Alabama Rural Health Association

Rural Roadshow Information 2023

Alabama Rural Health Association

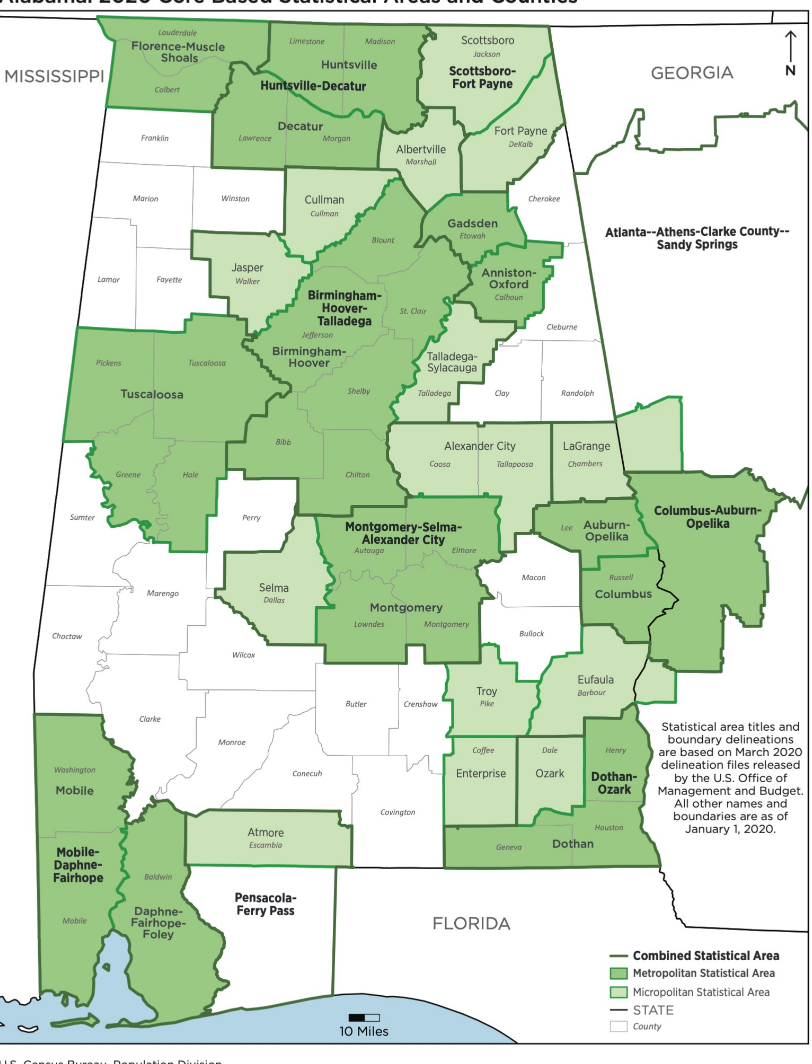
- Approximately 1,000 members
  - Among the top five Rural Health Associations in membership
- Fourteen-member Board of Directors
  - President – Farrell Turner
  - President-Elect – David Albright
  - Secretary-Treasurer – Russ Davis
  - Administrator – Ryan Kelly

Rural ?

- Many definitions of rural
  - Non-urbanized
  - Outside a Metropolitan Statistical Area (MSA)
  - Population Density

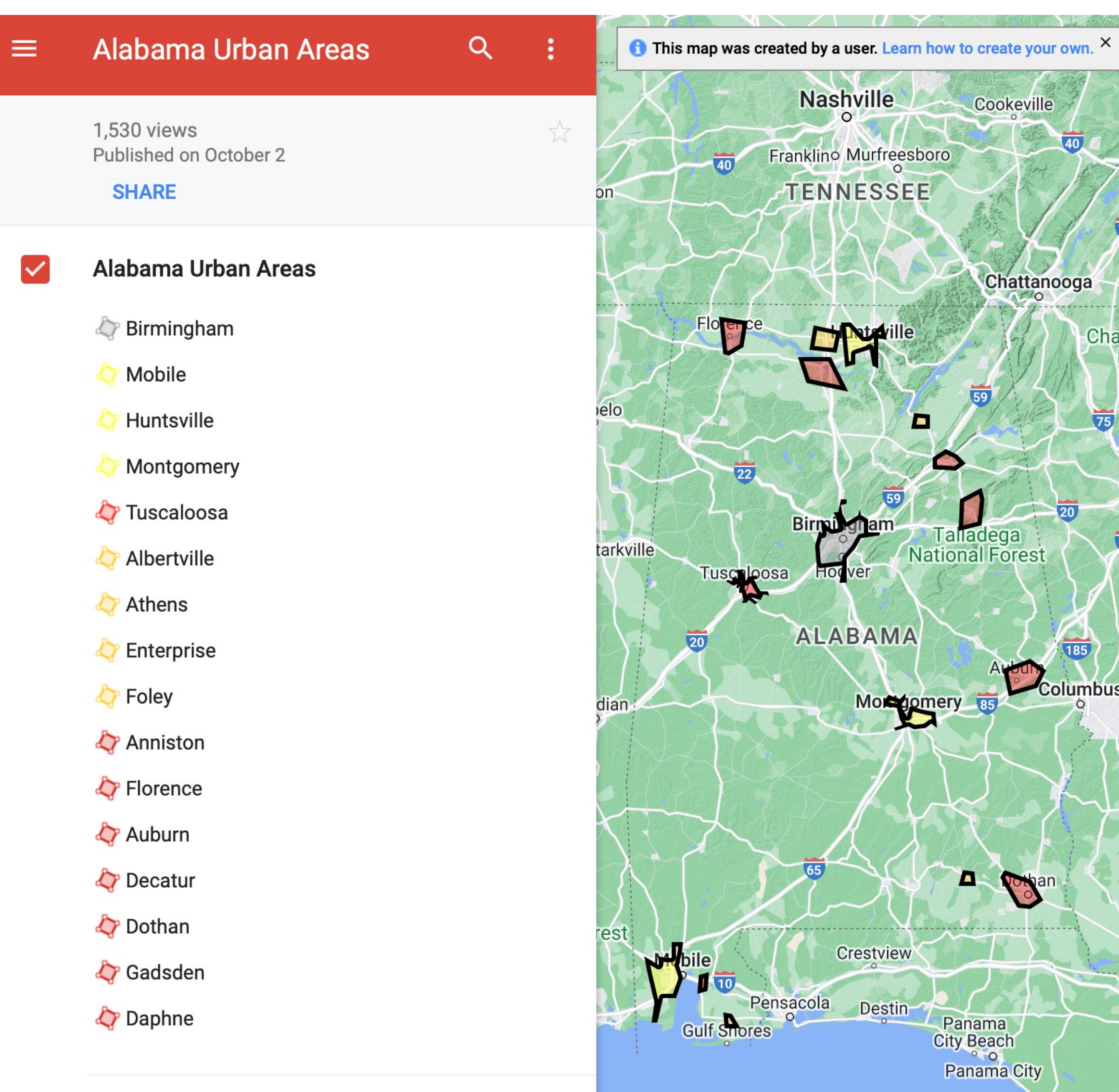
Who is Rural Alabama?

Alabama Metropolitan Statistical Areas Dark Green



U.S. Census Bureau, Population Division

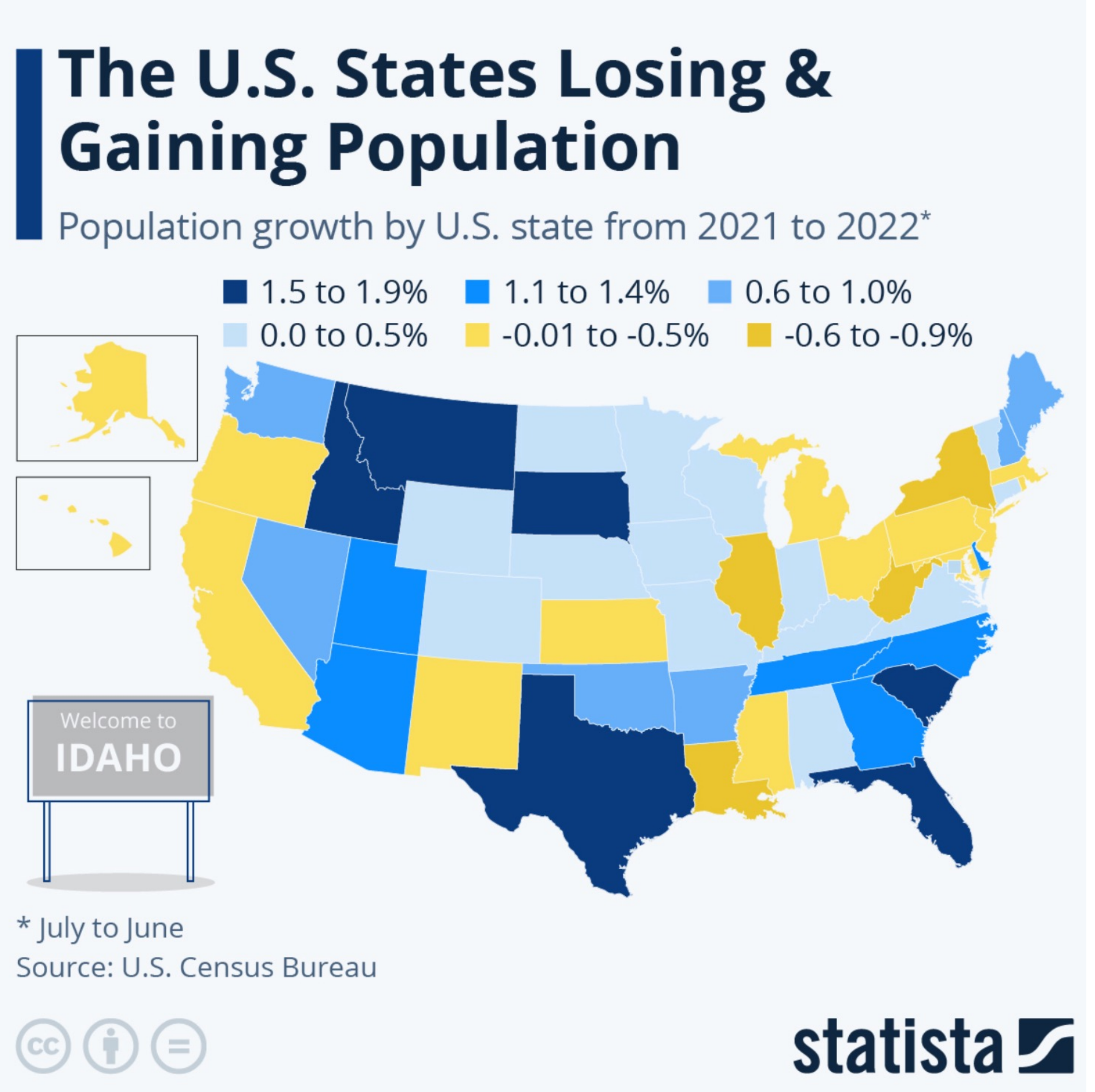
Alabama's Urbanized Areas



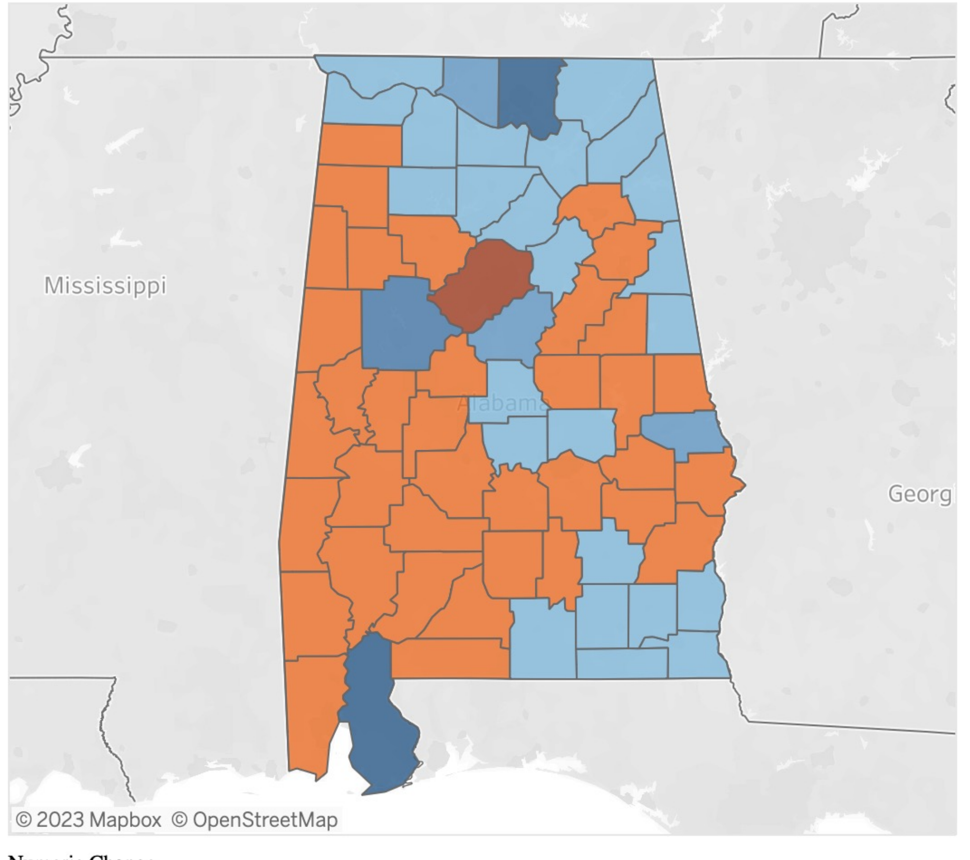
Alabama Population

Alabama	2020 TOTAL POP	2020 URBAN POP	2020 PCT URBAN POP	2020 RURAL POP	2020 PCT RURAL POP
2020	5,024,279	2,900,880	57.7	2,123,399	42.3
2010	4,779,736	2,821,804	59.0	1,957,932	41.0
Change	244,543	79,076	-1.3	165,467	1.3

Alabama is now the 8th most rural state in the nation, passing Kentucky in 2020


The U.S. States Losing & Gaining Population
Population growth by U.S. state from 2021 to 2022*
1.5 to 1.9%
1.1 to 1.4%
0.6 to 1.0%
0.0 to 0.5%
-0.01 to -0.5%
-0.6 to -0.9%
Welcome to
IDAHO
* July to June
Source: U.S. Census Bureau
statista

Cumulative Change Since 2020 Census



Numeric Change

-8,946 — 17,892

Numeric Change

- Population Estimate 2022
- 2021-2022 One-Year Numeric Change
- (selected) Cumulative Change Since 2020 Census
- Cumulative Natural Increase Since 2020 Census
- Cumulative Domestic Migration Since 2020 Census
- Cumulative International Migration Since 2020 Census

Cumulative Change Since 2020 Census

Ctyname	
Alabama	49,940
Madison County	15,405
Baldwin County	14,674
Tuscaloosa County	9,739
Limestone County	7,337
Shelby County	7,081
Lee County	6,529
Cullman County	2,808
St. Clair County	2,461
Lauderdale County	2,313
Marshall County	1,812
Elmore County	1,589
Coffee County	1,345
Autauga County	957

Alabama's fastest growing counties

Estimated population change from July 1, 2020 to July 1, 2021.

Search in table

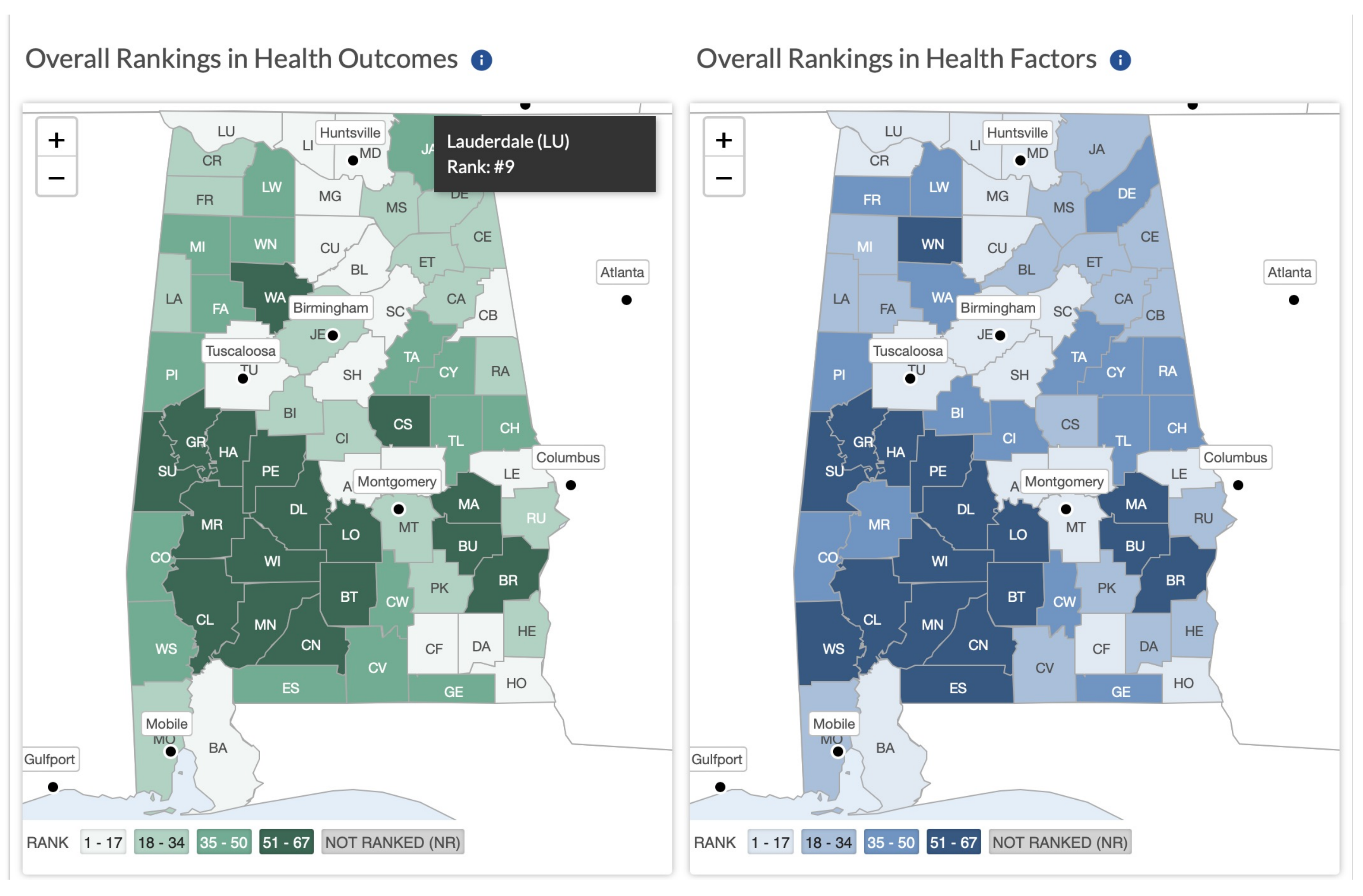
Page 1 of 7

	County	2020 population	2021 population	Population change	Percent change
1	Limestone	104,322	107,517	3,195	3.1%
2	Baldwin	233,140	239,294	6,154	2.6%
3	Henry	17,167	17,459	292	1.7%
4	Cullman	88,044	89,496	1,452	1.6%
5	St. Clair	91,333	92,748	1,415	1.5%
6	Lee	174,601	177,218	2,617	1.5%
7	Shelby	223,708	226,902	3,194	1.4%
8	Madison	389,696	395,211	5,515	1.4%
9	Elmore	88,116	89,304	1,188	1.3%
10	Bibb	22,223	22,477	254	1.1%

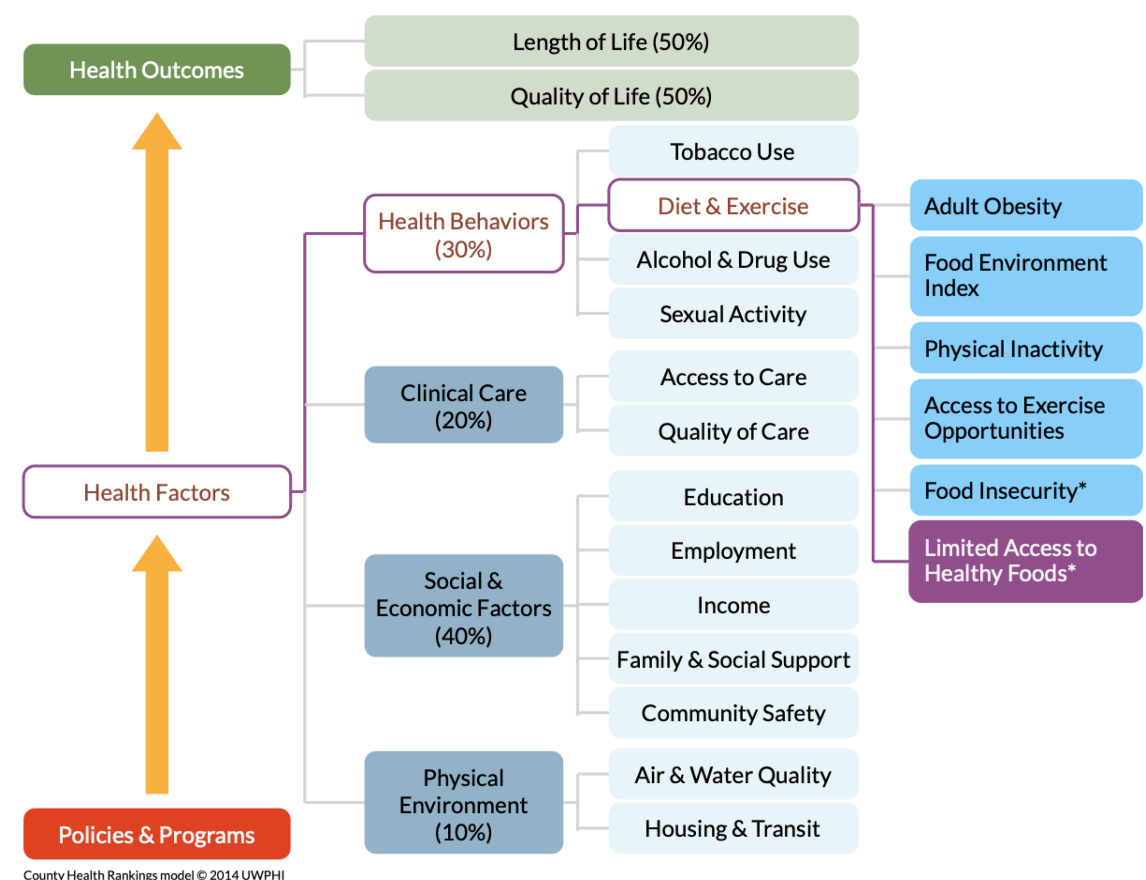
Get the data • Created with Datawrapper

Many of the fastest growing Counties are adjacent to an Urbanized area / MSA

County Health Rankings and Roadmaps



County Health Ratings Model



County Health Rankings Data Sources

- https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-measures

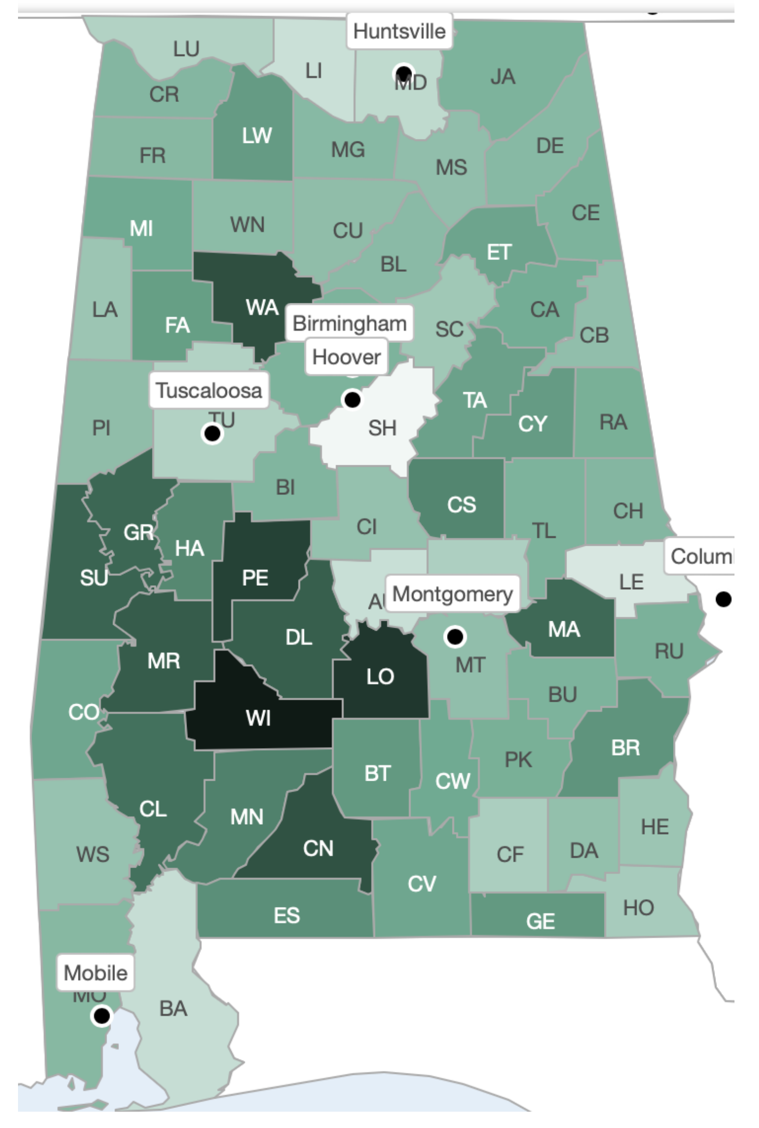
You are

Ranked Measures		Source
Health Outcomes		
Length of Life	Premature Death	National Center for Health Statistics - Mortality Fil
Quality of Life	Poor or Fair Health	Behavioral Risk Factor Surveillance System
	Poor Physical Health Days	Behavioral Risk Factor Surveillance System
	Poor Mental Health Days	Behavioral Risk Factor Surveillance System
	Low Birthweight	National Center for Health Statistics - Natality files
Health Factors		
Health Behaviors		
Tobacco Use	Adult Smoking	Behavioral Risk Factor Surveillance System
Diet and Exercise	Adult Obesity	Behavioral Risk Factor Surveillance System
	Food Environment Index	USDA Food Environment Atlas; Map the Meal Gap Feeding America
	Physical Inactivity	Behavioral Risk Factor Surveillance System
	Access to Exercise Opportunities	ArcGIS Business Analyst and Living Atlas of the Wo YMCA; US Census TIGER/Line Shapefiles

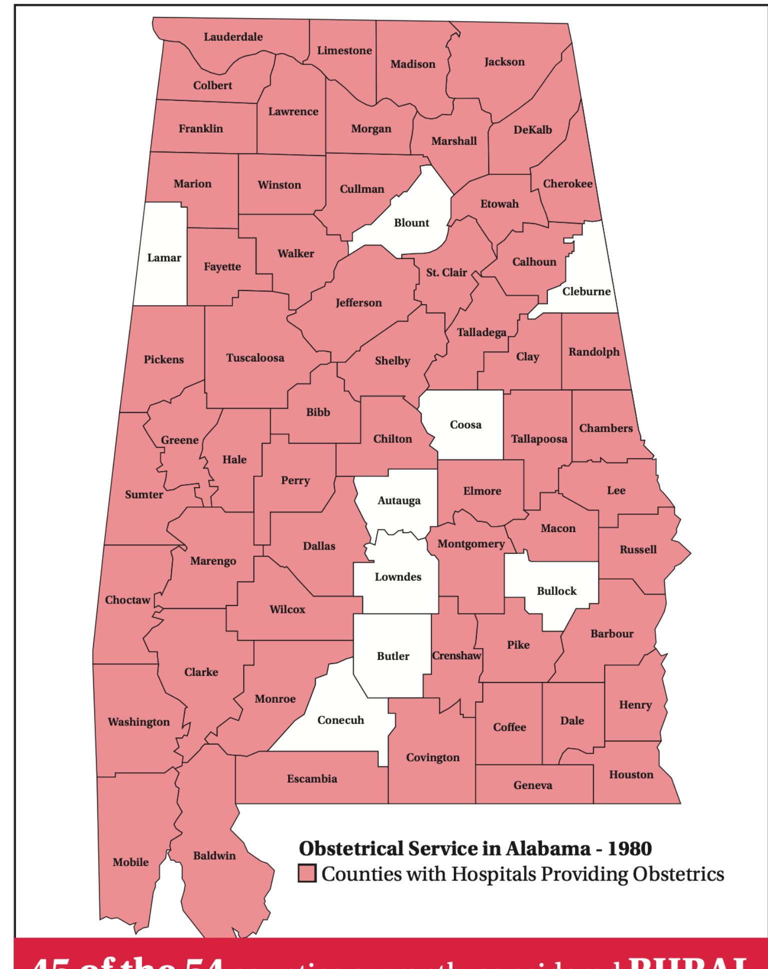
Rural vs. Urban – County Health Rankings

- Rural areas are more likely than urban
  - Greater years of potential lives lost
  - More Fair or poor health days
  - More physically unhealthy days
  - More mentally unhealthy days
  - Greater % of low birthweight babies
  - Higher % population who smoke
  - More obese adults
  - More physically inactive population
  - Higher teen birth rate
  - Higher % lack health insurance
  - More preventable hospitalizations
  - Higher unemployment rate
  - More children in poverty
  - Greater single-parent households
  - Greater income inequality
  - Higher long commute drives alone
- Rural areas are less likely than urban
  - Access to exercise opportunities
  - Drinking excessively
  - Alcohol impaired driving deaths
  - Lower sexually transmitted diseases
  - Fewer primary care physicians
  - Fewer dentists
  - Fewer mental health providers
  - Lower annual mammogram rate
  - Fewer vaccinations
  - Lower high school graduation rate
  - Lower % with some college
  - Lower social association rate
  - Lower violent crime rate
  - Severe housing problems
  - Shorter length of life (73.1 vs 75.0 years)
  - Worse quality of life, health behaviors, clinical care social and economic factors and physical environment

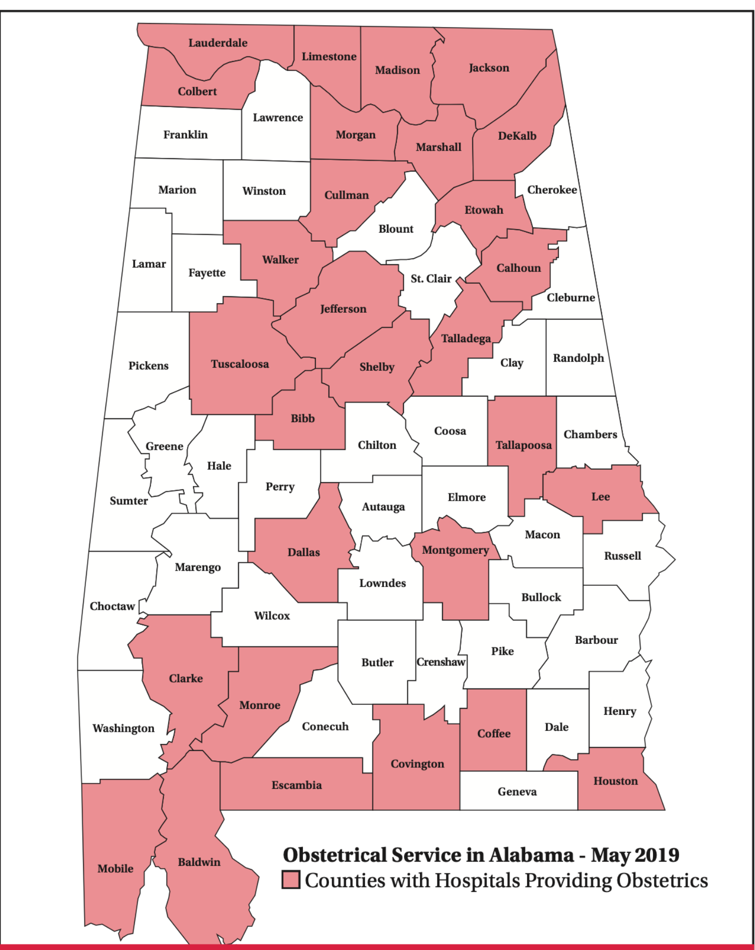
Premature Death in Alabama



A PICTURE OF THE LOSS OF RURAL OBSTETRICAL SERVICE IN ALABAMA 1980 TO 2019



45 of the 54 counties currently considered **RURAL** had hospitals providing obstetrical service in **1980**



16 of the 54 counties currently considered **RURAL** had hospitals providing obstetrical service **TODAY**

ADPH Office of Rural Health

Hospitals Need At Least 200 Annual Deliveries

Rural Hospital Administrators' Beliefs About Safety, Financial ...

by KB Kozhimannil · 2022 · Cited by 15 — Respondents reported that the minimum number of annual births needed to safely provide obstetric care was **200** (IQR, 100-350). From a financial...

North Carolina Health News
https://www.northcarolinahealthnews.org › 2022/04/22

Nearly half of rural hospitals lose money on births

Apr 22, 2022 — A large **number** of rural **hospitals** that cease attending to **births** wind up closing down the road, researcher says.

JAMA Network™

We defined birth volume categories as follows: 10 to 500, 501 to 1000, 1001 to 2000, and more than 2000 births per year. Birth volume categories are not standardly defined; these categories were consistent with previous studies[11,29-31] that used a threshold of 500 or fewer births per year as the smallest volume category. To describe the characteristics of obstetric hospitals and availability of services, we assessed the following measures: (1) the percentage of births within each birth volume category (in the AHA data, annually), (2) the percentage of obstetric hospitals (as hospital-years) in each birth volume category, (3) the geographic distribution of obstetric hospitals by birth volume among states, (4) the proximity of obstetric hospitals to other obstetric hospitals with respect to birth volume category, and (5) the urban adjacency of obstetric hospitals, with specific attention to isolated obstetric hospitals (defined as obstetric hospitals without another obstetric hospital within a 30-mile radius). The measurement of proximity of obstetric hospitals was chosen as a proxy for access to care and potential for regionalization because it is easier to shift births a short distance compared with a long distance. The percentages of births and obstetric hospitals and geographic distribution were determined using AHA survey variables. Obstetric hospital proximity was defined as obstetric hospitals within a straight-line distance of 30 miles or less, and isolated obstetric hospitals were defined as those without another obstetric hospital within a 30-mile radius.[32-34] Straight-line distance was used because of the study scope and associated computation time. Previous analyses have demonstrated that straight-line distance and driving distance produce similar results.[35-37] When proximity of

17 Alabama Counties have fewer than 200 annual births

2.1 children per woman

In developed countries, replacement level fertility can be taken as requiring an average of 2.1 children per woman. In countries with high infant and child mortality rates, however, the average number of births may need to be much higher.

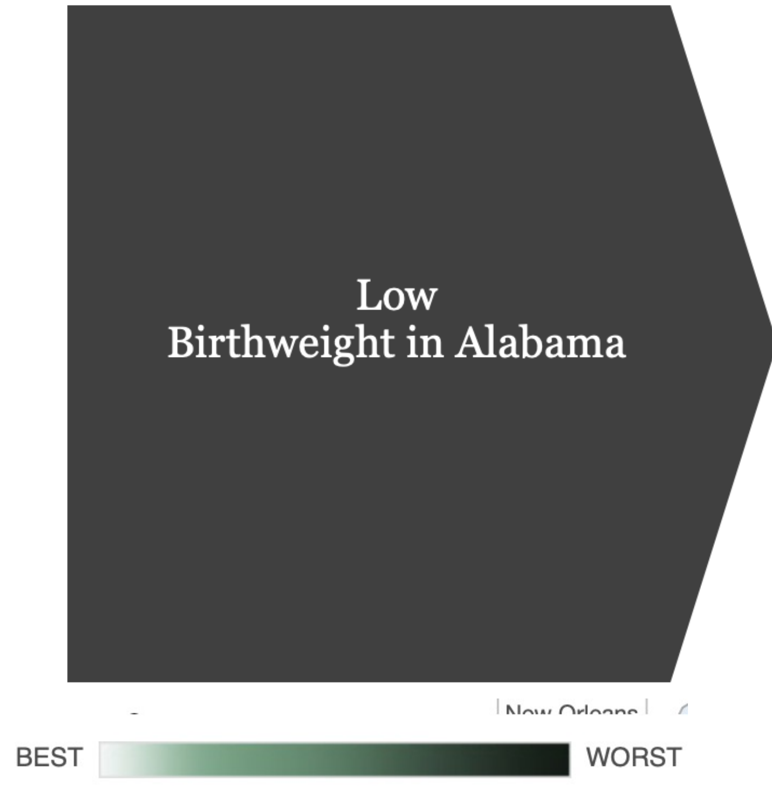
National Institutes of Health (.gov)
https://pubmed.ncbi.nlm.nih.gov › ...

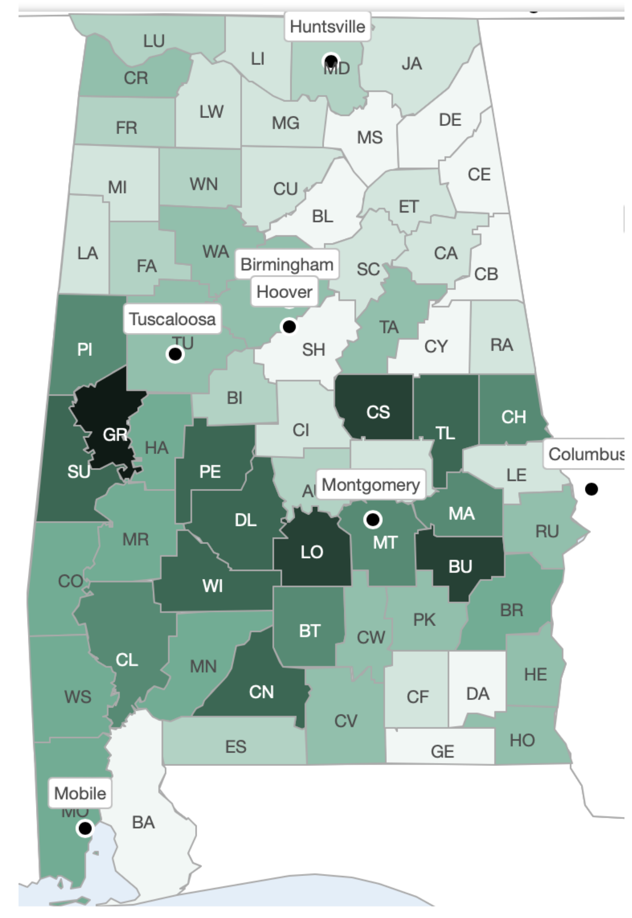
In Alabama, the birth rate is higher than the national average. There were 11.2 births for every 1,000 people in the state between July 1, 2020 and July 1, 2021 compared to 10.8 per 1,000 nationwide, according to the U.S. Census **Bureau's Population and Housing Unit Estimates Program. Alabama's birth rate ranks as the 17th highest among states.**

Despite the higher than average birth rate, **births did not outpace deaths in Alabama** in the most recent year of available data. Excluding net migration -- the number of people who moved to or from the state -- **Alabama's population contracted by 0.17% over the 12 months ending in July 2021**.

https://www.thecentersquare.com/alabama

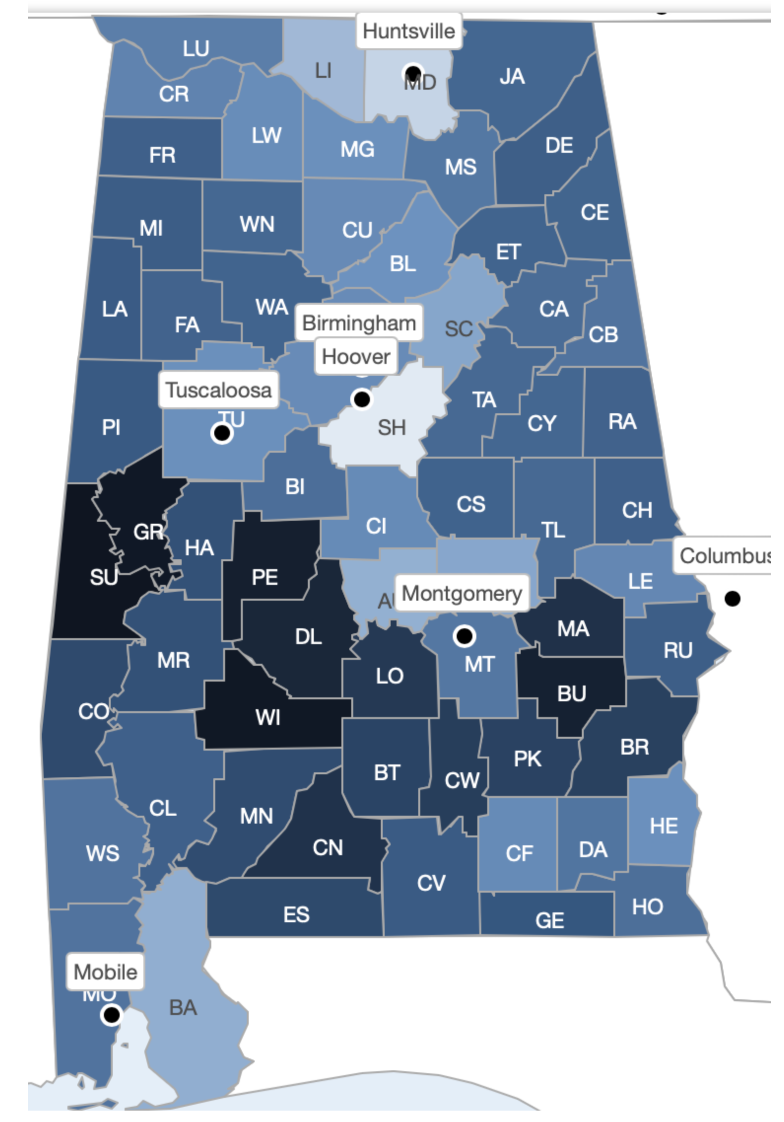
That could mean a change in the landscape of job opportunities and career choices in those communities, she said. "You might have less demand for teachers and more demand for nurses," she said. (AL.com)





County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

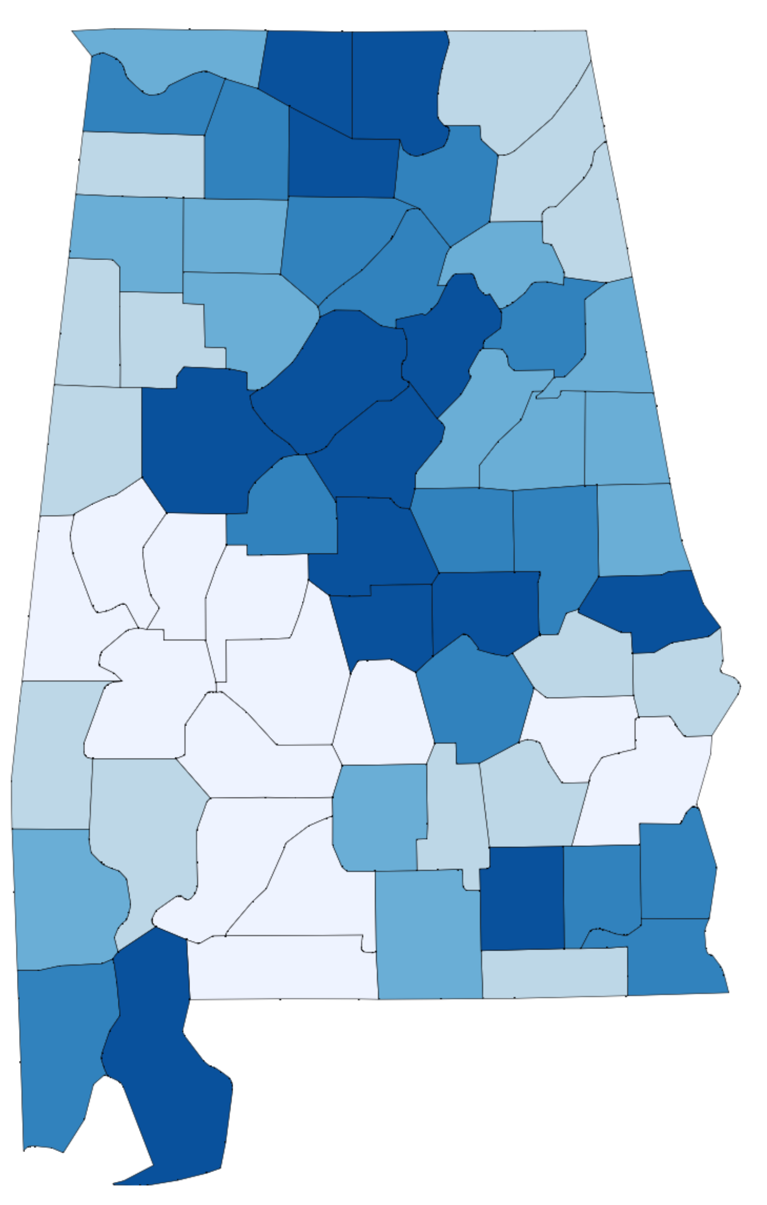
Median Household Income* in Alabama



BEST WORST

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

Alabama
Median Household Income by County 2021



Dollars

- 27,057 to 38,464
- >38,464 to 44,108
- >44,108 to 50,000
- >50,000 to 55,870
- >55,870 to 82,592

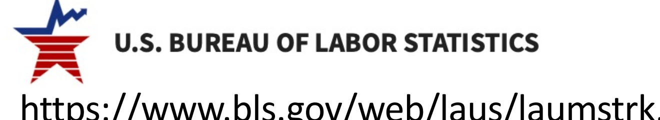
Sorted and Ranked by Workforce Participation Rate

Rank	STATE NAME	Workforce Participation % Nov 2023	Medicaid Expansion	Unemployment % Nov 2023	Rurality Rank
1	South Dakota	76.5	Expansion	2	7
2	District of Columbia	72	Expansion	5	
3	Utah	69.8	Expansion	2.8	44
4	Colorado	68.9	Expansion	3.3	38
5	Nebraska	68.9	Expansion	2.3	26
6	North Dakota	68.3	Expansion	1.9	11
7	Minnesota	67.5	Expansion	3.1	24
8	Iowa	67.2	Expansion	3.3	13
9	Virginia	66.7	Expansion	2.9	30
10	Kansas	66.2	No	2.9	25
46	Alabama	57.7	No	2.4	8

KFF

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

https://fred.stlouisfed.org/release/tables?eid=784070&rid=446



https://www.bls.gov/web/laus/laumstrk.htm

Workforce Participation
Sorted and Ranked by Unemployment Rate

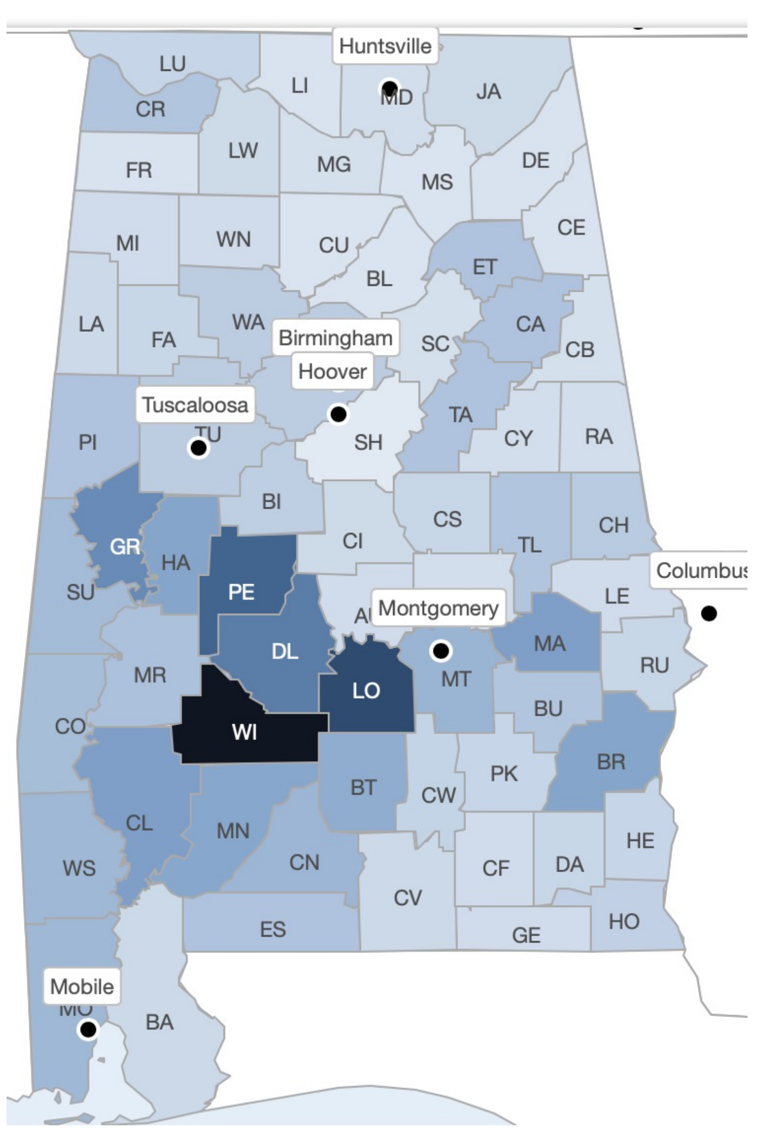
Rank	STATE NAME	Workforce Participation % Nov 2023	Medicaid Expansion	Unemployment % Nov 2023	Rurality Rank
1	Maryland	65.1	Expansion	1.8	37
2	North Dakota	68.3	Expansion	1.9	11
3	South Dakota	76.5	Expansion	2	7
4	Vermont	64.7	Expansion	2.1	1
5	Nebraska	68.9	Expansion	2.3	26
6	New Hampshire	65.1	Expansion	2.3	9
7	Alabama	57.7	No	2.4	8
8	Utah	69.8	Expansion	2.8	44
9	Florida	59.7	No	2.9	47
10	Hawaii	60.4	Expansion	2.9	39

Workforce Participation Rank for No Expansion

Rank	STATE NAME	Workforce Participation % Nov 2023	Medicaid Expansion	Unemployment % Nov 2023	Rurality Rank
10	Kansas	66.2	No	2.9	25
11	Wisconsin	65.9	No	3.3	18
39	Texas	64.6	No	4.1	36
23	Wyoming	64.2	No	3	12
36	Georgia	61.7	No	3.4	28
41	Florida	59.7	No	2.9	47
42	Tennessee	59.4	No	3.5	16
46	Alabama	57.7	No	2.4	8
48	South Carolina	57	No	3	19
53	Mississippi	53.5	No	3.3	4

Workforce Participation Sorted by Rurality Rank

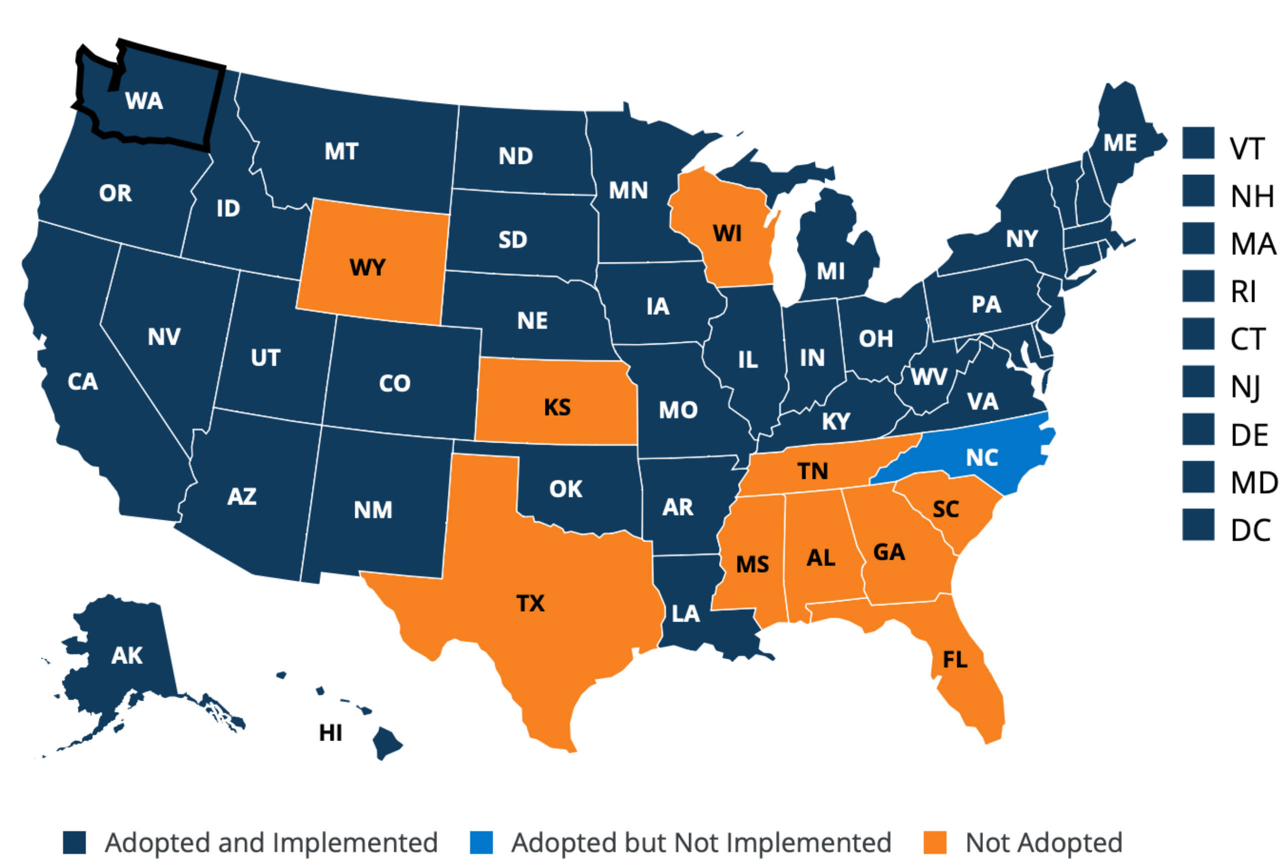
Rank	STATE NAME	Workforce Participation % Nov 2023	Medicaid Expansion	Unemployment % Nov 2023	Rurality Rank
1	Vermont	64.7	Expansion	2.1	1
2	Maine	59.3	Expansion	3	2
3	West Virginia	54.8	Expansion	4.2	3
4	Mississippi	53.5	No	3.3	4
5	Montana	62.7	Expansion	3	5
6	Arkansas	57.2	Expansion	3.3	6
7	South Dakota	76.5	Expansion	2	7
8	Alabama	57.7	No	2.4	8
9	New Hampshire	65.1	Expansion	2.3	9
10	Kentucky	56.9	Expansion	4.3	10



Unemployment in Alabama

BEST WORST

Status of State Action on the Medicaid Expansion Decision – as of 10/4/23



Uninsured in Alabama

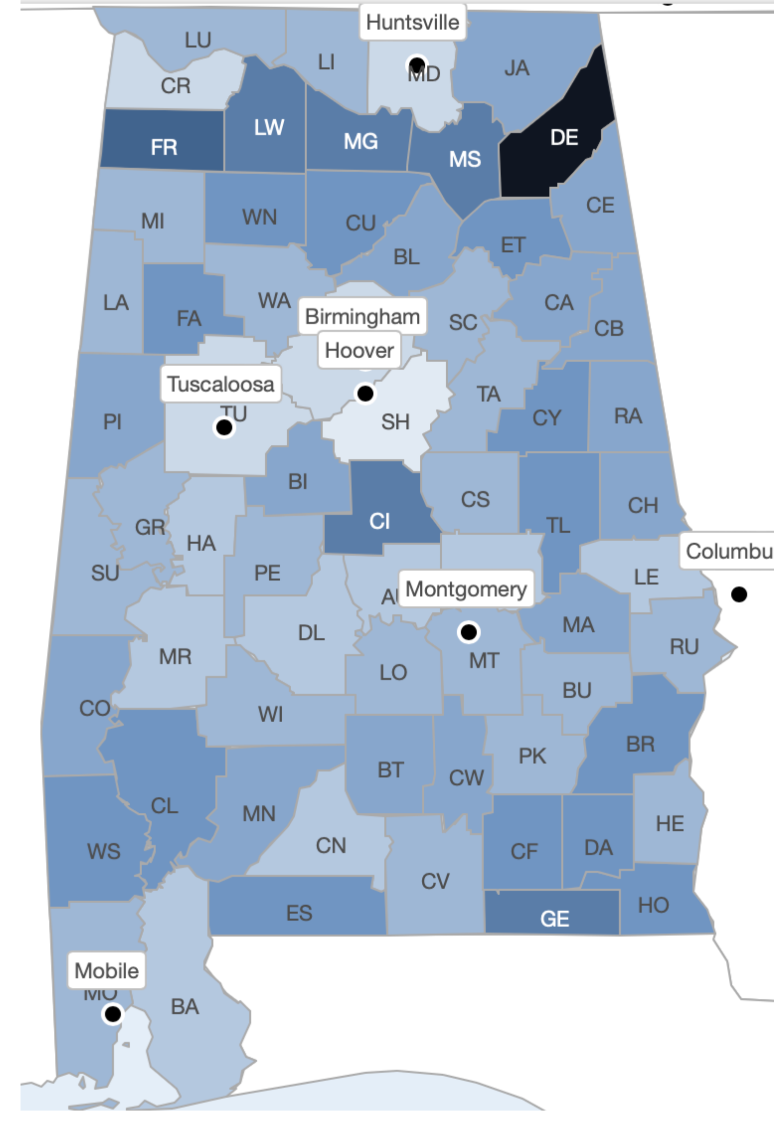


Figure 29

Average Annual Premiums for Single and Family Coverage, 1999-2023

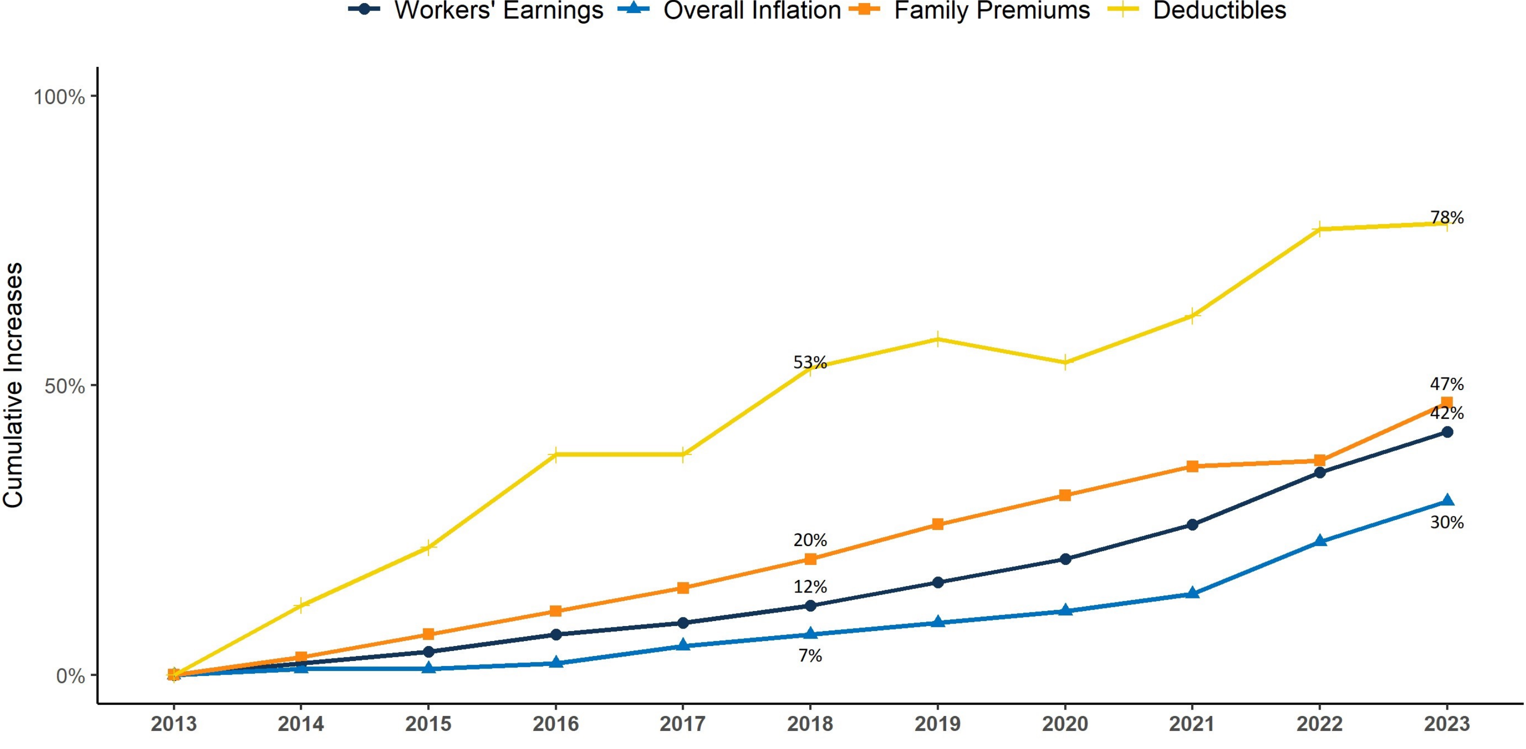
Year	Single Coverage	Family Coverage
1999	$2,196	$5,791
2002	$3,083	$8,003
2005	$4,024	$10,880
2008	$4,704	$12,680
2011	$5,429	$15,073
2014	$6,025	$16,834
2017	$6,690	$18,764
2020	$7,470	$21,342
2023	$8,435	$23,968

$0 $4,000 $8,000 $12,000 $16,000 $20,000 $24,000

SOURCE: KFF Employer Health Benefits Survey, 2018-2023; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 30

Cumulative Increases in Family Coverage Premiums, General Annual Deductibles, Inflation, and Workers' Earnings, 2013-2023

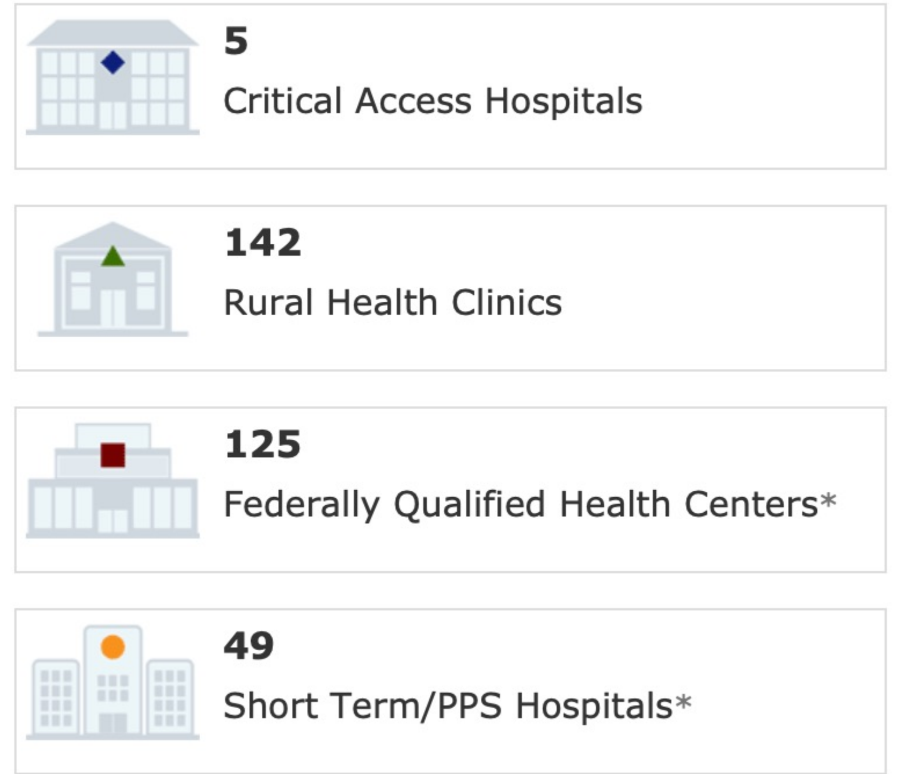


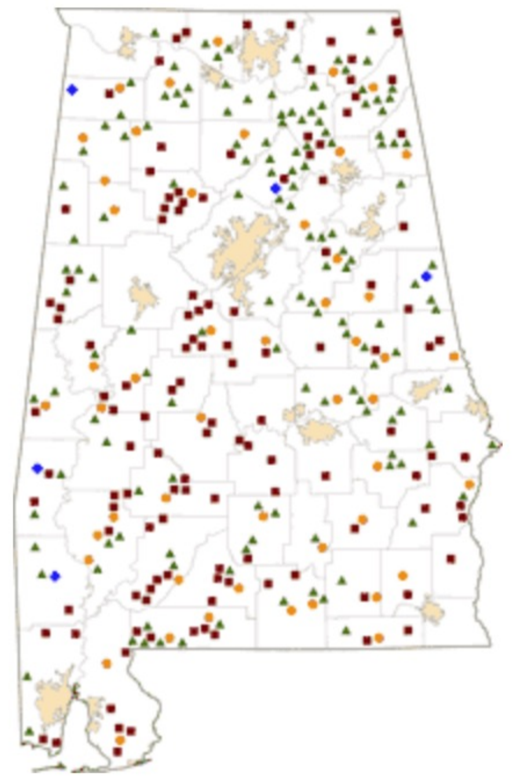
NOTE: Average general annual deductibles are for single coverage and are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

SOURCE: KFF Employer Health Benefits Survey, 2018-2023; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2013-2023; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2013-2023.

KFF

Alabama Rural Healthcare Facilities





*Sites according to data.HRSA.gov (July 2023), showing only locations outside of U.S Census Bureau Urban Areas with a population of 50,000 or more

Health Professional Shortage Areas: Primary Care, by County, 2023

Nonmetro | Metro | All

None of county is shortage area
Part of county is shortage area
Whole county is shortage area

Source: data.HRSA.gov, May 2023.

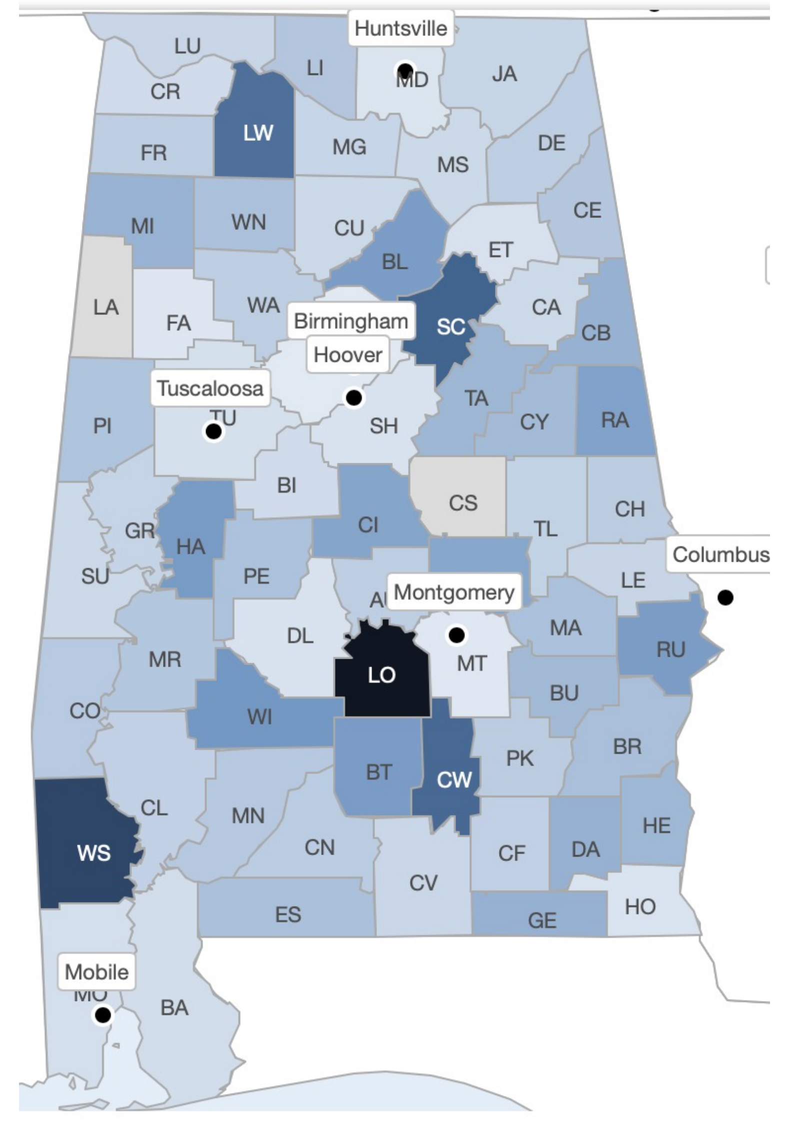
Every County In Alabama is a Health Professional Shortage Area

None of county is shortage area

Part of county is shortage area

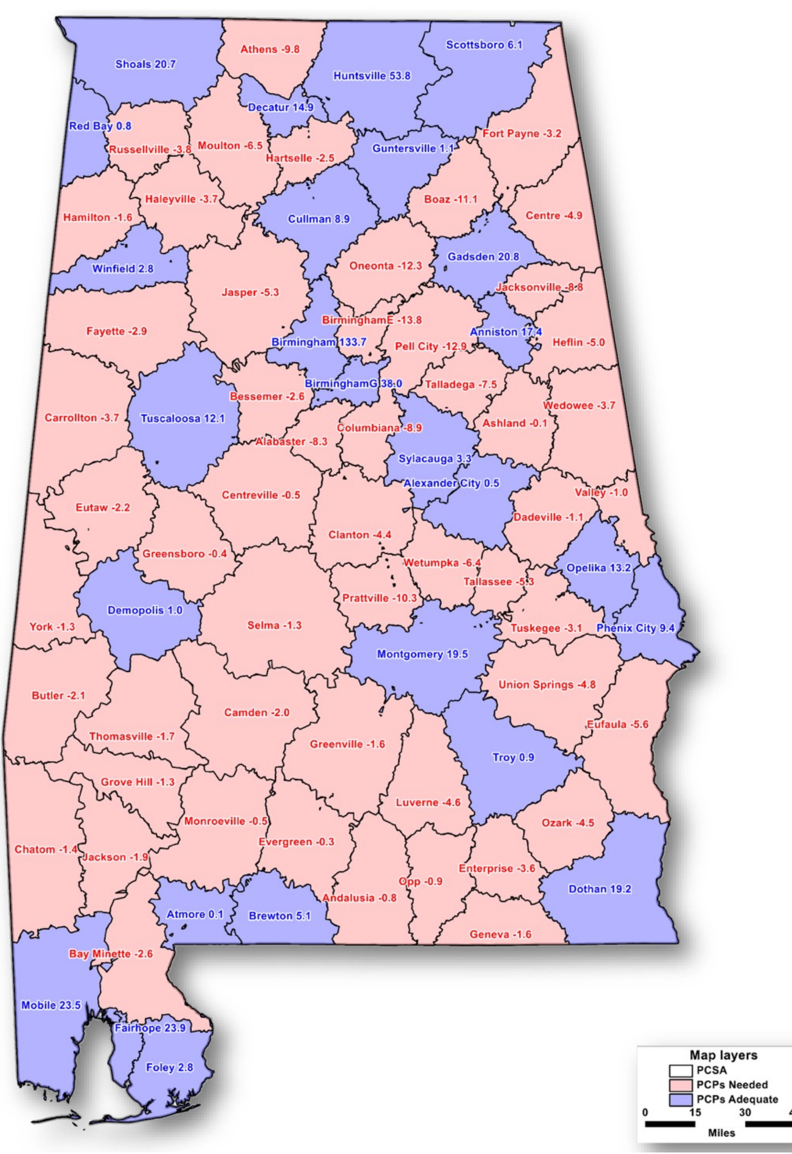
Whole county is shortage area

Primary Care Physicians in Alabama



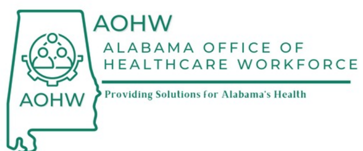
BEST WORST

County Health Rankings & Roadmaps
Building a Culture of Health, County by County



The map to the left shows Alabama's 79 PCP population centers as points of access for residents in their catchment areas (Primary Care Service Areas or PCSAs). The boundaries of these PCSAs place each population center equidistant from all other population centers

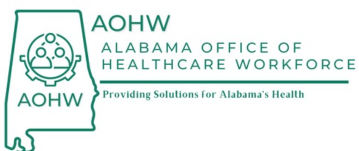
Towns and cities with shortages of PCPs in 2022 are denoted in red while centers in blue are population centers with an adequate number or a surplus of PCPs.



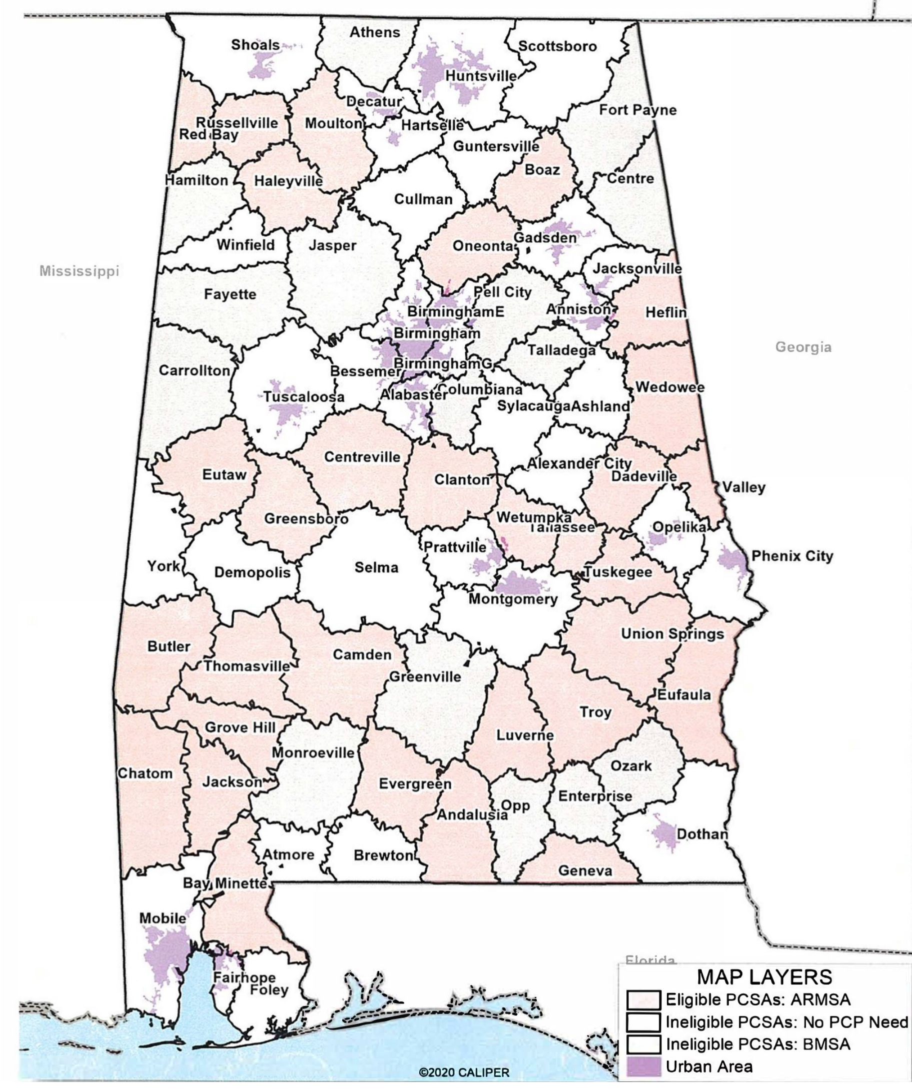
Physician Need for Population Centers in Alabama

Population Center	PCPs Avail.	Population Served by Available PCPs	PCPs Deficit(-) Surplus(+)	Rural/ Urban	Population Center	PCPs Avail.	Population Served by Available PCPs	PCPs Deficit(-) Surplus(+)	Rural/ Urban
BirminghamE	56	151,216	-13.7	Urban	Chatom	6	18,498	-1.4	Rural
Pell City	22	82,737	-12.8	Rural	Selma	25	43,167	-1.3	Rural
Oneonta	11	57,756	-12.3	Rural	York	3	11,047	-1.2	Rural
Boaz	21	79,445	-11.1	Rural	Grove Hill	2	8,077	-1.2	Rural
Prattville	23	77,861	-10.2	Urban	Dadeville	6	16,406	-1.1	Rural
Athens	18	70,164	-9.7	Rural	Valley	12	33,197	-1.0	Rural
Columbiana	3	30,866	-8.9	Rural	Opp	8	21,925	-0.8	Rural
Jacksonville	6	38,467	-8.8	Urban	Andalusia	9	22,947	-0.8	Rural
Alabaster	35	107,148	-8.3	Urban	Monroeville	8	21,268	-0.4	Rural
Talladega	6	33,490	-7.5	Rural	Centreville	27	28,027	-0.4	Rural
Moulton	7	31,822	-6.4	Rural	Greensboro	6	16,311	-0.4	Rural
Wetumpka	11	41,054	-6.4	Rural	Evergreen	4	10,673	-0.3	Rural
Eufaula	4	23,934	-5.6	Rural	Ashland	5	12,418	0.0	Rural
Jasper	29	82,410	-5.3	Rural	Atmore	9	20,530	0.0	Rural
Tallassee	1	15,997	-5.3	Rural	Alexander City	12	28,450	0.5	Rural
Heflin	3	20,258	-5.0	Rural	Red Bay	4	7,926	0.8	Rural
Centre	7	27,702	-4.8	Rural	Troy	15	38,036	0.9	Rural
Union Springs	1	14,986	-4.8	Rural	Demopolis	8	16,776	1.0	Rural
Luverne	2	16,203	-4.6	Rural	Guntersville	24	52,202	1.1	Rural
Ozark	9	31,172	-4.5	Rural	Winfield	10	17,994	2.8	Rural
Clanton	14	41,750	-4.3	Rural	Foley	48	88,514	2.8	Rural
Russellville	7	27,389	-3.8	Rural	Sylacauga	19	38,231	3.2	Rural
Carrollton	5	21,444	-3.7	Rural	Brewton	12	17,308	5.1	Rural
Wedowee	7	25,917	-3.7	Rural	Scottsboro	27	48,686	6.1	Rural
Haleyville	6	24,231	-3.7	Rural	Cullman	47	82,418	8.9	Rural
Enterprise	20	54,228	-3.6	Rural	Phenix City	12	91,956	9.3	Urban
Fort Payne	24	66,145	-3.2	Rural	Tuscaloosa	139	191,531	12.1	Urban
Tuskegee	4	18,480	-3.1	Rural	Opelika	63	118,044	13.2	Urban
Fayette	7	24,201	-2.9	Rural	Decatur	43	65,891	14.8	Urban
Bessemer	50	120,755	-2.6	Urban	Anniston	49	68,316	17.4	Urban
Bay Minette	11	34,148	-2.5	Rural	Dothan	90	133,675	19.1	Urban
Hartselle	17	47,430	-2.5	Urban	Montgomery	136	233,351	19.4	Urban
Eutaw	2	10,421	-2.2	Rural	Shoals	92	133,426	20.6	Urban
Butler	3	12,036	-2.0	Rural	Gadsden	65	95,579	20.8	Urban
Camden	2	9,743	-1.9	Rural	Mobile	247	407,700	23.5	Urban
Jackson	4	14,937	-1.8	Rural	Fairhope	67	77,010	23.9	Urban
Thomasville	4	14,568	-1.7	Rural	BirminghamG	109	147,137	38.0	Urban
Hamilton	5	16,766	-1.6	Rural	Huntsville	255	405,106	53.7	Urban
Greenville	8	23,242	-1.6	Rural	Birmingham	427	324,646	133.7	Urban
Geneva	6	18,394	-1.6	Rural	State Totals:	2,125.8	4,875,312	-219.9	20 59

Based on 2022 data, in 2023 Alabama needs an additional **220 primary care physicians** seeing an average of 20 patients per day, 5 days per week, 48 weeks per year, located in **53 specific population centers** to eliminate Alabama's shortage of PCPs



Alabama
Advanced Practice Nursing
ARMSA Eligible
Areas of Critical Need



Alabama Nursing Shortage 2023

A total of 38,727 experienced nurses in Alabama indicated that they intend to leave the profession within the next five years, according to a new survey conducted by the Alabama Board of Nursing.

As nurses in Alabama are paid the second-lowest median salary in the nation at $56,570, ahead of only South Dakota's $55,660, many have taken on second jobs, further contributing to burnout and eventual retirement.

Shared during a recent meeting of the legislative Health Care Task Force, the survey also revealed that based on current trends, nurse vacancies in the state could grow to as high as 14,000 by 2027, nearly double the current nurse shortage of around 7,200.

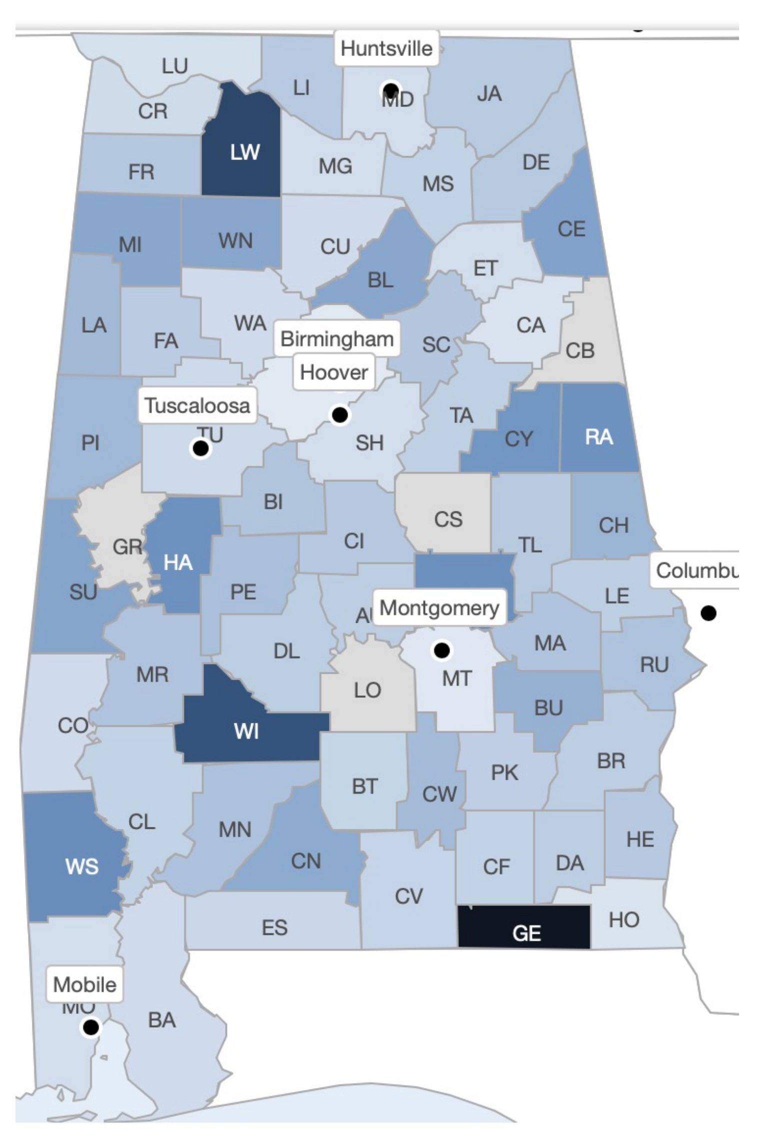
Broken down further, Alabama hospitals are currently short 5,422 registered nurses, 1,500 licensed practical nurses for long-term care, and 300 general licensed practical nurses.

Unanimously, the task force voted to support all four of Benson's recommendations. The task force's supported recommendations will be forwarded to the Legislature and considered during the next legislative session in 2024.

While the ABN did project about 25,000 new graduates will apply for nurse licenses in Alabama during that same five-year time frame, as well as an additional 8,500 from out of state, those numbers, Benson said, would not be sufficient to counter the projected losses.

https://aldailynews.com/nearly-39000-alabama-nurses-likely-to-leave-profession-in-next-five-years/

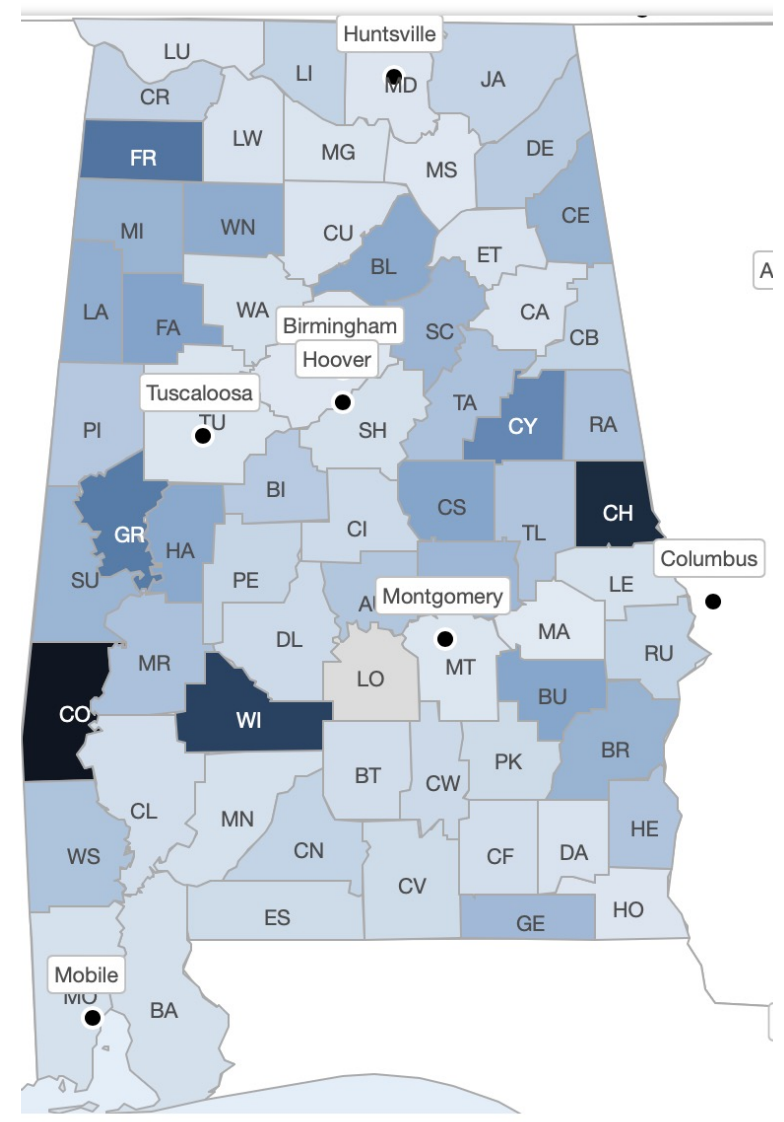
Dentists in Alabama



BEST WORST

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

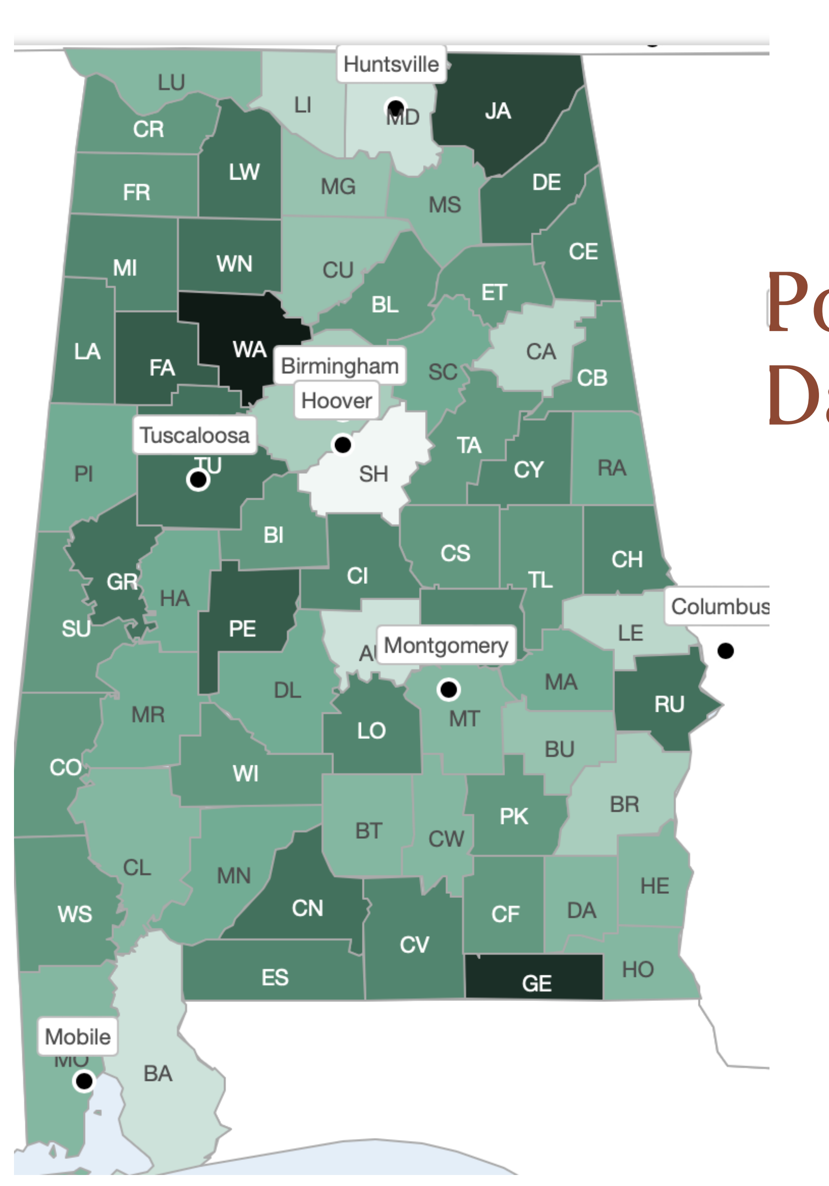
Mental Health Providers in Alabama



BEST WORST

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

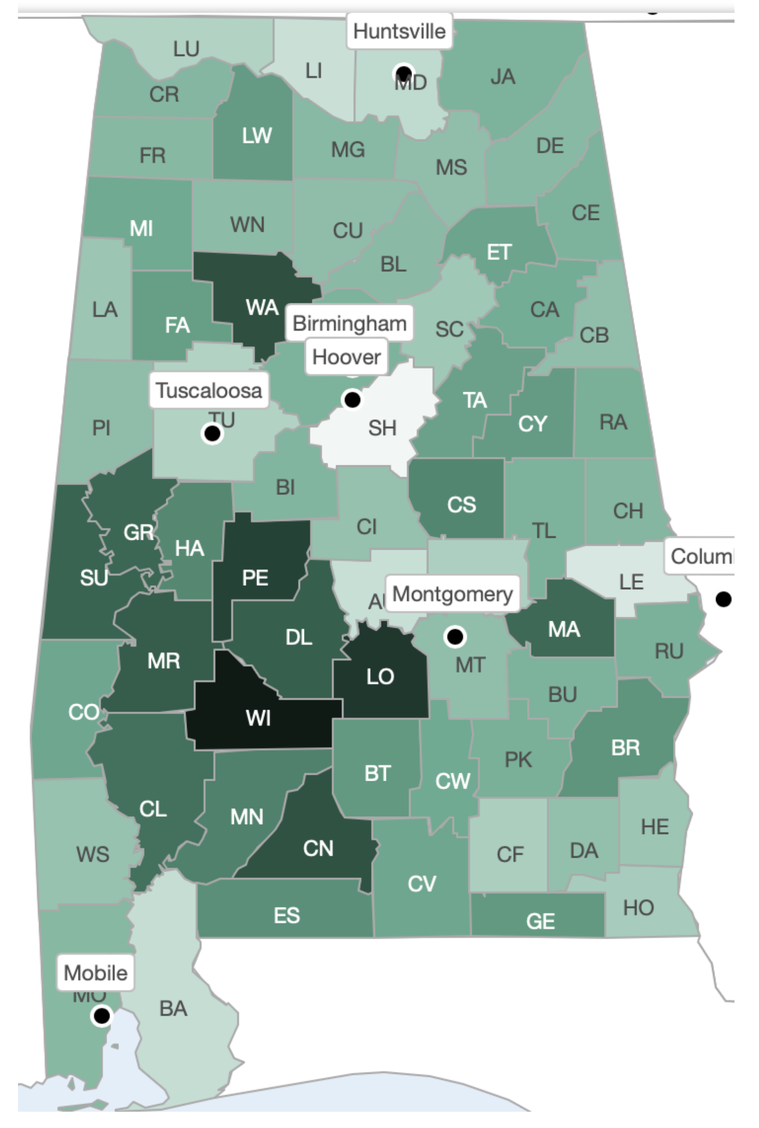


Poor Mental Health Days in Alabama

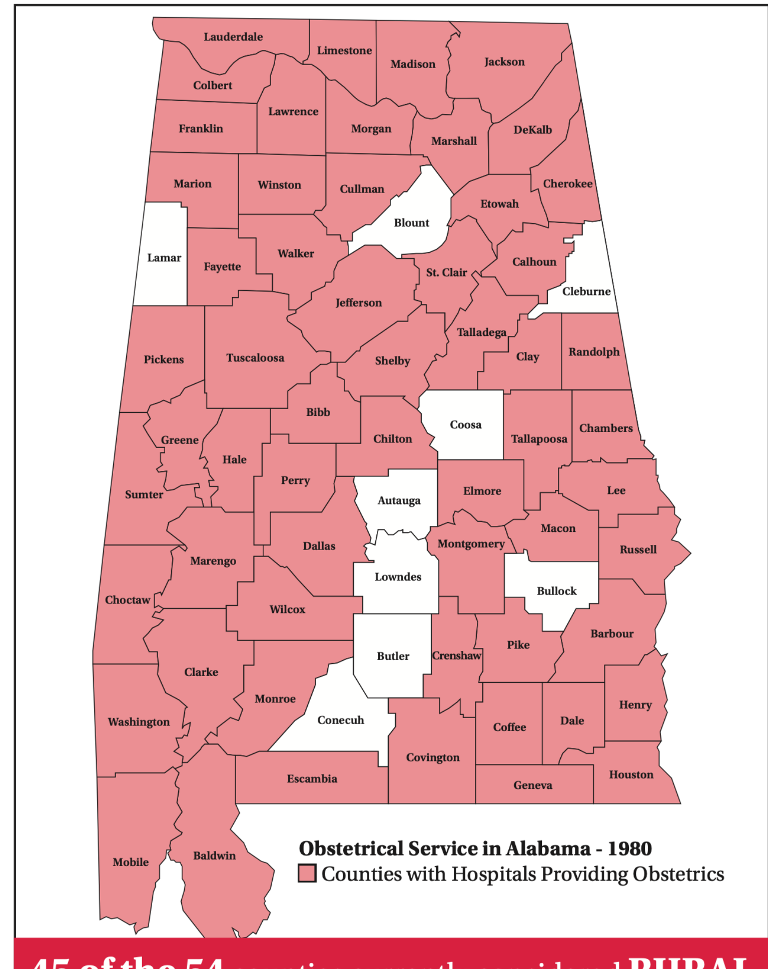
County Health Rankings & Roadmaps

Building a Culture of Health, County by County

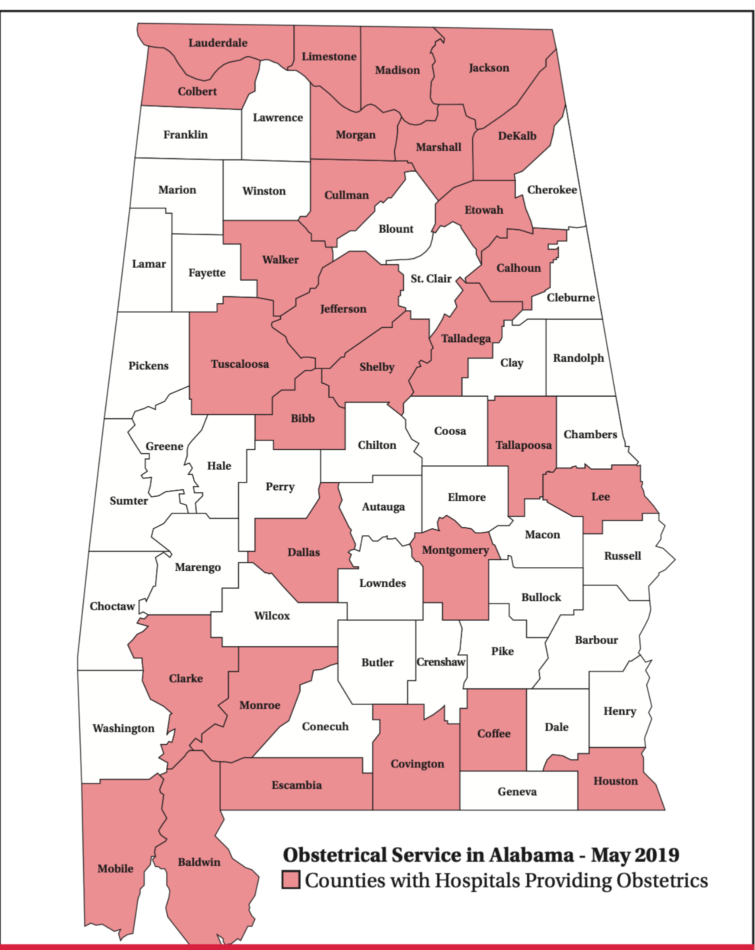
Premature Death in Alabama



A PICTURE OF THE LOSS OF RURAL OBSTETRICAL SERVICE IN ALABAMA 1980 TO 2019



45 of the 54 counties currently considered **RURAL** had hospitals providing obstetrical service in **1980**



16 of the 54 counties currently considered **RURAL** had hospitals providing obstetrical service **TODAY**

ADPH Office of Rural Health

17 Alabama Counties have fewer than 200 annual births

National Institutes of Health (.gov)
https://www.ncbi.nlm.nih.gov › articles › PMC8956977

Rural Hospital Administrators' Beliefs About Safety, Financial ...

by KB Kozhimannil · 2022 · Cited by 15 — Respondents reported that the minimum number of annual births needed to safely provide obstetric care was **200** (IQR, 100-350). From a financial...

JAMA Network™

We defined birth volume categories as follows: 10 to 500, 501 to 1000, 1001 to 2000, and more than 2000 births per year. Birth volume categories are not standardly defined; these categories were consistent with previous studies[11,29-31] that used a threshold of 500 or fewer births per year as the smallest volume category. To describe the characteristics of obstetric hospitals and availability of services, we assessed the following measures: (1) the percentage of births within each birth volume category (in the AHA data, annually), (2) the percentage of obstetric hospitals (as hospital-years) in each birth volume category, (3) the geographic distribution of obstetric hospitals by birth volume among states, (4) the proximity of obstetric hospitals to other obstetric hospitals with respect to birth volume category, and (5) the urban adjacency of obstetric hospitals, with specific attention to isolated obstetric hospitals (defined as obstetric hospitals without another obstetric hospital within a 30-mile radius). The measurement of proximity of obstetric hospitals was chosen as a proxy for access to care and potential for regionalization because it is easier to shift births a short distance compared with a long distance. The percentages of births and obstetric hospitals and geographic distribution were determined using AHA survey variables. Obstetric hospital proximity was defined as obstetric hospitals within a straight-line distance of 30 miles or less, and isolated obstetric hospitals were defined as those without another obstetric hospital within a 30-mile radius.[32-34] Straight-line distance was used because of the study scope and associated computation time. Previous analyses have demonstrated that straight-line distance and driving distance produce similar results.[35-37] When proximity of

2.1 children per woman

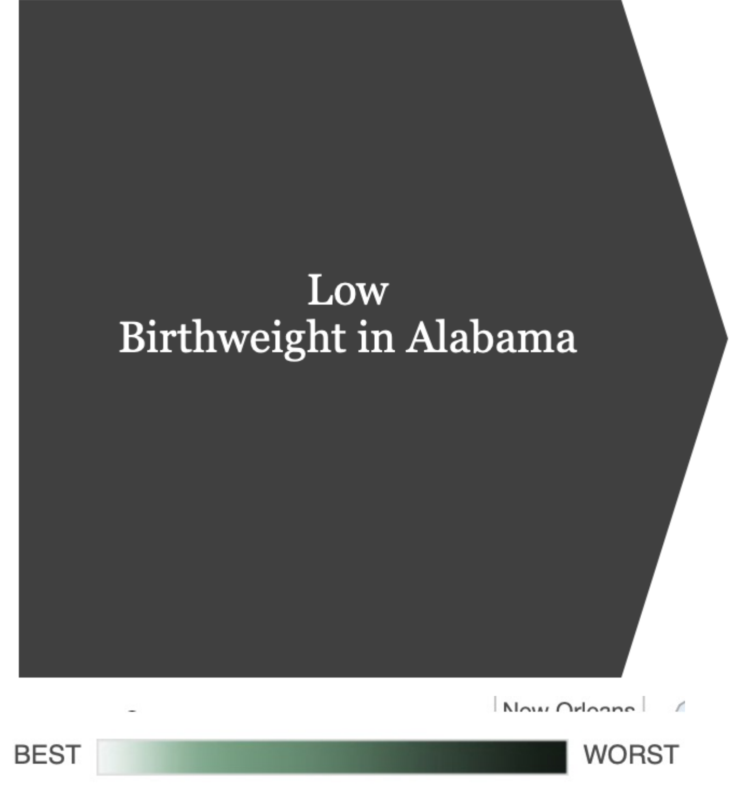
In developed countries, replacement level fertility can be taken as requiring an average of 2.1 children per woman. In countries with high infant and child mortality rates, however, the average number of births may need to be much higher.

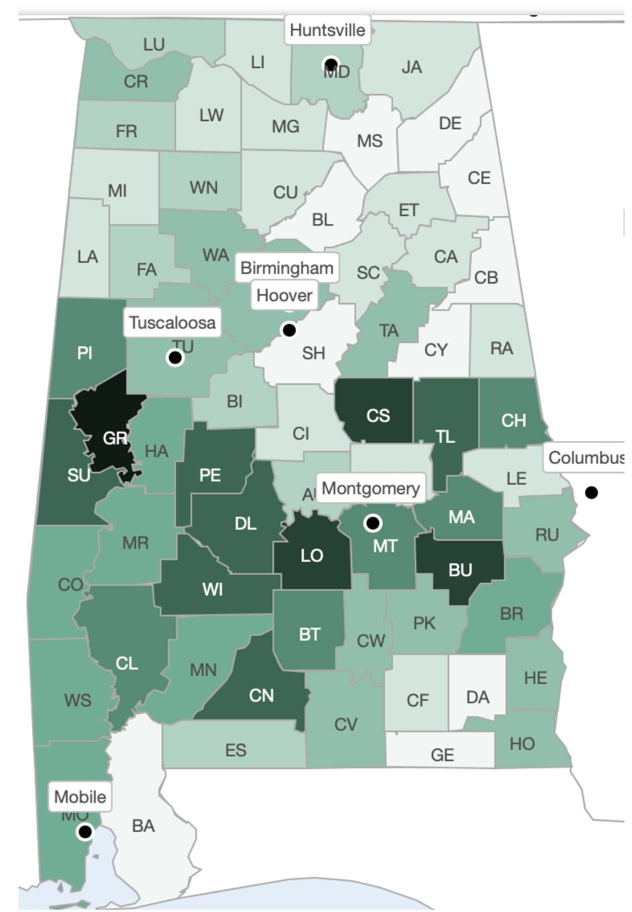
National Institutes of Health (.gov)
https://pubmed.ncbi.nlm.nih.gov › ...

That could mean a change in the landscape of job opportunities and career choices in those communities, she said. "You might have less demand for teachers and more demand for nurses," she said. (AL.com)

In Alabama, the birth rate is higher than the national average. There were 11.2 births for every 1,000 people in the state between July 1, 2020 and July 1, 2021 compared to 10.8 per 1,000 nationwide, according to the U.S. Census **Bureau's Population and Housing Unit Estimates Program. Alabama's birth rate ranks as the 17th highest among states.**

Despite the higher than average birth rate, **births did not outpace deaths in Alabama** in the most recent year of available data. Excluding net migration -- the number of people who moved to or from the state -- **Alabama's population contracted by 0.17% over the 12 months ending in July 2021**.
https://www.thecentersquare.com/alabama

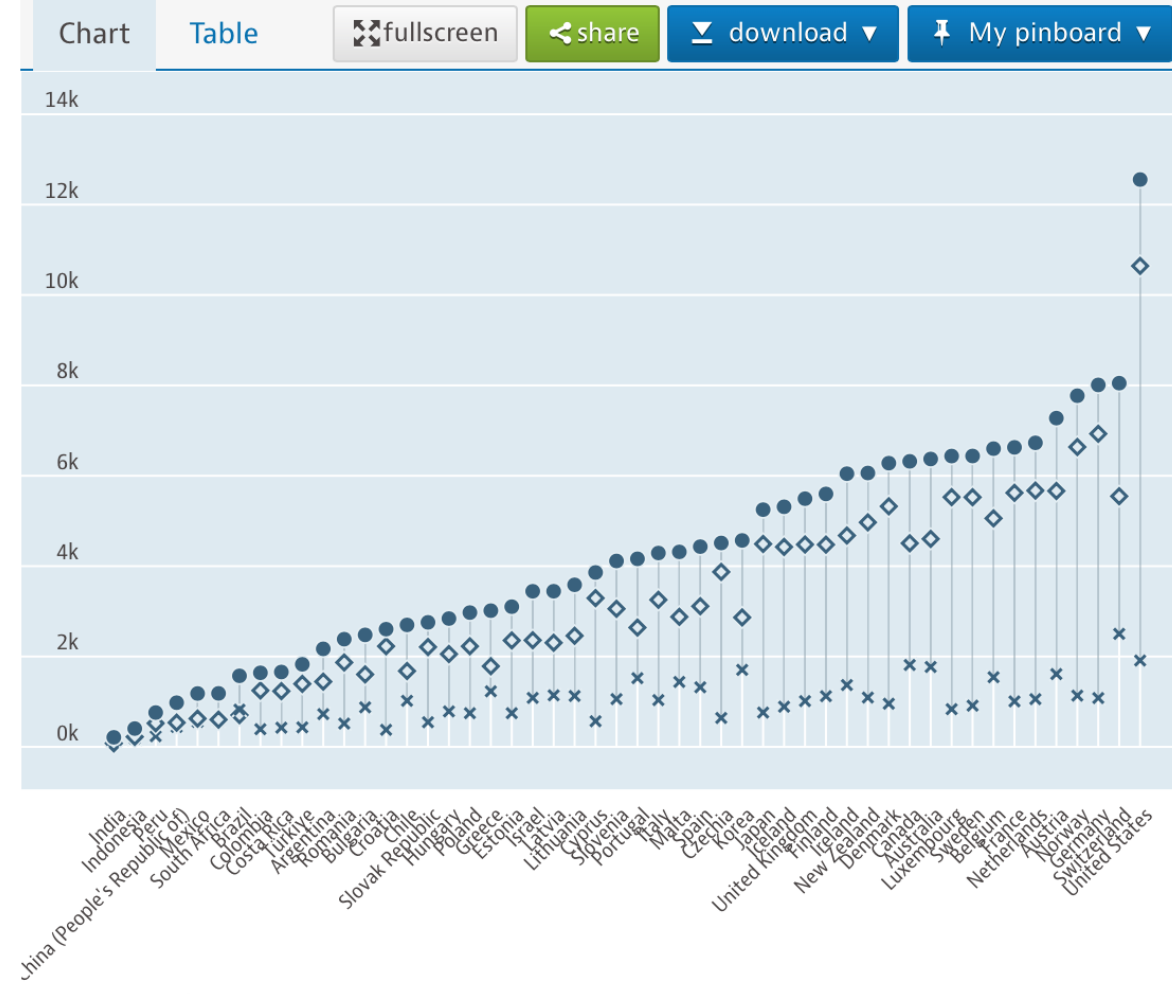




County Health Rankings & Roadmaps

Building a Culture of Health, County by County

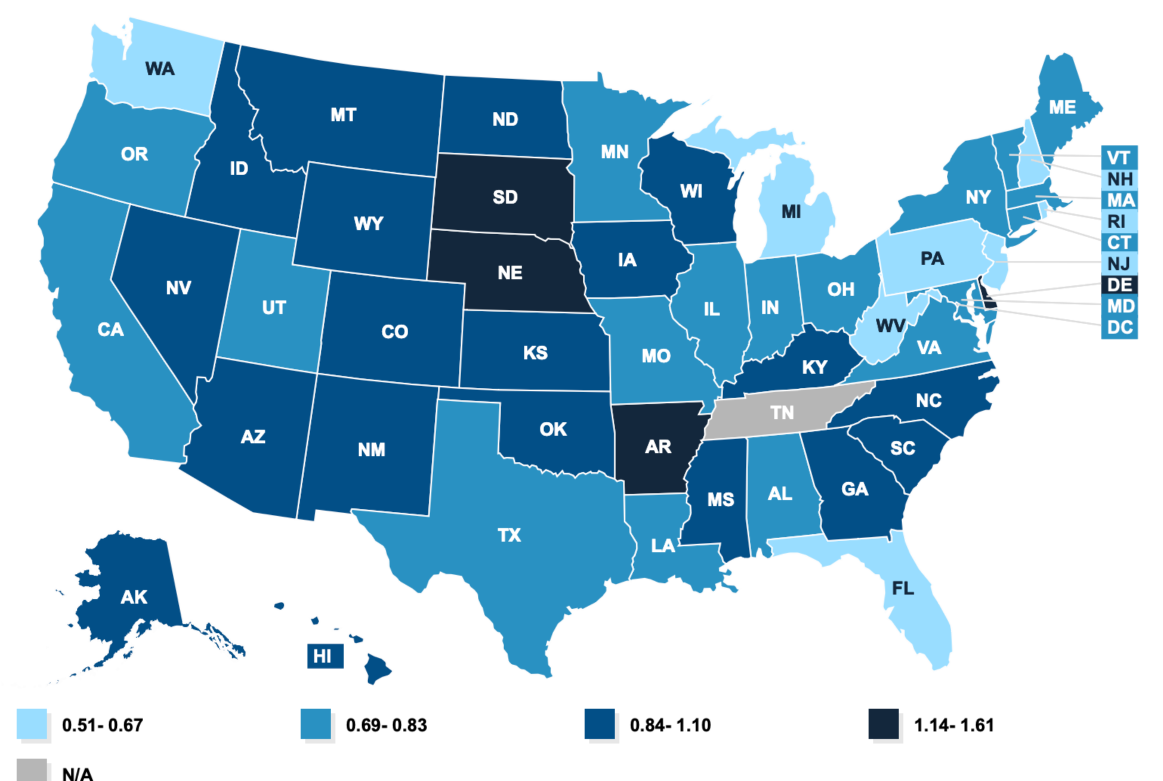
OECD Health Spending



Organization for Economic Development and Cooperation – Life Expectancy

HE1.1. Life expectancy has increased remarkably in OECD countries

Country	Panel A. Life expectancy at birth in 2008 or latest year (↘)	Panel B. Rise in life expectancy between 1983 and 2008 (in years)
Japan	82.7	5.7
Switzerland	82.2	6.0
Australia	81.5	6.0
Italy	81.5	6.7
Sweden	81.4	4.8
Iceland	81.3	4.2
France	81.2	6.4
Spain	81.2	5.1
Israel	81.1	6.6
Canada	80.7	4.5
Luxembourg	80.6	7.1
Norway	80.6	4.3
Austria	80.5	7.4
New Zealand	80.4	6.7
Netherlands	80.3	4.0
Germany	80.2	6.4
Greece	80.0	4.6
Finland	79.9	5.5
Ireland	79.9	6.8
Korea	79.9	12.5
Belgium	79.8	5.8
United Kingdom	79.7	5.4
Portugal	79.3	6.9
OECD	**79.3**	**6.0**
Chile	78.8	6.3
Denmark	78.8	4.3
Slovenia	78.8	6.7
United States	77.9	3.3
Czech Republic	77.3	6.6
Poland	75.6	4.5
Mexico	75.3	6.7
Slovak Republic	74.8	4.2
Estonia	73.9	3.8
Hungary	73.8	4.7
Turkey	73.6	13.9
China	73.1	6.6
Brazil	72.4	8.7
Indonesia	70.8	14.1
Russian Federation	67.8	0.2
India	63.7	7.5
South Africa	(51.5)	(-7.0)



Medicaid-to-Medicare Fee Index

Location	Other Services
Alabama	0.83
Georgia	0.97
Mississippi	0.90
South Carolina	0.84
Tennessee	N/A

Notes

The Medicaid-to-Medicare fee index measures each state's physician fees relative to Medicare fees in each state. The Medicaid data are based on surveys sent by the Urban Institute to the forty-nine states and the District of Columbia that have a fee-for-service (FFS) component in their Medicaid programs (only Tennessee does not). These fees represent only those payments made under FFS Medicaid. The Medicare-to-Medicaid fee index is a computed ratio of the Medicaid fee for each service in each state to the Medicare fee for the same services. Comparable Medicare fees are calculated using relative value units, geographic adjusters, and

More than a dozen of Alabama's 51 rural hospitals at immediate risk of closing

Alan Condon - Wednesday, February 15th, 2023

The Alabama Hospital Association has warned that more than a dozen of the state's rural hospitals are at immediate risk of closing, which would force large, urban hospitals to deal with increased capacity issues, local news outlet *WAFF* reported Feb. 15.

Hospitals in Alabama have lost $1.5 billion since 2020 — more than any other state since the start of the pandemic. That figure would have swelled to $2.4 billion without federal stimulus funds. However, in 2022, Alabama hospitals recorded their highest annual loss, at $738 million.

"The reality is we've got some hospitals that simply won't make it," Donald Williamson, MD, director of the Alabama Hospital Association, told *WAFF*.

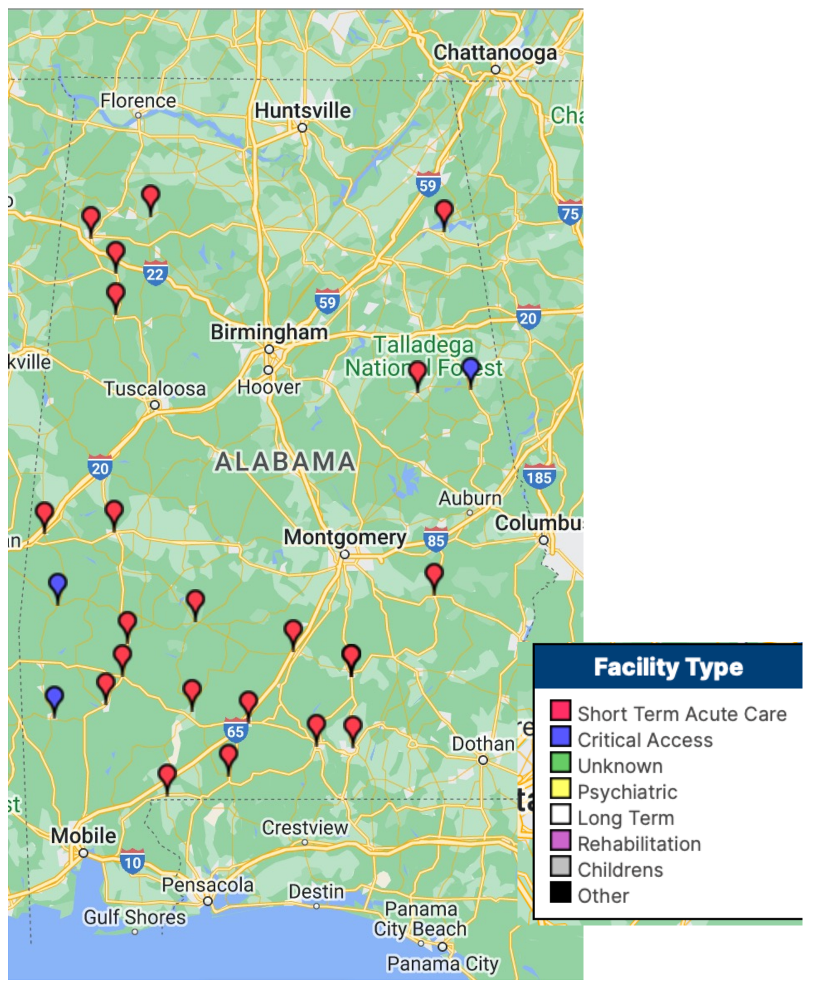
https://www.beckershospitalreview.com/finance/more-than-a-dozen-of-alabamas-51-rural-hospitals-at-immediate-risk-of-closing.html

Alabama’s Rural Hospitals

- 40 Rural hospitals in Alabama
- 35 of the 40 (87.5%) have operating losses

- Of the 35 rural hospitals with operating losses
  - 5,718 employees
  - $369 million in gross salaries
    - Over $10 million per hospital (avg)
  - $882 million Economic impact to the Alabama economy

Alabama’s Rural Hospitals



Hospital Name	CMS Certification Number	Beds	City	State
Andalusia Health	010036	83	Andalusia	AL
Atmore Community Hospital	010169	49	Atmore	AL
Atrium Health Floyd Cherokee Medical Center	010022	45	Centre	AL
Beacon Behavioral Hospital	014015	0	Luverne	AL
Bullock County Hospital	010110	61	Union Springs	AL
Clay County Hospital	010073	129	Ashland	AL
Crenshaw Community Hospital	010008	49	Luverne	AL
D.W. McMillan Memorial Hospital	010099	46	Brewton	AL
Evergreen Medical Center	010148	44	Evergreen	AL
Fayette Medical Center	010045	132	Fayette	AL
Grove Hill Memorial Hospital	010091	30	Grove Hill	AL
Hill Hospital Of Sumter County	010138	33	York	AL
J. Paul Jones Hospital	010102	21	Camden	AL
Jackson Medical Center	010128	35	Jackson	AL
Lakeland Community Hospital	010125	49	Haleyville	AL
Mizell Memorial Hospital	010007	59	Opp	AL
Monroe County Hospital	010120	46	Monroeville	AL
North Mississippi Medical Center - Hamilton	010044	115	Hamilton	AL
Northwest Regional Health	010086	38	Winfield	AL
Ochsner Choctaw General	011304	25	Butler	AL
Regional Medical Center of Central Alabama	010150	57	Greenville	AL
Tanner Medical Center East Alabama	011306	15	Wedowee	AL
TRMC Alabama	010174	29	Thomasville	AL
Washington County Hospital	011300	103	Chatom	AL
Whitfield Regional Hospital	010112	67	Demopolis	AL

Alabama Rural Hospitals At Risk of Closure

- Z-Score Analysis
  - Analysis of financial operating results that can be used to identify organizations that are not financially sound and are at risk of closure.
- Based on data obtained from American Hospital Directory (ahd.com) for operating results from 2021 and 2022.

- Results
  - 3 are in Financial Distress
  - 2 are in Financial Concern

Medical Credentialing is time-consuming and costly for everyone.

It can take weeks or even months to credential a provider. During that time, health professionals lose tens of thousands of dollars (or more) in lost income and facilities lose millions of dollars in revenue. This affects the industry-at-large, as it takes a multibillion-dollar hit.

Upon hiring, health professionals can't start work at their new facility for anywhere between a few weeks to six months, due to credentialing.

On the provider's end, the process only takes about three hours, as they submit around 20 different credentialing forms. For facility staff, credentialing takes about 20 hours per provider, as they complete several tasks, which may include:

- Initiate a background check
- Collect and verify credentials, clinical reputation and case history
- Collect and review claims, privileging and board history
- Check sanctions with the Office of Inspector General (OIG)
- Begin primary source verification such as American Medical Association (AMA), medical boards, and education history
- Present files to credentialing committees, executive committees, and facility stakeholders
- Establish a delineation of privileges and provide an appointment letter

Unfortunately, this process has to be done every time a provider is credentialed, with each facility collecting the same information. There's little-to-no communication between the facilities and every place has their own way of doing it, creating a redundancy that delays the process even further.

It costs providers thousands in lost income—the exact amount of which depends on how much they make and how long it takes to get credentialed. For a physician making the average annual income of $299,000, waiting a few weeks would cost them around $25,000 in lost income, and waiting six months (worst-case scenario) would cost them around $150,000 in lost income.

Slow credentialing costs individual facilities a lot of money, as well. According to a Merritt Hawkins survey, a single physician earns a facility an average of $2,378,727 per year. If credentialing that physician takes a few weeks, the facility would lose around $150,000 in revenue. If it takes six months, that's $1,189,363 in lost revenue for the facility.

This problem doesn't only affect a few physicians and a few facilities, but it also affects the entire healthcare industry. As an Institute of Medicine study found, the United States wastes half of the estimated $361 billion a year it spends on healthcare administration. Of course, that administrative waste isn't only on credential management, but slow credentialing still costs the industry billions of dollars a year on its own.

Credentialing Standardization

Speed the process
Lower costs

Code of Colorado Regulations
1000 - Department of Public Health and Environment
1014 - Colorado State Board of Health
Rule 6 CCR 1014-4 - COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION

- Schedule 6 CCR 1014-4-A - Colorado State Board of Health

Current through Register Vol. 45, No. 16, August 25, 2022

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION

This is the Colorado healthcare professional credentials application. The Colorado legislature has mandated that all health care entities and all health care plans engaged in the collection of information to be used in the process of credentialing of health care professionals use this form (C.R.S. § 25-1-108.7).

This uniform application has been designed to allow each credentialing entity to receive from you core credentialing information needed in common by all of them, without duplication.

THIS UNIFORM APPLICATION HAS BEEN DESIGNED TO ALLOW EACH PRACTITIONER TO COMPLETE A SINGLE FORM WITH CORE INFORMATION FOR SUBMISSION TO EACH CREDENTIALING ENTITY TO WHICH THE PRACTITIONER IS APPLYING. This application need not be used for case specific temporary privileges.

Texas Standardized Credentialing Applica...

Word, RTF and PDF versions are available on the Credentialing Application forms page.

The Texas Standardized Credentialing Application fulfills requirements of Senate Bill 544 (Acts 2001, 77th Leg., ch. 1369, §3, effectiv... 2001), providing for the Texas Insurance Commissioner to adopt a standardized form for verification of physician credentials.

Use of the application form by hospitals, HMOs and PPOs is required for credentialing of physicians. Hospitals and health plans may use this application for the credentialing of other health care professionals, as well.

The credentialing form is based on one developed by the Coalition for Affordable Quality Healthcare.

Colorado Timely Credentialing of Physicians

SB21-126 Timely Credentialing Of Physicians by Insurers intends to solve the long-standing issue CRHC members have been experiencing with long and uncertain wait times for credentialing of new providers by private insurance companies. The bill establishes timelines and parameters that insurance carriers must follow in considering applications for physicians to participate in their networks, including that an application process must be concluded within 60 calendar days of receiving the application. The Colorado Medical Society led the bill, working in partnership with the Colorado Association of Health Plans to negotiate the credentialing timeline outlined in the bill, as follows:

- 60 days to conclude the credentialing process and notify the applicant.
- 7 days from the carrier receiving an application for them to notify the applicant of said receipt.
- 10 days from receipt for the carrier to notify an applicant if the application is incomplete and provide the applicant with a detailed list of all items required to complete the application.
- If the carrier does not notify the applicant within the required timeframes and the carrier concludes the credentialing process, the applicant shall be considered a participating provider no later than 50 days from receipt.
- 30 days for the carrier to correct discrepancies in the network plan directory after a report of the discrepancy from a participating provider.
- All credentialing criteria made available by the carrier to all applicants and posted on their website.
- A participating provider remains credentialed and loaded in the carrier's billing system unless the carrier discovers information that the provider no longer meets their participation guidelines. Notification of a change in credentialing status must be made in writing with an explanation.

The bill served as a big win for rural health this session and sailed through the legislative process with almost no opposition. The legislation was framed as a means to increase healthcare efficiency and ultimately access. Legislators on both sides of the aisle lauded the bill for its robust stakeholder process and bipartisanship. CRHC provided invaluable support and member feedback during the formative stage of the bill in the summer of 2020. During the 2021 legislative session, CRHC testified in support of the legislation in multiple Senate and House committees, working with bill sponsors and proponents and tracking the bill through the legislative process.

CRHC Positon: SUPPORT
CRHC Policy Priority Area: Regulatory Impediments
Final Actions: Governor Signed July 6, 2021
Effective date: September 6, 2021
CRHC Lobbying Activities: CRHC testified twice in support of the bill in House and Senate health committees. CRHC worked closely with bill proponents, including CMS, to provide feedback from members as the legislation was developed.

How can you help?

- Utilize rural providers and facilities when you can
- Interact with your local elected officials and appointed officials
- Stay active in rural health matters
- If not already a member, join ARHA
  - Consider attending the ARHA Annual Conference in March 2024
- If not already a member, join NRHA
  - Consider attending NRHA Policy Institute and Hill Visits in Feb 2024

Thank You!

Farrell A. Turner, CPA, CPC, FHFMA
President, Alabama Rural Health Association
farrellt@arhaonline.org
256-201-0095 cell