Sec on CHCs

Gary is saying "linkages"

Challenge to be able to create a win-win — peers representing different com

Specialty care.

HPSA gave models

leverage communities to deal w/ indigent care problem —

States use tobacco $ Romance comm's States nuts doing it on their own.

State leveraging.
reduce
feds $ for planning
& development.

RWJ $17 million →
mirror Tompa
models.

comprehensive
services.

HealthGate Document

Record 1 from database: **HealthSTAR**

Order full text for this document

Title

Re-engineering the public hospital system: saving the safety net.

Author

Siegel B

Address

Tampa General Healthcare, Florida 33601, USA.

Source

Bull N Y Acad Med, 1996 Win, 73:2, 357-69

Abstract

Cities across America are grappling with the problem of how to provide care for the indigent and those on Medicaid. All levels of government are reducing their public funding for health care of indigent persons, and the rapid growth of managed care is making traditional cost-shifting more difficult as it transforms the practice of medicine itself. These issues are most acute in cities like Los Angeles and New York, which traditionally have relied on public hospital systems to serve as a safety net. This article focuses on the changes being wrought at the largest health-care system in the country for indigents, the New York City Health and Hospitals Corporation (HHC), on the progress it made during the first 18 months of a major re-engineering process, and on potential options for its future reform.

Language of Publication

English

Unique Identifier

97137176

Order full text for this document

MeSH Heading (Major)

Delivery of Health Care|EC/*OG; Hospitals, Public|EC/*OG; Hospitals, Urban|EC/*OG

MeSH Heading

Cost Allocation; Delivery of Health Care, Integrated|EC/OG; Financial Management; Financing, Government|EC; Health Care Reform; Hospital Restructuring; Human; Los Angeles; Managed Care Programs|EC; Medicaid; Medical Indigency|EC; Medical Staff, Hospital|EC; Medically Uninsured; New York City; Public Assistance|EC; Quality Assurance, Health Care; United States

---

Publication Type

JOURNAL ARTICLE

ISSN

0028-7091

Country of Publication

UNITED STATES

HealthGate Document

Record 1 from database: **HealthSTAR**

Title

Identify urban safety net hospitals and the populations they serve [abstract]

Author

Gaskin DJ; Hadley J

Address

Institute for Health Care Research and Policy, Georgetown University Medical Center, Washington, DC 20007, USA.

Source

Abstr Book Assoc Health Serv Res, 1997, 14:, 62-3

Abstract

RESEARCH OBJECTIVES: To assess the impact of potential Medicaid and Medicare policy changes on urban safety net hospitals (USN) provision of care to vulnerable populations. STUDY DESIGN: This study links 1991 and 1994 patient level information from hospital discharge abstracts from nine states with 1990 Zip code level data from the Census Bureau. The resulting data set allows us to develop profiles of the actual inpatient markets of hospitals. Each hospital market is characterized by its racial and ethnic composition, family structure, household income, poverty rate, educational attainment and employment status. Measures of hospital competition and HMO penetration are also calculated for each hospital. This analysis compares the market profiles of USN hospitals to those of other urban hospitals. We answer the following questions: 1) To what extent did the demographic and economic characteristics of persons residing in the geographic markets of USN hospitals differ from that of other urban hospitals? 2) To what extent were Medicaid and uninsured patients dependent upon USN hospitals for hospital care? 3) How did the role of USN hospitals in the provision of care to Medicaid and uninsured patients change between 1991-1994? 4) To what extent are USN hospitals exposed to hospital competition and managed care? 5) How have these market forces affected the role of USN hospitals? This analysis is unique because it defines a hospital's geographic market as the combination of Zip codes served by the hospital. All of the demographic, economic, and market structure variables are based on this patient origin market area. Previous studies have used county or MSA level demographic, economic, and market information to characterize hospital markets. PRINCIPAL FINDING: The 1991 market profiles indicate that USN hospitals serve disproportionately vulnerable populations and populations with special needs. USN hospitals' markets had higher proportions of minorities, non-English speaking residents, and persons living in non-traditional households. Adults residing in USN hospitals' markets were less educated, and more likely to be unemployed. Families in USN hospitals' markets had lower incomes and were more likely to be living at or below the federal poverty level. USN hospitals were located in more competitive hospital market. Compared to other urban hospitals, USN hospitals face similar levels of HMO penetration. The 1994 market profiles of USN and other urban hospitals have recently been added to our analysis files. Coupled with the 1991 market profiles, we anticipate discussing how the role of USN hospitals changed between 1991-1995, and whether increases in HMO penetration and hospital competition have affected their charity care mission. CONCLUSION: USN hospitals disproportionately serve vulnerable minority and low income communities that otherwise face financial and cultural barriers to health care. Public policies like Medicaid managed care that may adversely affect USN hospitals' financial status or erode their Medicaid patient base may in fact limit access for these vulnerable communities. RELEVANCE TO CLINICAL PRACTICE AND POLICY: Public

HELP WANTED FAIRY TALE CONSULTANT

HealthGate Document

Record 1 from database: **MEDLINE**

Order full text for this document

Title
What types of hospitals form the safety net?

Author
Fishman LE

Address
Office of Governmental Relations, Association of American Medical Colleges, Washington, DC, USA.

Source
Health Aff (Millwood), 1997 Jul, 16:4, 215-22

Abstract
This analysis describes hospitals that provide large amounts of uncompensated care and hospitals with sizable teaching programs, using data from the American Hospital Association. Despite current public financial support mechanisms, safety-net hospitals have a lower average total margin and a greater percentage with negative total margins than other groups of hospitals. For graduate medical education, however, the current public financial supports have assisted teaching hospitals with the largest training programs in maintaining their financial viability, although teaching hospitals' average total margins remain below those of nonteaching hospitals.

Language of Publication
English

Unique Identifier
97391361

Order full text for this document

MeSH Heading (Major)
Financing, Government|*SN; Health Care Surveys|*; Hospitals, Community|CL/EC/*SN/UT; Hospitals, Teaching|*EC; Medical Indigency|*SN; Uncompensated Care|*SN

MeSH Heading
American Hospital Association; Cost-Benefit Analysis|TD; Education, Medical, Graduate|EC; Forecasting; Human; Ownership; Social Welfare; United States

Publication Type
JOURNAL ARTICLE

ISSN
0278-2715

Country of Publication
UNITED STATES

HealthGate Document

Record 1 from database: **HealthSTAR**

possible model

Title
Refinancing Medicaid: one state's approach.

Author
Vancil DR; Shroyer LW

Address
Colorado Medicaid Program, Aurora, USA.

Source
Healthc Financ Manage, 1996 Mar, 50:3, 26-30

Abstract
In recent years, The Colorado Medicaid Program has initiated a number of new and innovative disproportionate share payment plans for hospitals. These initiatives are designed to increase access to hospital care for Colorado citizens, to ensure the future financial viability of key safety net hospitals, and to partially offset the state of Colorado's cost of funding the Medicaid program. Between 1991 and 1994, a net of $174 million in disproportionate share hospital payments was distributed to Colorado hospitals. A combination of hospital donations, voluntary contributions, intergovernmental agency transfers, and provider taxes raised a total of $579 million. The state of Colorado received $128 million through these special refinancing efforts. These payment efforts have had a major financial impact, and despite recent changes in Federal limitations on payments, other states may find a theoretical template for refinancing efforts in the Colorado model.

Language of Publication
English

Unique Identifier
96199049

MeSH Heading (Major)
Financial Management|*TD; Medicaid|*LJ; Outliers, DRG|*EC; State Health Plans|*EC

MeSH Heading
Colorado; Financing, Government; Hospitals, Public|EC/OG; Medical Indigency; Organizational Innovation; Reimbursement Mechanisms; United States

Publication Type
JOURNAL ARTICLE

ISSN
0735-0732

Country of Publication
UNITED STATES

HealthGate Document

Record 1 from database: **HealthSTAR**

Order full text for this document

Title

Medicaid's role in the health care safety net [abstract]

Author

Lillie Blanton M; Rowland D

Address

Kaiser Commission on the Future of Medicaid, 1450 G Street NW, Washington, DC 20005, USA.

Source

AHSR FHSR Annu Meet Abstr Book, 1996, 13:, 40-1

Abstract

BACKGROUND/OBJECTIVES: A key component of the nation's health care safety net -- Medicaid -- is at a critical juncture in its future. Budgetary pressures at the federal and state level are driving Medicaid restructuring efforts intended to reduce program spending while maintaining, if not improving coverage and access. Many states have sought waivers from federal Medicaid eligibility requirements in order to use Medicaid as a building block in their restructuring eforts. Managed care, in all its varying forms, has become the centerpiece of these restructuring efforts. This paper provides an overview of Medicaid's role as a safety-net insurance program for some of the nations poorest, sickest, and most disabled Americans and examines its role in several states presently restructuring their Medicaid programs by enrolling beneficiaries in managed care. The implications of the shift toward managed care on beneficiaries and safety-net providers are discussed. METHODS: Using preliminary data from the 1995 Kaiser/Commonwealth Low-Income Coverage and Access Surveys, we examine the impact of Medicaid restructuring initiatives on health coverage, health care arrangements (i.e., managed care vs. fee-for-service), and access to care in three states: Minnesota, Oregon, and Tennessee. Telephone interviews, conducted by Louis Harris and Associates, Inc., were held with approximately 2,000 low-income adults aged 18-64 in each state. Low-income households, defined as households with family income at or below 250% of poverty, were identified using random digit dialing. Interviews were obtained from 68 percent of the contacted households, yielding a total of 6,010 interviews in the three states. Data are weighted to represent the distribution of the low-income population in each state by gender, age, race/ethnicity, education, and adult household size. PRINCIPAL FINDINGS: In these three states, Medicaid is an extremely important source of health coverage for the low-income population, financing care for 1 in 4 nonelderly persons. Medicaid's role is also apparent when examining the size of the uninsured among the low-income population, which averaged 17 percent in these states compared to about 25 percent in the nation. Particularly striking are findings that two-thirds of the low-income population are enrolled in managed care, whether covered by Medicaid or private insurance. Within Medicaid, the enrollment in managed care is even higher, reaching three-fourths of program beneficiaries. The penetration rate varies by state, with the highest managed care enrollment in Tennessee. This shift to managed care has implications for where the low-income population obtains care, but in these states does not necessarily improve upon some access indicators. CONCLUSION/RELEVANCE: The Medicaid program has served as a major source of coverage for the low-income population and their health providers. Much of the care provided to program beneficiaries by safety-net institutions also subsidized the cost of care provided to the uninsured. Medicaid is a major source of funding for these safety-net providers, accounting for about 50 percent of the revenue to public hospitals and about a third of the revenues to community/migrant health centers. While the shift to managed

care presents opportunities -- such as the potential to improve access to a more coordinated system of care, it also presents challenges. Among the many challenges are how to finance care for the uninsured in a managed care environment and what options and resources are available for preserving safety-net providers for communities that remain unattractive to the emerging managed care industry. These are difficult choices and challenges that need to be moved to the forefront of the policy agenda.

Language of Publication
English

Unique Identifier
97604260

MeSH Heading (Major)
Managed Care Programs|*UT; Medicaid|OG/*UT; Poverty|*

MeSH Heading
Adolescence; Adult; Health Services Accessibility; Human; Medically Uninsured; Middle Age; Minnesota; Oregon; Tennessee; United States

---

Publication Type
ABSTRACT

Country of Publication
UNITED STATES

Return to the HealthGate Home Page.

9

HealthGate Document

Record 1 from database: **HealthSTAR**


Order full text for this document

possible model

Title
An empirical comparison of rural and urban safety-net hospitals.

Author
Gautam K; Campbell C; Barrington B
Address
Saint Louis University, USA.

Source
J Health Hum Serv Adm, 1997 Fal, 20:2, 217-29

Abstract
This study compares the characteristics of rural hospitals with urban safety-net hospitals and with "other urban hospitals" (non-teaching, non-safety-net urban hospitals that provide mainstream care in the United States). The objective is to examine if there are similarities between rural and urban safety-net hospitals, both of which serve underserved populations. The authors also wish to study if there are areas in which rural and urban safety-net hospitals are closer together compared to "other" urban hospitals. Based on the results, some potential areas of cooperation between rural and urban safety-net hospitals are discussed.

Language of Publication
English
Unique Identifier
98172873


Order full text for this document

MeSH Heading (Major)
Hospitals, Rural|EC/*OG/SN; Hospitals, Urban|EC/*OG/SN; Medical Indigency|*
MeSH Heading
American Hospital Association; Comparative Study; Cooperative Behavior; Financial Management, Hospital; Health Services Research|MT; Managed Care Programs; Organizational Affiliation; Poverty; United States

Publication Type
JOURNAL ARTICLE
ISSN
1079-3739
Country of Publication
UNITED STATES

HealthGate Document

Record 1 from database: **HealthSTAR**


Order full text for this document

Title

The future of the health care safety net in a changing environment [abstract]

Author

Mechanic RE; Baxter R

Address

The Lewin Group, Fairfax, VA 22031, USA.

Source

Abstr Book Assoc Health Serv Res, 1997, 14:, 133

Abstract

RESEARCH OBJECTIVE: To define the health care "safety net," describe how it differs across communities, understand financial and organizational pressures currently facing safety net providers and identify ways to support and strengthen safety net services. STUDY DESIGN: The study synthesized findings from interviews conducted during site visits to seven communities to analyze safety net issues and was supplemented with information from site visits in seventeen additional communities. The additional communities were not specifically focused on safety net issues, but included interviews with safety net providers, community advocates and public policymakers. A series of descriptive statistics was also compiled to support the analysis. PRINCIPAL FINDINGS: The concept of the "safety net" varies enormously acorss communities including: 1) the range providers and services considered to be part of the safety net; 2) the concentration or dispersion of indigent care; 3) the sources of financing and financial stability of safety net providers; 4) the level of community involvement and support; and 5) the participation of public versus private organizations. CONCLUSIONS: There are significant holes in the health care safety net. Many of these gaps could be addressed, to some degree by more effective coordination and linkages among safety net providers, other providers and the community. Safety net providers are also concerned about imminent financial pressures. In particular, the growth of Medicaid managed care and increasing competition for Medicaid patients by non-safety net providers is perceived as a major threat. Safety net providers are working to improve their operating efficiency and target resources more effectively. However, their flexibility to adapt quickly to changing market conditions is affected by local regulations, labor relationships, dependence on politically-driven funding mechanisms like disproportionate share and close medical school relationships. One potential danger of the new environment is that some of the operational strategies needed to compete successfully in the market for medical services may impact the ability of safety net providers' to provide critical (but not financially lucrative) services such as public health, behavioral health and social services. RELEVANCE TO PUBLIC POLICY AND HEALTH CARE DELIVERY: The vast differences in the "safety net" across communities reinforces the need for development of local solutions which take into account the unique assets, culture and capabilities found in individual communities.

Language of Publication

English

Unique Identifier

98605036


Order full text for this document

HealthGate Document

Record 1 from database: **HealthSTAR**

Title
Effects of health system changes on safety-net providers.

Author
Lipson DJ; Naierman N

Address
Alpha Center, Washington, DC, USA.

Source
Health Aff (Millwood), 1996 Sum, 15:2, 33-48

Abstract
Growing competition in health care markets and Medicaid managed care, combined with cuts in government funds that subsidize care to the uninsured, are challenging the viability of the safety net. In response to these pressures, "safety-net" providers in fifteen communities are integrating vertically and horizontally, contracting with or forming managed care plans, and seeking to attract paying patients. Such strategies appear to be successful for community-based primary care clinics, but other providers--including hospitals that cannot quickly develop primary care capacity, most local health departments, and providers that fail to attract Medicaid patients--are more vulnerable to health system changes. While the safety net may be intact now, access to care among the uninsured is more at risk in communities without state programs or local taxes that subsidize such care.

Language of Publication
English

Unique Identifier
96267797

MeSH Heading (Major)
Community Health Planning|*TD; Delivery of Health Care|*TD; Medically Uninsured|*; Organizational Innovation|*

MeSH Heading
Economic Competition; Health Services Research; Medicaid|OG; Social Welfare; United States

Publication Type
JOURNAL ARTICLE; MULTICENTER STUDY

ISSN
0278-2715

Country of Publication
UNITED STATES

HealthGate Document

Record 1 from database: **HealthSTAR**

Order full text for this document

Title
Safety net providers: teaching old dogs new tricks [abstract]

Author
Ross SL

Address
Division of Community Oriented Primary Care, Health and Hospital System, Parkland Memorial Hospital, Dallas, TX 75235, USA.

Source
AHSR FHSR Annu Meet Abstr Book, 1996, 13:, 41

Abstract
OBJECTIVES: Safety net institutions have traditionally provided primary, secondary and tertiary care that treated the disease and not its cause. Our programs are designed to change patient and staff expectations for care by implementing service improvements, proving disease management and positively impacting the health status of the individual and the community through the principles of community responsive care. CASE STUDIES: 1) Service improvements -- studies will be presented on specific patient service improvements in the areas of pharmacy, ambulatory care clinic, general medicine clinic and case management that resulted in decreased dwell time and improved patient and staff satisfaction; 2) disease management -- patient management and education programs in asthma, prenatal care and mammography have demonstrated reductions in emergency room visits and improved health outcomes; and 3) community responsive care -- several programs have been developed to address the need for community responsive care. Information will be provided related to the Community Oriented Primary Care Division, the Robert Wood Johnson Foundation supported "Reach Out Initiative," integrated health systems and injury prevention. RELEVANCE TO CLINICAL PRACTICE AND POLICY: The traditional role of the safety net provider should be changed to emphasize health and not disease. Creative ways to improve access and alter patients' behavior to allow measurable improvements in health status should be developed. Policies should reallocate resources to primary care, prevention and disease management.

Language of Publication
English

Unique Identifier
97604261

Order full text for this document

MeSH Heading (Major)
Community Health Services|*OG/ST; Primary Health Care|*OG; Quality Assurance, Health Care|*

MeSH Heading
Case Management; Disease Management; Health Services Accessibility; Human; Patient Satisfaction

HealthGate Document

Record 1 from database: **HealthSTAR**


Order full text for this document

Title

The emergency room as a usual source of care: permanent home vs. short-term safety net [abstract]

Author

Schur CL; Berk ML

Address

Project HOPE Center for Health Affairs, Bethesda, MD 20814, USA.

Source

Abstr Book Assoc Health Serv Res, 1997, 14:, 88-9

Abstract

RESEARCH OBJECTIVE(S): This study examines the characteristics of persons who use a hospital emergency room as their usual source of care (USOC) and, six months later, whether they continue to do so. This group is compared to persons with USOC in terms of service use and inability to obtain medical care, dental care, prescription drugs, mental health care and eyeglasses. STUDY DESIGN: The data come from the 1994 Robert Wood Johnson Foundation National Access to Care Survey and from the 1993 National Health Interview Survey. The RWJF survey was fielded in 1994 as a follow-up component to the 1993 NHIS. Vulnerable sub-populations were identified on the NHIS and then re-interviewed six months later. 450 follow-up interviews were conducted with a nationally representative sample of persons who reported on the 1993 NHIS that they used a hospital emergency room as their USOC. Also interviewed were persons with other care sites and persons who did not have a USOC. Data include demographics, insurance and health status, physician visits and hospitalization, and unmet need for care. PRINCIPAL FINDINGS: Earlier studies have suggested a chronic population of ER users who are more likely to be poor, racial/ethnic minorities, and uninsured; the concern is that care in an ER leads to less continuity of care and higher costs. Our findings suggest that the population using the ER as the USOC is quite dynamic. Of persons who initially reported the ER as their USOC, less than 20 percent reported six months later that the ER was still their regular site of care. In fact, those initially using the ER were twice as likely--at the 6-month followup interview--to have a physician's office as their USOC in the first interview, 37% were covered by private insurance, 27% by Medicaid, and 35% were uninsured. 87% reported being in good to excellent health and 35% were less than 18 years. Persons using the ER as the USOC were almost twice as likely as those in the general population to report not being able to obtain medical or surgical care, dental care, prescription drugs, eyeglasses, or mental health care in the preceding year. With the exception of dental care, they were also substantially more likely to report unmet need for services than those with no regular source of care. CONCLUSIONS: The study shows that those using the ER as their USOC are vulnerable with respect to medical care as well as supplementary services such as dental care and prescription drugs. The study also documents that the majority of those who use an ER for their USOC at one point in time do not do so for an extended period. RELEVANCE TO PUBLIC POLICY: Policymakers in both the public and private sector have tried to discourage use of the hospital emergency room for routine medical care. Managed care programs often prohibit use of a hospital ER for routine care; the amount of charity care may be declining as some ERs limit access in order to reduce cost. While the use of other sites of care as a USOC may increase continuity of care and decrease the likelihood of having unmet needs for health care services, it will be difficult to eliminate the role of the hospital ER in providing routine

care since the population using it is not static. Only a very small number of Americans continuously use the ER for routine medical care. The ER may serve as a short-term safety net for persons temporarily unable to access care through a physician's office.

Language of Publication
English

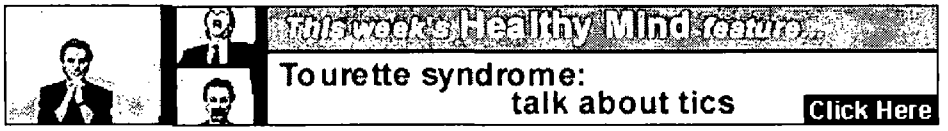
Unique Identifier
98604940

MeSH Heading (Major)
Emergency Service, Hospital|*UT; Health Services Accessibility|*

MeSH Heading
Data Collection; Human; Insurance, Health

Publication Type
ABSTRACT

Country of Publication
UNITED STATES



Return to the HealthGate Home Page.

HealthGate Document

Record 1 from database: **HealthSTAR**

Order full text for this document

Title
The evolution of support for safety-net hospitals.

Author
Fishman LE; Bentley JD

Address

Source
Health Aff (Millwood), 1997 Jul, 16:4, 30-47

Abstract
The federal government, mostly through the Medicare and Medicaid programs, has created and maintained a set of structural mechanisms to support uncompensated care and clinical education: disproportionate-share hospital payments and direct and indirect graduate medical education payments. This paper provides a history of how these traditional supports have evolved. We note that the need to reduce federal and state spending threatens the level of these payments, while changes in the health care delivery system highlight a range of design and technical inadequacies in the current support mechanisms.

Language of Publication
English

Unique Identifier
97391342

Order full text for this document

MeSH Heading (Major)
Hospital Restructuring|*EC; Hospitals, Teaching|*EC/UT; Medicaid|*EC; Medical Indigency|*EC; Medicare|*EC; Uncompensated Care|EC/*TD

MeSH Heading
Cost Control|TD; Education, Medical, Graduate|EC; Financing, Organized|TD; Forecasting; Human; Managed Care Programs|EC/TD; Poverty; Social Welfare; United States

Publication Type
JOURNAL ARTICLE; REVIEW; REVIEW, TUTORIAL

ISSN
0278-2715

Country of Publication
UNITED STATES

HealthGate Document

Record 1 from database: **HealthSTAR**

Title
The safety-net role of international medical graduates.

Author
Mick SS; Lee SY

Address
University of Michigan Department of Health Management and Policy, School of Public Health, Ann Arbor, USA.

Source
Health Aff (Millwood), 1997 Jul, 16:4, 141-50

Abstract
Abstract unavailable online.

Language of Publication
English

Unique Identifier
97391352

MeSH Heading (Major)
Foreign Medical Graduates|SN/*UT; Medical Indigency|*TD; Medically Underserved Area|*

MeSH Heading
Forecasting; Human; Social Welfare; Support, U.S. Gov't, P.H.S.; United States

Publication Type
JOURNAL ARTICLE; REVIEW; REVIEW, TUTORIAL

ISSN
0278-2715

Country of Publication
UNITED STATES

HealthGate's MedBook Store.com
Buy your Medical Books for LESS at the HealthGate MedBookStore...

Return to the HealthGate Home Page.

9

HealthGate Document

Record 1 from database: **HealthSTAR**


Order full text for this document

Title
Tennessee's failed managed care program for mental health and substance abuse services.

Author
Chang CF; Kiser LJ; Bailey JE; Martins M; Gibson WC; Schaberg KA; Mirvis DM; Applegate WB

Address
Fogelman College of Business and Economics, University of Memphis, TN 38152, USA. cchang@cc.memphis.edu

Source
JAMA, 1998 Mar, 279:11, 864-9

Abstract
In July 1996, Tennessee initiated a managed mental health and substance abuse program called TennCare Partners. This publicly funded "carve-out" experiment started chaotically and soon deteriorated into a crisis. Many patients did not receive care or lost continuity of care, and the traditional "safety net" mental health system nearly disintegrated. This qualitative case study sought to ascertain the impact of the TennCare Partners program. It points out that the program's difficulties stemmed directly from a flawed design that spread funds previously earmarked for severely mentally ill patients across the entire Medicaid population. States contemplating similar reforms should strive to protect vulnerable patients by risk-adjusting capitation payments and by focusing resources on care for severely mentally ill persons. States should also minimize program complexity and ensure the accountability of managed care networks for their patients' behavioral health care needs.

Language of Publication
English

Unique Identifier
98175757


Order full text for this document

MeSH Heading (Major)
Managed Care Programs|*OG; Medicaid|*OG; Mental Health Services|EC/*OG; State Health Plans|*OG

MeSH Heading
Adult; Aged; Capitation Fee; Case Management; Human; Medical Indigency; Mental Disorders|TH; Middle Age; Program Evaluation; Risk Management; Substance Abuse Treatment Centers|EC/OG; Substance-Related Disorders|TH; Tennessee; United States

Publication Type
JOURNAL ARTICLE