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Florida Access to Care Fund

Team Denver

GSCO x McKinsey CASE COMPETITION | FALL 2026

Executive Summary

A $2.4B plan that cuts the wait 38% by 2031 and needs no State general revenue from 2032 in the base case

Key Question

Key Question: How can Florida cut the average wait for a routine primary care visit in shortage areas (31 days today) by at least 25% by 2031, and keep the gains once the $3B Fund ends?

Strategy

1. Use Existing Capacity	2. Build Lasting Capacity	3. Maintain the Gains
Cut no-shows, phone-first telehealth with kiosks, pharmacist care: 3.4M visits with no new buildings	1,000 new clinicians placed through rural loan repayment, 40 mobile clinics, local health teams	200 rural residency slots and a $1.0B Florida Access Trust that pays the State's share after 2031

Impact

↓38%
wait by 2031
31 → 19.2 days (floor: 24.00)

$2.4B
of the $3B Fund
$1.4B programs + $1.0B Trust

$44M
State Revenue from 2032
Out of the total $150M

Key terms: *Shortage area = federally designated primary care Health Professional Shortage Area (HPSA). State GR = State general revenue,the money the case caps at $150M a year from FY2032.*

Florida Must Add 3.8-4.6M Visits a Year by 2031 Just to Reach the Floor

Seven million residents of shortage areas wait 31 days today; without action the wait rises to 33.4 days

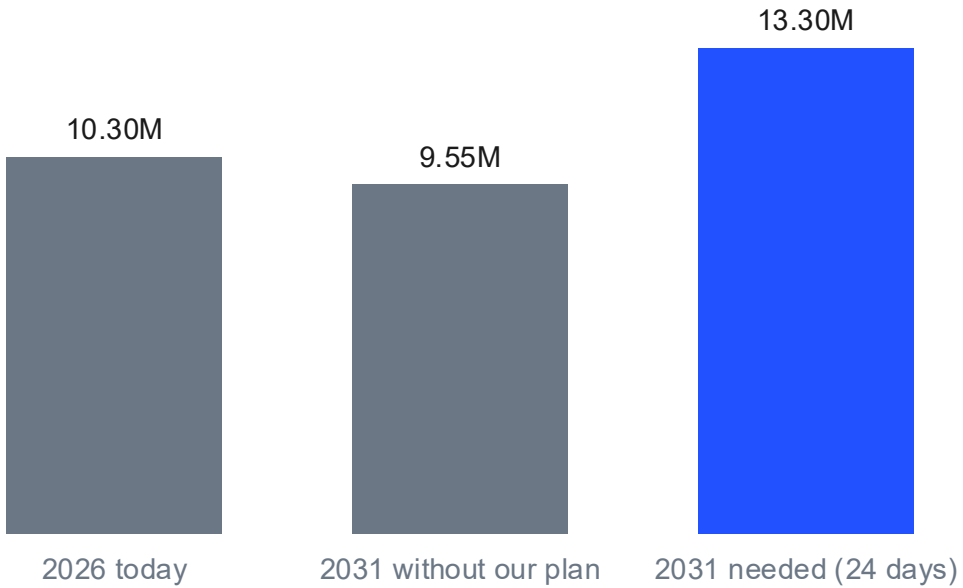
7.0 million
residents in primary care shortage areas[1]

31 days
average wait for a routine visit today[2]

20%
of booked visits are no-shows[2]

−1.5% a year
capacity lost as clinicians retire[2]

Completed primary care visits in shortage areas (millions per year)[3]



How to measure wait time

Wait time = (31 × 10.3M) ÷ completed visits a year

More completed visits means a shorter wait

Florida trails the U.S.[4]

Measure	Florida	U.S.
Primary care need met[5]	**39.6%**	48.2%
PCPs per 100K residents	**88.5**	94.4
Uninsured	**10.9%**	8.2%
Residents aged 65+	**21.8%**	18.0%

Key terms: *Shortage area (HPSA) = an area HRSA designates as having too few primary care clinicians, e.g., more than 3,500 residents perphysician. PCP = primary care physician.*

Where Florida loses Primary care capacity

Florida loses primary case capacity problems with their existing models: These problems are all fixable.

No-shows

2.6M
booked visits go unused every year (20% of 12.9M)

Simple visits in clinic slots

Since 2020
Florida pharmacists may test and treat minor conditions, but rarely do

Florida Senate 2020

Distance and connectivity

23%
of Madison County homes lack broadband (8.4% statewide)

Shrinking workforce

1,434
more practitioners needed to remove every shortage designation

Florida Senate 2026

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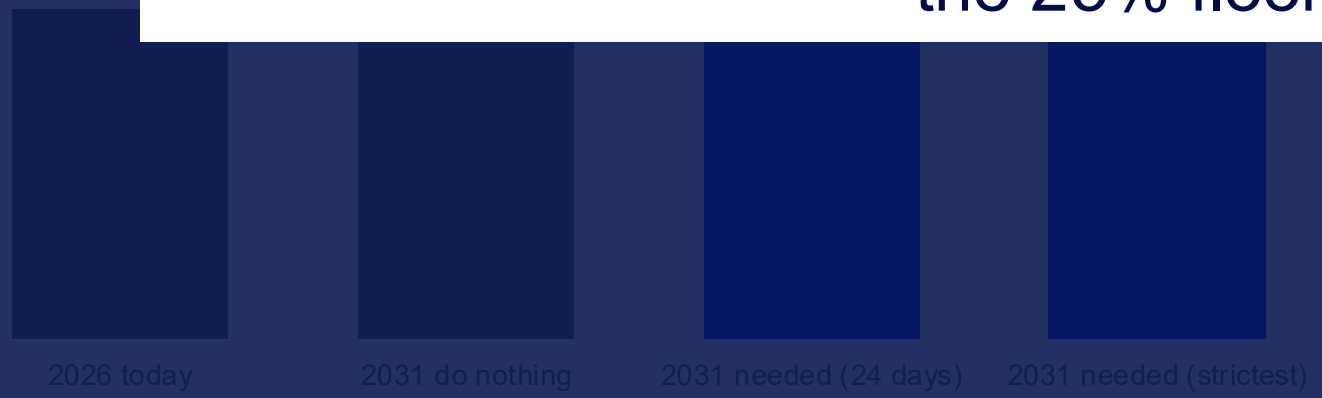
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20%
of booked visits are no-shows[2]

−1.5% a year
capacity lost as clinicians retire[2]

Key Takeaway: Florida's wait time is a **capacity problem**: retirements remove 1.5% of visits every year, so the State must add **3.8 to 4.6M completed visits a year** just to reach the 25% floor



ts a year
ore visits cuts

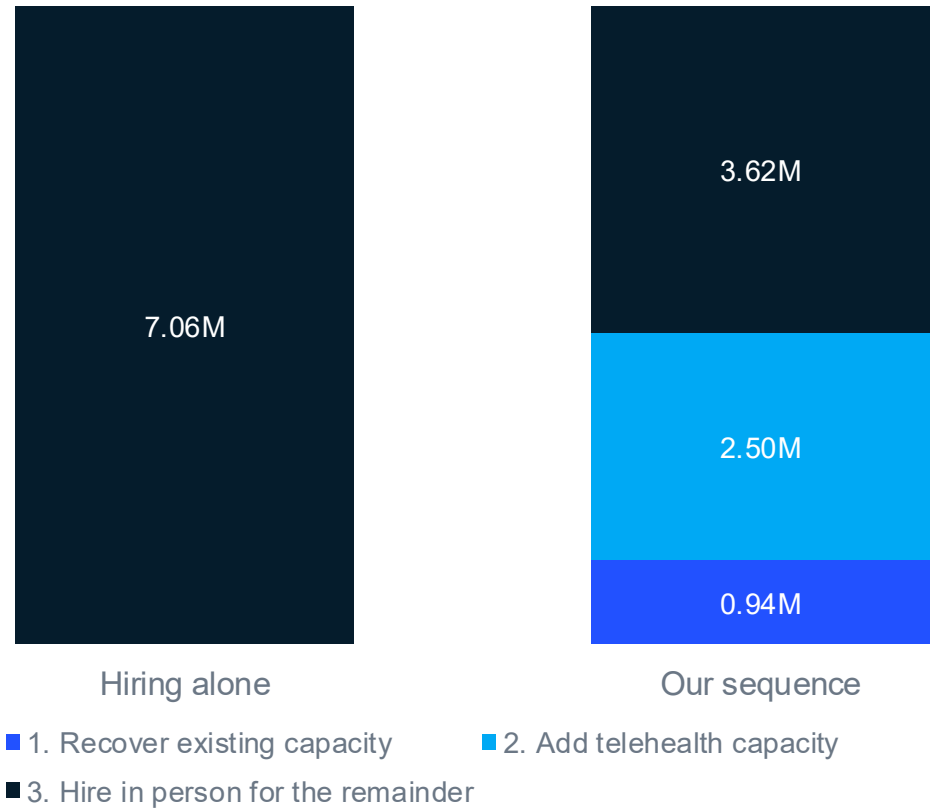
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Using Existing Capacity First reduces need to hire by 50%

Existing capacity is not used up due to no-shows + lack of reach. Fixing that is a cheaper solution and quicker solution than hiring labour

How 7.06M added visits a year are delivered (millions)



1 Recover existing capacity 0.94M

Cut no-shows and move minor conditions to pharmacies. No new clinicians required for that.

2 Add telehealth capacity 2.50M

500 clinicians by phone, video or kiosk. Each completes 5,000 visits a year, versus 4,000 for a physician, and earns a surplus.

3 Hire in person for the remainder 3.62M

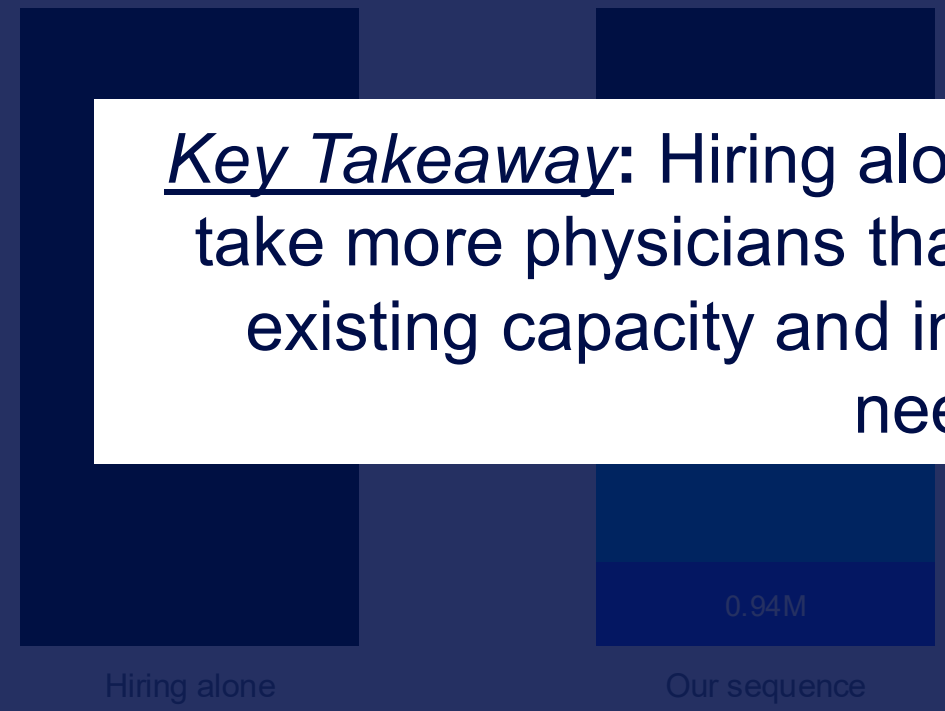
1,000 clinicians and 40 mobile clinics.

If we try to get out of this problem only by hiring, we would need ~1,765 physicians, 23% more than Florida's entire shortfall. The solution to the problem is a mixture of hiring + improving existing infrastructure in place.

Using Existing Capacity First Halves the Hiring Need

This is a sequence, not a choice: cheapest and fastest capacity first, hiring for what remains

How 7.06M added visits a year are delivered (millions)



1 Recover existing capacity 0.94M

Cut no-shows and move minor conditions to pharmacies. No new clinicians required.

Key Takeaway: Hiring alone cannot close the gap: it would take more physicians than Florida's entire shortfall. Using existing capacity and infrastructure first reduces hiring needs by 50%

mpletes 5,000
arns a surplus.

3 Hire in person for the remainder 3.62M

1,000 clinicians and 40 mobile clinics. Hiring alone would need ~1,765 physicians, 23% more than Florida's entire shortfall.

Key terms: *No-show = a booked visit the patient misses. Telehealth = a visit by phone or video. NP/PA = nurse practitioner / physician assistant.*

Sources: visit rates from Case A2 (physician 4,000; telehealth 5,000; NP/PA 3,300; van 2,800 a year); lever volumes from team model (Levers tab). Hiring-only equivalent = 7.06M ÷ 4,000 = ~1,765 physicians vs. 1,434 practitioners needed statewide (Florida Senate CS/SB 1480 analysis, 2026).

Neighborhood Health Teams: The Backbone

Every household in a shortage area gets a named local team accountable for getting it seen



Borrowed From

Costa Rica[3]
Every citizen assigned to a team by address; ~1 team per 4,500 people; ~94% coverage

Brazil[4]
4-6 community health agents per team; 13% fewer chronic disease hospitalizations

Florida[2]
No new buildings: teams sit inside 785 health center sites and 67 county health departments

WHAT THE TEAM DOES EACH WEEK

Calls patients likely to miss a visit and fixes the reason (transport, childcare, timing); books the right channel; helps residents without internet use a kiosk; enrolls uninsured residents in coverage; reports each county's wait to the yearly scorecard.

Key terms: *Community health worker (CHW) = trained local outreach worker, not a clinician; 1,200 in the plan. Health center = federallyfunded community health center (CHC) serving patients regardless of ability to pay. County health department = the State's public health office in each county.*

Sources: (1) Case A3. (2) Case A8, A11 (54 health center organizations, 785 sites; health departments in all 67 counties); ~295 teams = 65 rural (1 per ~20K residents) + ~230 urban (1 per 25K), team model Rural tab. (3) Commonwealth Fund (2021); PHCPI. (4) Macinko et al., Health Affairs (2010).

Seven Initiatives Add 7.1M Visits a Year and Keep Them After 2031

Initiatives 1–5 add visits before 2031; initiatives 6–7 keep them after the Fund ends

			2031 VISITS	UNIT ECONOMICS
1	**Cut no-shows**	20% to 14% with reminders and patient navigator calls	**+0.72M**	~$59 per added visit
2	**Telehealth**	500 clinicians by phone, video or kiosk; 300 kiosks	**+2.50M**	Earns +$181K per clinician a year
3	**Pharmacy First**	Pharmacists treat minor conditions under Florida's 2020 law	**+0.22M**	$45 per consult
4	**Clinician pipeline**	300 physicians + 700 NPs/PAs placed with rural loan repayment	**+3.51M**	NP +$12K; physician −$83K a year
5	**Mobile clinics**	40 vans on fixed rural routes	**+0.11M**	−$288K per van a year
6	**Rural residencies**	200 rural-track residents in 16 new programs with UF and FSU	**After 2031**	~31 rural doctors a year
7	**Florida Access Trust**	$1.0B permanent endowment funded FY2027–31	**After 2031**	$45M a year for the State's share

Total: 9.55M visits a year if nothing changes → 16.61M with the plan = **+7.06M visits a year by 2031**

Key terms: *Unit economics = what one clinician or van earns from billing minus what it costs, per year. Patient navigator = a CHW who calls high-risk patients before their visit.*

Sources: visit rates and reimbursement ($110 in-person, $90 virtual, 15% uninsured) from Case A2; volumes and unit economics from team model (Levers, UnitEcon, Pipeline tabs). No-show cost per visit = 650 outreach CHWs × $65,319 ÷ 0.72M; pharmacy fee is a team assumption. Full math in Appendix A4–A5, A9.

Initiatives 1–3: Existing Capacity Adds 3.4M Visits

No-show reduction, telehealth by phone and kiosk, and Pharmacy First need no new buildings

1. Cut No-Shows

+0.72M visits

11.94M booked × 6-point cut

- Text reminders for all; a second reminder for medium risk
- Highest-risk 30% get a patient navigator call that fixes transport, childcare or timing[1]
- Navigators cut no-shows 45% in studies; we assume 30%[2]

2. Telehealth

+2.50M visits

500 clinicians × 5,000 visits

- Phone visits have lower no show rates than in-person visits[3]
- 300 kiosks (private booths with a screen) in health departments, libraries and UF/IFAS offices; UF already runs 13[4]
- Earns ~$181K per clinician a year above cost[5]; 500 is ~1% of Florida's 50,378 APRNs[4]

3. Pharmacy First

+0.22M visits

~35 consults per 1,000 people

- Florida has allowed pharmacist test-and-treat since 2020, but it is underused[6]
- England delivered ~1.5M consultations in nine months[7]
- We assume reimbursement of ~$45 per consult, less than a clinic visit

Key terms: *APRN = advanced practice registered nurse, including nurse practitioners. Kiosk = a private booth with a screen and camera for a telehealth visit, for residents without home internet.*

Sources: (1) team design. (2) Manchester rapid review (navigator RR 0.55; phone RR 0.61); BMJ Open 2016 (text RR 0.75). (3) J Gen Intern Med (telehealth non-attendance). (4) Case A7, A11. (5) Team model UnitEcon tab: 5,000 × 0.85 × $90 − $201,888. (6) Florida Senate 2020 bill summary (s. 465.1895). (7) Pharmacy Magazine (CCA). Visit math: Appendix A4.

Initiatives 4–5: 1,000 New Clinicians and Targeted Mobile Clinics

Clinicians are placed inside existing clinics; 40 vans go only where nothing else reaches

Clinician Pipeline and Retention

+3.51M visits

300 physicians (1.20M) + 700 NPs/PAs (2.31M)[1]

- Rural loan repayment through FRAME: up to $150K for physicians and $90K for NPs over 4 years, repaid if they leave early[2]
- Mostly NPs/PAs: they start fast and break even; a physician runs an ~$83K annual deficit[3]
- Retention: priority for Florida graduates (75% stay)[2], a stay bonus in years 5–6, and 200 rural residency slots (initiative 6)

Mobile Clinics

+0.11M visits

40 vans × 2,800 visits each[1]

- Each van costs ~$541K a year: NP, RN, medical assistant and driver/CHW ($389K) plus $152K non-labor, matching the $550K benchmark[4]
- It collects ~$93.50 per visit: the case's $110 in-person rate on the 85% of patients who are insured[1]
- Deployed for reach, not volume: fixed weekly routes in rural counties where residents lack a car or internet

Key terms: *FRAME = Florida's existing loan repayment program for clinicians who work in shortage areas. NP = nurse practitioner; PA = physician assistant; RN = registered nurse.*

Sources: (1) Case A2 (visit rates; $110 per in-person visit; 15% uninsured). (2) Case A7 (FRAME maximums; 75% retention for Florida-trained physicians). (3) Team model UnitEcon tab: $374,000 revenue − $457,125 cost (salary $227,700, Case A9). (4) Team crew build-up (Mobile tab); $550K benchmark and RN $84,190 from Case A9.

Initiatives 6–7: Lock In the Gains After the Fund Ends

Rural residencies keep new doctors coming; a permanent Trust pays the State's share from 2032

6. Rural Residencies

200 residents by 2031

16 new rural programs × ~12.5 residents, with UF Health and FSU[1]

- Start-up grants of $750K per program, the federal HRSA model ($12M); then $160K per resident a year[2]
- 76% of rural-track graduates practice rurally[3]: ~31 new rural doctors a year once programs are full, about half of the ~68 replacements needed each year
- After 2031: paid by Medicare rural training funds and Florida's Slots for Doctors, with the Trust as backstop[2]

7. Florida Access Trust

$1.0B to a trust

Five $200M deposits, FY2027–31;

- The State contributes a $44M share from 2032: uninsured CHW and pharmacy costs, the program office, and loan repayment for ~68 replacement clinicians a year
- Can contribute up to 45M a year of reserve against Medicaid cuts or a residency funding gap
- Florida precedent: the Lawton Chiles Endowment has funded children's health from tobacco settlement money since 1999[5]

Key terms: *Residency = the 3-year paid training doctors complete after medical school. Endowment = money invested once whose yearly income is spent, so the principal lasts.*

Sources: (1) HRSA: 46 rural programs created 575 positions since 2019 (~12.5 each). (2) HRSA RRPD awards up to $750K over 3 years (Jun 2024); residency cost $160K/yr and Slots for Doctors from Case A7, A9. (3) Rosenthal (2000), via team research; 62% in-state retention. (4) 4.5% is below the 4.9% average endowment spending rate (NACUBO-Commonfund 2025). (5) s. 215.5601, F.S. Model: Pipeline, FY2032, Stress tabs.

Rural County Allocation

County	Pop (K)	Clin.	CHWs	Kiosks
Sumter	129.8	26	31	22
Highlands	101.2	21	24	17
Nassau	90.4	19	21	15
Monroe	82.9	17	20	14
Walton	75.3	16	18	13
Putnam	73.3	16	17	12
Columbia	69.7	15	17	12
Jackson	47.3	11	11	8
Gadsden	43.8	10	10	7
Suwannee	43.5	10	10	7
Levy	42.9	10	10	7
Hendry	39.6	9	9	7
Okeechobee	39.6	9	9	7
DeSoto	34.0	8	8	6
Wakulla	33.8	8	8	6
Baker	28.3	7	7	5
Bradford	28.3	7	7	5

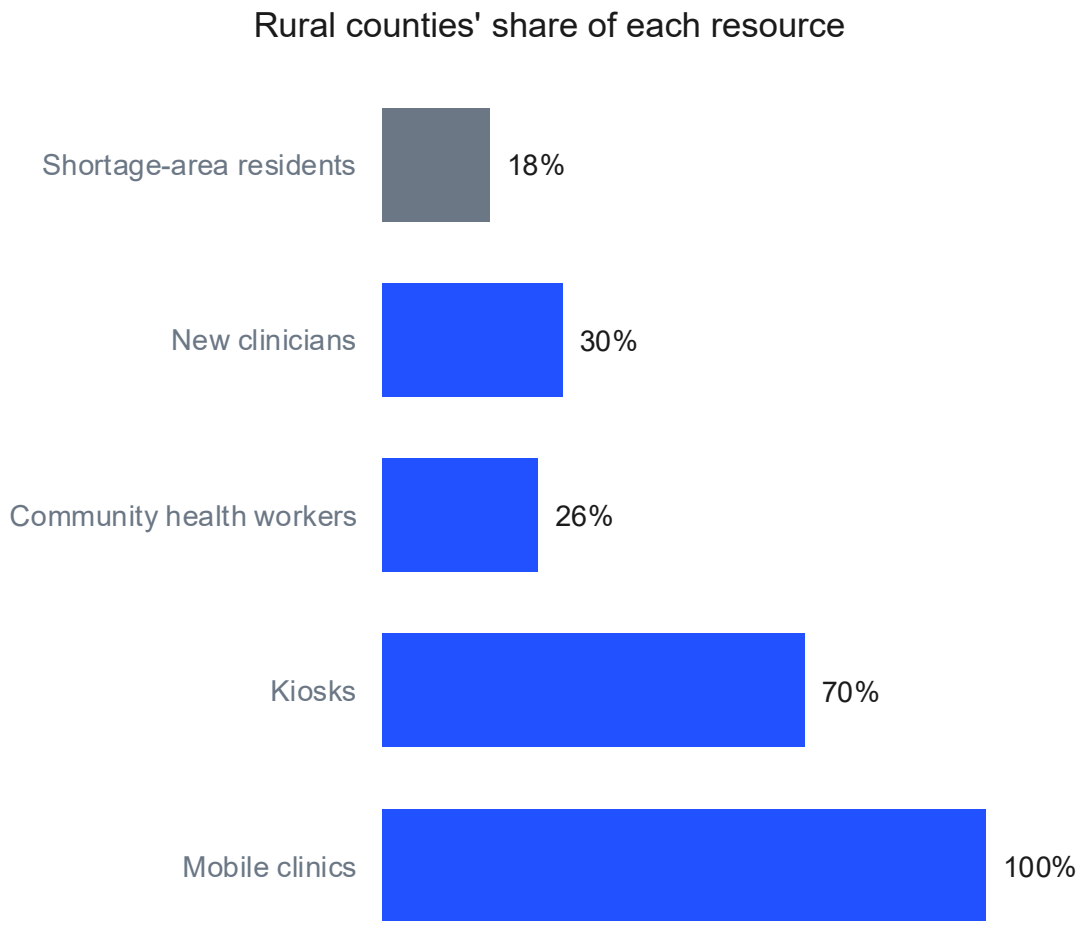
County	Pop (K)	Clin.	CHWs	Kiosks
Washington	25.3	7	6	4
Hardee	25.3	7	6	4
Taylor	21.8	6	5	4
Holmes	19.7	6	5	3
Madison	18.0	5	4	3
Gilchrist	17.9	5	4	3
Dixie	16.8	5	4	3
Union	16.1	5	4	3
Jefferson	14.5	5	4	2
Gulf	14.2	5	4	2
Hamilton	14.0	5	4	2
Calhoun	13.6	5	4	2
Franklin	12.5	4	4	2
Glades	12.1	4	4	2
Lafayette	8.2	4	4	1
Liberty	8.0	3	4	1

RURAL TOTALS

1.26M residents
300 clinicians
65 team hubs
307 CHWs
211 kiosks
40 mobile vans
200 rural residents

Rural Counties Get 30% of Clinicians for 18% of Residents

All 33 rural counties are covered, versus the 75% the case requires



Region	Pop.	Clin.	CHWs	Kiosks	Vans
Panhandle (11)	308K	80	78	50	10
North & Central (15)	619K	145	149	104	19
Heartland (6)	252K	58	60	43	8
Keys (1)	83K	17	20	14	3
Urban shortage areas	5.74M	700	893	89	0

Every rural county gets at least 3 clinicians, 1 neighborhood team hub, 4 community health workers and 1 kiosk. Urban areas get most of the no-show and pharmacy effort, because their bottleneck is wait lists rather than distance.

Key terms: *Rural county = ≤75,000 residents, or ≤125,000 next to a county that small (s. 288.0656, F.S.). Clin. = new in-person clinicians.*

Sources: populations from Case A4 (2020 Census; 33 rural counties, 1.26M people) and Case A3 (7.0M in shortage areas); allocation rules and totals from team model (Rural tab). Final split to be weighted by need: HPSA score, physicians per capita, uninsured rate, broadband.

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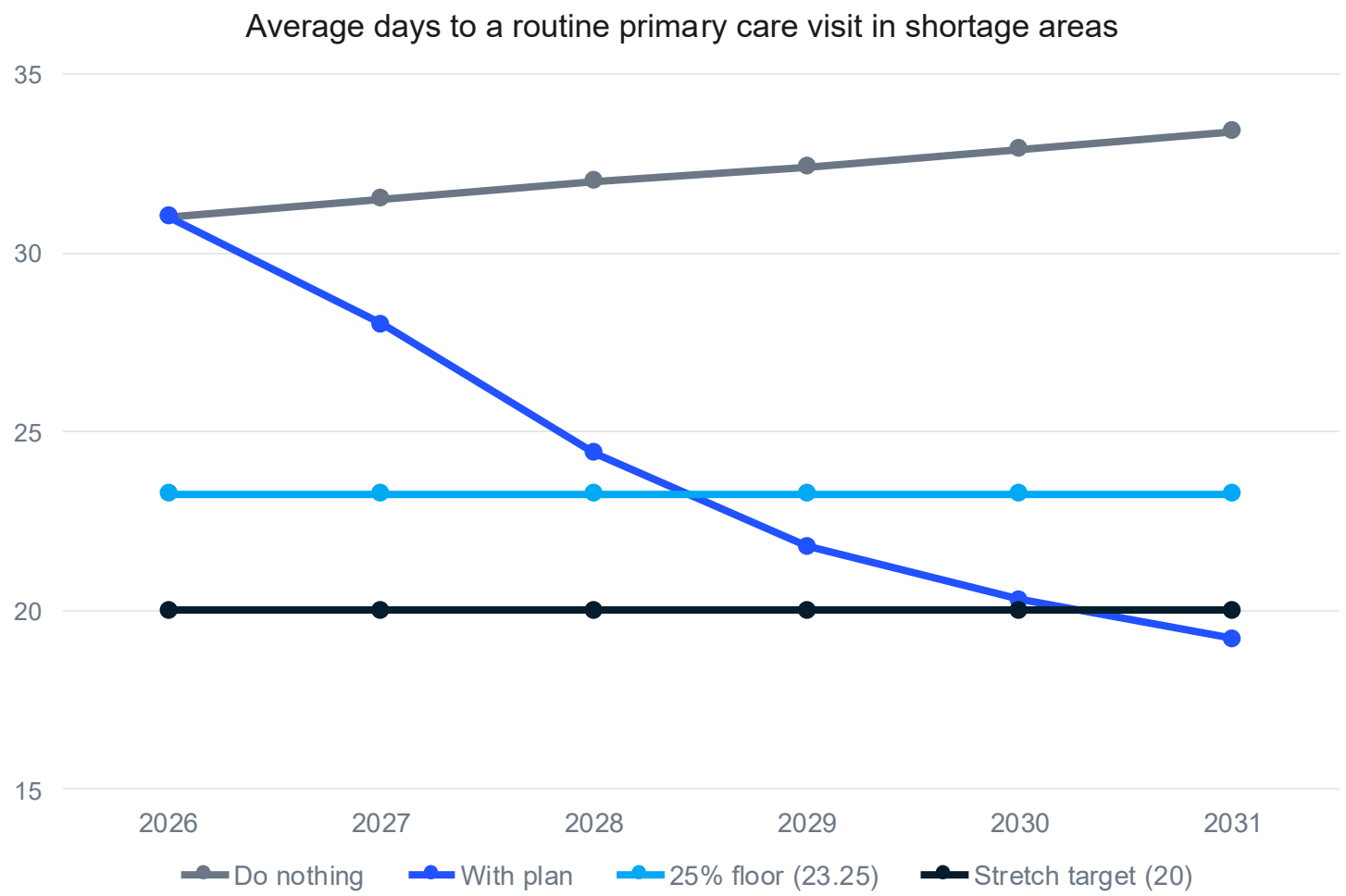
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				43	8
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				89	0

Key Takeaway: We have seven initiatives across 2 prongs: utilizing existing capacity through efficiency, and adding 1000 new clinicians; Then, residencies and a permanent trust keep our initiatives alive after 2031

Every rural county gets at least 3 clinicians, 1 team hub, 4 community health workers and 1 kiosk. Urban areas get most of the no-show and pharmacy effort, because their bottleneck is wait lists rather than distance.

Wait Times Fall to 24 Days by 2028 and 19 Days by 2031

The solution provides a 38% decrease in average days to primary care visit



24.4 days

by end of 2028 (−21%)

19.2 days

by 2031 (−38%)

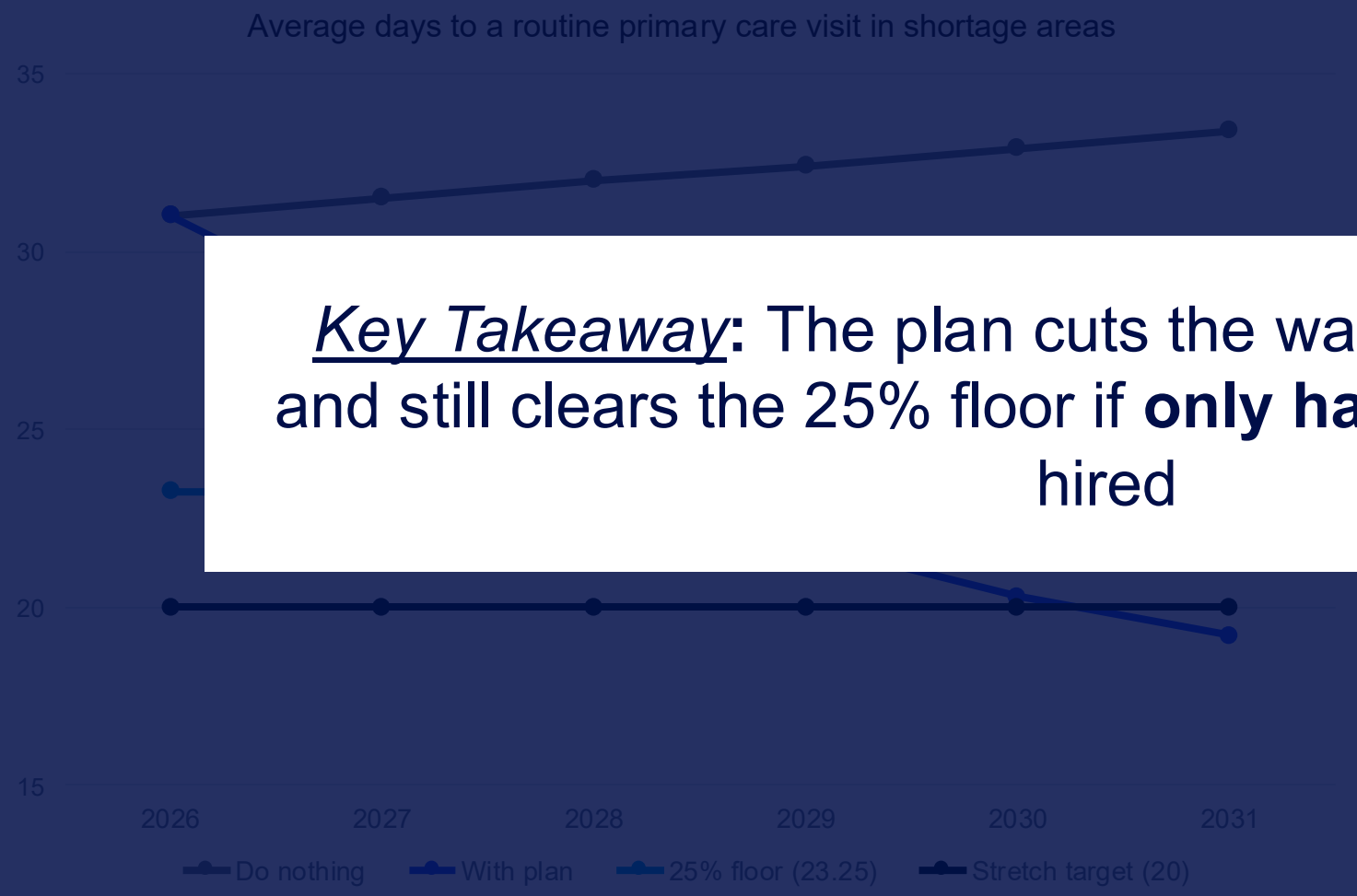
Stress test (2031)	Days
Telehealth 30% short	20.1
No-show program fails	20.1
Only half the clinicians hired	21.5

Key terms: *Floor = the case's minimum: a 25% cut from 31 days.*

Sources: Case A2 formula (days = 31 × 10.3M ÷ completed visits; 1.5% annual erosion); case brief (25% floor; teams may commit to a deeper stretch cut)

Wait Times Fall to 24 Days by 2028 and 19 Days by 2031

The plan beats the 25% floor and a 20-day stretch target under every reading of the case



24.4 days

by end of 2028 (−21%)

nstant is 32

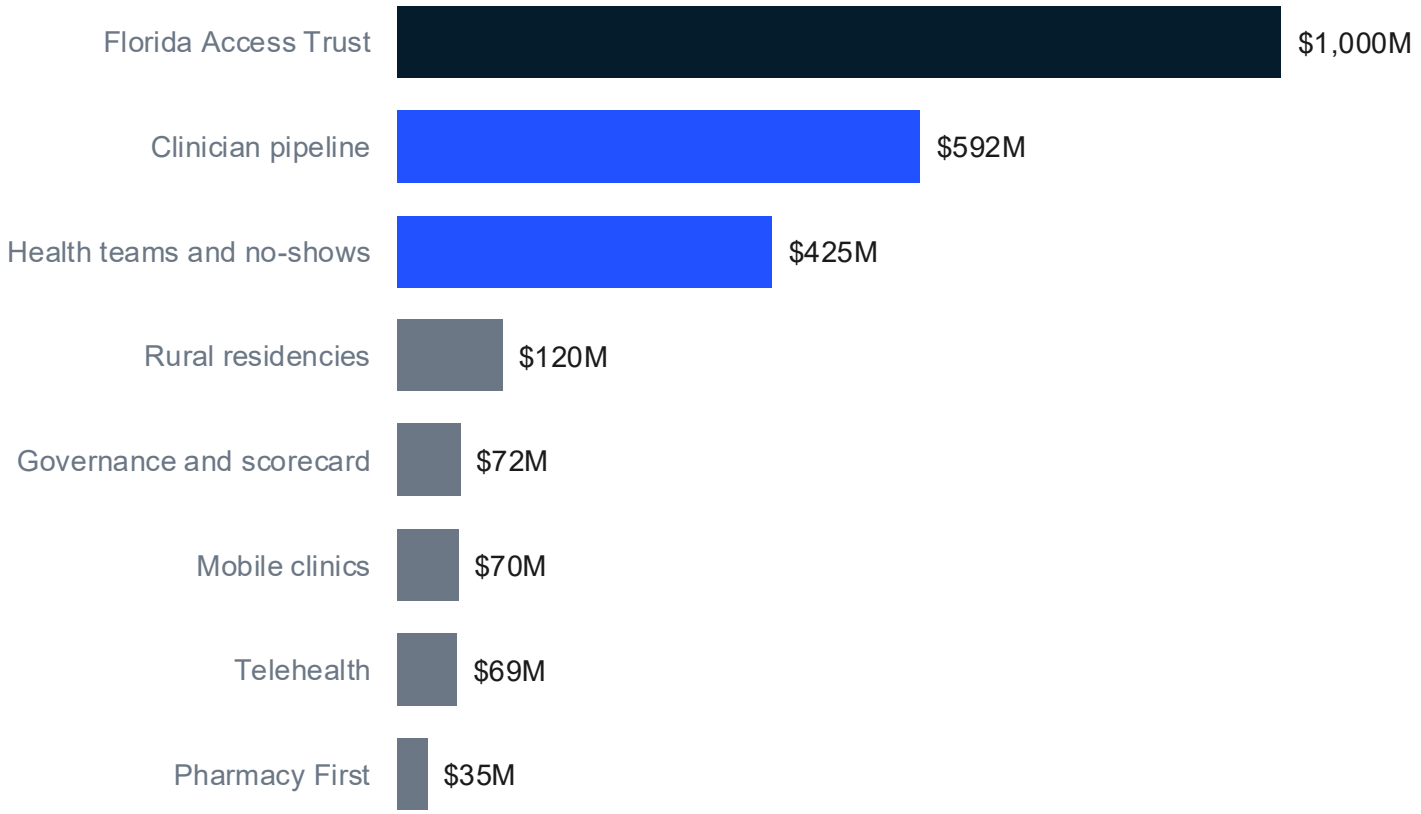
Key Takeaway: The plan cuts the wait **38%, to 19 days**, and still clears the 25% floor if **only half the clinicians** are hired

Stress test (2031)	Days
Telehealth 30% short	20.1
No-show program fails	20.1
Only half the clinicians hired	21.5

The Plan Deploys $2.4B : $1.4B for Care Now and $1.0B Access Fund

The last $0.6B from proposed budget stays with the state and can be allocated to other efforts

Where the $2.4B is allocated, FY2027–2031 ($ millions, programs incl. 30% contingency)



Cost Build-Up	
Initial Infrastructure	$346M
Operating, 5 years	$717M
Programs, modeled	**$1,063M**
× 1.3 contingency	$1,382M
+ Florida Access Trust Fund	$1,000M
Total ask	**$2,382M**

Why not the full $3B? 1,000 clinicians are already 70% of the statewide shortfall and the return on investment for additional spending will not be as effective

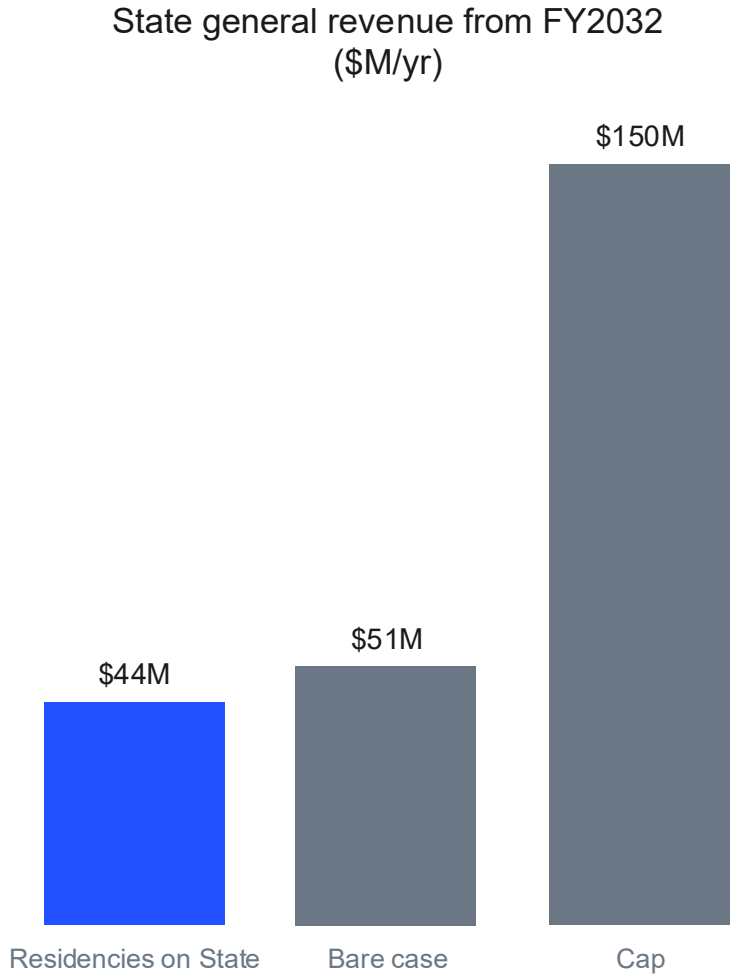
Key terms: *Contingency = a 30% margin on modeled program cost for overruns; not applied to the Trust, which is a fixed deposit.*

From 2032, Funding is split between profits, state, and Medicaid share

The Trust's $44M from the $150M Cap

Program, FY2032	Annual cost	Where funding is coming from?
Telehealth network (500)	$101M	Billing: $191M revenue, +$90M surplus
1,000 clinicians + 40 vans	Salaries	Billing; −$28M net, covered by telehealth surplus
Community health workers	$78M	Medicaid plans, Insurers; uninsured share ($12M) from the State
Pharmacy First	$10M	Insurers; uninsured share ($1.5M) from the State
Stay bonus, years 5–6	$7M	State for residents staying in Florida
Rural residencies (200)	$32M	Medicare; Slots for Doctors; State
Program office + loan repayment	$17M	State ($10M office + $7M for ~68 replacements a year)

Why Medicaid plans pay: 7.06M added visits ÷ 20 = 353K avoided ER visits × $1,200 = $424M a year in payer savings; at a 17.2% Medicaid share, plans save ~$ 72.9M, Where Medicaid pays about 50% of annual cost, $39M, lower than they savings by 53%



Key terms: *Consortium = one statewide network of community health centers that employs the new clinicians and keeps their billing. Medicaid plans = the private managed care companies that run Florida Medicaid. GME = federal graduate medical education funding.*

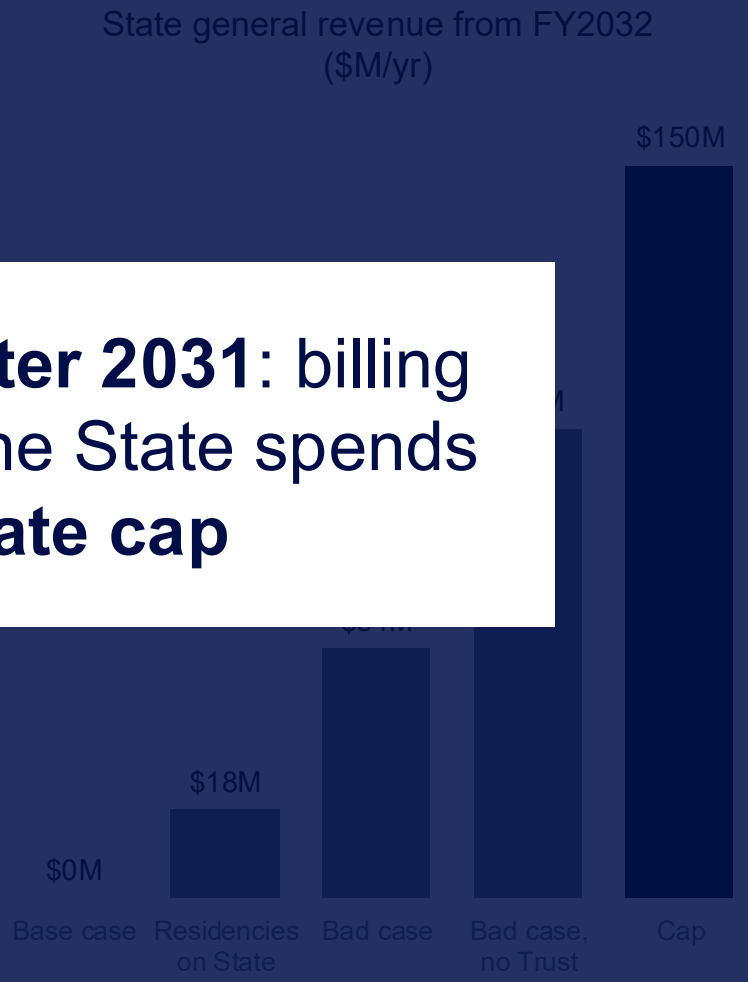
From 2032, Every Program Has a Payer and the State Pays $0

The Trust's $45M a year covers the State's $31M share; even the bad case uses a third of the $150M cap

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1,000 clinicians + 40 vans	Salaries	Billing; −$28M net, covered by telehealth surplus
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Why Medicaid plans pay: 7.06M added visits ÷ 20 = 353K avoided ER visits × $1,200 = $424M a year in payer savings; at a 30% Medicaid share, plans save ~$127M, far more than all 1,200 workers cost ($78M).

<u>*Key Takeaway*</u>: The plan **pays for itself after 2031**: billing and payer savings run the programs, and the State spends $44M, **using 29% of the yearly state cap**



Key terms: *Consortium = one statewide network of community health centers that employs the new clinicians and keeps their billing. Medicaid plans = the private managed care companies that run Florida Medicaid. GME = federal graduate medical education funding.*

Sources: team model FY2032 tab (Appendix A8). ER offset of 1 in 20 visits at ~$1,200 and $150M cap from Case A2 and brief; CHW contract route: KFF; Medicare CHI codes G0019/G0022: AAFP; rural GME: ECG (CAA 2021). Bad case = residencies on State funds + Medicaid plans fund only half of insured CHW cost. The 30% Medicaid share and 4.5% Trust draw are team assumptions.

Risks & Mitigation

The plan holds under realistic shocks, and the county scorecard flags trouble by 2028

	Risks	Mitigation	
Recruiting	Largest initiative: 3.51M visits from 1,000 hires	**NP-heavy mix, loan repayment, residencies; 21.5 days even at half**	✓
Medicare telehealth	Home telehealth rules for Medicare expire end of 2027[1]; 21.8% of Floridians are 65+[2]	**Kiosks inside clinics; weight telehealth toward Medicaid and commercial patients**	✓
Medicaid cuts	~$14B less federal Medicaid funding through 2034[2] threatens plan-funded CHWs	**$45M Trust reserve; bear case $51M out of $150M cap[3]**	✓
Trust returns	A market downturn could cut the $45M draw	**4.5% draw is below the 4.9% average[4]; with no Trust the worst case is $96M, still under the cap[3]**	✓

Sources: (1) AASM (Medicare telehealth flexibilities extended through Dec 31, 2027). (2) NACUBO-Commonfund Study of Endowments 2025.

Recommendation and Roadmap

Quick wins in year one, hiring through 2031, self-funding from 2032

FY2027 Launch

- Reminder and risk-scoring platform
- Telehealth network, 100 clinicians
- Pharmacy First protocols
- First 360 CHWs; first $200M Trust deposit

FY2028 Scale

- 840 CHWs; kiosks and vans live
- Rural residency programs open
- Checkpoint: 25 days or fewer (plan: 24.4)

FY2029–31 Build

- Hire to 1,000 clinicians
- 200 residents in 16 programs
- AHCA adds CHW rule to Medicaid contracts

FY2032+ Sustain

- Consortium runs on billing
- Plans fund community health workers
- State GR pays $44

Governance: one owner (Florida DOH Office of Rural Health); a yearly time-to-care scorecard for all 67 counties; any county above 26 days for two years gets the next mobile routes and hires.

19.2 days
by 2031, a 38% cut

$2.4B
of the $3B Fund

$44M State GR
from 2032

Key terms: *AHCA = Agency for Health Care Administration, which runs Florida Medicaid. The 26-day trigger is a team-set threshold, roughly the 2028 checkpoint.*

Appendix

APPENDIX

A1. Alternatives Considered and Why They Were Eliminated

Criteria Considered:	Speed to impact	Cost per added visit	Strength of evidence	Sustainability after 2031

Alternative considered	Why it was eliminated
Hiring-only plan	Needs ~1,765 physicians, 23% more than Florida's entire shortfall of 1,434; each runs a ~$83K annual deficit
Large mobile fleet (100 vans)	Beyond our 40 vans, each extra van adds 2,800 visits at a ~$288K annual loss ($196 per visit vs. $93.50 collected)
Halving no-shows to 10%	Goes beyond what published studies support; we assume a 30% relative cut instead
Free rides for every patient	A randomized trial of free rideshare for Medicaid patients found no reduction in missed visits (Chaiyachati et al., JAMA Intern Med 2018)
Spending the full $3B	Recruiting beyond 1,000 clinicians (70% of the shortfall) is not realistic by 2031; the next-best use, vans, costs $196 a visit
No Trust: spend it all on programs	Programs would need $31M of State GR a year from 2032 ($96M in the bad case) and would depend on yearly appropriations

APPENDIX

A2. Visit Math by Initiative and Year (millions)

Year	Do nothing	No-shows	Telehealth	Physicians	NPs/PAs	Mobile	Pharmacy	Total	Days (31)
2027	10.15	0.23	0.50	0.12	0.35	0.02	0.02	**11.38**	28.0
2028	9.99	0.52	1.25	0.36	0.81	0.07	0.07	**13.07**	24.4
2029	9.84	0.74	1.88	0.60	1.39	0.11	0.11	**14.66**	21.8
2030	9.70	0.73	2.25	0.90	1.85	0.11	0.18	**15.71**	20.3
2031	9.55	0.72	2.50	1.20	2.31	0.11	0.22	**16.61**	19.2

APPENDIX

A3. Unit Economics per Clinician or Unit per Year

Unit	Revenue / yr	Cost build-up	Cost / yr	Net / yr	Cost per visit
Physician	4,000 × 0.85 × $110 = $374,000	$227,700 × 1.25 + 2 staff ($112,500) + $60K space	$457,125	**−$83,125**	$114
NP/PA	3,300 × 0.85 × $110 = $308,550	$129,510 × 1.25 + 1.5 staff ($84,375) + $50K space	$296,263	**+$12,288**	$90
Telehealth NP	5,000 × 0.85 × $90 = $382,500	$161,888 salary + $40K platform and malpractice	$201,888	**+$180,613**	$40
Mobile van	2,800 × 0.85 × $110 = $261,800	Case average operating cost	$550,000	**−$288,200**	$196
Community health worker	$0 (no Florida Medicaid benefit)	$45,630 × 1.3 + $6K phone, training, supervision	$65,319	**−$65,319**	~$59*

*Cost per added no-show visit = 650 outreach CHWs × $65,319 ÷ 0.72M visits. Pharmacy First: $45 per consult. Source: Case A2, A9; BLS May 2025;. Benefits load, support staff and space are assumptions.

APPENDIX

A4. Five-Year Cost Build and Spend by Year ($M)

Operating	2027	2028	2029	2030	2031	Total
CHWs	23.5	54.9	78.4	78.4	78.4	313.5
Physicians: deficit + first-year shortfall	7.0	16.5	21.4	29.9	36.2	111.0
NPs/PAs: first-year shortfall	13.0	17.3	21.6	17.3	17.3	86.4
Rural residencies	0.0	8.0	16.0	24.0	32.0	80.0
Program office and scorecard	10.0	10.0	10.0	10.0	10.0	50.0
Mobile operating gap	2.3	6.9	11.5	11.5	11.5	43.8
Pharmacy consult fees	1.0	3.0	5.0	7.9	9.9	26.7
Telehealth ramp-year cost	6.1	0.0	0.0	0.0	0.0	6.1
Operating total	**62.8**	**116.5**	**163.9**	**179.0**	**195.2**	**717.5**

Spend by year	2027	2028	2029	2030	2031	Total
Operating (programs)	62.8	116.5	163.9	179.0	195.2	717.5
One-time (spread 40/30/15/10/5%)	138.2	103.7	51.8	34.6	17.3	345.6
Contingency (30% of the above)	60.3	66.1	64.7	64.1	63.8	318.9
Access Trust deposits (equal yearly)	200.0	200.0	200.0	200.0	200.0	1000.0
Total drawn from the fund	**461.4**	**486.2**	**480.5**	**477.7**	**476.3**	**2382.0**

One-time item	$M
Clinic space build-out (1,000 x $150K)	150.0
NP/PA loan repayment awards (700 x $90K)	63.0
Physician loan repayment awards (300 x $150K)	45.0
Telehealth platform (assumption)	35.0
Reminder and risk-scoring platform (assumption)	10.0
Mobile vehicles (40 x $250K)	10.0
Kiosks (300 x $40K)	12.0
County scorecard system (assumption)	5.0
CHW training (1,200 x $3K)	3.6
Rural residency program start-up grants (16 x $750K)	12.0
Total	**345.6**

Programs modeled:

$1,063.1M × 1.3 contingency = $1,382.0M; + Florida Access Trust $1,000M = $2,382.0M; $618M of the $3B stays unspent.

APPENDIX

A5. Pipeline Economics, Residency Expansion and Van Build-Up

Pathway	Cost per added visit	Calculation
Loan repayment (FRAME physician max)	$9.38	$150,000 ÷ 16,000 visits over 4 years
Rural-track residency	$39.79	$300,000 ÷ (0.62 × 0.76 × 16,000)
Standard residency slot	$142.59	$300,000 ÷ (0.50 × 0.263 × 16,000)

Rural residency expansion	Value
Residents in training by 2031 (50 a year from 2028)	200
New programs (200 ÷ 12.5 per program)	16
Start-up grants (16 × $750K)	$12.0M
Graduates a year at steady state (200 ÷ 3)	66.7
...practicing rurally in Florida (× 62% × 76%)	~31
Replacement clinicians needed a year after 2031	~68

Van crew and costs	$ / yr
Nurse practitioner ($130K + 30%)	169,000
Registered nurse ($84,190 + 30%)	109,447
Medical assistant ($40K + 30%)	52,000
Driver / CHW ($45K + 30%)	58,500
Crew total	**388,947**
Fuel, insurance, supplies, IT, oversight	152,000
Built-up total (vs. $550K benchmark)	**540,947**
ER savings to payers per van	168,000
Lean van (no RN)	431,500

APPENDIX

A6. Headcount and Assumptions

Role	Number
In-person physicians	300
In-person NPs/PAs	700
Telehealth clinicians	500
Clinic support staff	1,650
Community health workers	1,200
CHW supervisors (1:20)	60
Mobile crews (4 per van)	160
Rural residents (steady state)	200
Program office	~50
Total	**~4,820**

Assumption	Value	Sensitivity
Formula constant	31 (passes at 32)	High
No-show cut	20% to 14%	High
Recruiting pace	1,000 clinicians by 2031	High
Medicaid share of added visits	30%	High
Trust draw rate	4.5% a year	Medium
CHW loaded cost / headcount	$65.3K / 1,200	Medium
Benefits load	1.25× clinicians, 1.3× CHWs	Medium
Space and overhead	$60K MD, $50K NP a year	Medium
Pharmacy consult fee	$45	Low
Kiosk cost	$40K (team build suggests less)	Low

APPENDIX

A7. Glossary of Key Terms

Term	Meaning
Shortage area (HPSA)	Federally designated Health Professional Shortage Area: too few primary care clinicians for the population (e.g., >3,500 residents per physician)
Days to care	Average days from asking for a routine primary care visit to completing it; the case's success metric
Completed visit	A visit that actually happens, in person or virtual; booked visits minus no-shows
Community health worker (CHW)	Trained local outreach worker who helps residents get care; not a clinician
Patient navigator	A CHW who calls high-risk patients before a visit and removes barriers
Community health center (CHC)	Federally funded clinic that serves everyone regardless of ability to pay; higher Medicaid and Medicare rates
NP / PA	Nurse practitioner / physician assistant: licensed clinicians who provide most primary care
FRAME	Florida Reimbursement Assistance for Medical Education: the State's loan repayment program for shortage-area clinicians
Medicaid plans (MCOs)	Private managed care companies paid by the State to run Florida Medicaid
GME / Slots for Doctors	Federal and State funding for residency training positions
State GR	State general revenue; the case caps it at $150M a year from FY2032
Consortium	One statewide network of community health centers that employs the plan's clinicians and keeps their billing
Florida Access Trust	A $1.0B endowment funded by the plan; only its yearly income (4.5%) is spent

APPENDIX

A8. Sources

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Thank You