Alabama's Rural Health Plan

Medicare Rural Hospital Flexibility Program

October 1999

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I. PROFILE AND FORECAST RESULTS FOR THE STATE OF ALABAMA*

A. Demographics

Alabama has a population of approximately 4.4 million based on a 1998 revision of 1990 Census data. This represents an increase of 11.5 percent in comparison to the 1980 Census figure of 3.9 million. Percentages for populations below 20 years of age and over 65 remain roughly consistent with the 1980 census at 32 percent and 13 percent respectively. Minorities continue to comprise approximately 26 percent of the population, almost twice the national average.

With a ratio of 85.1 persons per square mile, Alabama is roughly similar to the nation as a whole with its ratio of 75.7 persons per square mile. While nearly 70 percent of Alabama's 67 counties are rural, there is a mix of urban and rural populations that is also roughly similar to the national profile.

The population of Alabama increased at an annual rate of 0.8 percent from 1975 to 1995 and is projected to continue at this level of growth throughout the forecast period (1995-2050). The largest changes will be in the demographic composition of the state, as the aging of the baby-boom generation causes an increase in the movement of working-age people into retirement. Since 1975, the working-age population has increased slightly as a percentage of all residents from 61 percent to 63 percent. At the same time, the share of the population over the age of 65 also increased, from 11 percent to 13 percent. Over the forecast period, this trend of increasing numbers of retirees will continue until, by 2050, 22 percent of all people in the state fall into the over-65 age cohort. The impact on the working-age population will be dramatic, as its share of the population drops to 56 percent. Although, prior to 1990, the State of Alabama had seen a net migration of people out of the state, this has changed, and the net migration into the state is predicted to continue through 2050. In that year, net in-migration to Alabama will be 48,000 people or 0.7 percent of the state's population.

B. Economic Data

The current Census reflects a median family income of $30,302 and a per capita income of $18,493. The number of Alabamians with income below the poverty level decreased slightly to 18 percent, including 14.3 percent of families with children, and 23 percent of all children. According to data from the Center for Demographic and Cultural Research at Auburn University at Montgomery, Alabama's per capita income ranked 43rd in the nation.

Alabama's total earned income rose at an annual rate of 8 percent since 1975, and will continue to rise, although at a slower rate of 5 percent, throughout the rest of the forecast

*Much of the information in this section was taken from *Economic Forecast of Population and Employment: State of Alabama*, Volume 1, December 1996, McGraw-Hill.

period, directly paralleling trends in the U.S. As with the trend in employment, the manufacturing sector, which in 1975 accounted for 28 percent of all earned labor income, only had a 23 percent share in 1995. This trend will continue, and in 2050, only 7 percent of all earned labor income will come from the manufacturing sector. The service sector will see the largest gain in share, from 25 percent in 1995 to 45 percent in 2050. Due to the increasing percentage of retirees in the state, unearned income plays a more important role in future years. In 1995, non-earned income (which includes Social Security and Medicare benefits) accounted for 31 percent of total personal income, while this percentage grows to 37 percent in 2050.

Real per capita income rose at an annual rate of 1.9 percent over the past 20 years, but this rate will slow to 0.7 percent for the remainder of the forecast period. The average Alabama resident had an income of $13,900 in 1987 dollars in 1995. This compares to $16,800 (1987 dollars) for the U.S. By 2050, the average Alabama resident will have an income of $21,100 (1987 dollars) compared to $27,700 (1987 dollars) for the U.S.

C. Employment

Civilian unemployment in Alabama averaged 5.1 percent in 1997, as compared to a national average of 4.5 percent. Although Alabama's rate is only slightly higher than the national average, the state's minority unemployment rate of 10.8 percent underscores a substantial barrier to health care. It should also be noted that a substantial number of those employed are in low income positions that fail to even exceed the poverty level.

In Alabama, 1.8 million non-farm workers were employed in 1997, reflecting an annual increase of approximately 2 percent since 1975. This rate of annual increase will slow to 1.1 percent through 2010, and then reduce further to 0.4 percent during the 2010-2050 time period. This slowdown in the rate of employment growth is consistent with trends seen throughout the United States, which are the result of rising productivity combined with a smaller labor force. As detailed below, employment reductions in the manufacturing and mining sectors and reduced job growth in the non-industrial sectors will contribute to this deceleration.

Manufacturing employment in Alabama accounted for 20 percent of all non-farm employment in 1995. The other large employment sectors are trade, services, and government, all of which have shares similar to manufacturing. This is a change from 1975 when manufacturing was the dominant sector with 28.7 percent of the jobs. This parallels the U.S. experience where the share of jobs in the manufacturing sector has fallen from 24 percent to 15 percent during the 1975 to 1995 time period. Within manufacturing, the dominant sector is now, and has historically been, durable goods, with 48 percent of all manufacturing employment, followed by non-durable goods, textiles, and then food processing. Over the forecast period, the manufacturing sector will lose its position as the sector with the highest employment, and by 2050, only 7 percent of jobs

will be in manufacturing, compared to 4.8 percent for the U.S. This drop is mainly attributable to increases in productivity and increased foreign competition, especially in the textiles sector. The services sector, which is projected to add over 480,000 new jobs to the Alabama economy by the year 2050, will see the largest increase in share and account for 35 percent of state employment. This growth is due to the continuing structural transition of the U.S. economy from a manufacturing-based economy to a service-based economy. The health services sector will see the strongest growth over the forecast period due to the aging of the population. The trade and government sectors will also be important factors in job creation, together increasing employment in the state by nearly 400,000 jobs.

Within manufacturing, other non-durable goods (non-durable goods excluding food, textiles, paper and chemicals) will experience the largest share increase from 23.3 percent in 1995 to 32.8 percent in 2050, despite a decrease in the actual number of jobs in the sector. The other non-durable goods sector will also experience the largest production increases from 1995 to 2050, with an average annual gain of 2.4 percent. Durable goods follow closely behind with 2.3 percent annual production growth. Due to fierce foreign competition in the textile sector, production will stay nearly constant over the forecast period. However, with the increases in labor productivity in this area, the production will be accomplished with 19 percent of the 1995 workforce. Food processing production will ease from an annual average growth rate of 2.3 percent from 1995 to 2000 to 0.9 percent from 2020 to 2050. Other sectors will remain steady at 1995 to 2000 growth rates.

D. Education

The 1990 Census indicates that 89 percent of all Alabamians enrolled in school attend public institutions, and that whites make up 67.7 percent of the total enrollment, while minorities (black and other) make up 32.3 percent. The 1990 Census also indicates that 19.4 percent of the population 25 and over has not completed high school or received a GED. Approximately 14 percent have less than a ninth grade education. Data also shows that 31.9 percent of those 25 and older who did not receive either a diploma or a GED are unemployed. It should also be noted that in 1996 the Alabama Department of Public Health, Pregnancy Risk Assessment Monitoring System (PRAMS) found that unintended pregnancies for women who did not complete high school were 66.1 percent, and for women with 13 plus years of education, the rate was only 37.6 percent.

EDUCATIONAL ATTAINMENT OF ALABAMIANS AGE 25 AND OVER

Educational Attainment By Race (Age 25 and Over)	Total	Pct.	White	Pct.	Blk./Oth.	Pct.
Less Than 9th Grade	348,848	13.7	235,969	9.3	112,879	4.4
9th - 12th Grade, No Diploma	494,790	19.4	348,248	13.7	146,542	5.7
High School Graduate or GED	749,591	29.4	600,172	23.6	149,419	5.9
Some College, No Degree	427,062	16.8	343,319	13.5	83,743	3.3
Associate Degree	126,450	5.0	95,690	3.8	30,760	1.2
Bachelor's Degree	258,231	10.1	220,946	8.7	37,285	1.5
Graduate/Professional Degree	140,997	5.5	119,439	4.7	21,558	0.8

E. Health Care Access

Alabama continues to experience a crisis that can be measured in the number of rural hospital closures, deaths from treatable causes of disease, distance traveled to deliver babies and other statistics. Fifty-six of Alabama's 137 hospitals are in non-MSAs. From June 1987 to date, approximately 17 rural hospitals have closed, and many of the remaining small rural hospitals are in a deficit situation. Declining admission rates continue confronting rural hospitals. Over 80 percent of rural hospitals have an average daily census of less than 50 patients. These hospitals serve a higher percentage of elderly patients and people whose diseases tend to be more acute resulting in higher hospital costs. Alabama's hospital closure rate is one of the highest in the nation.

Although constantly plagued by a shortage of state matching funds, the Medicaid Agency continues to make contributions to improved health care for Alabama's low-income population, increasing Medicaid eligibles from 595,769 for FY 1993 to 632,472 for FY 1997. This 6.2 percent increase represents a slowing rate from growth from the previous interval in which Medicaid experienced an eight percent rate of growth. The growth rate for FY 1999 will likely show a dramatic increase due to the expansion of children's coverage through the Children's Health Insurance Program (CHIP). The Medicaid Agency has paid prenatal care and delivery cost for approximately 50 percent or more of all births in Alabama in recent years.

The Alabama Department of Public Health, Center for Health Statistics, shows 549,270 (13.3 percent) persons were enrolled in Medicare during 1997, and an additional 112,781 (2.7 percent) were enrolled as Medicare disability beneficiaries.

Estimates of Alabama's uninsured population range from 750,000 (18.3 percent) to 925,000 (22.6 percent), with even the lower estimate exceeding the national average of 17 percent. With 1,506,146 (40.2 percent) of the Alabama population having incomes below 200 percent of the federal poverty level and with only 632,472 (14.6 percent) of

this group being eligible for Medicaid benefits, as many as 873,674 (20.2 percent) are likely uninsured or underinsured (1,506,146 - 632,472).

According to a recent Employee Benefit Research Institute survey, 761,000 or 20.6 percent of Alabama's non-elderly citizens have no health insurance. They place the national average at 16.6 percent. Recognizing that there is some overlapping of coverages, the State estimates 59.9 percent of its population is covered by private insurance, 20.6 percent are uninsured, and 28.2 percent are covered by public and other insurance. Approximately 35 percent of all uncompensated care is attributed to emergency room visits.

F. Barriers to Access

(1) Transportation.

There is a complete absence of public transportation in 20 percent of Alabama's counties, and 30 percent lack adequate public transportation. It is estimated that over 70 percent of the population has no access to public transportation and, as a result of a high poverty rate, many individuals also lack access to private transportation. According to the 1990 Census, as many as 20 percent of all families living in rural counties lack any personal transportation.

(2) Education

As previously stated, the 1990 Census indicates that 19.4 percent of the population 25 and over has not completed high school or received a GED. Approximately 14 percent have less than a ninth grade education. Data shows that 31.9 percent of those 25 and older who did not receive a diploma or a GED are unemployed.

(3) Provider Distribution

Although approximately 60 percent of the population resides in rural areas, almost 70 percent of all primary care physicians practice within Alabama's five largest counties. Approximately 38 percent are located in Jefferson County with another 31 percent distributed among Mobile, Montgomery, Madison and Tuscaloosa Counties. Less than 20 percent of the state's physicians practice in rural areas. The state has a population per primary care physician ratio of 1,358:1, but in many rural areas the ratio is well over 3,000:1. Thirty-eight percent (1,647,888) of Alabama's population resides in federally designated primary care health professional shortage areas (HPSAs). These HPSAs consist of 68 areas and population groups that would require 152.9 strategically placed primary care physicians to remove all HPSA designations. In addition to the shortage of

primary care physicians, there are also shortages of dentists, nurse practitioners, physician assistants, and laboratory technologists in rural communities.

(4) Economic & Cultural

Estimates are that as many as 1,350,000 (32.6 percent) Alabama citizens are medically indigent. Many are classified as the "working poor" who fail to qualify for any form of assistance. There also are major barriers to adequate health care which are cultural and associated with the dynamics of generations of poverty. In varying degrees of intensity, individuals do not know how and are not able to adapt to healthy life styles, are unaware of the importance of preventive and primary care and certainly do not know how to obtain it or if these services are available. These factors are compounded by lack of education, youth and the frailty of aging.

G. Mortality

In 1997, the five leading causes of death in Alabama were, as has been in recent years,

(1) Diseases of the Heart

(2) Malignant Neoplasms

(3) Cerebrovascular Diseases

(4) Accidents

(5) Chronic Obstructive Pulmonary Disease and Allied Conditions

Deaths from heart disease (13,522) represents 31.3 percent of all deaths in the state, and has remained rather constant at that level both in numbers and as a percentage of the total in recent years. Malignant neoplasms deaths (9,585) accounts for 22.2 percent of all deaths. Deaths from the remaining leading causes were cerebrovascular disease, 2,922; accidents, 2,313; and chronic obstructive pulmonary disease, 1,858.

Alabama's mortality rate for 1997 was 10.4 per 1,000 population, with a total of 43,208 deaths from all causes. The rate for males was 11.0 for the same time period.

The health statistic which continues to be of great concern is the state's infant mortality rate. In 1996, the Alabama rate of 10.5 per 1,000 live births was the worst of any state in the nation. Although it improved to 9.5 in 1997, it remains well above the national average of 7.1 for the same time period. In 1997 the State infant mortality rate was 7.5 for whites and 13.5 for minorities. A birth rate of 37.2 per 1,000 female teenagers and

an infant mortality rate of 13.4 appears to be the largest single contributing factor to Alabama's high infant mortality rate. The teen birth rate for 1997 was 29.3 for whites and 52.2 for minorities. Teenage births represent 17.6 percent of all births within the state.

Motor Vehicle (MV) fatalities in Alabama are 93 percent higher than the national rate. For the combined years 1979-1995, Alabama had the fifth highest state rate for MV fatalities in the nation. Alabama has not been able to achieve the declining trends in MV fatalities during these years as have many other states. As referenced above, accidents are the fourth leading cause of death in the state, and MV fatalities account for more than one-half of these accidental deaths. The risk of death from MV accidents is 63 percent higher for Alabama's rural residents than urban residents.

H. Morbidity

The American Cancer Society estimates that more than 20,000 new cases of malignant neoplasms are diagnosed, and are responsible for over 9,000 deaths in Alabama each year. The state has shown an increase in the incidence of malignant neoplasms each year for several years. Rates are now slightly higher for whites than in the general population.

Although measles reemerged as a serious health threat in 1989, it now appears that this threat has passed. There were three cases reported in 1991 and no cases in 1992, 1993, 1994, 1995, or 1996, and only one case in 1997.

Alabama continues to experience a high number of tuberculosis cases. A declining trend over the previous two years reversed in 1993. There were 484 reported cases of TB in 1990, 430 in 1991, and 418 in 1992. In 1993, the number of reported cases escalated to 487, and decreased slightly in 1994 to 433 reported cases. This down trend has continued with 420 cases reported in 1995, 422 in 1996, 405 in 1997. It is believed that conditions such as AIDS/HIV infection, high poverty, drug use, elderly population, and shortages of medical services are contributors to the high rate of tuberculosis.

The reported cases of AIDS/HIV infection in Alabama increased sharply in 1993. There were 247 new cases reported in 1990, 385 in 1991, and 437 in 1992. In 1993, reported cases jumped to 710, and decreased to 554 in 1994. New cases of AIDS reported were 617 in 1995, 618 in 1996, and 551 in 1997. Blacks and teenagers are the most vulnerable group. Predictions are that an increased trend is likely to continue for some time. Alabama has also experienced high levels of other sexually transmitted diseases in recent years. There were 11,799 new cases of gonorrhea and 2,540 of syphilis reported in 1997. Incidents are more prevalent in urban areas, but rural areas also experienced increases.

While statistics are not available, it is clear that oral health and poor dental habits are a

health problem in Alabama. They are compounded by the direct expense of private dental care and the lack of readily available insurance. Dental problems commonly go untreated and, at times, reach levels that cause general health endangerment.

II. RURAL PRIMARY CARE INITIATIVES IN ALABAMA

A. Alabama Family Practice Rural Health Board

Created by the state legislature in 1990, this Board is appropriated approximately $900,000 annually to address the insufficient distribution of primary care physicians in the state. A broad base of projects are supported to promote placement of physicians in underserved communities including recruitment/retention, medical student tracking, residency programs in rural areas, health fairs, preceptorship programs and other efforts.

B. Alabama Hospital Association Rural Community Hospital Constituency Section

This organizational structure in the Alabama Hospital Association (AlaHA) provides a forum for the state's rural hospitals to study issues of mutual concern and serve in an advocate role for rural communities. There are approximately 65 members of this council which is staffed by the AlaHA and meets regularly. This council serves as an important communication link with Alabama's rural health community and is a major asset in implementing the CAH Program in Alabama.

C. Alabama Primary Health Care Association (APHCA)

The APHCA is a non-profit health care organization governed by a 22-member Board of Directors. APHCA was incorporated in 1985 as a non-profit representative organization of the federally-funded Community Health Centers (CHCs) to create and strengthen a community-based primary health care delivery system covering the entire state. It also is an advocate and voice for increasing access to primary health care for Alabama's underserved populations.

D. Alabama Rural Health Association

The Alabama Rural Health Association is a non-profit membership organization whose primary mission is to work for the preservation and enhancement of health for rural citizens of the state. This is being accomplished by bringing together a diverse constituency with a shared commitment to this mission to assume leadership in its accomplishment through communication, education, and advocacy. The Association serves as a forum for the unified voices of health care providers, public officials, health care workers, educators, and consumers working to improve health in rural Alabama; provides a forum for the exchange and distribution of ideas and information related to the improvement of rural health; serves as an advocate for rural health; and encourages the development of appropriate health resources for rural Alabama.

E. Certified Rural Health Clinics

Alabama has 69 Certified Rural Health Clinics which have elected to pursue certification through Medicare and Medicaid. These clinics are geographically located in areas which are underserved medically and receive cost based reimbursement for services delivered to Medicaid and Medicare patients. Of the 69 clinics, 45 are free-standing or independent and 25 are provider-based.

F. Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) was authorized in August 1997 to provide funding to states to establish insurance for low income families. Alabama has implemented CHIP in two phases. Phase I, which began in February 1998, expanded Medicaid coverage to children ages 14 to 19 with family incomes below 100 percent of the Federal Poverty Level (FPL). As of June 1999, over 10,000 children had been enrolled in the Medicaid expansion.

ALL Kids was implemented as Phase II of Alabama's CHIP. ALL Kids is a private insurance program available to children with family income above the Medicaid levels and below 200 percent of FPL. ALL Kids provides a comprehensive, privately administered, benefit package including doctor's visits - both preventive and sick, prescriptions, dental and vision services, hospitalization, and limited mental health and substance abuse counseling. Families with incomes below 150 percent of FPL have no cost sharing while families with incomes above 150 percent of FPL pay $50 per child per year for premiums and small co-pays (from $1 to $5) for health benefits. As of June 1999, over 20,000 children had been enrolled in ALL Kids.

Families may apply for ALL Kids using a mail-in application which is also used to apply for Medicaid SOBRA benefits. Applications may be obtained throughout the community from County DPH offices, hospitals and social service agencies. To be considered for ALL Kids, children must not have other health insurance including Medicaid coverage.

G. County Health Departments

A wide array of services is available through Alabama's sixty-seven county public health departments which administers approximately 85 service sites.

Vital records can be obtained at county health departments from the Center for Health Statistics in Montgomery through an automated vital records system, usually within thirty minutes. **Environmental services** include inspections of food service establishments, dairies, milk processors, milk haulers, and seafood processing plants to assure safe foods for Alabamians; permitting of septic tanks, sampling of private well waters, and

monitoring of constructed wetlands to prevent water pollution; inspecting unauthorized dumps; collecting residential samples for environmental lead analysis and training of lead abatement contractors; responding to animal complaints such as dog bites and bats. **Clinical services** available include the Women's, Infants, and Children's Program (WIC) services in all county health departments. Medical and educational family planning services and breast and cervical cancer screening are also available in all county health departments. Availability of prenatal and perinatal services varies from county to county depending upon arrangements with other providers. Children's health services include clinical services, newborn screening for sickle cell and other genetic diseases, day care health and safety, lead poisoning prevention, and child death review. **Home care services** are delivered through most county health departments and include professional nursing services, home health aide services, physical therapy, occupational therapy and speech therapy, medical social work, personal care, homemaker care, skilled and unskilled respite care and adult day health care. **Detecting and preventing disease outbreak services** include food-borne and food supply-related illnesses; communicable diseases such as measles, influenza, hepatitis, meningitis, tuberculosis, and sexually transmitted diseases such as HIV or gonorrhea; zoonotic diseases transmissible to man such as encephalitis or rabies; and accidental releases of hazardous substances. **Health education and health promotion** materials and programs are provided in cardiovascular disease prevention; unintended and teen pregnancy prevention; cancer prevention; teen tobacco use prevention; injury prevention; healthy behaviors and life-style promotion.

H. Emergency Medical Services (EMS)

The mission of the Alabama EMS Division is to reduce preventable mortality and morbidity caused by trauma and other emergency medical conditions. The Alabama EMS Division's statewide priorities include: a) the expansion of the geographic area in Alabama covered by EMS response with advanced life support capability in both the urban and rural areas of the state; b) reduction in the average length of time required to deliver the necessary prehospital treatment to emergency patients in both the rural and urban areas of the state; and c) development of a statewide trauma system which takes into consideration existing national standards, regional patient flow patterns, local concerns, and the special needs of rural emergency patients.

I. Federally Qualified Health Centers

Alabama has 17 FQHCs which have approximately 85 delivery sites in 49 counties of Alabama's 67 counties. The mission of FQHCs is to make quality primary health care available to every citizen of Alabama regardless of race, religion, creed, ethnic background or their ability to pay. Collectively they serve approximately 240,000 patients annually and provide medical homes for many Alabamians who would otherwise not have accessible health care. Although the clinics are located in urban and rural areas, they are predominantly focused in rural communities which have the greatest access

problems. A health care network is under formation by Alabama FQHCs to strengthen efforts for Alabama's underserved population by preparing for the changing dynamics of the state's health care system.

J. Health Professional Recruitment/Retention

Although many programs have recruitment and retention as major objectives, the following initiatives were specifically developed to address this need.

Alabama Area Health Education Center (AHEC)

One of the core functions of the Alabama AHEC is recruitment and retention of health professionals. There is a particular interest in increasing the pipeline of minority and rural students entering health careers. Tuskegee AHEC has had a long and successful history with its summer scholars and other ongoing activities.

Alabama Board of Medical Scholarship Awards

This Board provides scholarships to Alabama residents who are enrolled in one of the state's medical schools and agree to a service obligation in delivering primary care to an Alabama community designated as a Health Professional Shortage Area. The scholarships cover the average cost of tuition, fees, and living expenses. The service obligations range from one to one and one-half years for each year the award was received, depending upon the population size of the community being served.

Alabama Community Scholarship Program

This program provides physician and mid-level practitioner education scholarships to students who reside in Alabama health professional shortage areas and wish to return home and practice primary care after training is completed. Scholarships are provided through a matching arrangement involving federal, state, and community funds. Contractual arrangements require the student to practice in their home (supporting) community for at least two years and up to the number of years for which educational support was received.

National Health Service Corps Loan Repayment/Scholarship Program

This program(s) is a joint federal-state physician placement program which prioritizes communities having difficulty in recruiting physicians to determine those which are the most severely underserved. Those selected are eligible for placement of a National Health Service Corps sponsored physician who is a participant in the loan repayment program or scholarship program. The loan repayment program will pay off medical school loans of physicians in return for obligated service to one of the severely underserved communities. The scholarship program provides medical school and living expenses to selected

students in return for a service obligation in a severely underserved community following completion of training.

National Health Service Corps Student/Resident Experiences and Rotations in Community Health (SEARCH) Program

This federally-funded program is administered through the state's Primary Care Office to increase the recruitment and retention of primary care health professionals who practice in underserved areas and provide health care to the state's underserved populations. In this program, medical students, family nurse practitioners, physician assistants, and clinical social workers are recruited to complete clinical rotations in a community health center setting.

Physicians Alabama Opportunity Fair (PAOF)

This involves the combined efforts of several organizations, agencies, and groups whose mission includes recruitment of physicians to rural communities. Activities under this program are performed throughout the year and culminate in a recruitment fair weekend which brings together about 60 physicians seeking placement locations and approximately 35 rural communities who are searching for physician recruits.

Rural Health Scholars Program

This program provides scholarships for approximately 25 outstanding high school juniors and seniors from rural communities each year to spend the summer in a medical education/service environment at the University of Alabama's College of Community Health Sciences to enhance their potential and desire to become physicians. Physicians with rural backgrounds are more likely to establish rural practices. The program includes attending seminars on health issues, mentoring by physicians, and other activities which orient the students to both a medical training environment and the life of a physician. An extension of this program enables its alumni to spend a month precepting in the office of a rural physician.

Rural Medical Scholars

Ten qualified students from rural areas are chosen each year as Rural Medical Scholars (RMS), a highly selective pre-medicine program of the University of Alabama College of Community Health Sciences and the University of Alabama School of Medicine (UASOM). Students with rural backgrounds interested in practicing medicine in a rural area are eligible for the RMS Program. Admission to the program is based on high academic achievement, character, and leadership qualities. Each RMS class will enter the UASOM after in-depth study of primary care, community medicine, and rural health issues.

State Income Tax Incentive

Recruitment of physicians to rural communities is encouraged through a state

income tax credit up to $5,000 annually for physicians willing to locate in a rural community of 25,000 or less residents. The physician must have admitting privileges to a Medicare certified hospital of 105 beds of less and which is located more than 20 miles from another acute care hospital. The qualifying physician may claim the credit for up to five years.

Student Clinical Rotations

Health professions training programs in Alabama are acutely aware of needs in recruitment of health workers to rural areas and establish clinical rotation opportunities to encourage their placement in rural Alabama. This includes students in a variety of professions including medicine, dentistry, pharmacy, nursing, social work, physician assistants, and several allied health professions.

Tuskegee Area Health Education Center (TAHEC)

TAHEC has been a major resource in recruiting health professionals for many years and offers several initiatives to encourage students to pursue careers in the health professions. A special focus is placed on addressing the importance of achieving cultural diversity in the health care workforce by attracting students from minority, disadvantaged and under-represented populations. TAHEC offers enrichment opportunities which are targeted to students from elementary through college years including those in health professions training programs. Activities are provided through partnerships including the Central Alabama Veterans Health Care System in Tuskegee and many other community agencies. Examples of activities for participants include informational seminars by health care providers, health career fairs, field trips to health care facilities, course offerings in math and science, computer skills development, and preceptorship placements among others.

K. Managed Care - Alabama

Commercial Managed Care is growing but has not had a major impact yet in rural Alabama. There were thirteen health maintenance organizations (HMO) serving almost 450,000 members as of January 1, 1999 which is approximately 10 percent of the state population. Forty-eight counties are served by at least one HMO. Both metropolitan and rural counties are served, however, an estimated 80 percent of enrolled members reside in Birmingham, Mobile and Montgomery Counties. Two HMOs offer Medicare replacement products, four HMOs offer Medicare supplement products, one HMO offers Medicaid products, all HMOs offer administrative services to self insured employers, three HMOs offer individual coverage, and one HMO offers only children services. All HMOs

are required to offer quality products, have sufficient numbers of providers, maintain quality improvement systems, maintain solvency, and generate data and reports. The greatest managed care influence in Alabama's rural communities has come from

Medicaid initiatives.

L. Managed Care - Medicaid

Managed care initiatives have been developed to transition Medicaid from a fee-for-service program to coordinated systems of care. The approach that has been taken has been designed to meet the unique health care infrastructure present in the state and its rural structure. The managed care environment in the state is developing rapidly, and it is anticipated that over time alternative risk-based systems will evolve. Overviews of the current operational managed care initiatives are discussed below.

1. Patient 1st Program

The Patient 1st Program is a primary care case management system operating under a 1915(b) waiver approved by the Health Care Financing Administration. The program was initiated in January 1997 and currently is operational in all counties within the state as of November 1, 1998, with the exception of Mobile County which participates in the Bay Health Plan. This program is mandatory for all Medicaid beneficiaries except for dually eligible beneficiaries, SOBRA adults and foster children. Approximately 300,000 beneficiaries are enrolled in the program.

Patient 1st physicians contractually agree to deliver and coordinate health care for eligible Medicaid beneficiaries who select, or are assigned to him/her as their primary medical provider (PMP). The intent of Patient 1st is to improve access to care, to enhance the physician/patient relationship by creating a "medical home," and to reduce costs now associated with unnecessary or inappropriate use of medical services. Enrollment is mandatory for Medicaid beneficiaries who reside in Patient 1st designated counties. Enrollees are required to select and use a PMP for most non-emergency care. PMPs refer for specialty care as needed. PMPs are general practitioners, family practitioners, pediatricians, OB/GYNs and internists who provide primary care services, certain lab and x-ray procedures, routine newborn care and patient education. Other providers may be assigned to patients with special needs on a case-by-case basis. Physicians who agree to serve as primary medical providers are paid a case management fee in addition to fee for service reimbursement for care actually provided. A Patient 1st PMP may be included in the Maternity Care Program to enhance continuity of care (particularly for women who use OB/GYNs for PMPs).

2. Medicare Complete

The most recent managed care initiative Medicare Complete was implemented in

January 1998. In this program, Medicare/Medicaid beneficiaries may voluntarily enroll in a Medicare approved HMO. Medicaid pays a capitated per member per month payment on the behalf of these beneficiaries, which covers all Medicare required co-payments. The program is operational in three urban counties and is expected to extend to other counties in the future. This is a cost effective program for Medicaid as the Medicare HMO covers all Medicare required co-insurance and deductibles for participants enrolled in the program.

3. Partnership Hospital Program

The Partnership Hospital Program has been operating in the State of Alabama under a 1915(b) waiver from HCFA since October 1996. The Partnership Hospital Program provides acute care inpatient hospital services to Medicaid beneficiaries statewide using a system of prepaid health plans with contracts with the Medicaid Agency to cover medically necessary inpatient acute care through subcontracts with hospitals.

4. Maternity Waiver Program/Maternity Care Program

The Alabama Medicaid Maternity Waiver Program was implemented in September 1988 under the authority granted by HCFA for a 1915(b) waiver. Authority granted under such waivers allowed Medicaid to establish local, coordinated systems of care in which targeted populations were directed to receive their medical care in environments that emphasized quality, access, and cost effective care. Alabama chose this option for the Maternity Waiver Program. The purpose of this managed care effort was to ensure that every pregnant woman had access to care with the goal of lowering Alabama's high infant mortality rate and overall improvement of maternal and infant morbidity. The program was started during a time that provision of maternity care was poor in the state and there were few organized systems of care.

The waiver has been renewed every two years since 1988 and is regarded by the Health Care Financing Administration as a model waiver. The Maternity Waiver Program has made a positive impact on the maternity health care delivery system in Alabama. Traditionally, Medicaid has relied on local entities within communities known as Primary Providers to implement the Maternity Waiver Program. The Primary Provider establishes and monitors delivery care systems. The Maternity Waiver Program has attracted a variety of Primary Providers and expanded into 43 of Alabama's 67 counties. Primary Providers to date have included hospitals, federally qualified health care centers, county health departments, and non-profit organizations. Responsibilities of Primary Contractors varied under the waiver and included, but were not limited to:

- establishing a comprehensive system of obstetrical care
- designing innovative delivery systems
- monitoring contract compliance
- negotiating payment rates
- maintaining a billing and reimbursement system
- overseeing the quality assurance process
- overseeing the grievance process
- utilizing existing and developing new resources to enhance care

The Balanced Budget Act of 1997 provided Medicaid with the authority to convert the Maternity Waiver Program to a State Plan based program. The State has elected to utilize this new authority and will convert the waiver program to an operational program called the Maternity Care Program, thus alleviating the need to renew the waiver every two years. In changing this program, there are several federal requirements that must be included. These are discussed briefly for informational purposes and include, but are not limited to:

- The program must be operated on a statewide basis.
- There must be a choice of health care providers within the Program.
- Requirements of the new Section 1932 of the Social Security Act must be met.
- Requirements of Section 1905(t) of the Social Security Act must be met.
- Certain exemptions from the program must be made for disabled persons, Indians who are members of a recognized tribe, foster children under the age of 18, persons eligible for Medicaid through institutional deeming, children under 19 who have disabling conditions and require treatment through multi-specialty clinics.
- Beneficiaries must be allowed to change Delivering Health Care Professionals at any time for cause and once within 90 days of the date of enrollment without cause in the Maternity Care Program.
- Information must be provided to beneficiaries as required in Section 1932 of the Act.
- Contracts with entities must include items as specified in Section 1932 of the Act.

A number of changes have been made to make the Maternity Care Program accountable, more comprehensive in its scope of services, and more effective in its opportunities for success. During this contract, Primary Providers will be known as Primary Contractors. Primary Contractors must be proactive in monitoring and reporting activities of subcontractors. Requirements for participation have been refined and standards are more objective and measurable.

Standardization and measurability of performance and outcomes is imperative in order for the program to operate under the new guidelines. The package of services for which the Primary Contractor is responsible has been expanded. Maternity Care districts have been formed and potential Primary Care Contractors must show that a care system will be operational in the entire district. Contract awards will go to one provider per district.

M. Rural Alabama Health Alliance

The Rural Alabama Health Alliance (RAHA) is an organization comprised of four rural West Alabama communities: Bibb, Fayette, Greene, and Pickens Counties; and Family HealthCare of Alabama, a community health center corporation with locations in nine counties. These communities came together in 1990 in response to their concern over the continuing health care crisis that exists in rural Alabama. This non-profit entity offers a model for collaboration among autonomous communities and was organized for the following purposes: (1) to promote medical and other health related education in rural communities; (2) to enhance rural health care; (3) to stimulate rural community development; and (4) to engage in fund raising related to such activities.

N. Alabama Area Health Education Center Program

Located at the University of South Alabama, this program is a partnership between our medical schools and communities. Geographically placed centers throughout the state contract with medical schools to provide health education of the communities and its health professionals. The medical schools are required to send their students and residents to these rural communities for training. They work closely with community-based health care institutions, such as rural hospitals, primary care clinics, and rural health clinics. There is strong emphasis on multidisciplinary training and continuing medical education. Other areas include minority and rural recruitment of health professionals. Funding is provided through the National AHEC Program with matching support from state funds and other sources.

O. State Office of Primary Care and Rural Health

The State Office of Rural Health (SORH) is administered through the Alabama Department of Public Health. This office administers the State Office of Rural Health program, the state Primary Care office, and state office of Minority Health and serves as state-level contacts for federal health initiatives in their respective areas of responsibility. The Office of Primary Care and Rural Health serves as contact for rural and minority health information and supports rural communities in health professions recruitment, identification of underserved communities, grant identification, telemedicine resources, and data collection/analysis.

P. Southern Rural Access Program

Family HealthCare of Alabama of Eutaw, Alabama, and the statewide Alabama Family Practice Rural Health Board have been awarded a grant of $286,917 from the Robert Wood Johnson Foundation through the Southern Rural Access Program. This 18-month grant began in early 1999 and marks the beginning of the initial three-year phase of a long-term effort by RWJF that has focused on improving access to health care in underserved rural areas including Alabama and seven other southeastern states. The first phase will be used as a planning period to develop strategies and specific plans to address issues crucial to the development of an efficient and effective rural community healthcare infrastructure.

Alabama's proposal calls for the establishment of separate committees to oversee the planning of each of the program's five components: a) development of a health professional education program that will focus on the recruitment of rural students into health professions, and the creation of a rural health leaders "pipeline" of academically prepared professionals; b) development of a centralized health professional clearinghouse and a standardized recruitment and retention plan for Alabama's underserved communities; c) creation of health care networks that will focus on cost efficiency and enhanced patient care services and referral systems; d) development of a revolving loan fund to provide working capital for the establishment of new primary care facilities and/or the renovation of existing facilities and other health care infrastructure improvement projects; e) exploration of community development approaches that will mobilize rural communities and their resources to improve health care and the overall quality of life of their residents.

Q. University of Alabama School of Medicine

UASOM has developed two branch campuses for training third and fourth year medical students in rural settings to deliver primary medical care. Campuses are in Tuscaloosa and Huntsville. The Assistant Dean for Rural Medicine works in promoting a rural focus on all campuses of the UASOM system. A rural clerkship is required for each medical student.

R. University of South Alabama College of Medicine

The college demonstrates its strong commitment to rural health needs as evidenced by its development of an Office of Rural Health. The Office administers the Alabama AHEC Program and coordinates the rural health activities of the University. The Assistant Dean for Rural Health is also a part of the development team for the Southwest Alabama Rural Telehealth Network.

S. University of South Alabama Telemedicine Program (SARTN)

In 1998, the University of South Alabama (USA) Telemedicine Project implemented the Southwest Alabama Rural Telehealth Network (SARTN). This network includes spoke sites linking medically underserved rural communities in Baldwin, Clarke, Mobile, Monroe, and Washington Counties to the regional health care resources of the USA Health System. Clinical applications include OB/GYN, ENT, Pediatrics, Gastroenterology, Trauma/EMS, Orthopedics, Radiology, Cardiology, Dermatology, Neurology, and Psychiatry. Other services include teleradiology and colposcopy. In addition, the USA College of Medicine utilizes the telehealth network to promote and develop training programs for primary care residents, medical students, mid-level providers and other allied health providers in rural areas.

III. ALABAMA RURAL HOSPITAL FLEXIBILITY PROGRAM

A. Medicare Rural Hospital Flexibility Program

The authorization by Congress of the Medicare Rural Hospital Flexibility Program (MRHFP) through the Balanced Budget Act of 1997 offers an option to rural states such as Alabama which can stabilize the accessibility of health services for many residents. The MRHFP establishes the Critical Access Hospital concept which is an acute care facility emphasizing the delivery of primary health care services consisting of outpatient care, emergency medical care, and restricted inpatient care. The availability of this new medicare provider type is available to eligible hospitals which wish to convert to CAH status and satisfy federal requirements to become designated as a CAH. Participating hospitals will receive cost based reimbursement for both inpatient and outpatient services delivered to Medicare eligible patients The Program became effective October 1, 1997, and the Health Care Financing Administration (HCFA) finalized its regulations as published in the May 12, 1998, Federal Register.

Eligible hospitals are those which are public or nonprofit and located in a non- Metropolitan Statistical Area (rural). A qualifying facility must agree to operate no more than 15 acute care beds at any time and discharge patients within 96 hours of admission unless an exception is granted because of inclement weather or other emergency conditions. CAHs which are swing bed facilities may operate up to 25 beds for acute care or SNF- level care; however, no more than 15 of those beds can be used for acute care at any time.

States participating in the Program must develop at least one rural health network consisting of at least one CAH and one or more full service hospitals. Network members must maintain agreements for patient referral and transfer, development and use of communication systems, and emergency and non-emergency transportation of patients. These agreements mirror the arrangements that currently exist between many small rural hospitals and larger partners. In addition, each CAH that is a member of a network must have agreements for credentialing and quality assurance with another hospital or the peer review organization. CAHs may utilize these agreements as needed, but are not required to turn over credentialing and quality assurance activities to another hospital or the peer review organization.

The intent of these network agreements is to ensure that CAHs are supported by larger full service providers and that the residents of Alabama's rural communities have ready access to a full range of services. There is no requirement or expectation that supporting hospitals acquire or take over the services of CAHs. On the contrary, network arrangements should be designed to support the continued provision of a maximum range of services at the local level and most will be structured to support continued local control of health care services.

Although only one network is required for a state's participation in the MRHFP, the federal intent clearly encourages more extensive use of networks to improve and integrate services in rural areas. As a result, each CAH in Alabama will participate in a network and maintain the agreements described above. In addition, CAHs and supporting hospitals are encouraged to include other providers, such as physicians, community health centers, and rural health clinics in their networks.

B. Alabama's Preparation for the MRHFP

Following passage of legislation authorizing participation of all states in the MRHFP, Alabama's rural hospitals began a study of the appropriateness of the Program for the state. The study was conducted through an ad hoc committee established through the Alabama Hospital Association's (AlaHA) Rural Community Hospital Constituency Section. AlaHA officials discussed the ad hoc committee's actions with representatives of the Alabama Department of Public Health (ADPH) which administers the state's medicare survey/certification program and State Office of Rural Health. The ADPH encouraged the ad hoc committee's efforts and committed to working with AlaHA and the state's rural hospitals to enable the state's participation if the MRHFP offered potential for stabilizing and improving Alabama's rural health care. The ad hoc committee concluded the program has definite benefits for several rural communities in the state.

On March 12, 1999, a meeting was held to formalize composition of Alabama's Critical Access Hospital Task Force to oversee development of the state's rural health plan. The Task Force includes rural hospital administrators and representatives from AlaHA, State Office of Rural Health, State Office of Emergency Medical Services, Bureau of Health Provider Standards' State Division of Provider Services (Medicare certification agent), Governor's Office and the State Medical Association. A list of Task Force members is included as Attachment A.

The Task Force encouraged the State Office of Rural Health to request the start-up funds available to states which are interested in participating in the MRHFP. In preparation for this request, the State Health Officer who is the chief executive for the ADPH notified the HCFA by letter of the state's intention of participating in the MRHFP and commitment to developing the state plan which provides required assurances and describes the state's plan for implementation.

Start-up funds have been requested and received. These funds are being used to educate the state's healthcare stakeholders on the MRHFP requirements and how conversion of a rural hospital to a CAH can benefit its constituents. Plans are under development to use these funds to assist local hospitals with high interest and probability of pursuing CAH status to conduct financial feasibility studies and community assessments/education needed to determine if conversion is appropriate.

C. Objectives of Critical Access Hospital Program in Alabama

Implementation of a CAH Program in Alabama will have the following objectives:

- Enhance access to basic medical care being delivered by rural hospitals through promotion of comprehensive planning efforts in the state's rural communities at risk for inadequate access.

- Provide a mechanism through networking and other collaborations to integrate health service delivery including EMS and enhance efforts to assure delivery of quality services in CAH communities.

- Assist in stabilizing financially troubled rural hospitals to continue health care access for elderly (medicare) residents, minority and other underserved populations, who have difficulty obtaining needed care outside their home communities.

The CAH Task Force has used these objectives in finalizing the state's rural health plan. The Task Force will also use these objectives in evaluating the success of the CAH Program as a model of care for rural communities in the state.

D. Criteria for Rural Network Designation in CAH Program

A rural health network is an organization involving at least one CAH and one or more full service hospitals which includes agreements on the following: a.) patient referral and transfer, b.) development and use of communication systems, and emergency and non-emergency transportation of patients.

In addition, each CAH which is a member of a network must have an agreement for staff credentialing and quality assurance with at least one hospital in the network, or a peer review organization (PRO) or equivalent entity, or another entity described in the rural health plan for Alabama.

Networking needs and opportunities will be identified during the community needs assessment which is required in the application process for CAH conversion. Potential areas for networking include but are not limited to: emergency care, specialized outpatient services, telemedicine, preventive clinical services, behavioral medicine, and substance abuse care. Other more extensive optional networking arrangements may be pursued depending on the wishes of the respective CAH. Technical assistance will be made available through CAH grant funds to aid communities in developing networking arrangements which they deem appropriate.

E. Critical Access Hospital Program Administration and Designation in Alabama

The ADPH's Office of Primary Care and Rural Health (State Office of Rural Health) is submitting this rural health plan which was developed by the CAH Task Force and includes the AlaHA, rural hospital directors, State Office of Emergency Medical Services, and Bureau of Health Provider Standards' Division of Provider Services which is Alabama's certification unit in state government. Other participants on the Task Force include representatives from the Governor's Office and Medical Association of the State of Alabama.

After approval, the plan will be reviewed in October of each year by the CAH Task Force to determine if revisions or updating is needed to ensure the plan remains viable.

Administration of Alabama's CAH Program will be provided through the ADPH and will involve a collaborative effort between the Bureau of Health Provider Standards' Division of Provider Services and Office of Primary Care and Rural Health.

The Office of Primary Care and Rural Health will serve as liaison to the Federal Office of Rural Health Policy and administer the grant funds to implement this program. It will work with the AlaHA and the CAH Task Force in planning activities which communicate the program's objectives and availability to rural hospitals and communities and other state stakeholders. It will collaborate with the Division of Provider Services in applying state "necessary provider" criteria to individual hospitals in determining eligibility. The Bureau of Health Provider Standards will distribute and receive applications for CAH conversion from interested hospitals, conduct surveys for CAH licensure/certification and be the state contact for the Region IV HCFA office in certifying individual hospitals as CAHs. It will serve as principal contact to HCFA in the program administration in Alabama. The Bureau provides assurance that no hospital will be surveyed for CAH certification purposes until all state criteria have been met.

The Office of Primary Care and Rural Health, AlaHA, and Bureau of Health Provider Standards' Division of Provider Services will provide ongoing educational services to hospitals interested in the CAH Program through public forums within eligible communities and through individual consultations.

To satisfy state requirements for designation as a CAH, a hospital must first agree to meet all federal requirements for certification. After all state requirements for designation are satisfied, a hospital may be surveyed by the ADPH's Bureau of Health Provider Standards.

F. Federal Criteria/Assurance for Certification

A hospital in Alabama must meet the following federally established criteria to be

considered for certification as a CAH:

5. is a public or nonprofit medicare-certified hospital currently in operation and located in a rural (non-MSA) area;

6. is located more than a 35 mile drive (or, 15 mile drive in the case of mountainous terrain or in areas with only secondary roads available) from another hospital or CAH,

or

is designated by the state as being a Necessary Provider of Health Care Services to area residents; (See Section G for Necessary Provider Criteria);

7. makes available 24-hour emergency care services that a state determines are necessary for ensuring access to emergency care in each community served by a CAH;

8. provides not more than 15 beds for acute inpatient care (or in the case of a swing bed facility not more than 25 beds which can be used interchangeably for acute or SNF-level care, but no more than 15 beds can be used at any time for acute care needs);

9. keeps each patient no longer than 96 hours, unless a longer time is required because of inclement weather or other emergency, or a peer review organization or other equivalent entity waives the 96 hour limit upon request on a case-by-case basis;

6. meets CAH staffing requirements;

7. is a member of a rural health network and has an agreement with at least one full-service hospital (Affiliate) in the network for:
   - patient referral and transfer
   - development and use of communications systems
   - provision of emergency and non-emergency transportation;

8. has an agreement regarding staff credentialing and quality assurance with **one** of the following:
   (a) a hospital that is a joint member in the rural health network,
   (b) a peer review organization or equivalent entity, or
   (c) another appropriate and qualified entity identified in the state rural health plan.

G. State Criteria for “Necessary Provider” Designation

Federal statutes and eligibility requirements governing the CAH Program allow states to designate a hospital as a Necessary Provider of Health Care Services for its area residents if it meets all requirements for a CAH except the mileage between hospitals requirement. Alabama will utilize this statutory provision and designate Necessary Provider of Health Care Services for hospitals located in a county considered "at risk" for losing primary health care access. Alabama has reviewed numerous indicators of underservice in communities to determine criteria most appropriate for Alabama. Five criteria have been selected and is based on the best judgement by the CAH Task Force and the Office of Primary Care and Rural Health which routinely identifies and works with vulnerable populations and underserved communities in the state. The following criteria will be used by the state in determining if a hospital should receive necessary provider designation.

If the hospital meets one or more of these criteria, Alabama's Bureau of Health Provider Standards, Division of Provider Services, in consultation with the Office of Primary Care and Rural Health, will declare the facility a Necessary Provider of Health Care Services.

Criteria 1. The hospital is located in an area designated as a Health Professional Shortage Area.

Criteria 2. The hospital is located in an area designated as a Medically Underserved Area.

Criteria 3. The hospital is located in a county with an unemployment rate higher than the state-wide rate of unemployment.

Criteria 4. The hospital is located in a county with a percentage of population age 65 years and older greater than the state's average.

Criteria 5. The hospital is located in a county where the percentage of families with incomes below 200% of the federal povery level is higher than the state average for families with incomes below 200% of the federal poverty level.

Any hospital which otherwise satisfies CAH criteria except the mileage requirement but does not meet at least one of the above criteria for certification as a Necessary Provider of Health Services may appeal to Alabama's State Health Officer. Evaluation of appeals will be based on submission of objective information which demonstrates the presence of extenuating circumstances which may adversely impact an area's access to health care if the hospital is not declared a Necessary Provider of Health Services. Based on the evidence presented, the State Health Officer may decide to issue a variance from established criteria and declare the appealing hospital a Necessary Provider of Health Care Services.

H. Critical Access Hospital Application

Extensive educational campaigns on the CAH Program are being planned for Alabama's rural communities. After Alabama's program has been finalized and established, all rural hospitals will be notified that applications for conversion to CAH status will be accepted.

Hospitals which are considering conversion to CAH status should contact the Bureau of Health Provider Standards's Division of Provider Services and discuss their interest and eligibility requirements to participate in the program. The Division of Provider Services will consult with the Office of Primary Care and Rural Health as appropriate to verify the hospital's eligibility especially regarding the mileage requirement and the hospital's designation as a Necessary Provider of Health Services. The Division of Provider Services will provide CAH application materials to the interested hospital. Consultation on CAH status will be available to hospitals from the AlaHA and State Office of Primary Care and Rural Health. Hospitals which decide to pursue conversion will submit a CAH Designation Application to the Division of Provider Services which includes the following information:

E. A community needs assessment including but not limited to an inventory of community health services and providers and any service gaps identified and options on how they could be filled.

F. A description of public information services conducted to inform community residents, public officials, health professionals and others of the proposed conversion to CAH status and its potential effects and benefits to the community.

G. A study that addresses the financial impact of hospital conversion to a CAH.

H. A signed network agreement involving at least one support hospital which is a full service facility and describing arrangements for patient referral and transfer, development of communications systems, and provision of emergency and non-emergency transportation.

I. A written agreement regarding staff credentialing and quality assurance with a joint network hospital or peer review organization. The CAH may utilize this agreement as needed, but is not required to turn over credentialing and quality assurance activities to another hospital or peer review organization.

J. Other information and documentation as required to establish eligibility and compliance with CAH designation requirements and enable evaluation of the CAH program in Alabama.

This application process is designed to encourage broad participation from a community's

stakeholders to encourage their support of its local health service structure and ensure they are aware of the changing role of a hospital with conversion to CAH status. This process will identify potential service gaps and the need to develop arrangements which fill these gaps.

II. Potential CAH Hospitals in Alabama

Rural hospitals in Alabama which may be interested in considering conversion to CAH status and also satisfy the mileage requirement or meet the state criteria for designation as a Necessary Provider of Health Services are listed below. Each facility listed meets at least one criteria for being designated as a Necessary Provider of Health Services. These facilities are listed in the Directory of Health Care Facilities, 1999, as published by the Alabama Department of Public Health, Division of Provider Services. It is important to note that this list simply indicates the hospitals in Alabama that meet basic CAH eligibility requirements. It is not expected that all of these hospitals will convert to CAH status and there is no requirement that they do so. The decision to pursue CAH conversion must be made by a facility's governing board, in consultation with residents of the community.

HOSPITAL	COUNTY
Lakeview Community Hospital	Barbour
Bibb Medical Center Hospital	Bibb
Bullock County Hospital	Bullock
Georgiana Hospital	Butler
L. V. Stabler Memorial Hospital	Butler
George H. Lanier Memorial Hospital	Chambers
Baptist Medical Center Cherokee	Cherokee
Chilton Medical Center	Chilton
Grove Hill Memorial Hospital	Clarke
Jackson Medical Center	Clarke
Thomasville Infirmary	Clarke
Clay County Hospital	Clay
Elba General Hospital	Coffee
Medical Center Enterprise	Coffee
Evergreen Medical Center	Conecuh
Andalusia Regional Hospital	Covington
Florala Memorial Hospital	Covington

Mizell Memorial Hospital	Covington
HOSPITAL (Continued)	**COUNTY** (Continued)
Crenshaw Baptist Hospital	Crenshaw
Cullman Regional Medical Center	Cullman
Woodland Medical Center	Cullman
Selma Baptist Hospital	Dallas
Vaughan Regional Medical Center	Dallas
Baptist Medical Center-DeKalb	DeKalb
Atmore Community Hospital	Escambia
D. W. McMillan Memorial Hospital	Escambia
Fayette Medical Center	Fayette
Russellville Hospital	Franklin
Red Bay Hospital	Franklin
Wiregrass Medical Center	Geneva
Greene County Hospital	Greene
Hale County Hospital	Hale
North Jackson Hospital	Jackson
Jackson County Hospital	Jackson
East Alabama Medical Center	Lee
B. W. Whitfield Memorial Hospital	Marengo
Marion Baptist Medical Center	Marion
Caraway Northwest Medical Center	Marion
Marshall Medical Center South	Marshall
Marshall Medical Center North	Marshall
Monroe County Hospital	Monroe
Pickens County Medical Center	Pickens

Edge Regional Medical Center	Pike
Randolph County Hospital	Randolph
HOSPITAL (Continued)	**COUNTY** (Continued)
Wedowee Hospital	Randolph
Hill Hospital of Sumter County	Sumter
Coosa Valley Baptist Medical Center	Talladega
Citizens Baptist Medical Center	Talladega
Russell Medical Center	Tallapoosa
Lakeshore Community Hospital	Tallapoosa
Walker Baptist Medical Center	Walker
Washington County Infirmary	Washington
J. Paul Jones Hospital	Wilcox
Carraway Burdick West Medical Center	Winston

The Office of Primary Care and Rural Health and AlaHA will work with these hospitals through public forums and individual consultations to ensure they are knowledgeable of the CAH option available to them. Technical assistance will be made available to those hospitals with interest in exploring CAH conversion for detailed studies of their operations and educating staff, physicians, other providers, and community residents about the CAH Program and its benefits and requirements. The program will be presented as an option (and not a requirement) for hospitals to consider in focusing resources to stabilize access to basic medical care and in identifying networking needs and opportunities with surrounding communities and resources.

ATTACHMENT A
CRITICAL ACCESS HOSPITAL TASK FORCE

Barry Cochran, Administrator, DeKalb Baptist Medical Center, Chairman

Clyde Barganier, Director, Office of Primary Care & Rural Health

Evan Dillard, Administrator, Marion Baptist Medical Center

Gordon Faulk, Administrator, Bullock County Hospital

Frank Harris, Administrator, Russell Medical Center

Jay Howser - Office of Policy, Office of the Governor

Steve Kennedy, Director, Division of Emergency Medical Services

Jane Knight, Vice-President, Member Relations, Alabama Hospital Association

Holley Midgley, Executive Vice-President, Alabama Chapter - American Academy of Family Physicians

Wendell Morgan, Medical Association of the State of Alabama

Moultrie Plowden, Administrator, Randolph County Hospital

Jim Prince, Division of Provider Services, Alabama Department of Public Health

Harold Reed, Administrator, Fayette Medical Center