

Rural HEALTH NEWS

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Future Uncertain for Rural Pharmacies

By Thomas D. Rowley

The skyrocketing prices of prescription drugs and how best to include them as a Medicare benefit have been the sources of heated debate and intense media coverage this year. Largely missing from both, however, has been attention to the men and women who not only fill the prescriptions but who also serve as the first line of health care to millions of Americans, especially in rural areas.

Paul Moore, a pharmacist and former hospital administrator in Atoka, Oklahoma, is watching the debate about prescription drugs closely and wondering how it will affect rural pharmacists and the communities they serve.

“In rural communities, pharmacists are critical to local health care, but we’re also critical to the functioning of the community,” Moore said. “We serve on the city council, the school board, the chamber of commerce. More so than our urban counterparts, we’re on a first-name basis and are a readily accessible source of medical information, whether in the pharmacy, at a ball game, or even at church. If anything hurts the economic viability of the rural pharmacy, I’m afraid that the next generation of pharmacists won’t even be around.”

Moore’s concern is not unfounded. The future of rural pharmacies has never been more uncertain. There are economic pressures from Medicaid and private-pay reimbursement, as well as those likely under a Medicare prescription benefit. Competition from mail-order pharmacies is rising, and the number of pharmacists is dwindling.

Interviews with pharmacists and pharmacy association executives around the country shed light on the trials and tribulations facing rural pharmacists, why most worry about the future, and why some are eyeing the exit.

Economic Woes

“The 800-pound gorilla” is how Douglas Hoey, Vice President for Practice Affairs at the National Community Pharmacists Association, characterizes the problem with third-

party payers—insurance companies and pharmacy-benefit managers (PBMs) who reimburse pharmacists for the prescriptions they fill.

The size of the beast has to do with the fact that prescriptions paid for by third parties account for more than 75 percent of all prescriptions filled,



Judy Vryland helps a customer at Rhodes Drug Store in Warrenton, VA. The drugstore also operates a gift shop and café.

according to the National Association of Chain Drug Stores (NACDS). The less-than-amiable depiction has to do with the belief that reimbursement rates are set too low—a complaint echoed in interview after interview.

“Third party, private pay is poor to miserable and is far and away the biggest problem facing retail pharmacies,” Hoey said.

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Crafting a Medicare Drug Plan That Doesn't Hurt Pharmacies

Congress adjourned in August without passing a Medicare prescription benefits bill, but most observers agree that such a bill is inevitable. The fate of rural pharmacies, however, remains up in the air.

“So far, we’ve dodged a bullet that some bad bill didn’t get passed this year,” said Paul Moore, a pharmacist and former hospital administrator, referring to the Medicare debate. His concern is that a Medicare benefits bill, unless it is carefully crafted and mindful of the obstacles facing rural pharmacies, could harm them.

“If Medicare gets involved, access to rural pharmacies could really suffer,” said Moore. “A Medicare prescription discount card would hurt the pharmacist’s margin. And, if he’s got low volume he can’t absorb it. He’s got the same cost as the big chains but not the volume to absorb it.”

Rather than simply relying on the PBM, Moore wants to see some precautionary measures that would protect rural pharmacies.

“We need a rural carve-out like the Critical Access Hospital designation that keeps access out there and keeps

the rural pharmacist in the community,” he said.

The research community seems to agree.

In the summer issue of *The Journal of Rural Health*, researchers Michelle Casey, Jill Klingner, and Ira Moscovice argue that the effects of a Medicare benefit on rural pharmacies will depend both on the extent to which rural pharmacies are allowed to participate in the program and on the reimbursement rates for rural pharmacies.

The study notes that a Medicare prescription drug benefit administered by a PBM that relies exclusively on mail-order and large chain pharmacies would be problematic for rural areas. That’s because many rural beneficiaries will be unable to use their local pharmacy, and local pharmacies will probably lose a large share of their current private pay business.

An August 2000 report from the University of Southern Maine and the Rural Policy Research Institute called on lawmakers to craft a drug benefit that ensured access to the full

range of pharmaceutical services for Medicare beneficiaries regardless of their geographic location. The report recommended that any prescription drug legislation include protections for local, low-volume pharmacies in rural areas, particularly for any plans that would rely on mail order or bulk purchasing to achieve cost savings.

Although there are concerns about a Medicare drug benefit, no one is arguing against it. Indeed, as the Maine report says, older rural Americans have a greater need for prescription drugs but less access to them than their urban counterparts. Obviously, then, a Medicare benefit would help many rural seniors. The argument, then, is how to benefit rural seniors without undermining the pharmacies that serve them.

“Unless we do something to help them,” said Moore, “we’re going to see rural pharmacies close.”



Rhodes Drug Store in Warrenton, VA.

Most of the pharmacists cited profit margins in the one to two percent range, and worried that they could decline further at the hands of third-party payers. The problem is particularly acute for small independent pharmacies that cannot make up for small margins by selling large quantities.

In some states, low reimbursement rates are a problem not just with private insurance but also with public insurance, that is, Medicaid, which accounts for 21 percent of all independent pharmacy prescriptions. And because Medicaid is typically one of the largest state expenditures, deficit-ridden states across the country are looking at ways to reduce their

Medicaid outlays. One way is to decrease prescription reimbursements.

Peter Dunn, a registered pharmacist in the south Texas town of Stockdale, owns and runs his own shop, which he bought from a cousin in 1986. It's the only pharmacy in a town of 1,200 that has only one part-time doctor and one dentist. Medicaid accounts for nearly 30 percent of his business.

"The only thing that is going to put us out of business is insurance and Medicaid," he said. "Insurance companies set the price; it's 'take it or leave it'. You don't have any say in what you're making."

Wilbur Heflin, pharmacist and owner of Remington Drug Co. in Remington, Virginia, which has been in his family since it opened in 1913, concurs. "If I had to pay rent, I'd bag it," he said.

Many in the field are concerned that a Medicare prescription drug benefit could add weight to the 800-pound ape. According to Al Roberts, one of two registered pharmacists at Rhodes Drug Store in Warrenton, Virginia, federal government involvement in pharmacy reimbursements will only make the problem worse.

For their part, insurance companies, pharmacy benefit managers, and government program administrators argue that they are simply trying to keep the cost of prescription drugs down in an era of rapidly increasing prices.

But Bill Eley, Executive Director of the Alabama Pharmacy Association, isn't impressed.

"The answer is not to cut the fees they pay to pharmacists," he said. "The problem is the cost of drugs."

Eley notes that the savings are not going as much to the consumers as into the pockets of the pharmacy benefit managers.

One of the ways insurance companies and PBMs are trying to hold the line on costs—one which adds to the

Paying for More Than the Pills

While pharmacists are clearly health care providers, they can't directly bill Medicare or private insurers for services as a physician or nurse practitioner can. Some folks, however, would like to change that.

Advocates are calling for changes that would allow pharmacists to directly bill for the medical management services they provide. They argue that along with filling prescriptions, pharmacists provide a wide array of health care services: advice, over-the-counter recommendations, drug interaction screening, consultation with physicians, health monitoring, and immunizations.

Under current law, however, pharmacists are paid only for the prescriptions they fill, not for the other services. And in an era of declining prescription reimbursements and competition from mail-order, that represents a financial loss for pharmacists.

Several bills have been introduced in Congress in recent years that would provide for coverage of pharmaceutical services. The most current proposed bill is Senate Bill 974, introduced by Senator Tim Johnson (D-SD). While passage of the bill at this time is uncertain, the fact that it is being debated shows that the issue is garnering more attention.

Dr. Charles Seifert, Regional Dean for Lubbock Programs, at the Texas Tech University School of Pharmacy, is a fan of the idea.

"Pay for the pharmaceutical services, and let the patients get the drugs wherever they can get them cheapest—internet, mail order, etc."

According to Seifert, such a plan would more than pay for itself since every dollar spent on advanced clinical pharmacy services saves some 16 dollars.

The pharmacists said the main competition for business is from mail-order (which includes the Internet). According to the Institute for Local Self Reliance, sales at mail-order pharmacies grew 24 percent in 2000 and accounted for some 15 percent of all prescription spending.

Just like other mail-order merchants (think Amazon.com versus the local independent book store), mail-order pharmacies can offer lower prices by dealing in huge quantities and avoiding the costs of owning, maintaining, and operating retail outlets. Because insurance companies and PBMs want to reduce the reimbursements they pay, they encourage—some say coerce—customers to get their drugs via mail-order.

The low overhead of mail-order and Internet pharmacies provides ample economies of scale and the insurance companies are taking advantage, according to Moore.

"Some insurance companies get docs to write two scrips—one for a 10-day supply at the local pharmacy, another for a 90-day supply from a mail-order pharmacy," Moore said.

Theoretically, the customer could, of course, fill both at the local pharmacy, which, if it wants to make any profit, has to charge a higher rate than the mail-order house. Choosing that route, however, would mean the

pinch rural pharmacies are feeling—is through the use of mail-order pharmacies.

While big chain retail stores may wreak havoc on many small independent retail businesses (think Home Depot versus the local hardware store) they don't seem to cause the pharmacists much concern. Hoey calls them "a distant number two" on

the list of obstacles facing rural pharmacists.

"I can compete with the big chains," said Dunn, "they're not that cheap. The majority of the time I'm a little cheaper—that surprises a lot of people."

customer paying for the drug out of his or her own pocket.

Moore and other rural pharmacists are concerned that reliance on mail-order pharmacy may have another hidden cost, particularly if they end up driving the local pharmacist out of business.

“Our concern is who is going to give them the drugs,” Eley said. “There won’t be anyone to tell them how to take it. There won’t be any pharmaceutical management. Too many of my guys tell me that folks bring in bottles and ask ‘what is this?’ We want people to get their drugs, but if they don’t take them the correct way it could be very harmful to them.”

In addition, to pharmaceutical care, there is the question of timeliness. Obviously, mail-order takes time, often more time than patients realize.

“Patients show up and ask you to loan them a few pills because their mail order hasn’t come in yet,” said Moore.

Given the geographic isolation in many rural communities, the distance between those who need the prescription drugs and the pharmacies that provide them is often great.

“If we went under, I don’t know how a lot of these people would get their drugs,” Dunn said. “A lot of them don’t drive. That’s why we deliver.”

In fact, new delivery methods for prescription drugs—whether through the mail or the Internet—also are

raising some other ethical questions. Because some PBMs own their own mail-order pharmacies, which benefit from policies that steer customers to them and away from retail pharmacies, complaints have been raised about conflicts of interest.

And because some PBMs receive so-called rebates from some drug manufacturers, other complaints have been raised that PBMs are steering

customers to certain drugs over other ones, even over drugs that were prescribed by a doctor.

“As a pharmacist,” said Hoey, “I would argue that that is not in the best interest of the patient. The insurance company is getting in the middle of medical care. To me, that’s a problem.”

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Pharmacy by Phone

Students in the Texas Tech University School of Pharmacy soon will experience some of the realities of rural pharmacy practice. At the same time, they will help people in remote rural areas get access to pharmaceutical care.

According to Dr. Charles Seifert, Regional Dean for Lubbock Programs at the school, there are several small tele-pharmacy projects around the country. Tech’s, however, will be the first in the country to involve students in training and one of only two that requires a rural clerkship.

The program will result in 17 fourth-year pharmacy students spending one week of their six-week rural clerkship doing and learning tele-pharmacy. Students will spend one day in a doctor’s office, one day at the central pharmacy, and three days at a remote site.

“When you get the students out to those small communities,” said Seifert, “they see some really good

things—drug interactions, untreated disease states—it’s really a study in itself.”

Two of the goals of the program are to have students on all the Tech campuses involved in tele-pharmacy, and to attract people into rural health care by giving them a way to do it without having to move out there.

As for the scope of services offered, Seifert envisions two-way video consultations between doctors, patients, and pharmacists. “We want to use it for a lot more than just the remote filling of prescriptions,” he said.

That philosophy fits in with the paradigm shift in pharmacy that Seifert sees coming, and thinks necessary. Advanced training will be critical, he said, as technology and everything else becomes more sophisticated.

Labor Woes

In 2000, there were 196,000 licensed pharmacists in the United States. They work in retail pharmacies, managed care facilities, hospitals, clinics, nursing homes, and research institutions. According to the National Community Pharmacists Association, 95 percent of U.S. counties have a pharmacy. Other studies have found that pharmacists are more widely distributed across rural areas than primary care doctors. The extent of their geographic coverage coupled with the ease of walking up to a pharmacy counter and asking a medical question prompts Hoey to say that “pharmacists are easily the most accessible health care professional in the United States.”

That’s the good news. Obviously, then, there must be some bad.

High as the numbers of pharmacists and pharmacies seem, there are some 7,000 pharmacist vacancies, according to a report by the federal government’s Health Resources and Services Administration. In 1998, there were only 2,700 vacancies. Part, but not all, of the slack is due to the fact that in 2000, pharmacy schools switched from a five-year degree to a six-year degree, effectively eliminating one year’s worth of graduates.

On top of that, data from the American Association of Colleges of Pharmacy show that the number of pharmacy graduates has been slowly dropping—in an industry that can pay starting retail pharmacists around \$80,000 a year and sometimes offers signing bonuses.

Finally, as is often the case, rural America gets fewer pharmacists than what might be considered its fair share. According to a 1996 study by the American Pharmaceutical Association, 25 percent of the nation’s population lives in rural America but only 12 percent of its pharmacists practice there.

Why the shortage? A few reasons.

Like other rural health care providers, pharmacists who wish to set up shop in the small towns and countryside face the obstacles that come from remoteness, isolation, a higher percentage of lower-income clientele, and so on. In addition, they face the curse of rising popularity.

According to NACDS, pharmacists in retail pharmacies alone filled three billion prescriptions last year—up 50 percent from 1990. The association’s data also show that four out of five patients who visit a doctor leave with a prescription. Obviously, that’s good for the pharmacy business. It is, however, something of a mixed blessing, considering the difficulty rural pharmacies face in getting back-

up. Although Remington, Virginia, has only 500 residents (not counting the surrounding area), Wilbur Heflin works 12 hours a day, six days a week. His only back-up comes from Mr. Roberts of Rhodes Drug up the road in Warrenton, who uses a week of his vacation so that Heflin can take one of his own. Heflin’s wife, who works beside him and also handles the soda counter, notes that her husband often “skips lunch to fill another prescription.”

Dunn, in south Texas, occasionally gets a pharmacist to come in and relieve him, but says it is expensive and that he doesn’t really trust them the way he trusts himself. “If I’m not there, the pharmacy closes,” he said.

A study of rural pharmacies in Minnesota, North Dakota, and South Dakota confirms the challenge. It found that more than half of the pharmacists surveyed had difficulty obtaining relief coverage for vacations and time off.

On top of that, pharmacists say that the administrative headache of dealing with third-party reimbursement is quickly becoming a migraine. Some research has shown that 20 percent of a pharmacist’s time is spent on third-party payer administration. Roberts sums it up this way: “I like what I do if I can stay off the phone and away from the insurance companies.”

Dunn said “Dealing with the insurance every day sort of gives you a bad attitude.”

The Toll on Pharmacists, Their Customers, and Their Communities

The combination of economic and labor woes is taking its toll on rural pharmacists. Many have opened sideline businesses. Dunn owns and runs a hunting ranch. Duane Thompson and his wife Becky, owners of Rhodes Drug Store, also own and run a gift shop and a café. Heflin and his wife dabble in antiques and collectibles on the side.

The low reimbursement rates drive pharmacies into other niches, said Roberts, pointing to the wall of flyfishing equipment next to the counter in Rhodes. “We have to have them all, in order to make it,” said Becky Thompson of the various enterprises.

The toll is also causing some pharmacists to think about leaving the business. Although none who was interviewed for this story said he or she has immediate plans to retire or sell, each spoke of the possibility in the not-too-distant future. Each also spoke of the desire for, and the improbability of, having their pharmacy continue.

“If the pharmacy makes it for another six to eight years,” said Dunn, “I’ll stick with it. But by the time I’m 48

to 50, I’m out. Hopefully, somebody will want to buy it. If they do, I’ll probably take the first decent offer I get.”

“We’d love to sell to someone who would keep it going the way it is,” said Mrs. Thompson. “But those folks are few and far between.”

When and if rural pharmacists succumb to the forces—through retirement or failure—the void they leave will have a great impact on their customers and communities. Granted, with or without a local pharmacy most people will still be able to get the drugs they need via mail-order. Indeed, many already are. What they cannot get from the postman is pharmaceutical service.

According to Moore, maintaining access to pharmaceutical service—the advice, over-the-counter recommendations, drug interaction screening, consultation with physicians, health monitoring, and immunizations that pharmacists provide in addition to dispensing medicines—is the number one issue when it comes to rural pharmacies. Already, he noted, there are a lot of small towns that do not have pharmaceutical services anymore. As a result, health care in those towns is not what it was, Moore said.

“Many times, the local pharmacy is the first point of contact,” Moore said. “Folks go to the pharmacist before the doctor, because they’re hoping not to go to the doctor.”

Denise Jackson, a clerk at Rhodes Drug Store, takes it one step further: “the older customers even call ‘em [the pharmacists] doctor.”

The consequences to the community of a closed pharmacy go beyond health care. Professor Gerald Doeksen at Oklahoma State University heads up the Operation Health Works project, which helps communities quantify the economic impacts of the health care sector. According to him, every job at a local pharmacy creates 1.2 to 1.6 other jobs in the community. And every dollar paid in salary generates 1.2 to 1.6 more dollars. For small, rural communities those numbers mean a lot.

And then there are what might be called the civic impacts. Paul Moore is a case in point. Originally a pharmacist, he went on to become hospital administrator and CEO. In all roles, he is a community leader and spokesperson on issues pertaining to health care. Indeed, because of their education, commitment, and connections to the community, pharmacists represent a valuable civic resource—one that would be sorely missed.

“When you pull any part of the health care sector out, the other parts look for better places to practice because they don’t have everything they need to take care of their patients,” said Moore. The pharmacist or the doctor, he explained, can move and get a job elsewhere; “it’s the community that will suffer.”

Charlie's Place: Helping Kids Stay Healthy

By Thomas D. Rowley

Young people in the tiny borough of Westfield, Pennsylvania — in rural Tioga County on the Allegheny Plateau—now have a place to go during the summer and after school where they can play, learn, cook, eat and even get help with their homework.

Charlie's Place is the result of a county-wide partnership aimed at promoting healthy behaviors in 10 to 15 year olds while also helping them to connect to their community and to develop good self-esteem. Community leaders in Westfield hope the center will help local youth combat obesity and avoid alcohol, tobacco, and substance abuse.

The center is named after former county commissioner and high school principle Charlie James who was instrumental in getting the idea going and rallying the community behind it. Charlie's Place is housed in a building donated by the borough that sits on the community park. Funding comes from a federal Office of Rural Health Policy outreach grant, with in-kind contributions and volunteer participation from some 200 individuals representing 28 organizations. It opened in September of 2001.

"We get around 20 kids a night. Some 75 different kids have come through the doors," said Tamara

Eberly, Executive Director of Tioga County Partnership for Community Health, which oversees Charlie's Place. "This really is a place where kids can go, feel a part of something, and develop good habits while they're at it. Plus, they are getting skills that they would never get any other way."

Eberly says that the many partners are key. For example, Laurel Health System, which owns the hospital, runs a "fit for life" program for the teens and pre-teens, running physical education activities, and teaching them about nutrition and how to cook.

Westfield is one of the poorest communities in the county and most of the participants are eligible for free lunch and breakfast programs. So, on top of teaching young people about good nutrition, the program feeds them a healthy supper as well.

Other partners include the county's Human Services Agency and its Development Corporation, the school district, Mansfield University, and individuals from the community. For staff, Charlie's Place relies on a program coordinator, a Vista volunteer, two part-time program assistants, and numerous volunteers.

According to Eberly, the community is more and more involved.

A big draw for the kids are the computers (two donated, three purchased), which they have used to design their own website and can use for help with homework. Since most do not have computers at home, and since their time online at school is quite limited, the computers at Charlie's Place are quite popular.

Down the road, Eberly hopes to open another center in a nearby community. Charlie's Place is also seeking national accreditation to help secure additional funding. Outside resources are a must, she said, in a community with so little money. Indeed, sustaining the program, said Eberly, is the biggest challenge.

Still, she is optimistic and has nothing but praise for the many partners: "It's our partners who are helping to keep the program alive, bringing their expertise. Everybody's willing to add a little piece. That's a real plus for us."

As for advice about how to replicate Charlie's Place, Eberly said "make sure you've got commitment from a broad continuum of your community. You'll find a way to make it work, if the community is behind you."

For more information, see the website designed by the Charlie's Place kids at www.geocities.com/charliesplaceone/.

Helping Residents Get to Care

In Huron County, Michigan, several agencies have joined together to make sure that area residents, especially seniors, have access to free transportation to their health care appointments.

- Senior Routes is a preplanned direct routing service that gets seniors to health and well-being appointments around the county. In addition to helping them access health care, it helps seniors maintain independence and frees them from driving in bad weather.

- Individualized Transport funds private transport for residents with fragile health conditions so that they can get to specialized services such as dialysis, cancer treatment, or high-risk pregnancy services. Individualized Transport can be used by residents of all ages who have exhausted their resources, cannot afford gas, do not have a driver or own an automobile, or cannot tolerate short bus rides.

These two programs have helped eliminate transportation barriers for residents living in rural areas of the county. The programs were supported by funds from the Rural Health Initiatives Non-Emergency Transportation Grants by the Michi-

gan Department of Community Health.

For more information, contact Karen Powell at (517) 355-8250.

Bringing Smiles to Rural Connecticut

A new mobile dental program in northeastern Connecticut hit the road on April 1, 2002, bringing oral health care to underserved populations in 12 of the 15 towns in rural Windham County. Because of the rural nature of the area, none of the towns has fluoride in their water.

“Across the Smiles” uses a 40-foot mobile unit that is fully equipped with two dental stations and is wheelchair accessible. The unit travels to public schools, recreational centers, Head Start programs, daycare sites, and community centers to provide routine preventive and restorative dental care. Prior to the van’s arrival, a screening process is completed in the schools to identify the children’s dental needs.

In addition, a “Read While You Wait” program has been started by local libraries for the patients. Program leaders also hope to start an educational program to help raise the awareness of oral health issues in the communities.

The program is operated by Generations Family Health Center, Inc., and is the result of a two-year planning process conducted by the Northeast Oral Health Initiative—an ad hoc committee of dedicated community leaders. Funding comes from the Connecticut Office of Health Care Access, the Connecticut Department of Social Services, and the Connecticut Department of Public Health. Others in the community have also lent support, providing sewage service, a garage to store the van, and power sources for the van to use at the various sites.

In its first three months of operations, the van has visited 22 sites and treated more than 325 children, many of whom have never been to a dentist and have many untreated cavities.

For more information, contact Dr. Margaret Smith at Margaret.ann.smith@penemco.com

Call for Input

Something newsworthy going on in your part of rural America? Send a one-paragraph summary to the editor at t-mrowley@juno.com.

A Targeted Look at the Rural Health Care Safety Net

The National Advisory Committee on Rural Health, April 2002

The report examines one of the key features of the modern rural health care system: the safety net—the web of professionals and institutions that provide care to the poor and uninsured regardless of ability of pay. It then looks closely at key safety net programs under the purview of the Secretary of Health and Human Services. Its findings fall into three categories: ensuring access to hospital services, ensuring access to primary care, and maintaining an adequate workforce.

Following a brief overview of the programs within each category, the Committee makes recommendations on how to improve the functioning of those programs. Recommendations range from encouraging the Secretary to work with Congress to raise the cap on Medicare DSH payments for rural hospitals to urging him to allow HHS to issue J-1 Visa Waivers.

In addition to recommendations that would help “mend” the net, the Committee suggests several ways the net might be “expanded.” These include such things as increasing

access to transportation, improving local public health services, and increasing health insurance coverage.

The report is available at <ftp://ftp.hrsa.gov/ruralhealth/NACReportbb.pdf>

An Update on Medicare+Choice: Rural Medicare Beneficiaries Enrolled in Medicare+Choice Plans Through September 2001

T. McBride, C. Andrews, A. Makarkin, and K. Mueller, Policy Brief PB2002-4, Rural Policy Research Institute, August 2002

Since passage of the Balanced Budget Act of 1997, enrollment in Medicare+Choice plans in all counties increased from 5.2 million persons in September 1997 to a peak of 6.3 million in September 1999, then declined to 5.6 million by September 2001. In addition, the number of risk contracts has dropped from a peak of 347 contracts in September 1998 to 179 contracts in October 2001, in part reflecting the exit of some plans that occurred during the 1999-2001 period.

This brief discusses Medicare+Choice enrollment in rural counties through September 2001 and plan entry and exit through January 2002.

Available at <http://www.rupri.org/healthpolicy> or by calling (402) 559-5260.

Tracking Medicaid Managed Care in Rural Communities: A Fifty-State Follow Up

P. Silberman, S. Poley, K. James, and R. Slifkin, *Health Affairs* 21 (4), 255-263, 2002

This study by the North Carolina Rural Health Research and Policy Analysis Center examines changes in rural Medicaid managed care strategies between 1997 and 2001. It shows that more rural counties were operating Medicaid managed care programs in 2001 than in 1997. Primary care case management (PCCM) programs continue to be the most prevalent rural Medicaid managed care program type, although the number of rural counties with fully capitated programs grew. Health plans are leaving rural Medicaid managed care programs, just as they are leaving urban areas. This has led some states with capitated programs to develop alternative managed care models, including enhanced PCCM programs.

Changes in the Balanced Budget Act, intended to encourage the growth of fully capitated Medicaid managed care programs, appeared to have little impact.

Reprints are available by calling (919) 966-5541.

The Proximity of Predominantly African American and Hispanic Rural Communities to Physicians and Hospital Services

D. Pathman, T. Konrad, and R. Schwartz, *Journal of Rural Health*, 18 (3), 416-27, Summer 2002.

This study assesses how local physician concentrations and distances to hospitals differ for rural communities of varying African American and Hispanic/Latino compositions. It uses data (primarily 1990) at the town-area level for nine southern and six western states to compare town-areas with low, medium, and high proportions of African Americans and Hispanics on their local physician-to-population ratios and distances to nearest hospital offering each of four levels of services.

Among the findings are that rural Hispanics, but not African Americans, face longer travel distances to

physicians, and both groups face longer distances to some types of hospital services than do non-minority rural individuals.

Reprints are available by calling (919) 966-5541.

Variance in the Profitability of Small-Town Rural Hospitals

J. Stensland and M. Milet, Project HOPE, Walsh Center for Rural Health Analysis, February 2002

The profitability of small-town rural hospitals varies widely from hospital to hospital. This study documents the variance in profitability and evaluates the characteristics that distinguish highly profitable small-town hospitals from struggling small-town hospitals. It also reports on strategies that small-town hospital administrators are using to achieve financial success and discusses public policy priorities for assisting small-town hospitals in rural America.

Among the findings are that patient volumes appear to explain a significant portion of the difference in small-town hospital profitability. No small-town hospital with fewer than 300 admissions was able to generate

significant profits and no small-town hospital with more than 2,500 admissions generated significant losses. Among the hospitals with between 300 and 2,500 admissions, there is a wide variance in profitability.

The case studies suggest that lower staffing levels and higher levels of visiting specialists can improve profitability. They also suggest that bad debt burdens can create significant financial strain.

Available at http://www.projecthope.org/CHA/rural/fs_hosp.pdf

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