOs, in order to adequately address the issue of potential undertreatment or poor quality care and to protect their enrollees, and in return for the privilege of being permitted use of gatekeepers, shall:

(1) Establish and maintain compliance with the same Department of Health standards regarding quality of care oversight as required of HMOs in 28 Pa. Code §§ 9.74, 9.75 and 9.93 (relating to quality assurance system; assurance of access to care; and external quality assurance assessment).

(2) Establish and maintain compliance with the same Department of Health standards regarding enrollee grievance systems as required of HMOs in 28 Pa. Code § 9.71 (relating to subscriber grievance systems).

(3) Establish and maintain data systems capable of making quarterly and annual reports to the Departments substantially equivalent to those required of HMOs as found in 28 Pa. Code §§ 9.91 and 9.92 (relating to annual reports; and quarterly reports).

(4) Submit and receive prior approval from the Department and the Department of Health of advertising, marketing and enrollee literature which adequately explains the role of the primary care gatekeeper and the limitations of coverage.

(5) Submit evidence of compliance with the Department of Health's accessibility and availability standard[illegible] established for HMOs, and evidence of

sufficient trained and experienced staff to monitor and control the delivery system on an appropriate local or regional basis.

(b) In applying the HMO standards to gatekeeper PPOs the Department of Health may take into consideration the fact that HMOs are independent entities while PPOs may be product lines of insurers.

[Pa.B. Doc. No. 91-1917. Filed September 27, 1991, 9:00 a.m.]

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 1241]

EPSDT Immunization Guidelines

Purpose

This statement of policy provides revised immunization guidelines for use in serving recipients during Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examinations.

Scope

This statement of policy applies to EPSDT certified providers.

Background

On January 18, 1991, the Department issued EPSDT Program Bulletin 1241-90-03, which revised EPSDT Immunization Guidelines.

Through recent information provided by representatives of the American Academy of Pediatrics (AAP) and as a result of their recommendations, the Department is issuing revised immunization guidelines to reflect changes in the recommended schedule for Haemophilus B Diphtheria Toxoid Conjugate Vaccine (HbCV).

Effective Date

This statement of policy shall take effect upon publication in the *Pennsylvania Bulletin*.

(*Editor's Note*: The regulations of the Department of Public Welfare, 55 Pa. Code Chapter 1241, are amended by amending Appendix D to read as set forth in Annex A.)

KAREN F. SNIDER,
Acting Secretary

Fiscal Note: 14-SOP-12. (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE

CHAPTER 1241. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT PROGRAM

APPENDIX D

EPSDT IMMUNIZATION GUIDELINES—STATEMENT OF POLICY

When performing EPSDT screening examinations, the following schedules should be used when providing immunizations.

1. Recommended Schedule for Active Immunization of Normal Infants and Children*

Recommended Age	Immunization(s)+	Comments
2 Mo.	DTP, OPV HBOC or PRP-OMP++	Can be initiated as early as age 2 wk. in high endemic areas or during epidemics
4 Mo.	DTP, OPV HBOC or PRP-OMP++	2-mo. interval desired for OPV to avoid interference with previous dose
6 Mo. 12 Mo.	DTP HBOC++ PRP-OMP++	A third dose of OPV is not indicated in the United States but is desirable in geographic areas where polio is endemic
15 Mo.	Measles, mumps, rubella (MMR) HbCV++	MMR preferred to individual vaccines; tuberculin testing may be done at the same visit
18 Mo.	DTP**§ OPV°	See footnotes
4-6 Yr.	DTP***, OPV	At or before school entry
10-12 Yrs.	Measles, mumps, rubella (MMR)****	MMR vaccination at entrance to middle school or junior high school
14-16 Yr.	Td	Repeat every 10 yr. throughout life

*For all products used, consult manufacturer's package insert for instructions for storage, handling, dosage and administration. Biologicals prepared by different manufacturers may vary, and package inserts of the same manufacturer may change. Therefore, the physician should be aware of the contents of the current package insert.