MEDICAID WORK AND COMMUNITY REQUIREMENTS: ARKANSAS EXPERIENCE

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09.22.21

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MEDICAID EXPANSION IN ARKANSAS

- Original legislation: Health Care Independence Program of 2013 (“Private Option”)
  - Premium assistance for private/commercial insurance
  - Pays providers commercial rates
  - Federal waiver through December 2016
- 2016 special session decision to continue as “Arkansas Works”
  - Emphasized work opportunities, personal responsibility; encouraged employer-based insurance

2017 'ARKANSAS WORKS': GOVERNOR'S PROPOSED CHANGES

- Cap Medicaid eligibility at 100% FPL (change from 138% FPL)
  - NOT APPROVED
- Eliminate 90-day retroactive coverage
  - APPROVED at 1-month limit
- Work and community engagement requirements (WCER) for adults — APPROVED
  - Phased approach
  - Exemptions (student, caretaker, etc.)
  - Online portal to register work activity

WCER TIMELINE: KEY DATES

May 4, 2017

Work and community engagement requirement for Arkansas Works enrollees passed by Arkansas General Assembly.

March 5, 2018

Centers for Medicare & Medicaid Services approves waiver amendments, including work requirement.

June 1, 2018

Work requirement reporting begins for new enrollees ages 30-49 (100% FPL and below).

September 1, 2018

First terminations occur due to non-compliance with work reporting requirements.

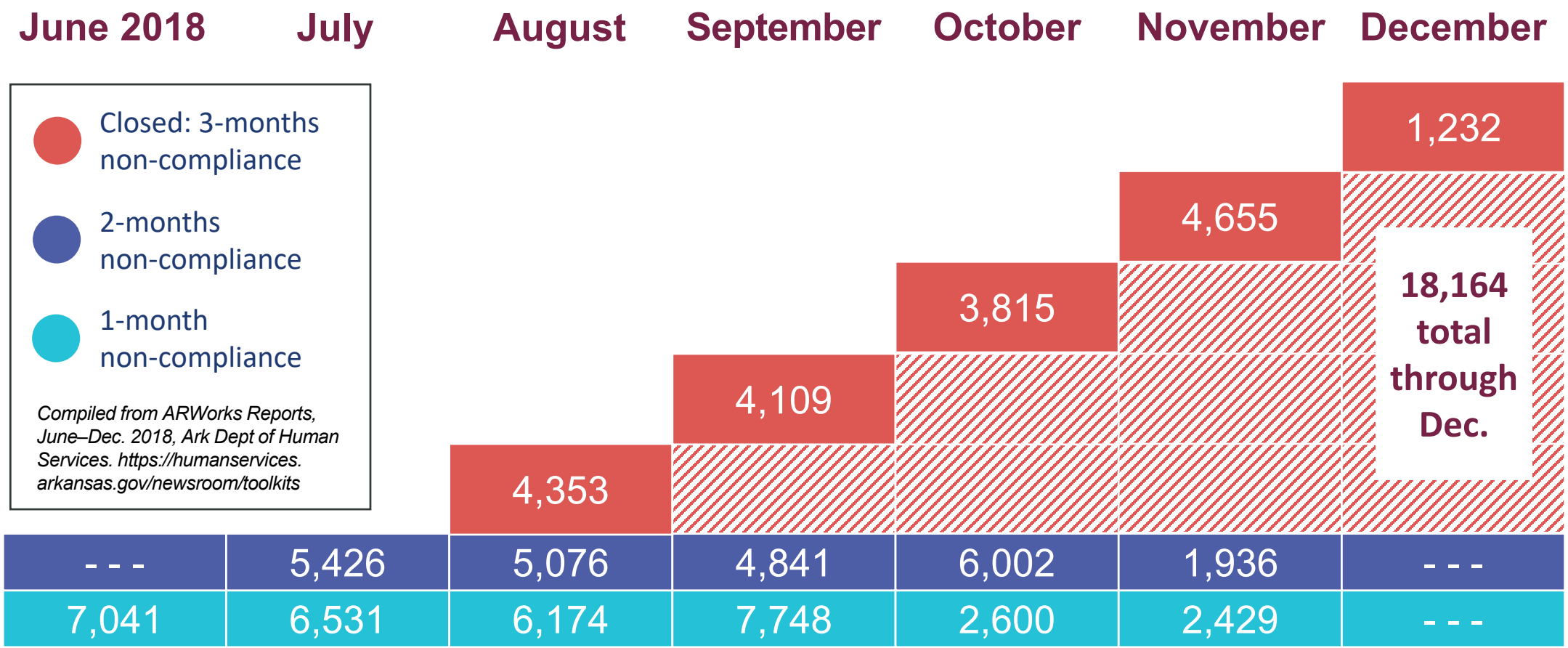
January 1, 2019

Work requirement applies to all enrollees ages 19-49 (up to 138% FPL).

March 27, 2019

D.C. district judge's ruling halts Arkansas's work and community engagement requirement for Medicaid.

ENROLLEES NOT MEETING WCER IN 2018 (PER REPORTING PERIOD)



ACHI WCER ASSESSMENTS

- Funded by RWJF Transforming Health & Health Care Systems
  - Qualitative phone interviews
    - Selected 100 organizations from DHS Resource Guide
    - Urban and rural counties in five public health regions
  - Assessment of change in actuarial risk due to WCER
  - Differential impact of WCER on people in counties with high unemployment
  - Re-enrollment following lock-out period
- Assessment of coverage procurement by individuals terminated due to WCER/change in income

WCER OUTREACH EFFORTS, APRIL–DEC. 2018

Includes DHS, AFMC, insurers, DWS

- Phone calls: 230,307
- Letters: 592,102
- Emails: 311,934
- Text Messages: 38,766
- Social Posts: 918

Source: Arkansas Works Program, December 2018 Report, Arkansas Department of Human Services.

COMMUNITY RESPONSE REPORT FINDINGS

- Consistent with previous practices in premium assistance approach, the state relied heavily on QHPs
  - Most successful communication routes were by phone, text, or email but reached only a small number of enrollees
  - Population frequently changed addresses
  - Significant confusion among enrollees
    - Did WCER apply to them?
    - How to navigate online portal (Dec. 2018—DHS began allowing phone reporting)
    - How to meet the WCER

Source: Arkansas Works Program, December 2018 Report, Arkansas Department of Human Services.

COMMUNITY RESPONSE REPORT FINDINGS

- Of 100 community organizations selected to be interviewed (from DHS resource list), 68 contact attempts were unsuccessful
- Of 32 who agreed to interview:
  - Fewer than 10 reported capacity to provide assistance, and even fewer reported that they had received calls for assistance
  - Organizations in rural areas reported greater barriers to meeting WCER, although some (particularly in urban areas) expressed strong opinions that those seeking employment would be able to find it

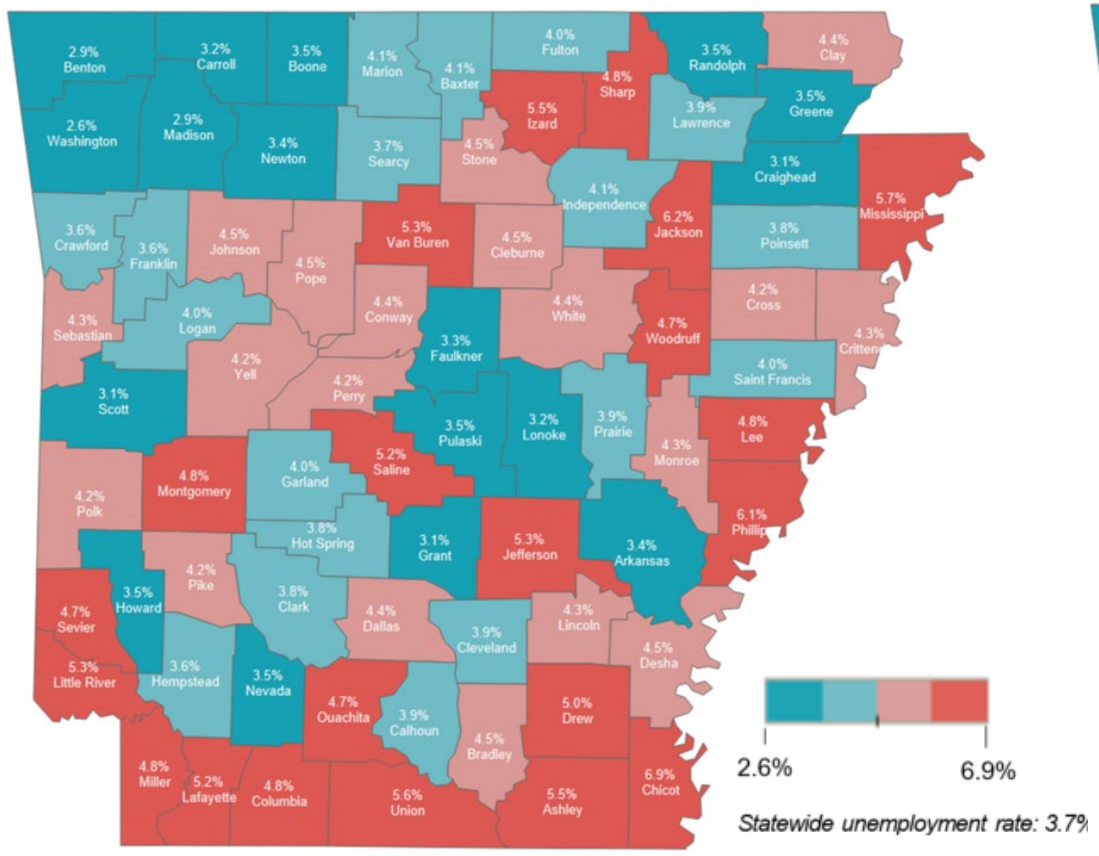
Source: Arkansas Works Program, December 2018 Report, Arkansas Department of Human Services.

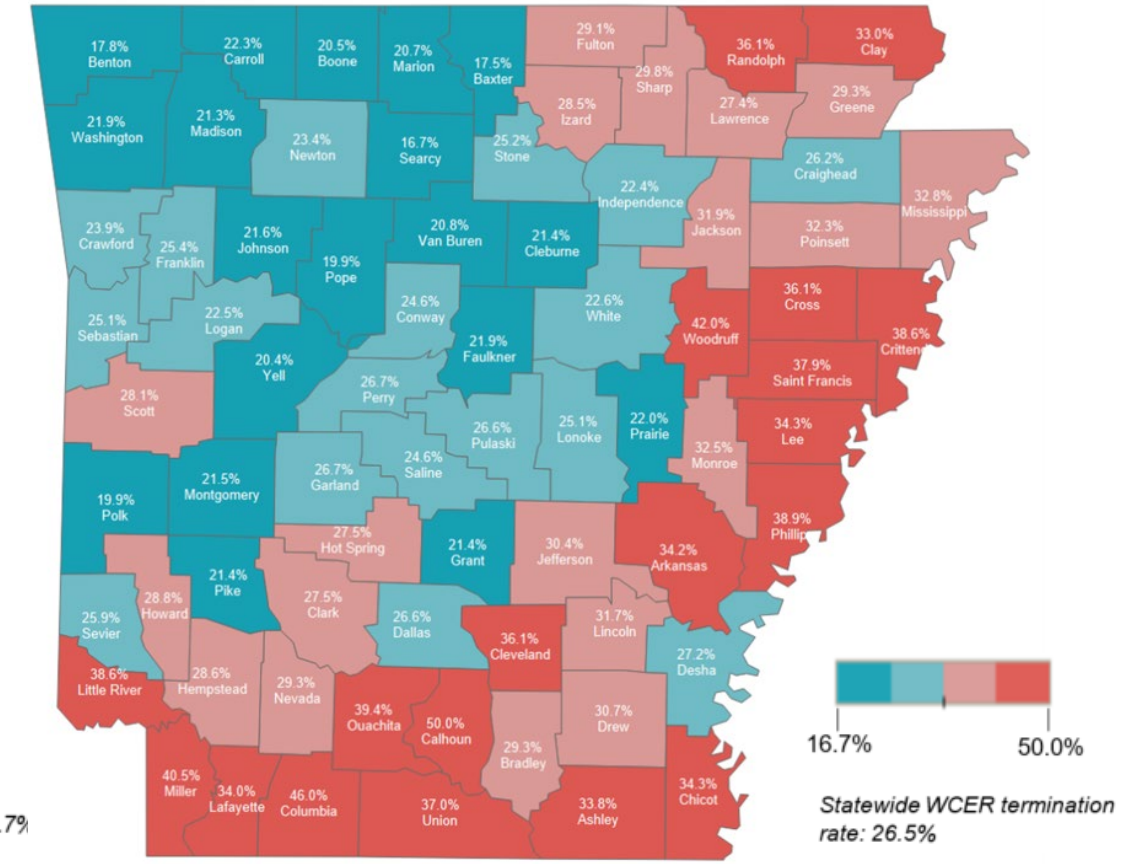
ACTUARIAL RISK REPORT FINDINGS

- Lower actuarial risk among enrollees who were terminated due to WCER non-compliance compared to all enrollees who were subject to WCER
- Considerably higher actuarial risk among enrollees who re-enrolled following termination due to WCER non-compliance compared to those who did not re-enroll
- Combination of termination of enrollees with lower actuarial risk and subsequent re-enrollment of individuals with higher actuarial risk worsened the aggregate risk profile — that is, increased average risk

Source: Arkansas Works Program, December 2018 Report, Arkansas Department of Human Services.

ACTUARIAL RISK REPORT FINDINGS





Source: Arkansas Works Program, December 2018 Report, Arkansas Department of Human Services.

WHERE (AR) WE NOW?

- *Becerra v. Gresham*
  - Dec. 2020 — SCOTUS agrees to hear AR case; schedules oral argument for March
  - Feb. 2021 — State gets notice of commencement of withdrawal of approval; DOJ asks SCOTUS to cancel oral argument
  - March 2021 — CMS formally withdraws approval; SCOTUS cancels oral argument
  - Pending briefings on decision to vacate lower court rulings
- AR Health and Opportunity for Me (ARHOME) waiver currently under CMS review

Source: Arkansas Works Program, December 2018 Report, Arkansas Department of Human Services.

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People Who Use Drugs, Medicaid, and Policy Churn

Nicolas Terry, Hall Render Professor of Law
& Executive Director, Hall Center for Law and Health
Indiana University Robert H. McKinney School of Law

Financial or Other Disclosures

I have no actual or potential conflict of interest in relation to this presentation

What a Difference a Year Makes?

2020

(1) The SUPPORT for Patients and Communities Act (H.R. 6) of 2018 provided substantial (albeit inadequate) funding for SUD yet in some ways seemed to signal federal “Mission Accomplished” moment with ongoing responsibilities pushed to states, notwithstanding that the opioid overdose state of emergency continues to be renewed , the most recent being July 7, 2021

(2) Not enough states have expanded Medicaid

(3) Conservative-favored “skin-in-the game” expansion “carrots” offered by the Obama Administration and work requirements offered by the Trump Administration not only reduced the Medicaid-eligible population but likely disproportionally impacted PWUD

(4) Existential threat to Medicaid and SUD funding as the Trump Administration encouraged states to convert from FMAP to block grants that inevitability would reduce eligibility or benefits

2021

(1) A few more states have expanded Medicaid, but not highly populated states (TX, GA, FL, NC)

(2) Starting in 2020 litigation and COVID-19 “maintenance of effort” Medicaid boost froze work requirement attacks on Medicaid .Biden Administration completing the work of the courts in unraveling unlawful requirements and block grant waivers

(3) American Rescue Plan Act of 2021 and possible Budget Reconciliation funding plan hint at the promise of reducing poverty and increasing access to health care but will changes be permanent?

(4) Substance use and the growing overdose death rate requires a major rethink of the social determinants, post-industrial employment, and the health care system but faces a governing party without a workable majority to enact major change.

Medicaid Pros & Cons

- There is a strong correlation between PWUDs and those eligible for Medicaid
- During a state of emergency the funding mechanisms for both original and expanded Medicaid allow for hard hit states to increase their expenditures on opioid interventions knowing that the federal government will cover a disproportionate share of the costs
- Because the Medicaid model funding is counter cyclical, states can rely on federal funding and their own reserves during times of economic downturn when unemployment can increase, often adversely impacting marginalized communities
- Arguably Medicaid MCOs are the best chance for persons upon release from corrections to have a warm handoff into community care
- Medicaid comes complete with a waiver process whereby the federal government can approve state demonstration projects, such as for improving social determinants

Medicaid Pros & Cons

- Even when functioning properly Medicaid's application processes, eligibility rules, and benefit limitations are structural determinants that impede access to needed diagnosis, treatment, and recovery services

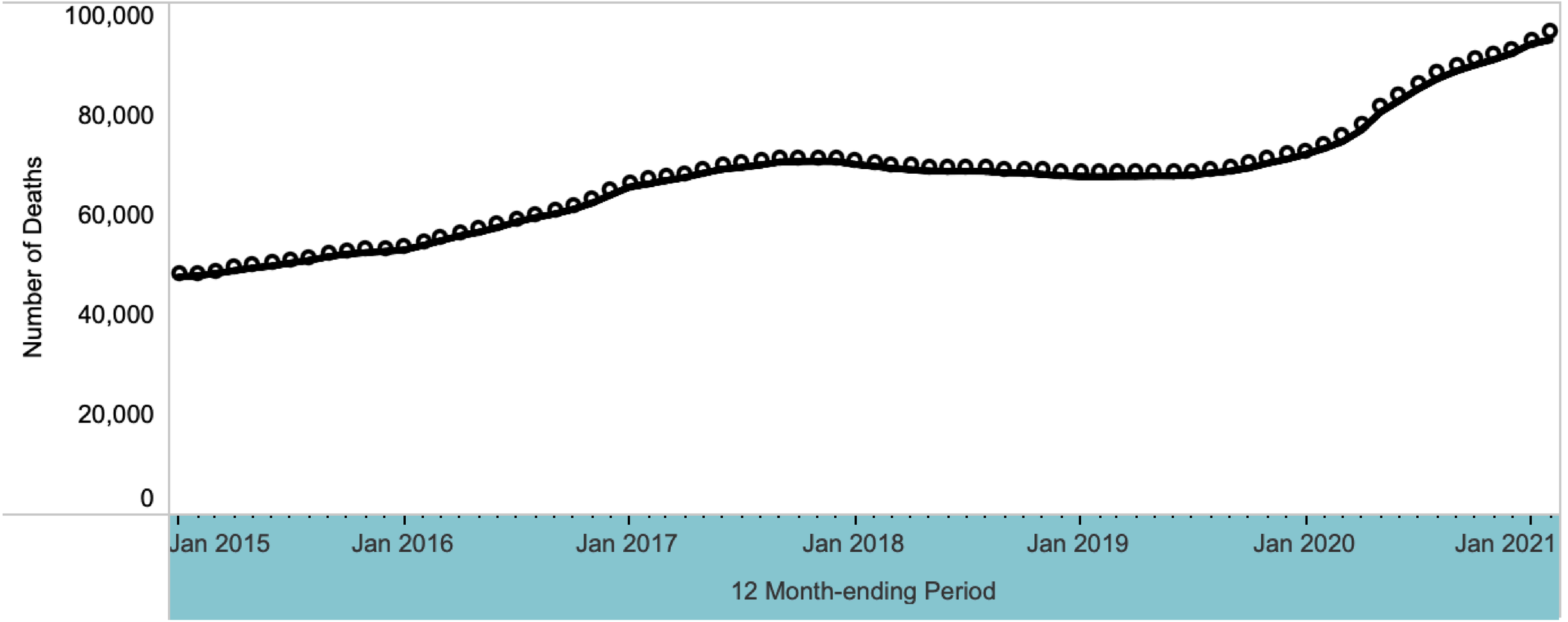
- The politicization and policy churn surrounding Medicaid suggest a perilous future for PWUDs who rely on it. The ACA's Medicaid expansion removed one structural determinant by increasing the Medicaid-eligible population. However, 12 states still refuse to expand Medicaid and the enhanced match that comes with it

  - Both expansion and non-expansion states have sought to reduce eligibility by adopting work requirements or changing to block grant funding; moves likely to adversely impact PWUDs. Lawsuits and "maintenance of effort" provisions in COVID-19 emergency legislation froze those efforts and those waivers are now being unwound by the new Administration

  - The seemingly inexorable churn of U.S. policy-politics and the episodic nature of funding for state SUD services re-emphasize the open question of how best to deal with the millions of persons without insurance, many of whom are PWUDs.

Based on data available for analysis on: 9/5/2021

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States



https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

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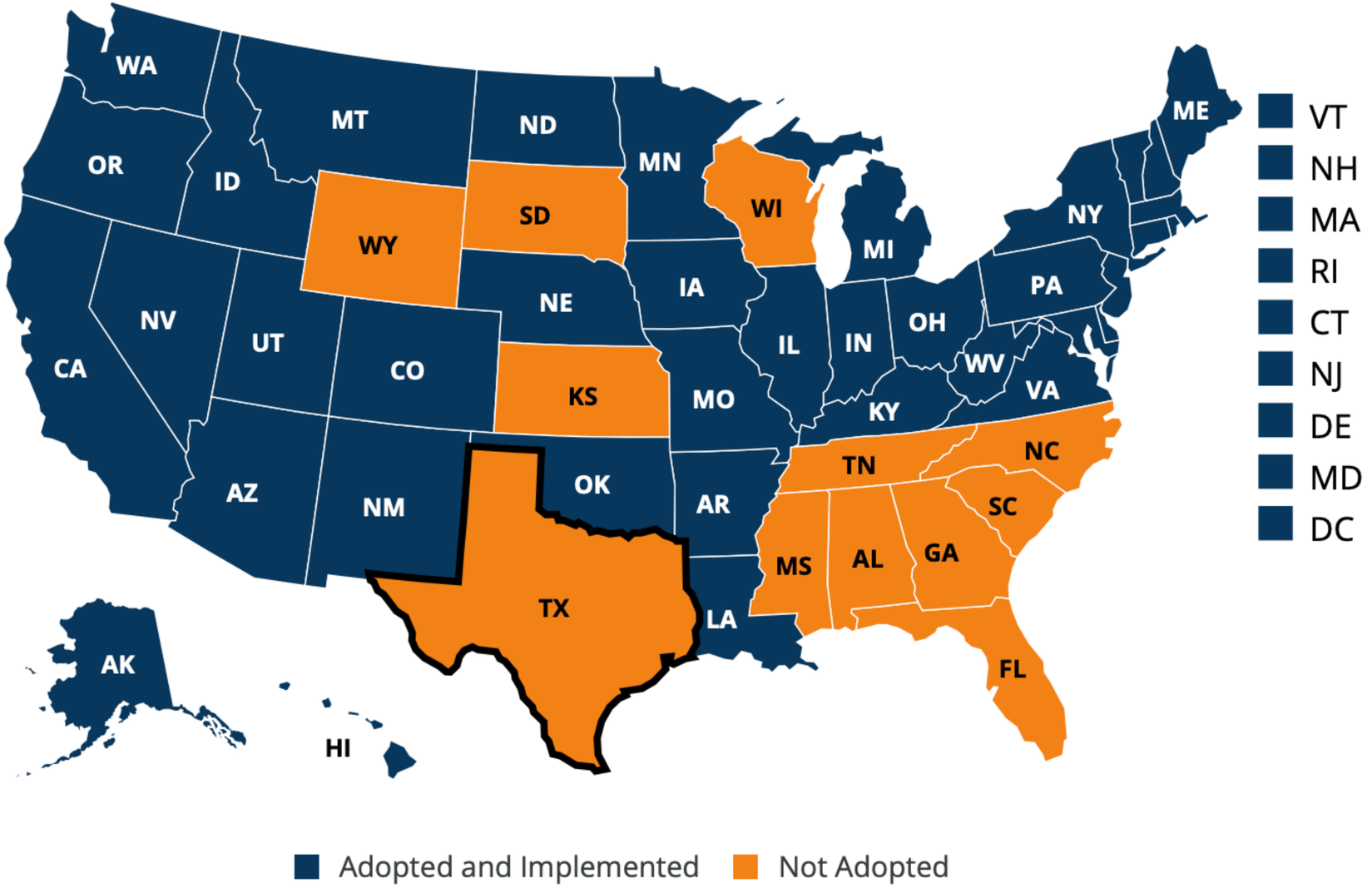
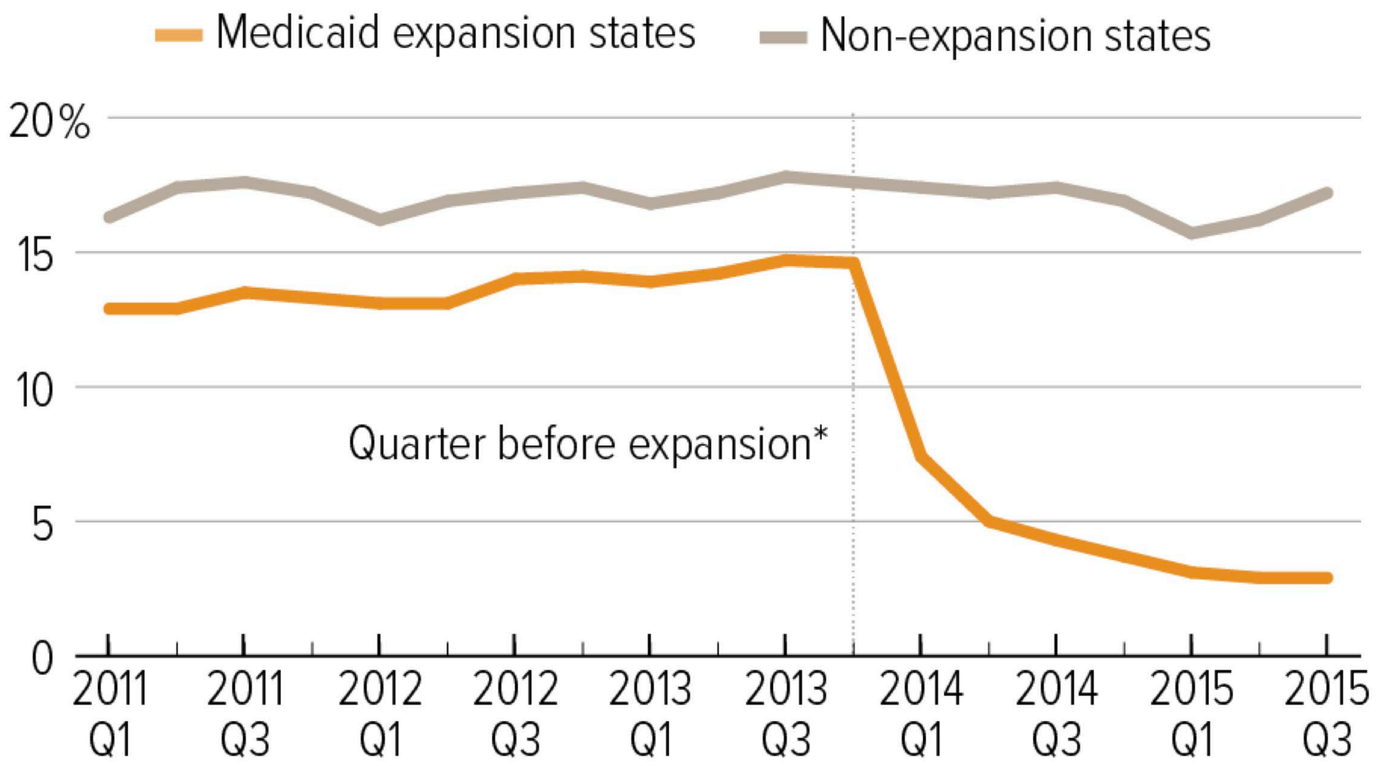
Status of State Action on the Medicaid Expansion Decision



https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

FIGURE 1

ACA Medicaid Expansion Reduced Share of Opioid-Related Hospitalizations in Which Patient Was Uninsured



*The Affordable Care Act (ACA) gave states the option to expand Medicaid to adults with income up to 138 percent of the poverty line starting in 2014.

Source: CBPP analysis of Healthcare Cost and Utilization Project data from the Agency for Healthcare Research and Quality. Analysis includes 26 states for which data are available for all of 2011-2015 and which either expanded Medicaid in January 2014, or had not expanded as of October 2015.

To Improve Behavioral Health,Start by Closing the Medicaid Coverage Gap By Jennifer Sullivan, Miriam Pearsall, and Anna Bailey, September 9, 2021

From: **Differences in Availability and Use of Medications for Opioid Use Disorder in Residential Treatment Settings in the United States**

JAMA Netw Open. 2020;3(2):e1920843. doi:10.1001/jamanetworkopen.2019.20843

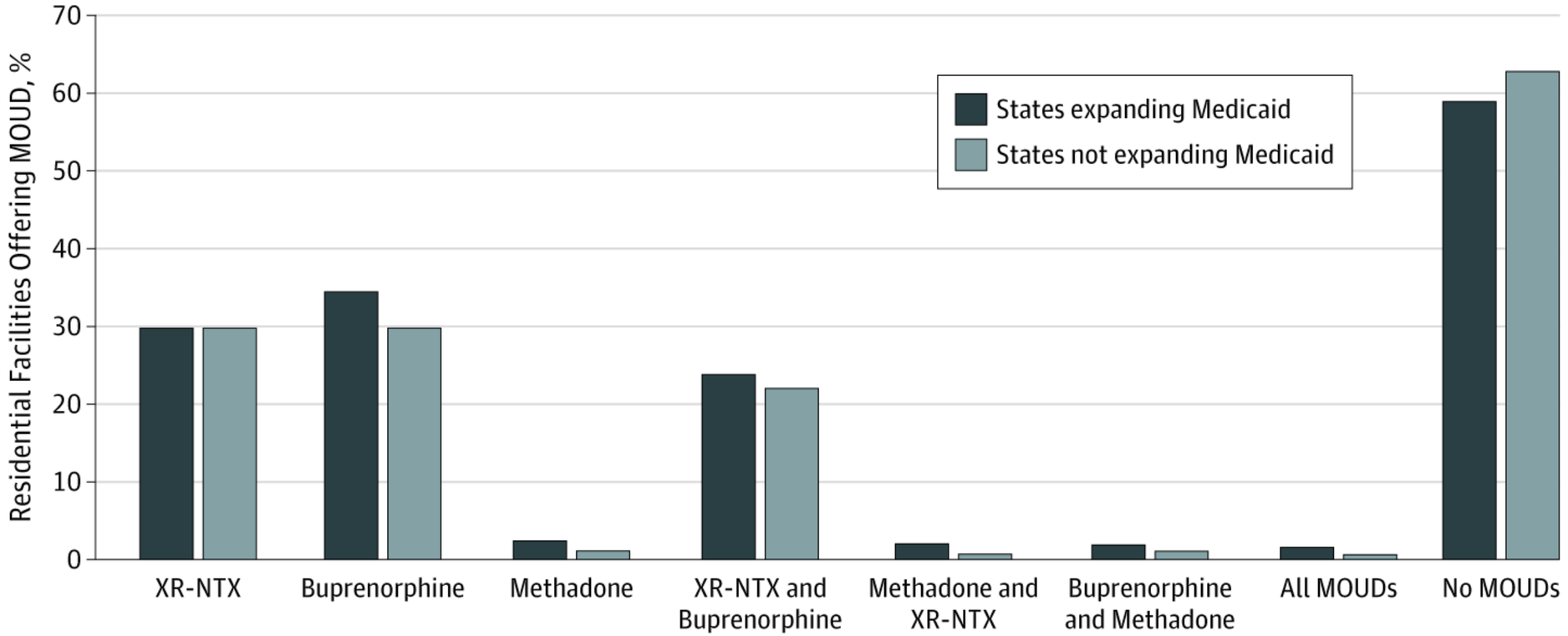
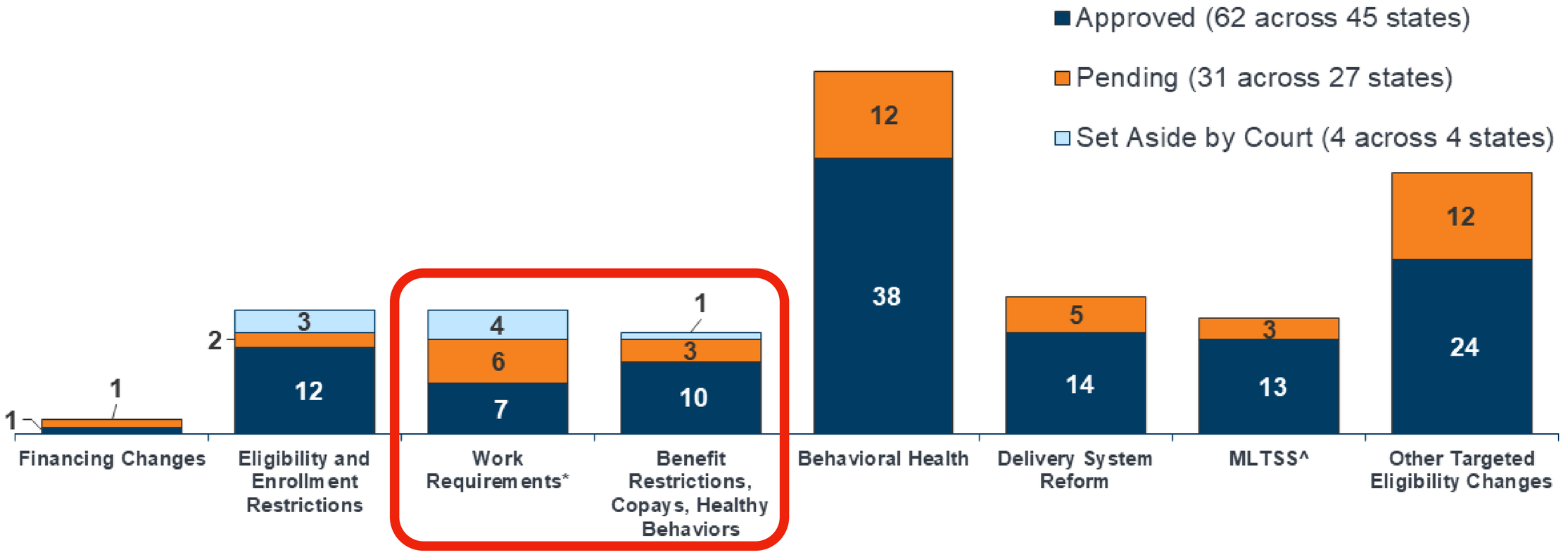


Figure Legend:

Availability of Medications for Opioid Use Disorder (MOUDs) and Combinations of MOUDs in Residential Treatment Facilities, by State Expansion of MedicaidFacility-level data were collected from the National Survey of Substance Abuse Treatment Services. No meaningful group differences were observed. XR-NTX indicates extended-release naltrexone.

Landscape of Approved vs. Pending Section 1115 Medicaid Demonstration Waivers, September 8, 2021



NOTES: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov.

* On 2/12/21, CMS under the Biden Administration sent letters to states with approved work requirements to begin the process of withdrawing these waiver authorities (see KFF Medicaid Waiver Tracker for more info).

^ "MLTSS" = Managed long-term services and supports.

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It’s All About the “Guardrails”

- May not waive certain statutory provisions, e.g., FMAP formula
- Budget neutral to the federal government
- “Experimental, pilot or demonstration project”
- “In the judgment of the Secretary, is likely to assist in promoting the objectives” of the Medicaid program

Gresham v. Azar (DC Cir. 2020)

- “[T]he Secretary’s analysis of the substantial and important problem is to note the concerns of others and dismiss those concerns in a handful of conclusory sentences. Nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking.”

- “While we have held that it is not arbitrary or capricious to prioritize one statutorily identified objective over another, it is an entirely different matter to prioritize non-statutory objectives to the exclusion of the statutory purpose.”

- Cert. granted Dec. 2020

- Biden DOJ filing-Because HHS is considering withdrawing the waivers, “these cases no longer present a suitable context” for the court to address. Feb. 2021

- SCOTUS removes case from docket, Mar. 2021

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

March 17, 2021

Dawn Stehle
Deputy Director for Health & Medicaid
Arkansas Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

Dear Ms. Stehle:

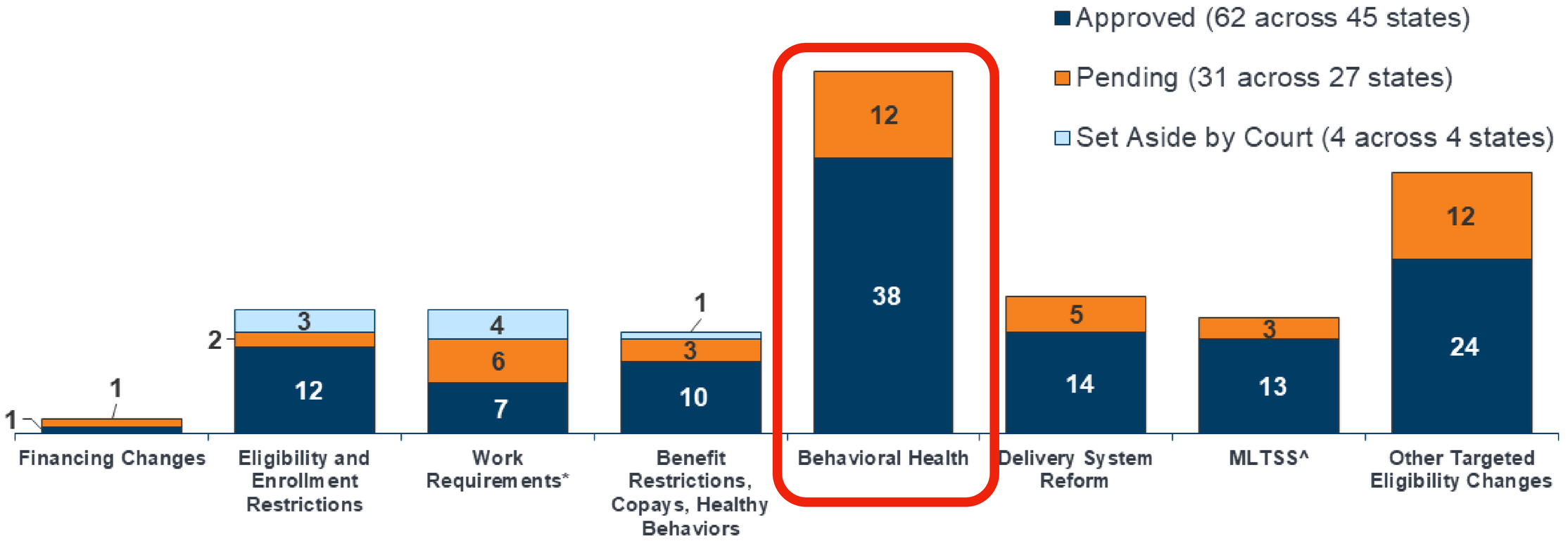
On February 12, 2021, the Centers for Medicare & Medicaid Services (CMS) sent you a letter regarding the March 5, 2018 amendment to the section 1115 demonstration project "Arkansas Works" (Project Number 11-W-00287/6). The letter advised that CMS would commence a process of determining whether to withdraw the authorities previously approved in the Arkansas Works demonstration that permit the state to require work and other community engagement activities as a condition of Medicaid eligibility. It explained that in light of the ongoing disruptions caused by the COVID-19 pandemic, Arkansas's community engagement requirement risks significant coverage losses and harm to beneficiaries. For the reasons discussed below, CMS is now withdrawing approval of the community engagement requirement in the March 5, 2018 amendment to Arkansas Works, which is not currently in effect and which, in any event, would expire by its terms on December 31, 2021.

Section 1115 of the Social Security Act (the Act) provides that the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act. In so doing, the Secretary may waive Medicaid program requirements of section 1902 of the Act, and approve federal matching funds per section 1115(a)(2) for state spending on costs not otherwise matchable under section 1903 of the Act, which permits federal matching payments only for "medical assistance" and specified administrative expenses.[1] Under section 1115 authority, the Secretary can allow states to undertake projects to test changes in Medicaid eligibility, benefits, delivery systems, and other areas across their Medicaid programs that the Secretary determines are likely to promote the statutory objectives of Medicaid.

The additional information that Arkansas submitted did not assuage the concerns we raised in the February 12, 2021 letter. The state did not dispute that the COVID-19 pandemic has had a significant impact on the health of Medicaid beneficiaries and that there is uncertainty about the lingering health effects of COVID-19. Nor did the state demonstrate that it has the infrastructure in place—such as subsidies for job-skills training and transportation, for example—that may be necessary to make compliance with the community engagement requirement feasible for beneficiaries and prevent large-scale coverage losses, and it did not provide evidence that such infrastructure would be in place in the aftermath of the pandemic. Indeed, as discussed below, the state's experience during the period in which the community engagement requirement was in effect in Arkansas indicates that there was inadequate infrastructure in place even to make beneficiaries aware of the requirement, and significant coverage loss occurred during that period. The state also did not address how it would assure that all beneficiaries would successfully be able to meet the requirement, understanding that the COVID-19 public health emergency will potentially have long-term effects on economic activities and opportunities.

In light of these concerns, for the reasons set forth below, CMS has determined that, on balance, the authorities that permit Arkansas to require work and community engagement as a condition of eligibility are not likely to promote the objectives of the Medicaid statute. Therefore, we are withdrawing the community engagement authorities that were added in the Secretary's March 5, 2018 amendment approval for the Arkansas Works demonstration.

Landscape of Approved vs. Pending Section 1115 Medicaid Demonstration Waivers, September 8, 2021



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Medicaid Section 1115 Waivers for Substance Use Disorders: A Review

Cathren Cohen, Héctor Hernández-Delgado, Alexis Robles-Fradet

While states have sought approval of Section 1115 SUD waivers for narrow and broad purposes, a close evaluation of approved state waivers and some of the proposed pending waivers shows that states have not addressed the needs of beneficiaries to access to SUD treatment in a manner that meets the growing needs of these individuals nor have they met the specific requirements of Section 1115 demonstrations. Through many of these waivers, states have weakened efforts to reinforce community-based SUD services while increasingly only seeking Section 1115 waiver authority to obtain Medicaid funding for treatment in residential facilities that are IMDs.

Medicaid and Beyond

- Parity laws meet the reality of paucity of providers.
  - “Final” step in the parity process promised by requiring mental and behavioral health services including SUD treatment as essential health benefits under ACA
  - 2019 National Drug Control Strategy identified “Critical shortages in trained and professional addiction service providers”
- New (Jan. 2021) HHS practice guidelines exempt clinicians with DEA # from the certification requirements related to training, counseling, etc., prior to Buprenorphine prescribing reducing the
  - Controlled Substances Act (CSA) still in force so “X Waiver” still required but application reduced to submission of Notice of Intent to SAMHSA. Only applies to 30 patients or fewer
- COVID-19 national emergency policy changes such as improved patient access (e.g., through home delivery to lockboxes) to Opioid Agonist Treatments (OAT) and access to telemedicine or even telephone access to prescribing) will expire
- General flaws in access to affordable care will impact PWUD at least as much as the general population; increases in cost-sharing outpacing wages decreasing actuarial value and creating class of underinsureds, out-of-network surprise billing will be somewhat tamed by the federal No Surprises Act of 2020 but will not protect persons who consent to non-emergency out-of-network services

Concluding Issues and Reservations

- Increases in Substance Use treatment continue to be the result of applying exceptions rather than changing the general rule
  - Section 1115 waivers are by definition exceptional, reflecting different state policies as to Medicaid spending (as are non-expansion decisions)
  - Other sources of revenue such as CARES Act and SUPPORT Act tend use short-horizon grant funding to states that arguably militate against building long-term plans/infrastructure (and even resemble the block grants reviled by many in the Medicaid world)
- After the first midterms of Obama Administration, through the midterms of the Trump Administration, and now into the Biden Administration we see governing parties without a workable majority to enact major change. Substance use requires a major rethink, whole-of-government, approach to social determinants, post-industrial employment, decarceration, and the health care system. Instead, we are likely to see continuing law and policy churn

State Policies on Access to Vaccination Services for Low-income Adults

Russell F. McCord, JD

Public Health Analyst

Public Health Law Program

Center for State, Tribal, Local, and Territorial Support

Introduction

Medicaid has traditionally provided health insurance to low-income children and their parents, pregnant people, older adults, and people with disabilities at little to no cost

- In 2010, the Patient Protection and Affordable Care Act (ACA) extended Medicaid eligibility to include childless adults with incomes at or below 138 percent of the federal poverty level[1]

In 2017, nearly 38 million adults were enrolled in Medicaid[2]:

- With expansion adults representing 19.4% of the total Medicaid population[3]

1. Eligibility. Medicaid website. https://www.medicaid.gov/medicaid/eligibility/index.html. Accessed October 1, 2019.
2. Majority of people covered by Medicaid, and similar programs, are children, older adults, or disabled. Population Reference Bureau website. https://www.prb.org/majority-of-people-covered-by-medicaid-and-similar-program. Accessed October 28, 2019.
3. Medicaid Enrollment – New Adult Group. Centers for Medicare & Medicaid Services website. https://catalog.data.gov/dataset/medicaid-enrollment-new-adult-group. Accessed October 1, 2019.

Traditionally eligible adults

- Adult vaccination services are not considered a mandatory benefit and are therefore determined by each individual state

Medicaid expansion adults

- By contrast, benefits packages for this population are required to cover 10 “essential health benefits,” including adult immunization services, with no cost-sharing[4]

Section 4106 incentive

- **As cost-sharing is a known barrier to the receipt of health services, such as vaccination[5,6], state Medicaid programs were encouraged to reduce cost sharing practices through the Section 4106 incentive**
  - Through this incentive, states received a 1% increase in the Federal Medical Assistance Percentage (FMAP) if their state matched preventive care benefits for their expansion and traditionally eligible populations with no cost-sharing[7]

4. Ku L, Paradise J, Thompson V. Data note: Medicaid’s role in providing access to preventive care for adults. The Henry J. Kaiser Family Foundation website. https://www.kff.org/medicaid/issue-brief/data-note-medicaids-role-in-providing-access-to-preventive-care-for-adults/. Accessed October 1, 2019.
5. Stoecker C, Stewart AM, Lindley MC. The cost of cost-sharing: The impact of Medicaid benefit design on influenza vaccination uptake. *Vaccines*. 2017;5(1):1-8 . doi.org/10.3390/vaccines5010008.
6. Artiga S, Ubri P, Zur J. The effects of premiums and cost sharing on low-income populations: updated review of research findings. The Henry J. Kaiser Family Foundation website. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/. Published January 30, 2018. Accessed October 1, 2019.
7. Gates A, Ranji U, Snyder L. Coverage of preventive services for adults in Medicaid - Appendices. The Henry J. Kaiser Family Foundation website. https://www.kff.org/report-section/coverage-of-preventive-services-for-adults-in-medicaid-appendices/. Published November 13, 2014. Accessed October 1, 2019.

Methods

- **Study conducted June 2018 to June 2019**
- **Two components**

Public Domain document review

- Included publicly available information related to benefits coverage of, payment for, and cost-sharing for adult vaccination services under Medicaid
- Material collected from the document review was organized into a brief document and integrated into the survey

Semi-structured Survey

- Recruited state Medicaid directors through the National Association of Medicaid Directors online directory
- Emailed survey and requested verification of Document Review info
- Scheduled phone interviews and collected both semi-structured telephone surveys and written responses from Medicaid directors or designated representatives

Adult vaccination access and reimbursement

- **We evaluated coverage benefits for the following 2018 Advisory Committee on Immunization Practices (ACIP)-recommended adult immunizations:**
  - Influenza (IIV, RIV, LAIV)
  - Tdap
  - MMR
  - Varicella
  - Zoster (recombinant)
  - 9vHPV
  - PCV13
  - PPSV23
  - HepA
  - HepB
  - MenACWY
  - MenB
  - Hib

Results

A public domain document review was conducted for all 51 Medicaid programs

- Provider Fee-for-Service (FFS) reimbursement fee schedules were evaluated for 49/51 programs as Hawaii and Tennessee are both under 100% Managed Care Organization (MCO) arrangements

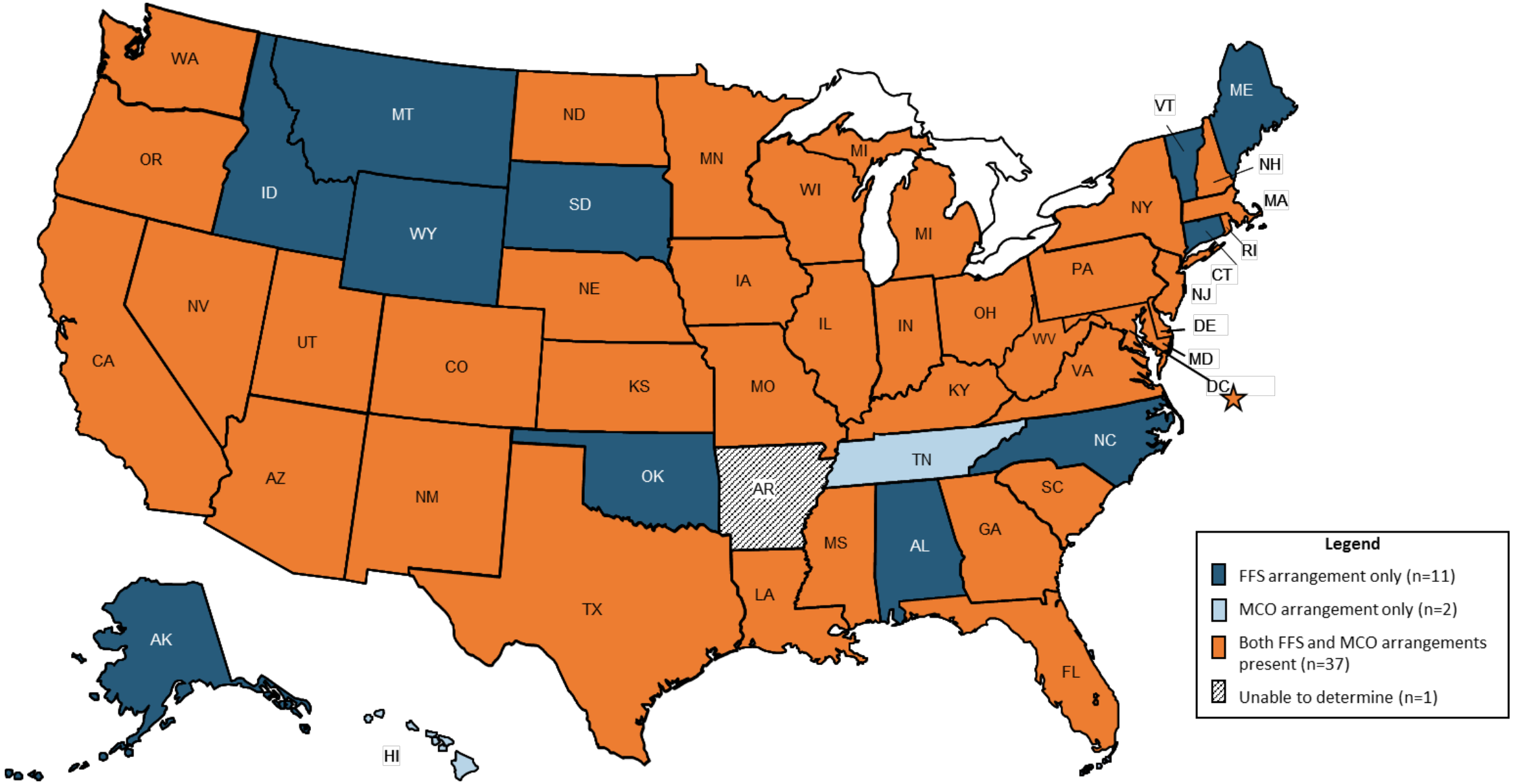
Forty-five (88.2%) state Medicaid programs validated document review findings and completed the survey

- 35 (78%) programs via telephone; 10 (22%) in writing
- Of those, 44 had usable data and were included in the analyses

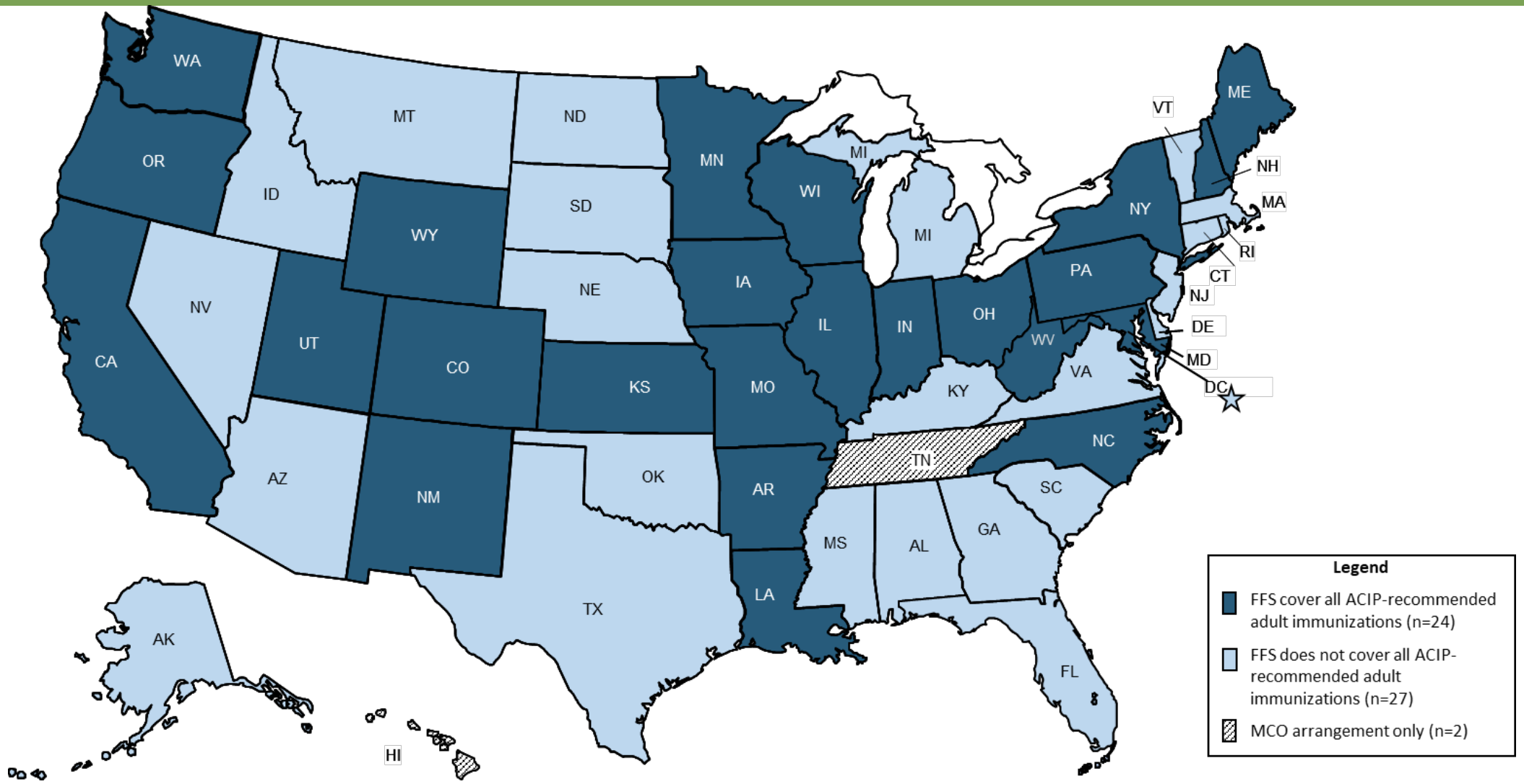
Access variables assessed

- Coverage (FFS & MCO)
- Reimbursement Amounts
- Cost Sharing (co-pays)
- Provider Type
- Provider Setting

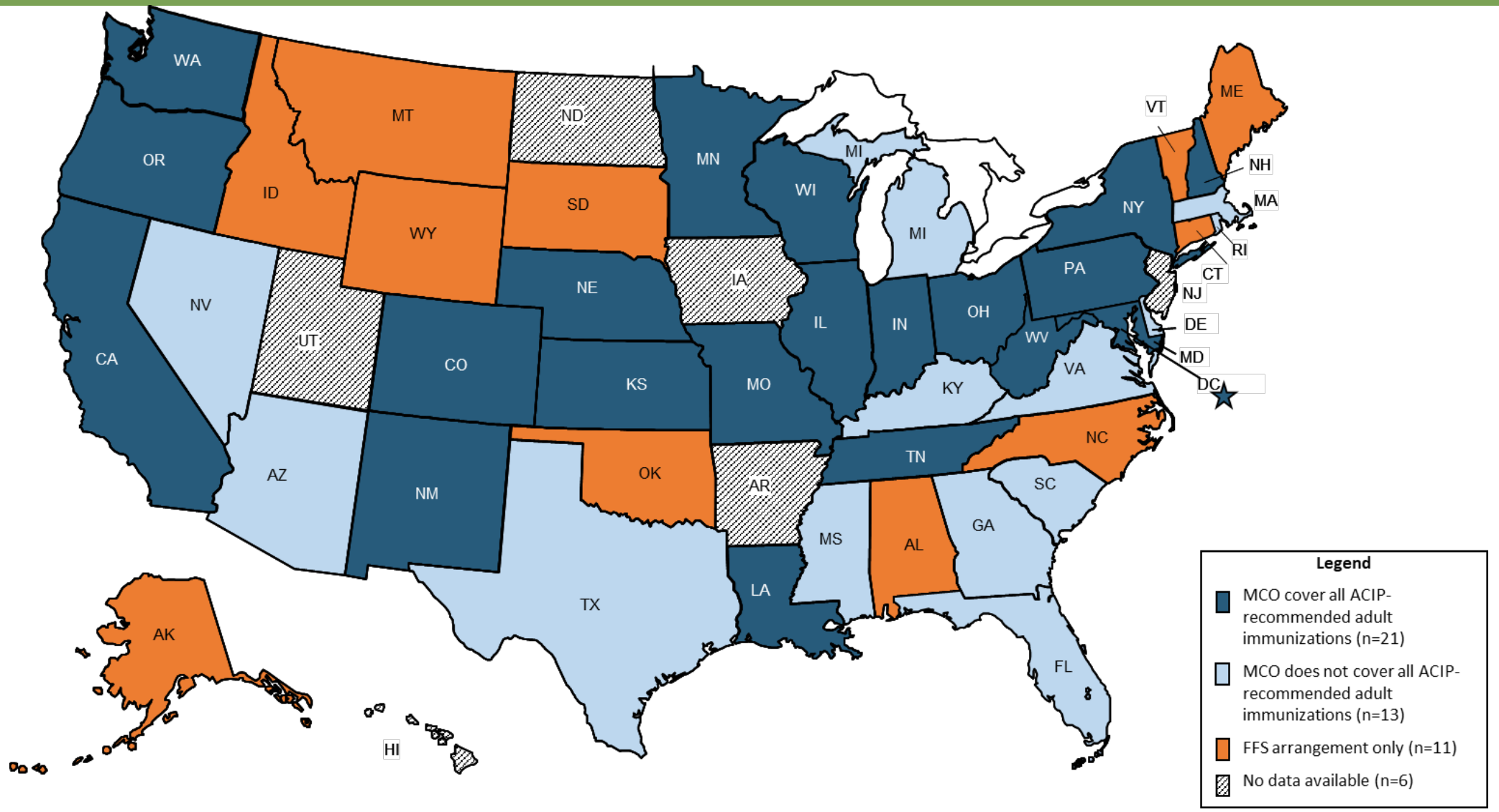
FFS and MCO penetration, by state in 2019



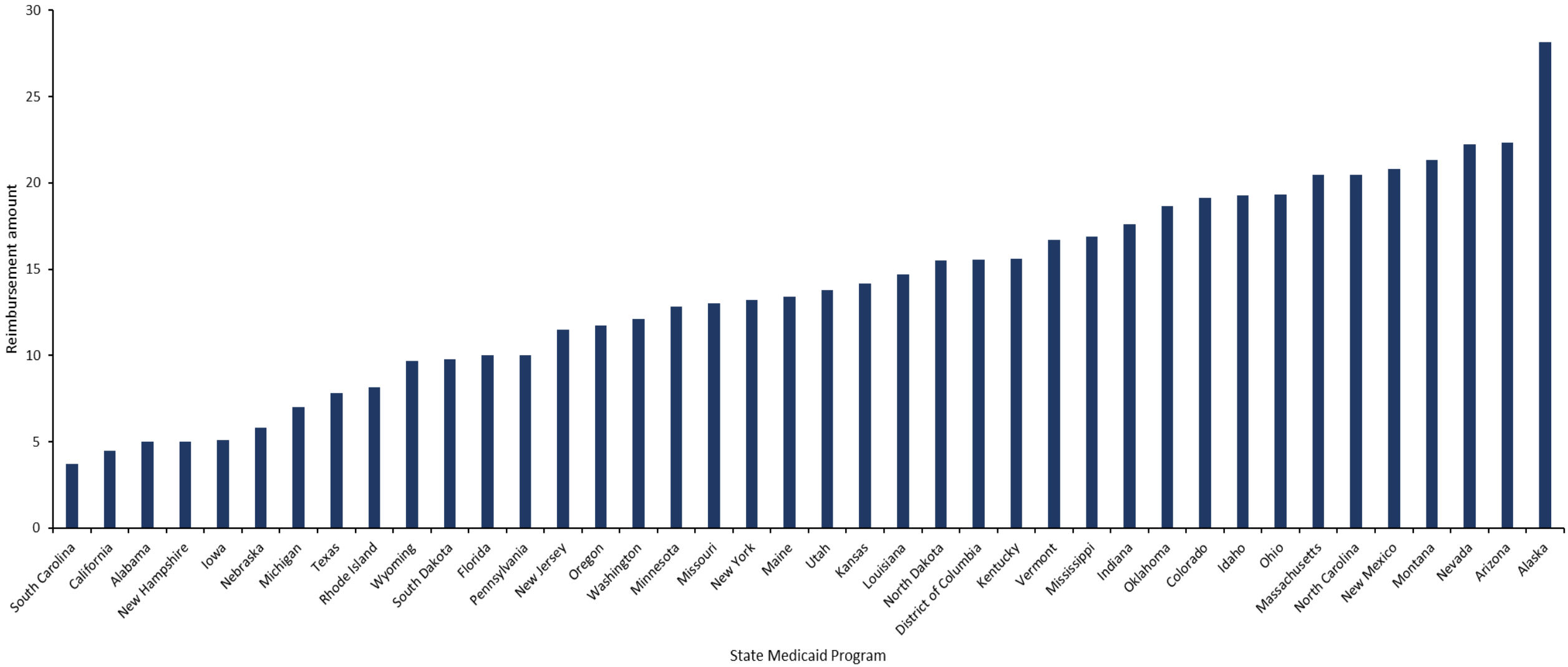
State Medicaid coverage of ACIP-recommended adult vaccines, FFS



State Medicaid coverage of ACIP-recommended adult vaccines, MCO



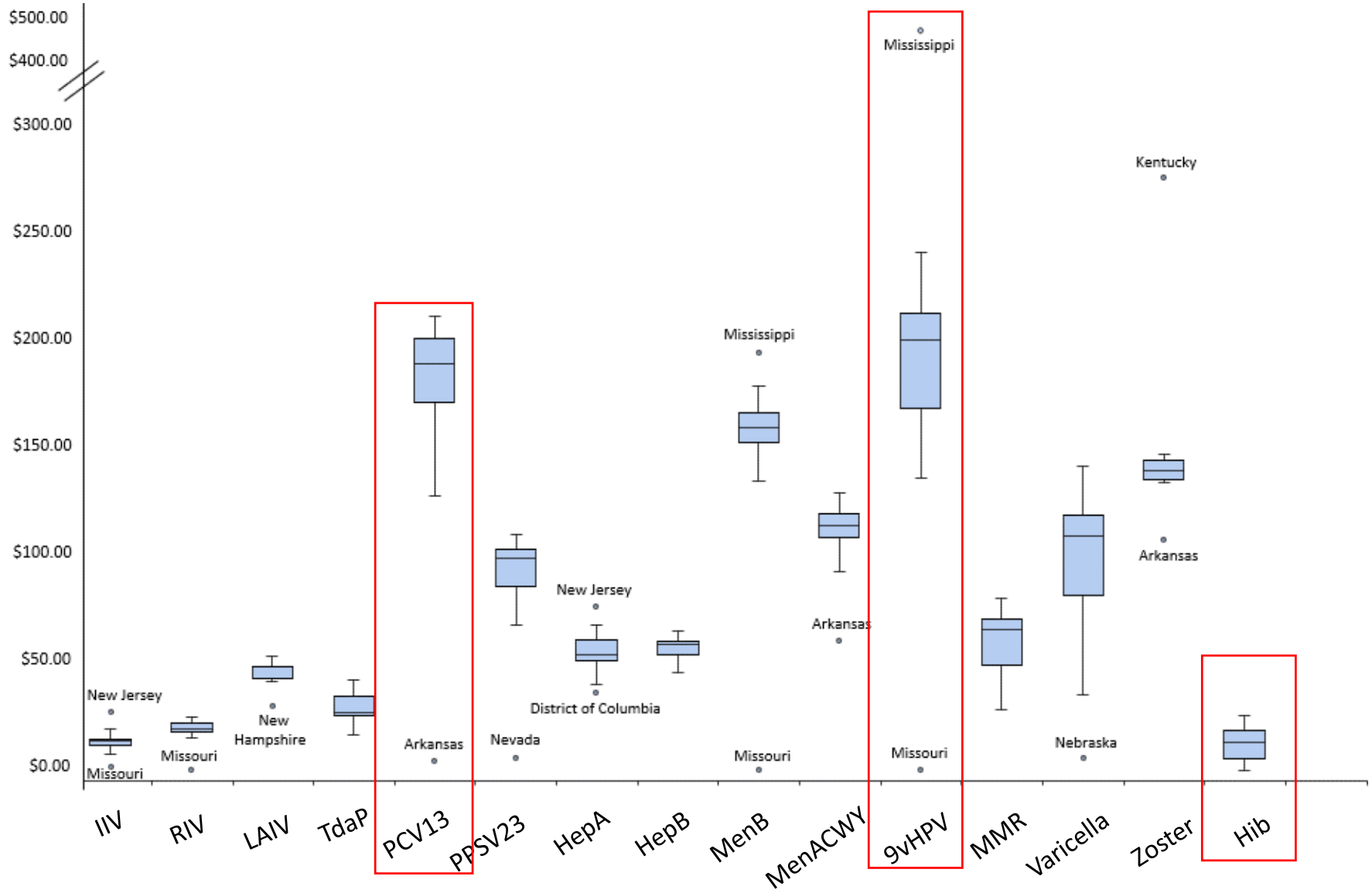
Reimbursement for first vaccine administered via intramuscular route, by state



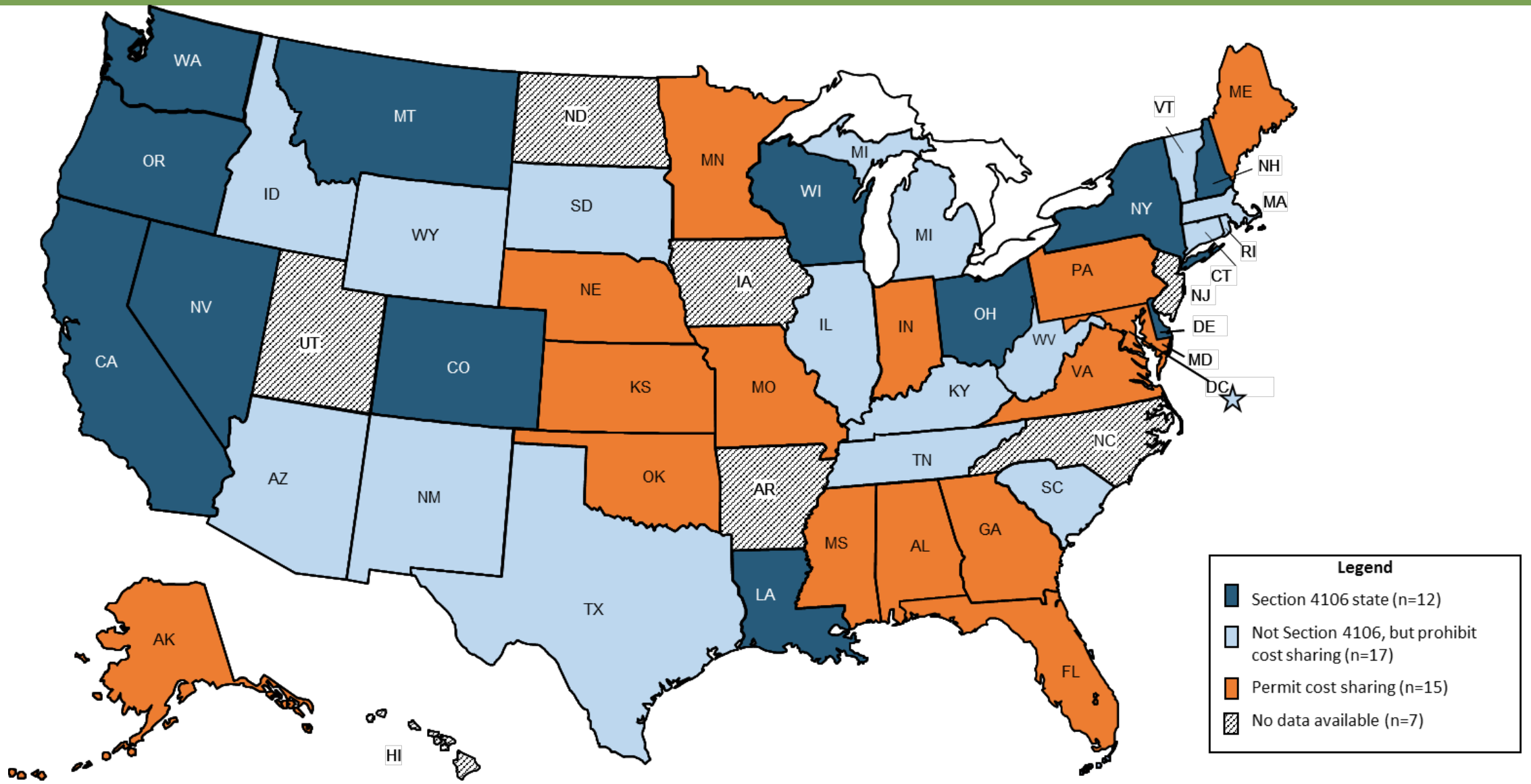
Reimbursement amounts for ACIP-recommended adult vaccine purchase under FFS

- **Median:**
  - 9vHPV = $204.87
  - PCV13 = $193.75
  - Hib = $18.09

- **Range:**
  - 9vHPV
    - $5.27 to $491.87
  - PCV13
    - $9.56 to $215.33
  - Hib
    - $5.27 to $30.80

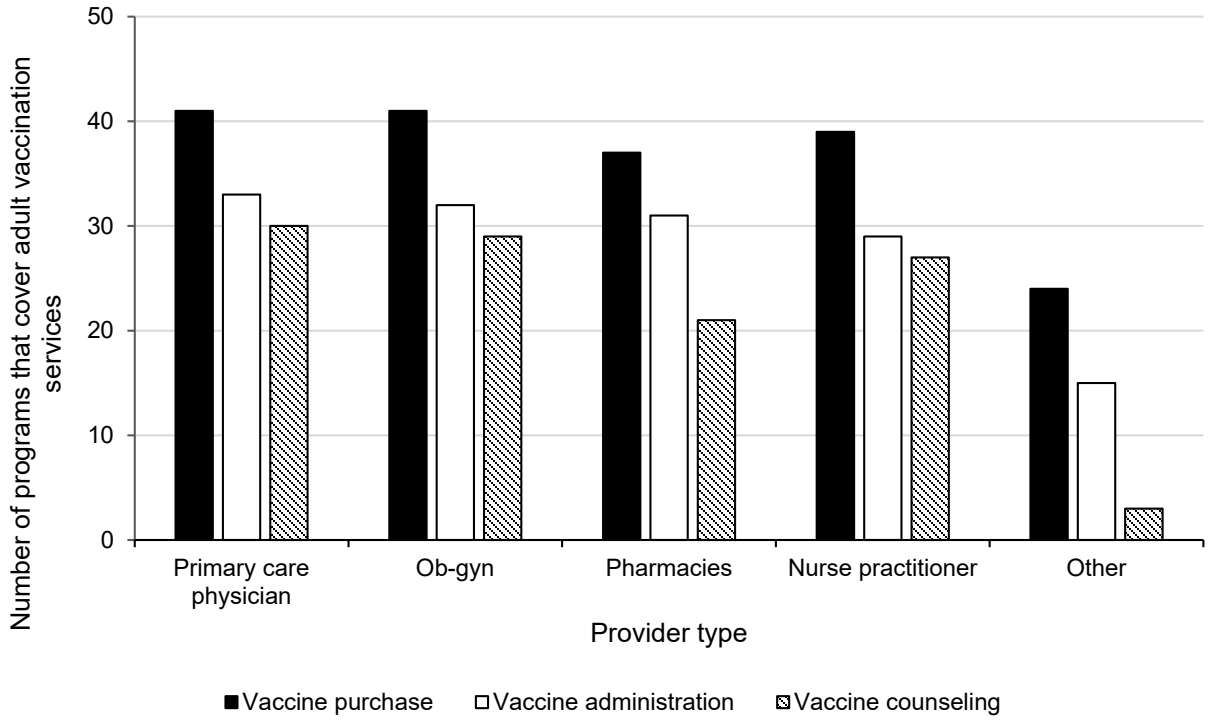


Cost sharing for adult vaccination services



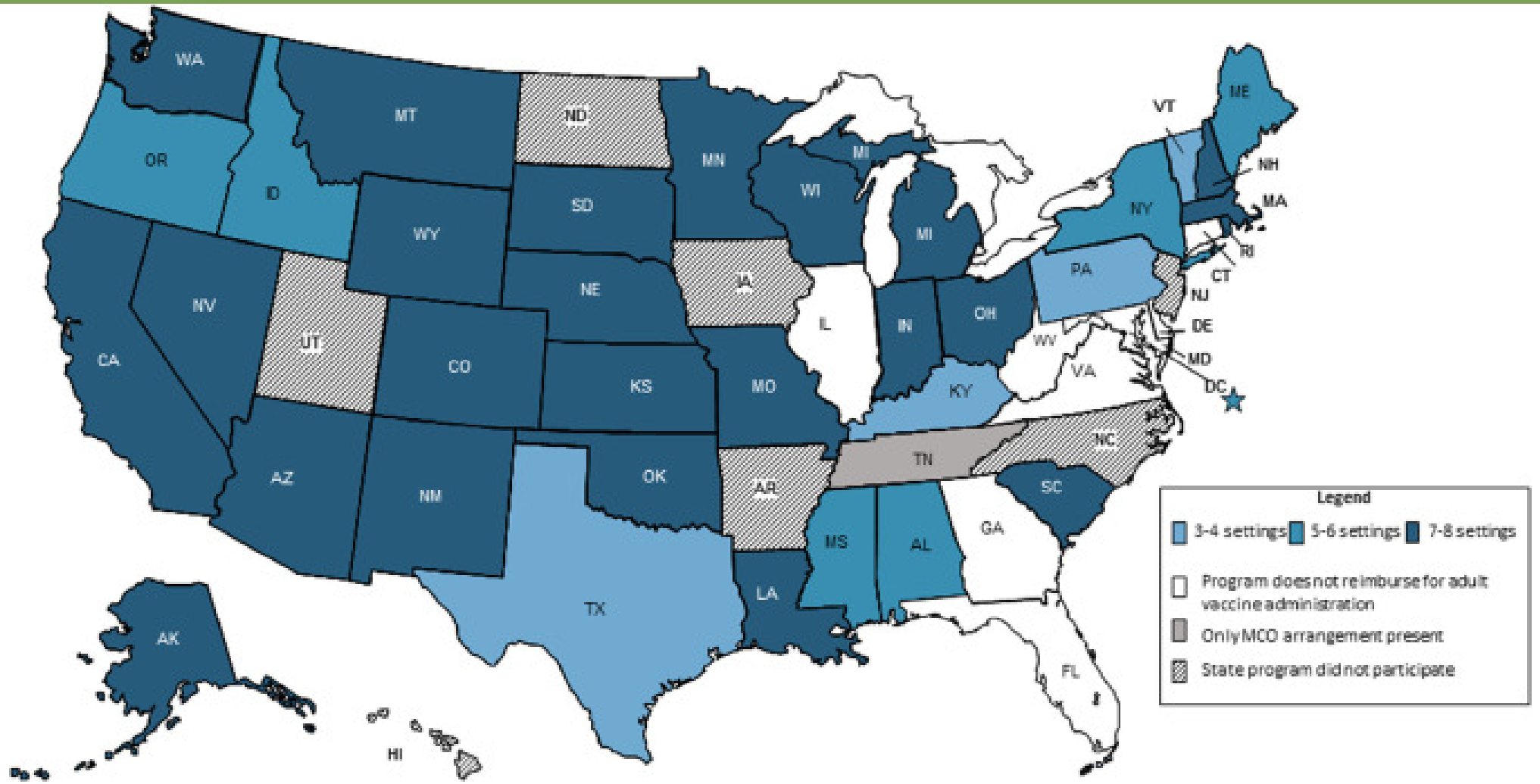
Provider Types:

1. Primary care physician
2. Obstetrician–gynecologist (OB-GYN)
3. Pharmacy
4. Nurse practitioner
5. “Other”
    - Nonphysician providers



Charleigh J. Granade, Russell F. McCord, Alexandra A. Bhatti, Megan C. Lindley, Availability of Adult Vaccination Services by Provider Type and Setting, American Journal of Preventive Medicine, Volume 60, Issue 5, 2021, Pages 692-700, ISSN 0749-3797, https://doi.org/10.1016/j.amepre.2020.11.013

The number of settings where vaccination services benefits are available under FFS, by program



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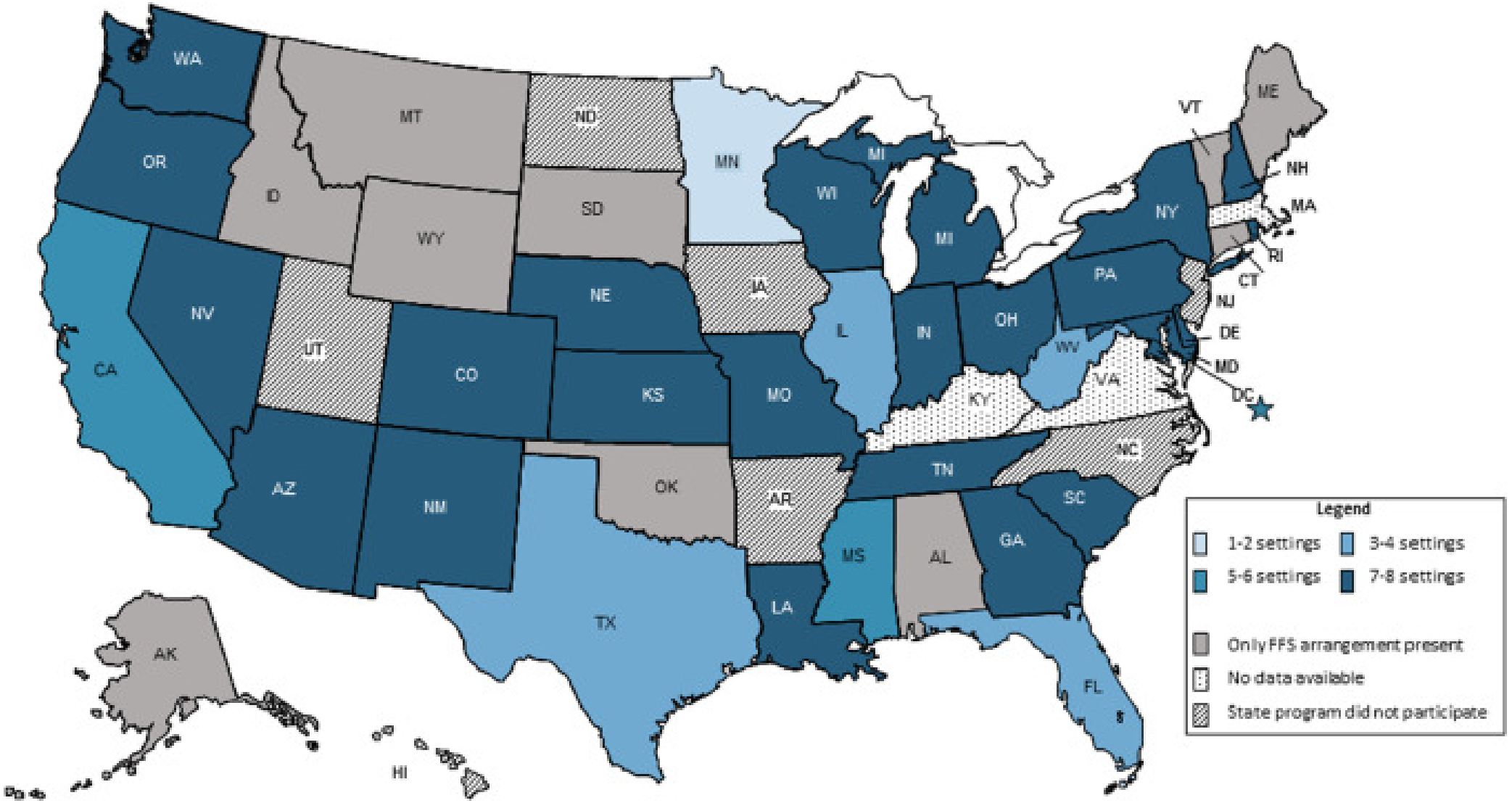
The number of settings where vaccination services benefits are available under MCO, by program



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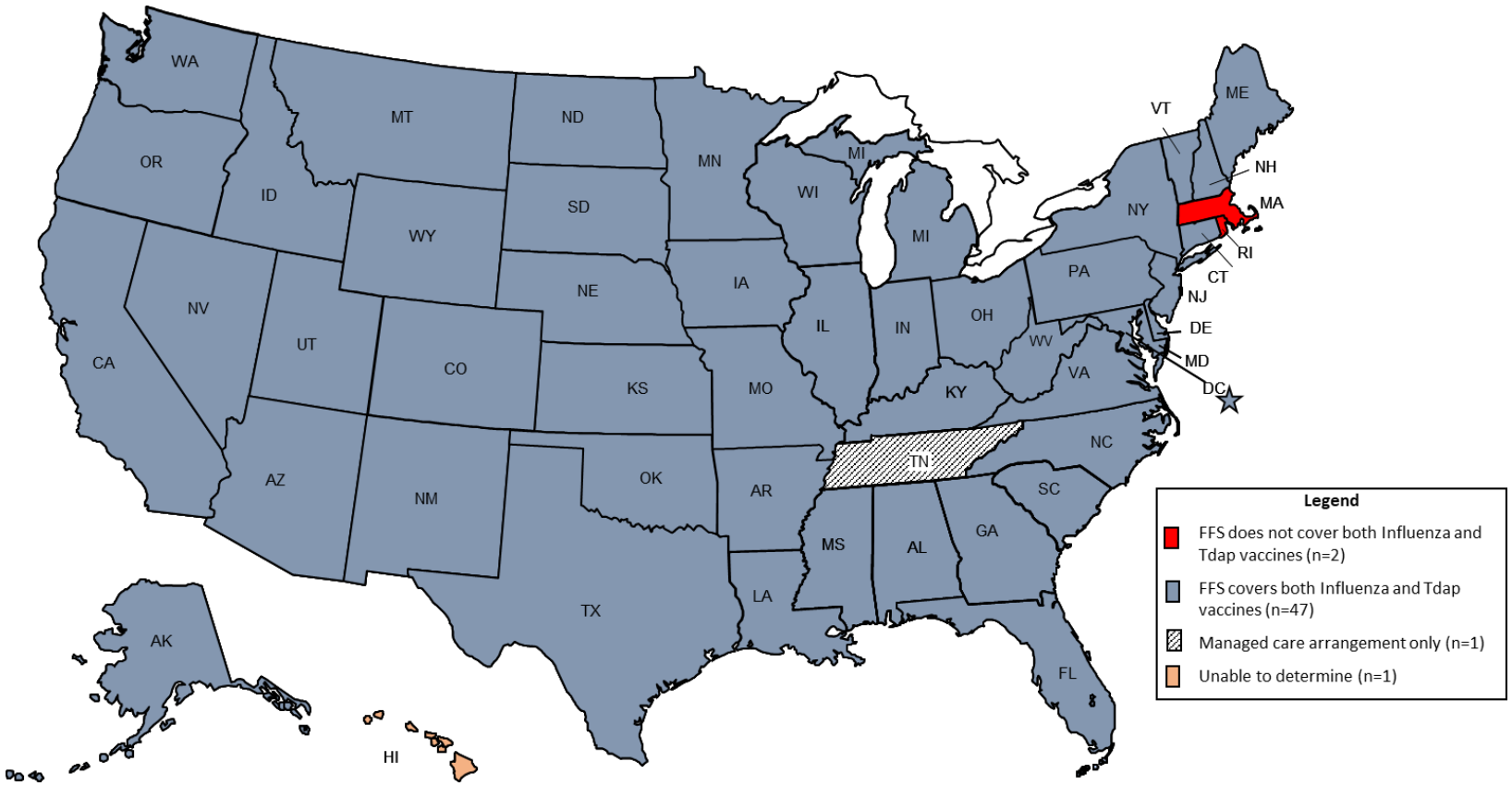
Conclusions

- **Majority of states provide some level of coverage for adult immunization**
- **Only 22/51 cover all ACIP-recommended adult immunizations for both FFS and MCO beneficiaries, 14 of those without cost-sharing**
- **High variability of state reimbursement policies for vaccine purchase and administration; reimbursements from Medicaid may not cover provider costs**
- **Inadequate reimbursement may therefore contribute to poor adult vaccination coverage by:**
  - Reducing incentives for healthcare providers to vaccinate adults experiencing poverty
  - Limiting Medicaid beneficiary access to vaccination

What next?

- **Analysis of vaccine policy for pregnant beneficiaries**
- **Analysis of Vaccines For Children (VFC) program policies and implementation**
- **Better ways to study Medicaid policy?**
- **How have things changed?**

Adult vaccination coverage, FFS



- Special Thanks to:
  - Charleigh Granade
  - Alexandra Bhatti
  - Megan Lindley

- Questions/Comments?
  - rmccord2@cdc.gov

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

Publications using this data:

- Granade CJ, McCord RF, Bhatti AA, Lindley MC. State Policies on Access to Vaccination Services for Low-Income Adults. *JAMA Netw Open.* 2020;3(4):e203316. https://doi:10.1001/jamanetworkopen.2020.3316

- Charleigh J. Granade, Russell F. McCord, Alexandra A. Bhatti, Megan C. Lindley, Availability of Adult Vaccination Services by Provider Type and Setting, American Journal of Preventive Medicine, Volume 60, Issue 5, 2021, Pages 692-700, ISSN 0749-3797, https://doi.org/10.1016/j.amepre.2020.11.013