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Ensuring equitable access to public health care: Two steps forward, one step back

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ABSTRACT

Advancements by the federal government to extend access to health care to Medicaid eligible populations have been countered by state government efforts to curtail program benefits and eligibility. Fiscally and philosophically-based legislation and Medicaid waivers have created a patchwork of state policies that contradict the original civil rights orientation of the program. This examination of equitable access to Medicaid programs and services reviews individual and community factors and fiscal and institutional barriers that contribute to discriminatory practices and then explores ways in which the Patient Protection and Affordable Care Act (ACA) addresses those issues. We find that the ACA funding authorizations for numerous innovative programs strives to substantially redress issues of discriminatory and inequitable service provision.

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A variety of policy efforts during the last decade have broadened the scope of eligibility for Medicaid recipients, such as increased income parameters and expansions of covered services. The number of eligible participants increased, as did those receiving services, yet a disparity remains between the number of eligible and active recipients. Enrolled participants increased by over 50% between 2000 and 2010, from 44.3 million to almost 68 million, yet in 2010 more than 20% of those eligible, or approximately 20 million people, did not receive health care (Tavener, 2012).

Those eligible for Medicaid services face a number of discriminatory barriers in their efforts to access health care. Academic literature and media accounts most commonly discuss federal and state fiscal and policy limitations; less frequently noted are the individual and community-based barriers. Individual-level impediments

include race, income, education, insurance status, and disability. Community-related limitations encompass community homogeneity, neighborhood socioeconomic factors, and neighborhood residential instability.

The comprehensive health care reform initiated by the Patient Protection and Affordable Care Act (ACA) aims to supplement existing Medicaid services by extending coverage to additional lower-income levels and reducing barriers to access. The ACA accomplishes this by distributing matching funds to states to cover the costs of extending coverage to additional participants and through grants for systems, infrastructure and workforce enhancements, as well as for efforts that encourage and support local community development, which also facilitates expanded access to care (U.S. Congress, 2009).

The US Supreme Court's ruling on the constitutionality of the ACA allows states to opt out of the expanded Medicaid coverage requirements (The Henry J. Kaiser Family Foundation, 2012). Several states with the highest rates of uninsured have embraced that option, despite federal funding of 100% for the first few years and then 90% through 2019 (The Advisor Board Company, 2013). On the other

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hand, federal budget restrictions and deficit-cutting measures, such as the recent sequestration, have the potential to reduce federal funding for social services and state transfers, which could negatively impact planned expenditures called for by the Act (Kogan, 2012). These actions could, to some degree, negate the ACA's efforts at reducing barriers to access.

1. Equitable access: disparities versus discrimination

Definitions of the term “equitable access” vary; in fact an international symposium on research of diseases of poverty, sponsored by the United Nations, provides an extensive discussion of access and equity. For this study we use what appears to be the most comprehensive and applicable understanding of the combined terms from their discourse:

Equal access for equal need, where equality of access means that two or more groups face barriers of the same height and where the judgment of the heights is made by each group for their own group; where need is defined as capacity to benefit; and where nominally equal benefits may be weighted according to social preferences such that the benefits to more disadvantaged groups may have a higher weight attached to them than those to the better off (Mooney & Blackwell (2004)¹ as cited in [United Nations Research Institute for Social Development, 2007](#)).

Reports of challenges to equitable access to health care, as experienced by racial and ethnic populations, prompted Congress to order the Institute of Medicine (IOM) to study disparities and discrimination in health care at the individual (provider and patient), institutional, and health system levels. In their report to Congress, the [IOM \(2003\)](#) defines disparities in healthcare as “racial or ethnic differences in the quality of healthcare that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention” (p. 3). In contrast, their understanding of discrimination embraces issues of access, and particularly equitable access, noting that it “refers to differences in care that result from biases, prejudices, stereotyping and uncertainty in clinical communication and decision-making” (p. 4). The authors go on to note that this is not a legal definition, and that federal, state, and international laws view discrimination differently, with varying emphases on intent or disparate impact.

The social determinants of health, as described by the [Centers for Disease Control and Prevention \(CDC\) \(2013, p. 1\)](#), are the social, cultural, and economic characteristics that impact the health and well-being of communities and their residents. They reflect aspects of discrimination in access to care based on assessment of the ways in which policy choices made by those with power and resources affect those without and play a substantial role in influencing

their health outcomes. These factors include early childhood development, educational attainment, employment opportunities, provision of basic survival needs including food and shelter, discrimination and social support, and access to quality health services. They also note that,

Addressing social determinants of health is a primary approach to achieving health equity. Health equity is ‘when everyone has the opportunity’ to ‘attain their full health potential’ and no one is ‘disadvantaged from achieving this potential because of their social position or other socially determined circumstance’ [5]. Health equity has also been defined as ‘the absence of systematic disparities in health between and within social groups that have different levels of underlying social advantages or disadvantages—that is, different positions in a social hierarchy’ (p. 1).

2. Medicaid's mission: equitable access to equitable care

Title XIX of the Social Security Act (1965) established the Medicaid program as a means for providing health care to the indigent, elderly and disabled, and low income families. It was designed in keeping with the egalitarian spirit of the times, which saw the abolition of other discriminatory practices through passage of the Civil Rights Acts of 1964 and 1968, The Voting Rights Act, The Economic Opportunity Act, and the initiation of the country's war on poverty. It assures equitable access to health care through anti-discrimination language oriented in civil rights.

...these rules ‘define what types of activities and practices by federally assisted grantees constitute discrimination and set forth procedures for remedying discriminatory conduct. The regulations bar both intentional acts of discrimination and activities that are neutral on the surface but that have a discriminatory effect. They also prohibit recipients of federal funds from subjecting persons to segregation or separate treatment on the basis of race or from establishing facility locations with discriminatory effects’ (Rosenblatt, Andrilla, Curtin & Hart, 1997, p. 93).

Despite the program's commitment to equitable access, there are several “historical barriers” to identifying those eligible for Medicaid and then getting them enrolled. The program itself is designed “to ensure that ineligible people can't mistakenly get in, as opposed to ensuring that eligible people can get in” (Lubell, 2013, p. 1), and the federal and state requirements are often confounding. In addition, many people are not aware that they are eligible, or assume that they do not qualify and tight state budgets generally do not provide for outreach efforts. Further, many of those eligible live in remote, rural areas of the country where there is often limited knowledge of public health care, resistance to being dependent on federal assistance, and little incentive to sign up for Medicaid until there is a real need for treatment (Lubell, 2013). And for those who are enrolled, there are numerous socio-cultural, institutional, and fiscal factors that hinder participants' ability to seek and receive

¹ Mooney, G. and Blackwell, S. (2004). “Whose health service is it anyway? Community values in healthcare.” *Medical Journal of Australia*, 180(2):76–78.

the care to which they are entitled (Rosenbaum, Serrano, Magar, & Stern, 1997).

3. Impediments to access: individual and community factors

Over the years, numerous studies have documented barriers to care for low-income and disabled Medicaid-eligible persons. Andersen (1968, 1995), for example, looked at behavioral variables existent in equitable and inequitable access and defined the two terms according to which predictors of realized access are dominant. The common dependent variable investigated was some measure of access to health care, and in these studies the variable was operationalized in several different ways. Subsequent studies focusing on neighborhood determinants of health adopted “individual reports of having a usual source of care” as a more encompassing measure of access.

Operationally, equitable access occurs when demographic and need variables account for most of the variance in utilization. Inequitable access occurs when ethnicity, health beliefs, and income determine who gets medical care. In some instances, studies have incorporated “usual source of care” as part of the operationalization of a larger measure, such as poor access to health care. For example, Kirby and Kaneda (2006) asked respondents whether they had a “particular doctor’s office, clinic, health center, or other place” to which they usually go when they are sick or need advice about their health. Respondents were also asked if whether that source was a hospital emergency room or if they or a family member could not get the care they needed during the previous twelve months. An affirmative response to any of the previous questions was coded as an individual having “poor access to health care.” Studies that utilize this methodology do not consider use of a hospital emergency room as an acceptable usual source of care.

Building on Anderson’s work, Litaker, Koroukian, and Love (2005) proposed a model that identified factors that influenced an individual’s report of having access to a usual source of care. Their model ascribes two levels to the contextual determinants of health care accessibility. The first level is similar to Andersen’s model in that it describes the characteristics of the individual. It is categorized into three domains representing features that predispose participants to seek services, enable them to obtain care, and present their need for care. This level is similar to the predisposing characteristics found in Andersen’s model.

The second level of contextual characteristics includes factors that reflect the structure, function, and accessibility of the health care system and presupposes a social and economic environment conducive to supporting these characteristics. This model proposes that these contextual factors represent the basic elements of a society that shape the opportunities available to its citizens and are independent of individual characteristics. In addition it captures the possibility of cross-level interactions between characteristics of individuals and their context leading to differential effects.

Individual-level determinants such as race, income, education, insurance status, and disability had been the predominate focus of researchers regarding access to

health care (Andersen & Davidson, 2001; Andersen, Rice, & Kominski, 1996; Berk, Shur, & Cantor, 1995; Nelson, 2002). As Litaker et al. (2005) illustrates, however, individual-level factors do not function in a vacuum; clearly, community-level elements are essential variables in determining access to health care.

Growing attention to the importance of these contextual factors indicates significant associations between community homogeneity, neighborhood socioeconomic factors, and neighborhood residential instability and the more traditionally understood individual barriers to public health services. Several of these correlations, including sense of community, race and ethnicity, socioeconomic status, and residential instability, are discussed here.

3.1. Sense of community

Ahern, Hendryx, and Siddharthan (1996) define sense of community as the perception of interconnection and interdependence, shared responsibility, and common goals. In their study, respondents who reported a lack of sense of community also described their neighborhood as a less favorable place to live, felt significantly less safe, and reported worse local race relations. Regarding predictability of health care experience, a lack of sense of community was positively related to more reported choice problems, more cost problems, and lower satisfaction. The results also indicated that perceptions of problems in health care were greater in the more diverse, transient, anonymous parts of the state.

Hendryx, Ahern, Lovrich, and McCurdy (2002) found that equitable access to health care is positively associated with community social capital, indicating that three interdependent community characteristics, “interpersonal trust, engagement in civic affairs, and reciprocity norms among citizens in a community determine the extent of cooperative and mutually beneficial behaviors occurring within the community.” They note that

Reciprocity norms are thought to lower transaction costs, facilitate cooperation, restrain opportunism, and balance self-interest and solidarity. Networks of civic engagement increase costs to transgressors in economic exchanges because others know of the transgression. Networks facilitate communication and the flow of information about others’ trustworthiness, reinforce reciprocity norms, develop reputations, and facilitate informal problem solving (p. 92).

Their examination of 22 major US cities concludes that social capital improves the probability and impact of community accountability mechanisms, and accountability mechanisms help protect and improve access to care. Conversely, the absence or constraint of any or all of these factors, such as challenges faced by minority and rural populations for acceptance in community and civic activities, serve to create or enhance barriers to access.

3.2. Race/ethnicity

In their study of ethnicity and racial homogeneity, Haas, Phillips, Sonneborn, and McCulloch (2004) found that

African-Americans who live in a county with a high prevalence of African-American residents experience lower rates of difficulty obtaining care and lower rates of financial barriers compared to those in a community of low prevalence. Likewise, Latinos also experienced higher rates of difficulty obtaining care when they lived in a county with a low prevalence of Latino residents compared to high prevalence; however, results concerning financial barriers were not significant. Correspondingly, Caucasians were more likely to experience difficulty obtaining care and financial barriers to care when they lived in a county with a high prevalence of Latinos. These findings suggest that the racial/ethnic demographics of a county of residence is associated with access to health care, and the ethnic composition of the area of residence could be associated with health care utilization or outcomes. Further, community homogeneity is associated with less difficulty in obtaining health care and reduced financial barriers to that care. This may be due to factors such as “hypersegregation” in which residential segregation does not decrease as income rises as it does for other racial/ethnic groups, or due to minority physicians being more likely to work in areas with more individuals of similar race/ethnicity.

3.3. Socioeconomic status

In a comprehensive study, Kirby and Kaneda (2005) examined the simultaneous effects of both community and individual-level factors on access to health care. They hypothesized that neighborhood socioeconomic disadvantage may create physical, service, and social environments that impede the ability to obtain care. Access to health care was operationalized in two ways:

1. Whether an individual has a provider from whom they usually obtain medical care (usual source of care provider); and
2. Whether they were unable to obtain health care in the previous year when they or a doctor thought it was necessary (unmet need).

Neighborhood disadvantage was the independent variable of interest and defined as those neighborhoods with a shortage of resources, either in the form of economic or human capital. It was operationalized based on three items: the percent of residents in a block group under 125% of the federal poverty line; the percent of residents over 16 who are unemployed; and the percent of residents over 18 with no high school diploma or GED.

They noted that a 4% increase in unemployment, 13% increase in prevalence of poverty, or 17% increase in high school dropout rate (the equivalent of one standard deviation in neighborhood disadvantage) was associated with a 24% decrease in the odds of having a usual source of care and an increase of 70% in the odds of experiencing an unmet need. The results of their study imply that little of the association between neighborhood disadvantage and access to health care is attributable to differences in the supply of health care or individual-level variables. It is indicative of the effects that neighborhood socioeconomic disadvantage itself has on access to health care.

3.4. Residential instability

In a subsequent look at community-level determinants, Kirby and Kaneda (2006) examined the association between neighborhood residential instability and access to health care. They found that a 10% increase in the number of residents in a neighborhood who have lived in their current homes for one year or less (residential instability) was associated with an increase of 23% in the odds of having poor access to health care. The prevalence of poverty and health care supply decreased the magnitude of the odds ratio, yet neighborhood residential instability remained highly significant. The addition of all individual-level variables provided similar results, suggesting that living in unstable neighborhoods increases the likelihood of having poor access to care.

Taken as a whole, these studies illustrate the interconnectedness of individual and community barriers to equitable care. Individual factors such as demographic and needs-based characteristics are augmented by environmental factors such as the racial/ethnic and economic make up of communities overall as well as residents' feelings of safety and security within their neighborhoods. Combined, these factors indicate a comprehensive network of barriers to access, making it all the more difficult for Medicaid-eligible populations to request and receive services.

4. Impediments to access: fiscal and institutional barriers

On a larger scale, federal and state governments exacerbate barriers to access through shifting funding schemes and institutional structures. Reductions in funding commitments from both levels of government and changes in program policies and structures primarily at the state level have served to exacerbate discrimination against particular Medicaid-eligible populations as well as the overall pool of eligible individuals.

At its inception in 1965, the goal of the federal Medicaid program was to encourage states to provide comprehensive medical care to the nation's poor. It was subsequently expanded to include the aged, blind, and disabled and has since undergone a number of administrative changes, such as the dismantling of the Office of Economic Activity, the program's original “home,” and dispersal of services to various agencies that began with Presidents Ford and Nixon. Fiscal commitments changed as well; after spending grew from \$1.6 billion in 1965 to \$23.3 billion in 1980 (\$11.7 billion and \$65.10 billion, respectively, in 2012 dollars), efforts to cap Medicaid spending began in earnest with President Reagan's budget in 1981 (OMB, 2013; Rowland, Lyons, & Edwards, 1988).

Responsibility for funding health care for Medicaid-eligible individuals shifted significantly toward state control with passage of The Omnibus Reconciliation Act in 1981. The Act reduced matching payment rates and established two new types of Section 1115 waivers that allowed states to mandate managed care for certain Medicaid populations and to expand coverage to home- and community-based long-term care services for the elderly and individuals with disabilities at risk of institutional care.

Funding to states reached record-setting levels after President Clinton's overhaul in 1996, but it came with record numbers of federal mandates and state preemptions. President Bush extended waiver flexibility while encouraging states to use the waivers to expand coverage, but by that time states were beginning to experience economic distress and began using waivers to reduce program spending rather than expand coverage. States have continued to receive funding increases from the Obama administration – essential to their ability to withstand the current recession – again with strings attached (Vestal, 2010). The across-the-board sequestration cuts resulting from the Budget Control Act of 2012 and ongoing efforts at deficit reduction, however, are limiting funds for most social safety-net programs as well as federal transfers to states.

Federal fiscal instability and variations in programmatic support as a result of changing policy priorities have allowed and, through the promotion of waivers, even encouraged states to be selective about the services and programs they provide to segments of eligible populations. Further, structural deficits have prompted states to significantly cut Medicaid spending in efforts to close budget gaps, further impacting eligibility standards and categorical requirements. These fiscal constraints, as well as ideological and political policy priorities, have resulted in legislation and institutional program restrictions that have targeted specific services and populations.

4.1. Fiscal impediments

The collapse of the financial markets in 2007 and 2008 and subsequent economic crises left states with budget gaps of unprecedented proportions. The national unemployment rate rose from close to 5% at the start of 2008 to almost 8% in the last quarter of 2012 (BLS, 2012). The Kaiser Commission on Medicaid and the Unemployed (2009) estimated that “For every one percentage point increase in unemployment, state revenues are expected to decline by 3 to 4 percent.” That translates to state revenue shortfalls of at least 15–20% per year over the past four years. In addition, Medicaid saw enrollment growth of 8% in 2009, the largest increase since the start of the millennium. Correspondingly, the costs of service delivery skyrocketed. State governments spent approximately \$335.1 billion on Medicaid services in 2009 alone. Facing revenue shortfalls, increased federal spending mandates, and the absence of other sources of fiscal support, state governments continue to question their ability to pay their share of spiraling Medicaid costs – particularly as they face spending cuts in other federal dollar-matching programs, such as education and transportation.

The federal Medicaid Act has always given states flexibility to determine program details. The use of waivers allows them to tailor services to meet population needs and fiscal constraints, and that by itself has engendered some of the discriminatory actions noted below. The recent recession and stagnant economic growth have encouraged the use of waivers and creative accounting methods to address fiscal needs while hoping for future revenue increases to

fill in subsequent funding gaps. To help balance their budget, for example, Kentucky's Governor Beshear called for a 35% reduction in payments to Medicaid providers for the balance of fiscal year 2011. His proposal “included moving \$166.5 million from next fiscal year to the current fiscal year. . . . make[ing] up the \$166.5 million loss in the second year by implementing a series of managed-care programs within Medicaid (Musgrove, Cheves, & Brammer, 2011, p.1)”.

For Illinois, the solution to the last several years' revenue shortfalls was to defer payments to providers, resulting in a backlog of nearly \$2 billion in unpaid bills. Budget cuts required just to pay overdue bills and retain service providers have been augmented by additional restrictions to existing Medicaid services and programs in efforts to limit budget shortfalls (Moser, 2012). Even so, doctors and other primary care providers have turned away Medicaid patients, forcing them to seek treatment in hospital emergency rooms, and nursing homes have seen staff layoffs, resulting in reductions in care, leaving the elderly and vulnerable at risk.

This is not the first time that Illinois has used budget gimmicks to reduce access to services and providers for low income and disabled populations. In its 2011, “nine-part series, ‘Medicare: System in Chaos,’” the Chicago Tribune noted that Governor Richard Ogilvie (R, 1969–1973) and his successor, Dan Walker (D 1973–1977), established the precedent for use of the gimmicks currently employed to handle the cost pressures—pay freezes, pay cuts and slower payments to doctors, hospitals, nursing homes, pharmacies and other health providers” (Moser, 2012). Similarly, in New Hampshire, “ten hospitals sued New Hampshire in federal court claiming that the state violated the federal Medicaid Act by making deep cuts to their reimbursement for budgetary reasons, not out of consideration of what amount was needed to adequately cover the costs of treating Medicaid patients” (Sunshine Review, 2012).

Table 1 illustrates the reductions made to essential Medicaid services by 13 states for fiscal year 2012. These cuts compound those made to essential and nonessential services in previous years. Arizona, for example, ended Medicaid payments for some organ transplants in anticipation of removing 280,000 adults from program eligibility (Davenport, 2010). California proposed \$1.7 billion in Medicaid cuts, “in part by limiting the number of doctor visits per year and prescriptions per month” (Weaver, 2011). In New York, projected cuts to Medicaid spending are expected to reach \$2 billion, including elimination of payments for circumcisions (Weaver, 2011); Indiana is planning to eliminate dental, vision, and podiatry treatments for adults (Kelly, 2011), and South Carolina is considering eliminating hospice care and using “medical monitoring devices” to “essentially speed-dial nurse-operators who could advise patients and avert an ER visit” (Weaver, 2011).

These Medicaid spending cuts are generally touted as essential to budget stabilization, yet in reality the total savings often amounts to less than 1% of states' annual budgets. And the savings are seen as “penny wise and pound foolish” (Galewitz, 2010, p. 1).

Table 1
 State reductions to Medicaid programs and services, FY 2012.

Alabama	Cut pay for doctors and dentists 10 percent Eliminated coverage for eyeglasses.
California	Added a \$15 fee for those who go to the emergency room for routine care and cut reimbursements to private hospitals by \$150 million.
Colorado	Eliminated some optional services of the state's CHP+ health insurance program for children, saving \$12.2 million. Reduced Medicaid general fund expenses by \$14.8 million by cutting certain expenditures and capping some services.
Connecticut	Weighing cuts likely to go into effect this fall.
Florida	Cut funding to hospitals that treat Medicaid patients by 5.6 percent, following a 12.5 percent cut a year ago. Requested permission to limit non-pregnant adults to two primary care visits a month unless they are pregnant, and to cap emergency room coverage at six visits a year.
Hawaii	Cut Medicaid coverage to 10 days a year for adults, exempting pregnant women, cancer patients, the elderly, the blind, and the disabled.
Illinois	Cut enrollees to four prescriptions a month; imposed a copay for prescriptions for non-pregnant adults. Raised eligibility to eliminate more than 25,000 adults and eliminated non-emergency dental care for adults.
Louisiana	Eliminated hospice care, dental care for pregnant women, and psychiatric services. Reduced payments to doctors and hospitals for Medicaid patients.
Maryland	Cut payments to hospitals totaling \$264 million.
Maine	Cut 12,600 low-income parents and caretakers and cut or reduced coverage for 8,300 elderly.
New Hampshire	Taxed hospitals 5.5 percent on net patient revenues. Lowered payments for caring for the poor by \$115 million.
South Dakota	Cut support of nursing homes by 1.8–4%, depending on what share of their residents are on Medicaid. Dentists, chiropractors and optometrists lost 6.4%. Ambulances lost 5.1%. The 10 largest medical centers – where about one in eight patients are on Medicaid – lost 11.48% of their Medicaid money.
Wisconsin	Added or increased monthly premiums for most non-pregnant adults with incomes above \$14,856 for an individual.

Sources: Kaiser Health News, 2012, States Cutting Medicaid Benefits as they Stagger under economic Downturn, <http://www.kaiserhealthnews.org/Stories/2010/September/30/medicaid-cutbacks.aspx>; South Dakota Democratic Party, 2011, Pinch of Medicaid Cuts Sets in Today, <http://www.sddp.org/2011/07/pinch-of-medicaid-cuts-sets-in-today/>; Baltimore Business Journal, 2012, O'Malley proposes cutting Medicaid spending to Md. Hospitals by \$264M, <http://www.bizjournals.com/baltimore/news/2011/01/21/medicaid-spending-to-md-hospitals.html?page=all>; Sunshine Review (2012), Colorado State Budget, http://sunshinereview.org/index.php/Colorado_state_budget, New Hampshire State Budget, http://sunshinereview.org/index.php/New_Hampshire_state_budget; and Hawaii state budget, http://sunshinereview.org/index.php/Hawaii_state_budget; The Times-Picayune, 2012, Louisiana cuts health care, Medicaid programs to rebalance budget, http://www.nola.com/politics/index.ssf/2012/12/louisiana_cuts_health_care_med.html; BDN Maine, 2012, Feds allow limited cuts to Medicaid, not to level LePage wanted, <https://bangordailynews.com/2013/01/08/politics/feds-allow-limited-cuts-to-medicaid-not-to-level-sought-by-lepage>.

Advocates for Medicaid recipients say they understand why states are cutting spending, but they argue that the moves eventually will lead to higher costs because people won't get preventive care or be able to avoid health complications.

Savings could also be accomplished through alternative spending cuts, reductions in legislative earmarks, revenue enhancements such as a minor tax levy or user fee attached to "Cadillac health care policies," or other options or combinations of options. While curtailing expenditures in response to budget shortfalls is to be expected, targeting discrete populations or services negatively impacts those already severely disadvantaged. Discontinued or limited services and poor payments to doctors and other providers create added barriers to access for the populations in need of them. Failure to pay providers in a timely fashion makes it difficult for them to continue to provide services to Medicaid-eligible patients, creating additional impediments to access to care.

4.2. Policy barriers

Ideological and institutional priorities can also preclude equitable and realized access to health care for segments

of the Medicaid population. Implementation of policy preferences and modification to existing policies are often oriented in ideological or service-delivery limitations or "improvements."

Oregon, for example, paved the way in advancing public policy to curtail Medicaid spending while expediting service delivery. In the early 1990s the state's plan to extend coverage through the use of a rationing system based on quality of life guidelines targeted the poor and disabled.

To expand Medicaid coverage to more persons, 122 of 709 services (treatment-condition pairs) were excluded from coverage after a complex, many-layered process of surveys and public discussion about health care priorities. But despite the plan's laudable extension of coverage to a wider segment of the state's low-income population, ...[it] made the poor the first targets of explicit rationing, and it did little to control provider fees or physician incomes (Menzer, 1992, p. 21).

The federal government ultimately prohibited the state from implementing the guidelines, noting specifically that they discriminated against and impeded access to care for various segments of the eligible population.

A decade later, Colorado passed legislation that denied Medicaid to the approximately 3500 legal immigrants in the state who were too poor to pay for their own medical care. The law was temporarily overturned by a federal judge approximately a month after passage because it denied access to care for the immigrants while extending benefits for US residents with the same financial status (ACLU, 2003).

Women's access to health care has long been dependent on the reigning ideology in each state. Medicaid statutes require states to cover all pregnant women and children up to age 6 with incomes up to 133% of the poverty level as well as costs for adoption services, which has a variable impact considering the considerable contrast in costs of living across the states.

...widely divergent eligibility requirements continue to plague the Medicaid program. ... a pregnant woman in family of three needs to have an annual income of less than \$22,128 in order to qualify ... in Wyoming, while her Minnesota counterpart can be covered with an income of up to \$45,650. Similarly, an infant's family's income would have to be less than \$22,128 in Virginia for the baby to be covered, but less than \$49,800 in Missouri. These are disparities that reflect local political decisions but have a ripple effect throughout the Medicaid program, undermining the very concepts of 'one nation,' equal opportunity, and equal protection (Ramerez and Wolfe, 2007, p. 20).

Realized access is also not a given for all Medicaid-eligible women nationwide. In 2011, Indiana passed legislation that denied Medicaid funding to Planned Parenthood, which provides diagnostic services, prenatal and pregnancy care for low-income women. The law was subsequently ruled discriminatory and is on hold as it works its way through the courts (*The Washington Post*, 2012). Similarly, the Texas legislature voted to cut Medicaid funding for Planned Parenthood. The Obama administration indicated that it would eliminate funding to the state for its women's health care program. According to the administration, "Medicaid law is clear—patients, not state government officials, are able to choose the health-care providers that are best for them and their families" (Radnofsky, 2012, p. 1).

Rameriz and Wolfe (2007) examined various aspects of Medicaid coverage, including scope of service and eligibility. The disparity in services provision for women was considerable: California, Minnesota, New York, Vermont, and Maryland scored highest; Idaho, South Dakota, Utah, Nevada, North Dakota, and Wyoming had the lowest rankings for accessibility and equity of services provided to women in comparison to those offered for men. States that scored the lowest on scope of service – which included coverage, population, and comprehensiveness – were Mississippi, Oklahoma, Alabama, Georgia; those with the highest scores were New York, Minnesota, Oregon and Washington.

Finally, there is a correlation between the political affiliation of state governors and the degree to which their state's population is uninsured (*The Brookings Institution*, 2012, p. 1).

... 19 states have rates of uninsured at or higher than the 16% national average. ... of these states, 14 have Republican governors—including the states with the seven highest rates of uninsured. These states—Texas, New Mexico, Nevada, Florida, Georgia, South Carolina, and Mississippi—have 14.5 million individuals without health insurance. More strikingly, these seven states have 29% of the nation's uninsured.

In short, fiscal stress brought about by the banking crisis and financial crash and augmented by efforts to reduce the deficit and debt, has impacted federal and state governments' capabilities to support public health services such as Medicaid. Across the board cuts in federal spending have reduced budgets for agencies that fund public health care programs and providers, which, in turn, have translated to lower federal transfers to states through grants and formulaic funding. This, combined with lower state general revenue receipts, has left states struggling to find ways to plug budget gaps. Further, ideological preferences color policy choices, particularly when it comes to funding social programs. Eliminating and reducing specific services and programs that apply to populations least able to put up a fight generally result in increased challenges to access to care.

5. The Affordable Care Act: increasing equitable access to equitable care

Because health equity refers to both outcomes and opportunities, the political implications of health equity require that health be seen as a "special good," directly responsible for individual well-being and capability. This implies that governments have a responsibility to guarantee opportunities to obtain health, and that reducing health inequities requires action on the social determinants of health, a social justice orientation, and the view that health policy must extend further than health care (*United Nations Research Institute for Social Development*, 2007, p. 3).

The Patient Protection and Affordable Care Act (ACA) is designed specifically to expand access to health care for the uninsured and low income populations. It includes initiatives to reduce the impediments to access experienced by those currently eligible for Medicaid and also assists states with the necessary funding to support current programs and services, increase offerings and add, train, and retain professional personnel. It also expands access to health care by providing supplements to those who are within 400% of the poverty level and extends Medicaid coverage to a significant number of potential new and existing participants. The ACA's provisions to increase access to care for existing and newly-eligible Medicaid populations answer many of the challenges delineated above. The Act establishes a national floor for income eligibility and extends eligibility to a larger scope of low-income individuals, while providing states with the independence to customize implementation. It also provides funding for conversion to or establishment of new systems to improve quality of care at point of contact and establishes a new agency to coordinate activities between Medicaid and Medicare and state

insurance exchanges. In addition, the Act provides funding for community health centers, workforce training, recruitment and retention, and local economic development in order to expand participants' access to quality health care and encourage community support.

6. Facilitating equitable access: two steps forward

6.1. Fiscal and institutional factors

By design the ACA accommodates states' ideological priorities and fiscal conditions. Its goal is to improve access to health care for the majority of citizens through federal and state-run insurance exchanges for those whose incomes fall between 133% and 400% of the poverty level and through expanded Medicaid coverage for those with income at or below 133% of the federal poverty level; however, states have considerable leeway when it comes to compliance. They can choose to develop their own exchanges, rely on those created by the federal government, or create a hybrid of the two.

Further, expansion of coverage to newly-eligible Medicaid populations is optional. States can opt out and refuse the accompanying funding or participate to the extent compatible with state leadership priorities, complete with commensurate matching funds. For states that elect to extend Medicaid coverage to newly eligible residents, this includes ACA matching funds of 100% for the first few years of implementation, falling afterward to a 90% match through 2019. The Congressional Budget Office (Thomas, 2012) estimates that by 2022 the federal government will spend \$931 billion on Medicaid programs and services to accommodate an anticipated additional 30 million eligible participants.

Structural support for states is also available through ACA authorizations of \$137 million for public health infrastructure and \$40 million for training grants for state, local, and tribal public health projects. A number of other initiatives authorize federal funds transfers to states, including Public Health Workforce grants of approximately \$45 million, which will assist state health programs in improving access and the quality of services delivered in underserved areas of the country. Approximately \$52 million for Public Health Capacity grants to research infectious diseases and \$133 million to Research and Tracking initiatives for evaluation of existing preventive services, as well as those developed through the \$49 million Prevention Research grant, which will target efforts to inform practitioners, educators, and other decision makers (Healthcare.gov, 2012). Finally, Medicaid options for home- and community based services include options that "provide states with financial incentives in the form of enhancements to the Medicaid matching rate" (Iritani, 2012, p. 1).

The ACA also established an extensive array of programs and funds to supplement and expedite Medicaid service delivery and has allocated funds to facilitate their implementation through promotion of new systems, infrastructure, personnel, and health care initiatives. Again, states stand to receive new fiscal support, in this case through funds such as the Health Center Trust Fund (HCTF), which authorizes \$1.5 billion for capital expenditures and

\$9.5 billion to support expanded operations for fiscal years 2011 through 2015. An additional \$1.5 billion has been allocated for expansion of the National Health Service Corps, which is tasked with recruiting and training supplemental health care professionals for rural and underserved areas of the country.

6.2. Individual and community factors

A large portion of the ACA focuses on individual- and community-oriented issues that are targeted to increase access to more and better services. For example, it authorizes \$75 million over three years to test the effectiveness of Medicaid services to the mentally ill in psychiatric facilities, care that was previously prohibited by Medicaid (Baker, 2011). And while Medicaid expansion was not anticipated to begin in earnest until 2014, when the federal government's 100% match goes into effect, five states – California, Minnesota, Connecticut, New Jersey, and Washington – have already extended coverage to over half a million individuals (Kliff, 2012).

Minority participants have faced resistance to Medicaid care from various fronts. In his 2008 study, Smedley finds that

Because racial and ethnic minorities are disproportionately uninsured, state efforts to expand access to health insurance have great potential to improve access to care for communities of color. But health insurance coverage expansions alone do not ensure that health care disparities will be eliminated. To make a measurable impact, health care reform efforts must also make systemic change, such as improving the health care infrastructure in underserved communities and stimulating the growth of culturally and linguistically appropriate services (p. 449).

He also identified policy factors, including improving and streamlining enrollment and education practices that would facilitate equitable access to equitable care. Further, he noted that implementation of patient education, training for health care employees, and community health planning would all reduce barriers to access for racial and ethnic minorities (Smedley, 2008).

The ACA goes a long way in meeting those recommendations through establishment of funds and programs such as the National Prevention, Health Promotion and Public Health Council and the Prevention and Public Health Fund, both of which are charged with elevating and coordinating national prevention activities and increased quality of care through research, education, service, and program enhancement. According to the US Department of Health and Human Services, "This new initiative will increase the national investment in prevention and public health, improve health and enhance health care quality" (HealthReform.gov, 2012, p. 1).

The Act's Prevention Fund expands access to preventive and wellness care; for example, \$250 million was recently delivered to states through grants to support training and development of health care professionals who deliver preventive services within local communities.

Further, \$298 million from the Fund and \$222 million in Community and State Prevention grants are earmarked for state and community initiatives to provide preventive care for major illness and obesity, reduce health disparities and discrimination, and launch a consolidated chronic disease prevention and education program. In addition, the Critical Wellness Fund allocated \$182 million to “fund new preventative Medicaid benefits, expand immunization services and activities, and strengthen employer participation in wellness programs” (HealthReform.gov, 2012, p. 1).

The Affordable Care Act gives significant attention to community-oriented initiatives. On a small scale, the ACA provides \$70 million in Behavioral Health Screening and Integration with Primary Health grants to communities to help them coordinate and integrate primary care and mental health services into community-based settings. On a broader scale, the ACA makes a considerable investment in community health centers (CHCs), long an important source of access to care for low-income individuals. It allocates \$11 billion to support CHCs and establish over 1,000 new ones, primarily in rural and underserved areas of the country.

The expansion of CHCs is instrumental for extending coverage to millions of uninsured Americans since they currently provide services for an estimated one in three low-income people and one in four low-income minority residents (HHS, n.d.; Hurley, 2007). CHCs “. . . expect to see patient rolls skyrocket from the 23 million now treated to more than 40 million in the next five years.” Levine (2011, p. 1) also asserts that ACA funding is essential because,

In fiscal year 2011, 23 states decreased funding for health centers and four eliminated health center appropriations entirely. . . Overall, state funding has decreased by 42 percent over the past two years, while the number of uninsured patients – which now include more jobless middle-class Americans – jumped 36 percent nationally from 2004 to 2009.

Community health centers have been shown to act as drivers for local community development. It is estimated that federal investment in CHCs through 2015, primarily achieved through the ACA, will generate \$53.9 billion in economic activity and over 284,000 jobs in communities across the country (National Association of Community Health Centers, 2011). The US Department of Health and Human Services (2011, p. 1) notes,

Community health centers also provide high-quality jobs in communities nationwide. . . Since the beginning of 2009, health centers have added more than 18,600 new full-time positions in many of the nation’s most economically distressed communities.

The availability of more CHCs will enable states to accommodate the substantial increase in participants resulting from the ACA Medicaid expansion. Individuals and local communities will substantially benefit directly through funding for CHCs and all the ancillary funds established to facilitate infrastructure and systems upgrades, recruitment, training and retention initiatives directed at health care practitioners and support staff, and efforts aimed at illness prevention and wellness care. Indirect

benefits generated by related community development will help local communities retain health care and support professionals and services; it will also support some of the necessary factors, such as education and planning, that were identified by Smedely (2008) as necessary to reduce the impediments to equitable access and care (Table 2).

7. Challenges to the ACA’s access expansion plans: one step back

While the ACA significantly improves and expands equitable access to equitable care, its efforts fall short in some ways. First, despite the federal government’s dollar for dollar match for the first few years and 90% match thereafter through 2019 for new participants, state Medicaid spending is expected to more than double by 2019 to \$327.6 billion (OMB, 2013). The Illinois State Comptroller, for example, estimates that the expansion costs alone through 2019 could reach \$2.4 billion (Sweet, 2012). While a number of states are finally seeing improvements in their financial condition, 58% of the states still anticipate deficits totaling \$49 billion for FY 2013, and that is on top of the over \$530 billion cumulative shortfall for the previous four years. As states continue to have a difficult time closing budget gaps, finding the 10% in required matching funds will be challenging (Sweet, 2012; Walsh & Cooper, 2012).

In addition, the benefits for those newly eligible must, at a minimum, match the essential health benefits required of coverage that will be made available through planned federal and state insurance exchanges programs. Fiscal constraints and coverage requirements may result in the loss of some services for new participants that are covered in the traditional Medicaid package, such as long-term care, which may cause a new set of access parity issues. Also, public healthcare systems still contend with high provider turnover and chronically understaffed facilities (Hurley, Felland, & Lauer, 2007; Savageau, Ferguson, Bohlke, Cragin, & O’Connell, 2011). Factors that contribute to provider and professional personnel recruitment and retention challenges include disproportionate staffing of family practice physicians (Rosenblatt, Andrilla, Curtin, & Hart, 2006), limited training opportunities in community health centers (Ferguson, Cashman, Savageau, & Lasser, 2009; Morris, Johnson, Kim, & Chen, 2008), lack of income potential, and lack of opportunity for professional experiences (Daniels, VanLeit, & Skipper, 2007).

Community health centers are essential to accommodate the additional Medicaid enrollees, yet additional centers may also encourage office-based physicians to limit their Medicaid practices. Further, increasing the number of CHCs may escalate reliance on these providers to only care for the Medicaid population and further worsen selective enrollment practices previously seen in traditional managed care plans (Cutler, McClellan, & Newhouse, 2000). Care of Medicaid patients is already becoming increasingly concentrated among a minority of physicians who provide a relatively large amount of care to Medicaid patients. The proportion of all Medicaid physician revenue accounted for by physicians who derived 30% or more of their practice revenue from Medicaid increased from 43.1% in 1996–1997 to 51% in 2004–2005. At the same time, the proportion of

Table 2
 The impact of the affordable care act on barriers to equitable access.

	Barriers to equitable access	ACA solutions	Potential impediments
<i>Eligibility</i>	<i>Individual:</i> Race/ethnicity, health beliefs, income, ability to seek and obtain care <i>Financial:</i> Eligibility standards and categorical requirements <i>Institutional:</i> Legislative policies	Expanded eligibility, with 100–90% funding match	Expansion of eligibility parameters not mandatory for states Federal matching rates unknown after 2020
<i>Access to care</i>	<i>Individual:</i> Race/ethnicity, health beliefs, income, ability to seek and obtain care <i>Community:</i> Neighborhood socioeconomic factors, residential stability, social networks <i>Institutional:</i> Program interpretation and implementation <i>Financial:</i> Program/service cuts or elimination	Funding for additional Community Health Centers and community health education programs	Reliance solely on CHCs and managed programs to provide care for additional participants Challenges to outreach efforts to move some eligible populations to participant status
<i>Programs and services</i>	<i>Financial:</i> Government fiscal instability, program/service cuts or elimination <i>Institutional:</i> Program interpretation/implementation, ideological priorities	Additional grants for health care professional recruitment, training and retention and community development	States' budget shortfalls offset by use of waivers to limit and eliminate services and programs

Medicaid physician revenue accounted for by physicians deriving less than 20% of practice revenue from Medicaid decreased from about 38% to 28.4% (Cunningham & May, 2006). Unchecked, this could result in inadequate care and/or inequitable access to health services.

Finally, a number of states opted out of the ACA's Medicaid expansion provision on ideological bases, claiming that it represents an overreach of government power "that threatens the basic liberties that all Americans enjoy and must retain" (Brookings Institution, 2012). Of the top ten states with the greatest number of uninsured (19–25% of the state's population), seven of those states – Texas, New Mexico, Nevada, Florida, Georgia, South Carolina, and Mississippi – all with Republican governors, initially refused the additional funding. And of that top ten, only California and Arkansas, with Democratic governors, and Nevada, with Republican leadership, plan to expand enrollment. The Brookings study indicates that support from electoral forces and the drive for re-election, rather than constituency needs, drove Republican decision-making. Since then, however, the governors of Nevada, New Mexico and Florida have decided to participate in the ACA's Medicaid expansion. That brings the total number of participating states to 26, with 15 states declining and the remainder still on the fence (The Advisor Board Company, 2013). The American Medical Association notes that the decision to accept or reject Medicaid expansion is not always the governor's to make; "in many states the legislature will weigh in as well. Since January more than 70 bills have been filed in state legislatures related to Medicaid expansion" (AMA, 2013). Refusal to participate in Medicaid enrollment expansion and the potential refusal of other, related grant funding options act as significant impediments to equitable access and care for the uninsured in those states.

8. Conclusion

Medicaid has been plagued by states' inability to enroll eligible participants, limited and selective access to high quality, equitable health care for select populations, ethnic, racial and gender discrimination in service provision, rising costs, and poor coordination of services for high-cost individuals. The ACA addresses these issues through establishment of a national floor for eligibility, increased funding for community health centers, the creation of the Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid (CMS) and numerous funding initiatives that provide grants to states to expand systems and infrastructure, research and education, programs and services, and recruitment and retention of professional personnel.

The primary intent of the legislation is to ensure access to care for a large percentage of the population who are currently uninsured, have little or no access to health care, or are unaware that they qualify for publically provided care. It is designed specifically to reduce barriers to equitable access, but implementation is the key to success. Those states that expand Medicaid coverage or otherwise take advantage of grant funding available from the ACA will see advances in equitable access. However, while the ACA promises to increase Medicaid access substantially for those in need, the ways in which it can redress issues of discrimination and inequitable service provision and access will be limited to the ability of the federal government to subsidize state program costs, the success of ACA-driven community development, in part through expanded development and use of Community Health Centers and recruitment, training and retention efforts, and the states' participation in the ACA's programs and subsidies.

It remains to be seen whether building upon the existing Medicaid program will significantly decrease the historical barriers that prevent eligible populations from participating in the program, or the discriminatory practices that inhibit access for participating populations. It may be that a more successful way to eliminate bias and ensure equitable access to health care would be to eliminate state discretion and program responsibility and fully embrace the idea of public health care as a national responsibility – making it a “special good” based on the CDC’s social determinants of health, as suggested by the United Nations Research Institute on Social Development. Future research on impediments to and supports for equitable access within other federally funded health programs, such as Medicare and Veterans’ Affairs, and on successful models from outside the United States, could provide a basis for comparison and serve to illustrate best practices to achieve equitable access nationwide.

References

- ACLU. (2003). Court orders temporary halt to Medicaid cutoffs in ACLU suit on behalf of legal immigrants. *ACLU-Colorado*. Retrieved from <http://aclu-co.org/print/641>
- The Advisor Board Company. (2013). Where each state stands on ACA’s Medicaid expansion. *The Daily Briefing*. Retrieved from <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap#lightbox/1/>
- Ahern, M. M., Hendryx, M. S., & Siddharthan, K. (1996). The importance of sense of community on people’s perceptions of their health-care experiences. *Medical Care*, 34(9), 911–923.
- American Medical Association (AMA). (2013). Issue brief: Medicaid expansion. *Advocacy Resource Center*. Retrieved from <http://www.ama-assn.org/resources/doc/arc/medicaid-expansion-issue-brief.pdf>
- Andersen, R. M. (1968). *Behavioral model of families’ use of health services*, Research Series No. 25. Chicago, IL: Center for Health Administration Studies, University of Chicago.
- Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36, 1–10.
- Andersen, R. M., Rice, T. H., & Kominski, G. F. (1996). *Changing the U.S. health care system: Key issues in health services, policy and management*. San Francisco, CA: Jossey-Bass.
- Andersen, R. M., & Davidson, P. L. (2001). Improving access to care in America: Individual and contextual indicators. In *Changing the U.S. health care system: Key issues in health services, policy and management*. San Francisco, CA: Jossey-Bass.
- Baker, S. (2011). Medicaid to test expanded mental health coverage. *The Hill, Healthwatch*. Retrieved from <http://thehill.com/blogs/healthwatch/medicaid/176089-medicaid-to-test-expanded-mental-health-coverage>
- Berk, M. L., Shur, C. L., & Cantor, J. C. (1995). Ability to obtain health care: Recent estimates from the Robert Wood Johnson Foundation National Access to Care Survey. *Health Affairs*, 14, 139–146.
- Brookings Institution. (2012). Give me liberty or at least your votes: A study of governors’ altruism on health care. Retrieved from <http://www.brookings.edu/research/papers/2012/07/05-healthcare-hudak>
- Bureau of Labor Statistics (BLS). (2012). *Databases, tables, calculators by subject: Labor force statistics from the current population survey*. Retrieved from <http://data.bls.gov/timeseries/LNS14000000>
- Centers for Disease Control and Prevention. (2013). *Social determinants of health*. Retrieved from <http://www.cdc.gov/socialdeterminants/FAQ.html#a>
- Cunningham, P., & May, J. (2006). Tracking report: Results from the community tracking study. Medicaid patients increasingly concentrated among physicians. *Center for Studying Health System Change*. Retrieved from <http://hschange.org/CONTENT/866/>
- Cutler, D. M., McClellan, M., & Newhouse, J. P. (2000). How does managed care do it? *RAND Journal of Economics*, 31(3), 526–548.
- Daniels, Z. M., VanLeit, B. J., & Skipper, B. J. (2007). Factors in recruiting and retaining health professionals for rural practice. *Rural Health*, 23(Winter (1)), 62–71.
- Davenport, P. (2010). Arizona Medicaid cuts include transplant funding. *KTAR.com*. Retrieved from <http://ktar.com/category/local-news-articles/20101001/Arizona-Medicaid-cuts-include-transplant-funding/>
- Ferguson, W. J., Cashman, S. B., Savageau, J. A., & Lasser, D. H. (2009). Thirty years of family medicine residency training: Characteristics associated with practice in a health professions shortage area. *Family Medicine*, 41(6), 405–410.
- Galewitz, P. (2010). States cutting Medicaid benefits as they stagger under economic downturn. *Kaiser Health News*. Retrieved from <http://www.kaiserhealthnews.org/Stories/2010/September/30/medicaid-cutbacks.aspx>
- Haas, J. S., Phillips, K. A., Sonneborn, D., & McCulloch, C. E. (2004). Variation in access to health care for different racial/ethnic groups by the racial/ethnic composition of an individual’s county of residence. *Medical Care*, 42(7), 707–714.
- HealthReform.gov. (2012). *Affordable Care Act: Laying the foundation for prevention*. Retrieved from <http://www.healthreform.gov/newsroom/acaprevention.html>
- Hendryx, M. S., Ahern, M. M., Lovrich, N. P., & McCurdy, A. H. (2002). Access to health care and community social capital. *Health Services Research*, 37(1), 85–101. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/pmc1430349/>
- Hurley, R. E., Felland, L. E., & Lauer, J. (2007). *Community health centers tackle rising demands and expectations (issue brief #116)*. Washington, DC: Center for Studying Health System Change.
- Institute of Medicine (IOM). (2003). In B. D. Smedley, A. Y. Stith, & A. R. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington DC: National Academies Press.
- Iritani, K. M. (2012). States’ plans to pursue new and revised options for home- and community-based services. GAO-12-649. *US Government Accountability Office (GAO): Medicaid*. Retrieved from <http://gao.gov/products/GAO-12-649>
- Lubell, J. (2013). Medicaid-eligible but not enrolled? ACA a likely stimulus. *Amdnews.com*. Retrieved from <http://www.amednews.com/article/20130218/government/130219943/4/>
- Kasier Commission on Medicaid and the Uninsured. (2009). *Rising unemployment, Medicaid and the uninsured*. Retrieved from <http://www.kff.org/uninsured/upload/7850.pdf>
- Kaiser Henry J., Family Foundation, The. (2012). *A guide to the Supreme Court’s decision on the ACA’s Medicaid expansion*. Retrieved from <http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-decision/>
- Kelly, N. (2011). Education, Medicaid cut in proposed state budget. *Journalgazette.net*. Retrieved from <http://www.journalgazette.net/article/20110113/NEWS07/110119776> [1/21/2011 12:59:07 PM]
- Kirby, J. B., & Kaneda, T. (2006). Access to health care: Does neighborhood residential instability matter? *Journal of Health and Social Behavior*, 47(2), 142–155.
- Kirby, J. B., & Kaneda, T. (2005). Neighborhood socioeconomic disadvantage and access to health care. *Journal of Health and Social Behavior*, 46(1), 15–31.
- Kliff, S. (2012, July 3). Obamacare’s Medicaid expansion already covering a half-million Americans. *The Washington Post, Wonkblog*. Retrieved from <http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/07/03/obamacares-medicaid-expansion-already-covering-a-half-million-americans/#>
- Kogan, R. How the across-the-board cuts in the budget control act will work. *Center on Budget and Policy Priorities*. Retrieved from <http://www.cbpp.org/cms/?fa=view&id=3635>
- Levine, D. (2011). Will community health centers survive budget cuts? *Governing.com*. Retrieved from <http://www.governing.com/topics/health-human-services/Will-Community-Health-Centers-Survive-Budget-Cuts.html>
- Litaker, D., Koroukian, S. M., & Love, T. E. (2005). Context and health-care access: Looking beyond the Individual. *Medical Care*, 43(6), 531–540.
- Menzer, P. J. (1992). Oregon’s denial disabilities and quality of life. *Hastings Center Report*, 22(6), 21–25.
- Morris, C. G., Johnson, B., Kim, S., & Chen, F. (2008). Training family physicians in community health centers: A health workforce solution. *Family Medicine*, 40(4), 271–276.
- Moser, W. (2012). *Illinois’s Medicaid Mess*. Chicago Magazine. Retrieved from <http://www.chicagogmag.com/Chicago-Magazine/The-312/February-2012/Illinois-Medicaid-Mess/>
- National Association of Community Health Centers. (2011). Calculating the cost: State budgets and community health centers. *State Policy Report #39*.

- Nelson, A. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. *Journal of the National Medical Association*, 94(8), 666–668.
- Office of Management and Budget (OMB). (2013). Table 8.5-Outlays for mandatory and related programs, 1962–2017. *Historical Tables*. Retrieved from <http://www.whitehouse.gov/omb/budget/Historicals>
- Radnofsky, L. (2012, March 15). Texas Medicaid funds cut over Planned Parenthood. *The Wall Street Journal, Politics*. Retrieved from <http://online.wsj.com/article/SB10001424052702303863404577283972576906862.html>
- Rameriz, A. B., & Wolfe, S. M. (2007, April). Unsettling scores: A ranking of state Medicaid programs. *Public Citizen Health Research Group*.
- Rowland, D., Lyons, B., & Edwards, J. (1988). Medicaid: Health care for the poor in the Reagan era. *Public Health*, 9, 427–450.
- Rosenbaum, S., Serrano, R., Magar, M., & Stern, G. (1997). Civil rights in a changing health care system. *Health Affairs*, 16(1), 90–105.
- Rosenblatt, R. A., Andrilla, C. H., Curtin, T., & Hart, L. G. (2006). Shortages of medical personnel at community health centers. *JAMA*, 295(9), 1042–1049.
- Savageau, J. A., Ferguson, W. J., Bohlke, J. L., Cragin, L. J., & O'Connell, E. (2011). Recruitment and retention of primary care physicians at community health centers: A survey of Massachusetts physicians. *Journal of Health Care for the Poor and Underserved*, 22, 817–835.
- Smedley, B. (2008). Moving beyond access: Achieving equity in state health care reform. *Health Affairs*, 27(2), 447–455.
- Sunshine Review. (2012). *New Hampshire state budget*. Retrieved from http://sunshinereview.org/index.php/New_Hampshire_state_budget
- Sweet, L. (2012, June). Topinka warns Medicaid expansion in Obama health care law could be costly for Illinois. *The Chicago Sun Times*. Retrieved from http://blogs.suntimes.com/sweet/2012/06/topinka_warns_medicaid_expansi.html
- Tavener, M. B. (2012). *2011 Actuarial report on the financial outlook for Medicaid*. Office of the Actuary, Centers for Medicare & Medicaid Services, US Department of Health and Human Services. Retrieved from <https://www.cms.gov/ActuarialStudies/Downloads/MedicaidReport2011.pdf>
- Thomas. (2012). House Report 112-421 – Concurrent resolution on the budget-fiscal year 2013. Committee Reports, 112th Congress (2011-2012), House Report 112-421. *Library of Congress*. Retrieved from http://thomas.loc.gov/cgi-bin/cpquery/?&sid=cp112gbc6D&r_n=hr421.112&dbname=cp112&sel=TOC.140572&
- United Nations Research Institute for Social Development. (2007). *Equitable access to health care and infectious disease control: Concepts, measurement and interventions*. Retrieved from http://whqlibdoc.who.int/hq/2007/WHO_TDR_UNRISD_FIOCRUZ_CN19_07_3_eng.pdf
- (2009). *U.S. Congress H. R. 3590—111TH Congress: Patient Protection and Affordable Care Act*. Retrieved from <http://docs.house.gov/energycommerce/ppacacon.pdf>
- U.S. Department of Health and Human Services (n.d.). Health disparities and the Affordable Care Act. Retrieved from <http://www.healthcare.gov/law/infocus/disparities/index.html>
- U.S. Department of Health and Human Services. (2011). *HHS awards Affordable Care Act funds for organizations to become community health centers*. Retrieved from <http://www.hhs.gov/news/press/2011pres/09/20110915f.html>
- Vestal, C. (2010). Is it time for a new balance between states and the feds? *The Pew Charitable Trusts*. Retrieved from <http://www.stateline.org/live/printable/story?contentId=454040>
- Walsh, M. W., & Cooper, M. (2012, July 17). Fiscal crisis in states will last beyond slump, report warns. *The New York Times*. Retrieved from <http://www.nytimes.com/2012/07/18/us/in-report-on-states-finances-a-grim-long-term-forecast.html?hp&pag>
- Washington Post, The. (2012, July 8). Medicaid official says Ind. law denying funding to Planned Parenthood violates women's rights. *The Washington Post, National Section*. Retrieved from http://www.washingtonpost.com/national/medicaid-official-says-ind-law-denying-funding-to-planned-parenthood-violates-womens-rights/2012/07/08/gJQATozjWW_story.html
- Weaver, C. (2011). As Medicaid budgets squeezed, states consider eccentric ideas on cutting costs. *Kaiser Health News (KHN)*. Retrieved from <http://www.kaiserhealthnews.org/Stories/2011/March/30/medicaid-costs-circumcision.aspx?p=1>