

# Did Medicaid expansion close African American-white health care disparities nationwide? A scoping review

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## Research Article

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# Abstract

## Objectives

To investigate the impact of the Affordable Care Act's (ACA) Medicaid expansion on African American-white disparities in health coverage, access to healthcare, receipt of treatment, and health outcomes.

## Design:

A search of research reports, following the PRISMA-ScR guidelines, identified twenty-six national studies investigating changes in health care disparities between African American and white non-disabled, non-elderly adults before and after ACA Medicaid expansion, comparing states that did and did not expand Medicaid. Analysis examined research design and findings.

## Results

Whether Medicaid eligibility expansion reduced African American-white health coverage disparities remains an open question: Absolute disparities in coverage appear to have declined in expansion states, although exceptions have been reported. African American disparities in health access, treatment, or health outcomes showed little evidence of change for the general population.

## Conclusions

Future research addressing key weaknesses in existing research may help to uncover sources of continuing disparities and clarify the impact of future Medicaid expansion on African American health care disparities.

## Full Text

In the United States, stark health disparities can be observed between whites—the most advantaged group in terms of wealth and power—and African Americans—one of the most economically and socially disadvantaged groups. African Americans continue to fall significantly behind whites in 7 of 10 key measures of healthcare coverage and access and in 19 out of 27 health status measures (1). Continuing health disparities between whites and African Americans decrease individual workforce participation, productivity, and generation of wealth and result in greater loss of life for African Americans. Disparities also result in considerable estimated direct (\$136 billion) and indirect (\$36.6 billion) public costs (2).

The Affordable Care Act's (ACA) commitment to reducing such seemingly intractable health disparities was emphatic. The text of the original bill (Pub. L. No. 111–148. 3–23–2010) contained 34 references to “disparities,” 28 references to either “discrimination” or “non-discrimination,” 33 instances using either the

word “racial” or “race,” and 35 instances using either the word “ethnicity” or “ethnic” (3). A key ACA instrument to increase health equality was Medicaid eligibility expansion. Resulting increases in coverage were expected, in turn, to facilitate access to preventative care and treatment. Medicaid eligibility expansion was envisioned as a pathway to advancing health equity—an equal opportunity to be healthy (4).

Due to the African American-white income and wealth gaps, expansion of Medicaid eligibility may be a powerful tool for reducing African American-white health disparities. However, following a 2012 Supreme Court ruling, 19 states declined expanded Medicaid, and 12 states continue to decline it as of August 2021. African Americans’ over-representation in non-Medicaid eligibility expanding states may have limited achievement of the ACA’s disparity reduction goals for African Americans (5). Given this variation in Medicaid expansion policies across states, how much Medicaid expansion furthered the ACA’s objective of closing African American-white disparities in healthcare coverage, access, treatment, and health outcomes is a key question to ask for evaluating the ACA’s disparity reduction aims.

### ***Understanding Medicaid expansions’ impact on disparities***

Medicaid expansion focused on standardizing eligibility requirements, conferring eligibility on everyone with incomes below 138% FPL. To fully understand eligibility expansions’ impact on African American-white health disparities specifically, research must capitalize on Medicaid expansion’s comprising a natural experiment with “treatment” (Medicaid expansion states) and control (non-expansion states) conditions. To attribute coverage, access, utilization, and health outcome disparity reductions to Medicaid expansion specifically, investigators must explicitly compare (1) African Americans’ and whites’ coverage, access, utilization, and health outcome rates (2) before and after Medicaid expansion, in (3) expansion versus non-expansion states. If Medicaid expansion did indeed close African American-white health disparities, the differences-in-differences-in-differences (DDD) assessment should point to a significant interaction indicating that non-white versus white disparities declined (difference #1) following Medicaid expansion (difference #2) more in expansion states than in non-expansion states (difference #3). Individual and environmental controls are also needed to adjust for demographic and other differences, apart from race, which might bias comparisons and confound assessment of progress. Moreover, equity implies equal non-white/white proportions of coverage, access, treatment, and health outcomes given equivalent levels of need, which calls for an assessment of relative disparities.

Using these methodological standards as a conceptual framework for sampling and analysis, the current study conducts a scoping review of the research to report on the state of knowledge about the impact of the Medicaid eligibility expansion’s impact on African American-white disparities in health coverage, access to healthcare, receipt of treatment, and health outcomes. The review assembles and interprets study findings, critiques methods, and identifies key questions for future study. It highlights areas in need of additional study to fully understand how much Medicaid expansion achieved African American-white disparity reduction and what lessons must be learned for further progress.

## Methods

A systematic search of the literature was conducted using the Preferred Reporting Items for Scoping Reviews/Meta-Analysis extension for Scoping Reviews (PRISMA-ScR) and evidence-based model utilization of PICO for framing questions a priori (6). PICO components consist of Problem/Patient/Population, Intervention/Indicator, Comparison, Outcome, and (optional) Time element or Type of Study, which are essential in the formulated question and search criteria. The focus population is the national population of non-disabled, non-elderly adults; the intervention of interest is Medicaid expansion; the comparator is Black and white racial identity; the outcomes of interest include health coverage, access, treatment, and outcomes or status; the time criteria requires that studies observe outcome pre- and post-Medicaid expansion; the Type of Study criteria requires that studies be quantitative. Thus, the focus of the scoping review was on investigations that were (1) nationwide, (2) assessed African American-white differences in coverage, access, treatment, and outcomes or status (3) before and after Medicaid expansion implementation (2014), and (4) compared Medicaid expansion and non-expansion states.

## Search strategy and study selection

A database search was conducted examining research reports from January 2014 through June 2021 to identify the sample of research studies to examine. This involved searching the following databases: CINAHL Complete, Health Source-Consumer Edition, Health Source: Nursing/Academic Edition, MEDLINE, APA PsychInfo, Psychology and Behavioral Sciences Collection, Social Work Abstracts. Abstracts were searched using the following terms: *African American or Black or African-American or Black American AND Medicaid expansion AND whites AND disparit\**. The search was conducted on July 1, 2021. Search results were narrowed to include only studies published in English. This yielded 47 articles. Of these articles, seven were removed (six duplicates, one dissertation). Full text review of the remaining 40 articles excluded 28 articles (19 non-national samples, five lacked pre- and post- ACA observations, three lacked focus on Medicaid expansion, and one was non-empirical), leaving 12 articles remaining for further review. These studies were imported into a reference management system used to organize the literature.

A Kaiser Family Foundation (KFF) literature review on the effects of the Affordable Care Act's (ACA) Medicaid expansion on health disparities was also closely examined for research reports (7, 8). The KFF review examined published literature starting in January 2014 and ending in July 2020. KFF's studies included all research on the impacts of Medicaid expansion for all race or ethnic groups for outcomes, including health coverage, healthcare access and utilization, and economic well-being for individuals and state governments. Abstracts from KFF's 65 studies were screened for this review by four of the authors according to the criteria outlined above (national scope, assessed African American-white differences in coverage, access, treatment, and health outcomes before and after Medicaid expansion implementation, comparing Medicaid expansion and non-expansion states) resulting in 58 articles. Abstract screening eliminated 27 studies. Of the 31 remaining studies, 11 were eliminated after full-text review due to lack of

national scope (n = 8), failure to identify Black-white disparities specifically (n = 2) and focus on non-target populations and outcomes (n = 1). This process yielded 20 studies from the KFF review, meeting the criteria. These studies were also imported into the reference management system.

The remaining 12 articles from the database search and screening were added to the 20 articles from the KFF sample. Within the 32 articles reported, six from the database search were duplicates of reports from the KFF sample and were removed. The review examined the remaining 26 articles or reports published from January 2014 through June 30, 2021, that use quantitative methods to investigate changes in health disparities between African American and white non-disabled, and non-elderly adults, before and after ACA Medicaid expansion, comparing states that did and did not expand Medicaid, using nationwide data. The PRISMA flow diagram (see Fig. 1) outlines the search strategy and screening results.

[Insert Fig. 1]

Using reference management software, three separate reviewers independently conducted databases searches and screened articles for inclusion based on inclusion criteria. Full text review was conducted by four members of the research team, and any conflicts about inclusion were resolved via discussion with the study's principal investigator (primary author). Interrater agreement was over 95%.

## **Data extraction, analysis, and reporting**

Critical review of the sample of studies focused on assessing the current state of knowledge about the impact of Medicaid expansion upon African American-white healthcare coverage, access, treatment, and health outcome disparities and questions remaining, given the strengths and limitations of each study. Using the triple difference research design as the standard to guide analysis, the data charting for each study included capturing the research aim, data sources, sample characteristics, covariates used, types of disparities measured, and key findings for each of the outcomes assessed. Outcomes of interest included health coverage, access to health care, and health care outcomes or health status. The analysis of research design specifically coded for how many of which differences were assessed, how disparities were measured (relative or absolute disparities), and what types of health coverage were assessed (public, private, or any-source health coverage). Findings were also coded for whether significance testing was conducted or reported for each difference.

## **Results**

Reporting formats vary, and information is presented to maximize comparability in Table 1. In this table, we organize studies in chronological order.

[Insert Table 1]

## **Data Sources**

Investigators reported national findings for the general U.S. population or persons with an identified illness. The former used nationally representative surveys providing information on insurance coverage—usually any coverage or reduction in un-insurance—and indicators of healthcare access and utilization. The latter used health records, registries, and other databases tracking persons with the illness of concern and providing information on coverage and treatment (see Table 1).

## **Difference in difference study designs**

Three studies either assessed a single difference excluding the triple interaction or used unadjusted estimates (9–11). Twelve studies tested double differences. Of these, four studies tested differences in outcomes before and after the ACA and between African Americans and whites but failed to test differences between expansion and non-expansion states (12–15). Eight studies tested differences in outcomes before and after the ACA and between expansion and non-expansion states but failed to test differences between African Americans' and whites' outcomes (16–23). Eleven studies tested all three differences: before and after the ACA implementation, between Medicaid expansion and non-expansion states, and between African Americans and whites (24–34).

## **Study results: Changes in coverage disparities**

The research documents significant gains in coverage associated with the ACA, but it clarifies surprisingly little about Medicaid eligibility expansion's impact on African American and white racial disparities in Medicaid coverage. Un-insurance is the most commonly examined outcome variable (17 studies), but only eight of these studies specify public or private health coverage outcomes (10, 11, 19, 22, 23, 27, 29, 32). Findings for coverage disparity reduction are mixed. Percentage point reductions in un-insurance disparities were shown under Medicaid expansion (13, 28, 29, 35, 36), but several studies reported that disparity reductions were not statistically significant (24, 25, 28–30). Several failed to report statistical testing of disparity reduction itself (10, 11, 13, 14, 16, 18, 19, 23, 36). Three studies documented reversed expectations, showing greater coverage gains for African Americans than whites in non-Medicaid expansion states (14, 27, 29).

In studies focusing on populations with specific illnesses, one study found Medicaid expansion to be associated with African American-white disparity reduction in coverage (31). Other studies focusing on patients with specific health conditions found no significant disparity reduction in coverage for patients with specific conditions or failed to test for significant changes in disparities (11, 23, 37).

## **Study results: Changes in access and treatment disparities**

Medicaid eligibility expansion disparity reduction in access and treatment were examined only in 14 out of the 26 studies, and findings were mostly negative. While one research team reported that disparity reduction was greater in expansion states for young adults (27), the majority of studies reported no statistically significant effects for African American-white disparities (12, 24–26, 32, 37, 38) or failed to report significance testing (9, 12, 13, 15, 17, 22, 23). Though not studied widely in the general population—only seven general population studies examined outcomes beyond coverage—disparities in indicators of

healthcare access (usual source of care, having a personal doctor, delaying care due to cost) and treatment (having a wellness exam, flu shot) appear to be unchanged by Medicaid expansion (Hayes et al. 2017; Baumgartner et al. 2020; Buchmueller and Levy 2020; Singh and Wilk 2019; Breslau et al. 2020; Lee and Porell 2018b; Yue, Rasmussen, and Ponce 2018a). In studies focusing on populations with specific illnesses, access to treatment for specific conditions either showed no significant disparity reductions due to Medicaid expansion (32) or failed to test the significance in either disparity changes or differences between Medicaid expansion and non-expansion states (11, 15, 22, 23, 37).

## **Study results: Changes in health status or outcome disparities**

Only seven of the 26 studies examined African American disparity reductions in health outcomes (20, 21, 23, 31, 33, 34, 38). One study found that expansion was not associated with significant changes in self-reported health status, number of poor physical or mental health days, or days with health-related activity limitations (38). County-level variation rates of low infant birth weight or preterm births reduced for African Americans in expansion states and increased in non-expansion states—but the size or significance of the racial disparities or changes in them due to expansion was not tested (34). No significant changes in infant mortality rates were observed in either expansion or non-expansion states for whites or African Americans (20). However, in a study examining changes in maternal mortality, expansion was significantly associated with reductions in maternal mortality rates. Reductions in Medicaid expansion states were largest for Black mothers, but the size of Black-white disparities before or after expansions or the significance of any changes in disparities were not measured or tested (21). No significant disparity reductions were found in survival rates in patients with specific life-threatening health conditions (23, 31, 33).

## **Discussion**

This review indicates that African American disparities in health access, treatment, or health outcomes—with the important exception of maternal mortality rates—remain largely unchanged by Medicaid expansion. However, whether Medicaid eligibility expansion reduced African American-white health coverage disparities remains an open question: Absolute disparities in coverage appear to have declined in expansion states, although exceptions have been reported. Future research addressing key weaknesses or oversights in existing research may help to uncover sources of continuing disparities and clarify the impact of Medicaid expansion on changes in health coverage disparities.

## **Improving research precision and rigor**

Improved research efforts can clarify the answer to this question—and identify structural sources of continuing disparities—by more carefully targeting Medicaid eligibility expansion as a source of disparity reduction and accounting for, or specifically examining, the role of variation in broader ACA-related health system changes. Further studies should examine changes in relative health disparities as well as

absolute health disparities and must examine disparity changes for African Americans separately from disparity changes for other racial or ethnic groups. Deeper investigations of African American-white disparity reductions in healthcare access, treatment, and health outcomes—which appear to be relatively unchanged by Medicaid expansion—should consider community and provider-level treatment contexts that may impact African Americans especially and have sometimes been impacted by the ACA's health reforms.

*Testing the triple interaction.* To test disparity reduction directly, studies need to document significant reductions in the differences between 1) African American and whites' coverage, access, utilization, and health outcome rates, 2) before and after Medicaid expansion, 3) in expansion versus non-expansion states. Only 11 out of 26 studies tested for the significance of all three differences. Of these studies, no study examining the general population found significant disparity reductions in health coverage, treatment, access, or health outcomes associated with Medicaid expansion. However, coverage disparity reductions were found for young adults and patients with acute myocardial infarctions. Less than half of the sample studies used a full triple difference analysis, and to overcome present uncertainty, investigators must routinely comply with this requirement.

*Absolute versus relative disparities.* Relative disparities target equity, and only one study examined relative disparities (14). The investigators found that African American-white relative disparities were not significantly changed from 2013 to 2014 in Medicaid expansion states but were significantly reduced in non-expansion states. Absolute disparities can close when African Americans' rates begin far enough away from whites' that larger absolute gains are required merely for African Americans' gains to keep pace with whites' gains (39).

*Disaggregating Medicaid expansion from other ACA elements.* The ACA ushered in many innovations apart from the Medicaid eligibility expansion. The Medicaid application process was streamlined as online filing options increased and verification and certification procedures capitalized on new technologies (40). Individuals with incomes between 100% and 400% FPL became eligible for "Premium Tax Credits" on a sliding scale to purchase private, non-group coverage through state or federally-operated healthcare exchanges (41), and persons with incomes between 100–250% FPL became eligible for cost-sharing subsidies. Gains were concentrated among those with incomes between 138–250% of the FPL—those who were eligible for the ACA's cost-sharing reductions and among whom African Americans are also over-represented (42, 43). In non-expansion states, premium tax credits and subsidies could offset denial of access to expanded Medicaid for persons with incomes above 100% FPL.

Marketplaces, which informed inquiring persons about Medicaid eligibility, actively sought enrollees through vigorous outreach efforts. Community targeted advertising raised awareness, and marketplaces provided individual counseling on eligibility and options, sometimes facilitated by culturally sensitive enrollment assistors (44). Safety net hospitals faced new incentives to avoid hospital readmission and reduce lengths of stay by shifting newly eligible patients to Medicaid-funded outpatient care (44). Funding was increased for new Federally Qualified Health Centers, which disproportionately support

African Americans through targeting services for the poor (45). These and other developments promised to reduce barriers to coverage and access for non-white, low-income adults—lessening healthcare disparities throughout the United States as many previously eligible people become aware of Medicaid eligibility and enrolled (“woodwork effect”) (46). New research must examine the impacts of ACA policy elements on disparities in specific types of health insurance coverage rather than on the all-inclusive “un-insurance.”

## **Advancing knowledge: Beyond Medicaid expansion’s eligibility requirements**

Additional advances in research should examine variation in state implementation of Medicaid expansion. This includes attention to the role the Section 1115 Medicaid waivers have played in expanding Medicaid eligibility—both before and after the ACA’s implementation—and the extent to which changes in health coverage disparities are attributable to enhanced awareness of health coverage possibilities resulting from vigorous outreach and health coverage enrollment efforts in both expansion and non-expansion states.

*1115 Medicaid Waivers.* Medicaid 1115 waivers were issued to 14 states between 2004 and 2012 for early Medicaid expansion, and, in some states, early expansion significantly affected coverage rates (47). Two studies excluded these states from consideration (19, 25), but others failed to account for the possible pre-ACA reduction in coverage increase and disparity. Investigators may have underestimated ACA expansion’s impact on disparities by neglecting early expansion. Medicaid waivers played a dual role in Medicaid eligibility expansion. In addition to the 1115 waivers approved prior to the ACA Medicaid expansion, after the ACA Medicaid eligibility expansion, several initially rejecting states expanded Medicaid eligibility through Section 1115 waivers.

These states used these waivers to customize eligibility standards to accommodate better ideological and fiscal reservations (48). Some states expanded Medicaid with restrictions—requiring premium payment to begin coverage, using health savings accounts, tying healthy activities to waived premiums, or including work requirements. These are complex to implement and present grave administrative challenges (49, 50), reducing uptake of Medicaid coverage (51). Arkansas’ coverage gains did not differ in gains from traditional Medicaid expansion (52), but Arkansas’ addition of work requirements in June 2018 resulted in thousands losing coverage—reportedly due to administrative complexity (53). African Americans have experienced race-related aversive experiences with bureaucratic programs (54), and waiver-imposed barriers may deter African Americans especially.

More research is needed to identify the impact of waivers on disparities. This knowledge is critical to informing future approvals for state maneuvers to expand Medicaid conditionally or partially through these policies. Currently, 63 waivers have been approved across 45 states, and 28 applications in 22 states are currently pending decisions from the Centers for Medicaid and Medicare Services (CMS) (55).

*Outreach and Enrollment Assistance.* Disparity reduction in non-expansion states points to the possibility that some states reduced enrollment barriers for African Americans especially. Advertising, enrollment assistance, and greater enrollment incentives for FQHCs and safety net hospitals to maximize enrollment likely increased Medicaid uptake. Conceivably, previously uninsured African Americans who were eligible for Medicaid prior to Medicaid expansion disproportionately responded to ACA messages about coverage possibilities, were less deterred by burdensome enrollment procedures due to streamlining efforts under the ACA or were disproportionately gaining enrollment through newly available Federally Qualified Health Centers or in safety-net hospitals as they encouraged covered outpatient care.

## **Populations with Chronic or Critical Conditions**

Among eight studies focusing on populations with specific illnesses, one study found Medicaid expansion to be associated with African American-white disparity reduction in coverage (31). However, none of these studies report significant reductions in disparities in access to treatment, survival rates, or health outcomes. Coverage disparity reductions in populations with critical or chronic conditions, and associated changes in access to care, must be considered considering the presence of strong incentives to find insurance coverage for costly medical procedures. Providers are motivated to facilitate enrollment to avoid the burden of uncompensated care—the very “adverse selection” that concerns insurers and necessitated the ACA’s requirement that persons with pre-existing conditions not be denied coverage (56). Opportunities for gaining coverage are likely more available in expansion states, and thus coverage disparity reductions observed under strong incentives to enroll must be understood on their own terms and may not be generalized to the wider population.

## **Access, Treatment, and Health Outcomes**

This review also highlights that there is limited evidence supporting the expectation that disparity reductions in coverage translated into disparity reductions in access, utilization, or health outcomes. Refinements are needed to determine better whether such reductions occurred and how. Studies assessing access and treatment utilization should consider other non-cost-related barriers to healthcare access—including barriers that may impact African Americans especially. Size and location of provider supply, program outreach and cultural responsiveness, and other determinants of receiving care may be relevant. An expansion of Community Health Centers funded by an ACA-created trust fund, where African Americans disproportionately are treated, is particularly ripe for study as an ACA-related trigger for change in provider supply. Focusing directly on access and treatment disparities is indicated, taking us beyond inconclusive findings from present approaches measuring only the onset of the ACA and its immediate impacts on coverage disparities.

Examinations of the ACA’s impact on disparities in health outcomes and health status—which may result from higher health insurance rates but will likely take longer to emerge—should also be examined in the coming decade. Due to the impact of a wide range of social determinants upon health—and the disproportionate exposure of African Americans to determinants that negatively impact health status and

health outcomes (57)—the impacts of the ACA on health outcomes will be complex to untangle and likely more difficult to detect.

## **Conclusion**

Stressing non-discrimination and promoting cultural sensitivity (3, 44), the ACA sought to reduce, if not eliminate, racial and ethnic disparities in insurance coverage, access, treatment, and health outcomes. The ACA introduced a suite of disparity-sensitive policy tools to achieve these aims. Preliminary findings regarding African American disparity reductions in healthcare access, receipt of treatment, or health outcomes are discouraging, and structural sources of continued disparities call for deeper investigations of ongoing barriers to care.

Global improvement appears to have occurred in health coverage disparities, and these are associated with the onset of the ACA. Disentangling the role of a prominent instrument for disparity reduction—Medicaid expansion—remains elusive and considerable room persists for additional disparity reduction. For gains that have been achieved in health coverage disparity reduction, it is unclear how much gains in coverage were due to expanded eligibility for Medicaid and how much was due to energetic efforts to encourage take-up.

The ACA is built upon long-existing health care policy (58) and has become intricately incorporated into the U.S. health care system (59). Incremental policymaking theories indicate that future policing health will build upon the policy lever established under this policy (60), as is exemplified by the recently enacted American Rescue Plan Act, which extended and increased the marketplace subsidies and increased state incentives to participate in Medicaid eligibility expansion. Thus, identifying policies and actions under the ACA that failed to adequately close gaps in health coverage and treatment for African Americans and isolating the most potent ACA mechanisms for reducing disparities can inform future policy responses targeting these remaining inequities.

## **Declarations**

### **Ethics approval and consent to participate**

This study did not collect primary data or involve human subjects. No consent for participation was required and this study was exempt from approval from the University of Texas at Arlington's Institutional Review Board.

### **Consent for publication**

Not Applicable

### **Availability of data and materials**

The datasets generated and/or analyzed during the current study are not publicly available due to articles being in subscription-based journals. However, they are available from the corresponding author on reasonable request.

### **Competing interests**

The authors declare that they have no competing interests.

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This study was unfunded.

### **Authors' contributions**

LS conceived of the study, oversaw its execution and analysis, and drafted a majority of the manuscript. GG provided direct supervision of data collection, contributed to the analysis, and wrote a substantial portion of the manuscript. LK, KK, and AR collected and coded the data. NW provided conceptual input and editing on the final manuscript.

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Not Applicable

### **Author's Information**

Not Applicable

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## Table 1

Table 1 is available in the Supplementary Files section.

# Figures

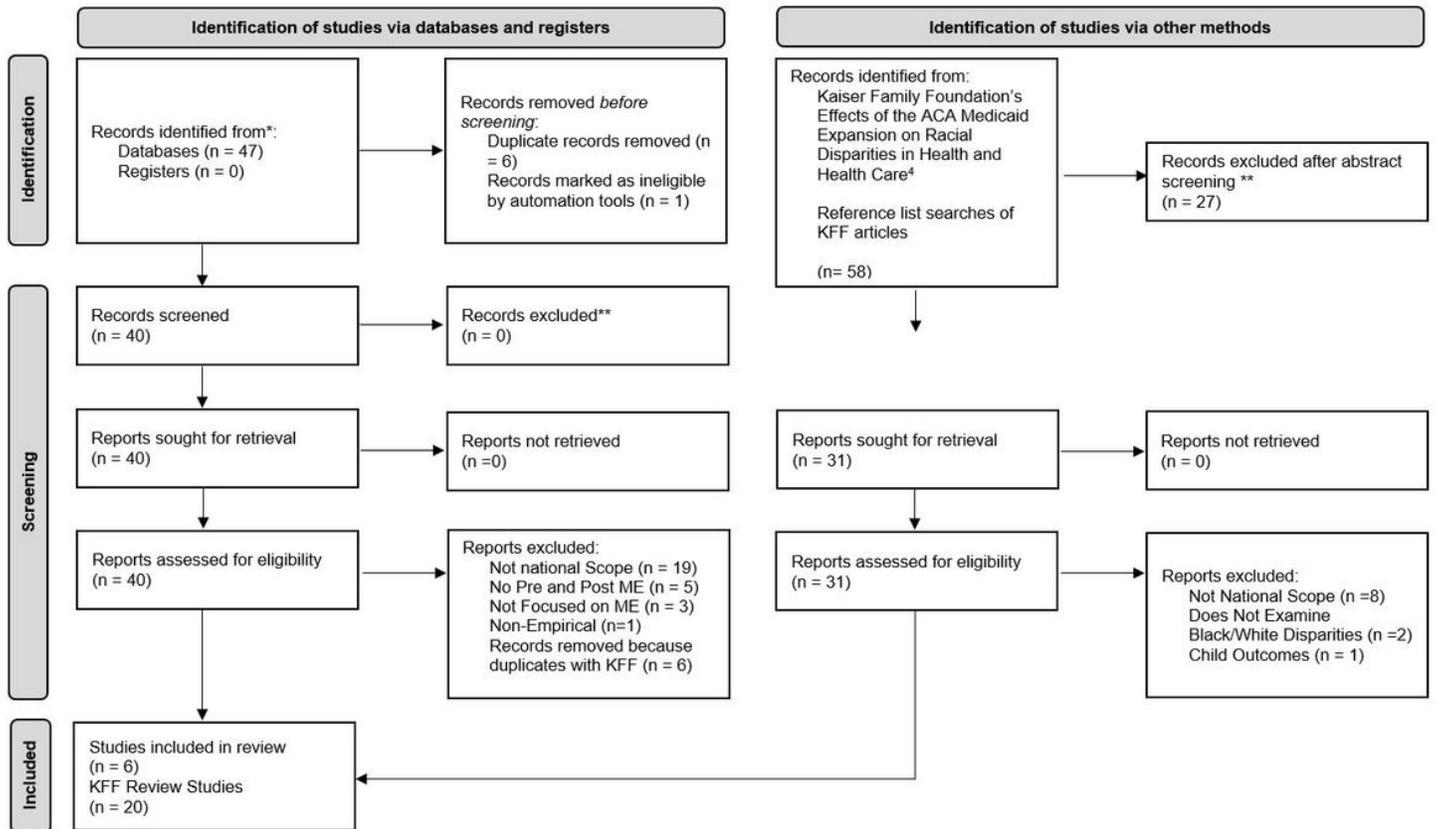


Figure 1

PRISMA-ScR 2020 flow diagram.

Adapted from: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: <http://www.prisma-statement.org/>

## Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [Table1.docx](#)
- [PRISMA ScR Checklist ME Scoping Review.docx](#)