Healthy San Francisco

Our Health Access Program

Annual Report to the San Francisco Health Commission (for Fiscal Year 2011-12)

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I. SUMMARY AND OVERVIEW OF 2011-12 ACCOMPLISHMENTS

At the end of fiscal year 2011-12, Healthy San Francisco (HSF) celebrated its fifth year of operation. Its accomplishments during that year were no less significant than the ones achieved during its inaugural year (2007-08). HSF continued to focus on its core objectives to improve access to care, appropriate service utilization, quality of care and patient experience.

It did so in the following ways:

Access to Care Highlights

- Ended fiscal year (FY) 2011-12 with 46,822 participants
- Since inception, HSF has provided access to care to over 116,000 uninsured adult residents.
- Added two new primary care medical homes to the network for a total of 37.

Appropriate Service Utilization Highlights

- Had an office visit rate per year (3) is the same as the national Medicaid average.
- Had avoidable ED utilization (8%) which was lower than State's Medi-Cal average of 18%.

Quality of Care Highlights

- Implemented a new health education outreach campaign to improve diabetic care.
- Had a readmission rate was below the national rate of 18%.
- Met national Medicaid average (86%) of participants with asthma getting medication.

Participant Experience Highlights

- Participant complaint rate was remained stable over the past two years.
- Health Access Questionnaire found that participants continuously enrolled in the program reported less ER utilization, a usual source of care, less difficulty accessing care, improved rating of medical care and less delays accessing care.

In FY2011-12, the Department of Public Health's estimated HSF expenditures totaled $101.1 million. Of that amount, $23.7 million was covered by revenue and $77.4 million was covered with a City and County General Fund subsidy. In addition, private community HSF providers incurred $38.7 million in net HSF expenditures. In total, estimated FY2011-12 HSF expenditures totaled $139.8 million. With a total of 549,525 participant months, the estimated per participant per month expenditure was $255

Healthy San Francisco was again distinguished for its groundbreaking work. It was as selected as one of the five 2011 Innovations in Government finalists recognized by the Ash Center for Democratic Governance and Innovation at the John F. Kennedy School of Government, Harvard University.

The Department's and Healthy San Francisco's foray into the Affordable Care Act (ACA) preparation and implementation began in earnest on July 1, 2011, when the Department successfully transitioned over 10,000 participants from HSF into a new federally supported program, SF PATH, designed to help prepare uninsured adults for ACA implementation.

It is estimated that 60% of the combined HSF and SF PATH populations will be eligible for health insurance beginning January 1, 2014. In January 2014 HSF will have been in operation for 6.5 years and

in many respects San Francisco will be ahead of the curve in its local health reform preparations because HSF has:

- Addressed some of the "pent-up" demand for health care services that can occur with new health insurance programs
- Promoted participant use of medical homes and preventive services
- Expanded the number of providers serving uninsured individuals
- Developed a mechanism for identifying those eligible for health insurance (One-e-App)
- Positioned providers to compete successfully in a more competitive health care landscape

Moving forward, the Department, its community partners and HSF will increasingly focus its activities on ACA preparedness over the next two years.

As in previous years, this annual report is designed to provide the public, participants, providers, researchers, other interested communities and policy makers with detailed information on how the Department operates Healthy San Francisco, and how it monitors and tracks its performance.

II. FIVE YEAR RETROSPECTIVE – PROGRAM MILESTONES

Since 2007, San Francisco's health care community has partnered to provide health services to a diverse uninsured adult population through the Healthy San Francisco (HSF) program. HSF provides comprehensive affordable health care to uninsured adults irrespective of the person's employment status, immigration status or pre-existing medical conditions. It integrates public and private providers into a single, coordinated system of care.

From its debut on July 2, 2007, demand for HSF and health care services has been high. The program's initial two month pilot enrolled over 1,800 uninsured adult residents when projections were that only 600 – 1,000 residents would enroll. As of June 30, 2012, HSF had served over 116,000 residents. This is a significant achievement for a City and County of approximately 800,000 residents where HSF enrollment is voluntary.

During its first five years, the great recession and global financial crisis (2007 – 2012) resulted in an increase in the number of uninsured individuals across the nation and in San Francisco. The Department responded by increasing the number of primary care medical homes, enhancing existing Department clinic capacity, and investing in quality improvement initiatives designed to improve clinic efficiency and patient experience.

The primary care medical home is the foundation of HSF and has contributed to a more organized health care delivery system for uninsured adults. HSF's innovative health care access model is recognized locally and nationally. Its success over the past five years is chronicled in the timeline accompanying this section. The timeline highlights milestones in enrollment, provider network expansion, evaluation findings, and program recognition.

> *"But for me, Healthy San Francisco works. My medical home is just blocks from my apartment, and the services are effective even for a complicated, misunderstood condition like mine. San Francisco, you make me so proud."*
>
> Ms. Bola Odulate
> KQED Radio Perspective Series (9/19/2011)
> (www.kqed.org/a/perspectives/R201109190735)

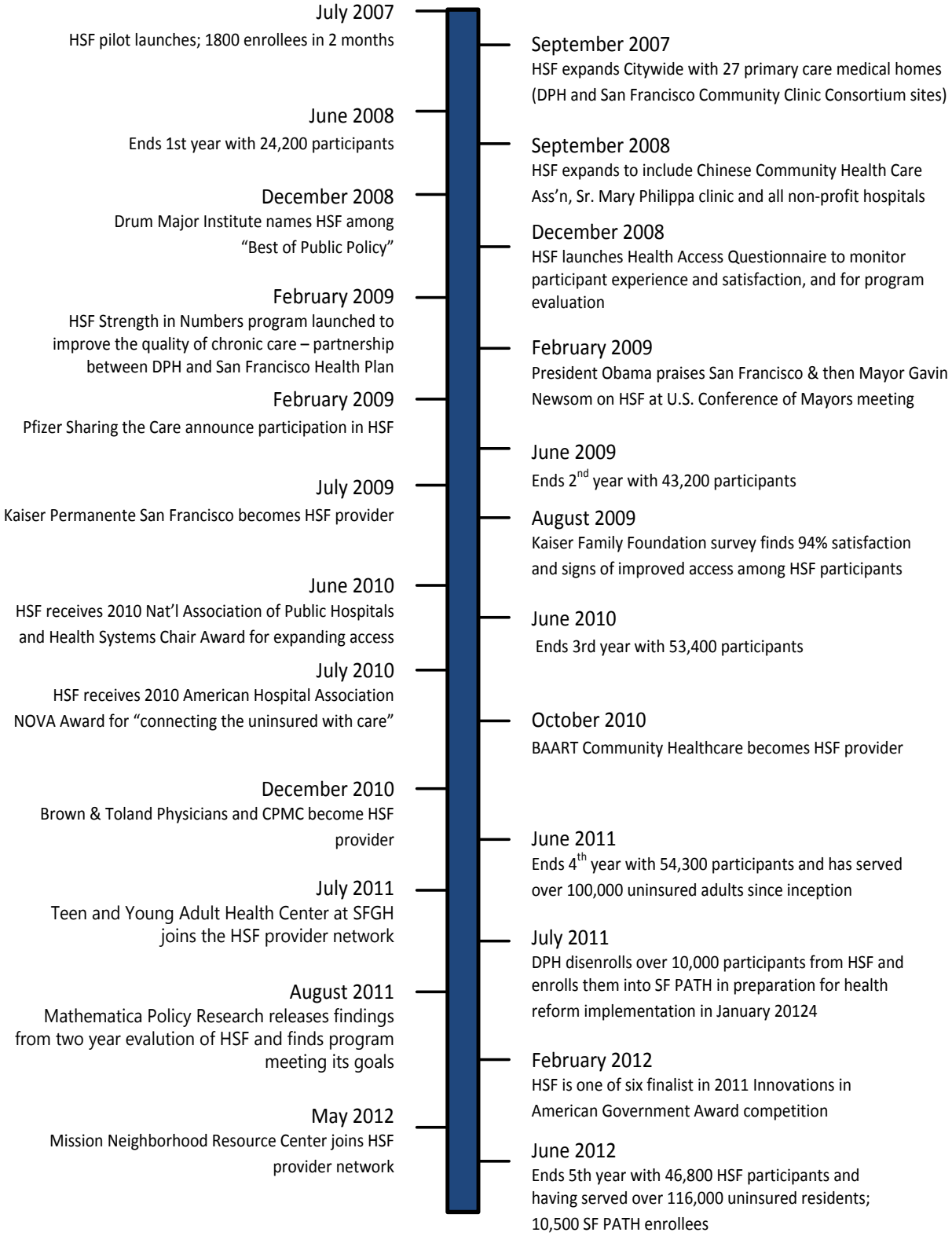
One key event not listed on the timeline is the City and County of San Francisco's successful legal defense of the San Francisco Health Care Security Ordinance. In November 2006, the Golden Gate Restaurant Association (GGRA) filed a federal lawsuit challenging the legality of HSF's companion program in the Ordinance, the Employer Spending Requirement (ESR). The ESR requires certain businesses to make health care expenditures on behalf of designated employees. While the lawsuit did not challenge HSF, it was by far, the single most significant obstacle encountered by the program in its first five years. The lawsuit created a cloud over both HSF and the ESR, before either program was implemented and called into question the future of both programs. It had a profound ripple effect on HSF and created ambiguity among participants, providers and the public with respect to the sustainability and viability of the program. The case reached the U.S. Supreme Court and in June 2010, the Court announced that it would not hear GGRA's petition. This decision effectively upheld a lower federal Court decision, allowed continuation of the ESR and provided clarity to the San Francisco community.

HSF has served dual purposes: (1) providing health care services to uninsured adults and (2) preparing the Department, other providers and HSF participants for key implementation components of the

Affordable Care Act (ACA) in January 2014. An estimated 60% of uninsured residents in San Francisco's two health access programs will become insured under ACA. HSF is well poised to make a successful transition. At the same time, thousands will remain uninsured after ACA and need access to care. HSF and its health care access model will remain relevant even with ACA implementation.

HSF has demonstrated the effectiveness of local health reform, the importance of leveraging existing resources, and ability of medical homes to reduce duplication, improve care coordination and reduce avoidable hospitalizations. Its next five years will be as fruitful and forward thinking in its approach to providing for the health needs of the residually uninsured.

Summary of Healthy San Francisco Milestones (July 2007 to June 2012)



III. HEALTHY SAN FRANCISCO – SF PATH TRANSITION

On July 1, 2011, 10,116 Healthy San Francisco (HSF) participants (19% of the HSF population) were disenrolled from the program and simultaneously enrolled into the "San Francisco Provides Access To Healthcare" (SF PATH) program. The impact of migrating over 10,000 individuals to another program will be seen in various program statistics.

HSF and SF PATH are two separate health care access programs. SF PATH was created in response to California's "Bridge to Reform" Demonstration 1115 Medicaid Waiver. The waiver allowed for the development of a new state-wide health care program called the Low Income Health Program (LIHP). LIHP is designed to move low-income uninsured individuals into a coordinated system of care to improve access to care, enhance quality of care, reduce episodic care and improve health status. LIHP ends on December 31, 2013 when enrollees will transition into health insurance under Medi-Cal or the California Health Benefits Exchange as a result of the Affordable Care Act. The Department's LIHP program is called SF PATH.

The Department's participation in LIHP is an extension of its participation in California's former 1115 Waiver program called the Health Care Coverage Initiative. That Initiative provided the Department with federal reimbursement to cover a portion of the cost of care of some designated HSF participants who met federal guidelines. SF PATH is comprised of these former HSF participants who met the federal Initiative and LIHP eligibility guidelines, and who have a Department medical home. In addition, SF PATH enrolls new applicants based on eligibility and selection of a Department. Federal reimbursement that the Department once received for HSF participants who meet Initiative eligibility is now provided to the SF PATH program and its enrollees. The SF PATH provider network is the Department.

The impact of disenrolling over 10,000 HSF participants is seen in the following

Reductions In	• number of currently enrolled HSF participants • number of new HSF applicants and participants due to SF PATH eligibility • number of HSF participants in with a Department medical home • number of service encounters • other statistics such as customer service calls, complaints, etc. • amount of HSF expenditures
Changes In	• service utilization (both type of service and rates) • distribution of HSF participants across medical homes • demographics of the HSF population • statistics such as disenrollment, complaints, expenditures per person
Elimination Of	federal funding for HSF since these funds are now used for SF PATH enrollees

Throughout this report, reference to the "HSF-SF PATH transition" is made to ensure that the reader understands the primary underlying cause of significant changes in data from 2010-11 to 2011-12.

IV. HEALTH CARE SECURITY ORDINANCE

In June 2006, the San Francisco Board of Supervisors adopted the San Francisco Health Care Security Ordinance (Ordinance No. 218-06) which created two new City and County programs, the Employer Spending Requirement (ESR) and the Health Access Program, renamed Healthy San Francisco (HSF) in April 2007. Both ESR and HSF work in tandem and are designed to address the health needs of San Francisco's uninsured residents and workers. The Office of Labor Standards Enforcement (OLSE) oversees the implementation of the ESR while the Department oversees the implementation of HSF.

The ESR requires designated employers to spend a minimum amount of money on health care expenditures for their eligible employees. Employers have many options to fulfill the mandate, such as private health insurance plans, health reimbursement plans, the City Option (i.e., Healthy San Francisco).

During FY2011-12, the Board of Supervisors amended the Ordinance with respect to the ESR. The OLSE's analysis of calendar year 2010 employer expenditures found that among employers who had elected to use reimbursement plans, on average 20% of funds allocated to the reimbursement accounts were used by certain employees. The Board of Supervisors sought to address the unintended consequence of un- or under-utilized health reimbursement plans by certain employers. The San Francisco Health Commission supported amending the Ordinance.[1]

In November 2011, the Board of Supervisors adopted Ordinance No. 232-11 amending provisions of the Health Care Security Ordinance (HCSO). The following ESR changes took effect on January 1, 2012 as a result of Ordinance No. 232-11:

- All businesses with 20 or more employees and nonprofit organizations with 50 or more employees must post the 2012 Official OLSE Notice at every workplace or job site.
- There are new rules and requirements for employers that impose a surcharge on customers to cover, in whole or in part, the costs of the HCSO spending requirement.
- There are new rules and requirements for employers that utilize reimbursement accounts to satisfy, in whole or in part, the HCSO spending requirement.

The Ordinance No. 232-11 did not amend any HSF provisions.

[1] Health Commission Resolution No. 8-11 "Resolution Supporting Intent of Amendments to the San Francisco Health Care Security Ordinance."

V. 2010-11 PROGRAM ACTIVITIES

A. COMMUNICATIONS, OUTREACH, APPLICATIONS AND ENROLLMENT

This section of the report discusses outreach, application and enrollment trends in the Healthy San Francisco (HSF) program. Volume statistics in this area will differ significantly from FY2010-11 data due to the HSF-SF PATH transition.

Key 2011-12 highlights were:

- HSF ended fiscal year (FY) 2011-12 with 46,822 uninsured adult residents enrolled in the program, a 12% decrease from the end of FY 2010-11.
- Based on the 2009 California Health Interview Survey (released in February 2011), the HSF and SF PATH (10,448 enrollees) programs combined were serving 89% (57,270) of the estimated 64,000 uninsured adult population in San Francisco.
- Almost 2,000 residents obtained health insurance through the HSF application process that helps identify those eligible for, but not enrolled in health insurance.
- HSF ended the fiscal year with approximately 69,214 individuals ever disenrolled.
- In total, since inception, HSF has provided access to care to over 116,000 uninsured adult residents (46,822 currently enrolled plus the 69,214 currently disenrolled).

Communications and Outreach

The HSF website (www.healthysanfrancisco.org) continues to be the most accessible and versatile program communications tool. HSF uses word of mouth and community outreach to generate interest and attention. The website had a total of 192,031 visitors during the year – an average of 16,000 monthly. The website has both Chinese language and Spanish language components. In addition to the website, the general public can obtain information on San Francisco's health access programs (HSF and SF PATH) and where to apply for the programs by calling the City and County's 24 hours a day/7 days a week 3-1-1 system. While call volume for these health access programs decreased during FY2011-12, they continued to be a top-rated reason that people call 3-1-1 after inquires about MUNI information and street repairs. On average, 353 people called 3-1-1 each month for information on San Francisco's health access programs (HSF and SF PATH) during FY2011-12 (total of 4,240 calls).[2]

HSF recognizes the value in providing a social media outlet for program exposure, and in leveraging social media to engage HSF participant populations that have proven harder to engage through more traditional program communications channels such as mail and telephone. During this fiscal year, the Department's HSF third-party administrator, San Francisco Health Plan, began regularly posting program material on the HSF Facebook page (http://www.facebook.com/HealthySF). Content ranged from links to articles highlighting the program to health education tips and notices for community events. During FY2011-12, the number of "likes" for the Healthy San Francisco Facebook page increased by 52% from 148 to 225.

[2] Due to the method in which 3-1-1 call data is collected, this information cannot be obtained for HSF only.

Applications

HSF enrollment starts with the trained Application Assistors (AAs). HSF has 195 AAs who assist residents in applying for the program at 31 different locations throughout the City. During FY2011-12, AAs processed 60,130 applications through the web-based eligibility and enrollment system – One-e-App.

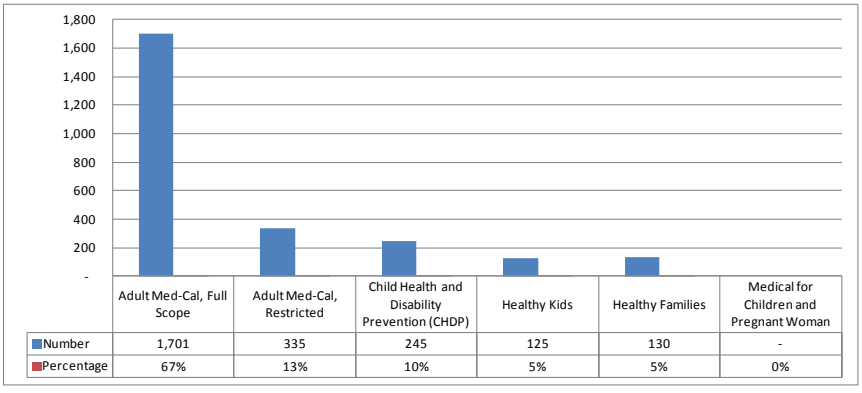
Table A1
Application Volume – No. of HSF Applications Processed for All Dispositions (July 2011 – June 2012)

Distribution of One-e-App Applications by Type	% of Applications	# of Applications	Avg. Household Size Applying
New	33%	19,922	1.1
Renewal	40%	24,200	1.2
Modified	27%	16,008	1.2
	100%	**60,130**	**1.2**

There were 60,130 applications processed for 62,857 unique applicants with an average of 1.2 people applying per household.[3] For any application processed, the applicant can be determined eligible for HSF, eligible for another program or ineligible for any program. Of the 62,857 program applicants, 95% were determined eligible for and submitted to a health program, 4% did not have an eligibility determination made or did not complete an application and about 1% were determined ineligible for any program. An eligibility determination may not be made if the application is still in process or if the application is cancelled before a final eligibility determination is made. Ineligibility occurs if the applicant exceeds the income eligibility threshold, is not within the age eligibility range, has health insurance or is not a San Francisco resident.

In FY2011-12, a total of 2,536 applications received were determined preliminarily eligible for other health programs (excluding SF PATH) as seen in Graph A1. Eighty percent were determined eligible for Medi-Cal demonstrating HSF's role in identifying uninsured residents eligible for, but not enrolled in, public health insurance and facilitating enrollment into the appropriate program with use of One-e-App.

Graph A1
Number of Applications Processed for Other Health Programs (July 2011—June 2012)



[3] An individual can have more than one application in a fiscal year. For example: (1) a new and a renewal or modified application or (2) a renewal application and a modified application. In addition, an application can have multiple applicants.

Enrollments, Disenrollments and Percentage of Uninsured

HSF is a voluntary program. As such, there is no expectation that all uninsured adults will enroll in the program. While the program is designed to facilitate enrollment to the greatest extent possible and does not have any penalties for failure to enroll or disenroll, it is inevitable that some uninsured adult residents will elect not to participate. According to the 2009 statewide California Health Interview Survey (CHIS) released in February 2011, there are an estimated 64,000 uninsured adults in San Francisco.[4]

At the end of the fiscal year, there were 46,822 participants enrolled in HSF. This is a 12% decrease in enrollment compared to the end of FY2010-11 (54,348 participants). The reduction is due principally to the July 1, 2011 transfer of 10,116 HSF participants to SF PATH, and usual yearlong enrollment and disenrollment activity. At the end of FY2011-12, HSF was serving 73% of the estimated uninsured adults.

Table A2
Enrollment and Percentage of Uninsured Adults Enrolled

Fiscal Year	Enrollment at end of FY	Estimated No. of Uninsured Adults	Enrolled as % of Uninsured Est.
2007-08	24,210	73,000	33%
2008-09	43,200	60,000	72%
2009-10	53,428	60,000	89%
2010-11	54,348	64,000	85%
2011-12	46,822	64,000	73%

HSF is one of two health care access programs for uninsured adults overseen by the Department. The other is SF PATH. There were 10,448 SF PATH enrollees at the end of FY2011-12. Combining HSF and SF PATH enrollment reveals that an estimated 89% (46,822 + 10,448 = 57,270) of San Francisco's uninsured adults were participating in programs designed to ensure access to health care.

Table A3
City-wide Health Access Enrollment (HSF and SF PATH) and Percentage of Uninsured Adults Enrolled

Fiscal Year	HSF Enrollment	SF PATH Enrollment	Total Enrollment	Estimated No. of Uninsured Adults	Enrolled as % of Uninsured Est.
2011-12	46,822	10,448	57,270	64,000	89%

Enrollment fluctuates daily as new people enroll, existing participants renew eligibility and participants disenroll. At the end of the FY2011-12, 69,214 HSF participants were currently disenrolled from the program. Disenrollments can occur because participants no longer meet the program eligibility criteria, no longer choose to remain in the program and voluntarily disenroll, do not pay the quarterly participation fee, etc. Since its inception in July 2007, HSF has served 116,036 unique uninsured San Francisco adult residents as noted in Table A4. Of these, 46,822 are current participants and 69,214 are former participants who are currently disenrolled from the program.

[4] The University of California at Los Angeles' Center for Health Policy Studies has conducted the California Health Interview Survey (CHIS) survey since 2001. The survey is done every two years. The 2009 survey findings were released February 2011. Because the City and County does not conduct a separate survey to estimate the number of uninsured residents, the Department relies on CHIS for the estimate of uninsured residents. The CHIS information was used to determine the potential maximum number of participants (assuming that all uninsured adult residents are all enrolled in this voluntary program at any one time, which is unlikely).

Table A4
Unduplicated Count of Total Ever Enrolled by Fiscal Year

Fiscal Year	Currently Enrolled at end of FY	Currently Disenrolled at end of FY	Total Ever Enrolled at End of FY (Enrolled + Disenrolled)
2007-08	24,210	1,059	25,269
2008-09	43,200	11,958	59,698
2009-10	53,428	27,137	80,565
2010-11	54,348	45,889	100,237
2011-12	46,822	69,214[5]	116,036

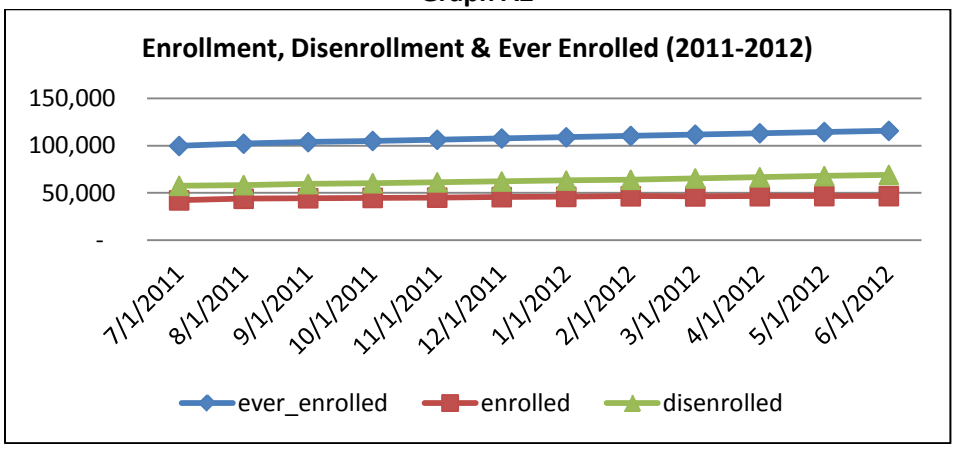
At the end of the FY 2011-12, the HSF disenrollment rate was 60%. The higher disenrollment rate is due to the HSF-SF PATH transition of over 10,000 participants.

Table A5
HSF Disenrollment Rate

Total Ever Disenrolled	Less Re-enrolled	Equals Currently Disenrolled	Plus Currently Enrolled	Equals Ever Enrolled	Disenrollment Rate = (46,822 ÷ 116,036)
85,227	16,013	69,214	46,822	116,036	60%

As the number of HSF participants increases over time so does the number of disenrolled participants. This is because as more participants are enrolled, more are required to renew, and more may not because they no longer meet the program eligibility criteria, no longer choose to remain in the program and voluntarily disenroll, etc. In addition, given that HSF is a voluntary program and individuals can re-enroll after a disenrollment without penalty, the Department expects that there will always be a certain level of enrollment mobility within the program. The following graph shows enrollment, disenrollment and ever enrollment trend for the past fiscal year.

Graph A2



Disenrollment Analysis

The Department regularly monitors and analyzes participant disenrollments. By the end of FY2011-12, 69,214 individuals were currently disenrolled from HSF for the following reasons:

[5] Includes 10,116 disenrolled due to transfer to SF PATH program.

Table A6
Disenrollments By Reason

Current Disenrollments by Reason	Number	Percent
Transitioned to SF PATH Program	9,235	13%
Program Eligibility	13,649	20%
Participation Fee	5,794	8%
Annual Renewal	40,299	58%
Other/Voluntary	237	<1%

1. *Disenrollments Due to Program Eligibility* (20% - 13,649 participants)
The data indicates that 20% of those disenrolled no longer met the HSF eligibility requirements.

Table A7
Program Eligibility Disenrollments

Disenrollment Reason	Number	Percent
Enrolled in Public Coverage (including Medi-Cal and PCIP)	5,234	38%
Exceeds Program Age Requirements	3,066	22%
Enrolled in Employer or Private Insurance	2,484	18%
Determined Eligible for Other Programs During Renewal or Modification or Ineligible	1,719	13%
Not a San Francisco Resident	1,146	8%

2. *Disenrollments Due to Participation Fee* (8% - 5,794 participants)
Disenrollments due to insufficient payment of the quarterly participation fee comprised 8% of program disenrollments at the end of FY2011-12. These disenrollments were reflected in the following manner:

- Participant communicates that they could no longer afford the participation fee – 284 disenrollments
- Insufficient payment of the participation fee – 5,510 disenrollments

Disenrollment due to participation fee can occur for many reasons and may mask other disenrollment reasons. These disenrollments do not always indicate inability to pay. For example, a HSF participant above 100% FPL paying a participation fee, who during their 12-month HSF eligibility period, obtains health insurance, may simply disregard the quarterly participant fee invoices. While program guidelines direct HSF participants to contact HSF Customer Service with any changes in health insurance status, some may neglect to do so. In such cases the disenrollment is erroneously coded as failure to pay the participant fee when the correct code should be disenrollment due to eligibility – receipt of health insurance. For some people, participation fee disenrollment may represent the fact that they already received the services they needed.

The Department analyzed the utilization of services among those with a participation fee related disenrollment from the time period July 2007 to June 2012. It was able to do analysis on 3,024 (55% of 5,510) of these disenrolled individuals based on the fact that the individual sought services

from the Department after HSF disenrollment. These 3,024 individuals had a total of 45,623 clinical encounters after a HSF participation fee related disenrollment. Because there is no program penalty for re-enrollment after a disenrollment, the data documents that 45% of the encounters were HSF; that is, 45% of the people with HSF participation fee disenrollments eventually re-enrolled and received health care services under HSF. Twenty-one percent (21%) of the encounters were paid for by health insurance (public or private) or other payor sources after HSF disenrollment. This supports the notion that some disenrollments coded as "insufficient payment" are in actuality disenrollments due to obtaining health insurance. The majority of the remaining encounters (28%) were related to HSF participants who transitioned into SF PATH.

Table A8
Financial Class of Department Provided Health Care Services to 3,024 Individuals with Participation Fee Related Disenrollments (Post Disenrollment)

Financial Class/Payor Source	# of Encounters	Percent
Private Health Insurance (incl. Workers Comp)	499	1%
Patient Pay	1,129	2%
CMAP (County Medical Assistance Program)	1,503	3%
Other Payor Source	1,601	4%
Public Health Insurance	7,482	16%
SF PATH	12,778	28%
Healthy San Francisco	20,631	45%

HSF participants are informed at the time of application and in program materials that modifications to their application can be made at any time due to changes in San Francisco residency, household size and/or household income. From 2007 to 2012, 7,663 HSF participants had adjustments that resulted in a lower federal poverty level (FPL) group. The lowering of the FPL resulted in either: (1) a reduction in the participation fee or (2) no participation fee at all.

Table A9
HSF Participants with a Lower FPL Group in a Later Application

Process Used to Adjust Participant Household Income	HSF Participants with a Lower FPL Group in a Later Application
Mid-Term Modification	1,165
Re-Enrollment	4,505
HSF Renewals	1,993
All	7,663

3. *Disenrollments Due to Incompletion of Annual Renewal* (58% - 40,299 participants)
HSF eligibility is for a 12-month period and the program requires participants to renew their eligibility annually. If the renewal is not done before the 12-month period expires, the participant is disenrolled from the program due to non-renewal. HSF participants receive notices and telephone calls to remind them to renew before the end of their eligibility period.

Similar to what occurred in FY2010-11, the majority of disenrollments in FY2011-12 were due to failure to renew (58%). Of note, approximately 77% (30,851) of the individuals disenrolled for this reason have annual incomes at or below 100% FPL and therefore pay no participation or point-of-service fees (with the exception of fees for emergency care, when appropriate). As a result, there should be no financial barriers to program renewal for over three-fourths of the individuals disenrolled for this reason.

In addition, just as disenrollments due to failure to pay participation fee can mask different disenrollment reasons, the same holds true for disenrollments due to an incomplete annual renewal. For example, someone who has moved outside San Francisco or someone who has obtained health insurance may not contact HSF customer service and inform the representative that they should be disenrolled from the program. The person may simply choose not to respond to the renewal notices which results in the disenrollment being categorized as failure to renew.

Over the years, the Department has implemented new program components to promote on-time renewal and will continue to do so in the future. Data from the Health Access Questionnaire (discussed in Section IVE) reveals that 35% of participants renewing on time did so to be entered into the HSF lottery for a free gift card a program feature that was launched in FY2010-11.

4. *Disenrollments Due to Other Reasons* (<1% - 202 participants)

The remaining disenrollments are voluntary or involuntary due to dissatisfaction with the program, death, or providing false or misleading information on the program application.

Table A10
Disenrollments due to Other Reasons

Disenrollment Reasons	***Number***	***Percentage***
Program Dissatisfaction (admin, services, medical home, etc.)	137	58%
Participant is Deceased	66	28%
False or Misleading Information on HSF Application	34	14%

Reenrollments

Individuals who are disenrolled from the program have the option to re-enroll at any time with no penalty or wait period. Since the inception of the program in July 2007, a total of 14,265 individuals who had been disenrolled from the program re-enrolled and were current participants at the end of the FY2011-12. The data indicates that the initial disenrollment reasons for the majority of re-enrollments were incomplete annual renewal (78%). It also indicates that those with incomplete annual renewals have the shortest length of time (in terms of days) between disenrollment and re-enrollment. Those with a program eligibility disenrollment have the longest length of time.

Table A11
Re-enrollments by Original Disenrollment Reasons (July 2007 – June 2012)

Type	Number	Percent	Category	Reenroll in 0-30 Days	Reenroll in 31-90 days	Reenroll in 91-180 days	Reenroll After 180 days	All Days
Program Eligibility	1,448	10%	% of Reenroll	7%	17%	22%	55%	100%
			Avg # Days	18	55	128	469	252
Participation Fee Related	1,698	12%	% of Reenroll	19%	23%	16%	42%	100%
			Avg # Days	20	59	130	486	243
Incomplete Renewal	11,088	78%	% of Reenroll	36%	24%	12%	28%	100%
			Avg # Days	16	59	129	446	164
Other	31	0%	% of Reenroll	19%	32%	3%	45%	100%
			Avg # Days	14	58	164	512	338
Total	14,265	100%	% of Reenroll	31%	23%	13%	32%	100%
			Avg # Days	16	58	129	455	182

Churn (Multiple Enrollments and Disenrollments)

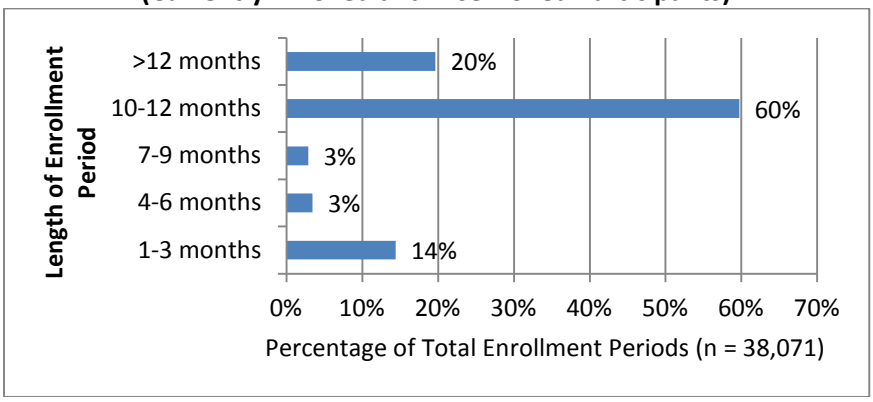
In an effort to determine the impact of the program's eligibility and enrollment provisions on program retention, the Department examines the frequency of multiple enrollments and disenrollments by program participants (known as "churn" for the purposes of this report). The Department defines churn as a program participant with two or more disenrollments. Specifically, a participant has enrolled into the program at least twice and has been disenrolled from the program at least twice. Since the program's inception (from July 2007 to June 2012), 17,340 individuals have had at least two disenrollments. The program has witnessed an increase in participants with multiple disenrollments which is reflective of the increased enrollment over time.

Table A12
Enrollment Status of Individuals with Multiple Enrollments and Disenrollments
(Fiscal Years 2010-11 and 2011-12)

	As of June 30, 2010		As of June 30, 2011		As of June 30, 2012	
	Number	Percent	Number	Percent	Number	Percent
Currently Enrolled	1,175	37%	2,388	27%	4,258	25%
Currently Disenrolled	2,044	63%	6,380	73%	13,082	75%
Total	3,219	100%	8,768	100%	17,340	100%

By virtue of churning through the program, these individuals will all have more than one enrollment period (e.g., an individual with two disenrollments will have two enrollment periods, etc.). A high-level enrollment analysis was conducted on the 17,340 individuals and found that, collectively, there were 38,071 enrollment periods (i.e., the period of time between an enrollment and disenrollment). The data further indicated that most of the individuals with multiple enrollments (60%) had enrollment periods lasting 10 – 12 months and that 20% had enrollment periods lasting more than 12 months (meaning that their disenrollment had occurred after renewing in the program). As a result, those with multiple disenrollments are generally not short-term participants.

Graph A3
Length of Enrollment Periods of Individuals with Two or More Disenrollments
(Currently Enrolled and Disenrolled Participants)



A churn analysis was done on a subset of the 17,340 participants with multiple disenrollments, namely the 13,082 who are currently disenrolled. Of those who are currently disenrolled the following is a distribution by number of disenrollments:

- 10,880 (83%) had two disenrollments,
- 1,960 (15%) had three disenrollments,
- 223 (2%) had four disenrollments,
- 18 (0%) had five disenrollments and
- 1 (0%) had six disenrollments.

The analysis below examines those who had two disenrollments (83% of the population). The disenrollments are grouped by disenrollment type. The data indicates that the majority of HSF participants with two disenrollments were disenrolled for failure to renew, program eligibility or other reasons (81%), 18% were in instances in which one of the disenrollments related to the participation fee and 2% were cases in which both of the disenrollments related to the participation fee.

Table A13
Churn Analysis of Multiple Disenrollments -- Those with Two Disenrollments (July 2007 – June 2012)

Disenrollment Reasons	***Number***	***Percentage***
Two Failure to Complete Renewals	4,771	44%
One Failure to Complete Renewal and One Program Eligibility	3,544	33%
One Failure to Complete Renewal and One Participation Fee	1,366	13%
One Participation Fee and One Program Eligibility	524	5%
Two Participation Fees	224	2%
Two Program Eligibility	410	4%
Two Other Disenrollments or One Disenrollment Coded Other & One Disenrollment Coded Another Reason	41	0%

B. PARTICIPANT DEMOGRAPHICS

This section of the report provides an overview of uninsured adults residents enrolling in HSF and the education provided to participants and Application Assistors.

Key FY2011-12 highlights were:

- The demographics of the HSF participation population changed between FY2010-11 and FY2011-12 due to the HSF-SF PATH transition, but continued to serve a low-income, older and ethnically-diverse community.
- Eighty-four percent of the population was existing versus new participants.

Participant Demographics

The following provides demographic data on the 46,822 participants enrolled at the end of FY2011-12 along with any observed changes in demographic trends. Homeless individuals comprise 10% of all HSF participants (street, shelter and doubled-up).

Table B1
Demographics for HSF Participants

Age	8.5% are 18-24; 43.5% are 25-44; 23% are 45-54; 25% are 55-64
Ethnicity	44% Asian/Pacific Islander; 27% Latino; 16% Caucasian; 4% African-American; 3% Other; <1% Native American; 6% Not Provided
Gender	50% Female; 50% Male (December 2011 data indicated 174 HSF participants stated transgender at enrollment)
Income	59% at/below 100%FPL; 27% between 101-200% FPL; 11% between 201-300% FPL; 3% at/above 300% FPL
Language	41% English; 22% Cantonese/Mandarin; 17% Spanish; 1% Vietnamese; 1% Filipino (Tagalog and Ilocano); <1% Other; 18% Not Provided

Table B2
Changes/Trends in HSF Participant Demographics (FY2010-11 to FY2011-12)

Age:	Slight increase in percent of participants aged 25-44 – from 42% to 43% Slight decrease in percent of participants aged 55-64 – from 26% to 25%.
Ethnicity:	Increase in the percent of Asian/Pacific Islander – from 41% to 44%. Increase in the percent of Latino – from 24% to 27%. Decrease in the percent of Caucasian – from 19% to 16%. Decrease in the percent of African-American – from 7% to 4%.
Gender:	Increase in the percent of female – from 48% to 50%
Income:	Decrease in the percent of participants with incomes at/below 100%FPL – from 66% to 59% All other income levels had slight increases in percentage
Language:	Decrease in the percent who indicate English as their preferred language – from 51% to 41% Decrease in the percent who indicate Cantonese/Mandarin as their preferred language – from 27% to 22%.

The Department does not collect demographic information on an applicant's immigration status, employment status and/or pre-existing medical conditions consistent with the San Francisco Health Care Security Ordinance which states that HSF program eligibility will not take into account those factors.

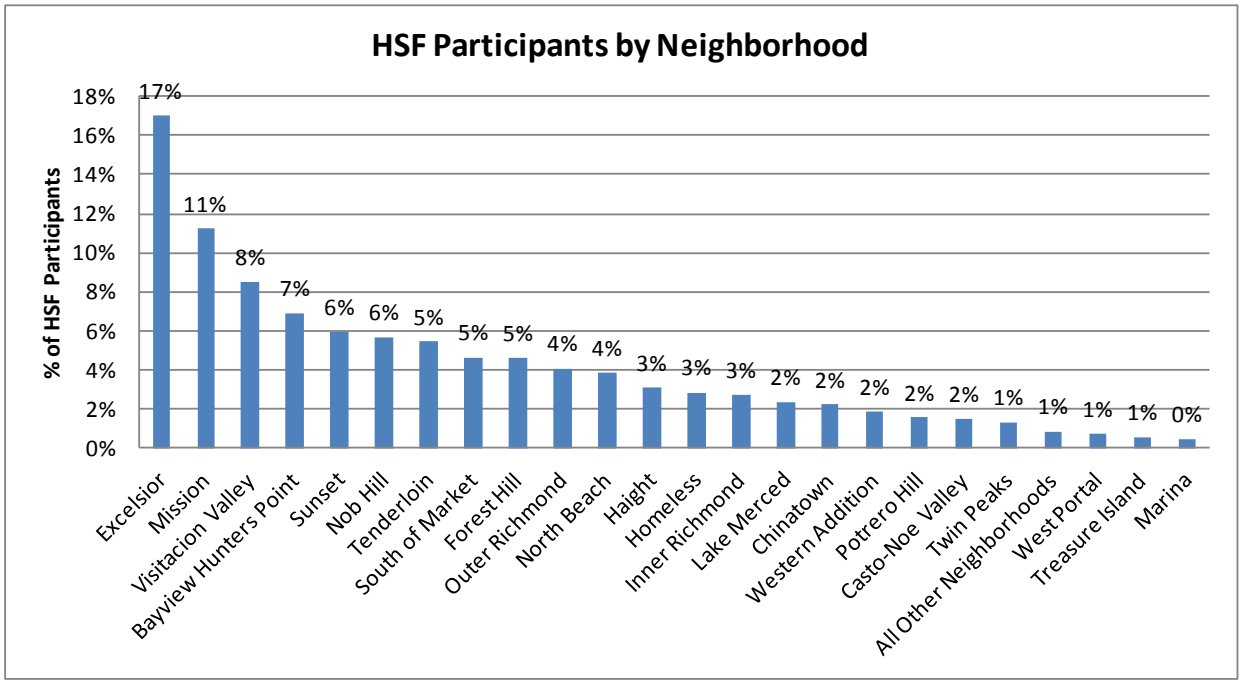
HSF Population – New versus Existing

At the end of the FY2011-12 fiscal year, 84% of those enrolled in HSF were existing safety net patients (indicated that they had a previous visit, within two years, to a HSF medical home prior to enrollment). The remaining 16% were "new" – defined as an individual who self-reported that they had not received clinical services within the last two years from the primary care medical home they selected as part of the HSF application process. It is important to note that over time, the percentage of participants that are new will decline as once "new" users become "existing" users after enrollment and as they renew their HSF eligibility.

Neighborhood Distribution

HSF participant distribution by neighborhood highlights the geographic dispersion of enrollment. The City's Excelsior and Mission neighborhoods collectively represent roughly 28% of all participants.

Graph B1



C. PROVIDER NETWORK (DELIVERY SYSTEM)

This section of the report describes the HSF delivery system (e.g., medical homes, hospitals, etc.).

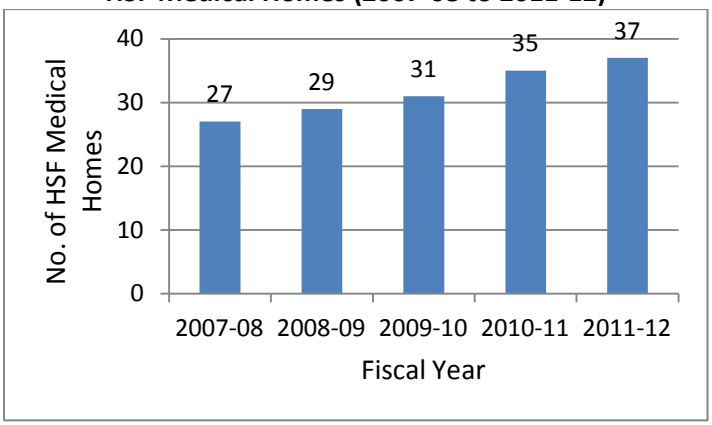
Key FY2011-12 highlights were:

- The number of HSF medical homes increased from 35 to 37.
- Overall 57% of the medical homes were open to accepting new participants for more than half of the year.
- There was a significant decrease in the number of HSF participants with a Department medical home. This was because of the HSF-SF PATH transition.

Medical Home Expansions and Capacity

HSF ended the FY2011-12 with 37 medical homes – a 6% increase from fiscal year 2010-11.

Graph C1
HSF Medical Homes (2007-08 to 2011-12)



In July 2011, Teen and Young Adult Health Center at San Francisco General Hospital and in May 2012, Mission Neighborhood Resource Center joined the HSF provider network. Both medical homes provide primary and preventive care. HSF participants who select either of these medical homes will receive emergency, specialty, diagnostic, pharmacy and inpatient services from San Francisco General Hospital.

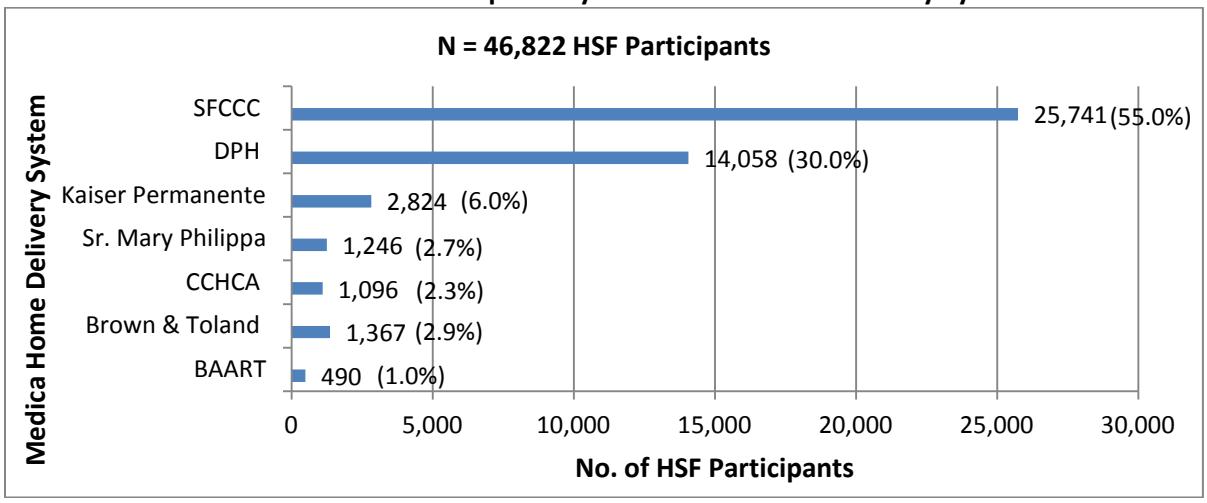
To ensure that there is sufficient capacity to serve both new and existing HSF participants the HSF program tracks each medical home's capacity (i.e., "open/closed" status) twice a month. HSF medical home open/closed status is determined primarily by such factors as appointment availability and total number of patients (from all payor sources) seen at the medical home. During the FY201112, on average, 21 (57%) of the 37 HSF medical homes were open.

Medical Home Distribution

At the time of enrollment, HSF participants select a medical home. The primary care medical home is where participants receive all of their primary care and preventative care services. The medical home also coordinates a participant's needed access to specialty, inpatient, pharmacy, ancillary, and/or behavioral health services and helps a participant navigate through the delivery system. There were

seven delivery systems at the end of FY2011-12: BAART Community HealthCare, Brown & Toland Physicians – California Pacific Medical Center, Chinese Community Health Care Association – Chinese Hospital (CCHCA), Department of Public Health, Kaiser Permanente Medical Center San Francisco, San Francisco Community Clinic Consortium (SFCCC) affiliated clinics and Sister Mary Philippa Health Center.

Graph C2
Distribution of HSF Participants by HSF Medical Home Delivery System



Hospital Participation in HSF Network

Hospital care is a critical component in the HSF service continuum. There were no changes in this aspect of the delivery system.

San Francisco General Hospital provides a range of specialty, urgent care, diagnostic, emergency care, home health, pharmacy, durable medical equipment (DME), and inpatient services to all HSF participants with a Department medical home. In addition, it provides all or some of those services to HSF participants with the following medical homes:

- BAART Community HealthCare
- Brown & Toland (home health; after hours urgent care)
- Glide Health Services (SFCCC affiliated)
- Kaiser Permanente (home health only)
- North East Medical Services (SFCCC affiliated)
- San Francisco Community Clinic Consortium (SFCCC) affiliated clinics
    - Haight Ashbury Free Health Center
    - Lyon Martin Health Services
    - Mission Neighborhood Health Center
    - Native American Health Center
    - South of Market Health Center
    - St. Anthony's Medical Clinic
- Sister Mary Philippa Health Center

In addition to SFGH, the following non-profit hospitals continue to play a vital role in HSF:

- California Pacific Medical Center (4 campuses) – (1) inpatient services to those with North East Medical Services as their medical home and (2) inpatient and hospital-based outpatient services to those with Brown & Toland Physicians as their HSF medical home,
- Chinese Hospital – partners with Chinese Community Health Care Association (CCHCA) to provide the full scope of primary care, specialty and inpatient services to those with CCHCA as the HSF medical home,
- Saint Francis Memorial Hospital (Dignity Health) – inpatient and other specialty services to those with Glide Health as the HSF medical home,
- St. Mary's Medical Center (Dignity Health) – inpatient and other specialty services to those with Sr. Mary Philippa as the HSF medical home and
- UCSF Medical Center – referral-based diagnostic imaging services at Mission Bay site.

Hospital participation in HSF is separate and apart from the general ETMALA obligations that all hospitals (public, non-profit or for-profit) must adhere to. In the case of emergency services, HSF participants will receive services at the nearest available hospital with clinical capacity. This may or may not be the hospital associated with their medical home.

Behavioral Health Services

While most of the HSF medical homes (32 out of 37) provide some form of either mental health assessment, mental health services or substance abuse screening, the Department provides all contracted behavioral health services for HSF participants at all of the medical homes – both its own and the private providers.

Specifically, HSF program offers mental health, and alcohol and drug abuse care. HSF participants have access to the comprehensive array of community-based services offered by Community Behavioral Health Services (CBHS), including, but not limited to: (1) information and referral services, (2) prevention services, (3) a full range of voluntary behavioral health services, including self-help, peer support, outpatient, case management, medication support, dual diagnosis treatment, and substance abuse services and (4) 24-hour psychiatric emergency services and a crisis hotline. HSF participants have access to these confidential services from either their HSF medical home or health care professionals at CBHS.

If a HSF participant needs access to behavioral health services (mental health and/or substance abuse) that are not provided at their HSF medical home (Department or non-Department), then a primary care provider can refer the participant to CBHS for care. However, HSF participants do not need a referral from their HSF medical home provider to access services from CBHS – they can call CBHS directly and self-refer.

D. HEALTH IMPROVEMENT INITIATIVES

This section of the report focuses on HSF Health Improvement Program. This program focuses on preventive health services, improves the quality of chronic care, facilitates the Healthy San Francisco Quality Improvement Committee, and provides quality and utilization data reporting. The Department's Third-Party Administrator, the San Francisco Health Plan, oversees the health improvement activities for HSF.

Key FY2011-12 highlights were:

- Implemented a new health education outreach campaign to improve diabetic care
- Sponsored HSF medical home participation in Rapid Dramatic Performance Improvement Program to improve care experience
- Expanded the *Strength In Numbers* program to improve chronic care management and use of disease registries

Quality Improvement Program

The HSF Quality Improvement Program promotes preventive health services, improves the quality of chronic care, facilitates the HSF Quality Improvement Committee, and provides quality and utilization data reporting. Functions handled by the HSF Quality Improvement Program include:

- Monitor and improve HSF participant clinical outcomes and access through *Strength in Numbers*
- Produce and disseminate health education material for HSF participants directly or through participating medical homes
- Deliver training on customer service, provider-patient communications, appointment access and other topics to participating providers
- Accept and resolve complaints of HSF participants about care and access to care
- Coordinate and host the quarterly Quality Improvement Committee of the HSF provider network

Health Education

As part of the quality improvement initiatives to promote preventive care and management of chronic conditions, HSF mails health education "Well Woman" and "Well Man" materials to participants. This material focuses on ensuring that all HSF participants are prepared for their primary and preventive care visits and have a good understanding of preventive service needs based on gender and age. In addition, there is regularly updated wellness information available online through the HSF Facebook page.

During FY2011-12, HSF started the planning and design of a diabetes "passport" brochure. This new health education outreach campaign is a brochure that includes pages for individualized notes for participants to fill out with their primary care team, with latest screening test results, current medications, and other information to help participants with diabetes to be informed partners in their care. The diabetes passport will be mailed to all HSF participants with diabetes, along with the announcement of an opportunity to opt in to a new cell phone text-message program to promote effective diabetes self-care habits.

The quarterly participant newsletter *Heart Beat* continues to be an important means for communicating health education messages to our participants. *Heart Beat* regularly includes articles on topics such as chronic conditions, emergency preparedness nutrition, wellness tips, and HSF's community partnerships.

Care Experience

In FY2011-12, several HSF-funded initiatives aimed at improving the patient experience within the HSF medical home network were launched.

HSF sponsored four clinics in Coleman Associates' Rapid DPI (Dramatic Performance Improvement) program. In this intense program, 3 to 5 consultants work side-by-side with clinic staff for one week, redesigning clinic processes to improve teamwork, patient access, and visit efficiency. This week is followed by two months of coaching, monitoring and reporting of performance measures, and continuous quality improvement. In FY2012-13, HSF will sponsor more clinics in the Coleman Rapid DPI program and the customer service training.

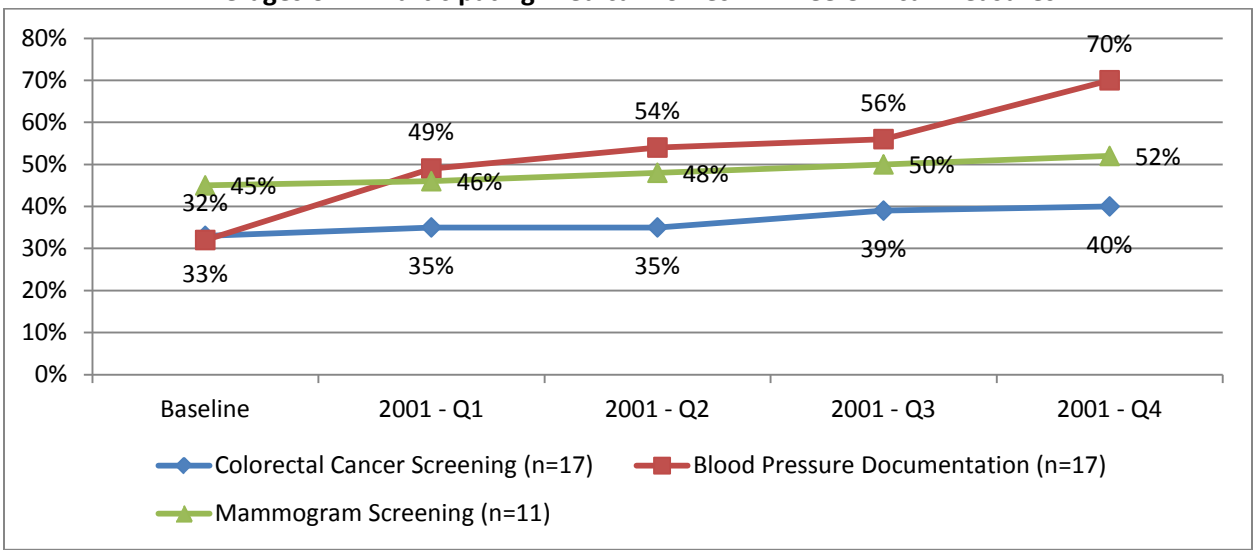
HSF also began the first part of its patient experience improvement Action Series with a program focusing on customer service. It is a series on appointment access improvement and a daylong training on provider-patient communication. Nine medical homes were selected for this training, which provides tactical protocols for responding to challenging patients, handling patient concerns proactively, and providing patient-centered personalized service. After the training sessions, participating clinics implement sustainability strategies and measure their improvement progress over time. HSF will be adding two more programs to the Action Series in FY2012-13.

Strength in Numbers

The *Strength in Numbers* Program was developed in collaboration with San Francisco medical home leaders to improve chronic care and prevention services for HSF participants, invest in chronic care registries, and create standardized measurement and improvement structure across the San Francisco safety net. It aims to improve clinical outcomes by supporting the chronic care model in HSF medical homes through disease registries. Registries enable clinics to make measurable improvements in diabetes measures, spread the use of disease registries to other chronic conditions, and spread the use of panel management to proactively identify and monitor patients overdue for clinical interventions. Medical homes that provide care to at least 350 HSF participants are eligible to participate in the program. Medical homes are required to work on improving clinical outcomes in certain chronic conditions and meet specified clinical care measures. *Strength in Numbers* provides technical assistance to medical homes in order to accelerate the integration of chronic care disease registries and financial incentives based on meeting improvement thresholds over baseline. The program is on a calendar year program and budget cycle.

The *Strength in Numbers* 2011 program year ended on January 31, 2012. Participating medical homes reported improvement from baseline in all four diabetes measures from spring of 2009 through 2010. In 2011, the compliance rates were maintained. Over the course of the 2011 Strength in Numbers program year, the average compliance rates across all participating clinics improved for several measures. For example, the graph below features improvement in three preventive health screening measures: colorectal cancer screening, mammogram screening and electronic documentation of blood pressure.

Graph D1
Averages of All Participating Medical Homes in Three Clinical Measures



The 2012 *Strength in Numbers* program aims to push performance on the core diabetes measures and through a partnership with the Center for Excellence in Primary Care, the *Strength in Numbers* program will offer health coaching and panel management trainings to participating medical homes. In 2012, *Strength in Numbers* was expanded to five new HSF medical homes thereby making an even greater impact on the health of HSF participants. In addition, for the 2012 program year, Strength in Numbers was modified in the following manner:

- The measurement set was expanded to place increased emphasis on clinical outcomes. For example, for the 2012 program year, more than half of the participating Strength in Numbers medical homes will report on Blood Pressure Control (< 140/90), instead of reporting solely on blood pressure electronic documentation.
- The program was expanded to offer medical homes a number of optional measures, including important preventive health screening measures such as cervical cancer screening and Hepatitis B vaccination rates.
- Inclusion and promotion of un-blinded clinic-specific quarterly data began with the distribution of first quarter 2012 reports in June 2012. It is hoped that this data will be used by sites to monitor both their internal progress as well as their improvement compared to their peer organizations. In addition, the data routinely shared with medical homes will focus on reducing variation within a system of care. By highlighting a clinic's individual highest and lowest performance within a measure, the program's aim is to build awareness of opportunities to standardize clinical practice.

E. SERVICE UTILIZATION

This section examines the clinical and service data of HSF participants to determine whether the program is meeting its goals with respect to improved health outcomes and appropriate utilization of services.

Key FY2011-12 highlights were:

- Participants' office visit rate per year (3) is the same as the national Medicaid.
- Emergency department (ED) utilization is lower than the State average.
- Avoidable ED utilization (8%) remains lower than State's Medi-Cal average of 18%.
- Readmission rate was 7% - below the national rate of 18%.
- Timely follow-up after an inpatient discharge remained constant.

The clinical services data was analyzed in areas related to: (a) use of primary care services, (b) quality of care and (c) effectiveness of care. As the Department has noted in the past, analysis of service utilization is dependent upon having complete data from all HSF providers – hospitals and medical homes. For this report, 90% of the hospital data comes from San Francisco General Hospital. While all non-profit hospitals have provided clinical data on HSF participants, the Department believes that the data may be incomplete. Therefore, emergency department visits, inpatient admissions, hospital days, and surgical procedures are likely underreported for FY2011-12 leading to low rates of utilization in these clinical areas. These low rates can be misleading and should be viewed within the context of underreporting. This was also the case in previous years. See Appendix A for a description of the HSF data warehouse and data source submission.

Utilization data for FY2011-12 will differ significantly from FY2010-11 data due to the HSF-SF PATH transition. There will be an absolute reduction in the number of services used with an approximately 20% reduction in the number of participants (as of the July 2011 transfer). In addition, there may be a change in averages and/or utilization rates depending upon the distribution of health service usage patterns among the remaining participants and health care needs.

Rate of Chronic Conditions

Almost 63% of HSF's participants have one or more chronic diseases/conditions based on the HSF independent program evaluation of HSF conducted by Mathematica Policy Research, Inc. These are defined as HSF participants with diabetes, asthma, hyperlipidemia and/or hypertension. Utilization across medical homes is in large part determined by the health status of the population. Data from the evaluation found significant variation in the percentage of HSF participants with chronic conditions across medical homes with the highest being in CCHCA (73%), the Department (67%) and Sister Mary Philippa (65%).[6]

[6] The 2010-11 HSF Annual Report noted that Kaiser (40%), NEMS (58%) and SFCCC (59%) had rates of chronic conditions within their HSF population that were lower that than the overall rate (63%) for the entire HSF population.

Summary of Key Utilization

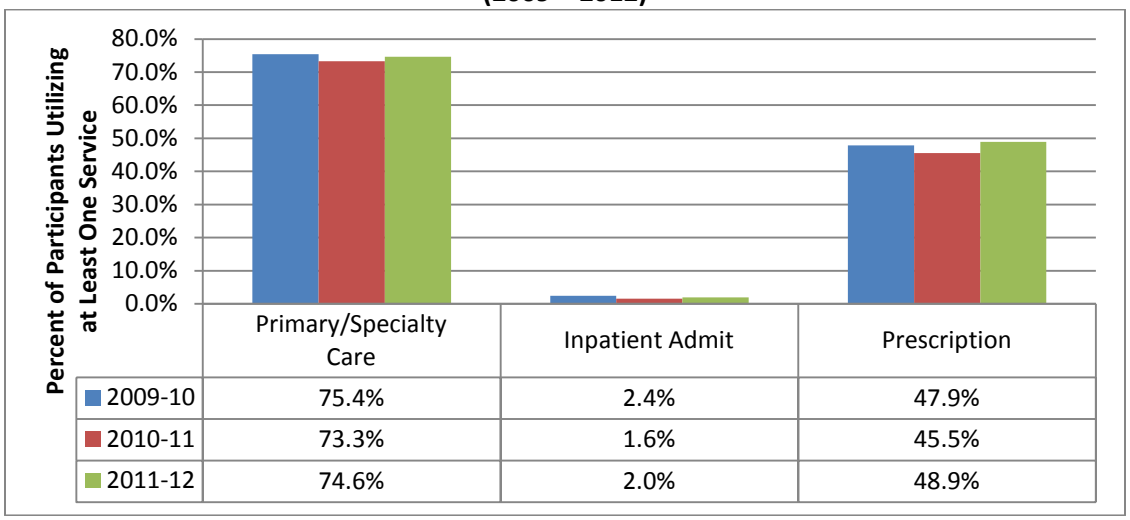
The data below indicates overall utilization within the HSF population. The data reflects the most recent 12-month period with actual, not annualized data which is FY 2010-11.[7]

Table E1
Summary of Utilization Data – Percentage of Participants Utilizing at Least One Service
(July 2010 – June 2011)

Service	Percent
Primary / Specialty Care	74.64%
Inpatient Admission	2.05%
Prescription	48.93%

Over the past three years, the percentage of all HSF participants receiving at least one service (primary care/ specialty, inpatient and/or prescriptions) in a 12-month period has remained relatively constant as indicated in the graph below

Graph E1
Percentage of Participants Utilizing at Least One Service
(2009 – 2012)



	Primary/Specialty Care	Inpatient Admit	Prescription
2009-10	75.4%	2.4%	47.9%
2010-11	73.3%	1.6%	45.5%
2011-12	74.6%	2.0%	48.9%

An examination of utilization data for HSF participants who have ever been enrolled for any length of time indicates that only 4% had a service encounter the first week of enrollment and no other encounters during their enrollment. The data reveals that HSF participants receive health services throughout the period of their enrollment. There were 114,293 individuals ever enrolled from July 2007 to March 2012 of which 82,384 (72%) had at least one encounter during their enrollment.

[7] The FY2010-11 HSF Annual Report provided this information for the time period April 2009 to March 2011.

Table E2
Percent of Participants Who Have a Service Encounter in First Week of Enrollment and Subsequent Utilization

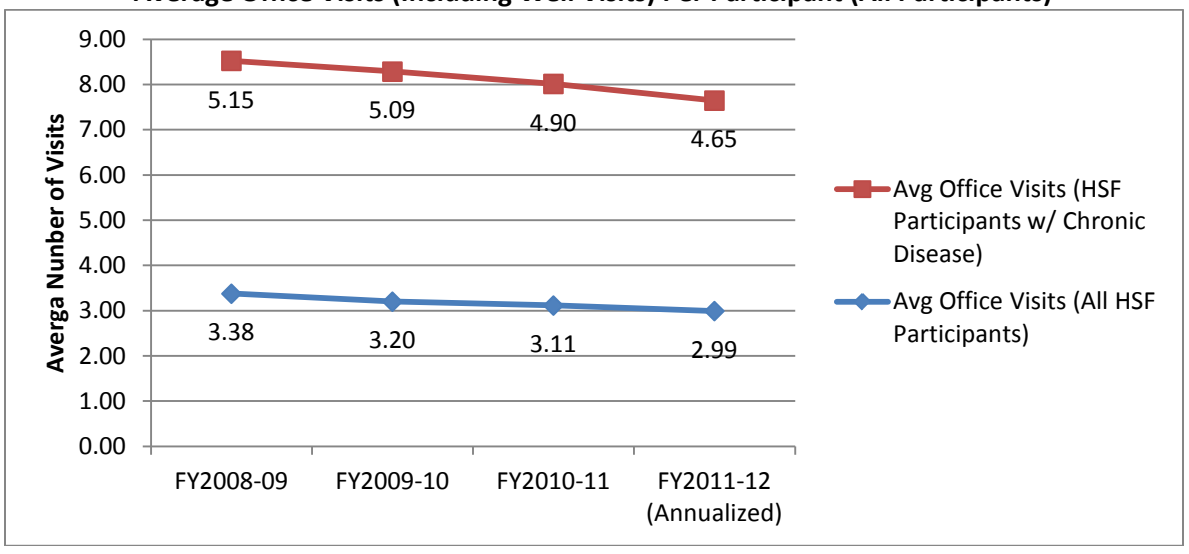
Service Encounter Type	# Participants w/ Service Encounter	# of Participants	% of Those with Encounters
Only has service encounter during first week of enrollment and at no other time during enrollment	3,458	82,384	4%
Has at least one encounter during first week of enrollment and has encounters at other times during enrollment	15,497	82,384	19%
Has at least one encounter during entire enrollment period	82,384	82,384	100%

Preventive and Primary Care Services

This section provides statistics on ambulatory care visits to physician offices for routine office visits, consultations, and preventive well visits. Data indicates that HSF participants utilize primary care at the same rate as the national Medicaid population for both those with and without chronic conditions. However, utilization of preventive services continues to be more difficult to measure, due to HSF's status as a payer of last resort, with participants accessing screening services through other publicly funded programs.

HSF participants' average office visits decreased slightly in 2011-12 to 2.99 per participant per year and remains consistent with the National Medicaid Average of 3 visits per year [National Health Statistics Reports, DHHS (2009); Centers for Medicare and Medicaid Services]. The data also suggests that the ambulatory care utilization rate for HSF participants with chronic conditions (4.65) is similar to the U.S. rate with an average of 5 visits per year for patients with chronic conditions (Division of Health Care Statistics, U.S. Department of Health and Human Services, 2009).

Graph E2
Average Office Visits (Including Well Visits) Per Participant (All Participants)



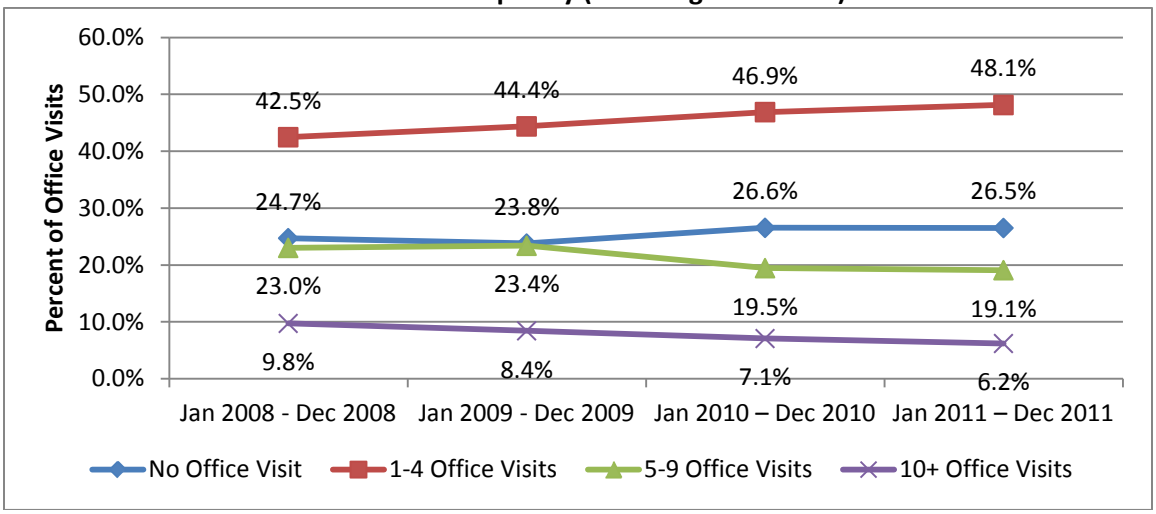
The table below displays the information contained in the graph above by medical home system. Most medical homes, with the exception of BAART and Kaiser experienced relatively small changes in the average number of office visits for their HSF population.

Table E3
Average Office Visit Utilization by Delivery System

Medical Home System	July 2008 - June 2009	July 2009 - June 2010	July 2010 - June 2011	July 2011 - Mar 2012 (annualized)	Last 2 Year Variance
BAART	N/A	9.00	5.25	3.63	-31%
Brown & Toland	N/A	N/A	3.50	3.31	-5%
CCHCA	3.82	4.20	4.30	4.40	2%
DPH	3.62	3.57	3.55	3.36	-5%
Kaiser	N/A	1.86	2.33	2.72	17%
SFCCC	3.01	2.78	2.65	2.69	2%
SMP	4.53	3.98	3.98	4.01	1%
Total	**3.38**	**3.20**	**3.11**	**2.99**	-4%

Almost 27% of HSF participants did not have an office visit after twelve months of continuous enrollment. This has remained constant over the past two calendar years. Over time there has been a decrease in the percentage of participants with five or more office visits per year and an increase in the number with one to four visits per year.

Graph E3
Office Visit Frequency (Including Well Visits)



The Department cannot reliably use HSF utilization data to analyze the utilization of some preventive services, due to Healthy San Francisco's structure as a payer of last resort. Since participants are required to apply to any available public programs, low-income women obtain mammograms and pap smears through State programs (e.g., Every Woman Counts and the State Family Planning Program), and the data is therefore not available for analysis. Although encounter data only shows 15% of women receiving mammograms, and 24% of women receiving cervical cancer screening, it is highly likely that the actual screening rate is much higher.

The data shows that in FY2011-12, HSF met the National Medicaid benchmark for colorectal cancer screening among women at 55%. The colorectal cancer screening rate for men in HSF was 43%, below the national target, but represented a six percentage point improvement from last year's rate of 37%. Improving colorectal cancer screening rates was a priority for the 2011 Strength in Numbers Program.

Table E4
Percentage of Women's Health Preventive Screening

July 2008 – March 2012				
Women's Preventive Screening	Participants Received Screening	Eligible Participants	Percentage	Nat'l Medicaid Average
Cervical Cancer	7,354	30,817	23.86%	64.80%
Colorectal Cancer	6,967	12,732	54.72%	54.50%
Mammogram	3,002	19,483	15.41%	50.00%

Table E5
Percentage of Men's Preventive Screening for Colorectal Cancer

July 2008 – March 2012				
Men's Preventive Screening	Participants Received Screening	Eligible Participants	Percentage	Nat'l Medicaid Average
Colorectal Cancer	5,660	13,174	42.96%	54.50%

Appropriate Utilization

This section provides statistics on inpatient admission, emergency department visits, and visits to physician offices for routine office visits, consultations, and preventive well visits. HSF participants are using services at a rate similar to what is seen in insured populations. The use of the emergency department for avoidable conditions remains lower than the State benchmark, and hospital admissions decreased.

As noted above, over 90% of the hospital data comes from San Francisco General Hospital and there is likely underreporting from the participating private hospitals. As a result, the decreases witnessed in utilization of hospital-based services (in particular, inpatient admissions and emergency department visits) may be low and may not be a complete representation of utilization within this population. In addition the HSF-SF PATH transition resulted in changes in utilization for the overall population.

Emergency Department

Utilization of the emergency department (ED) for HSF participants is 133 per 1,000 participants for all participants which is low compared to the State average of 275 visits per 1,000 (Henry J Kaiser Family Foundation, State Health Facts, 2008).

Participants with chronic conditions utilize the emergency room more frequently than those without chronic conditions (172 visits per 1,000 participants compared to 117 visits per 1,000 participants). Consistent with previous years, the top five diagnostic categories for emergency department (ED) visits were: (1) respiratory symptoms, (2) abdominal symptoms, (3) general symptoms, (4) other cellulitis and abscess, and (5) non-dependent abuse of drugs.

Table E6
ED Visits Per 1,000 Participants Per Year

Data Period	ER Visits	Participant Months	ER Visits/1,000	Variance to Previous Period
July 2008-June 2009	6,006	436,014	165.30	N/A
July 2009-June 2010	8,628	620,320	166.91	0.97%
July 2010-June 2011	8,376	685,894	146.54	-12.20%
July 2011-Mar 2012 (annualized)	4,735	425,355	133.58	-8.84%

The ED visit rates show that 93% of participants had no emergency room visit in calendar year 2011.[8]

Table E7
ED Visit Frequency

ED Visit	January 2009 – December 2009 Percent	January 2010 – December 2010 Percent	January 2011 – December 2011 Percent
No ER Visit	89.83%	90.81%	92.62%
1-4 ER Visits	9.80%	8.81%	7.19%
5-9 ER Visits	0.28%	0.3%	0.16%
10+ ER Visits	0.09%	0.08%	0.03%
Total Participants	100%	100%	100%

During calendar year 2011, there were 192 HSF participants with three or more ED visits. The top five outpatient diagnoses for those with three or more ED visits were: (1) respiratory symptoms, (2) non-dependent abuse of drugs, (3) abdominal and pelvic symptoms, (4) general symptoms and (5) alcohol-induced mental disorders. A review of demographic data reveals that the following have a higher incidence of frequent ED utilization:

- homeless (4.4%) rather than housed (0.42%),
- men (0.89%) compared to women (0.52%),
- African Americans (8.83%), Native Americans (4.23%), Samoans (3.45%) and Whites (3.17%) in comparison to all ethnic groups (0.69%),
- those with a chronic disease (0.92%) relative to those without a chronic disease (0.55%) and
- those aged 45 – 54 (1.03%) compared to all age groups (0.69%)

In comparison to all medical homes, on average, in which 0.69% of the continuously enrolled HSF population would have three or more ED visits, the following medical homes had a higher percentage of HSF participants with three or more ED visits: South of Market Senior Center (10.00%), Glide Health Services (5.63%), Housing and Urban Health Clinic (3.92%), Sister Mary Philippa Health Center (3.8%), Native American Health Center (2.78%) and Curry Senior Center (2.50%).

Avoidable Emergency Department Visit Rate

The avoidable emergency department visit rate for HSF was 8% using conditions defined by the "Medi-Cal Managed Care ER Collaborative Avoidable Emergency Room Conditions." This rate is below the average for both San Francisco Health Plan (15%) and California's Medi-Cal average for adults (18%).

[8] This analysis uses data from HSF participants who were continuously enrolled during the 12-month period.

Ninety-nine percent (99%) of participants did not access emergency department care for avoidable conditions. This has been consistent over the past three years.

Table E8
Average Avoidable ED (AED) Rate

Data Period	AED Rate	Variance
July 2008-June 2009	9.31%	N/A
July 2009-June 2010	8.00%	-14.08%
July 2010-June 2011	7.69%	-3.86%
July 2011-Mar 2012 (annualized)	8.17%	6.30

Table E9
Avoidable ED (AED) Visit Frequency

AED Visit	Jan. 2009 – Dec. 2009 Percent	Jan. 2010 – Dec. 2010 Percent	Jan. 2011 – Dec. 2011 Percent
No AED Visits	98.61%	98.85%	99.20%

Hospitalization

Data shows continued decreases in hospital utilization for HSF participants. It's important to note that the significant decrease in hospital days per 1,000 participants and average length of stay is in large part due to the HSF-SF PATH transition of over 10,000 participants in July 2011. As a result, the decrease cannot be attributed solely to changes in health status of the patient population.

Overall hospital admissions for all HSF participants decreased (from roughly 26 to 23 per 1,000 participants). The data indicate that HSF participants with a Department medical home have higher hospital admission rate (30.5 per 1,000 participants) than HSF participants with non-Department medical homes which is consistent with the high level of chronic conditions within this population. Acute days were 90 per 1,000 participants with an average length of stay of 3.95 days. The data reveals that in FY2011-12, the top five diagnoses for hospitalization were alcohol withdrawl, cellulitis and abcess of leg/upper arm, acute pancreatittis, unspecified psychosis and pneumonia/organism unspecified.

Graph E4
Acute Hospital Admissions Per 1,000 Participants Per Year

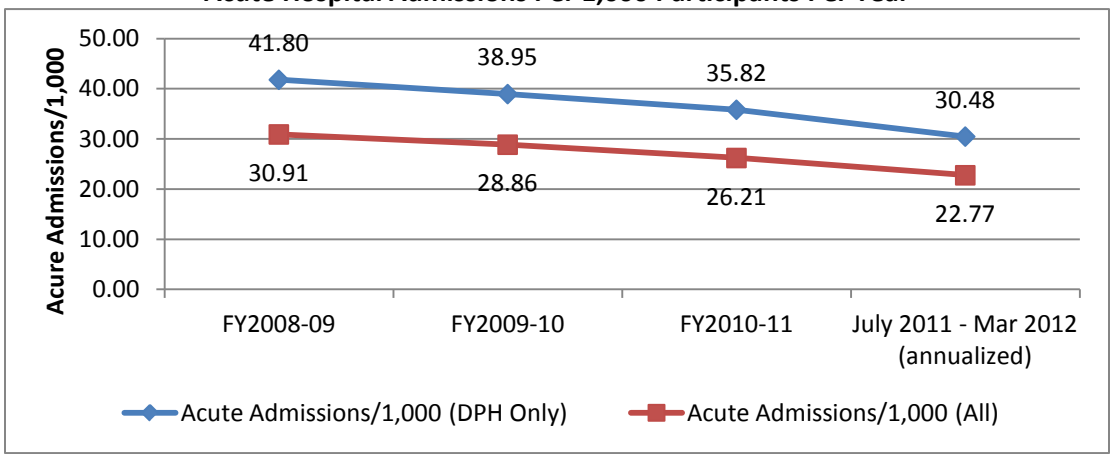


Table E10
Acute Hospital Days Per 1,000 Participants Per Year and Average Length of State (ALOS)

Data periods	Admits	Acute Days	Acute Days/1,000	ALOS
July 2008-June 2009	1,123	5,420	149.17	4.83
July 2009-June 2010	1,492	6,369	123.21	4.27
July 2010-June 2011	1,498	6,014	105.22	4.01
July 2011-Mar 2012 (annualized)	807	3,191	90.02	3.95

For comparative purposes, the rates for San Francisco Health Plan's Medi-Cal population (Measurement Year 2010; Tiermed Database) are:

- 55.68 hospital admissions per 1,000 members,
- 219.6 days/1,000 members and
- average length of stay is 3.94 days.

Behavioral Health

Mental health utilization decreased and substance abuse service utilization increased both for those with and without a chronic disease from FY2010-11 to FY2011-12. This may be due to the HSF-SF PATH transition. Mental health utilization continues to be higher than substance abuse utilization.

Table E11
Average Mental Health Visits Per Participant (CBHS and Encounter Data)

	Data periods	Mental Health Visits	Average Visits	Variance to Previous Period
With Chronic Disease	July 2008-June 2009	14,548	1.15	N/A
	July 2009-June 2010	16,211	0.90	-21.22%
	July 2010-June 2011	18,452	0.95	4.64%
	July 2011 – March 2012 (annualized)	9,535	0.87	-3.99%
Without Chronic Disease	July 2008-June 2009	35,404	1.50	N/A
	July 2009-June 2010	39,960	1.18	-20.91%
	July 2010-June 2011	46,504	1.24	4.35%
	July 2011 – March 2012 (annualized)	19,065	0.78	-34.15%

Table E12
Average Substance Abuse Visits Per Participant (CBHS and Encounter Data)

	Data periods	Substance Abuse Visits	Average Visits	Variance to Previous Period
With Chronic Disease	July 2008-June 2009	4,901	0.39	N/A
	July 2009-June 2010	5,197	0.29	-25.03%
	July 2010-June 2011	5,654	0.29	0.02%
	July 2011 – March 2012 (annualized)	3,952	0.36	24.12%
Without Chronic Disease	July 2008-June 2009	13,313	0.56	N/A
	July 2009-June 2010	10,433	0.31	-45.09%
	July 2010-June 2011	11,325	0.30	-2.67%
	July 2011 – March 2012 (annualized)	9,005	0.37	19.13%

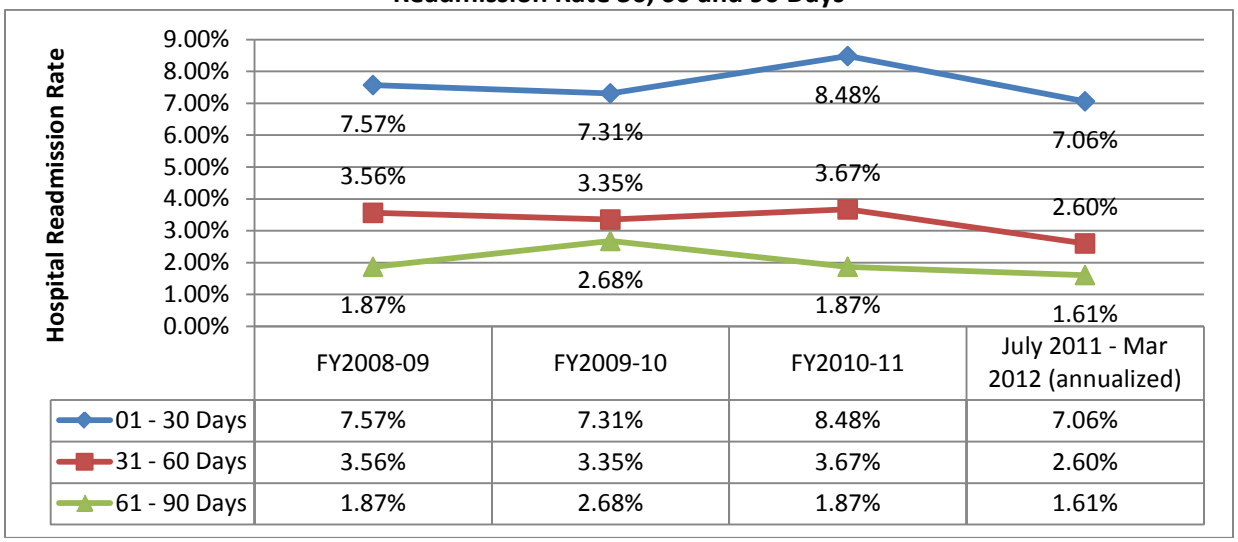
Quality of Care

This section provides statistics on readmission rates and quality of care provided to participants. The 30-day HSF readmission rate was 7% in FY2011-12, and the rate of diabetics and asthmatics getting recommended care are within the range of the insured population.

Hospital Readmissions

Readmission data is a good indicator for quality of care. HSF's 30-day readmission rate of 7% is lower than the 18% national rate of hospital readmission within 30 days (AHRQ).

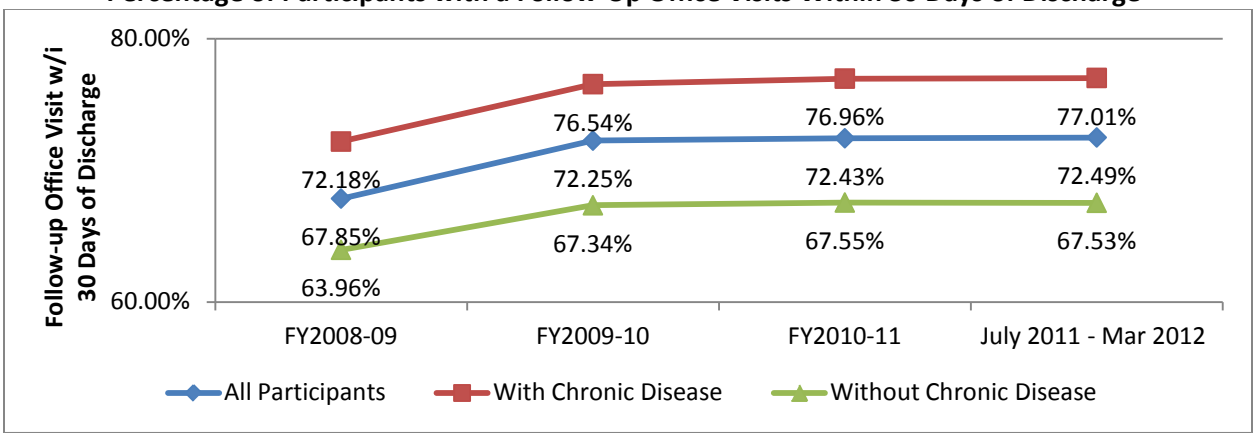
Graph E5
Readmission Rate 30, 60 and 90 Days



	FY2008-09	FY2009-10	FY2010-11	July 2011 - Mar 2012 (annualized)
01 - 30 Days	7.57%	7.31%	8.48%	7.06%
31 - 60 Days	3.56%	3.35%	3.67%	2.60%
61 - 90 Days	1.87%	2.68%	1.87%	1.61%

The data also indicates that the follow-up office visits within 30 days of discharge have remained stable over the last three years at 72% for all participants. For those with chronic disease, the rate was 76% and for those without chronic disease the rate was essentially unchanged at 68%. By comparison, the Center for Medicare and Medicaid Services reported in a Medicare beneficiary claim study, 50% of patients readmitted within 30 days of discharge did not have a bill for a physician visit between hospital discharge and readmission.

Graph E6
Percentage of Participants with a Follow-Up Office Visits Within 30 Days of Discharge



HEDIS Measures

To assess the quality of care provided to HSF participants, the Department monitors the quality of care for participants with chronic disease. The indicators used are based on the Healthcare Effectiveness and Data Information Set (HEDIS) performance measures, as outlined by NCQA. Participants enrolled for 12 months with asthma and diabetes were measured against HEDIS benchmarks.

The data indicates that the percentage of participants with diabetes getting HbA1c tests is 70% compared to the national Medicaid average of 77%, and the percent of diabetics getting LDL (cholesterol) testing is slightly less than the National Medicaid Average at 65% compared to 71%. For asthma, the data shows that 87% of participants with asthma are getting the medication they need to control their asthma, equivalent to the National Medicaid average of 87%.

Table E13
Percentage of Participants Receiving Tests Compared to Medicaid
(January 2011 – December 2011)

Measure	HSF Percentage	National Medicaid Average
Diabetic Care Test - HbA1c	69.62%	77.40%
Diabetic Care Test - LDL	65.11%	70.90%
Asthma Test - Medication	87.46%	86.90%

Out of Network Utilization

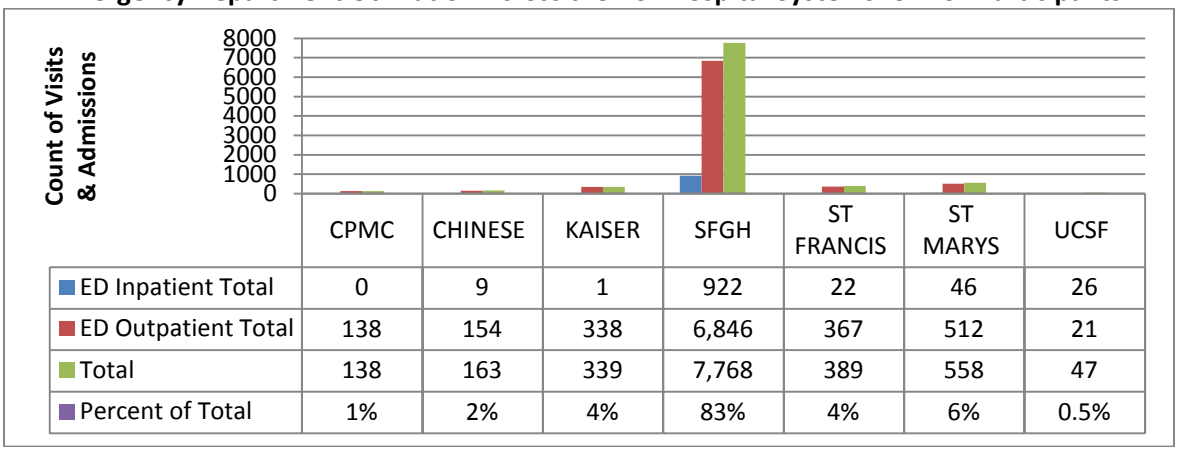
HSF is based on the premise that participants receive their care through a network of providers affiliated with the medical home they have selected. HSF requires the selection of a medical home by the applicant at the time of program enrollment to help ensure that the participant has a usual source of care and to minimize episodic care. At the same time, the Department recognized that it was not entirely reasonable to expect or witness system-wide affects of participant behavior in the first few years of the program. Changes in health seeking behavior (e.g., emergency department utilization) due to system changes take time, perhaps two to three years to observe.

Out-of-network utilization provides some perspective on whether participants are seeking care appropriately. Out of network utilization can be defined in many ways; however, for the purposes of this report, it is defined as a HSF participant's receipt of services by a medical home or hospital that is not affiliated with their medical home. As with last fiscal year, the Department examined hospital-based emergency department (ED) utilization within the HSF population with a specific focus on where a HSF participant received this care. The limitations of this analysis still exist; namely:

1. it examines solely the location where the service was received,
2. it does not examine the type of clinical service provided to determine if there was appropriate or inappropriate utilization of the out of network facility and
3. there is a relatively limited amount of non-profit hospital data.

Overall, the data reveal that the majority of ED services were provided by San Francisco General Hospital (SFGH). The following graph provides summary information on the count of HSF participants with hospital-based ED visits and inpatient stays by hospital system. San Francisco General Hospital provided 83% of the care. As noted previously in this report, SFGH provides ED services for the Department, SFCCC and BAART medical homes.

Graph E7
Emergency Department Utilization Across the HSF Hospital Systems for HSF Participants



	CPMC	CHINESE	KAISER	SFGH	ST FRANCIS	ST MARYS	UCSF
ED Inpatient Total	0	9	1	922	22	46	26
ED Outpatient Total	138	154	338	6,846	367	512	21
Total	138	163	339	7,768	389	558	47
Percent of Total	1%	2%	4%	83%	4%	6%	0.5%

The data below provides some general information on out-of-network ED access by HSF participants. Both tables should be read as follows using CCHCA – Chinese as an example: "HSF participants with CCHCA – Chinese as their medical home had 68 ED outpatient visits of which 56 were within the network and 12 were outside of network. These participants also had eight (8) ED inpatient visits of which four were within the network and four were outside of network."

Table E14
Emergency Department Outpatient Utilization – Within and Outside Medical Home Network

Medical Home and Affiliated Hospital	Within MH Network	Outside MH Network	Total	Percentage Outside MH
BAART - SFGH	22	4	26	15%
Brown & Toland - CPMC	12	6	18	33%
CCHCA - Chinese Hospital	56	12	68	18%
DPH Clinics - SFGH	4,654	162	4,816	3%
Glide - St. Francis	327	319	646	49%
Six SFCCC Clinics - SFGH	338	13	351	4%
Kaiser - Kaiser Med. Center	632	70	702	10%
NEMS – SFGH	1,209	34	1,243	3%
Sr. Mary Philippa - St. Mary's	474	32	506	6%
Total	**7,724**	**652**	**8,376**	**8%**

Table E15
Inpatient Utilization – Within and Outside Medical Home Network

Medical Home and Affiliated Hospital	Within MH Network	Outside MH Network	Total	Percentage Outside MH
BAART - SFGH	1	0	1	0%
Brown & Toland - CPMC	0	0	0	0%
CCHCA - Chinese Hospital	4	4	8	50%
DPH Clinics - SFGH	628	17	645	3%
Glide - St. Francis	22	47	69	68%
Six SFCCC Clinics - SFGH	1	8	9	89%
Kaiser - Kaiser Med. Ctr	77	8	85	9%
NEMS - SFGH	158	5	163	3%
Sr Mary Philippa - St. Mary's	43	3	46	7%
Total	**934**	**92**	**1,026**	**9%**

Finally, further analysis revealed that of the 652 out-of-network ED outpatient visits, 57% (374) occurred at San Francisco General Hospital & Trauma Center and that 63% (58 of 92) of the out-of-network inpatient admissions were at this facility.

Health Care Utilization Among Those with Multiple Enrollments and Disenrollments

This analysis examines the health care utilization of those HSF participants with multiple enrollments and disenrollment to determine whether an individual had a service during a given enrollment period (i.e., the period of time between an enrollment and disenrollment). By virtue of churning through the program, all of these individuals will have more than one enrollment period (e.g., an individual with two disenrollments will have two enrollment periods, etc.).

This analysis calculated length of enrollment in terms of months. This is important to determine whether individuals were enrolled in the program for a sufficient period of time to receive a service. An enrollment period will range in length of days.[9] As indicated in Section V.A. of this report, 17,340 individuals have had at least two HSF disenrollments and collectively had 38,071 enrollment periods (i.e., the period of time between an enrollment and disenrollment). Of the 38,071 enrollment periods, 60% had enrollment periods lasting 10 – 12 months and 20% were had enrollment periods in excess of 12 months.

An examination of utilization data for the 17,340 individuals suggest that they use health care services soon after enrolling or that health care needs may factor into their decision to enroll in HSF. The analysis counted the number of patients in the enrollment periods and found that there were 26,962 patients. The number of patients (26,962) is greater than the number of unique individuals (17,340) because in this analysis, an individual can be a patient (i.e., receive a service) in more than one enrollment period (i.e., duplicated). Each time an individual receives one service in an enrollment period, they are counted as a patient.

[9] For example, individuals disenrolled for program eligibility or failure to pay participation fee can be disenrolled mid-year while individuals disenrolled for failure to renew will have 365 days of enrollment before being disenrolled. In addition, while HSF enrollment is primarily done at the medical home site, it is not the case that each person enrolling into the program on a particular day will be in need of a service on that day or shortly thereafter.

The data indicate that 62% of the patients had their initial office visit within the first 60 days of enrollment with almost half (46%) having their first visit within 30 days. The data does not suggest that those with multiple enrollment periods are enrolling in HSF and not receiving services.

Table E31
Length of Days to Initial Office Visit for Individuals with Two or More Disenrollments

First Initial Office Visit (Days After Enrollment)	No. of Patients (Duplicated)	Rate
01-30 Days	12,322	46%
31-60 Days	4,333	16%
61-90 Days	2,473	9%
>90 Days	7,798	29%
Total	**26,926**	**100%**

F. PARTICIPANT EXPERIENCE AND SATISFACTION

This section highlights the various mechanisms in the HSF program to obtain feedback from participants and to gauge their experiences. This includes the call center, tracking of complaints and surveys.

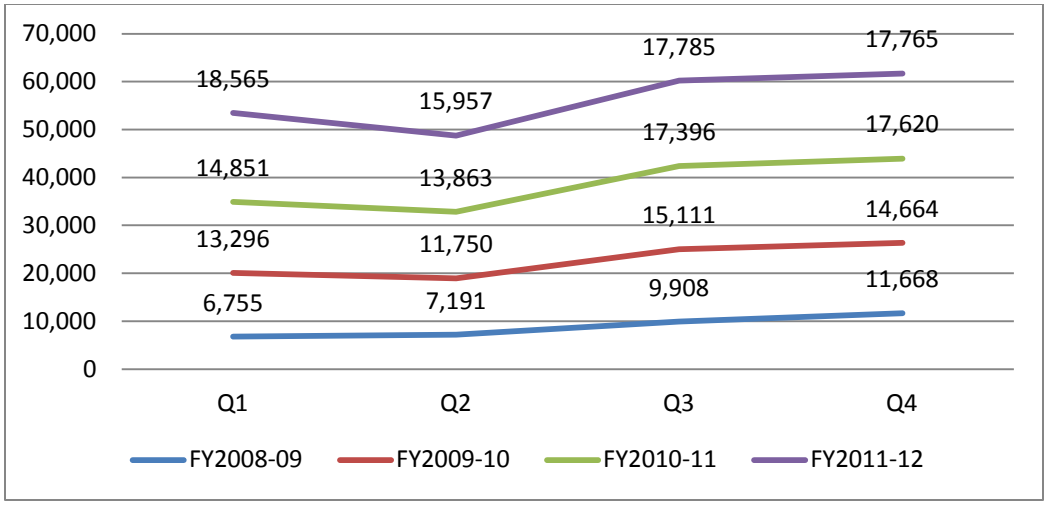
Key FY2011-12 highlights were:

- HSF Customer Service received a total of 70,072 calls in FY2011-12
- The HSF complaint rate was 0.79 per thousand participants for FY2011-12.
- There were a total of 435 participant complaints with the top complaints in the area of access (21%) and quality of service (20%).
- Health Access Questionnaire found that participants continuously enrolled in the program reported less ER utilization, a usual source of care, less difficulty accessing care, improved rating of medical care and less delays accessing care. Respondents did not consistently view their general health status as improved.

Customer Service Center Call Center

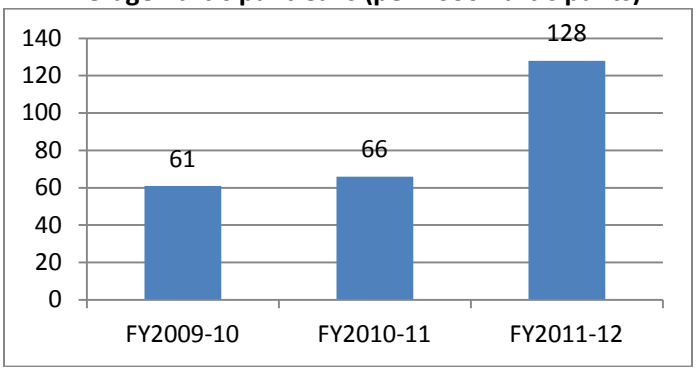
The Healthy San Francisco Customer Service Center supports all HSF customers, including participants, potential participants, medical homes, City Option employers and City Option employees. These activities are performed by the third-party administrator, the San Francisco Health Plan (SFHP). Functions include: (1) providing telephone assistance to participants, providers, and employers, (2) scheduling enrollment appointments for the HSF enrollment site at SFHP and (3) handling participant complaints. Customer Service Center received a total 70,072 incoming calls (applicants, participants, providers, employers, others) from July 2011 to June 2012 - a 10% increase from FY2010-11's total of 63,730 calls.

Graph F1
Total Call Volume Per Quarter



The call rate for FY2011-12 averaged 128 calls per 1,000 participants compared to 66 calls per 1,000 participants during FY2010-11.

Graph F2
Average Participant Calls (per 1000 Participants)



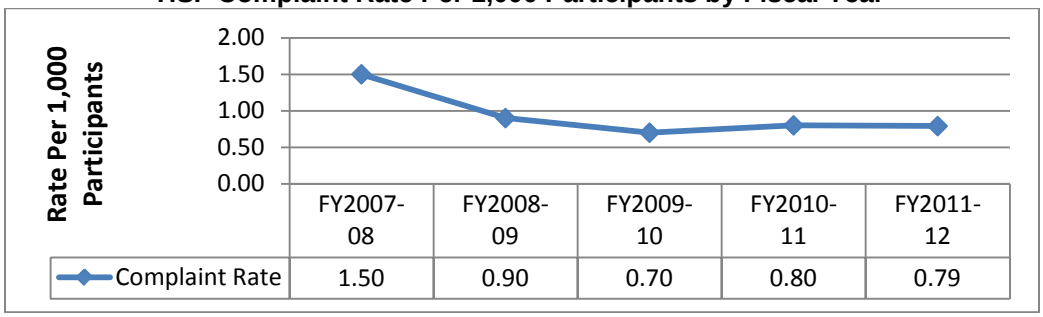
Participant Complaints

The HSF Customer Service Center intakes all customer complaints and is responsible for resolving all non-clinical complaints. Resolution of all clinical complaints, as well as, complaints oversight and reporting are handled by HSF Quality Improvement. During FY2011-12, the HSF Customer Service Center received a total of 435 complaints and the key trends were:

- The complaint rate[10] for FY2011-2012 was 0.79 per 1,000 participants, similar to the FY2010-11 complaint rate of 0.80.
- Access issues were 20.9% of the total complaints received in the FY2011-2012, compared to 27.5% of the total complaints received in the FY2010-2011.
- Quality of service issues were 20.2% of the total complaints received in the FY2011-2012, compared to 26.6% of the total complaints received in FY2010-11.

Over the last three fiscal years, the participant complaint rate per 1,000 participants has remained relatively stable fluctuating from 0.7 to 0.9 per 1,000 participants.[11]

Graph F3
HSF Complaint Rate Per 1,000 Participants by Fiscal Year



[10] The complaint rate is calculated by taking the number of complaints filed within the specified time period and dividing that number by the number of participants within the program during that specified time period. The resulting number is then multiplied by 1,000. The rate of complaints is a frequency measure, where each participant can complain in any month; therefore, the denominators for each month are added to reflect differences in population from month-to-month and equal probabilities of filing complaints.

[11] Note that because tracking of complaints began in January 2008, the complaint rate for FY2007-08 included only six months of complaint data.

The top three complaints categories were Access, Quality of Service, and Other. A description of some of the top complaints is below:

- Access: This refers to clinical services not being available when and where the participant expected.
- Quality of Service: This refers to the participant's perception of the service they received (both clinical and non-clinical). Quality of service complaints may relate to any of the following: (1) participant interaction with the care provider(s), (2) the environment in which care is delivered, (3) interactions with the care provider staff, (4) administrative or communication difficulties with physicians/staff, the hospital or other providers and/or (5) service interactions with customer service staff, participant billing, HSF Application Assistor, etc.
- Other: This category includes complaints about the medical home that deal with a myriad of issues, such as when a participant wants a specialized treatment/provider that is only available at another medical home or a participant has general complaints about a medical home that are not related to a specific service or a specific appointment (e.g., a medical homes serves too many homeless people from participant's perspective, etc.)

Table F1
HSF Participant Complaints by Category (FY 2011-12)

Attribute	Number	Percent
Access Issue	91	20.9%
Quality of Service	88	20.2%
Other	85	19.5%
Enrollment Issue	67	15.4%
Billing	43	9.9%
Quality of Care	25	5.8%
Coverage Interpretation	23	5.3%
Cultural, Linguistic & Health Education	13	3.0%
Total	**435**	**100%**

Health Access Questionnaire

Healthy San Francisco administers a Health Access Questionnaire at the point of application and at annual renewals.[12] HSF participant responses to this questionnaire allows the Department to gauge individuals' pre- (if participant is a first time applicant) and post-HSF (for those who have renewed) experiences with healthcare in a quantifiable manner. The questionnaire is useful in helping capture participant experience for ongoing program monitoring and evaluation purposes.

Application Assistors ask the HSF participants the designated questions from the questionnaire. Responses to the questionnaire represent self reported data. Eligibility for HSF is not affected by a participant's responses to the questionnaire. A participant is given the options of refusing to answer a question or saying that they do not know the answer. Questionnaires are available in Spanish, English, and Chinese as needed.

[12] This program feature was launched in December 2008 with 10 questions and in Spring 2010 an eleventh question was added on program renewal.

During FY2011-12, HSF administered 49,677 questionnaires to first time HSF enrollees, renewing, and reenrolling members. The survey answers of those who were new to the program reflect those participants' experiences with healthcare access before HSF enrollment, while renewal applicants' answers should reflect the HSF experience with healthcare access.

Three separate analyses were conducted for this year's report:

- An analysis of all responses from all the questionnaires received.
    - This summarizes data on all participants and does not distinguish between new HSF participants and renewal participants. It provides a snapshot of the answers from all 49,677 surveys administered in FY2011-12.

- A year-to-year analysis for those participants who have taken four questionnaires and have been continually enrolled in HSF without breaks in participation.
    - This examines the responses of the 3,283 participants who have been enrolled in HSF for four consecutive years without breaks in coverage.

FY2011-12 Health Access Questionnaire Responses

Appendix B provides detailed information on all participant responses to the 11 survey questions in FY2011-12. Participant self-reported data continues to suggest that patient experience with HSF is improving. Compared to FY2009-10 and FY2010-11, questionnaire respondents in FY2011-12 indicated the following responses:

- A higher percentage (64%) indicated that their health was excellent, very good or good for the FY2011-12 as opposed to previous years (58% in FY2010-11 and 52% in FY2009-10).

- A greater percentage of people (47%) reported that it was not difficult to access medical care when necessary than in FY2010-11 and FY 2009-10 (45% and 34%, respectively).

- A lower percentage of respondents (6%) delayed getting care or a medicine prescribed to them in the past 12 months than in FY2010-11 and FY2009-10 (8% and 11%, respectively).

- A steady decline in the percentage of respondents (9%) visiting a hospital or emergency room for their own health over the years (12% in FY 2009-10 and 10% in FY 2010-11).

- A steady decline in the percentage of respondents (9%) claiming to smoke cigarettes over time (14% in FY 2009-10 and 11% in FY 2010-11).

Year-to-Year Health Access Questionnaire Comparison

By the end of the FY2011-12, the following number of participants had taken the questionnaire for consecutive years with no disruption in enrollment:

- 23,802 participants - two times,
- 11,256 participants - three times,
- 3,283 participants -four times.[13]

[13] There were 241 individuals that had more than one continuous enrollment period. For those 241, only the surveys from their most recent continuous enrollment period were included. In addition, enrollment with no disruption in program participation includes those with on-time renewal (no gap in enrollment) and those with a disenrollment and reenrollment period of less than 15 days.

Information on the medical home selection of the individuals taking multiple questionnaires reveals that the majority of HSF participants continuously enrolled had either a Department or a SFCCC medical home which is consistent with data that shows these two medical homes have 85% of HSF enrollment. The data indicates that those who were continuously enrolled were less likely to change medical homes during their enrollment. Specifically, less than 3% of those with two questionnaires, 1.5 for those with three questionnaires and 1.2% of those with four questionnaires changed medical homes during their HSF enrollment.

Table F2
Number and Percentage of Participants Changing Medical Homes after HAQ1

	Number Participants	HAQ1		HAQ2		HAQ3		HAQ4	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
2 Questionnaires	23,802	Baseline	Baseline	640	2.70%	N/A	N/A	N/A	N/A
3 Questionnaires	11,256	Baseline	Baseline	313	2.80%	154	1.40%	N/A	N/A
4 Questionnaires	3,283	Baseline	Baseline	80	2.40%	61	1.90%	40	1.20%

With respect to the ethnicity, data reveals that Asian/Pacific Islanders are more likely to be continuously enrolled.

Table F3
Ethnic Distribution of HAQ1, HAQ2, HAQ3 and HAQ4 Participants

	HAQ1		HAQ2		HAQ3		HAQ4	
Ethnicity Group	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Asian/Pacific Islander	9,764	41%	9,873	41%	5,987	53%	1,837	56%
Black/African American	1,512	6%	1,596	7%	355	3%	52	2%
Hispanic	5,815	24%	5,943	25%	2,581	23%	875	27%
Native Amer/Alaskan Native	80	0%	82	0%	15	0%	1	0%
Other	708	3%	720	3%	310	3%	59	2%
White	4,418	19%	4,619	19%	1,616	14%	373	11%
Not provided	1,505	6%	969	4%	392	3%	86	3%
Total	23,802	100%	23,802	100%	11,256	100%	3,283	100%

In previous years, the Department has analyzed the results for participants who have taken the questionnaire two (FY2009-10 and FY2010-11) and three times (FY2010-11). For this analysis, the Department examined those with four questionnaires over four consecutive years of enrollment. Analysis of participants' responses over four questionnaires allows for the effects of HSF programming on participant health perceptions and behaviors to be inferred over the greatest amount of time, between 2008 and 2012. For this analysis, HAQ1 refers to the first questionnaire taken by the participants, HAQ2 refers to the second questionnaire, HAQ3 to the third and HAQ4 to the fourth. The analysis examines responses in the aggregate and the variance calculation is the absolute difference between the HAQ1 and HAQ4 responses.

Of the eleven Health Access Questionnaire questions, seven are appropriate for year-to-year comparative analysis:

1. Would you say that in general your health is excellent, very good, good, fair, or poor?

2. In the last 12 months, did you visit a hospital emergency room for your own health?
3. What kind of place do you go to most often to get medical care? Is it a doctor's office, a clinic, an emergency room, or some other place?
4. Overall, how difficult is it for you and/or your family to get medical care when you need it – extremely difficult, very difficult, somewhat difficult, not too difficult, or not at all difficult?
5. How do you rate the medical care that you received in the past 12 months --excellent, very good, good, fair, or poor?
6. During the past 12 months, did you either delay getting care or not get a medicine that a doctor prescribed for you?
7. Was cost or lack of insurance a reason why you delayed getting care or did not get the prescription?

The questionnaire data from those continuously enrolled in HSF indicates that over time, participants reported overall good general health, less ED utilization, utilization of services at a clinic, health center, or hospital clinic, a good medical care rating and fewer delays accessing care due to cost.

General Health

An examination of HSF participant responses shows fluctuation in participant responses to being in excellent or very good general health. At the same time, a greater percentage report being in fair or good health (from 60% at HAQ1 and 63% at HAQ4). There was a consistent reduction in the percentage who indicated that they were in poor general health.

Table F4
General Health

General Health	HAQ1	HAQ2	HAQ3	HAQ4	Variance	☺/😐/☹
Excellent	7.3%	5.5%	3.9%	4.4%	-2.9%	☹
Very Good	17.9%	14.6%	11.2%	13.6%	-4.4%	☹
Good	40.5%	42.6%	52.2%	49.8%	9.3%	☺
Fair	19.4%	18.2%	13.0%	13.3%	-6.1%	☺
Poor	2.4%	2.0%	2.1%	1.9%	-0.5%	☺
Don't Know or Refused	12.4%	17.1%	17.5%	17.0%	4.6%	😐

Hospital Emergency Department

A review of survey data to hospital emergency department use within the last 12 months reveals that over time, fewer participants indicated that they received care in an emergency department.

Table F5
Hospital Emergency Department Use

ED Visit in Last 12 Months	HAQ1	HAQ2	HAQ3	HAQ4	Variance	☺/😐/☹
Yes	10.1%	8.5%	7.1%	5.3%	-4.7%	☺
No	76.9%	74.6%	75.4%	77.4%	0.4%	☺
Don't Know or Refused	13.0%	17.0%	17.5%	17.3%	4.7%	😐

Medical Care Location

An examination of survey data shows that participants are more likely to receive health services at a clinic, health center, or hospital clinic. In addition, over time, less than 1% of participants indicated that they had no one place to receive care or received care at some other place.

Table F6
Medical Care Location

Medical Care Location	HAQ1	HAQ2	HAQ3	HAQ4	Variance	☺/😐/☹
Doctor's Office	10.9%	7.2%	9.1%	10.9%	0.0%	😐
Clinic/Health Center/Hospital Clinic	64.7%	73.0%	72.6%	71.9%	7.2%	☺
Emergency Room	1.7%	0.6%	0.2%	0.3%	-1.4%	☺
Some Other Place	0.9%	0.2%	0.1%	0.1%	-0.8%	☺
No One Place	7.5%	1.9%	0.6%	0.6%	-6.9%	☺
Don't Know, Refused	14.3%	17.1%	17.3%	16.3%	2.0%	😐

Medical Care Access

The data reveals that from HAQ1 to HAQ3, respondents reported reductions in the level of difficulty receiving care. However, this trend was slightly reversed in responses from HAQ3 to HAQ4 in which there were increases in the percentage of participants stating that it was extremely very or somewhat difficult to get access to medical care. At the same, there was positive trend in the percentage of participants stating that accessing medical care was not too difficult, or not difficult at all.[14]

Table F7
Medical Care Access

Medical Care Access	HAQ1	HAQ2	HAQ3	HAQ4	Variance	☺/😐/☹
Extremely Difficult	1.4%	1.0%	0.8%	2.2%	0.8%	☹
Very Difficult	6.8%	5.4%	2.6%	3.9%	-3.0%	☺
Somewhat Difficult	16.7%	16.4%	15.4%	17.1%	0.4%	☹
Not Too difficult	36.0%	34.7%	39.0%	36.6%	0.5%	☺
Not Difficult At all	17.4%	22.4%	22.9%	22.2%	4.8%	☺
Don't Know, Refused	21.7%	20.1%	19.4%	18.1%	-3.6%	😐

Medical Care Rating

A review of the questionnaire data reveals that over time, participants are more likely to rate their medical care as fair, good or very good (combined percentages) and less likely to rate it as excellent. There was a reduction in the percentage of participants that rate their care as poor.

Table F8
Medical Care Rating

Medical Care Rating	HAQ1	HAQ2	HAQ3	HAQ4	Variance	☺/😐/☹
Excellent	10.6%	10.2%	7.9%	7.3%	-3.3%	☹
Very Good	16.9%	18.6%	19.0%	19.5%	2.6%	☺
Good	38.8%	40.9%	46.7%	48.2%	9.4%	☺
Fair	6.9%	8.3%	6.0%	5.7%	-1.2%	☹
Poor	1.5%	0.6%	0.4%	0.5%	-1.0%	☺
Don't Know, Refused	25.4%	21.3%	20.0%	18.8%	-6.6%	😐

[14] During FY2011-12, the State of California's implementation of two new initiatives for insured populations (timely access to non-emergency health care and Medi-Cal managed care for seniors and persons with disabilities) and its statewide program for some uninsured adults (Low Income Health Program) is believed to have impacted access to care for uninsured populations such as HSF participants. All three of these new State provisions require timely access to care standards that prioritize certain populations over others with respect to access to clinical appointments.

Delay in Getting Care/ Medication
An examination of survey data reveals that participants are less likely to report having delayed care or getting prescribed medication.

Table F9
Delays in Getting Care

Delay in Care	HAQ1	HAQ2	HAQ3	HAQ4	Variance	☺/😐/☹
Yes	8.7%	3.8%	3.9%	2.8%	-5.8%	☺
No	71.6%	75.8%	76.9%	78.3%	6.7%	☺
Don't Know, Refused	19.8%	20.4%	19.1%	18.9%	-0.9%	😐

Delay in Care for Cost Reasons
An examination of questionnaire data shows that individuals are less likely to report having a delay in care for reasons of cost.

Table F10
Delays in Care Due to Costs

Delay in Care-Cost Reasons	HAQ1	HAQ2	HAQ3	HAQ4	Variance	☺/😐/☹
Yes	10.2%	8.0%	6.9%	6.6%	-3.6%	☺
No	64.5%	68.4%	72.0%	72.4%	7.9%	☺
Don't Know, Refuse	25.2%	23.7%	21.1%	21.0%	-4.2%	😐

Participant Perception of Health Status Compared to Utilization
As part of the Department's review of participant experience, there was a desire to assess how a HSF participant's perception of their health status compared to their actual utilization of services. To accomplish this, the analysis trended HSF participants who renewed their participation in HSF and completed the Health Access Questionnaire (HAQ) between July 2011 and March 2012.

The data indicates that participants' perception of their health status or of the medical care they receive seems to generally coincide with their utilization of services.

Of HSF participants who indicated that they had an ED visit when responding to the HAQ at renewal only 35% had an ED visit recorded in the HSF utilization data warehouse. It is possible the ED visit data in the HSF database is incomplete due to underreporting from private hospitals, as cited earlier in this section of the report.

Table F11
Does ED Utilization Response Match Information in Database

ED Visit in HAQ Response	ED Visit in Utilization Database	Percent HAQ Responses w/ Visit
1,205 Participants	428 Participants	35.52%

Predictably, participants who reported their health status as poor had more than twice as many office visits and three times as many ED visits as those who reported their health status as excellent, very good or good.

Table F12
How Does the Utilization of Services Vary for Those Participants Renewing Based on Their Self-Reported Health Status?

Health Status	Respondents	Average Primary Visits	Average Emergency Visits
Excellent/Very Good	3,295	2.62	0.07
Good	7,587	3.49	0.11
Fair	1,743	5.11	0.16
Poor	266	7.92	0.42

Those participants who reported that access to medical care was "extremely or very difficult" had 20% higher emergency room utilization than those who reported that access was "not that difficult."

Table F13
Do Renewing Participants Who Find it Difficult to Get Medical Care When Needed Have a Higher Rate of Avoidable ED visits?

Access to Medical Care	Respondents	Average Avoidable Emergency Visits
Extremely/Very Difficult	2,857	1.10%
Not That Difficult	10,034	0.92%

Renewing participants were asked about their interactions with the system and perception of care and access to services. The data revealed that 33% of participants who rate their health as excellent or good have a chronic condition, compared to 66% of those who rate their health as poor.

Table F14
Are Renewing Participants with Chronic Conditions More Likely to Rate Their Health as Fair or Poor Than Those Without Chronic Conditions?

Health Status	Respondents	Proportion w/ Chronic Disease	Proportion w/o Chronic Disease
Excellent/Very Good/Good	10,882	32.81%	67.19%
Fair	1,743	60.69%	39.31%
Poor	266	65.77%	34.23%

There was no difference in the incidence of chronic conditions among participants who rated their medical care as good/excellent, compared to those who rated it as poor.

Table F15
Are Renewing Participants with Chronic Conditions More Likely to Rate the Medical Care They Receive as Excellent or Very Good Than Those Without Chronic Conditions?

Medical Care	Respondents	Proportion w/ Chronic Disease	Proportion w/o Chronic Disease
Excellent/Very Good/Good	11,561	45.66%	54.34%
Fair	829	48.85%	51.15%
Poor	501	45.59%	54.41%

Results showed that smokers had, on an average, twice as many emergency department visits per person as non-smokers, despite having less incidence of chronic disease.

Table F16
Do Smokers Utilize Services at a Higher Rate than Non-Smokers and Do They Have a Higher Rate of Chronic Disease?

	Respondents	Average Primary Visits	Average Specialty Visits	Average Emergency Visits	Proportion w/ Chronic Disease	Proportion w/o Chronic Disease
Smokers	1,245	3.47	0.06	0.16	40.05%	59.95%
Non-Smokers	11,547	3.36	0.12	0.08	41.04%	58.96%

H. EMPLOYER SPENDING REQUIREMENT

This section examines employer selection of the City Option (Healthy San Francisco and Medical Reimbursement Accounts) to meet the mandate of the Employer Spending Requirement as outlined in the San Francisco Health Care Security Ordinance.

Key 2011-12 highlights were:

- There was a 12% increase in the number of San Francisco employers who have ever elected to use the City Option (Healthy San Francisco/Medical Reimbursement Account) to meet the Employer Spending Requirement (from 1,265 in FY2010-11 to 1,429 in FY2011-12).
- By the end of the fiscal year, these 1,429 employers had elected to use the City Option to make health care expenditures on behalf of almost 86,396 employees.
- A total of $40.955 million was contributed in FY 2011-12 by employers on behalf of eligible employees.

Program Description

Certain San Francisco businesses are required to make health care expenditures on behalf of their employees in accordance with the Health Care Security Ordinance. The requirement is known as the Employer Spending Requirement (ESR). The ESR went into effect on January 9, 2008 for employers with 50 or more employees and on April 1, 2009 for for-profit employers with 20 – 49 employees. In complying with the Ordinance, employers have a variety of options to choose from, such as health insurance, direct reimbursement to employees, health spending accounts, the City Option, etc. The ESR is overseen by the San Francisco Office of Labor Standards Enforcement, not the Department of Public Health.

City Option Activity

The Employer Spending Requirement Portal which is a component of the HSF website is maintained by the San Francisco Health Plan as HSF's third-party administrator. The portal is the mechanism by which employers identify employees for whom the employer is using the City Option. When an employer chooses the City Option, their employees will receive either Healthy San Francisco or a Medical Reimbursement Account depending upon the employee's eligibility.

- If the employee is eligible for HSF, the employee will be notified and must complete the HSF application process to get enrolled in the program. An employer does not enroll an employee into HSF. The employee must take action and go through the HSF application process in order to become a HSF participant.

- If the employee is ineligible for HSF, then they will be given a Medical Reimbursement Account (MRA). All funds contributed on the employee's behalf by the employer are deposited into this account and the employee can access these funds for reimbursement of out-of-pocket health care expenses.

Since ESR implementation, data on the City Option indicate the following as of June 30, 2012:

- 1,429 employers had selected the City Option to meet the ESR -- an increase of 164 employers using the City Option from last fiscal year when there were 1,265 employers.

- Employers deposited $40.955 million to provide the City Option for their employees.

- Of the funds contributed in FY2011-12, 62% ($25.368 million) were for employees receiving a Medical Reimbursement Account and 38% ($15.587 million) were for employees potentially eligible for HSF.

Employer payments are submitted to the HSF Third-Party Administrator (San Francisco Health Plan - SFHP) for processing. SFHP transfers the Healthy San Francisco component of the employer payments to DPH on a periodic basis. DPH then submits these funds to the City Controller's Office for processing and deposit. In accordance with the Health Care Security Ordinance, those funds are used for the HSF program. Since the ESR began, $64.948 million in employer contributions (including $15.587 million in FY2011-12) have been transferred from the Third-Party Administrator to the City and County of San Francisco.

Employer health care expenditures designated for a Medical Reimbursement Account are not transferred to the City and County of San Francisco. Participant eligibility and contribution information for these employees is forwarded to the Medical Reimbursement Account vendor and accounts are created for each employee to use for reimbursable health care expenses.

Employee Data

As noted above, under the City Option, employees are eligible for either HSF or they receive a Medical Reimbursement Account (MRA). The following is the distribution of those employees with respect to program eligibility:

Table H1

City Option Employees by Program (Unduplicated Count) as of June 30, 2012 (Past and Present)[15]

Category	Description	Number
HSF-Eligible Employees	City Option employee whose contributing employer has at some time in the past submitted these specific attributes: residency as "San Francisco," other insurance flag as "no," AND age between 18 and 64, inclusive.	40,479
MRA Employees	City Option employee whose contributing employer has at some time in the past submitted any combination of the following information for this City Option employee: residency not in "San Francisco," or other insurance flag as "yes", or age between 0-17 inclusive, or age greater than or equal to 65.	52,547
HSF and MRA Employees	City Option employee whose contributing employer(s) has at some time in the past submitted contributions designating this employee as both HSF eligible and MRA eligible. These individuals are counted above in either the "HSF-Eligible Employees" or "MRA Employees." The number is negative to eliminate duplicate counting of employees.	(6,630)
All City Option Employees	Employees with HSF contributions + employees with MRA contributions - employees with both HSF & MRA contributions.	86,396

[15] The table reflects all employees whose employers have submitted rosters with payments.

During the fiscal year, HSF Customer Service Center began completing transfers of City Option employer contributions from HSF to MRA based on an employee's ineligibility for HSF (i.e., because they were insured, did not reside in San Francisco, or were not between the age of 18 and 64). In FY2011-12, over 1,300 transfers were completed for a total of approximately 4,700 since ESR launch.

Of the 40,479 employees who have ever been determined potentially eligible for HSF based on employer submitted information, their status is as followings

Table H2
Potential City Option HSF Eligible Employees by Disposition[16]

HSF Eligibility Disposition	Number	Percent
HSF Enrollment (Current and Past)	9,214	23%
Employee Request for Fund Transfer from HSF to MRA	4,705	12%
HSF to MRA Transfers Due to Incorrect Employer Information	13,881	34%
Disposition Determination in Process, Inadequate Data or Unresponsive Outreach	12,679	31%
All Employees (Potential Duplication re: HSF & MRA Individuals)	40,479	100%

Of the 52,547 employees with an MRA, the reasons for designation based on HSF program eligibility are listed below. The utilization rate of MRA funds by employees was 55% in FY2011-12.

Table H3
MRA Designation Reasons

Reasons for MRA	Number	Percent
Not a San Francisco Resident	29,912	57%
Not Between the Ages of 18 and 64	686	1%
Has Health Insurance	10,578	20%
Combination of One of More Eligibility Reason	11,371	22%
All Employees	52,547	100%

Employer Data

The following is basic information on employers electing to use the City Option for all or some of their employees. Note that an employer may use City Option to augment any existing health care expenditures that they are making which are below the required ESR expenditure levels. Excluding those employers for which no data is reported (134 out of 1,429), the data indicate that:

- the majority of employers who have elected the City Option are either in the other services (24%), retail trade (14%) or professional/scientific/technical services (12%),
- 2% have fewer than 20 employees, 15% have 20 – 49, 11% have 50 – 99, 22% have 100 – 499 and 40% have 500 or more employees, and
- 81% are for profit and 9% are non- profit.

[16] The table reflects all employees whose employers have submitted rosters with or without payment. There were 48 employees for whom payment had not been received as of June 30, 2011.

Table H4
City Option Employers (1,429) by Industry Type

Count by Industry (*North American Industry Classification System* code)	Number	Percent
Accommodation and Food Services (72)	91	6%
Administrative & Support and Waste Management & Remediation Services (56)	8	1%
Agriculture, Forestry, Fishing and Hunting (11)	2	0%
Arts, Entertainment, and Recreation (71)	59	4%
Construction (23)	24	2%
Educational Services (61)	41	3%
Finance and Insurance (52)	118	8%
Health Care and Social Assistance (62)	81	6%
Information (51)	27	2%
Management of Companies and Enterprises (55)	7	0%
Manufacturing (31-33)	29	2%
Mining, Quarrying, and Oil and Gas Extraction (21)	2	0%
Other Services (except Public Administration) (81)	340	24%
Professional, Scientific, and Technical Services (54)	178	12%
Public Administration (92)	3	0%
Real Estate and Rental and Leasing (53)	35	2%
Retail Trade (44-45)	200	14%
Transportation and Warehousing (48-49)	22	2%
Utilities (22)	4	0%
Wholesale Trade (42)	24	2%
Unreported	134	9%

Table H4
City Option Employers by Company Size

Count by Company Size	Number	Percent
0-19 employees	24	2%
20-49 employees	225	16%
50-99 employees	160	11%
100-499 employees	310	22%
500+ employees	576	40%
Not reported	134	9%

Table H5
City Option Employers (1,429) by Tax Status

Count by Tax Status	Number	Percent
For-profit	1,159	81%
Non-profit	132	9%
Public (Publicly-traded)	4	0%
Not reported	134	9%

J. EXPENDITURES AND REVENUES

This section provides estimated expenditures and revenues for the HSF in FY2011-12. As with the previous sections, the HSF-SF PATH transition impacts expenditures, revenues and costs per participant.

Key FY2011-12 highlights were:

- Estimated that HSF expenditures totaled $139.86 million.
- Department HSF expenditures totaled $101.1million - of that amount, $23.76 million was covered by revenue and $77.37 million by City General Fund subsidy.
- Private HSF medical homes and non-profit hospitals incurred $38.7 million in net HSF expenditures.
- With a total of 549,525 participant months, the estimated total per participant per month expenditure was $255 ($139.86 million divided by 549,525).

The Department tracks expenditures through a financial class that has been created for HSF. Expenditures from each Department division are combined to provide an overview of HSF finances. The FY2011-12 Department costs and revenue calculations are estimates. The financial data that follows is comprised of the following components:

- estimated private community provider HSF expenditures,
- estimated system-wide HSF expenditures (all HSF providers) and,
- estimated Department cost of care to indigent and uninsured persons (HSF and non HSF).

Estimated HSF expenditures totaled $139.86 million in FY 2011-12. Department specific HSF expenditures totaled $101.1 million and of that amount, $23.76 million in expenses were covered by revenue and $77.37 million was covered by a City and County General Fund subsidy. Private HSF medical homes and non-profit hospitals incurred $38.7 million in HSF net expenditures. With a total of 549,525 participant months in FY2011-12, the estimated total per participant per month expenditure was $255 ($139.86 million divided by 549,525) based on all estimated HSF expenditures. Overall, Department expenditures for uninsured individuals (those enrolled in HSF, those enrolled in SF PATH and others) in FY2011-12 is estimated at $179.8 million, excluding behavioral health services for the non-HSF or non-SF PATH population.

Total Estimated HSF Expenditures and Revenues

System-wide estimated HSF expenditures for FY2011-12 are estimated at $139.86 million. It includes estimated HSF expenditures for private medical homes and the Department. Because the Department expenditure calculation includes reimbursement to non-Department HSF medical home providers and to avoid potential double-counting of expenditures, the net HSF expenditure for private medical homes is used. Expenditure detail follows in Table J2.

Table J1
Summary of Estimated System-wide FY2011-12 HSF Expenditures (All HSF Providers)

Delivery System	Estimated Cost
Total Department HSF Expenditures	$101,132,119
Private Provider Net HSF Expenditures	$21,436,106
Non-Profit Hospital Charity Care Expenditures	$17,297,376
All HSF Provider Expenditures	$139,865,602

Table J2
Estimated Total Department and Non-Department HSF Expenditures (Fiscal Year 2011-12)

	2007-08	2008-09	2009-10	2010-11	2011-12
ENROLLMENT					
Total Participant Months	130,114	420,878	596,647	656,361	549,525
REVENUE					
General Fund	$0	$0	$0	$0	$0
Health Care Coverage Initiative	$8,136,224	$19,199,749	$22,855,381	$27,400,000	$0
Participation Fees and DPH POS	$836,493	$3,208,577	$5,046,830	$5,791,742	$8,067,498
ESR (Employer Health Care Expenditures)	$4,187,554	$18,236,251	$13,970,440	$12,966,266	$15,587,137
Reserve for Unearned Rev. (Enrollee & ESR)	($1,046,889)	($4,559,063)	($1,563,176)	$0	$0
Transfer of Unused MRA Funds	--	--	--	$3,565,831	$0
Philanthropic Grants (Evaluation)	$0	$450,000	$140,000	$210,000	$105,190
TOTAL REVENUE	$12,113,382	$36,535,514	$40,449,475	$49,933,839	$23,759,825
DPH EXPENDITURES					
Administration					
HSF Administration	$0	$752,122	$697,757	$788,742	$766,497
Evaluation	--	--	--	$719,088	$105,190
Third-Party Administrator (SFHP)	$3,039,107	$5,132,291	$6,180,527	$6,567,316	$6,656,012
Services					
Cost of Services (SFGH, Clinics, UCSF)	$38,030,229	$91,431,700	$97,374,760	$106,295,039	$61,989,030
Behavioral Health	$2,183,284	$20,099,554	$23,440,070	$20,375,732	$16,168,695
Non-DPH Provider Reimbursement	$2,153,255	$6,683,671	$11,516,867	$14,396,117	$14,942,338
Information Systems					
Eligibility/Enrollment System (One-E-App)	$393,000	$240,702	$282,636	$267,810	$270,449
Siemens Information Technology	$200,000	$200,000	$203,578	$223,936	$233,908
Capital					
Capital Projects	$0	$0	$562,280	$0	$0
SUBTOTAL DPH EXPENDITURES	**$45,998,875**	**$124,540,040**	**$140,258,475**	**$149,633,780**	**$101,132,119**
ESTIMATED DPH PER PARTICIPANT PER MONTH EXPENDITURE ($98.2M ÷ 549,525)	**$354**	**$296**	**$235**	**$228**	**$184**
NON-DPH EXPENDITURES					
Private Medical Homes Net HSF Expenditures	--	--	$23,629,093	$16,328,385	$21,436,106
Non-Profit Charity Care Expenditures	--	--	--	$11,812,682	$17,297,376
SUB-TOTAL NON-DPH EXPENDITURES			$23,629,093	$28,141,067	$38,733,482
TOTAL DPH AND NON-DPH EXPENDITURES	**$45,998,875**	**$124,540,040**	**$163,887,568**	**$177,774,847**	**$139,865,602**
ESTIMATED TOTAL PER PARTICIPANT PER MONTH EXPENDITURE ($136.94M ÷ 549,525)	**N/A**	**N/A**	**$275**	**$271**	**$255**
DPH REVENUE LESS DPH EXPENDITURES = GENERAL FUND SUBSIDY ($23.76M - $98.2M)	($33,885,493)	($88,004,526)	($99,809,000)	($99,699,941)	($77,372,294)

Participant months totaled 549,525 (i.e., the addition of the number of participants enrolled during the month for the 12 month fiscal year). A "per participant per month" expenditure amount represents, on average, the cost of services utilized by a participant on a monthly basis. This cost recognizes that some participants will use services in any given month and that some will not. The estimated total per participant per month expenditure was $255 ($139.86 million in expenditures divided by 549,525 participant months). This represents all estimated costs and not just Department costs.

Due to the HSF-SF PATH transition that occurred in FY2011-12, it is important to provide context for any comparative analysis between FY2011-12 and past fiscal years. There was an absolute reduction in HSF participant months, revenues, and expenditures in FY2011-12. A change in participant months or expenditures either will change per participant per month expenditures. For FY2011-12, the estimated $255 per participant per month calculation reflects the customary change in these two areas, in addition to changes in the calculation based on the shift of service costs of 10,000 enrollees to SF PATH under the HSF-SF PATH transition. It is difficult to separate these two factors and provide definitive information on how much of the per participant per month reduction of $16 from FY2010-11 was due to either factor.

Department Expenditures

Department expenditures totaled an estimated $101.1 million in FY2011-12. Department expenditures are categorized into the major categories of administration, services, information systems and capital. Key expenditures highlights are:

- service costs were 92% of total estimated Department expenditures at $93.1 million,
- administration (including the evaluation and information technology) was roughly 8% of total estimated Department expenditures at $8.0 million,

A portion of Department expenditures reflects reimbursement for non-Department medical homes and emergency ambulance transportation, incremental UCSF reimbursement for services rendered at San Francisco General Hospital, and incremental behavioral health provider funding. In addition, as noted in Section V.C., a portion of Department service costs at San Francisco General Hospital support hospital based specialty, urgent care, diagnostic, emergency care, home health, pharmacy, durable medical equipment and/or inpatient services to not only Department clinics, but several other private providers in the network.

Department Revenues

Non-General Fund revenues totaled $23.76 million. As noted in Table J2, it includes contributions from employers using the City Option to fulfill the Employer Spending Requirement, participant fees (both participation and Department point-of-service fees) and grants for the evaluation that ended in the first quarter of FY2011-12. Participants with income at or above 101% of the Federal Poverty Level (FPL) pay participation fees to remain in the program and are billed quarterly. As of June 30, 2012, approximately 40% of participants were at or above 101% of FPL. For the fiscal year ending June 30, 2012, the participant payment rate was approximately 80% with quarterly participation fees of $7.47 million received from participants and forwarded to the Department.[17] Participants with incomes at or above 101% FPL also pay point-of-service fees when accessing certain services. The Department only collects information on point-of-services fees paid by HSF participants accessing services within the Department. For the fiscal year ending June 30, 2012, the Department collected an estimated $596,600 in HSF point-

[17] The payment rate is calculated using the Quarterly Cash Received and dividing by the Quarterly Billed Amount. Cash received represents cash collected in that quarter only. Cash collected and Billed Amount will never match by quarter because participants have 60 days to pay their invoice. Therefore, payments will not always be made in the same quarter they were billed.

of-service fees. The amount of point-of-service fees paid by HSF participants to non-Departmental HSF providers is not known to the Department and is not included in the calculations. [18]

General Fund Subsidy

The difference between the expenditures and the revenue was covered by a City and County General Fund subsidy. It is represented as a negative number to show the shortfall between revenues and expenditures. The FY2011-12 General Fund subsidy was $77.37 million.

Department Per Participant Per Month Costs

As noted above, there was a total of 549,525 participant months in FY2011-10. The estimated total Department per participant per month expenditure was $184 ($101.1 million in expenditures divided by 549,525 participant months). Of the $184 per participant per month cost, $43 (23%) was covered by revenue and $141 (77%) was covered by General Fund subsidy.

Estimated Private HSF Provider Costs and Revenue of Serving HSF Participants

It is estimated that health services to HSF participants cost private HSF providers $38.73 million:

- $21.43 million by medical homes after revenues of $22.43 million are deducted from total expenses of $43.86 million and
- $17.30 million in hospital charity care expenses.

Table J3
Estimated Expenditures and Revenue for Private HSF Medical Homes

Medical Home	Expenditures	HSF Funding and Other Revenues	Net Expenditures
BAART	($137,291)	$74,500	($62,791)
Brown & Toland Physicians	($944,839)	$0	($944,839)
CCHCA & Chinese Hospital	($1,969,327)	$1,960,050	($9,277)
Glide Health Services (specialty affiliation with Saint Francis Memorial Hospital)	($5,235,987)	$575,000	($4,660,987)
Kaiser Permanente	($11,527,575)	$4,469,294	($7,058,281)
North East Medical Services	($10,700,622)	$5,815,012	($4,885,610)
San Francisco Community Clinic Consortium Affiliated Clinics (includes SFCCC Administration)	($8,378,060)	$8,378,060	$0
Sister Mary Philippa Clinic (affiliation with St. Mary's Medical Center)	($4,972,128)	$1,157,807	($3,814,321)
All Non-DPH Medical Home Health Systems	($43,865,829)	$22,429,723	($21,436,106)

Of the $22.43 million in revenues available to medical homes, $14.68 million (65%) was funding from the Department. Department funding to private HSF providers is not designed or intended to cover the entire costs of delivering care to HSF participants. The Department does not have sufficient funding to

[18] Non-departmental HSF medical homes/providers are not required to report or remit to the Department any point-of-services fees collected from HSF participants. Fees collected by the non-Department private community providers support the delivery of care at those medical homes.

provide reimbursement at that level. In addition, prior to HSF, the majority of the HSF providers were providing services to their HSF participants, but through their specific sliding scale clinic programs for uninsured clients. To the fullest extent possible, HSF providers have worked to enroll their existing uninsured clients into the HSF program. Under HSF, these providers are now receiving some reimbursement for a population that they provided services to and previously received no City and County reimbursement. [19]

Charity care services by non-profit hospitals are estimated at $17.3 million. Hospitals count these expenses in different ways. As a result, the costs may include any of the following:

- services to HSF participants affiliated with the medical home the hospital partners with or
- services to HSF participants not affiliated with the medical home the hospital partners with.

Costs included in Table J3 are not included in the Table J4 cost calculations to avoid double counting.

Table J4
Estimated HSF Charity Care Expenditures by Non-Profit Hospital

Hospital Charity Care	HSF Expenditures
California Pacific Medical Center	$4,539,951
Chinese Hospital	$188,831
Kaiser Permanente	$2,772,003
Saint Francis Memorial Hospital	$4,891,635
St. Mary's Medical Center	$4,046,602
UCSF Medical Center	$858,354
All Non-Profit Hospital Charity Care	$17,297,376

In examining the HSF private community provider expenditure data, it is important to underscore that there is no uniform mechanism for calculating HSF costs for these providers. Each health entity used its own established processes and procedures for estimating its costs and provided that information to the Department. In addition, in the area of charity care, some hospitals providers report costs on a calendar year not fiscal year basis.

Estimated Department Costs of Serving Indigent and Uninsured

The Department provides services to uninsured individuals ineligible for HSF or not yet enrolled in HSF, and provides services that are not in the HSF scope of benefits (e.g., dental, long-term care, etc.) on a sliding scale basis to uninsured individuals at San Francisco General Hospital and in Community Oriented Primary Care. It is estimated that the costs of providing services to this population was approximately $61.5 million in FY2011-12. The LIHP/SF PATH population is estimated at $40.1 million in expenditures.

[19] Prior to HSF, Haight Ashbury Free Clinic, Lyon-Martin Health Center and Mission Neighborhood Health Center had contracts with the Department to provide health services to medically indigent adults.

As a result, the Department's estimated cost of serving the indigent and uninsured in FY2011-12 is $202.8 million. This does not include behavioral health expenditures for the non-SF PATH and non-HSF population.

Table J5
Estimated Costs of Serving Indigent and Uninsured (Fiscal Year 2011-12)

Uninsured Patient Population	Estimated Cost
HSF Uninsured Population	$101,132,119
Non-HSF Uninsured Population (not including LIHP)	$61,541,624
LIHP/SF PATH Population	$40,105,341
Entire Uninsured Population	$202,779,084

APPENDIX A
Data Source and Submission

Healthy San Francisco (HSF) maintains a clinical data warehouse that is managed by the program's third-party administrator, the San Francisco Health Plan (SFHP). In this role, SFHP defines the encounter data submission standards, ensures quality data is collected and processed, and analyzes and reports the data received to the Department annually. Collection and analysis of encounter data is one key approach to ascertaining the extent to which the program is meeting its goals.

The source data for this report came from the HSF data warehouse which includes all medical and pharmacy services, the Health Access Questionnaire which is administered during the HSF application process and membership data from the One-e-App system. The data being reported includes all services incurred from July 2008 through March 2012. For FY2011-12, the analysis allows for a three month lag for data completion. Therefore, the analysis does not use actual data for the months of April 2012 to June 2012. The data has been trended comparing 12 months of actual data from July 2008 to June 2009, July 2009 to June 2010, and July 2010 to June 2011. The FY2011-12 data has been annualized for 12 months for comparative purposes.

SFHP monitors HSF submissions by service category and total submissions received by provider on a monthly basis. See Attachment A. This ongoing monitoring provides a better understanding of the total submissions received, loaded and used for the development of utilization analyzes. Analysis of service utilization is dependent upon having complete data from all HSF providers. In FY2011-12, over 90% of institutional service data was from San Francisco General Hospital which strongly suggests underreporting of HSF encounter level data is occurring at the private hospitals.

In addition, at any given time, a non-profit hospital could provide charity care services to a HSF participant. Since FY2009-10, the Department has worked with hospitals to receive utilization data on this population. While data has been received from each hospital system in FY2011-12, for some hospital systems, the data has not been consistently submitted and may not capture all of the services provided. The Department continues to work collaboratively with the non-profit hospitals in this area.

Hospital System	Encounter Data for HSF Population or HSF Service	Encounter Data for HSF Participants Receiving Charity and/or Discounted Care
California Pacific Medical Center (4 campuses)	Inpatient encounters for NEMS HSF Participants; Encounters for Brown & Toland HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
Chinese Hospital	Encounters for CCHCA HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
Kaiser Permanente	Encounters for Kaiser HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
Saint Mary's Medical Center	Encounters for Sister Mary Philippa HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
San Francisco General Hospital	Encounters for DPH HSF Participants; specialty, diagnostic, inpatient encounters for SFCCC HSF Participants at some medical homes; BAART HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
St. Francis Hospital	Encounters for Glide HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
UCSF Medical Center	Encounters for HSF Participants receiving diagnostic services at Mission Bay	Encounters for any HSF participant, irrespective of medical home, that received services from hospital

Appendix B
Summary of FY 2011-12 Health Access Questionnaire Responses
(New Applicants and Continuing Participants)

The 49,677 questionnaires were administered to 48,564 participants:

- 47,470 participants took the survey only one time during the year,
- 1,076 participants took the survey twice during the year (i.e. a new applicant who renewed eligibility before the end of his/her 12 month term),
- 17 participants took the survey three times (likely due to disenrollment and reenrollment) and
- 1 participant took the survey four times (likely due to disenrollment and reenrollment).

No.	Question	Key 2011-2012 Responses	Key 2010-2011 Responses	Key 2009-2010 Responses	Key 2008-2009 Responses
1	Would you say that in general your health is excellent, very good, fair, or poor?	64% of all respondents indicated their health was Excellent, Very Good, or Good.	58% of all respondents indicated their health was Excellent, Very Good, or Good.	52% of all respondents indicated their health was Excellent, Very Good, or Good.	58% of all respondents indicated their health was Excellent, Very Good, or Good.
2	During the past 12 months, was there any time you had no health insurance at all?	48% of all respondents indicated that they did not have health insurance for some time in the past 12 months.	49% of all respondents indicated that they did not have health insurance for some time in the past 12 months.	53% of all respondents indicated that they did not have health insurance for some time in the past 12 months.	53% of all respondents indicated that they did not have health insurance for some time in the past 12 months.
3	What is the main reason why you did not have health insurance?	The most common reason noted was "enrollment in Healthy San Francisco." 33% cited HSF as the reason they did not have health insurance.	The most common reason noted was "enrollment in Healthy San Francisco." Twenty-nine percent (29%) cited HSF as the reason they did not have health insurance.	The most common reason noted was "cost of health insurance and/or co-payments." Twenty-seven percent (27%) cited it as the reason they did not have health insurance.	The most common reason noted was "cost of health insurance and/or co-payments." Twenty percent (20%) cited it as the reason they did not have health insurance.

No.	Question	Key 2011-2012 Responses	Key 2010-2011 Responses	Key 2009-2010 Responses	Key 2008-2009 Responses
4	In the last 12 months, did you visit a hospital emergency room for your own health?	9% of all respondents stated that they had visited a hospital emergency room in the previous 12 months.	10% of all respondents stated that they had visited a hospital emergency room in the previous 12 months.	12% of all respondents stated that they had visited a hospital emergency room in the previous 12 months.	14% of all respondents stated that they had visited a hospital emergency room in the previous 12 months.
5	What kind of place do you go to most often to get medical care? Is it a doctor's office, a clinic, an emergency room, or some other place?	69% of all respondents most often receive care at a clinic, health center, doctor's office or hospital clinic and 2% of all respondents most often receive care in an emergency room.	63% of all respondents most often receive care at a clinic, health center, doctor's office or hospital clinic and 2% of all respondents most often receive care in an emergency room.	71% of all respondents most often receive care at a clinic, health center, doctor's office, or hospital clinic and 8% of all respondents most often receive care in an emergency room.	54% of all respondents most often receive care at a clinic, health center, doctor's office or hospital clinic and 4% of all respondents most often receive care in an emergency room.
6	Overall, how difficult is it for you and/or your family to get medical care when you need it- extremely difficult, very difficult, somewhat difficult, not too difficult, or not at all difficult?	47% of all respondents said it was Not At All Difficult or Not Too Difficult to access care when they needed it.	45% of all respondents said it was Not At All Difficult or Not Too Difficult to access care when they needed it.	34% of all respondents said it was Not At All Difficult or Not Too Difficult to access care when they needed it.	43% of all respondents said it was Not At All Difficult or Not Too Difficult to access care when they needed it.
7	How do you rate the medical care that you received in the past 12 months – excellent, very good, good, fair, or poor?	24% rated the medical care they received in the past 12 months as Excellent or Very Good.	23% rated the medical care they received in the past 12 months as Excellent or Very Good.	39% rated the medical care they received in the past 12 months as Excellent or Very Good.	26% rated the medical care they received in the past 12 months as Excellent or Very Good.
8	During the past 12 months, did you either delay getting care or not get a medicine that a doctor prescribed for you?	6% of all respondents said they had delayed getting care or did not get a medicine prescribed to them during the past 12 months.	8% of all respondents said they had delayed getting care or did not get a medicine prescribed to them during the past 12 months.	11% of all respondents said they had delayed getting care or did not get a medicine prescribed to them during the past 12 months.	12% of all respondents said they had delayed getting care or did not get a medicine prescribed to them during the past 12 months.

No.	Question	Key 2011-2012 Responses	Key 2010-2011 Responses	Key 2009-2010 Responses	Key 2008-2009 Responses
9	Was cost or lack of insurance a reason why you delayed getting care or did not get a prescription?	Overall, 10% of respondents said cost or lack of insurance was a reason why they had delayed care.	Overall, 10% of respondents said cost or lack of insurance was a reason why they had delayed care.	Overall, 14% of respondents said cost or lack of insurance was a reason why they had delayed care.	Overall, 14% of respondents said cost or lack of insurance was a reason why they had delayed care.
10	Do you now smoke cigarettes every day, some days, or not at all?	Overall, 9% of respondents smoked (either every day or some days).	Overall, 11% of respondents smoked (either every day or some days).	Overall, 14% of respondents smoked (either every day or some days).	Overall, 16% of respondents smoked (either every day or some days).
11	Which of the following had the greatest influence in your decision to come in today to renew? Gift card lottery, phone call from HSF, reminded when visited medical home, reminded when called medical home, or you remembered?	Forty-three percent (43%) of respondents stated the lottery offer as the reason for coming in for renewal.	Thirty-five percent (35%) of respondents stated the lottery offer as the reason for coming in for renewal.	Not Available – question was not asked	Not Available – question was not asked