FLORIDA STATE UNIVERSITY

LOCAL INNOVATIONS IN HEALTH CARE FOR THE UNINSURED:

A Comparison of Existing Public/Private Community Initiatives
to Establish Action Recommendations for Florida’s Local Governments

AN ACTION REPORT SUBMITTED TO
THE FACULTY OF THE COLLEGE OF SOCIAL SCIENCES
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REUBIN O’D. ASKEW SCHOOL
OF PUBLIC ADMINISTRATION AND POLICY

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December 2, 2004
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Senator Durell Peaden, Jr.
Chair, Subcommittee on Health & Human Services
598 North Ferdon Boulevard
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Senator Peaden:

Upon your request as a member of the Governor’s Task Force on Access to Affordable Health Insurance I submit to you LOCAL INNOVATIONS IN HEALTH CARE FOR THE UNINSURED: A Comparison of Existing Public/Private Community Initiatives to Establish Action Recommendations for Florida’s Local Governments.

The six public/private community initiatives identified in this report as programs that share financial and service responsibility for health care to low-income, uninsured populations in their geographic regions are 1) Boston HealthNet Pilot Plan, 2) Wishard Advantage, 3) Ingham Health Plan, 4) Hillsborough County HealthCare Plan, 5) JaxCare, and 6) CareNet.

With the State of Florida’s commitment to assist local communities in addressing the uninsurance problem of their respective counties, a look into public/private partnerships demonstrates the State’s responsiveness to the changing face of health policy. This report advances Florida’s commitment to the exploration of all possible options for addressing the health care needs of Floridians and provides an illustration of what can be achieved when governments and private providers work together to address health care for indigent residents.

Respectfully,

Joy Fulton
A report submitted Tuesday in Tallahassee to the Governor’s Task Force on Access to Affordable Health Insurance has reviewed six so-called “public/private community initiatives” that have been created to address the growing number of low-income, uninsured residents of communities scattered throughout the country.

Plans in Boston, Massachusetts; Marion County, Indiana; Ingham County, Michigan; Hillsborough County, Florida; Duval County, Florida; and Leon County, Florida are being viewed as possible program models that Florida’s local governments may be able to adopt to address the needs of their indigent populations.

The six initiatives offer access to primary health care for residents who qualify based on their income levels. The Poverty Level Guidelines published yearly by the federal government are utilized to determine an individual’s eligibility and each initiative differs in its income requirements. The specific services covered, financing sources, and administrative entities also varies with each program.

The report is said to be part of an ongoing investigation into what steps the State Legislature will need to take in this year’s session to service Florida residents’ health care needs in a time of limited funding.
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EXECUTIVE SUMMARY

PROBLEM: Access to Health Care for the Low-Income, Uninsured Population

A community’s high rate of uninsurance can adversely affect the overall health status of the community, the financial stability of its health care institutions and providers, and the access of its residents to services, such as emergency departments and trauma centers (Institute of Medicine [IOM], 2004). Communities throughout the nation are rethinking health care delivery and financing for low-income, uninsured residents. This report reviews public/private community initiatives that share financial and service responsibility for the delivery of health care to the indigent population and makes action recommendations emphasizing practical policy options for Florida’s local governments.

FOCUS ON THE COMMUNITY

The ability of local governments to identify private resources to assist in the development of health care initiatives for low-income, uninsured residents comes at a time when federal and state funding of existing health care programs are under scrutiny due to the fiscal shortfalls brought on by a downturn in the United States economy. Recognizing the potential for continuing decreases in funding of public programs for the uninsured, communities are exploring the development of partnerships with the private sector to take care of this growing population.

METHODS

Information for this report was compiled using federal, state, and local government websites; library databases; and health policy organization and foundation websites. A comparison of the literature aided in development of action recommendations.

COMMUNITY INITIATIVES REVIEWED

The six public/private community initiatives identified for this report are as follows:

1. Boston HealthNet Pilot Plan—Boston, Massachusetts
2. Wishard Advantage—Marion County, Indiana
3. Ingham Health Plan—Ingham County, Michigan
4. Hillsborough County HealthCare Plan—Hillsborough County, Florida
5. JaxCare—Duval County, Florida
6. CareNet—Leon County, Florida

Each initiative was evaluated against four criteria: eligibility requirement(s), funding mechanism(s), program administration, and political support.
RECOMMENDATIONS

Considering Florida’s geographic, economic, and demographic diversity, the Boston HealthNet Pilot Plan and Wishard Advantage do not provide a framework of service delivery that would benefit Florida’s local governments in their quest to care for an indigent population.

In a Florida community that houses more than one hospital that is not public or a teaching institution, the Ingham Health Plan model could provide the needed framework for setting up access to care for the low-income, uninsured population. Political support for amendments to the state’s Medicaid plan would be necessary to direct funds to this type of program.

The use of the Hillsborough County HealthCare Plan model could be a feasible option for Florida’s larger counties with a population of at least 800,000 residents due to its funding structure being defined in the Florida Statutes Section 212.055(4) (2004). It is unclear how this approach might be implemented in smaller counties with a restricted tax base.

JaxCare stands in the forefront as the community initiative that incorporates the greatest amount of private sector support from inception to implementation of the program. This model is suitable for Florida counties with a large base of indigent, working uninsured individuals and small businesses.

CareNet could be implemented in any Florida county that currently has a volunteer network of care to service its low-income, uninsured residents. Political support for implementing an additional property tax would be necessary to fund this type of program.
I. PROBLEM STATEMENT

Today there are approximately 45 million Americans without health insurance (United States Census Bureau, 2004). As for the population of uninsured persons in Florida, the Kaiser Family Foundation (2004), utilizing 2001 and 2002 state data, estimate that 2,849,880 Floridians or 17 percent of Florida’s total population of 16,349,150 are uninsured. A substantial body of research shows that there are serious health and financial consequences associated with not having health insurance. However, despite these findings the number of uninsured Americans continues to grow.

According to Diane Rowland, Executive Vice President and Executive Director of the Kaiser Commission on Medicaid and the Uninsured (2004), the uninsured are predominately adults from low-income working families—three-quarters of the uninsured are between the age of 18 and 65; two-thirds have incomes below 200 percent of the Federal Poverty Level (FPL) or $28,696 for a family of three in 2002; and the majority, eight in ten, come from working families (Figure 1). In most of these cases, the worker holds a job that does not offer health insurance (IOM, 2004). In others subsidized coverage may be offered, but the employee declines due to the cost or because they do not perceive the need for coverage. Individual health policies are expensive and may be unavailable for those who have a pre-existing health condition. Young adults often lose eligibility under their parents’ policies when they reach age 19 or graduate from college. Spouses lose coverage under a family policy via separation, divorce, retirement, or upon death of the policyholder.

Uninsured children and adults alike suffer worse health and die sooner than those with insurance (IOM, 2004). Lack of insurance results in less preventative care, delayed diagnosis,
and once diagnosed these individuals tend to receive less therapeutic care and have higher mortality rates than the insured.

Having even one uninsured person in a family can jeopardize that family’s financial stability and health (IOM, 2004). People without health insurance pay about 35 percent of their medical bills themselves. The remaining costs of uncompensated care, also known as charity care, are largely borne by taxpayers through subsidies to hospitals and clinics. State and local government capacity to finance health care for uninsured persons is most limited during economic downturns precisely when the need is greatest.

The Institute of Medicine (2004) reports that the persistence of sizable uninsured populations in many communities in the United States has important local effects. These include: 1) significant financial strain on health care providers and institutions that can lead to loss of valuable community resources such as trauma centers or physician practices, and 2) redirection of funds to the uninsured away from core public health programs that address the control of communicable diseases and emergency preparedness.

A number of communities in Florida have designed and implemented coverage models to provide care for the uninsured population in their geographic regions (Governor’s Task Force on Access to Affordable Health Insurance [Task Force], 2004). Some local initiatives utilize taxing authority authorized by Section 212.055(4) Florida Statutes (2004) to fund their programs. Other communities have developed public/private partnerships or have established volunteer programs within their counties and municipalities to make health care coverage available to the uninsured in their areas.

Communities throughout the nation are rethinking health care delivery and financing for low-income, uninsured residents. The purpose of this report is to review public/private
community initiatives and partnerships that share financial and service responsibility for the
delivery of health care to the low-income, uninsured populations in their geographic regions and
make action recommendations emphasizing practical policy options for Florida’s local
governments.

The Community Tracking Study (CTS) developed by the Center for Studying Health
System Change will be utilized for the examination of national data. The CTS is a longitudinal
study that tracks changes in local health care systems nationwide through the use of in-depth
surveys and comprehensive site visits (Nichols, Ginsburg, Berenson, Christianson, & Hurley,
2004). The twelve communities being evaluated are as follows: Boston, Massachusetts;
Cleveland, Ohio; Greenville, South Carolina; Indianapolis, Indiana; Lansing, Michigan; Little
Rock, Arkansas; Miami, Florida; Northern New Jersey; Orange County, California; Phoenix,
Arizona; Seattle, Washington; and Syracuse, New York.

To facilitate the study of community health care initiatives in Florida, existing
public/private partnerships for the low-income, uninsured will be identified and analyzed on a
per county basis. Action recommendations will be derived by illuminating the structure,
strengths, and weaknesses associated with each of the programs.

II. LITERATURE REVIEW

While health economists debate the overall effect of rising health expenditures, several
believe that our national health care system is at a breaking point including many stakeholders in
Florida (House Select Committee on Affordable Health Care for Floridians, 2004). Escalating
health care costs have vast economic, political, and social repercussions that cannot be ignored.
Enormous amounts of literature exist to address each of these concerns, however the focus for
this report will be on the challenges and repercussions facing communities in their quest to care for the uninsured.

The recent explosion of health policy literature that examines community initiatives (Cunningham & Kemper, 1998a; Cunningham & Kemper, 1998b; Felland & Lesser, 2000; Hendryx, Ahern, Lovrich, & McCurdy, 2002; Norton & Lipson, 1998) comes at a time when federal and state funding of existing health care programs are under scrutiny due to the fiscal shortfalls brought on by a downturn in the United States economy after the attacks of September 11, 2001. Recognizing the potential for continuing decreases in funding of public programs for the uninsured, policy makers are exploring a plethora of ideas to take care of a growing population.

The most accurate illustration on the numbers of the uninsured in this country come from the U.S. Census Bureau’s report *Income, Poverty, and Health Insurance Coverage in the United States: 2003* (2004). This report presents the data on health insurance coverage based on information collected in the 2004 Annual Social and Economic Supplement to the Current Population Survey. An estimated 15.6 percent of the population, or 45.0 million people were without health insurance coverage in 2003, up from 15.2 percent and 43.6 million people in 2002.

The breakdown of this information reveals a cycle of what takes place with health insurance coverage during times of economic hardship. The percentage and number of people covered by employment-based health insurance fell between 2002 and 2003 from 61.3 percent or 175.3 million to 60.4 percent or 174.0 million (U.S. Census Bureau, 2004). The percentage and number of people covered by government health insurance programs increased between 2002 and 2003 from 25.7 percent or 73.6 million to 26.6 percent or 76.8 million. These numbers were
driven by increases in the number of people covered by Medicaid (33.2 million in 2002 and 35.6 million in 2003) and Medicare (38.4 million in 2002 and 39.5 million in 2003).

When individuals lose health insurance coverage in the private market either through the loss of a job, an employer canceling coverage, or a dramatic increase in premiums, one of two things happen: individuals qualify for health insurance coverage provided by public programs or they assess the risk of not having health insurance and decide to go without coverage.

As for coverage provided by public programs, Medicaid and the State’s Children’s Health Insurance Program (SCHIP) help fill in the gaps for some of the lowest income people, but this publicly sponsored coverage is directed primarily at children and pregnant women and varies in availability across the states (Rowland, 2004).

Individuals who decide to forgo the cost of coverage in the private market may make a change of lifestyle to accommodate being without health insurance that affects not only themselves, but also their families and communities. In a report released by Covering Kids & Families (2001), one in every five parents of uninsured children has or would keep their children out of a sporting or athletic event because of fear that their kids might get injured and they would have no way of paying for their care. In the context of the community, school districts in at least 23 states prohibit uninsured students from participating in athletic activities.

Knowing that accidents happen and the common cold never stays with one person, individuals who do not have health insurance look to the emergency rooms of their local hospitals for care. Research by Hadley and Holahan (2004), the House Select Committee on Affordable Health Care for Floridians (2004), the IOM (2004), and Norton and Lipson (1998) breakdown the cost of providing emergency room services and hospital care to the uninsured in terms of the strain it places on the government. With the primary source of funding for
uncompensated care coming from government dollars, projected federal, state, and local spending available to pay for the care of the uninsured in 2004 is $34.6 billion—about 85 percent of the total bill that will be accumulated for caring for the uninsured (Hadley & Holahan, 2004). Taxpayers, the physicians providing charity care, and those who have insurance, will pay for the other 15 percent of the uncompensated care bill.

Many facilities and providers cannot afford to absorb the cost of charity care and have consequently closed or stopped providing it. As a result according to Reed, Cunningham, and Stoddard (2001) there was a 4 percent decrease in the number of providers supplying charity care between 1996 and 1999.

To illustrate how the cost of paying for the uninsured directly affects the premiums insured individuals pay as a result of how hospitals make up for the loss of revenue, a report by the State Coverage Initiatives Program (2004) explains:

The overall cost of free care and bad debt (debt written off by providers due to non-payment for care provided) through the nation’s charity hospitals, clinics, and individual providers may be much greater than…[previous] estimates due to cost-shifting in the system. Cost-shift is the practice of charging higher rates to one set of patients (usually privately insured) to make up for revenue lost on another set (publicly insured or uninsured patients). States are becoming more sophisticated in measuring the impact of free care or bad debt, using it to better understand the impact of the uninsured on the overall health care system (including on [sic] employers). (p. 21)

The loss of the providers of care for the medically indigent, coupled with escalating health care costs passed onto the insured by the remaining providers leaves policy makers questioning the structure of the commonly defined “safety net” in their communities. Norton
and Lipson (1998) define the health care safety net as consisting of inpatient and ambulatory health care providers that are legally obligated to provide care for those who cannot afford to pay for it. It includes public and private nonprofit hospitals, public health departments, community health clinics, and federally qualified health centers. These clinics are entitled by federal law to receive cost-based Medicaid reimbursement because they meet certain criteria for community involvement and are dedicated to providing care to all in need. The problem with the current safety net structure revolves around government reimbursement and the recurring theme among the reviewed literature denotes fiscal uncertainty with this system.

Aware of the reimbursement strategies safety net providers are utilizing, as well as the uninsured population’s lack of access to preventive and primary care, policy makers are examining local innovations in restructuring and/or expanding community safety nets in order to keep up with the growing number of the uninsured, the changing health care marketplace, and the evolving financing structure. The principal policy research organization for this type of health care policy is the Center for Studying Health System Change (HSC).

Understanding the economic health and capacity of community safety nets is important and represents one of the primary areas of health system change that HSC has been tracking through its CTS site visits every two years since the study’s inception in 1996 (Felland, Kinner, & Hoadley, 2003). The twelve nationally representative communities of the CTS are Boston, Massachusetts; Cleveland, Ohio; Greenville, South Carolina; Indianapolis, Indiana; Lansing, Michigan; Little Rock, Arkansas; Miami, Florida; Northern New Jersey; Orange County, California; Phoenix, Arizona; Seattle, Washington; and Syracuse, New York.

Felland, Lesser, Staiti, Katz, and Lichiello’s (2003) examination of how market and policy pressures affected the safety net providers of the CTS communities between 1996 and
2001 reveals that the pressures felt by the safety net providers and their responses have varied due to underlying conditions in the individual communities. The safety net in three-quarters of the communities (Boston, Indianapolis, Lansing, Miami, Greenville, Phoenix, Orange County, Seattle, and Syracuse) was stable or improved by the end of the study period, leading to improved access to primary and preventive care for the low-income, uninsured. However, the safety net in three sites (Cleveland, Northern New Jersey, and Little Rock) deteriorated.

One of the key ways safety net providers strengthened their financial viability was to implement strategies that focused on improving efficiencies and increasing direct and indirect revenues to support charity care (Felland, Lesser, Staiti, et al., 2003). Safety net leaders lobbied for increases in funding from all levels of government and private foundations. Second, some communities worked to extend the pool of providers to care for the uninsured which was part of the third successful strategy—encouraging the uninsured to seek more primary and preventive care. In turn this would reduce reliance on emergency room departments and pass a cost savings on to these communities.

The three sites of the CTS study that experienced a deterioration of their safety nets were unsuccessful in their attempt to expand their provider networks as private market forces of intense competition impeded their attempt to attract providers to care for an indigent population (Felland, Lesser, Staiti, et al., 2003). Without provider support for expansion of safety net programs, adequate funding to reinforce these safety net providers was not available and the viability and capacity of these programs within the Cleveland, Northern New Jersey, and Little Rock communities declined between 1996 and 2001.

Information gathered from this analysis of the safety net providers of the CTS during a time of economic uncertainty with strained public funding, welfare reform, and the
implementation of Medicaid managed care, illustrates the innovation of communities in the face of adversity. Of the nine communities that Felland, Lesser, Staiti, et al. (2003) define as being stable or improving by the end of the study period, three—Boston, Indianapolis, and Lansing—are engaged in public/private partnerships to provide a system of health care for the low-income, uninsured. The Boston HealthNet Pilot Plan for Boston Medical Center patients; the Wishard Advantage program for Marion County, Indiana residents; and the Ingham Health Plan for Ingham County, Michigan residents will be utilized in this report as an example of community innovation outside the state of Florida.

III. METHODOLOGY AND EVALUATIVE CRITERIA

Methodology

A comparative literature review is the chosen methodology for this report with information being assembled from the following electronic data sources:

- Academic literature was accessed using the Ovid, InfoTrac OneFile, and ProQuest databases;
- The Worldwide Web was utilized to obtain government reports from the U.S. Census Bureau and the Florida Agency for Health Care Administration;
- Topic papers on the uninsured population were downloaded from relevant health policy foundations and organizations such as the Kaiser Family Foundation, the Center for Studying Health System Change, and the Urban Institute; and
- Online Sunshine, the official Internet site of the Florida Legislature, provided the necessary links in order to analyze applicable Florida Statutes.

The qualitative research methods used in this report constitute the collection of secondary data to develop action recommendations for Florida’s local governments.
The analysis of the collected data reveals the U.S. Census Bureau’s report *Income, Poverty, and Health Insurance Coverage in the United States: 2003* (2004) to be the only quantitative portion of this project.

A review of how information on the uninsured population was assimilated on the Internet sites of the health policy foundations and organizations led to an exploration of their funding sources to examine the possibility of bias in their research. The accumulation of federal grant funding streams and private philanthropic donations does not lead one to a definitive answer when trying to validate the reliability of a data source. However, the information produced by the foundations and organizations accessed for this report have been replicated in other scholarly journals such as JAMA, The Journal of the American Medical Association, and used by the State of Florida’s Governor’s Task Force on Access to Affordable Health Insurance.

**Evaluative Criteria**

The public/private partnerships identified for this project, while not exhaustive in the sense of community initiatives, were intended to represent government and private sector collaborations that communities had undertaken to finance, organize, and provide health care for their low-income, uninsured residents. In addition, the following four criteria guided the decision for inclusion in this report:

- **Eligibility Requirement(s)** are the defining element in these programs. To qualify individuals must not be eligible for public insurance such as Medicaid and Medicare (Andrulis & Gusmano, 2000). These community initiatives are designed to serve as “payers of last resort” and as a result, they often incorporate screening for Medicaid and other government programs as part of the enrollment process. Due to the enrollment structure of public insurance, these programs
followed suit and established eligibility requirements based on an individual’s income as a percent of the Federal Poverty Level (FPL) (Figure 2).

- **Funding Mechanism(s)** are the significant difference between these community initiatives and those that base their programs on a volunteer network. Each of the programs included in this report have an identified funding stream. The variation in financing techniques between the programs illustrates the innovation of each community in their efforts to extend health care access to a needy population.

- **Program Administration** refers to the public and private agencies and institutions that oversee these programs. The inclusion of this criterion allowed for single-entity programs, such as hospital community clinics, to be excluded from this report.

- **Political Support** for the development and preservation of these public/private community initiatives. This criterion allowed for the exploration of the political landscape in which these programs originated and have been maintained.

The criteria selected represent the major elements of what substantiates these public/private community initiatives from the original safety net providers. By identifying the funding mechanisms and program administration of each initiative, Federally Qualified Health Centers, local health departments, and volunteer care networks could be eliminated from inclusion in this report.

**IV. MANAGEMENT POLICY OPTIONS**

The six public/private community initiatives identified for this report as programs that share financial and service responsibility for health care to low-income, uninsured populations in their geographic regions are 1) Boston HealthNet Pilot Plan, 2) Wishard Advantage, 3) Ingham
Health Plan, 4) Hillsborough County HealthCare Plan, 5) JaxCare, and 6) CareNet. Each program was evaluated based on the previously defined criteria and a description of the structure, strengths, and weaknesses of each initiative will lead to action recommendations for Florida’s local governments.

As for the services offered by the initiatives, each program builds upon a comprehensive package that includes outpatient, inpatient, emergency, and specialty care (Andrulis & Gusmano, 2000). Each offers some form of care management that enhances early detection of medical problems, promotes preventive care, and reduces inappropriate utilization of emergency room and inpatient services. These programs aim to improve health and lower costs by reducing care in improper settings while eliminating avoidable illnesses and hospitalizations (Silow-Carroll, Anthony, Seltman, & Meyer, 2001).

Initiative 1: Boston HealthNet Pilot Plan

The Boston City Hospital established the Boston HealthNet Pilot Plan in November 1995 (Andrulis & Gusmano, 2000). Originally the program was to be a voluntary plan for patients who qualified for the State of Massachusetts Free Care program and was developed as a prototype for the hospital’s Medicaid managed care plan. However, in July 1996 Boston City Hospital merged with Boston Specialty and Rehabilitation Hospital and Boston University Medical Center Hospital to form Boston Medical Center (BMC). With the merger, BMC and its fourteen affiliated community health centers became the largest safety-net provider in the state.

As a hospital trying to compete with commercial managed care companies poised to capture a large patient base with Medicaid managed care coming onto the health care scene, the Boston HealthNet Pilot Plan morphed into a business strategy. BMC was going to use the pilot program as a place to “capture” Medicaid eligible patients and then automatically enroll them
into the hospital’s Medicaid managed care plan once the program became operational. However, that fell through when the Health Care Financing Administration denied them the right to automatically transfer patients from one program to the other.

Struggling for market share and recognizing the constraints of Medicaid eligibility, the Boston HealthNet Pilot Plan is no longer primarily for those who are potentially eligible for Medicaid (Andrulis & Gusmano, 2000). It has evolved into a program for individuals who are in transition between health insurance plans and those who are not categorically eligible for the state’s Free Care program.

**Eligibility Requirement(s)**

Under this program individuals must verify their residency status for the state of Massachusetts and have a family income below 200% of the FPL to be eligible for full free care (Andrulis & Gusmano, 2000). Individuals with family incomes between 200% and 400% of the FPL are eligible for subsidized care on a sliding fee scale.

**Funding Mechanism(s)**

The amount to cover the receipt of care is drawn from the state’s Free Care Pool and varies according to demand for services (Silow-Carrool et al., 2001). According to Andrulis and Gusmano (2000) the hospitals must fund $215 million dollars of the pool. Since July 1997, private sector payers that do business in Massachusetts such as insurers, HMOs, and third party administrators have also been required to contribute directly to the Free Care Pool. The Pool also receives another $30 million from the state in the form of federal government participation funds.
Program Administration

BMC employees at the medical center and the affiliated community health centers are trained to approach and assist prospective applicants in the enrollment process for the Boston HealthNet Pilot Plan (Andrulis & Gusmano, 2000).

Political Support

As noted by Andrulis and Gusmano (2000) there is strong political support for the program. The Mayor of Boston claims BMC to be “his” hospital and backs their community initiative efforts. The State of Massachusetts Division of Health Care Financing and Policy are supporters of managed care and commend BMC’s efforts to incorporate it into their operations.

Initiative 2: Wishard Advantage

The Health and Hospital Corporation (HHC) of Marion County, Indiana created the Wishard Advantage program in 1997 (Andrulis & Gusmano, 2000). It is a managed care program for low-income, uninsured residents of Marion County, Indiana.

Andrulis and Gusmano (2000) report that the Mayor of Indianapolis and HHC officials wanted to improve the efficiency of the public hospital system while reducing the amount of duplicative funding for episodic, hospital-based care and shift the emphasis to primary and preventive care. With this goal established, HHC officials concluded that a managed care approach for services provided to indigent patients would lead to greater continuity and management within the hospital system and thus the Wishard Advantage program was born.

Eligibility Requirement(s)

Individuals must be a Marion County resident, not qualify for any other type of health care assistance program, and have an annual income at or below 200% of the FPL (Andrulis & Gusmano, 2000). There are no cost sharing mechanisms for enrollees with incomes at or below
150% of the FPL. Patients with incomes between 150% and 200% of the FPL are charged for their medical care on a sliding scale basis.

**Funding Mechanism(s)**

Andrulis & Gusmano (2000) found that HHC used $20 million in federal disproportionate share (DSH) matching funds to capitalize the program and finances it through city and county property taxes.

**Program Administration**

HHC of Marion County has primary responsibility for the administration of Wishard Advantage (Andrulis & Gusmano, 2000). The recent establishment of a community board helps guide the policy issues for the program.

**Political Support**

HHC officials claim that there is strong support for Wishard Advantage from the Mayor of Indianapolis, but that the state does not pay a great deal of attention to the program (Andrulis & Gusmano, 2000). However, the Governor has been supportive of their requests for assistance and has used his political leverage against the Board of Trustees at the Indiana University Medical School when they threatened not to be supportive of the use of their physicians in the Wishard Advantage program.

**Initiative 3: Ingham Health Plan**

The Ingham County Health Department launched the Ingham Health Plan (IHP) on October 1, 1998 (Silow-Carroll et al., 2001). It is a health coverage program for low-income, uninsured residents of Ingham County, Michigan who are not eligible for Medicaid or other public coverage programs.
The idea for IHP was decided by county officials who were considering several options to improve access to care for uninsured residents in the face of the Medicaid managed care movement of the mid-1990s (Silow-Carroll et al., 2001). At that time estimates of Ingham County’s uninsured population, which includes Lansing, were at 10% of the county’s total population and officials wanted to make the best investment of limited financial resources.

According to Silow-Carroll et al. (2001) IHP is not an insurance product, but a program that provides a defined set of outpatient services to enrollees. Services must be provided at participating locations by participating providers and the program links enrollees to a regular and consistent source of primary care.

**Eligibility Requirement(s)**

IHP enrolls former members of the State Medical Plan and previously uninsured individuals with incomes below 250% of the FPL (Silow-Carroll et al., 2001). The requirements of the State Medical Plan limit enrollment to individuals with monthly incomes of less than $263 who do not qualify for Medicaid. As for the cost sharing methods of IHP, formerly uninsured individuals have a copayment of $5 for primary care services, a $10 copayment for specialty care, and they do not pay for laboratory services. Former State Medical Plan members do not have any type of cost share requirements.

**Funding Mechanism(s)**

At the onset of program development county officials wanted to combine the money they were already designating as indigent care funds with the money the state was using to fund the State Medical Plan in Ingham County (Silow-Carroll et al., 2001). These two sources of funding would be considered as additional shares to the state’s Medicaid DSH payment system and would allow for the county to draw down additional funding from the federal government. In
order to separate the IHP payments coming in from the federal government from those going to other providers of indigent care, a corporation was formed to pass the money through—Ingham Health Plan Corporation.

**Program Administration**

Ingham Health Plan Corporation’s ten-member board of directors manages IHP (Silow-Carroll et al., 2001). All of the board members are from the local community and include former or current city, county, and state officials; physicians; representatives from the two participating hospital systems; and two enrollees of IHP. The Corporation also enlists the consulting and legal assistance of three private firms from the area. In addition, the county health department participates in the administration of the program.

**Political Support**

An examination of the information available on IHP does not explicitly mention the political players in the development of the program. However, considering county officials are credited with the idea for IHP and state officials had to “approve” their plan to combine county and state funding sources in order to gain federal funding, one can speculate the presence of political support with this community initiative.

**Initiative 4: Hillsborough County HealthCare Plan**

The Hillsborough County HealthCare Plan (HCHCP) was created in 1991 by the Board of County Commissioners and became operational in February 1992 (Andrulis & Gusmano, 2000). It is a comprehensive managed care plan for low-income, uninsured residents of Hillsborough County, Florida.

In 1990 Hillsborough County’s indigent health care costs were projected to reach $105 million by 1997 (Local Innovations in Health Care Conference [Conference], 2000). Under a
state mandate to provide health services to this population, the Hillsborough Board of County Commissioners began to question the price of care. The Board asked a community planning committee to look into these financial projections and they uncovered the fact that the indigent population got their only health care at the local public hospital’s emergency room. With this information, the planning committee put together a managed care plan for the County emphasizing prevention.

This plan became HCHCP with the focus of providing high quality, cost effective health care to low-income, uninsured residents (Andrulis & Gusmano, 2000). Aware of the pathways to care the indigent residents of the county utilize, HCHCP emphasizes primary and preventative services, early intervention, health education, and coordinates social services for individuals if applicable.

**Eligibility Requirement(s)**

Individuals must be residents of Hillsborough County, have no other health insurance coverage, and have an annual income at or below 100% of the FPL (Andrulis & Gusmano, 2000). In some cases citizens with incomes over 100% of the FPL and no other coverage can qualify under the Medical Crisis Intervention Program with copayments required based on their income (Hillsborough County Department of Health and Social Services, 2004). Medical Crisis Intervention cases are approved for those conditions that are expensive to treat either because of severity or they are classified as a “chronic medical condition”. Older citizens who have Medicare, but are within poverty guidelines, may qualify for limited assistance with items that Medicare does not cover such as prescriptions and eyeglasses.
**Funding Mechanism(s)**

As defined in the Florida Statutes Section 212.055(4) (2004) counties with a population of at least 800,000 residents may levy a discretionary sales surtax at a rate that may not exceed 0.5% for the purpose of providing health care services to indigent individuals. It is under this statute that was adopted in 1991 that Hillsborough County began collecting its revenue for the HCHCP. However, the original statute of 1991 had a sunset provision that required the State Legislature to reauthorize the sales tax in 1998 and it also required an ad valorem property tax that totaled $26.8 million in Hillsborough County (Andrulis & Gusmano, 2000).

According to Andrulis and Gusmano (2000) the program’s revenue from FY 1992 to FY 1997 exceeded expenditures and when it was time to reauthorize the sales surtax, HCHCP’s reserve balance had grown to over $156 million. It was decided that the ad valorem property tax portion of the original statute contributed to this surplus and when the reauthorization of the statute took place, it was removed. The County also agreed to the sales surtax being reduced from 0.5% to 0.25% until the plan’s reserve balance became equal to 110% of the previous year’s expenses or until March 1, 2001—whichever came first.

**Program Administration**

Hillsborough County Department of Health and Social Services operates the HCHCP that divides the county into four zones and contracts with one preferred provider network in each zone (Andrulis & Gusmano, 2000). There are hospitals, primary care physicians, and specialty physicians in each network. Policy issues and oversight of the program comes from the Board of County Commissioners and a fifteen member Hillsborough County Advisory Board.
Political Support

Originally the plan to begin HCHCP was set for 1990; this was pushed back to 1991 due to lack of support from the State Legislature when asked to back a health care plan that proposed new taxes. Hillsborough County leaders mobilized again in 1991 and the Legislature approved their request for funding through taxation.

Political support for the existing program appears stable, but there is not a great deal of support for expansion (Andrulis & Gusmano, 2000). The current political climate opposes expansion of government programs or an increase in taxes. HCHCP has been so successful at providing health care for individuals with incomes at or below 100% of the FPL, that they have publicly created a sense of closure on the problem of the uninsured as a whole in Hillsborough County.

Initiative 5: JaxCare

JaxCare is a public/private partnership designed to provide a countywide managed system of care for low-income, working uninsured residents of Duval County, Florida (Task Force, 2004). The JaxCare program targets individuals who do not have health insurance or access to health care safety net programs because of their financial condition (JaxCare, 2004).

According to JaxCare (2004) this initiative began in 2000 under the “Communities In Charge” program of the Robert Wood Johnson Foundation. Communities In Charge – Jacksonville (CIC-JAX) formed a local coalition of public and private sector stakeholders that were determined to tackle the financial problems associated with the working uninsured population. During 2002 CIC-JAX held forums that involved the targeted stakeholders along with national and regional experts on the uninsured to discuss this population and develop a
business plan appropriate for Jacksonville. In order to execute this plan, JaxCare, a Florida 501(c)(3) not-for-profit corporation was formed (JaxCare, 2004).

Currently, JaxCare is classified as a two-year pilot program under Senate Bill 46-E passed by the 2002 Florida Legislature (Task Force, 2004). This bill authorizes the establishment of the Health Flex Pilot Program whose focus is to expand the availability of health options for low-income, uninsured residents of the state of Florida. According to the Task Force (2004) the major provisions of this legislation focus on the exemption of state mandated coverage benefits, allow for a range of entities to provide health care coverage, and denote select counties to participate in the pilot program. Those who qualify to become a provider of a Health Flex Pilot Program may design benefit packages that include any combination of benefits, limitations, and underwriting criteria.

**Eligibility Requirement(s)**

To participate in this program individuals must be residents of Duval County, between 19 and 64 years of age; have a family income between 150% and 200% of the FPL; not be eligible for government sponsored health care coverage; be employed for the last three months by a JaxCare participating business; work at least 20 hours per week at the participating business; and they have to be without any health insurance for at least six months (JaxCare, 2004).

**Funding Mechanism(s)**

As indicated by JaxCare (2004) the pilot program is funded by a combination of the city of Jacksonville grant dollars, hospital contributions, foundation grants, corporate donations, employer fees, and patient copayments. Businesses pay $50 per employee per month and if the participating businesses elect to cover the spouses of his/her employees then an additional fee of $50 per month for the eligible spouse is assessed. The employees do not pay monthly premiums,
but they do pay a $15 enrollment processing fee and associated copayments for the care provided. Examples of copayments are $10 per doctor visit; $5 per routine lab visit; $5 per prescription (generic only); $100 per hospital visit; $100 per emergency room visit; and $100 per outpatient surgery visit.

**Program Administration**

JaxCare’s staff makes up the Provider Relations, Care Management, Utilization Management, and Quality Management departments of the corporation. United Benefits Insurance processes JaxCare members’ claims, while the Duval County Health Department manages the pharmaceutical portion of the program. United Way of Duval County also participates by providing their 211 services for electronic access to eligibility, referral, and case management information.

**Political Support**

As part of the Health Flex Pilot Program, JaxCare has received political support from the State Legislature in addition to the Governor who is an advocate of the Health Flex approach to expanding coverage for the low-income, uninsured residents of Florida. Due to JaxCare’s development it suffices to say the program would not exist without political support at the city and county level as well.

**Initiative 6: CareNet**

CareNet is a public/private collaboration designed to deliver primary health care and specialty care services to low-income, uninsured residents of Leon County, Florida (Leon County Government, 2004).

CareNet, in its current form, has been in existence since December 11, 2001 when the Leon County Board of Commissioners voted unanimously to fund the program that originated in
1997 to provide greater access to health care for the county’s indigent population. According to
the Leon County Government (2004) the vote to elect the CareNet program came after several
months of analyzing possible project models designed to address the county’s growing number
of uninsured residents. The first step the Board of Commissioners took in setting up such a
system was to hold a public hearing on a previously proposed ordinance for creating a primary
health care services Municipal Service Taxing Unit (MSTU). On June 12, 2001 the ordinance
was adopted and staff of Leon County began exploring funding options to create a health care
program for the identified population.

On July 31, 2001 the Board of Commissioners voted to approve the funding of the
Uninsured Health Care Program for one year by using $500,000 from the self-insurance fund;
levy a countywide MSTU of 0.06 mill that would generate approximately another $500,000; and
exercise the option of transferring $200,000 from the Intergovernmental Transfer/Special
Medicaid Program (Leon County Government, 2004). From September 2001 to November 2001
a committee with members appointed by the Board of Commissioners, studied health care
delivery system models that if chosen would utilize the previously mentioned funding streams to
begin providing care to Leon County’s low-income, uninsured residents. Upon exploration of
the options, the decision to additionally fund the CareNet model was made by the committee and
presented to the Board of Commissioners who on December 11, 2001 voted to adopt this
program.

*Eligibility Requirement(s)*

To be eligible for the CareNet program individuals must be currently uninsured; a Leon
County resident; not eligible for any other health care program or subsidies; under the age of 65;
and have an income up to 200% of the FPL (Leon County Government, 2004). All residents
with incomes below 100% of the FPL are provided services free of charge. The cost share amount for residents with incomes up to 200% of the FPL is determined based on their income.

**Funding Mechanism(s)**

The funding for CareNet stands as what the Board of County Commissioners decided in July 2001—$500,000 from the self-insurance fund; 0.06 mill additional ad valorem property tax; and $200,000 Intergovernmental Transfer involving a county collaboration with local hospitals to acquire matching funds from the Special Medicaid Payment Program (Leon County Government, 2004). The county funds began supplementing the CareNet program on January 1, 2002.

**Program Administration**

Employees of the Bond Community Health Centers and the Neighborhood Health Services clinics determine individuals’ eligibility to receive primary care services through the CareNet program (Leon County Government, 2004). In cooperation with the CareNet program medical services are provided to eligible members via the Bond and Neighborhood health clinics, specialty doctors of the We Care Network, Tallahassee Memorial Health Care, Tallahassee Community Hospital, Leon County Health Department, and the Florida A&M University College of Pharmacy.

**Political Support**

The political support of the CareNet program is apparent at the county level with the continuous involvement of the Board of County Commissioners. County officials along with appointed members of the Leon County Health Care Advisory Council have proposed spending $4.3 million a year to ensure primary care access to all uninsured Leon County residents, paying
V. CONCLUSION

These six public/private community initiatives differ in features such as eligibility guidelines, services covered, financing sources, and administrative entities (see Table 1). However the programs have a common theme—to provide access to primary health care for the low-income, uninsured residents. Evaluated against the decision criteria with the objective of this report to make action recommendations for Florida’s local governments, two of the initiatives are not being recommended for further exploration: 1) Boston HealthNet Pilot Plan and 2) Wishard Advantage.

The Boston HealthNet Pilot Plan basis its eligibility requirements on the broad category of state residency and targets the patients who “happen” to utilize BMC services. Besides lacking a defined population base to draw from, the funding mechanism for this program would not attract the political support it would need to survive in Florida. The creation of a state Free Care Pool would be difficult on Florida’s rural counties considering not every county has a hospital that could contribute to the pool or serve as the focus of a program to provide care to its indigent residents.

Wishard Advantage is set up as a managed care program. Mimicking the HMOs of the early 1990s and carrying with it the possible stigma of patients not being in “control” of their care and providers not being able to have a say in their reimbursement rates, the uptake of the program in Florida could be sluggish as it has been in Marion County. According to Andrulis and Gusmano (2000) there were just over 20,000 individuals enrolled in the program as of 2000. In 1997 program administrators projected they would be able to enroll at least 30,000 individuals...
in the first year of existence. Lower than expected enrollment has placed financial strains on the program.

As for the Ingham Health Plan, the structure of the program as a non-profit corporation that provides a defined set of outpatient services to enrollees has the potential to work in any of Florida’s counties. Health care provider support for the program would need to be solicited along with county health departments for the implementation of the program. However, the financing mechanism would be difficult to establish because in this system hospitals that participate in the program have to filter DSH payments from the federal government back into the corporation. Public hospitals in Florida that are struggling to capture their own DSH payments would have difficulty “buying in” to this plan.

The Hillsborough County HealthCare Plan serves as a staff model managed care program, but overcomes the traditional HMO stigma associated with managed care by dividing the county into four zones with a preferred provider network in each zone (Andrulis & Gusmano, 2000). The plan provides access at twelve different neighborhood sites eliminating barriers such as transportation and customizes a member’s primary care plan with the most convenient location for that person. Unfortunately, the financing mechanism of levying surtax for this plan limits its replication status to four other counties in Florida with a population of at least 800,000 residents—Broward, Palm Beach, Pinellas, and Miami-Dade counties.

JaxCare is the community initiative that incorporates the greatest amount of private sector support for their program outside of the traditional health care provider role of physicians. By marketing to employers, JaxCare presents itself as “helping” those who consider themselves to be the foundation of the community. However with this increased emphasis on employers, plan “buy in” becomes the focus for survival. The main objective of wanting to provide access to
health care for low-income, uninsured working residents needs to be publicized to assure the providers within the plan see it as a way for them to be compensated for providing care to the indigent. This initiative is suitable for Florida counties with a large base of indigent, working uninsured individuals and small businesses. Civic-minded employers need to be targeted to develop and sustain this type of program.

CareNet as an existing plan that was expanded to serve a growing population, represents a community initiative that could be implemented in any Florida county that currently has a volunteer network of care set up to service its low-income, uninsured residents. Conversely, the funding mechanisms for this plan require political support to implement an additional property tax and this could meet opposition in other counties.
VI. REFERENCES


Indigent Care and Trauma Center Surtax, Chapter 212 Florida Statutes § 055(4) (2004).

Retrieved October 5, 2004, from
http://www.flsenate.gov/Statutes/index.cfm?p=2&App_mode=Display_Statute&Search_String=&URL=Ch0212/SEC055.HTM&Title=->2004->Ch0212->Section%20055#0212.055


Figure 2

Characteristics of the Uninsured, 2002

Age

- Children Under 19: 21%
- Adults 19-34: 40%
- Adults 35-54: 31%
- Adults 55-64: 8%

Income

- <100% FPL: 36%
- 100-199% FPL: 28%
- 200-299% FPL: 16%
- 300% FPL and Above: 19%

Work Status

- Full-Time Workers: 56%
- Part-Time Workers: 12%
- 2 or More Full-Time Workers: 14%
- No Workers: 19%

Total = 43.3 million uninsured

Note: Percentages may not total 100% due to rounding.
### 2004 Poverty Level Guidelines

All States (except Alaska and Hawaii) and D.C.

Income guidelines as published in the Federal Register on 2/13/04

#### Annual Guidelines

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For family units of more than 8 members, add $3,180 for each additional member.

#### Monthly Guidelines

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<tr>
<th>Initiative Name (Location)</th>
<th>Boston HealthNet Pilot Plan (Boston, MA)</th>
<th>Wishard Advantage (Marion County, IN)</th>
<th>Ingham Health Plan (Ingham County, MI)</th>
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<tbody>
<tr>
<td><strong>Eligibility Requirement(s)</strong></td>
<td>• State resident&lt;br&gt;• Family income below 200% of FPL = full free care&lt;br&gt;• Family income between 200% and 400% of FPL = subsidized care on a sliding fee scale</td>
<td>• County resident&lt;br&gt;• Annual income at or below 150% of FPL = no cost sharing&lt;br&gt;• Annual income at or below 200% of FPL = charged using a sliding fee scale</td>
<td>• County resident&lt;br&gt;• Annual income below 250% of FPL = $5 copay for primary care, $10 copay for specialty care&lt;br&gt;• Former member of the State Medical Plan = no cost sharing</td>
</tr>
<tr>
<td><strong>Funding Mechanism(s)</strong></td>
<td>Reimbursement from the state’s Free Care Pool</td>
<td>Federal disproportionate share (DSH) matching funds used to capitalize the program&lt;br&gt;Financed through city and county property taxes</td>
<td>Draws down money from the federal Medicaid program in the form of DSH payments</td>
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<tr>
<td><strong>Program Administration</strong></td>
<td>Boston Medical Center (BMC) employees</td>
<td>Health and Hospital Corporation (HHC) of Marion County</td>
<td>Ingham Health Plan Corporation and the county health department</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td>• Abortion and sterilization&lt;br&gt;• Dental care&lt;br&gt;• Emergency outpatient&lt;br&gt;• Family planning&lt;br&gt;• Hospital inpatient/outpatient&lt;br&gt;• Lab, radiology, pathology&lt;br&gt;• Mental health inpatient/outpatient&lt;br&gt;• Non-hospital physician services&lt;br&gt;• Physical, speech, and language therapy&lt;br&gt;• Preventive care&lt;br&gt;• Primary care&lt;br&gt;• Substance abuse inpatient/outpatient&lt;br&gt;• Vision care&lt;br&gt;• 23 hr. hospital observation stays&lt;br&gt;• Allergy testing and treatment&lt;br&gt;• Ambulance&lt;br&gt;• Audiograms&lt;br&gt;• Bone Densitometry&lt;br&gt;• Cardiac Rehabilitation&lt;br&gt;• Chemotherapy&lt;br&gt;• Consultations by specialist&lt;br&gt;• Contraceptive services&lt;br&gt;• CT scan/CV stress test/MRI&lt;br&gt;• Dental Services&lt;br&gt;• Emergency room visit&lt;br&gt;• GI procedures outpatient&lt;br&gt;• Hearing and sight testing&lt;br&gt;• Immunizations&lt;br&gt;• Inpatient services&lt;br&gt;• Mammography&lt;br&gt;• Mental health inpatient/outpatient&lt;br&gt;• OB/GYN&lt;br&gt;• Physicals&lt;br&gt;• Routine laboratory testing&lt;br&gt;• Routine X-rays&lt;br&gt;• Smoking cessation&lt;br&gt;• Speech, occupation, and physical therapy&lt;br&gt;• Surgery&lt;br&gt;• Vision screening&lt;br&gt;• Weight control programs</td>
<td>• Outpatient laboratory services&lt;br&gt;• Outpatient physician services&lt;br&gt;• Outpatient primary care&lt;br&gt;• Outpatient specialty care&lt;br&gt;• Prescription drugs&lt;br&gt;• Radiology&lt;br&gt;• The following services are only provided for former members of the State Medical Plan: &lt;br&gt;• Durable medical supplies&lt;br&gt;• Emergency services&lt;br&gt;• Outpatient hospital services</td>
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<tr>
<th>Initiative Name (Location)</th>
<th>Hillsborough County HealthCare Plan (Hillsborough County, FL)</th>
<th>JaxCare (Duval County, FL)</th>
<th>CareNet (Leon County, FL)</th>
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<tr>
<td><strong>Eligibility Requirement(s)</strong></td>
<td>• County resident&lt;br&gt;• Annual income at or below 100% of FPL = no cost sharing&lt;br&gt;• Annual income over 100% of FPL and do not qualify for any other coverage = eligible for Medical Crisis Intervention Program with copays based on income</td>
<td>• County resident 19-64 years of age&lt;br&gt;• Family income between 150% and 200% of FPL = associated copays for care provided&lt;br&gt;• Employed by a participating JaxCare business for the last 3 months, work at least 20 hrs/wk, and uninsured for at least 6 months</td>
<td>• County resident under the age of 65&lt;br&gt;• Annual income up to 200% of the FPL = charged using a sliding fee scale&lt;br&gt;• Annual income below 100% of FPL = no cost sharing</td>
</tr>
<tr>
<td><strong>Funding Mechanism(s)</strong></td>
<td>Sales surtax of 0.25% authorized by Florida Statutes Section 202.055(4) for counties with a population of at least 800,000 residents</td>
<td>City of Jacksonville grant dollars, hospital contributions, foundation grants, corporate donations, employer fees, patient enrollment fees and copays</td>
<td>$500,000 from the county’s self-insurance fund, 0.06 mill additional ad valorem property tax, intergovernmental transfer of $200,000 to acquire federal Medicaid DSH payments</td>
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<tr>
<td><strong>Program Administration</strong></td>
<td>Hillsborough County Department of Health and Social Services</td>
<td>JaxCare employees, United Benefits Insurance employees, and the Duval County Health Department</td>
<td>Employees of Bond Community Health Centers and the Neighborhood Health Services clinics</td>
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<tr>
<td><strong>Services</strong></td>
<td>• Case management of acute and chronic conditions&lt;br&gt;• Dental&lt;br&gt;• Diagnostics&lt;br&gt;• Durable medical equipment&lt;br&gt;• Family planning&lt;br&gt;• Health education/screenings&lt;br&gt;• Hearing aids&lt;br&gt;• Home health care&lt;br&gt;• Hospital-based outpatient services&lt;br&gt;• Immunizations&lt;br&gt;• Inpatient services&lt;br&gt;• IV Therapy&lt;br&gt;• Medical transportation&lt;br&gt;• Mental health (short-term care)&lt;br&gt;• Orthotics/Prosthetics&lt;br&gt;• Oxygen therapy&lt;br&gt;• Pharmaceuticals&lt;br&gt;• Primary care&lt;br&gt;• Rehabilitative services&lt;br&gt;• Specialty care&lt;br&gt;• Vision care&lt;br&gt;• Well-child visits</td>
<td>• Ambulance services&lt;br&gt;• Durable medical equipment&lt;br&gt;• Emergency room&lt;br&gt;• Generic pharmaceuticals&lt;br&gt;• Home Health Care&lt;br&gt;• Inpatient hospital services&lt;br&gt;• Mental health outpatient/inpatient&lt;br&gt;• MRI, PET, CT scans&lt;br&gt;• Outpatient diagnostic lab and x-ray&lt;br&gt;• Outpatient hospital surgery or observation&lt;br&gt;• Outpatient physical, occupational, and speech therapy&lt;br&gt;• Physician services&lt;br&gt;• Primary care&lt;br&gt;• Skilled nursing facility services&lt;br&gt;• Specialty care&lt;br&gt;• Substance abuse outpatient/inpatient&lt;br&gt;• Urgent care center services&lt;br&gt;• Anesthesiology&lt;br&gt;• Diagnostics&lt;br&gt;• Durable medical equipment&lt;br&gt;• Home health care&lt;br&gt;• Hospitalization&lt;br&gt;• Lab services&lt;br&gt;• Pathology&lt;br&gt;• Primary care&lt;br&gt;• Radiology&lt;br&gt;• Specialty care&lt;br&gt;• Surgery</td>
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