HANDOUT Re: Item E

Research Report

Overview of Uncompensated Care

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Prepared for THE HEALTH REFORM LEGISLATIVE TASK FORCE

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UNINSURED IN ARKANSAS

Uncompensated care—health care that is provided without payment—has largely been the result of a lack of health insurance coverage among significant portions of the population. The federal Patient Protection and Affordable Care Act of 2010 (ACA) sought to provide individuals greater access to health insurance by expanding the income eligibility levels for Medicaid and by providing insurance premium subsidies to individuals who make too much money to qualify for Medicaid, but still have difficulty affording health insurance coverage. If more people have insurance coverage, uncompensated care should decrease. The objective of this report is to provide data, where available, on the uninsured rates in Arkansas, the cost of uncompensated care and funding that the state and federal government have historically provided to offset hospitals and other health care providers' uncompensated care.

UNINSURED RATE BY AGE

The official numbers for the rates of uninsured following the Jan. 1, 2014, implementation of the Affordable Care Act are not yet available, but the 2013 rates provide a baseline for comparing future data. The state's overall uninsured rate (16%) and its rate among all individuals under age 65 (18.8%) were above the national averages for those groups in 2013.[1] However, the percentage of uninsured among children and the elderly are lower than the national average. Because people over age 65 are eligible for Medicare and more insurance options have been available for children (Medicaid and ARKids), insurance coverage expansion efforts in the Affordable Care Act have largely focused on the 18- to 64-year olds.

2013 Uninsured	Arkansas	U.S.
All People	16.0%	14.5%
Under 65	18.8%	16.7%
Under 18	5.5%	7.1%
65 and over	0.4%	1.0%

Source: Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2013 http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2013/acs-tables.html

UNINSURED RATE BY INCOME LEVEL

Medicaid expansion through the Private Option as well as premium subsidies offered through the Health Insurance Exchange were designed to target lower-income adults who do not qualify for Medicare. Medicaid expansion covers individuals up to 138% of the federal poverty level (FPL), while premium subsidies are available to individuals up to 400% of FPL who are not offered affordable health insurance by their employers. In 2013 there were 215,416 uninsured Arkansans at or below 138% of FPL and another 202,832 who were between 138% and 400%.[2]

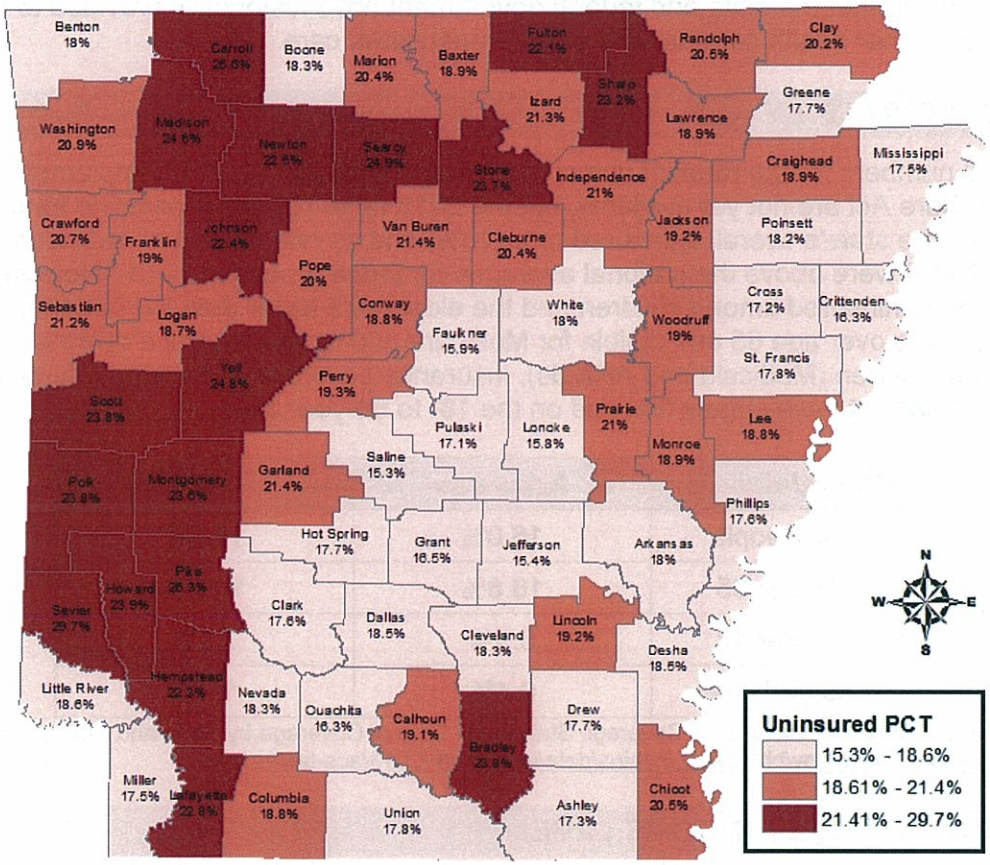
Arkansans Under 65	2013 # Uninsured
</=138% of FPL	215,416
138% to 400% of FPL	202,832
All under 400% FPL	418,248
All incomes	458,560

Source: Small Area Health Insurance Estimates, http://www.census.gov/did/www/sahie/

UNINSURED RATE BY COUNTY

The U.S. Census Bureau's Small Area Health Insurance Estimates program provides estimated rates of uninsured among residents under 65 by county. Arkansas county-level uninsured rates among residents under age 65 range from 15.3% (Saline County) to 29.7% (Sevier County). The map below shows that the state's western and northern counties had the highest rates of uninsured individuals in 2013.

Arkansas's Under 65 Uninsured in 2013
Population under 65: 2,433,909 Uninsured: 458,560
Total Uninsured in Arkansas 18.8%



CHANGES IN INSURANCE COVERAGE IN ARKANSAS

Because official rates of uninsured will not be known for some time (new data may be available in September 2015), determining the impact of ACA implementation on the state's uninsured is difficult to do with accuracy. However, some data are available to begin to measure the impact.

GALLUP POLL

The Gallup polling organization conducts an annual telephone survey (cell phone and landline) on individual insurance status throughout each calendar year. The survey asks adults ages 18 and older: "Do you have health insurance coverage?" The survey results for 2014 indicate that Arkansas had an 11.1 percentage point drop in the rate of uninsured, the most significant reduction of any state. Arkansas's rate decreased from 22.5% in 2013 to 11.4% in 2014.[3] (Comparable data by the Census Bureau's American Community Survey suggest that in 2013, the rate of uninsured among adults age 18 and older was about 19.4%.) Nationwide, the Gallup

poll found a 3.5 percentage point drop in the U.S. rate of uninsured, decreasing from 17.3% in 2013 to 13.8% in 2014.

	2013	2014
Arkansas	22.5%	11.4%
U.S.	17.3%	13.8%

The Gallup survey found that of the eleven states with the largest percentage point drop, ten had expanded Medicaid under the Affordable Care Act. (Montana had the tenth largest uninsured rate change, but did not expand Medicaid.)

MEDICAID EXPANSION AND HEALTH INSURANCE EXCHANGE ENROLLMENT

A reduction in the state's uninsured may also be evident in the number of individuals enrolled in the states new insurance options. In 2013, before the Private Option and the Health Insurance Exchange, 58.1% of Arkansans had private insurance, while nearly 38% had some type of government insurance coverage.[4]

2013	Arkansas	U.S.
Private Insurance	58.1%	65.0%
• Employment Based	46.2%	54.0%
• Direct Purchase	12.2%	11.9%
• TRICARE	3.3%	2.6%
Government Insurance	37.9%	31.6%
• Medicaid	21.6%	17.9%
• Medicare	19.1%	15.9%
• VA Care	3.4%	2.2%
Uninsured	16%	14.5%

Note: Rates sum to more than 100% due to some individuals having multiple types of insurance.

Source: Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2013, http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2013/acs-tables.html

Today nearly 66,000 people are obtaining coverage through the Health Insurance Exchange, and about 240,000 people are obtaining it through Medicaid expansion. (Adults between 17% and 138% of the federal poverty level qualify for one of two categories under Medicaid expansion: Medically Frail or Private Option.) Data were not collected on the prior insurance status of Health Insurance Exchange enrollees (i.e., were they previously uninsured or switching from another health plan), so it's difficult to know precisely what impact this new coverage has had on the state's uninsured population.[5] According to the Department of Human Services, about 4,500 Medicaid expansion enrollees had health insurance before enrolling in the Private Option in 2014, and about 6,200 enrollees had health insurance before enrolling in 2015.[6]

Enrollees	Traditional Medicaid	Medically Frail	Private Option[7]
2013	807,968	0	0
2014	805,260	22,359	207,341
2015 YTD	722,135	23,640	215,493

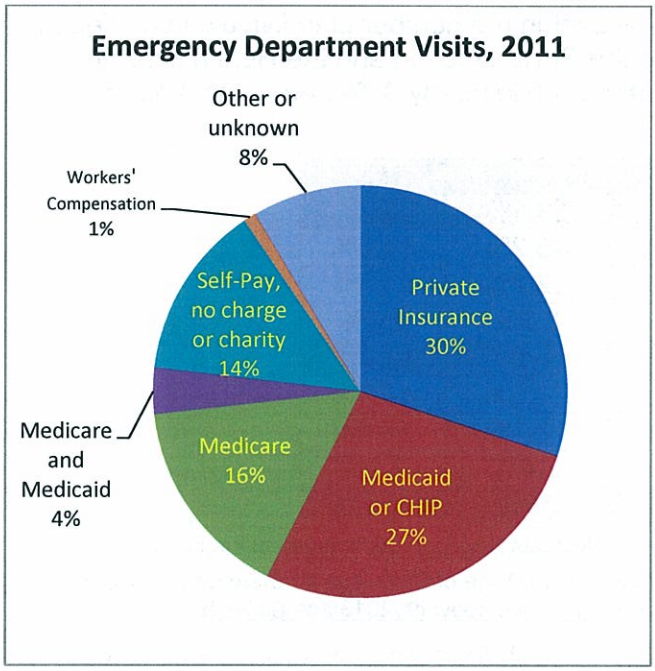
	Health Insurance Exchange
2013	0
2014	43,446[8]
2015	65,731[9]

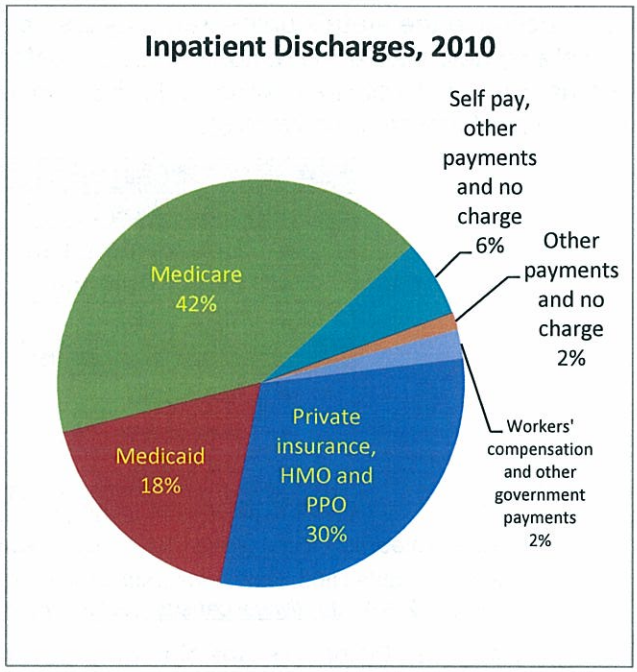
Sources: Arkansas Department of Human Services and U.S. Department of Health and Human Services

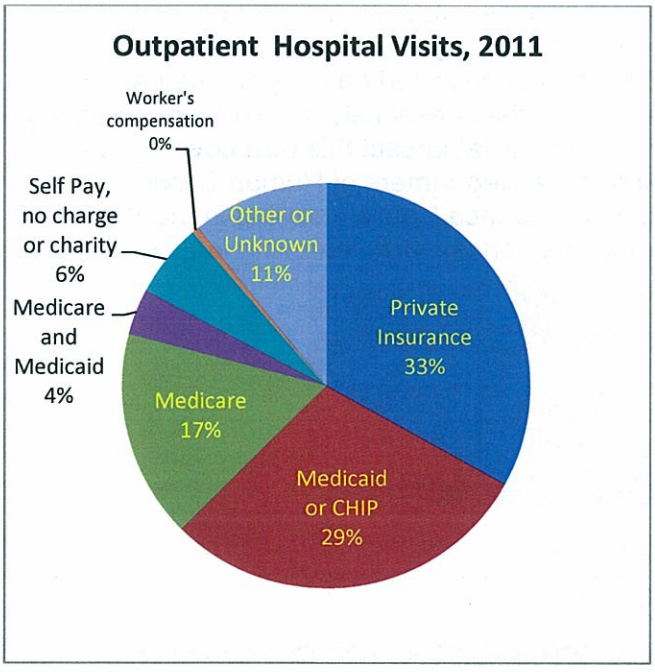
UNINSURED POPULATION BY SERVICE PROVIDER

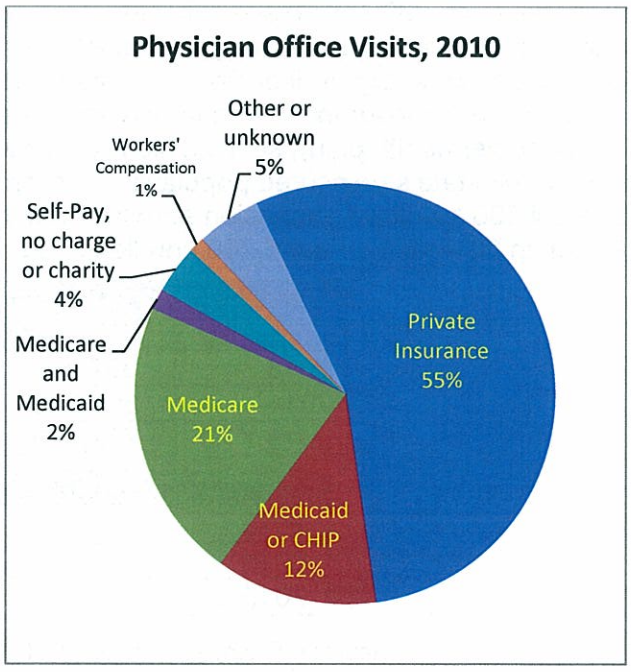
Some national data are available to assess the amount of care provided to uninsured patients. However, the most recent data are from 2010 and 2011. According to three surveys conducted by the Centers for Disease Control and Prevention—the National Hospital Ambulatory Medical Care Survey, the National Ambulatory Medical Care Survey, and the National Hospital Discharge Survey—uninsured patients (described below as "self-pay" and "no charge or charity") made up:

- 14% of all emergency department visits in 2011[10]
- 6% of hospital inpatient discharges in 2010[11]
- 6% of hospital outpatient visits in 2011[12]
- 4% of physician office visits in 2010[13]









CALCULATING THE COST OF UNCOMPENSATED CARE

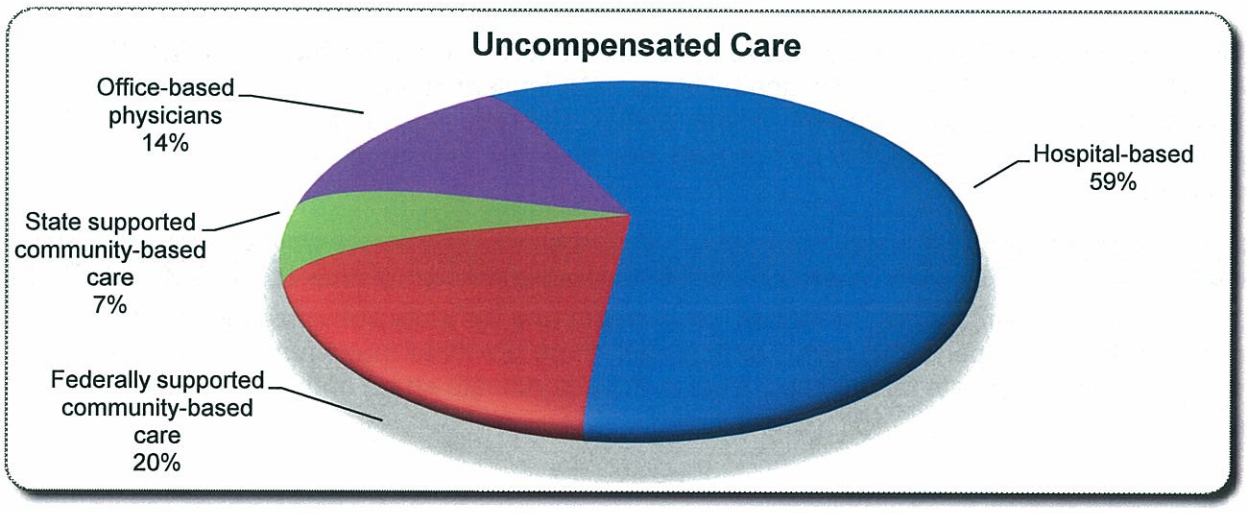
There are a number of different definitions for uncompensated care with no single correct way to calculate it. This section of the report provides information on various ways it has been defined and the available data on its cost nationally and in Arkansas.

URBAN INSTITUTE

Typical reviews of uncompensated care focus on uncompensated care in hospitals because that's where the majority of uncompensated care is provided. However, some organizations have estimated the cost of uncompensated care in all settings. The most up-to-date estimates for uncompensated care across health care providers come from the Urban Institute's report, "Uncompensated Care for Uninsured 2013: A Detailed Examination."[14] The Urban Institute provided two estimates for uncompensated care using two methods.

- Under the first approach, the report's authors used household survey data from the Medical Expenditure Panel Survey. They identified the cost of services provided to uninsured individuals for which no payment was made, and they added in indirect payments made on behalf of the uninsured. These indirect sources include payments made by the Veterans Administration, local and state health departments, and automobile insurance. The report authors noted that they consider services paid for by these payers to be uncompensated care because they are "indirect sources, which would most likely have been paid by a health insurance plan, private or public, had the individual been insured," according to the report. Using this approach, the Urban Institute estimated that **uncompensated care cost about $84.9 billion** in 2013. Of that amount, $49 billion was provided for uninsured individuals for which no payment was made, and $35.9 billion was care provided to uninsured individuals that was paid for through indirect sources.
- The report's second approach attempts to estimate uncompensated care by health care provider type. For this assessment the authors used "published data from government sources and provider data." The report does not include uncompensated care provided by dentists, pharmacists and long-term care providers. Using this methodology and these data sources, the report authors estimated that **uncompensated care totaled $74.9 billion** in 2013.

The report found that hospitals provide nearly 60% of all uncompensated care, while physicians provide about 14%. State and federally supported community-based care, which the authors define as spending by the Veterans Administration, the Indian Health Service, the Community Health Centers, the Maternal and Child Health Bureau and the HIV/AIDS Bureau, make up about 27% of uncompensated care provided.



HOSPITAL UNCOMPENSATED CARE

Because the largest amount of uncompensated care is provided by hospitals, discussion on the cost of uncompensated care typically centers on hospitals. Since 2010, the Centers for Medicare and Medicaid Services (CMS) has required hospitals to report information on uncompensated care as part of their annual financial reporting. The calculation CMS requires hospitals to use to report uncompensated care is similar to the one used by the American Hospital Association. The calculation adds together the cost of charity care and bad debt.

- **Charity care** is care that hospitals provide but for which they do not anticipate receiving payment. In these situations, the patient qualifies for the hospital's financial assistance policy, and the hospital agrees to provide care without payment or with limited payment.
- **Bad debt** is care that hospitals provide with the expectation that payment will be collected, but instead the patient does not pay.

To determine the *cost* of charity care and bad debt, CMS requires hospitals to multiply the associated *charges* by a cost-to-charge ratio, which is essentially a hospital's expenditures as a percentage of charges.

To obtain independent uncompensated care figures for hospitals, the Bureau of Legislative Research (BLR) downloaded Medicare Cost Report data from CMS. Hospitals report the uncompensated care information through a worksheet included in the Medicare Cost Reports they file with the federal government each year. Federal rules require that cost reports cover 12 months of operations, but providers are allowed to base the reports on the fiscal year they to which they adhere. Therefore, some 2013 cost reports cover calendar year 2013, while others cover July 2013 to June 2014 and still others cover October 2012 to September 2013. This is particularly important to keep in mind when attempting to detect the impact of Medicaid expansion or other aspects of the Affordable Care Act on uncompensated care. Additionally Medicare Cost Reports are filed with CMS by intermediaries known as Medicare Administrative Contractors (MACs). The MACs file the cost reports in batches at various times, so a complete set of cost reports for any given year may not be available for 18 months after the year ends.

According to the most complete year of data, 2012, 86 Arkansas hospitals (not including psychiatric hospitals or children's hospitals, which are not required to report uncompensated care) reported a total of **$355.5 million in uncompensated care costs**, including **$167.3 million in charity care** and **$188.2 million in bad debt**. According to the 2013 Medicare Cost Reports for Arkansas hospitals, which contain data for most but not all hospitals, 77 Arkansas hospitals reported a total of **$333.9 million** in uncompensated care. This includes **$169.3 million in charity care** and **$164.6 million in bad debt**.[15]

Of the 23 hospitals that reported a 2013 Medicare Cost Report for the fiscal year (7/1/13-6/30/14) that included the first six months of the ACA implementation, 14 saw a reduction in uncompensated care compared with a year earlier. The reduction in these hospitals totaled about $28.8 million. Overall, the 23 hospitals saw an **$18.2 million decrease in uncompensated care**.

FUNDING TO OFFSET HOSPITAL-BASED UNCOMPENSATED CARE

There are a number of ways the federal government and the state subsidize health care providers for uncompensated care. For hospitals, there are three major funding programs designed to compensate facilities that treat a disproportionate share of uninsured and low-income patients.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH)

Beginning in the 1980s, hospitals that serve a disproportionate number of low-income patients have been eligible for Medicare DSH payments. Historically, a hospital qualified for Medicare DSH payments based on a calculation known as the "disproportionate patient percentage" (DPP), which considers the proportion of a hospital's 1.) patients who are on Medicare and Supplemental Security Income (SSI) as well as 2.) patients who are on Medicaid. The amount that qualifying hospitals receive is calculated as a percentage of the hospitals' base inpatient payments. The percentage used for each hospital is based on whether the hospital is urban or rural, the size of the hospital and whether the hospital serves as a rural referral center.[16]

To determine the amount of Medicare DSH funding hospitals received, the BLR downloaded payment data from CMS. For federal fiscal year 2012, the most recent year for which the BLR was able to obtain what appears to be a complete year of data, 41 Arkansas hospitals received a total of **about $107 million** in Medicare DSH payments.

The Affordable Care Act establishes a method of reducing Medicare DSH funding over time starting in 2014. The ACA and CMS rules divide the Medicare DSH payment into two new payment types:

- **Empirically justified DSH payments**: Medicare DSH payments are calculated under the previous methodology, but hospitals will receive just 25% of the amount they previously received for this part of the DSH payment.
- **Uncompensated care payments**: The remaining 75% is made available to hospitals, but the Affordable Care Act calls for the total amount to be reduced based on the decrease in the national percentage of uninsured. Hospitals receive the uncompensated care payments based on their share of Medicaid and Medicare SSI inpatient days.[17]

While the ACA calls for Medicare DSH cuts, the total amount of DSH funding nationwide was projected to increase in FY 2014. That's because the overall funding amount is based, in part, on the number of hospitals' inpatient days paid by Medicaid, which increased due to Medicaid expansion. According to CMS estimates, Medicare DSH payments increased by more than $1 billion for FY 2014 to $12.2 billion.[18] However, reductions to the total DSH funding will materialize in FY 2015, when CMS estimates that it will distribute just under $11 billion.[19]

MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH)

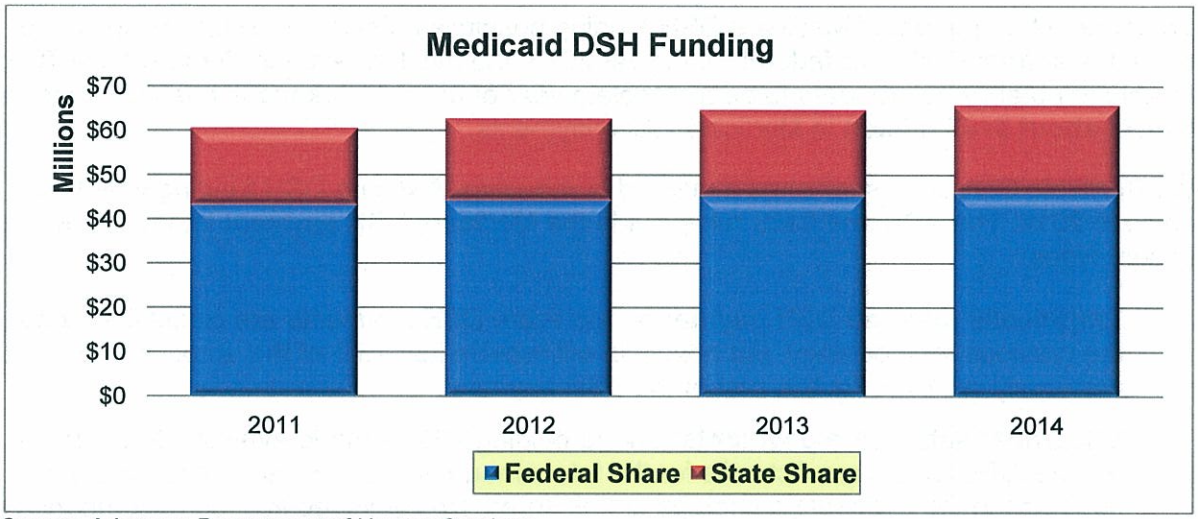
A similar program designed to compensate hospitals' for treating low-income patients is the Medicaid DSH program, which is funded by both the federal government and states. In 2014, the Medicaid DSH program provided $11.6 billion nationally in federal funds.[20]

DSH funding is provided to states as a single capped annual allotment. The allotment is based on each state's prior year allotment, adjusted by the change in the consumer price index. However, states' allotments cannot exceed 12% of their prior year Medicaid medical assistance expenditures.[21] The total Arkansas Medicaid DSH payments are typically between $60 million and $66 million each federal fiscal year. In 2014, the federal allotment was about $46 million, and the state funded another nearly $20 million.[22] The amount of Arkansas's 2015 allotment has not been released.

States are allowed to determine how the funding will be divvied up among hospitals. The distribution methodology established in the Arkansas Medicaid State Plan results in the Arkansas State Hospital and UAMS receiving the majority of the Medicaid DSH funding.[23] In 2014, the Arkansas State Hospital received about $819,000, and UAMS received about $63.7

million, or 98.5% of the state's total Medicaid DSH funding (based on 2013 allotment). Four other hospitals collectively received a little over $106,000.

The Affordable Care Act called for set reductions in the Medicaid DSH funding beginning with a $500 million reduction in 2014 and ending with a $4 billion reduction in 2020. However, Congress passed legislation that delayed the reductions but increased their overall impact. The 2014 legislation increased the total amount of Medicaid DSH reductions from $18.1 billion over a seven-year period starting in 2014 to a $35.1 billion reduction over an eight-year period starting in 2017.[24] The table below shows the federal allotment and state share for the last four federal fiscal years. Each year of allotment is paid to hospitals in the following year.



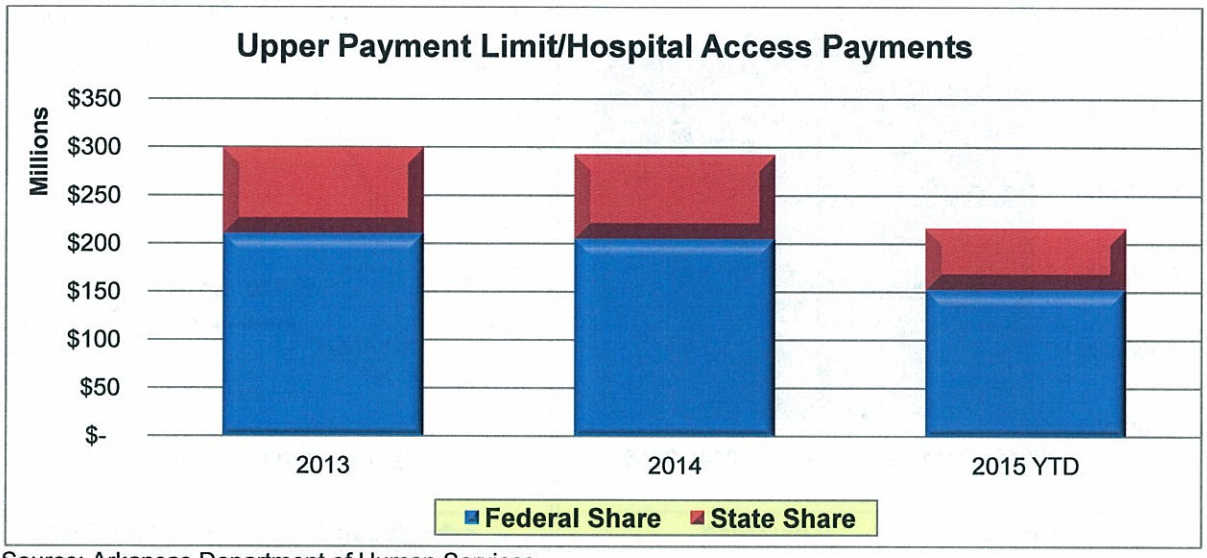
Source: Arkansas Department of Human Services

UPPER PAYMENT LIMIT/HOSPITAL ASSESSMENT FEE

Another program states use to offset hospitals' uncompensated care is upper payment limit supplementary funding. Upper payment limit funding is not a federally designated funding program like Medicare DSH and Medicaid DSH, but rather methods that states have developed to maximize federal match dollars. Federal regulations set a maximum reimbursement amount that state Medicaid programs can pay providers, known as the "upper payment limit" (UPL). Generally, this limit is set at the rate that Medicare pays for a particular service. Most state Medicaid programs reimburse providers at a lower rate than the UPL, creating a gap between the state rates and the maximum allowable. To draw down the federal dollars associated with this gap without spending additional state revenue, states allow health care providers to put up the state match. Since 2001, Arkansas Medicaid, like most other state Medicaid programs, has used this provision to draw down additional federal dollars and provide hospitals with additional payments.

There are a variety of types of UPL programs in Arkansas benefiting different categories of hospitals. The largest program, known as the Hospital Access Payment program, was created by Act 562 of 2009. This legislation requires most hospitals to pay an annual fee to fund the state's share of a new category of UPL payments for hospitals. Each hospital's fee is calculated as a percentage of its net patient revenue. Over the last three years, the **assessment fee has been set between about 1.4% and 1.64% of net patient revenue and has generated between $59.5 million and $71.1 million**. This funding is used as the state match to draw down additional federal dollars. The UPL payments are divvied up among Arkansas hospitals based on their share of Medicaid discharges and the Medicaid paid claims for outpatient hospital services.

Collectively, all UPL funding programs provide about **$300 million in supplemental payments** for Arkansas hospitals.



Source: Arkansas Department of Human Services

In 2012, the U.S. Government Accountability Office calculated each state's Medicaid DSH and other supplemental payments (e.g., UPL/Hospital Assessment Program) made in FY2010. According to the report, Medicaid DSH represented about 2% of the state's total Medicaid payments made that year and the other supplemental payments represented about 8%, for a total of about 10%. Nationwide, Medicaid DSH and other supplemental funds represented about 8.35% of states' Medicaid payments.

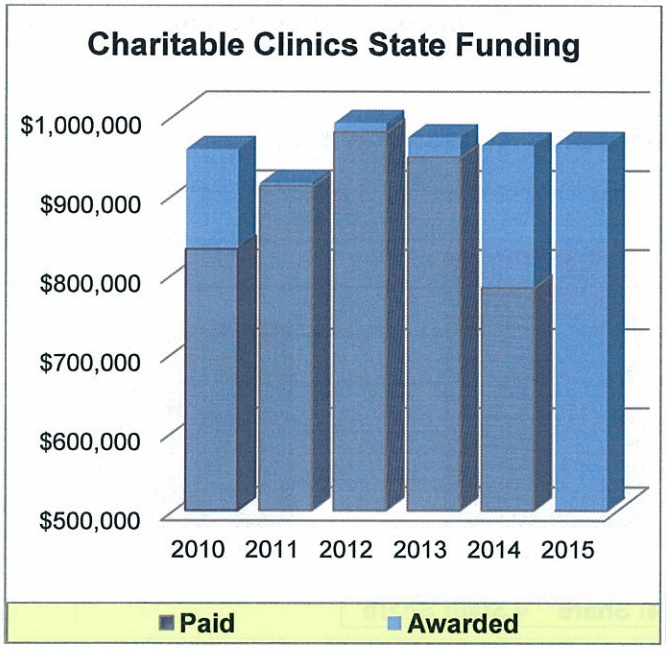
FUNDING TO OFFSET OFFICE-BASED UNCOMPENSATED CARE

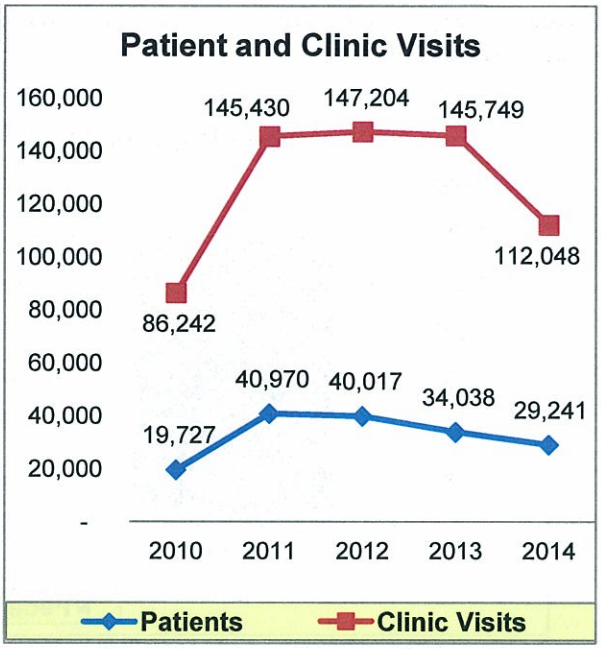
The state also provides funding to offset care provided in other types of clinical settings. The following sections provide a few examples.

CHARITABLE CLINICS

A network of about 20 charitable care clinics operate across the state to provide free or low-cost health care. By Board of Health rule, clinics designated as "free or low-cost health care clinics" do not accept any health insurance.[25] To afford care they frequently use volunteer health professionals.

The state subsidizes these clinics with grant funding provided through the Arkansas Department of Health totaling nearly $1 million annually. Charitable care clinics are awarded funding for the year based on a budgeted amount. They receive the grant funding on a reimbursement basis as they purchase supplies, equipment and other needed resources. Typically, charitable care clinics are reimbursed for at least 97% of their award amount, according to data provided by the Health Department. However, in FY 2014, which included the first six months of the Private Option, charitable care clinics requested reimbursement for just 81% of their budgeted amounts. (Funding has not yet been reimbursed for FY 2015.) This may reflect the drop off of patient loads and clinic visits as patients obtained health insurance. In the six months before Jan. 1, 2014, the charitable care clinics saw 18,153 patients and 11,088 in the six months after that date, a 39% reduction. Clinic visits dropped by more than 45% in the second half of the fiscal year.[26]

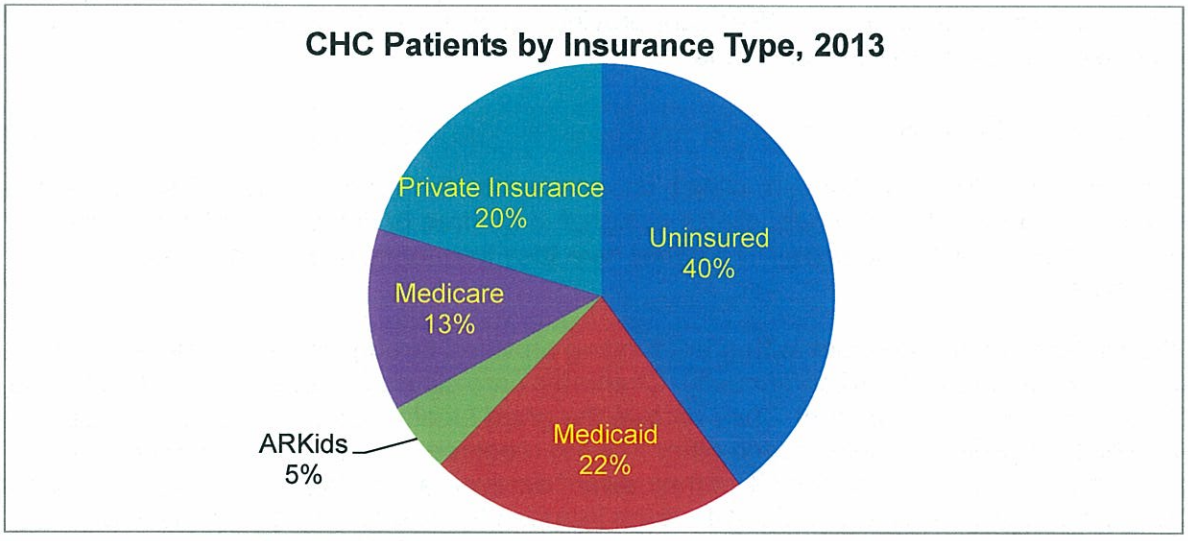




Source: Arkansas Department of Health

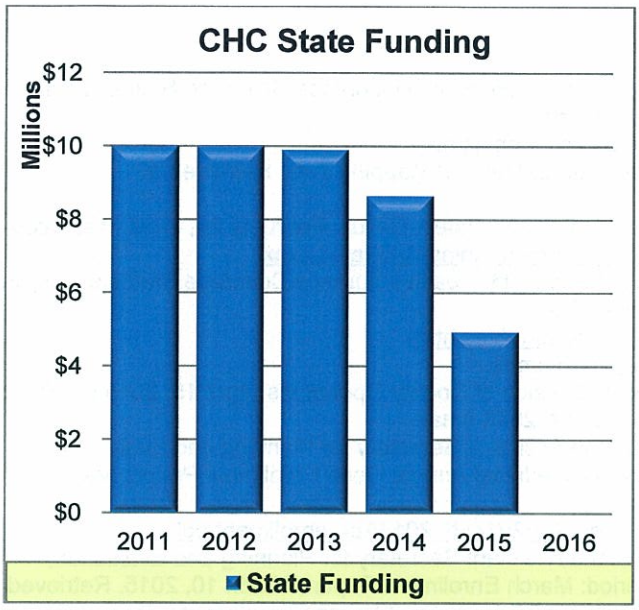
COMMUNITY HEALTH CENTERS

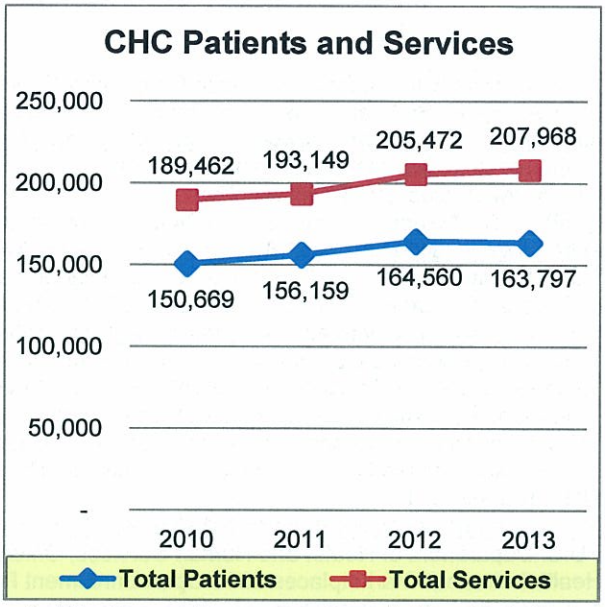
Community health centers (CHCs), also known as federally qualified health centers, are medical clinics that receive enhanced Medicaid and Medicare reimbursement. To qualify, the clinics must offer comprehensive medical services, serve an underserved area or population and offer services on a sliding fee scale.[27] There are 12 federally qualified health centers in Arkansas operating more than 100 clinics. In 2013, more than half of CHC patients had incomes under 150% of the federal poverty level, and 40% were uninsured.[28]



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Uniform Data System

Historically the Arkansas General Assembly has subsidized care by allocating $10 million through the Arkansas Department of Health. The Health Department distributed the funding to the CHCs based, in part, on each center's share of uninsured patients. In 2014, the state funding was reduced to about $8.6 million in anticipation that CHCs would see fewer uninsured patients as the ACA implementation got underway. The funding was cut to just under $5 million in FY 2015 and has been cut completely in FY 2016.[29]



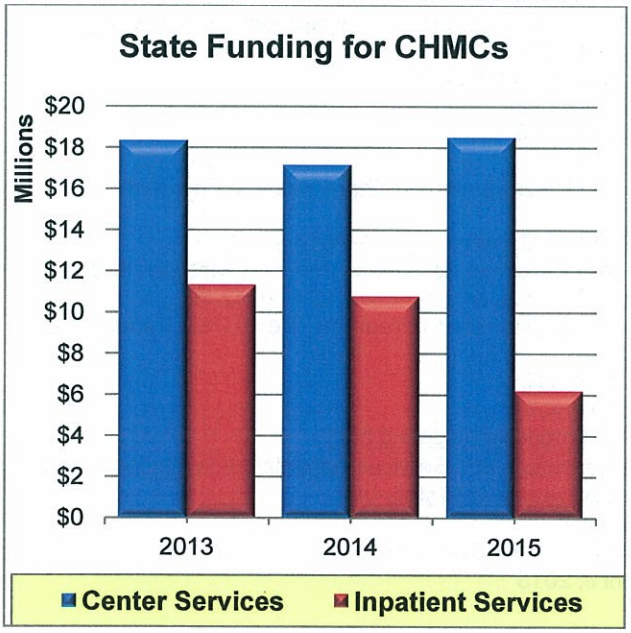


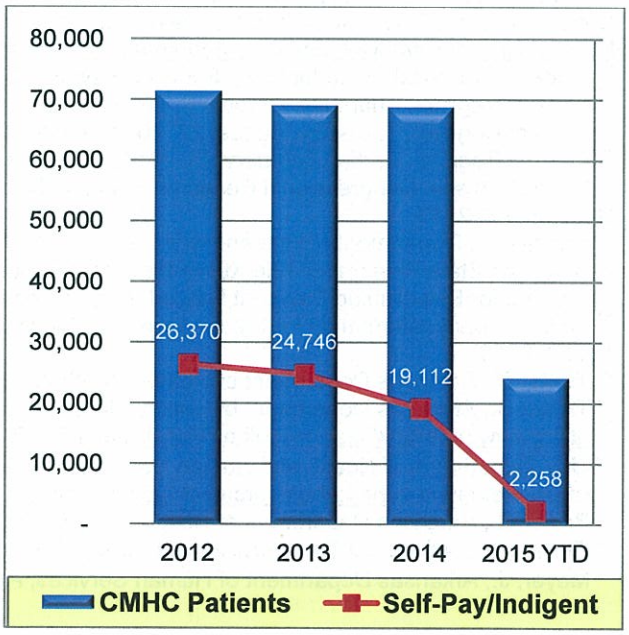
Sources: Arkansas Department of Health and U.S. Department of Health and Human Services, Uniform Data System

COMMUNITY MENTAL HEALTH CENTERS

The state subsidizes uncompensated mental health care by providing annual funding to Community Mental Health Centers (CMHCs). There are 13 CMHCs in Arkansas, and each center is responsible for providing mental health services for the residents in their designated geographical area. CMHCs receive state funding on a per capita basis to help them provide acute mental health services. CMHCs also receive state funding to contract with local hospitals to pay for inpatient mental health services for indigent patients.

To adjust state funding as more CMHC patients obtain insurance coverage, the state opted to decrease the amount of funding dedicated to inpatient treatment. The 2015 funding was reduced by $4.5 million from 2014 levels.[30] While the number of CMHC patients remained mostly unchanged between 2013 and 2014 when the Private Option began, the number of indigent patients dropped by about 22%. In 2014, self-pay patients made up 28% of CMHCs' patient load, but so far in 2015, self-pay patients make up just 9% of patients.[31]





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[2] Small Area Health Insurance Estimates, Interactive Data Visualization and Mapping Tool. Retrieved at http://www.census.gov/did/www/sahie/
[3],Witters, D., Arkansas, Kentucky See Most Improvement in Uninsured Rates, Gallup. February 24, 2015. Retrieved at http://www.gallup.com/poll/181664/arkansas-kentucky-improvement-uninsured-rates.aspx
[4] U.S. Census Bureau, 2013 American Community Survey, Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2013. Retrieved from http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2013/acs-tables.html
[5] Crone, C., Arkansas Department of Insurance, March 27, 2015 email.
[6] Anderson, Delia, Arkansas Department of Human Services, Division of County Operations, April 15, 2015 email.
[7] Bierman, S., Arkansas Department of Human Services, April 14, 2015 email.
[8] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Marketplace Summary Enrollment Report for the Initial Annual Open Enrollment Period, May 1, 2014. Retrieved at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf
[9] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report, March 10, 2015. Retrieved at http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf
[10] Centers for Disease Control and Prevention, National Hospital Ambulatory Medical Care Survey, Table 6. Expected source(s) of payment at emergency department visits: United States, 2011. Retrieved at http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2011_ed_web_tables.pdf
[11] Centers for Disease Control and Prevention, National Hospital Discharge Survey, Number of discharges from short-stay hospitals and of days of care, with average length of stay and standard error, by principal expected source of payment, sex, age, and geographic region: United States, 2010. Retrieved at http://www.cdc.gov/nchs/data/nhds/6expectedsoruce/2010expec6_numberprincipal.pdf
[12] National Hospital Discharge Survey National Hospital Ambulatory Medical Care Survey, Table 4. Expected sources of payment at outpatient department visits: United States, 2011. Retrieved at http://www.cdc.gov/nchs/data/ahcd/nhamcs_outpatient/2011_opd_web_tables.pdf
[13] Centers for Disease Control and Prevention, National Ambulatory Medical Care Survey, Table 5. Expected sources of payment at office visits: United States, 2010. Retrieved at http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf
[14] Coughlin, T., Holahan, J., Caswell, K., and McGrath, M., The Urban Institute, Uncompensated Care for Uninsured in 2013: A Detailed Examination, May 2014. Retrieved at http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/
[15] Centers for Medicare & Medicaid Services, Cost Reports by Fiscal Year, Retrieved at http://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Cost-Reports-by-Fiscal-Year.html
[16] Department of Health and Human Services, Medicare Disproportionate Share Hospital, Rural Health Fact Sheet Series, August, 2014. Retrieved at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Disproportionate_Share_Hospital.pdf
[17] MedPAC, Hospital Acute Inpatient Services Payment System, October 2014
[18] Federal Register, Thursday, October 3, 2013, Volume 78, No. 192.
[19] Federal Register, Thursday, August 22, 2014, Volume 79, No. 163
[20] Federal Register, Friday, February 28, 2014, Vol. 79, No. 40
[21] Mitchell, Alison, Congressional Research Service, "Medicaid Disproportionate Share Hospital Payments," December 2, 2013.
[22] Russell, K., Department of Human Services, Division of Medical Services, April 2, 2015 email.
[23] Arkansas State Plan under Title XIX of the Social Security Act, Medical Assistance Program, Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services, Attachment 4.19-A, p. 12-22
[24] Federal Funds Information for States, President Signs Bill to Extend Health Programs, Delay DSH Reductions, April 7, 2014
[25] Trotta, D., Arkansas Department of Health, March 26, 2015 email.
[26] Trotta, D., Arkansas Department of Health, March 30, 2015 email.
[27] http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html
[28] U.S. Department of Health and Human Services, Health Resources and Services Administration, Uniform Data System, Retrieved at http://bphc.hrsa.gov/uds/datacenter.aspx?year=2013&state=AR
[29] Brech, R., Arkansas Department of Health, April 7, 2015 email
[30] Green, C., Arkansas Department of Human Services, April 8, 2015 email
[31] Meyer, J., Arkansas Department of Human Services, April 9, 2015