

At the Line:

An Analysis on the Debate of Access to Quality Healthcare Following the Expansion of
Medicaid Under the Affordable Care Act

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Abstract

The success of a healthcare bill's effects on the healthcare delivery system is based on several measurements. For example, include enrollment, expenditure, and utilization of healthcare services are often present in this conversation. The way in which we measure success has shifted over time to realign with the end goals we set for our healthcare system. This project, focusing on Medicaid, is comprised of a literature review documenting both these changes and a history of the Medicaid system that concludes with the after-effects of the recent expansion under the Affordable Care Act. Following this section is a compilation of original research in the form of interviews conducted with healthcare professionals that explores questions left unanswered by the studies reviewed. These two segments weave together a comprehensive understanding of the experience that low-income individuals face when obtaining medical care. The project concludes that the importance of refocusing the debate on the success of the healthcare system is essential. An emphasis on utilization, and a more open forum between state Medicaid plans are both necessary to understanding and overcoming the obstacles of the modern healthcare system.

Contents:

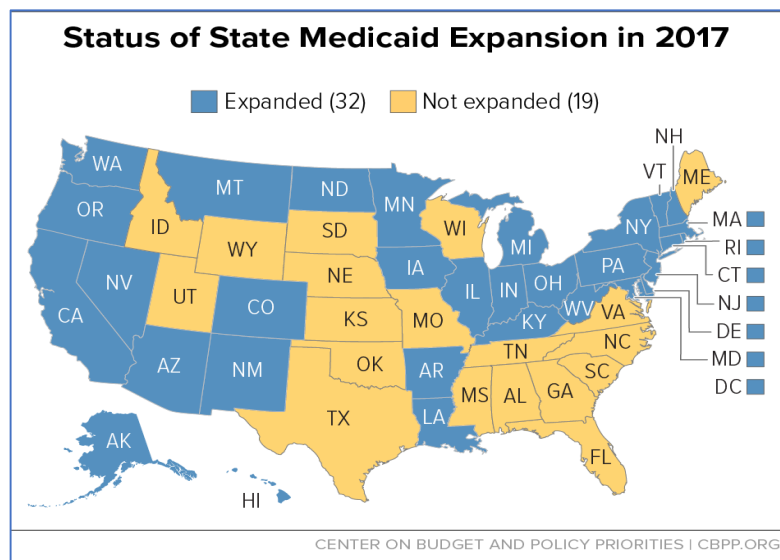
Introduction	3
A Brief History of Medicaid / Literature Review	7
Early Medicaid.....	8
First Major Expansion Era.....	12
Pre-ACA Medicaid Era.....	15
ACA Expansion Era.....	19
Interviews	30
Unseen Barriers.....	31
The Illinois System.....	33
Measuring Access.....	36
Afterward	38
Acknowledgments	42
References.....	43

Introduction

The goal of this work is to uncover problems that our healthcare system faces, any possible solutions that can be used to correct them, and the consequences of these solutions. Especially important in healthcare system analysis is the third of these topics. When creating public policy, one must keep in mind that no action happens in a vacuum, and unintended consequences are inevitable. In 2010, when the Patient Protection and Affordable Care Act (PPACA, or within this paper ACA) was passed, many changes were introduced to our healthcare system. The overall goal of the legislation was to address the issue of nearly 50 million uninsured Americans. To help achieve this goal, the ACA implemented a mandatory expansion of Medicaid, allowing for near-total reimbursement to states to cover

medical expenditures for those below 138% of the Federal Poverty line. This includes all citizens that earn at or below approximately \$16,000 per year individually or approximately \$32,700 per year for a family of four (healthcare.gov, 2016).

Figure 1



Although, in 2012, the Supreme Court ruled a mandatory expansion unconstitutional, and an *optional* state-wide expansion funded at a rate of 90% by the federal government was implemented instead. Since then, 32 states and Washington DC have adopted the new eligibility standards, but 19 have yet to do so (shown in Figure 1).

It is common in healthcare analysis to assess a policy's success and failure based on several statistics that tell a story about its overall effects on a population. Thus, a thoughtful choice must be made. Which measurements will adequately depict the current situation and drivers of its advantages and downfalls? With the healthcare system becoming increasingly complex, this question becomes increasingly difficult to answer. The polarity found in the debate on the efficacy of the ACA has caused for much confusion. Part of this project's purpose is evaluate the debate itself, namely what we can say about performance given the measurement of certain variables.

Since the ACA aims to address the disparities across income level, geography, and access to social resources in medical care received throughout the country, it is logical to examine measures of access to gauge its success. In healthcare policy analysis of this kind, access can be measured by observing enrollment and utilization. These numbers will tell different stories, yet on the surface they logically lend themselves as a proxy for access to care. In theory, a citizen enrolled in Medicaid possesses the security to see a doctor due to the coverage that the program offers. As Medicaid enrollees seek medical care, the services and drugs they consume can be measured in terms of utilization. Hence, these measures are useful in assessing a population's access to medical care during a given period.

Though it is logical to associate enrollment and utilization with access to healthcare, this project focuses on a variety of measures. Making choices of measurement brings with it assumptions about what the statistics can tell us. For example, the Medical Dictionary (2002) defines utilization as "the consumption of services or supplies, such as the number of office visits a person makes per year with a health care provider, the number of prescription drugs taken, or the number of days a person is hospitalized." Focusing on utilization allows for a specific targeting medical procedures is a systematic

manner to assess progress toward improving health outcomes. On the other hand, enrollment is a very simple way to evaluate a population's access to healthcare, but it can at times fall short in assessing the quality of healthcare. Nonetheless, enrollment trends will be woven consistently throughout this project, as they have been very well-documented, and provide a simple way to gauge the program's size. Further still, aggregate medical expenditure is ever-present in the debate on the success of the ACA, as it has other implications on insurance markets. Cost is the main driver of premium expense, and can affect to who has access to health insurance. Although expenditure is not innately synonymous to access to healthcare, it is certainly related. We will see all three of these trends measured in studies surrounding the Medicaid system, and used to determine how effective it is in serving its recipients with access to quality healthcare.

This project is divided into two main sections. Following the introduction is a literature review that examines research findings from studies done on previous nationwide Medicaid expansions, on more recent Medicaid expansions at the state level, and on the Medicaid expansion implemented as a part of the Affordable Care Act. This section serves two major purposes. First, to provide a brief history of Medicaid's expansions, organized into four distinct time periods to assess the major changes and their effects: Early Medicaid Era (1965-1986), First Major Expansion Era (1986-1993), Pre-ACA Medicaid Era (1993-2009), and the ACA Medicaid Era (2010-2017). This section also studies the way the performance of Medicaid was being measured throughout its history, and how it has developed over time.

Also, incorporated into this analysis is a local view of Illinois' experience with the Medicaid system. Population-wide statistics are crucial in understanding the effectiveness of the ACA's Medicaid expansion, but often time there is more to be learned from individuals working in the field. Their stories can illuminate misconceptions,

explain confounds, and even open the door to new discussion. This project includes findings from interviews with six healthcare professionals working in various areas. After the findings have been summarized, this section examines any interesting answers, stories, and examples given by the professionals, and how they reinforce, or perhaps reshape, the understanding of the drivers of utilization with respect to Medicaid. Finally, the paper summarizes conclusions made from this discussion, and offer recommendations for the future. In this project, I argue that the way in which the public discusses the success of the healthcare system is often misguided, and that a better understanding of the effects of the ACA, particularly the expansion of Medicaid is necessary in order to improve the quality of the healthcare system overall. Moreover, issues of access to quality healthcare have many layers, and this project uncovers hidden barriers of access that Medicaid recipients face when receiving healthcare services.

The Affordable Care Act, and its nation-wide option to expand Medicaid may soon be repealed in light of the American Healthcare Act (H.R.1628) passed by the House of Representatives. The proposed bill plans to roll back the expansion and possibly convert Medicaid at the national level into a block grant program. It is currently being discussed by the Senate, and will be voted upon in the coming months. Regardless of the outcome of the future of Medicaid, it is my hope to increase my own, as well as all readers', understanding of the current forces that affect access to quality healthcare, and how this translates to overall health status in a population. Furthermore, this knowledge should prove useful in evaluating any proposed changes to the current Medicaid system.

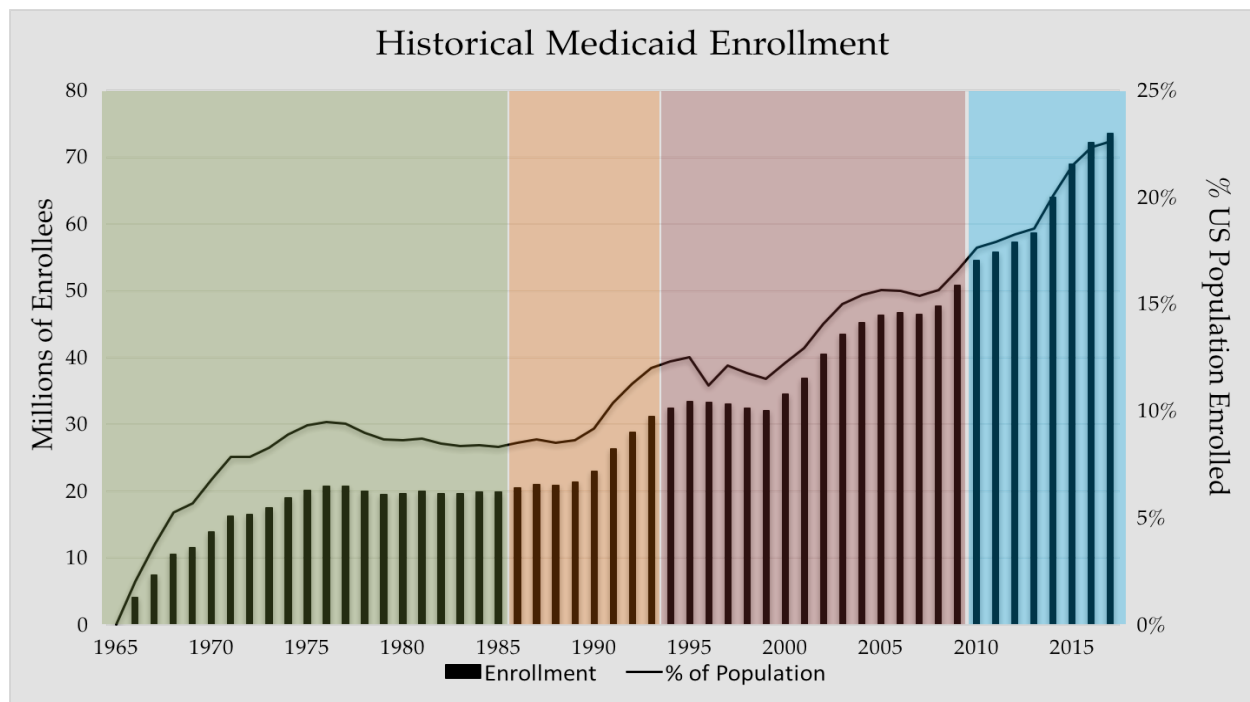
Figure 2

Figure 2: An illustration of national enrollment in Medicaid since its inception in millions of individuals each year, as well as the growth in percentage of the population over the same time frame. The figure has been segmented into four different colored areas to represent the four periods discussed in this project.

A Brief History of Medicaid – Literature Review

In order to contextualize the most recent Medicaid Expansion under the Affordable Care Act, it is important to examine other expansions that the Medicaid system has undergone during its lifetime. In 1965, Medicaid was created under the Johnson administration in conjunction with Medicare as a part of the Social Security Act (SSA). The program was in many ways an expansion of the existing Kerr-Mills Program, which already provided financial assistance to the portion of the aged population in need of supplemental coverage towards their medical expenses (Provost; Hughes, 2000).

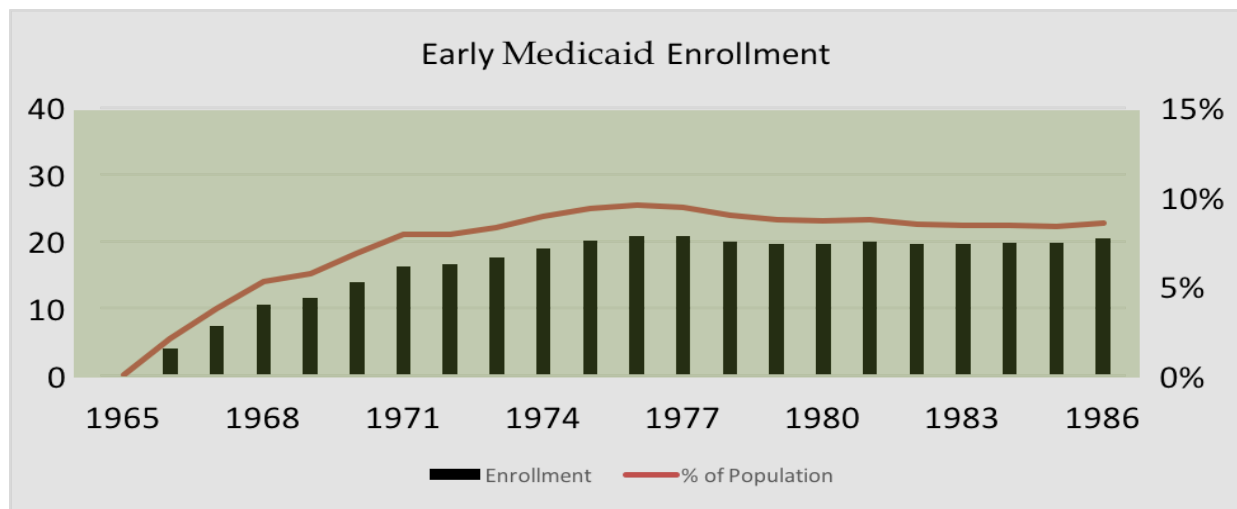


Figure 2.1 – An amplification of the first portion of the main enrollment chart (Figure 2).

Early Medicaid (1965-1986)

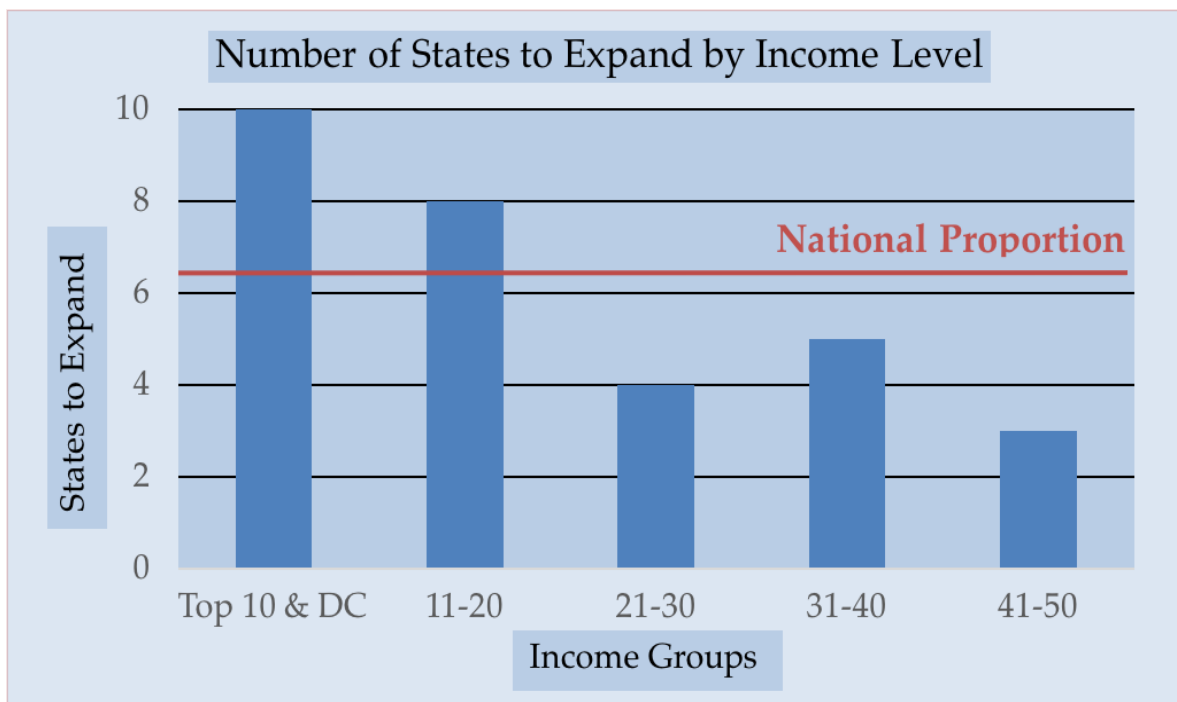
The first Era of the Medicaid program is important to note because it illustrates the beginning of a time that placed increased importance on medicine. The United States began to notice the effects of inequality on healthcare. It recognized the importance of investing in its citizens in the form of medical services. In 1977, the administrative duties of Medicaid's were handed over the Health Care Financing Administration (HCFA). This entity was created and tasked with the oversight of Medicaid and Medicare programs from a national perspective. Data collection to a higher degree for healthcare systems gave analysts a more quantifiable way to draw conclusions. At this time, the Medicaid program had gained its footing as a major source of financial security for millions of Americans.

Buchanan, Cappelleri, and Ohsfeldt of the American Society for public Administration (1991) studied Medicaid extensively during the 11-year period of 1977-1987. They perform a regression analysis of state-level expenditures and its correlation with several state-level variables such as personal income per capita, the previous year's

expenditures, political ideology, inter-party competition, number of physicians, enrollment, and the federal matching rate. Their goal was to determine which factors can best predict the degree to which a state invests in the medical care of its low-income population. The study found significant correlations with current-year Medicaid expenditures on: income per capita, previous year's expenditures, and number of physicians. The authors conclude that "wealthier states tend to spend more on Medicaid covered services for the poor than do states with lower incomes" (71). Furthermore, they assert that "[these spending gaps] may become even more pronounced in the future, especially if the national economy slips into a period of economic contraction during the 1990s" (72) because of "[then] current fiscal crises facing most state governments" (72). We now have the advantage of time to show us that the economy's downward movement in the years that followed was short-lived, and we will discuss later how Medicaid expenditures reacted correspondingly.

When applying these findings to this project's questions, we must address the fact that, despite its importance, utilization had not quite taken hold in the healthcare system analysis quite yet. This analysis sets the stage for predicting the nature of states responses to structural changes to the Medicaid system, as well as the explanatory power of state economic conditions. For example, when stratifying the states into five groups based on income per capita in 2015 (i.e. the top 10 states & DC, states 11-20, 21-30, etc.), we observe a similar trend relating state income to ACA Medicaid Expansion adoption (State Science & Technology Institute, 2016). Currently, 32 states (including DC have adopted the expansion), which amounts to 63% (Kaiser Family Foundation, 2017). All but one of the wealthiest states (10 of 11, 91%) adopted the expansion. The Figure 2 shows the clear difference in higher income states' willingness to adopt the expansion, versus the willingness of low-income states.

Figure 3



We see a clear relationship between state income per capita & devotion to Medicaid, also found in the Buchanan, Cappelleri, and Ohsfeldt study, within the most recent expansion. Upper-income states are above the national expansion adoption rate, whereas middle- and low-income states are below.

This period was comprised of a series of ‘Omnibus’ Legislations that refined and expanded coverage to several different groups throughout the population by adjusting the income level required for eligible mothers and their children (Kaiser Family Foundation, 2015). These changes set precedent for the way in which eligibility determination is debated even today, and led the country into the following period of major cost increase. Aside from these expansions in coverage, the financing of Medicaid expenditures was altered greatly with the Section 1915b and 1915c Waivers that “required [states] to provide additional payments to hospitals treating a disproportionate share of low-income patients (i.e., disproportionate share hospitals [DSH])” (Provost; Hughes,

2000). The effects of this legislation were not realized until the next period. The focus on healthcare expenditures within Medicaid largely characterize the way a state's program is measured. Though expenditures play a large role in how we discuss success of our current healthcare system, it does not adequately display access. Within Illinois, over half of the total expenditure on Medicaid patients can be attributed to just 10% of the patients (Shafrin, 2013). Since the majority of the cost describing this population is allocated to such a small portion, it is inappropriate to use expenditure as a measure of access in this context. We can label state per capita income as an expansion indicator because it remains significant in determining state willingness to embrace new expansions to Medicaid. However, there is little to take away in terms of access measures. Enrollment is the best proxy we have for this for this period, as utilization was unmentioned in the study above.

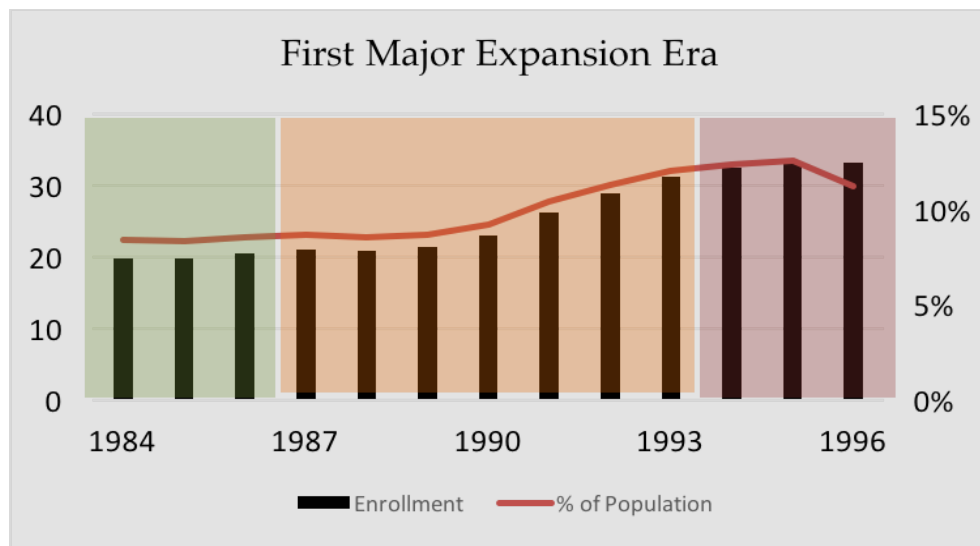


Figure 2.2 – An amplification of the second portion of the main enrollment chart (Figure 2).

First Major Expansion Era (1986-1993)

The impact of the Omnibus legislations that aimed to reshape the Medicaid system on a national level, as one might expect, was a drastic rise in both enrollment and expenditure. Some of the major expansions that occurred were a result of the aforementioned legislation. From an enrollment standpoint, Holhan & Liska report:

Federal law required coverage of all pregnant women, infants, and children under age six with incomes below 133 percent of the federal poverty line regardless of AFDC reciprocity. States were given the option to extend coverage to pregnant women and infants up to 185 percent of the poverty line with federal matching payments and 33 states have done so. States are now required to cover children ages 6 through 12 up to the federal poverty line. Poor children ages 13 to 18 are scheduled to be phased in by the year 2002. Between 1988 and 1992, 4.5 million pregnant women and children were covered through these mandates. These new eligible groups composed about 50 percent of the total increase in enrollment, though they accounted for a substantially lower share of total spending growth (Holhan & Liska, 1996).

One would expect that the large growth in expenditure during this period would be attributed to the major increase in recipients belonging to the groups mentioned above. This growth in expenditure, however, was the result of the absorption of many Medicare

recipients, specifically low-income elderly individuals. Medicaid began subsidizing premium and out-of-pocket costs for low-income Medicare recipients, thus driving costs upward. The slight dip in GDP in 1990-91 (Bureau of Economic Analysis, 2017) and the peaking of the unemployment rate in 1992 (Bureau of Labor Statistics, 2017) accounted for an increase in the eligible population (refer to Figure 1 above) independent of the new eligibility standards, which also increased costs. Given these other significant drivers of expenditure, the inclusion of impoverished children and their mothers were a small portion of the large increase in costs seen in this period.

Now that the history of this period has been discussed, we will delve into the considerations and analysis made by prominent health economists on this. Much like the most recent expansion, there was a concern regarding the crowding out of private insurers resulting from the increase in the public insurance enrollment. Gruber and Cutler (1996) assessed the validity of this criticism following the rapid growth in Medicaid enrollment in the early and mid 90s. The goal of the study was to forensically account for coverage gains following the expansions to Medicaid, and attribute them to one of several categories: the increase in the eligible population due to economic downturn, the transferal from the private insurance market, and the absorption from the previously uninsured population (outside of those whose income reduction resulting from the recession caused them to become eligible). Overall, full-year Medicaid enrollment rose by 4 million between 1987 and 1992. The authors attribute 2.1 million of these gains to the actual expansions (379), amounting to over 50% of gains. On the other hand, private coverage fell by 1.7 million for these groups of the population (381), signaling a movement of roughly this magnitude from private coverage to Medicaid. Thus, it was concluded that there was in fact a degree of crowding out due to these expansions. Based on this assumption, approximately 42.5% of the enrollment growth in

Medicaid was a result of crowding out. The remainder of gains, less than 10%, can then be associated with the economic downturn experienced during this period. As a side note, nearly 90 percent of those made eligible during this period were employed (381).

In their conclusion, the authors suggest that future expansions to the system should be designed to reduce the amount of crowding out in private insurance coverage (383), and suggest that Medicaid's discrete eligibility standards are to cause for this (either fully-eligible or not at all). Their policy recommendation of "subsidizing the purchase of private insurance for low-income people, with a sliding scale that offers high subsidies for the poor, and low subsidies as income increases" (383) is a direct foreshadowing to the Affordable Care Act. Jonathon Gruber, one of the authors of the study, was a key player in designing the structure of the Act. Nonetheless, there is a clear path of development here towards the motivation behind this portion of the ACA. The realization of this mechanism will be discussed later in the project under the section covering the most recent expansion.

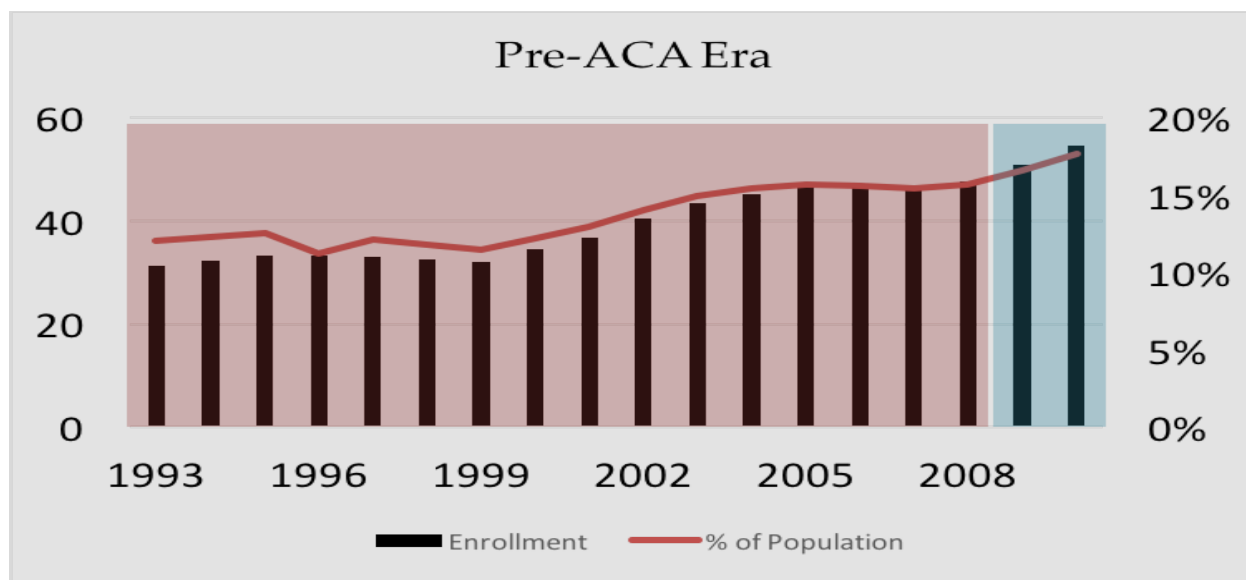


Figure 2.3 – An amplification of the third portion of the main enrollment chart (Figure 2).

Pre-ACA Medicaid (1993-2009)

The mid-90s brought a slowing to both expenditure and enrollment, as well as the sharpest decrease in program history for the percentage of the population covered by Medicaid. At this point the states were being bled financially by DSH waivers, so legislation was passed in 1991 that placed a ceiling on payments. Again, like most of these legislative changes, the effects took several years to realize. The uptick in the overall economy also contributed to the trend of lower enrollment and lower expenditures. Holhan and Liska (1996) report that, “Following four years of rapid expansion, Medicaid program growth slowed precipitously after 1992. After four years with an average annual growth rate of 22.4 percent, Medicaid spending grew on average by 9.5 percent per year between 1992 and 1995.” These slower rates of growth continued into the early 2000s, finally decelerating to an average of just 5.2% per year during the six years leading up to the ACA (CMS, 2014).

To further analyze these new trends, we examine a state-by-state breakdown of expenditure and enrollment during this period. Cantor, Thompson, & Farnham (2013) look at several variables for each state's Medicaid system, and give an extensive historical recap of this era and its characteristics. They note:

A remarkable trend towards devolution characterized this period. The Clinton and GW Bush Administrations were much more willing to approve comprehensive demonstration waivers...than prior administrations...Many states used these waivers to reinvent their Medicaid systems in major ways (72).

States applied for funding through the comprehensive demonstration waivers that proposed new programs or allocations for additional funding. This era distances itself from the 1980s in that the majority of expansion and reform took place at a state level. In their study, they compare growth rates across enrollment and expenditure. Interestingly enough, among the ten most populous states, Illinois experienced most rapid growth in both expenditure and enrollment over this time period.

One historical event also relevant to this era was the threat of conversion to a block grant program that Medicaid faced in 1995 (Kaiser Family Foundation, 2015). In short, this would have restructured Medicaid from a means-tested program (one that has eligibility requirements, and covers all that qualify) to one that would be given a fixed allocation of funds. In effect, states would be charged with full control of eligibility requirements, covered benefits, and any other financial concerns. States already had a large amount of control over their respective Medicaid systems, and this change would have transferred even more autonomy over to the states. The vote was passed in both the House and the Senate, but was ultimately vetoed by President Clinton.

Focusing on the latter years of this period, two precursors to the ACA also occurred. In 2006, Massachusetts rolled out a health bill that was ultimately used as a model for the ACA, including an expansion of Medicaid (MassHealth/CommCare) coverage to those up to 150% of the FPL, and subsidies to purchase coverage up to 300% of the FPL. This state-wide expansion was heavily studied for the purpose of projecting the effects of the ACA. Gruber (2013) notes that the strongest of the studies on this topic employ a,

“[Difference]-in-difference” (DD) approach [that] allows researchers to consider how reform impacted Massachusetts relative to other states which were subject to similar time series shocks in outcomes. That is, this approach controls for both long-standing differences across states *and* time series trends in outcomes.

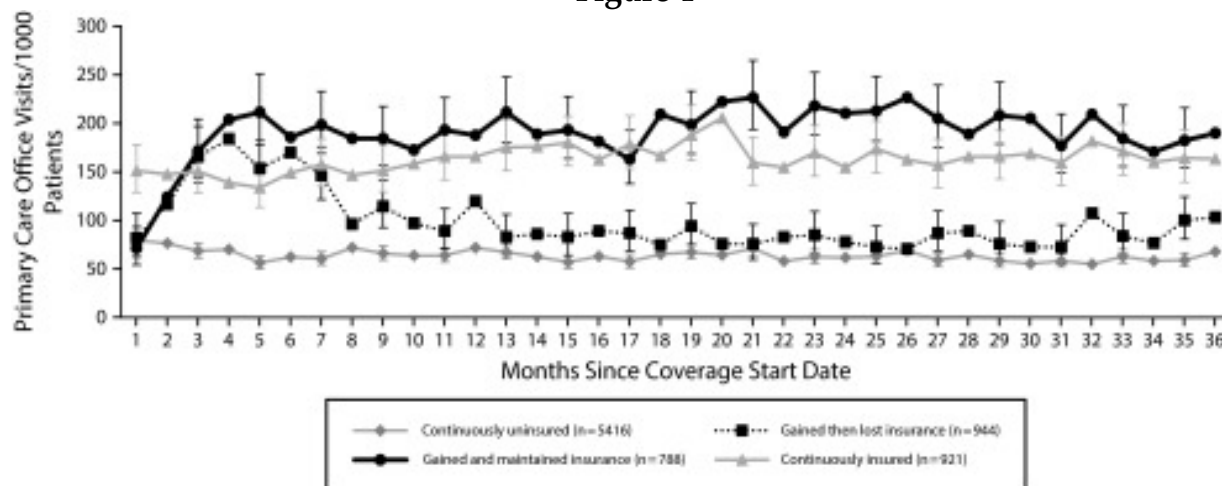
Miller (2012) uses this methodology in her study *The Effect of Insurance on Emergency Room Visits: An Analysis of the 2006 Massachusetts Health Reform*. Based on a regression model, she compared Massachusetts emergency room utilization with other states before and after the reform. She finds that there is a significant difference. Thus, the higher rate of insured individuals in the population contributes to a more effective and efficient delivery of care, as primary care utilization increased over the same time period. This would suggest the similar results for a national expansion of insurance coverage.

Two years later, to conduct an experimental healthcare system expansion, the state of Oregon randomly selected and enrolled 10,000 low-income, uninsured adults into their Medicaid system. Hatch et al (2016) examined the utilization rate changes following this state’s expansion. Shown in Figure 3 are the utilization rates of Primary Care Provider (PCP) visits in the three years following the Oregon Experiment’s expansion. Four different groups are examined based on insured status, as seen in the legend. One of the main takeaways illustrated by this chart is the importance of maintaining coverage.

Though *gaining, then losing insurance* still slightly increases one's propensity to visit a primary care provider over the continuously uninsured, the differences in utilization from those maintaining coverage are still disparaging. Overall, the authors conclude that:

Our findings suggest that utilization of primary care services at CHCs will increase in the wake of ACA-supported Medicaid expansion. Discontinuity of insurance may pose a significant barrier to accessing essential primary care services, particularly after initial coverage periods expire. As clinics, educators, and policymakers begin making projections for future clinical and workforce demands, our study supports continued investment in primary care and CHCs to meet the health care needs of vulnerable patients in the United States (Hatch et al, 2016).

Figure 4



Obtaining insurance is only the first step towards access to quality healthcare, whereas maintaining coverage is the long-term solution. Gains in outcomes from preventative services provided through access to a primary care provider can only be realized over time, which is what makes this challenge so important. Looking forward to the national optional expansion on a national level, it begs the question of how applicable these findings are to the rest of the country. Can concentrated changes to a state's Medicaid system always be successfully implemented at a national level? How far can associations be drawn across state lines?

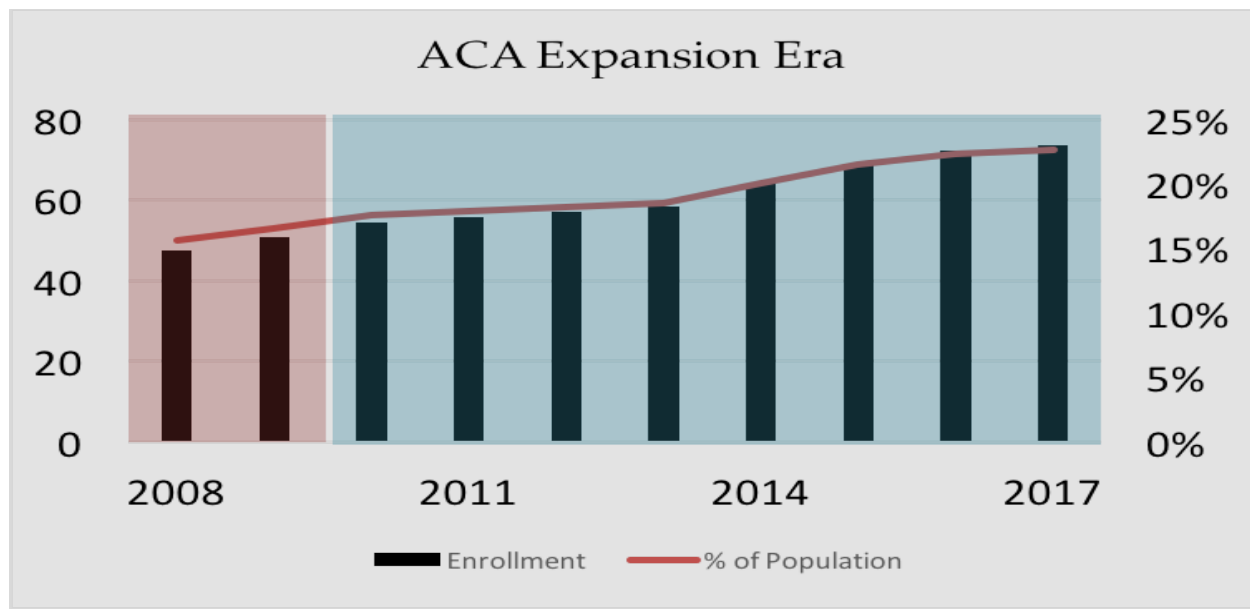


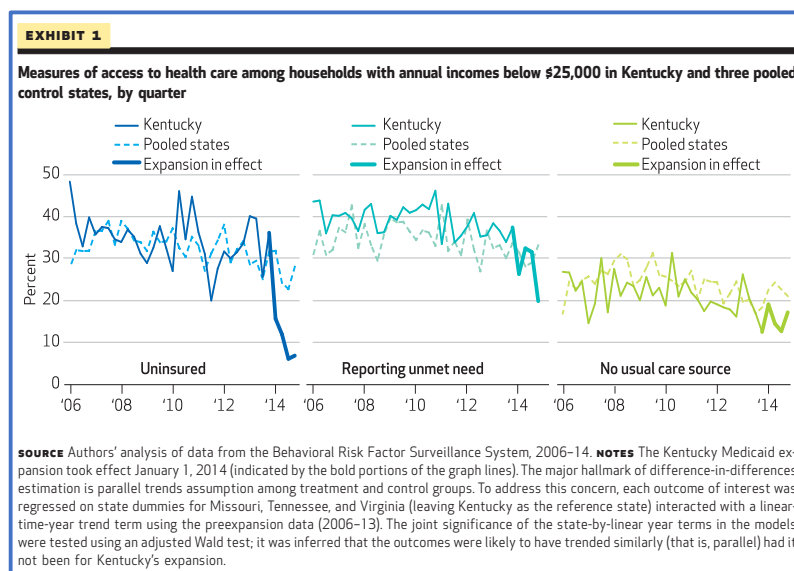
Figure 2.4 – An amplification of the final portion of the main enrollment chart (Figure 2).

ACA Expansion Era (2010-2017)

To transition from discussing major state-level Medicaid expansions happening prior to the ACA, we will start our review of literature on the most recent period by considering Kentucky's success with implementing their Medicaid expansion under the ACA. Benitez, Creel, and Jennings (2016) also carried out a quasi-experimental differences-in-differences study that juxtaposed Kentucky's experience during their expansion to several contiguous states that chose not to expand. They examined proportions of individuals who: were uninsured, had unmet medical needs due to financial barriers, and had a regular source of care. They restricted their study population to those who would be potentially affected by the Medicaid expansion (based on income and age requirements). Most notable was the sharp decrease in uninsured rate in Kentucky versus the other states considered. The other two measures also showed a smaller divergence between Kentucky and the other states (see Figure 5).

The study shows positive effects on access to healthcare that the ACA expansion provided to the citizens of Kentucky. It would be interesting, however, to see a more extended realization of the data to determine the long-term consequences of the expansion.

Figure 5



Obtaining insurance is a relatively quick process compared to finding a regular source of care. Establishing a stable relationship with a doctor can take years, as it takes time to develop a proper understanding of the patient's needs and to fortify the provider's credibility. Another benefit of using longer-term data is that the *renewal dilemma* can be seen and assessed. This challenge occurs at transition between two policy periods when the patient must renew coverage, and the patient has issues in successfully doing so. This issue will be further observed in following studies.

On the topic of measuring access to quality healthcare at a national level, Sommers, Gunja, and Feingold et al (2015) released a study in the Journal of the American Medical Association that measured access to healthcare both before and after the ACA expansion in various ways, comparing trends between expansion and non-expansion states. Participants were questioned on their access to a personal physician, "easy access to medicine," their ability to afford care, self-perceived health status, and the extent to which poor health inhibits their daily lives. Like the previous study, it should be mentioned that

this study examined the perspective of the healthcare consumer, rather than the provider/administrator. Making this choice causes for some pitfalls. For example, the study noted that it was limited to a “low response rate, between 5% and 10%, similar to other household telephone polls without financial incentives for participation” (2). Additionally, the credibility of this study may be challenged as surveys on the healthcare system given to the public result in negative findings, regardless of how questions are phrased. However, this study uses differencing in its approach (before the expansion and after the expansion), which controls for this issue.

Now, there are also some benefits to examining these variables from the perspective of the consumer. As was will observe later in the Artiga & Gates article, simply because a person is assigned or connected with a physician does not necessarily mean that they are successful in coordinating with that doctor. It is important to ask the patient directly if they have a “personal physician.” Though they may be assigned to one systematically, the patient may be better suited to articulate how well they are able to utilize their healthcare. This study is also noteworthy due to its use of other measures of access to care such as patient perceived health status, inability to afford necessary medical care, and patient perceived ability to easily access medicine. The study goes on to explain and show that the worsening trends found in these measures have been largely reversed in expansion states, and have not significantly been changed in non-expansion states. There was one exception in the case of “ability to afford care,” in which the differences-in-differences assessment did show a significant improvement. Altogether, this study illuminates the clear differences in access to healthcare following the expansion.

Miller and Wherry (2017) uncover many interesting findings in their comprehensive study regarding the effects on access to healthcare following the ACA's Medicaid expansion. Another quasi-experimental differences-in-differences study, the authors analyze variables surrounding enrollment in insurance, utilization of several preventative services, financial strain related to obtaining care, and other access-related variables before and after the expansion in expanding states versus non-expanding states for strictly low-income individuals. The study takes measurements before the expansion, 6 months after, 1 year after, and 2 years after in order to measure the impact of time. Significant changes in insurance enrollment took effect quite soon. On the other hand, variables such as "needed follow-up care but did not receive it because could not afford it", "needed to see a specialist but did not because could not afford it", "took less medicine in order to save money", and "problems paying or unable to pay medical bills" all took until the Year 2 measurement to significantly change (953-954). Other notable findings include a decrease in the overall uninsured rate of 8.2%, a decrease in the national private coverage rate of 7.6%, and an *increase* in the national Medicaid coverage rate of 15.6% (953-954).

This study highlights several key questions. First, what causes for a delayed tackling of financial obstacles, when insurance enrollment seems to be immediate? Next, the greatest magnitude of positive change for utilization of preventative services was an increase of 6.0% for utilization of "blood level checks". Similarly, the greatest magnitude of favorable change for financial strain variables was a decrease of 7.9% for "[worrying] about to pay medical bills if become sick or have an accident" (953-954). These percentages do not closely resemble the overall percentage increase in Medicaid enrollees. Why is it that enrollment in Medicaid does not guarantee solutions to the

problems of being uninsured? Surely, we cannot expect to see Medicaid enrollment and these other outcomes move in lock-step, but the levels of convergence displayed in this study suggest that enrollment in the current Medicaid system is not sufficient in order to receive optimal levels of medical care. Of course, the nature of the study may have a bias toward negative responses, given that individuals often see the medical profession in a negative light. Still, the degree to which positive outcomes lag behind enrollment begs further discussion on how to ensure quality healthcare to low-income individuals.

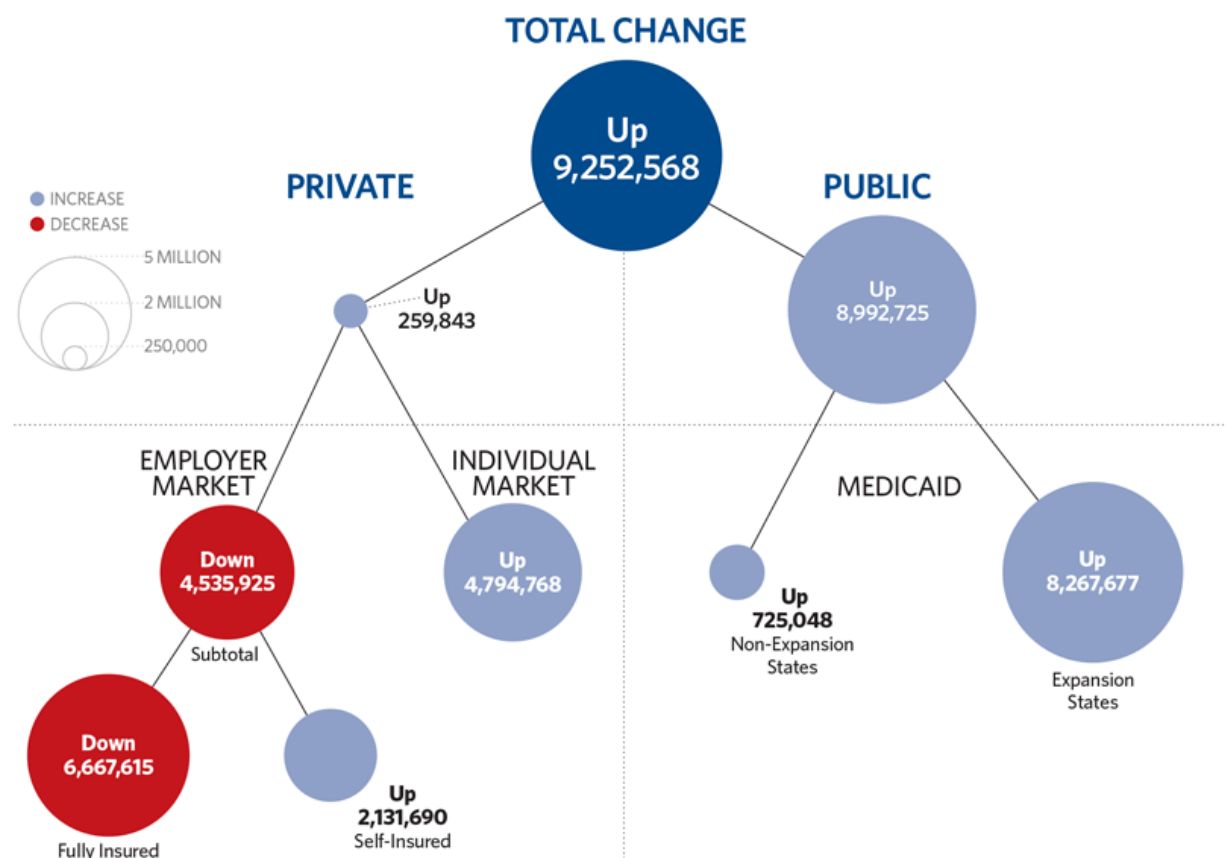
In an attempt to track and assess large scale trends on a variety of measures, Gray, Song, & Richardson (2015) of athenaResearch produced *Observations on the Affordable Care Act: 2014*, a report that evaluated changes ranging from new patient volumes to changes in insured rates. Although the study takes the general population into account, the results are still important based on the fact that as of October 2015, the 9.25 million that have gained coverage following the Affordable Care Act, Medicaid has increased 8.99 million (Haislemaier, 2015). The authors assert that “concerns that physicians would be overwhelmed with new patients have not been borne out,” and “providers are conducting a higher proportion of more comprehensive patient evaluations” (3). Furthermore, this study corroborates the contention that expansion states have made significant improvements in decreasing the uninsured rate over non-expansion states. This article also addressed the concern of crowding out resulting from expanding Medicaid, stating that a small but increasing number (1.1% and 1.4% in 2013 and 2014 resp.) switched from commercial insurance to Medicaid (12). This, however, is much smaller than the degree of crowding out seen in the late 80s and early 90s. Not surprisingly, the Medicaid expansion was accompanied by subsidies for those between

138% and 400% of the FPL to purchase private insurance, as suggested by Cutler and Gruber in 1991. This eliminates the discrete nature of government provision of health insurance, and limits crowding out.

Figure 5

New 2014 Health Insurance Enrollment: Increase Mostly Due to Medicaid

The number of Americans with health insurance increased by 9.25 million in 2014. However, the vast majority of that increase was the result of nearly 9 million individuals being added to Medicaid, while the net enrollment increase in private health insurance was just 260,000 people. Shown below are changes in health care enrollment from December 2013 to December 2014.



It is also worth expanding the claim related to changes in the patient-provider relationship changes following the ACA Medicaid Expansion. The authors report that

While physicians are not seeing much greater numbers of new patients, there is some indication they are conducting more comprehensive assessments for the new patients they do see. Our second measure of new-patient volumes uses billing codes for evaluation and management (E&M) services (7).

Gray et al go on to explain that these E&M services are being billed at an increased rate for patients, specifically coded to signify having not seen a doctor in at least three years. It would be expected that the rise in these procedures should be met with a proportionate rise in patient counts. Since it has been established that this is not the case, the authors to conclude that “the ACA may have increased the rate at which physicians are establishing new relationships with patients” (7).

The authors further posit that “the ACA has dramatically benefited uninsured individuals with stable provider relationships” (9). This claim draws upon data of uninsured individuals who had visited a primary care provider in at least two of the last three years, as well as the decrease in uninsured rates seen especially in expansion states. Upon further review, the authors were simply stating that uninsured individuals that went to the doctor in years prior became insured at a higher rate than years prior. Though this finding is positive in illustrating the ACAs success in coverage gains, the original assertion is quite misleading in its wording. Yet, this brought about ideas that tie in quite well with the focuses of this paper: how can we assess the stability of the patient-provider relationship? Is it necessary to go beyond primary visits to capture the whole picture?

Artiga & Gates (2014) focus on the effects that the ACA Medicaid Expansion had specifically on the homeless population. The study was conducted in a focus group setup:

with staff and community partners at federally qualified health centers that serve individuals experiencing homelessness at four sites in states that have expanded Medicaid. Focus groups were also conducted at a site in Jacksonville, FL to gain insight into experiences in a state that has not expanded.

The motivation behind focusing in on the homeless population was to expose other factors that these individuals face (outside of financial barriers) that are negatively impactful on their health, and in turn their lifestyles. Not surprisingly, “Of [Homeless patients served] in 2013, 57% were uninsured, compared to 35% uninsured patients served at all health centers and over four times the rate of the general population.” Thus, it seems logical that expanding Medicaid could have noticeable effects on this group.

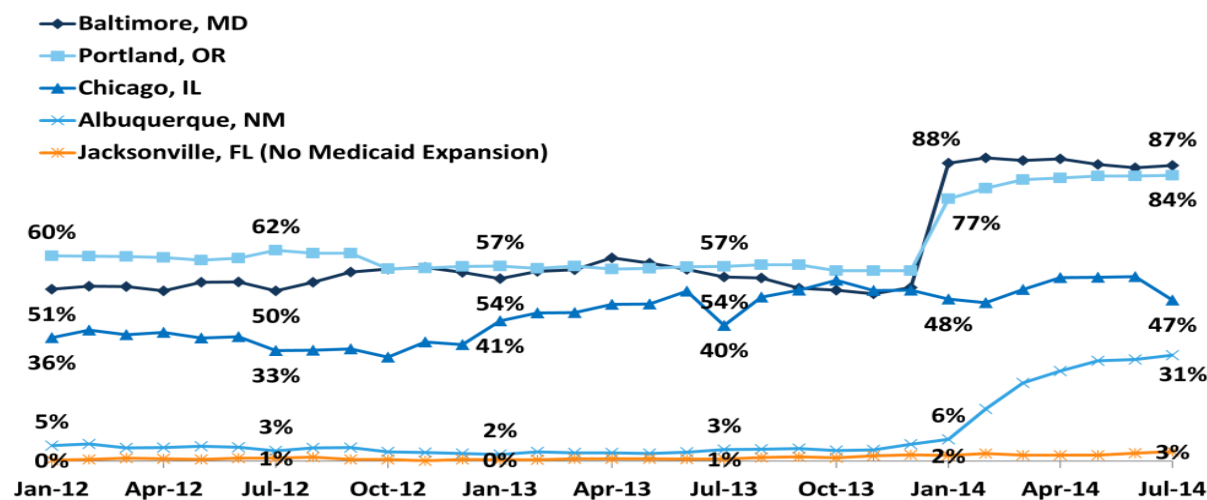
In general, the authors find that there was a clear difference between the sites in expansion states and the site located in the non-expansion. On both eligibility and percentage of insured (presumably through Medicaid), expansion sites saw increases while the non-expansion site saw little to no change in insurance enrollment and eligibility. It should be noted that perhaps this study could be made better by examining more sites in non-expansion states, but it observes many other important facts within states that expanded worth talking about in the scope of this project. For instance, the study specifically references how the site in Chicago, Il. chose to adopt outreach efforts linked to the expansion earlier than other states. This caused for the gains to come sooner in Chicago than other sites.

Other summarized findings from the surveys of providers at these sites include an increased access to a broad range of benefits, thus allowing for a more complete treatment experience. The improvement of options for care also caused individuals to feel more involved in their healthcare experience due to their expanded choices. This boost in the ability to treat patients more holistically was also felt on the provider side, and led to developments in long-term planning for patient health. Not all findings were necessarily positive, though. Despite these improvements in coverage and health outcomes, the authors still found that many barriers existed for this population. Individual patients lack education and skills necessary to understand their newly acquired coverage, despite a

strong willingness to become enrolled. On top of this, many newly insured individuals continued to see their normal provider even though they now had increased options for care.

Figure 6

Percent of Visits with Insured Clients by Study Site, January 2013-July 2014



Source: data reported by National Health Care for the Homeless study sites, 2014.



Also, maintaining coverage from one enrollment period to the next was a common struggle for this population due to the difficulty of regularly reporting income. We see this above in Figure 6, especially in Chicago, as enrollment drops noticeably during July of both 2013 and 2014. We can presume then that at the time of coverage renewal, there is a lag in reobtaining coverage officially. What is also distinct about Illinois is the slow gradual increase, as opposed to the sharp explosion at the start of the expansion.

Artiga & Gates study extensively covers the implementation of managed care for homeless individuals, and those on Medicaid in general. The challenges that accompany the network setup are largely organizational. Understanding what is covered, both for providers and patients, is a large issue when it comes to treatment. Managed care

organizations often do not offer the same benefits, so treatment of the patient can be affected by the enrollees membership in a certain plan. Another common challenge for Medicaid lies in matching individuals with networks that can properly accommodate their needs. After examining obstacles with managed care mentioned by the participants, it sparked the question: is managed care the best option for homeless individuals, or even Medicaid recipients overall?

The idea of *health outside of health* is quite important. Social determinants like stable housing is quite important to maintaining good health status. The state of New York has taken measure to solve this by implementing, “supportive housing programs to provide vulnerable high-cost Medicaid members with rental subsidies, new capital construction and pilot projects to test new models of care. Since 2012, over 11,000 high acuity Medicaid members have been served” (health.ny.gov). They contend that:

Early findings demonstrate that investments in social determinants, such as housing, can have a profound impact on health care costs and utilization, including a 40% reduction in inpatient days, 26% reduction in emergency department visits, 15% reduction in overall Medicaid health expenditures (Ibid).

Following the consideration of this series of studies, many patterns have been unearthed, several new ideas have been uncovered, but other questions have been raised. We have seen the realization of a past policy idea implemented into the Affordable Care Act as a sign of progress towards further understanding the complex nature of insurance markets in healthcare. We have noticed other barriers to not only obtaining insurance coverage, but sustaining it. A debate on managed care and its place in the public healthcare insurance system has begun. The uniqueness of Illinois’ Medicaid has been displayed. The population of Medicaid recipients has been completely redefined. And finally, new ways in which access can be measured have been revealed and put to use. From here we

move to the interview section of project. These interviews have been included to add another dimension to this analysis, and address questions left unexplained by previous studies. They provide a more comprehensive study of the barriers that Medicaid recipients face, especially in Illinois, and how to gauge the success of mechanisms in place to correct them.

Interviews

Though it is essential in proving theory, empirical research can only go so far in telling the story of Medicaid, leaving many questions unanswered. The following statements contain the views of healthcare professionals who have personal experience with the Medicaid system in Illinois, and even had a role in its development. In the interest of professionalism, and out of respect for the interviewees, only the occupations and backgrounds will be depicted in this project. Each interviewee will be referred to by their profession (i.e. *The actuarial interviewee contends that...*, *the diabetes educator interviewee has stated that...*, etc.) Their opinions and findings will be discussed in light of the questions raised by review of literature on the expansion of Medicaid.

This section summarizes these findings by way of crafting a narrative. The questions addressed during the interviews dealt with various topics and were adjusted for each interviewee. That is, many (but not all) interviewees were asked the same questions, though they often were nuanced to more adequately fit the interviewee's background. The interviews uncover unmeasured barriers that Medicaid recipients face, as well as the uniqueness of the Illinois system. Lastly, a question was asked that surrounded the topic of assessing a health act's performance and how well it achieves its goals.

Unseen Barriers

The literature that was studied unveiled how Medicaid recipients can face many obstacles in receiving medical care, even beyond ability to pay. The presence of obstacles has been further explored in the interviews. Part of the problem is rooted in finding a primary care provider who will treat Medicaid recipients. It is widely believed that those on Medicaid are often confined to an area with little to no access to a doctor willing to accept the reimbursements provided by Medicaid. The Healthcare Systems Administrative interviewee provided some clarity on the topic by saying that this is the case only in locations where Medicaid recipients are uncommon. In her view, neighborhoods with a high concentration of Medicaid recipients actually did not have as much of an issue with this. Nonetheless, in areas less dense with Medicaid recipients, this challenge still troubles many individuals.

The literature review also touched upon the issue of sustaining a stable relationship with one's provider. These issues were also echoed in the interviews in response to questions asked about non-financial barriers to care facing the Medicaid-receiving population. According to the Healthcare Systems Administrative interviewee, there are many people who do not appear to see the benefit in preventative medicine, and do not prioritize making time for regular check-up appointments. This issue often cultural for patients who do not 'buy into' medicine. Part of this issue also lies in language barriers, especially since communicating medical information can be much more complicated than everyday conversation. This is known as a lack of medical literacy, and can lead to a misunderstanding of the importance of certain procedures if it is not adequately stressed to the patient. This is an example of an obstacle that lies outside of the control of health insurance provision, and more to do with education. Healthcare delivery is a multi-faceted issue, and thoughtful planning is necessary to coordinate an

effective solution. Medical literacy issues show that enrollment in public insurance can sometimes fall short in providing a quality medical experience, and thus cause us to reexamine our assessment.

Other barriers to quality care lie in the benefits covered by Medicaid and, more importantly, those that are not. An interviewee specializing in Government Relations and Advocacy spoke about the process of adding and maintaining a benefit to eligible coverage being difficult. Lobbying at the state level is heavily involved, and sometimes not even scientific evidence is enough to obtain approval. For example, Massage Therapy could yield major cost savings if used in place of expensive prescription drugs. The interviewee stated that long-term utilization of massage therapy is much healthier than long-term prescription drugs, as well as more effective. He also highlighted the fact that, “The Joint Commission Standard PC.01.02.07 recommends massage therapy as a non-pharmacologic strategy for managing pain. Nationally, physicians are being encouraged to use non-pharmacologic strategies to combat the opioid epidemic occurring across the country.” A myriad¹ of well-respected major hospitals and medical centers recognize this benefit as a preferred part of integrative care for lower-back pain, yet all of this is of little consequence to the Illinois state Medicaid system, that still refuses to cover this treatment. Illinois’ financial situation has greatly affected Medicaid. In the midst of a budget crisis, the state government has shifted to the right on fiscal policy by cutting outlays to a large degree. In 2015, \$106 million was cut from Medicaid (Sun Times). This has affected the ability to obtain reimbursement payments on the provider side, and has caused obtaining and sustaining benefit approval to become much more difficult. The interviewee adds

¹Cedars-Sinai Medical Center, Mayo Clinic, Cleveland Clinic, M.D. Anderson Cancer Center, Duke University Integrative Medicine, and Memorial Sloan Kettering Cancer Center

that this is just one of the many examples, and that this issue is not unique to Illinois. Further still, this problem is not even unique to Medicaid, and must be solved at a population level in order to improve the quality of our overall healthcare system.

One final barrier faced by Medicaid recipients, and all low-income patients, is excessive harassment for payment. The Cardioelectrophysiologist (CEP) interviewee provided insight on this topic, and how the situation has worsened over the years. He said that those on Medicaid were specifically targeted with phone calls at obscene hours in the morning for the purpose of collection. He said his ability as a physician to stave off these calls, and to make treatment more affordable for patients, has lessened over the years. This is caused by the corporatization of hospitals, especially in an urban setting, that has become quite common more recently. He also argues that something as simple as a hospital's mission statement that pledges efficiency and profit over quality treatment can make a huge difference in the way physicians are able to make decisions in treating their patients.

The Illinois System

The state controlled nature of Medicaid makes looking at the Illinois experience valuable. Despite not having the precursory role that Oregon and Massachusetts had in shaping the Affordable Care Act, Illinois' situational setup is certainly quite unique. For instance, the interviewee specializing in Healthcare Solutions and Innovation has noted that Illinois has aggressively implemented Managed Care into its Medicaid delivery

system. Managed Care Community Networks (MCCNs) are in place across the states and are very similar to HMOs. Though Illinois has a relatively low percentage of Medicaid enrollees in managed care compared to other states, but the state is pursuing alternative solutions to the unseen barriers mentioned in the previous section by way of other organized medical networks. It has embraced this setup much more in recent years, which has resulted in rapid growth. Thus, the number of managed care enrollees strictly in the traditional sense is deflated, but overall is quite substantial. The interviewee argued that the implementation of managed care is crucial for patients in need of a stable provider relationship, which is very common for Medicaid recipients.

To help achieve this goal of pursuing the best ways to organize how insured individuals obtain care, the ACA has established the Center for Medicare & Medicaid Innovation (CMMI). This organization grants funding to several competing entities that attempt to improve the way managed care is delivered. These entities are commonly known as Accountable Care Entities (ACEs) and Care Coordination Entities (CCEs). These model plans serve to fill in gaps where MCOs and MCCNs fail to provide “high touch care,” or home health services and services performed within the community. The interviewee argues that these types of models are much more effective in overcoming the unseen barriers faced by Medicaid recipients. Insurance companies and other overseers of MCOs cannot train staff necessary to perform these services, so the importance of investing in ACEs and CCEs to contract their services are necessary to craft a holistic healthcare experience (Illinois Department of Healthcare and Family Services, 2017). She also stated the importance of data collection for healthcare analysis. By providing many individuals with insurance, the Medicaid expansion has paved the way for new observation. Data for uninsured individuals are much harder to record, and essentially

do not add to trend assessment in pursuit of improving the healthcare system for low-income individuals.

Illinois' unique geography creates other issues. Much of the population resides in urban neighborhoods with limited access to nutritional food. The Illinois Advisory Committee (2011) specifies in their report to the US Commission of Civil Rights that:

food deserts are closely affiliated with communities that are generally of poorer health than communities with ready-access to nutritious food. In Chicago, food deserts are also a civil rights issue. Although food deserts exist in cities, suburbs, and rural areas and impact all races nationwide, in Chicago food deserts tend to disparately impact African American communities and are intimately aligned with the city's racially segregated housing patterns. Food deserts carry great costs to those who live in them and society as a whole (5).

The interviewee specializing in Diabetes Education believes this to be major issue when it comes to everyday health outside of the formal healthcare system. This leads to an overutilization on prescription drugs rather than a focus on dietary changes. In the report cited above, it is also mentioned that, "obesity, as a public health problem, costs the state of Illinois \$3.4 billion a year because of the secondary diseases with which it is associated...addressing food deserts is one way to address the exorbitant costs associated with the public health problem of obesity" (6). Another major geographical obstacle that affects some Chicago neighborhoods is adequate transportation. Patients are unable to easily reach their provider, so they are unable to maintain consistent contact. This is how the ACEs and CCEs using high touch care can improve overall outcomes, as well as lower costs through home health care. The idea is that an investment in the individual's health today will create future benefits that far outweigh the costs seen today in implementing these new care models.

Expanding on the idea of geographic disparity, the effects of scarcity of medical care in parts of the city and its surrounding areas are astounding. Just between the bordering communities of Austin and Oak Park, life expectancy varies by nearly 10 years.

There are other factors at play here, but even with violent crime taken into account, alarming inequities still exist. Infant mortality rate per 1000 is almost 10 deaths greater in Austin (Rush University Medical Center, 2016). This is one example of many disproportionately poor health outcomes found in Chicago.

Measuring Access

The last major topic covered in the interviews was on the measurement of access to quality healthcare. With a better understanding of what can stand in the way of this goal, as well as the mechanisms in place to combat them, a more critical assessment of how quality is judged can be made. When asked about measuring access to healthcare, the interviewees responded in similar ways, but with subtle differences in elaboration. Two of the interviewees (Actuary and Healthcare Systems Administrator) broadened the definition of utilization measurements. Formally, the National Committee for Quality Assurance (NCQA) and the Center for Medicare & Medicaid Services recognize a tool known as Healthcare Effectiveness Data & Information Set (HEDIS measures) “to measure performance on important dimensions of care and service” (NCQA, 2013). The common theme however was that access to healthcare is a complex trend to observe, and that sociodemographic variables play a large role in this regard. Furthermore, everyday habits are also important to observe, reinforcing the idea of *healthcare outside of healthcare*.

In Illinois specifically, the success of ACEs and CCEs are based on Health and Quality of Life (HQOL) Measures. These consist of Access/Utilization Counts on primary

care visits, prevention and screening services, and more specialized services for specific conditions (Illinois.gov). Integrated Care Programs (ICPs) also examine follow-up rates as a measure of utilization. These organizations have even set up a system of contacting patients at risk of repeating an adverse event shortly after their visit. This system aims to more appropriately address the patients hierarchy of needs by taking advantage of the resources available to the patient, as well as those within the managed care organization. The utilization measures are then used to prioritize certain services based on their effectiveness, and how important they are to a community's health. Yet, the Healthcare Solutions & Innovations interviewee brought up how this methodology can inhibit certain individual patients from obtaining proper care based on their unique needs. Another overall goal of ACEs and CCEs is to limit the amount of absences from school and time off from work due to an illness. We saw in the article focusing on homeless Medicaid recipients, measuring this addresses the cyclical nature of illness and how it recurrently affect one's ability to learn and work.

The actuarial interviewee also presented average wait time for a PCP appointment as a common measure of access. An MCO bases its success on some utilization counts, but more so on its quickness to resolve claims issues, as well as approve procedures. It also places emphasis on how large of a network it builds using counts of added physicians. We see here that the motives echo what was stated by the Healthcare Solutions & Innovations interviewee about managed care lacking a holistic approach, solely based on its goals. All in all, these measures aim to move Medicaid managed care from a fee-for-service reimbursement schedule into a pay-for-performance model.

Afterward

Once again, the federal government is in the process of reworking and voting on a bill that may cause the Medicaid Expansion under the ACA to become obsolete. Yet, despite the future of the Medicaid system, the silver lining to a project such as this is that there is something to be learned from the assessment of performance. In other words, the most recent presidential election can speak to the fact that many feel that the ACA is that it is a complete and utter failure that should be *repealed and replaced* at all costs. It is beyond the scope of this project to debate this point. However, it is certainly within the scope of this project to make the claim that this public view of the ACA says something about society's general understanding of healthcare. As was mentioned before, the ACA was comprised of many parts, one of which being the state option to expand Medicaid.

The national conversation surrounding the pitfalls purportedly resulting from this bill illuminates that the significance of this portion of the bill is understated. Granted, organizations like the Henry J. Kaiser Family Foundation have provided the public with extensive research of the coverage gains resulting from the ACA, yet the portrayal of on most major media outlets continues to primarily follow the exiting of insurance companies from the exchanges in states across the nation. This is not to say that occurrences such as these are not significant, but seeing as one of the primary goals of the ACA was to expand coverage to *quality healthcare* perhaps other narratives should be brought into the conversation. Especially when these gains in coverage, a good starting point in this discussion, have occurred mainly outside of the state exchanges.

Though it is true that Medicaid coverage has been shown to improve health outcomes (Sommers, Baicker, & Epstein, 2012), policy experts still claim that Medicaid recipients are provided with sub-standard care (Blase, 2011). So, how can the system be

adjusted to close this gap? Coverage is clearly the first step, but what are the following actions to be taken? Early opinions following the implementation of Care Coordination Entities from the field show that bringing medicine to the patients is an effective solution by in achieving positive health outcomes, and in the long-run more effective from expenditure standpoint. Moreover, the process by which benefit packages are assembled is an excellent topic for further research. If scientific evidence is not substantial to win the favor of those approving benefit coverage, then what is necessary? Perhaps the better question is: how can the process of assembling scientific evidence to display financial gains and improvements in outcomes be adjusted to hold more weight? It could be the case that the problems fall outside either of these question, but this is certainly a topic worthwhile of investigation.

Standards of measurement shape the following debates on the efficacy of health programs. These standards of measurement have shifted over time, and should continue to do so in order to arrive at an optimal solution that yields the greatest benefit to patients. Should access remain a priority of the healthcare system, the country needs an overhaul of the surrounding discussion. The state-run nature of the Medicaid system contains an unexploited advantage. While the years leading up the ACA brought about many state-level changes through the waiver system, the results of these waivers are heavily left out of discussion and analysis. In order to improve the overall quality of Medicaid systems across the nation, there should exist a Public Analysis Forum for State Medicaid System Structures.

This entity's purpose would be to compare, contrast, and debate the existing systems and their effects. There is currently an unused advantage of having a vast array of differing Medicaid systems with differing mechanisms and setups. States officials could view this Forum and more efficiently make decisions about their current setup.

There could be a system of rankings that yield grants to incentivize publishing of findings. This would serve to create competition for the prioritization of improving quality of Medicaid system. It is important to state that the goal should not be to find one clear solution to proposed issues, and there should always be diversity within the pool of options. A crop yield should not be homogenous, or else it falls victim to the same disease. State Medicaid systems shouldn't be identical, or else they fall victim to the same complications.

This project has brought together a series of studies that highlight the changing discussion surrounding how the effectiveness of a healthcare system can be measured. The upshot of this assembly is that the method in which research is being conducted matters to the discussion that follows. This may seem to be an obvious conclusion, but choosing different measures provides us with different views of Medicaid. When we gain simplicity and accuracy by choosing to examine enrollment, we miss out on deeper levels of assessment regarding the quality of care. In order to properly carry out these deeper-level assessments, we must think carefully about the driving forces at the root of the problems facing those in our healthcare system. The ACA has created entities to pursue this question, but it is important that findings regarding the prioritization of effective services be well-publicized and engrained into the national discussion regarding how to structure the healthcare system. In closing, there is much to be learned outside formal studies of Medicaid. Low-income individuals face a unique experience in receiving medical care, and this experience cannot be fully captured solely with aggregate statistics. We need to expand the healthcare debate beyond just that which occurs within the healthcare delivery sector. Other factors play a strong role in driving poor health outcomes, and this must be recognized if these outcomes are to be significantly improved.

In her book, *Planning for a Nation's Health*, Budrys (1986) recognizes the shifting of national priorities in regard to our healthcare system. To provide a brief summary, starting in the first half of the 1900s, the importance of medicine was widely-distributed and the medical education system underwent significant reform. Following this, socioeconomic inequality characterized the 1960s, and as a result, the healthcare system prioritized expansion of access to the benefits of medicine. The 1970s saw large aggregate increases in costs, so the country's objectives shifted to cost control measures via the studying the effects of medical procedures. Finally, the 1980s shifted the focus yet again to administrative efficiency, and largely privatized the medical sector. It is clear to see that each of these concerns is still present in our debate today. Yet, little certainty currently exists as to where we are headed. That is, what will the administration choose as its next priority, and how will it achieve this goal? The causes of this tendency to fixate on one result of a piece of legislation are numerous, especially in the political arena. Yet, what is important to take away from this analysis is that a trend of carelessness in focus has now plagued the discussion surrounding the healthcare industry. It is time for the nation to take a step back and reassess its goals and its solutions for the coming years with respect to the structure and financing of its healthcare system.

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