Healthy San Francisco

Our Health Access Program

Annual Report to the San Francisco Health Commission (Fiscal Year 2012-13)

Table of Contents

I. SUMMARY AND OVERVIEW OF PROGRAM ACCOMPLISHMENTS

Healthy San Francisco (HSF) celebrated its sixth year of operation at the end of fiscal year 2012-13 (FY2012-13), the final fiscal year before the implementation of the Patient Protection and Affordable Care Act (ACA) on January 1, 2014. The program has continued to focus on providing health care to San Francisco's uninsured adult population while also preparing for health care reform under the ACA. In addition, enrollment in San Francisco's Low Income Health Program (LIHP), called San Francisco Provides Access to Health Care (SF PATH), will continue until December 31, 2013. SF PATH expedites the transition of low-income individuals into expanded Medi-Cal under the ACA through automatic enrollment (of those who meet the 133% or less of the Federal Poverty Level (FPL)) into Medi-Cal effective January 1, 2014. By June 30, 2013, 9,844 people were enrolled in the SF PATH program.

The following highlights just some of the HSF program's accomplishments in FY2012-13 as well as in the program overall:

Access to Care

- FY2012-13 ended with 51,158 participants, an increase of approximately 9% from FY2011-12.
- As of June 30, 2013, HSF has provided access to care to over 131,000 uninsured adult residents since the program's inception.

Appropriate Service Utilization

- The average number of office visits per participant per year has consistently been 3 visits, the same as the national Medicaid average.[1]
- As of March 2013, the avoidable Emergency Department utilization rate was slightly under 8%, down approximately 1.4% from FY2008-09.

Quality of Care

- As of March 2013, the 30-day hospital readmission rate was slightly under 8%, much lower than the Medi-Cal population 30-day hospital readmission rate of almost 19%.
- The percentage of HSF participants who received diabetic care tests exceeded national Medicaid averages by approximately 3%.

Participant Experience

- The Health Access Questionnaire found that participants continuously enrolled in the program reported infrequent ER utilization, having a usual source of care, having little difficulty accessing care, good to very good rating of medical care and few delays accessing care.

In FY2012-13, the Department of Public Health's estimated HSF expenditures totaled $121.22 million. Of this amount, $24.31 million was covered by revenue and an estimated close to $97 million was covered with a City & County of San Francisco General Fund subsidy. In addition, private community HSF providers incurred an estimated $37.94 million in net HSF expenditures. Therefore, the total sum of estimated FY2012-13 HSF expenditures totaled nearly $159 million. With a total of 612,462 participant months, the estimated per participant per month expenditure was $259.

[1] National Health Statistics Report, DHHS (2009); Centers for Medicare and Medicaid Services

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 DPH operates HSF and how it monitors and tracks its performance.

The development of this FY2012-13 HSF Annual Report was delayed for several months due to staff transitions and preparations for Covered California's open enrollment period. In addition, staff was preparing for the Modified Adjusted Gross Income (MAGI) Medi-Cal Expansion. As a result, some of the anticipated events occurring after FY2012-13 have since passed, but will be reviewed and discussed in the following fiscal year annual report.

This year's report will also incorporate efforts to prepare for the implementation of the ACA. HSF is a trusted source of information for participants and thus will have a key role to play in transitioning participants to health insurance options, most notably, Medi-Cal and Covered California. However, despite the expansion of health insurance options under the ACA, there will be people who will be unable to qualify for or purchase health insurance. HSF will still be here for those San Franciscans who need it.

II. HEALTHY SAN FRANCISCO AND HEALTH REFORM

Since 2007, San Francisco's health care community has partnered together 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 age 18-64, 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, 2013, HSF had served over 131,000 residents. This is a significant achievement for a city and county of approximately 800,000 residents where HSF enrollment is voluntary.

Shortly after the program launched, the global recession occurred and the local economy was also negatively affected, thus increasing the number of residents who became eligible for and enrolled in HSF. The Department of Public Health 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. While the economy has rebounded and San Francisco enjoyed one of the fastest growth rates of metropolitan areas in the country this year, we continue to see an increase in enrollment in HSF.

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. The program's successful approach to providing health care to San Francisco's uninsured residents is reflected in similar provisions that have been incorporated into the Patient Protection and Affordable Care Act (ACA).

Impact of Health Care Reform to Healthy San Francisco

The ACA, which takes effect on January 1, 2014, will create a new marketplace, a health benefit exchange, for consumers to purchase health insurance and potentially receive a subsidy based on their income. On January 10, 2013, Governor Brown released his proposed FY2013-14 budget, affirming the State's commitment to implement the Medicaid expansion under the ACA, meaning that a majority of uninsured San Franciscans, including HSF and San Francisco Provides Access to Health Care (SF PATH) participants, would be eligible for new insurance options either through Medi-Cal expansion or by purchasing discounted health insurance through Covered California, California's Health Benefit Exchange.

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 ACA in January 2014. An estimated 60% of uninsured residents in San Francisco's two health access programs will become insured under the ACA. In several ways, HSF has been ahead of the curve in terms of preparing for the changes that came with the implementation of the ACA by:

- Addressing some of the "pent-up" demand for health care services that can occur with new health insurance programs
- Promoting participant use of medical homes and preventive services
- Expanding the number of providers serving uninsured individuals

- Developing a mechanism for identifying those eligible for health insurance (One-e-App, HSF's eligibility and enrollment system)

With approximately 59% of San Francisco's uninsured population participating in HSF, it has been easier to target outreach and education to the uninsured population that may qualify for upcoming public and private health insurance options. This year, HSF will leverage existing resources to communicate with participants about new changes that ACA will bring. These efforts include the creation of a health care reform webpage on the HSF website and the inclusion of ACA-focused articles in HSF program communications with Application Assistors as well as participants.

The Department has also started to actively engage the Human Services Agency of San Francisco (HSA) to prepare for health care reform. The discussions have focused on coordinating the transition of HSF and SF PATH participants to Medi-Cal. To explore the opportunity to leverage individuals' existing connections with DPH or HSA programs, HSF and HSA staff performed a series of data exchanges. Program staff found that nearly 70% of County Adult Assistance Programs (CAAP) participants who were between 18-64 years old were either enrolled in HSF or SF PATH or had been at one time. Conversely, only 44% of the CalFresh (California's Supplemental Nutrition Assistance Program) participants in the same age range were known to either program, indicating that this may be a good target population for outreach. In October 2012, the interdepartmental group was expanded to include the Mayor's office and the Controller's office in order to develop a city-wide approach for implementing health care reform.

Through San Francisco's Health Care Security Ordinance (HCSO) (discussed in Section III), for-profit employers with 20 or more employees and non-profit employers with 50 or more employees must financially contribute towards health care costs per hour the employee works. In 2015,[2] the ACA will require employers with 50 or more employees to financially contribute for each employee towards health care costs. The City Option (discussed in Section IV-G) is one way that employers can choose to comply with San Francisco's HCSO. Employees who are enrolled in the City Option and meet HSF eligibility will be enrolled into HSF with a discounted participant fee. The City is continuing to investigate what impacts the ACA will have on the HCSO and the City Option.

Low Income Health Program (LIHP) - SF PATH

In addition to HSF, the Department also administers another coverage program, SF PATH, which was created in response to California's "Bridge to Reform" Demonstration 1115 Medicaid Waiver and allowed for the development of a new statewide health care program called the Low Income Health Program (LIHP). LIHP was 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 eligible enrollees transition into health insurance under Medi-Cal or Covered California as a result of the ACA.

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 (HCCI). That Initiative provided the Department with federal reimbursement to cover a portion of the cost of care of some designated HSF participants who met certain 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 enrolled new applicants based on eligibility and selection of a Department clinic as

[2] In February 2014, this requirement was delayed to 2016.

their medical home. Federal reimbursement that DPH once received for HSF participants who met Initiative eligibility is now provided to the SF PATH program and its enrollees and the SF PATH provider network consists of the Department clinics, San Francisco General Hospital, and Laguna Honda Hospital.

The Department's participation in the State LIHP allows for administrative transition of participants into Medi-Cal on January 1, 2014 without additional effort on the participants' end; those eligible for health insurance through Covered California must enroll. On July 1, 2011, 10,116 HSF participants (19% of the HSF population at the time) were disenrolled from HSF and simultaneously enrolled into SF PATH. As of June 30, 2013, there were 9,844 participants enrolled in SF PATH. SF PATH will continue to enroll eligible participants until the program end date of December 31, 2013.

Each participating county's LIHP determines the maximum eligible income for participation in the program. Since November 2011, the maximum income for SF PATH participants was 25% FPL. In order to encourage more eligible San Francisco residents to take advantage of the auto-transition to Medi-Cal starting on January 1, 2014, the Department raised the maximum income limit for SF PATH from 25% FPL to 133% FPL on June 28, 2013. All SF PATH participants with incomes up to 133% FPL who meet eligibility requirements will automatically be transitioned into Medi-Cal Expansion on January 1, 2014.

An estimated 125,000-166,000 currently uninsured individuals will become eligible for either Medi-Cal Expansion or subsidized insurance through Covered California. HSF and the Department are currently planning to capitalize on the existing infrastructure to assist HSF participants as well as the broader San Francisco community to enroll into these new options. The program's goal is to have all HSF enrollment sites certified to be enrollment sites for new healthcare options. This will allow San Francisco residents a one-stop shopping opportunity for enrolling in ACA coverage. However, even with outreach and streamlining application processes, between 42,700 and 52,000 are estimated to remain residually uninsured, including an estimated 18,000 who are not eligible for new insurance programs under the ACA. These individuals will continue to need access to care. HSF will continue to provide health care coverage for these individuals and its health care access model will remain relevant even with ACA implementation.

III. HEALTH CARE SECURITY ORDINANCE

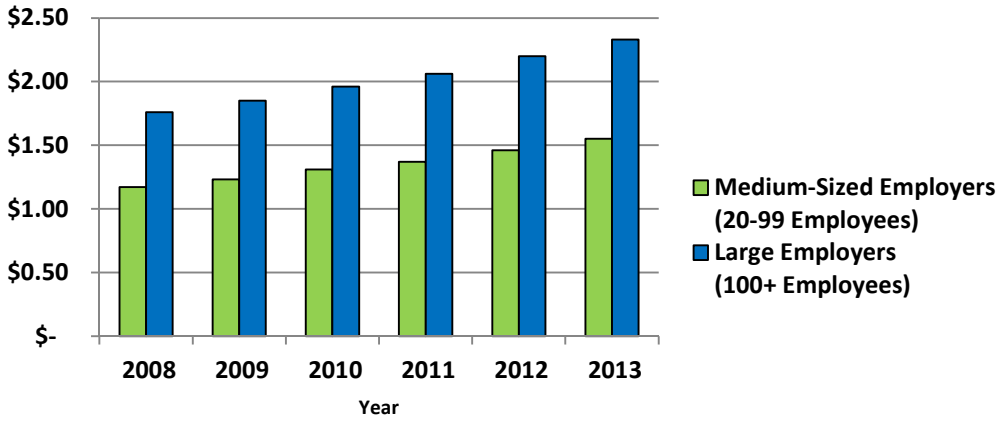
On July 25, 2006, the San Francisco Board of Supervisors passed the San Francisco Health Care Security Ordinance (HCSO) (No. 218-06; Chapter 14 of the San Francisco Administrative Code) and Mayor Gavin Newsom signed the ordinance into law on August 4, 2006. The HCSO mainly created two new City & County programs:

1. Employer Spending Requirement (ESR), which requires employers in San Francisco to make health care expenditures on behalf of their employees, and
2. Health Access Program, renamed Healthy San Francisco (HSF) in April 2007.

The Office of Labor Standards Enforcement (OLSE) oversees the implementation of the ESR while the Department of Public Health oversees the implementation of HSF.

The ESR took effect for all employers with 50 or more employees on January 9, 2008. On April 1, 2008, the ESR applied to for-profit employers with 20 or more employees and nonprofit employers with 50 or more employees. These Covered Employers are required spend a minimum monetary amount on health care expenditures for their eligible employees; Figure III-1 below shows the gradual increase in the required minimum amount to spend per employee per hour since the implementation of the ESR. In 2013, the minimum expenditure was $1.55 for medium-sized employers (20-99 employees) and $2.33 for large employers (100+ employees).

Figure III-1
Health Care Security Ordinance Minimum Health Care Expenditures
Per Covered Employee Per Hour by Year



To be eligible, Covered Employees must meet the following criteria:

- Entitled to minimum wage
- Employed by employer for at least 90 days
- Works at least 8 hours per week

Employers have many options to fulfill the ESR, including offering private health insurance plans, offering health reimbursement plans, or contributing to the City Option. The City Option is a program that allows employers to submit and direct health care expenditures to HSF if the employee is eligible; if

the employee is not eligible for HSF, expenditures go to a Medical Reimbursement Account (MRA) that is established for the employee.

On November 8, 2006, the Golden Gate Restaurant Association filed a lawsuit against the HCSO in the United States District Court, claiming that the ESR preempts the Employee Retirement Income Security Act (ERISA), a federal law that set minimum standards for any voluntarily established pension or health plans. In December 2007, the United States District Court for the Northern District of California determined the ESR invalid because it violated ERISA. The following month, the City & County of San Francisco filed an appeal and an Emergency Motion For A Stay Pending Appeal, which allowed the HCSO to go into effect as scheduled. On June 28, 2010, the U.S. Supreme Court refused to hear the case, and so the HCSO remained in effect as planned.

As a result of the HCSO, some San Francisco-based businesses have chosen to raise the prices of the products and services they provide. Other businesses, primarily restaurants, have added health surcharges to customers' bill in order to pass the health care expenditure to the customer. Restaurants usually charge either a flat fee per guest or a certain percentage of the restaurant bill. A provision was added to the HCSO in 2011, to take effect on January 1, 2012, that required restaurants that collect health surcharges to report to the OLSE both the amount collected from surcharges and the amount spent towards employees' health care. It also required that the monetary amount collected from surcharges not be greater than the amount spent on covered employees' health care. In addition, all Covered Employers must post the Official OLSE Notice of the ESR at every workplace or job site.

On January 25, 2013, City Attorney Dennis Herrera, Assemblymember Tom Ammiano, Supervisors David Campos and David Chiu, representatives from San Francisco restaurants, and representatives from OLSE launched an initiative to target restaurants that issued surcharges on customers for ESR costs but used little to none of the collected money on its Covered Employees. The initiative offered a one-time amnesty offer of 50% payment of what is actually owed, as long as the restaurant business is under full cooperation with the investigation. The application for the amnesty offer expired on April 10, 2013. More than 48 restaurant businesses applied for the program. As of May 8, 2013, 18 of these restaurant businesses have reached an agreement and $844,644 has been collected to be distributed among 1,500 employees. In addition, 12 restaurant businesses were found to be in compliance with the HCSO and received "Clean Bills of Health". As of June 30, 2013 the investigation was still ongoing.

The ESR has given San Francisco the opportunity to be well-prepared for implementing the Patient Protection and Affordable Care Act (ACA). Beginning 2015,[3] a federal mandate will require employers with 50 or more employees to offer health insurance to most of their full-time workers. San Francisco already does this under stricter criteria (20 or more employees for for-profit businesses).

[3] In February 2014, this requirement was delayed to 2016.

IV. FY2012-13 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.

Communications and Outreach

HSF relies heavily on positive public relations, community outreach, and word of mouth to generate interest and attention.

The HSF website (www.healthysanfrancisco.org) continues to be the most accessible and versatile program communications tool and had a total of 221,239 visitors during FY2012-13 with an average of 55,310 visits per quarter. The website has both Chinese and Spanish language components. The general public can also obtain information on HSF and the San Francisco Provides Access to Health Care (SF PATH) programs by calling the City & County of San Francisco's 24 hours a day/7 days a week 3-1-1 System. Call volume for these health access programs went from 465 calls during the first half of FY2012-13 to 1,415 calls during the second half of FY2012-13 and continued to be a top-rated reason that people called 3-1-1 after inquiries about MUNI information and street repairs. In the last quarter of FY2012-13, an average of 238 people each month called 3-1-1 for information on HSF and SF PATH.[4]

HSF recognizes the value in providing a social media outlet for program exposure and in leveraging social media to engage HSF participants who have proven harder to engage through more traditional program communications channels such as mail and telephone. The Department of Public Health's HSF third-party administrator, San Francisco Health Plan (SFHP), regularly posts program materials on the HSF Facebook page (http://www.facebook.com/HealthySF). In addition to HSF content, examples of other topics have included suggestions for healthy recreational activities, community events, and emergency preparedness reminders. During FY2012-13, the total number of "likes" for the HSF Facebook page increased by 53% from 225 to 344.

Applications

HSF enrollment begins with trained Application Assistors (AAs). As of June 30, 2013, HSF had 195 AAs who assisted San Francisco residents in applying for the program at 31 different enrollment sites throughout San Francisco. In FY2012-13, AAs processed 61,489 applications through the web-based eligibility and enrollment system, One-e-App.

HSF program continues to offer trainings for new AAs and refresher trainings for new and current AAs throughout the year. During FY2012-13, the HSF program offered four refresher trainings with 159 attendees, provided three new AA trainings, and trained 46 new AAs.

For any application processed, the applicant can be determined eligible for HSF, preliminarily eligible for another public program, or ineligible for any program. Of the 61,489 applications processed, 97.4% of applicants were determined by One-e-App (the eligibility and enrollment system for HSF) to be eligible for and submitted to a health program, 1.3% did not have an eligibility determination made or did not complete an application and about 1.3% 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

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

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.

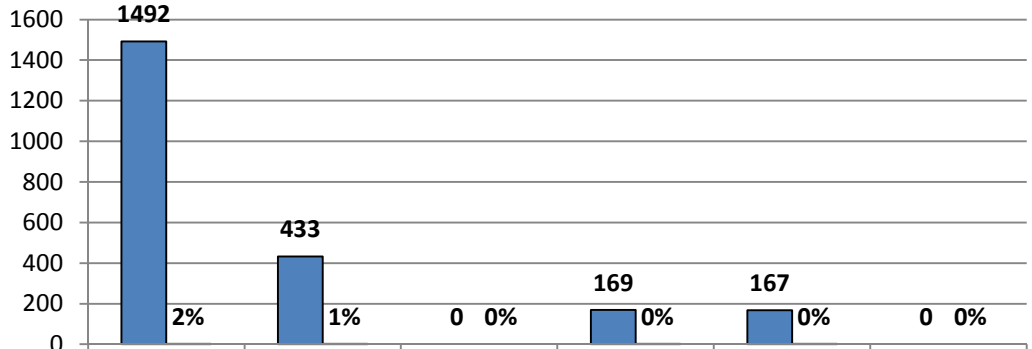
There were 73,007 unique applicants from the 61,489 applications processed, with an average of approximately 1.5 people applying per household.[5] A total of 70,865 applicants had an application submitted for a program. Almost half of these submitted applications were for renewals (Table A1).

Table A1
Application Volume – Number of HSF Applications Processed for All Dispositions
(July 2012 – June 2013)

One-e-App Applications by Type	% of Applications	# of Applications
New	26%	18,723
Renewal	47%	33,066
Modification	27%	19,066
Total	**100%**	**70,865**

Of the 70,865 applicants who had an application submitted, 68,604 (97%) were applicants who were found eligible for either HSF or SF PATH. In addition, a total of 2,261 (3%) applicants were determined preliminarily eligible for other health programs (Figure A1). Of these applications, 85% were determined eligible for either adult Full-Scope or Restricted Medi-Cal, thus 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 the use of One-e-App.

Figure A1
Number of Applications Processed for Other Health Programs and Percentage of all Applicants
(FY2012-13)



	Adult Medi-Cal, Full Scope	Adult Medi-Cal, Restricted	Child Health and Disability Prevention (CHDP)	Healthy Kids	Healthy Families	Medi-Cal for Children and Pregnant Woman
Count	1492	433	0	169	167	0
Percent	2%	1%	0%	0%	0%	0%

[5] 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

Because HSF is a voluntary program, there is no expectation that all uninsured adults will enroll in the program. While HSF 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 eligible uninsured adults will elect not to participate. According to the 2008-2010 American Community Survey (ACS) 3-Year Estimates, there are an estimated 87,000 uninsured adults age 18-64 in San Francisco. According to the 2011-12 California Health Interview Survey (CHIS) released in August 2013, there are an estimated 69,000 uninsured adults age 18-64 in San Francisco.[6]

At the end of FY2012-13, there were 51,158 participants enrolled in HSF, representing approximately 59% of the estimated uninsured adults age 18-64 residing in San Francisco. This is a 14% decrease in HSF's enrollment of the estimated uninsured compared to the end of FY2011-12 (46,822 participants). The decrease is due to the City & County of San Francisco utilizing the ACS 2010 estimates instead of the CHIS estimates as in previous years. The ACS 2010 estimates of uninsured adults were 18,000 higher than the CHIS estimate for the same period (Table A2).

Table A2
Enrollment and Percentage of Uninsured Adults Age 18-64 in San Francisco

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%
2012-13	51,158	87,000	59%

There were 9,844 SF PATH enrollees at the end of FY2012-13. An estimated 70% (51,158 + 9,844 = 61,002) of San Francisco's uninsured adults age 18-64 were participating in either HSF or SF PATH, programs designed to ensure access to health care (Table A3).

Table A3
City-wide Health Access Enrollment (HSF and SF PATH) and Percentage of Uninsured Adults Age 18-64 in San Francisco

Fiscal Year	HSF Enrollment	SF PATH Enrollment	Total Enrollment	Estimated No. of Uninsured Adults	Enrolled as % of Uninsured Est.
2012-13	51,158	9,844	61,002	87,000	70%

Enrollment fluctuates daily as new people enroll, existing participants renew eligibility and participants disenroll. At the end of the FY2012-13, 79,850 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

[6] Prior to FY 2012-2013, the Department utilized the biennial (now continuous) CHIS estimates produced by University of California Los Angeles Center for Health Policy Research to estimate the number of insured residents. Because the City & County of San Francisco does not conduct a separate survey to estimate the number of uninsured residents, the Department has relied on other surveys for estimates of uninsured residents. Since the ACS uses a three year rolling average instead of a biennial survey (since 2009) like CHIS, the City & County of San Francisco has decided to use the ACS to estimate the total uninsured residents. This report has been updated to incorporate the new estimate.

participation fee, etc. The number of participants that are currently disenrolled also account for individuals that transitioned into SF PATH. At the start of the SF PATH program, over 10,000 individuals who were eligible for SF PATH were administratively transitioned into SF PATH and disenrolled from HSF. As of June 30, 2013, HSF has served 131,008 unique uninsured San Francisco adult residents since the program's inception in July 2007 (the sum of the 51,158 individuals currently enrolled and 79,850 currently disenrolled).

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)	Disenrollment Rate (%)
2007-08	24,210	1,059	25,269	4%
2008-09	43,200	11,958	59,698	20%
2009-10	53,428	27,137	80,565	34%
2010-11	54,348	45,889	100,237	46%
2011-12	46,822	69,214[7]	116,036	60%
2012-13	51,158	79,850	131,008	61%

At the end of the FY 2012-13, the HSF disenrollment rate was 61%. There was a large increase in the disenrollment rate in FY2011-12 due to the administrative transition of eligible HSF participants to SF PATH; over 10,000 participants were disenrolled from HSF as part of this transition. However, in FY2012-13 the rate remained similar to the FY2011-12 disenrollment rate, indicating a steady percentage of participants who are enrolled in HSF and are remaining in the program.

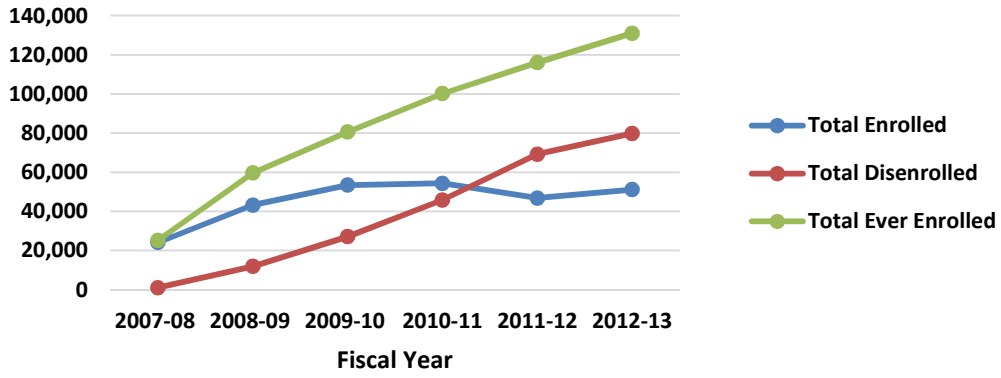
Table A5
HSF Disenrollment Rate

Total Ever Disenrolled	Less Re-enrolled	Equals Currently Disenrolled	Plus Currently Enrolled	Equals Ever Enrolled	Disenrollment Rate = (79,850 ÷ 131,008)
90,093	10,243	79,850	51,158	131,008	61%

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 renew 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. Figure A2 shows enrollment, disenrollment and ever enrollment trends for the past fiscal years.

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

Figure A2
Enrollment, Disenrollment, and Ever Enrolled (FY2007-08 to FY2012-13)



Disenrollment Analysis

The Department regularly monitors and analyzes participant disenrollments. By the end of FY2012-13, 79,850 individuals were currently disenrolled from HSF for the following reasons:

Table A6
Disenrollments By Reason

Current Disenrollments by Reason	Number	Percent
Transitioned to SF PATH Program	8,653	11%
Program Eligibility	16,227	20%
Participation Fee	7,099	9%
Annual Renewal	47,577	60%
Other/Voluntary	294	<0.1%

Disenrollments Due to Transition to SF PATH Program (11% - 8,653 participants)
11% of HSF participants transitioned into San Francisco's other health coverage program, SF PATH.

Disenrollments Due to Program Eligibility (20% - 16,227 participants)
20% of those disenrolled no longer met the HSF eligibility requirements. Table A7 lists specific program eligibility disenrollment reasons.

Table A7
Program Eligibility Disenrollments

Disenrollment Reason	Number	Percent
Enrolled in Public Coverage (including Medi-Cal and PCIP)	5,645	35%
Exceeds Program Age Requirements	3,925	24%
Enrolled in Employer or Private Insurance	3,139	19%
Determined Eligible for Other Programs During Renewal or Modification	1,959	12%
Not a San Francisco Resident	1,383	9%
Ineligible for City & County Program	176	1%

Disenrollments Due to Participation Fee (9% - 7,099 participants)
Disenrollments due to insufficient payment of the quarterly participation fee comprised 9% of all program disenrollments at the end of FY2012-13. These disenrollments were reflected in the following manner:

- Participant communicates that they could no longer afford the participation fee – 341 disenrollments
- Insufficient payment of the participation fee – 6,758 disenrollments

Disenrollments due to participation fee can occur for many reasons besides inability to pay and may mask other disenrollment reasons. For example, a HSF participant at/above 100% FPL paying a participation fee obtains health insurance during their 12-month HSF eligibility period and may simply disregard the future quarterly participant fee invoices. While program guidelines instruct 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. Therefore, for some individuals, 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 2013. It was able to do analysis on 4,499 (63% of 7,099) of these disenrolled individuals based on the fact that the individual sought services from the Department after HSF disenrollment. These 4,499 individuals had a total of 81,694 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 the majority of encounters (71%) were either HSF (12%) or SF PATH (59%); that is, 71% of the people with HSF participation fee related disenrollments eventually re-enrolled and received health care services under HSF or SF PATH. Twenty-four percent (24%) 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.

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 2013, 7,735 HSF participants had adjustments that resulted in a lower federal poverty level (FPL) group. In FY2012-13, 65 individuals had an occurrence of FPL reduction. Of these individuals, 59 had one occurrence and 6 had more than one occurrence. The lowering of the FPL resulted in either: (1) a reduction in the participation fee or (2) no participation fee at all. More than half had an FPL reduction during re-enrollment (Table A8).

Table A8
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	1,186
Re-Enrollment	4,536
HSF Renewals	2,013
All	**7,735**

Disenrollments Due to Incompletion of Annual Renewal (60% - 47,577 participants)
HSF eligibility is for a 12-month period and the program requires participants to renew their eligibility in-person 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 FY2011-12, the majority of disenrollments in FY2012-13 were due to failure to complete annual renewal (60%). Of note, approximately 74% of the individuals disenrolled for this reason had 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 about 74% of the individuals disenrolled for this reason.

However, 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 either moved outside San Francisco or has obtained health insurance may not inform HSF Customer Service that they should be disenrolled from the program; the person may 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. Data from the Health Access Questionnaire (discussed in Section IV-E) reveals that 46% of participants renewing on time did so because they received notice to enter into the HSF lottery for a free gift card, a program feature that was launched in FY2010-11.

Disenrollments Due to Other/Voluntary Reasons (<0.1% - 294 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. The majority of disenrollments due to other/voluntary reasons was because of program dissatisfaction (Table A9).

Table A9
Disenrollments Due to Other Reasons

Disenrollment Reasons	Number	Percent
Program Dissatisfaction (admin, services, medical home, etc.)	159	54%
Participant is Deceased	69	23%
False or Misleading Information on HSF Application	33	11%
Other	32	11%

Re-Enrollments
Individuals who are disenrolled from HSF have the option to re-enroll at any time (assuming they meet eligibility criteria) with no penalty or wait period. As of June 30, 2013, 10,243 disenrolled individuals re-enrolled into HSF and were current participants at the end of the FY2012-13. The data indicates that the initial disenrollment reasons for the majority of re-enrollments were incomplete annual renewal (76%). 43% of those disenrolled for failure to renew re-enrolled within 60 days of the end of their original enrollment end date. 68% of those disenrolled because they didn't meet program eligibility requirements re-enrolled more than one year after the end of their original enrollment end date. Compared to FY2011-12, there has been a 28% decrease in the number of participants who have re-enrolled into HSF, and this is expected to decline as more health insurance options become available to participants with the implementation of the Patient Protection and Affordable Care Act (ACA).

Table A10
Re-Enrollments by Original Disenrollment Reasons (July 2007 – June 2013)*

Type	Number	Percent	Category	Reenroll in 0-30 Days	Reenroll 31-60 Days	Reenroll 61-90 Days	Reenroll 91- 180 Days	Reenroll 181-365 Days	Reenroll 366+ Days	All Days
Program Eligibility	1,123	11%	% of Reenroll	7%	4%	1%	4%	15%	68%	100%
			Avg # Days	15	45	74	139	313	658	506
Participation Fee Related	1,334	13%	% of Reenroll	15%	13%	8%	17%	17%	29%	100%
			Avg # Days	18	45	74	130	261	836	327
Incomplete Renewal	7,768	76%	% of Reenroll	29%	14%	7%	11%	12%	27%	100%
			Avg # Days	16	44	74	131	268	762	268
Other	18	<1%	% of Reenroll	6%	11%	0%	6%	33%	44%	100%
			Avg # Days	27	59	0	122	326	804	481
Total	**10,243**	**100%**	**% of Reenroll**	**25%**	**13%**	**7%**	**11%**	**13%**	**32%**	**100%**
			Avg # Days	**16**	**44**	**74**	**131**	**273**	**746**	**302**

**Due to rounding, percentage totals may not exactly equal to 100%.*

Churn (Multiple Enrollments and Disenrollments)

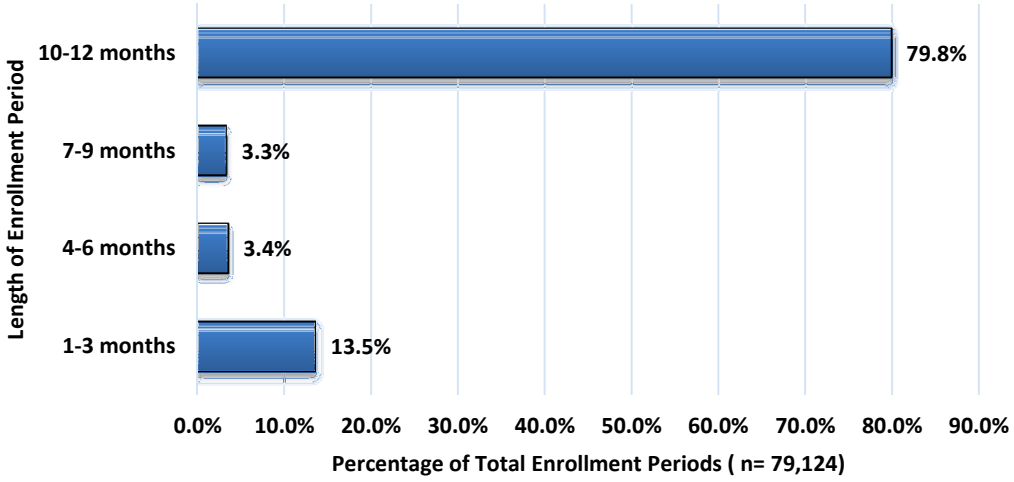
In an effort to determine the impact of the program's eligibility and enrollment provisions on program retention, the Department examines the frequency of multiple enrollments and disenrollments by program participants (known as "churn" for the purposes of this report). The Department defines churn as 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 in July 2007 and up to June 30, 2013, 34,781 individuals have had at least two disenrollments, a 101% increase from June 2012. The program has witnessed an increase in participants with multiple disenrollments, which is reflective of the increased enrollment over time.

Table A11
Enrollment Status of Individuals with Multiple Enrollments and Disenrollments
(FY2010-11 to FY2012-13)

	As of June 30, 2011		As of June 30, 2012		As of June 30, 2013	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Currently Enrolled	2,388	27%	4,258	25%	9,251	27%
Currently Disenrolled	6,380	73%	13,082	75%	25,530	73%
Total	**8,768**	**100%**	**17,340**	**100%**	**34,781**	**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). A high-level enrollment analysis was conducted on the 34,781 individuals and found that, collectively, there were 79,124 enrollment periods (i.e., the period of time between an enrollment and disenrollment). The data further indicated that most of individuals with multiple enrollments (80%) had enrollment periods lasting 10–12 months. As a result, those with multiple disenrollments are generally not short-term participants.

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



The churn analysis that was done on the 34,781 participants with multiple disenrollments had the following distribution by number of disenrollments:

- 26,727 (77%) had two disenrollments,
- 6,718 (19%) had three disenrollments,
- 1,182 (3%) had four disenrollments,
- 138 (.4%) had five disenrollments,
- 14 (0%) had six disenrollments, and
- 2 (0%) had seven disenrollments.

The analysis below examines those who had two disenrollments (77% of the churn population). The disenrollments are grouped by disenrollment type. The data indicates that the majority of HSF participants with two disenrollments were disenrolled for 2 instances of failure to renew, 2 instances of program eligibility, or 1 instance of failure to review and 1 instance of program eligibility (85% total). 10% were in instances in which one of the disenrollments was related to the participation fee and 5% were cases in which both of the disenrollments related to the participation fee.

Table A12
Churn Analysis of Multiple Disenrollments -- Those with Two Disenrollments (July 2007 – June 2013)

Disenrollment Reasons	***Number***	***Percentage***
Two Failure to Complete Renewals	15,468	58%
One Failure to Complete Renewal and One Program Eligibility	3,493	13%
One Failure to Complete Renewal and One Participation Fee	2,226	8%
One Participation Fee and One Program Eligibility	561	2%
Two Participation Fees	1,192	5%
Two Program Eligibility	3,703	14%
Two Other Disenrollments or One Disenrollment Coded Other & One Disenrollment Coded Another Reason	84	0%

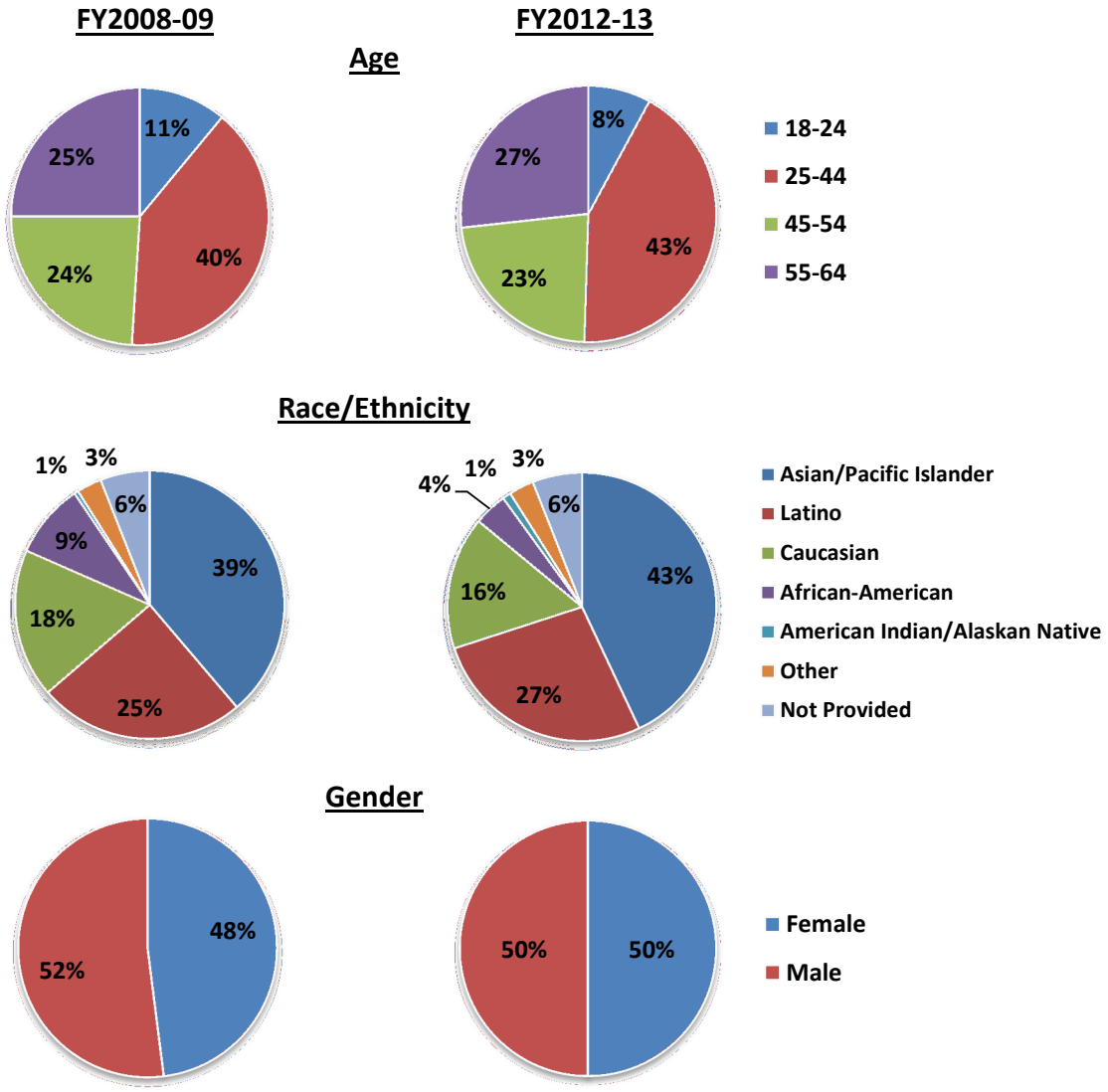
B. PARTICIPANT DEMOGRAPHICS

This section provides an overview of uninsured adult residents enrolling in Healthy San Francisco (HSF).

Demographic Characteristics

The following provides demographic data on the 51,158 participants enrolled in HSF at the end of FY2012-13. Figure B1 below compares the demographic characteristics of the HSF population at the end of FY2008-09 (the first full fiscal year for HSF) with the end of FY2012-13. Overall, the demographic pattern of the HSF population has remained the same. For each demographic, the majority of the HSF population has been between the ages of 25-44, Asian/Pacific Islander, at/below 100% Federal Poverty Level (FPL), and English-speaking. The male to female ratio has consistently been nearly equal. At the end of FY2012-13, there were 222 participants who reported being transgender.

Figure B1
Demographic Comparison of HSF Participants, End of FY2008-09 and FY2012-13*

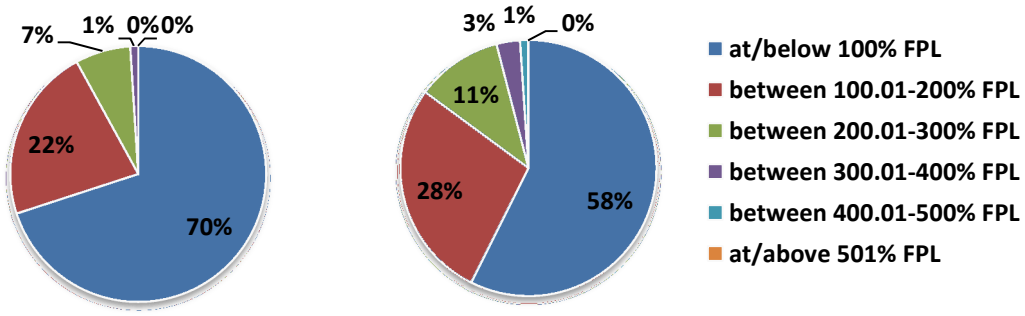


222 HSF participants indicated being transgender at the end of FY2012-13.

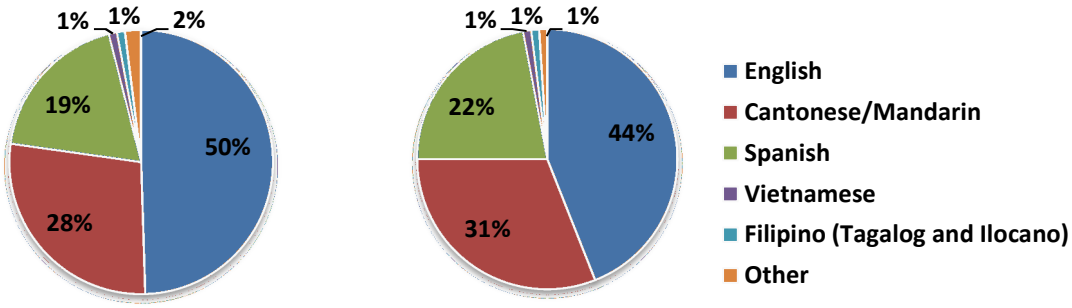
(Figure B1 cont.)

FY2008-09 **FY2012-13**

Income**



Spoken Language



Note that the sum of percentages per chart may not equal exactly to 100% due to rounding.
****FPL eligibility was expanded from 300% FPL to 500% FPL in February 2009.***

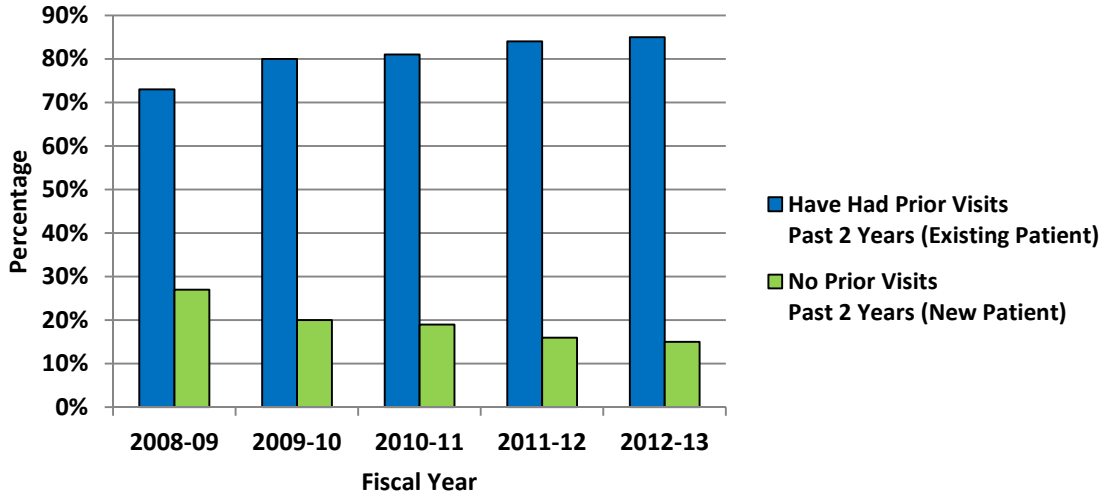
In compliance with the City and County Refuge Ordinance (also known as the Sanctuary City Ordinance), the Department of Public Health does not collect demographic information on an applicant's immigration status, employment status, or pre-existing medical conditions; this is consistent with the San Francisco Health Care Security Ordinance (HCSO), which states that these factors do not contribute to determining HSF eligibility.

HSF Population – New versus Existing

At the end of FY2012-13, 85% of those enrolled in HSF were existing patients (indicated that they had a previous visit, within two years, to a HSF medical home prior to enrollment). The remaining 15% 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.

Over time, the percentage of participants that are "new" has slowly declined due to "new" users becoming existing users after HSF enrollment and continued annual renewal. The proportion of "new" users is also expected to further decline as uninsured individuals who would normally be eligible for HSF instead obtain health insurance coverage through the Patient Protection and Affordable Care Act (ACA). Figure B2 on the following page shows the gradual decline of "new" participants in the HSF program.

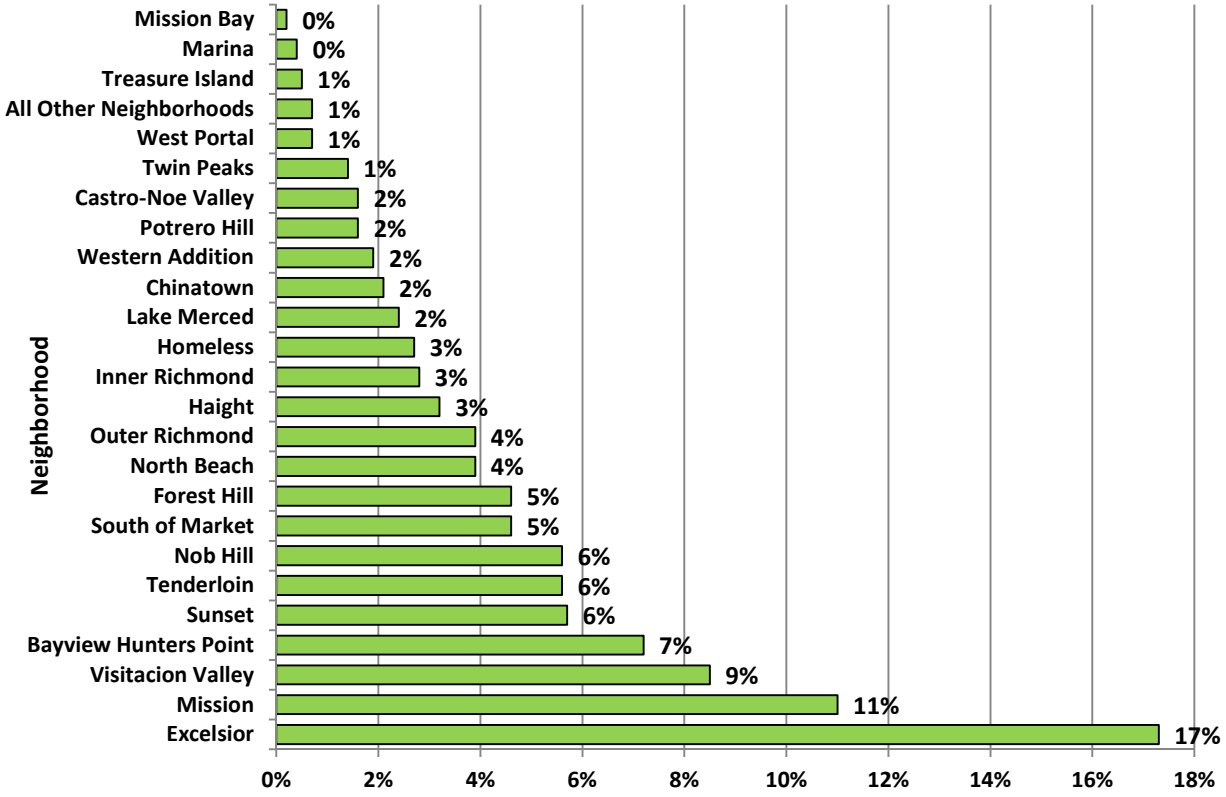
Figure B2
New vs. Existing Participation in Healthy San Francisco



Neighborhood Distribution

At the end of FY2012-13, HSF participants were primarily dispersed among 23 of approximately 36 of San Francisco's neighborhoods, and 28% of all HSF participants resided in either the Excelsior or Mission neighborhoods. About 3% of HSF participants reported being homeless; this number may be an underestimate, as some homeless individuals may be using their medical clinic or transient housing facility's address when applying for HSF. Figure B3 below shows the break-down of HSF participants by neighborhood.

Figure B3
Healthy San Francisco Participants by Neighborhood



C. PROVIDER NETWORK (DELIVERY SYSTEM)

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

Medical Home Expansions and Capacity

HSF ended FY2012-13 with 37 medical homes, the same as FY2011-12.

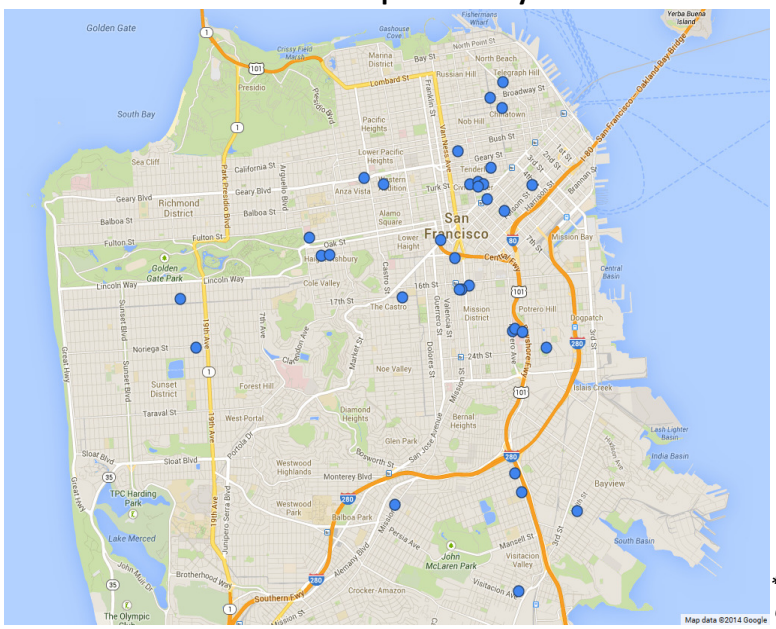
HSF was piloted in July and August of 2007 in two medical homes: Chinatown Public Health Center and North East Medical Services. By the end of FY2007-08, there were 29 medical homes in the HSF network. In FY2008-09, the Chinese Community Health Care Association/Chinese Hospital and Sr. Mary Philippa were added as medical homes. The following fiscal year (FY2009-10), Kaiser Permanente and an additional North East Medical Services (NEMS) location were added. In FY2010-11, two BAART Community HealthCare clinics and Brown & Toland were added, and in FY2011-12, Mission Neighborhood Resource Center and the Teen/Young Adult Health Center were added to the network.

To ensure 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 capacity is determined primarily by such factors as appointment availability and total number of patients (from all payor sources including Medi-Cal, Healthy Kids, Healthy Workers, sliding scale, and self-pay) seen at each medical home. As of July 16, 2013, 18 HSF medical homes were open.

Medical Home Distribution

At the time of enrollment, HSF participants select a medical home 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. Figure C1 below shows the distribution of HSF medical homes throughout San Francisco using Google Maps.

Figure C1
Map of Healthy San Francisco Medical Homes*



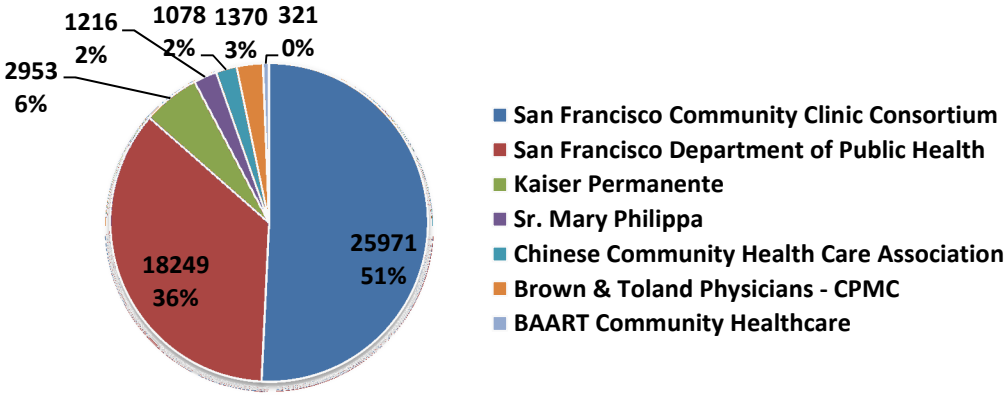
Brown & Toland Physicians – CPMC is not on this map; actual physician locations for this medical home vary.

There were seven delivery systems at the end of FY2012-13:

- BAART Community Healthcare
- Brown & Toland Physicians – California Pacific Medical Center (CPMC)
- Chinese Community Health Care Association (CCHCA) – Chinese Hospital
- Department of Public Health
- Kaiser Permanente Medical Center San Francisco
- San Francisco Community Clinic Consortium-affiliated clinics (SFCCC)
- Sr. Mary Philippa Health Center

The diversity of delivery systems that see HSF patients is a huge collaborative achievement for the City & County of San Francisco and enforces the mission and goal of providing coordinated health care to all residents of San Francisco. At the end of FY2012-13, more than half of HSF participants had a medical home that was part of the SFCCC, and the next popular medical home system was the Department (Figure C2).

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



Hospital Participation in HSF Network

San Francisco General Hospital (SFGH) 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 the mentioned services to HSF participants with the following medical homes:

- BAART Community HealthCare
- Brown & Toland Physicians (home health; after hours urgent care)
- Glide Health Services (SFCCC-affiliated)
- Kaiser Permanente (home health only)
- North East Medical Services (SFCCC-affiliated)
- Remaining SFCCC-affiliated clinics
- Sr. Mary Philippa Health Center

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

- CPMC (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 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
- UCSF Medical Center – referral-based diagnostic imaging services at Mission Bay site as well as services such as cardiac surgery which are not provided at SFGH

Hospital participation in HSF is separate from the general Emergency Medical Treatment & Labor Act (EMTALA) 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 provide some form of either mental health assessment, mental health services or substance abuse screening, the Department's Community Behavioral Health Services (CBHS) provides all contracted behavioral health services for HSF participants at all medical homes – both its own and the private providers.

Specifically, the 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 the Department's 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. CLINICAL COMPONENT/SERVICES UTILIZATION

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

The clinical services data was analyzed in areas related to use of primary care services, quality of care, and effectiveness of care. As the Department of Public Health 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, 49% of the hospital data came from San Francisco General Hospital (SFGH), and 51% came from non-SFGH hospitals and clinics. While all non-profit hospitals have provided clinical data on HSF participants, the Department believes that this data may be incomplete due to varying reporting mechanisms of each organization. Therefore, emergency department visits, inpatient admissions, and hospital days are likely underreported for FY2012-13. For FY2011-12, 90% of the hospital data came from San Francisco General Hospital (SFGH). The disparity of hospital data from non-profit hospitals leads to underreported utilization data. The comparison between FY2011-12 and FY2012-13 should be viewed within the context of underreporting. See Appendix A for a description of the HSF data warehouse and data source submission.

Summary of Key Utilization

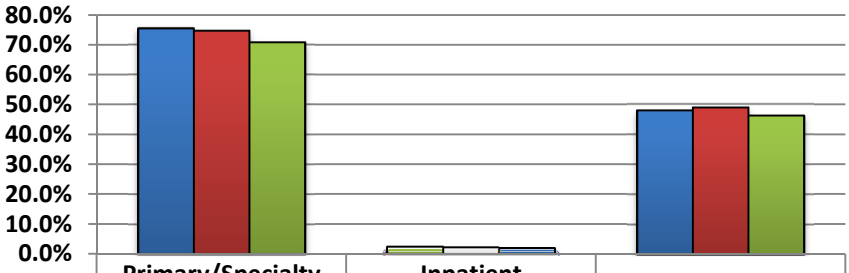
The data below indicates the percentage of participants who were continuously enrolled in HSF from July 2011 to June 2012 and utilized at least one service for each service type. The data reflects the most recent fiscal year with complete data available.

Table D1
Summary of Utilization Data – Percentage of Participants Utilizing at Least One Service
(July 2011 – June 2012)

Service	Percent
Primary / Specialty Care	70.74%
Inpatient Admission	1.89%
Prescription	46.20%

From April 2009 to June 2012, 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 Figure D1 on the following page (note that 2009-10 is only available for nine months). Utilization slightly decreased and could be due to a number of factors, including improved health status.

Figure D1
Percentage of Participants Utilizing at Least One Service (2009 – 2012)

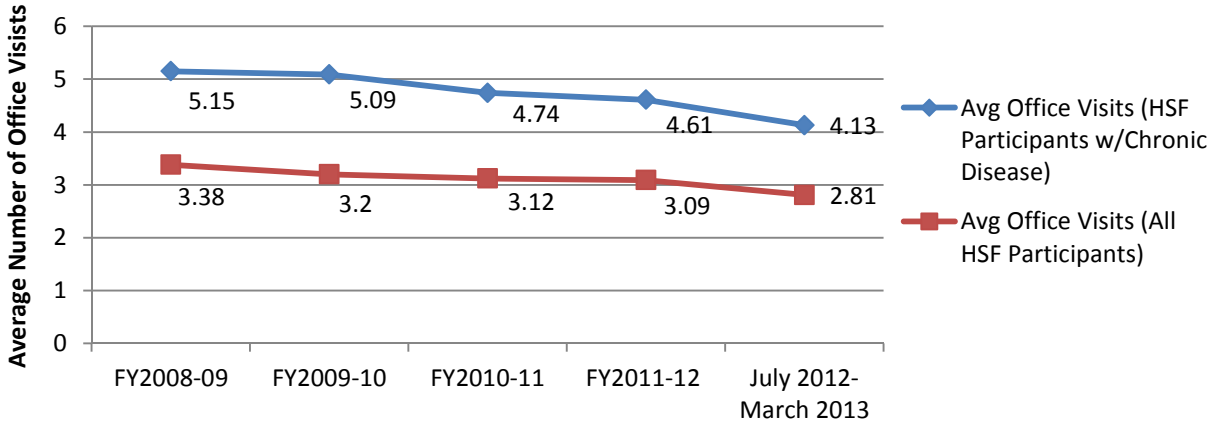


	Primary/Specialty Care	Inpatient Admission	Prescription
Apr 2009 - Mar 2010	75.4%	2.4%	47.9%
Jul 2010 - Jun 2011	74.6%	2.1%	48.9%
July 2011 - Jun 2012	70.7%	1.9%	46.2%

Preventive and Primary Care Services

HSF participants' average office visits decreased slightly in 2012-13 to 2.81 per participant per year, which is slightly below 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 average number of office visits for HSF participants with chronic conditions (4.13) is slightly lower than 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).

Figure D2
Average Office Visits (Including Well Visits) Per Participant (All Participants)



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 preventive and screening services through other publicly funded programs.

The table below displays the information contained in the graph above by medical home system. Most medical homes, with the exception of BAART and Department, experienced relatively small changes in the average number of office visits for their HSF population. Beginning FY2011-12, the Department began deployment of the Department's ambulatory electronic health record system, eClinicalWorks,

which impacted provider productivity at each clinic for 2 to 3 months post roll-out. This system-wide disruption may have compromised access to primary care, thus resulting in a decrease of utilization of the Department's medical homes.

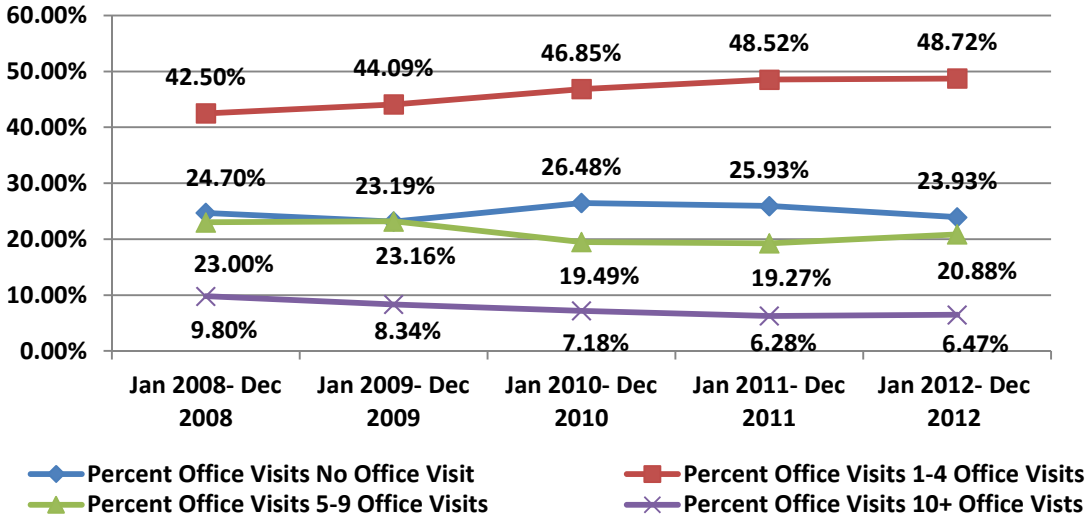
Table D2
Average Office Visit Utilization by Delivery System

Medical Home System	July 2008 - June 2009	July 2009 - June 2010	July 2010 - June 2011	July 2011 - June 2012	July 2012- Mar 2013	Last 2 Year Variance
BAART	N/A	9	5.15	3.6	2.62	-48%
Brown & Toland	N/A	N/A	3.5	3.25	2.93	-5%
CCHCA	3.82	4.2	4.3	4.42	4.41	0%
DPH	3.62	3.57	3.55	3.36	2.64	-26%
Kaiser	N/A	1.86	2.33	2.57	2.72	1%
SFCCC	3.01	2.78	2.65	2.89	2.81	0%
SMP	4.53	3.98	3.98	4.05	3.74	-5%
Total	**3.38**	**3.2**	**3.12**	**3.09**	**2.81**	**-4%**

CCHCA = Chinese Community Health Care Association
DPH = Department of Public Health
SFCCC = San Francisco Community Clinic Consortium

Almost 23.9% of HSF participants did not have an office visit after twelve months of continuous enrollment. This has remained constant over the past three calendar years. Over time there has been a slight 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.

Figure D3
Office Visit Frequency (Including Well Visits)



The Department cannot reliably use HSF utilization data to analyze the utilization of some preventive services, due to HSF'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 that data is therefore not available for analysis. Although encounter data only show 18.2% of women receiving mammograms and 19.5% of women receiving cervical cancer screening, it is highly likely that the actual screening rate is much higher.

In FY2012-13, HSF met the National Medicaid average for colorectal cancer screening among women at 55.5%. The colorectal cancer screening rate for men in HSF was 46.6%, below the national target of 54.5%. Improving colorectal cancer screening rates is a priority of the Strength in Numbers Program (discussed in Section IV-E).

Table D3
Percentage of Women's Health Preventive Screening (July 2008 – March 2013)

Women's Preventive Screening	Participants Received Screening	Eligible Participants	Percentage	National Medicaid Average
Cervical Cancer	5,217	26,768	19.49%	64.80%
Colorectal Cancer	5,979	10,771	55.51%	54.50%
Mammogram	3,035	16,725	18.15%	50.00%

Table D4
Percentage of Men's Preventive Screening for Colorectal Cancer (July 2008 – March 2013)

Men's Preventive Screening	Participants Received Screening	Eligible Participants	Percentage	National Medicaid Average
Colorectal Cancer	4,881	10,471	46.61%	54.50%

Appropriate Utilization

The use of the emergency department for avoidable conditions remains lower than the State average, and hospital admissions have decreased.

Emergency Department

Utilization of the emergency department (ED) from July 2012 to March 2013 was 166 per 1,000 participants, which is lower than the State average of 294 visits per 1,000 (Henry J Kaiser Family Foundation, State Health Facts, 2011).

Participants with chronic conditions utilized the ED more frequently than those without chronic conditions (288.11 visits per 1,000 participants compared to 87.81 visits per 1,000 participants). While patients without chronic conditions have maintained lower rates of ED visits compared to the State average, higher ED utilization among participants with chronic conditions persist. Consistent with previous years, the top diagnostic categories for outpatient ED visits were: (1) abdominal symptoms, (2) respiratory symptoms, (3) general symptoms, (4) cellulitis and abscess, and (5) nondependent abuse of drugs.

Table D5

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	8,403	686,394	146.91	-11.98%
July 2011-June 2012	6,630	572,395	138.99	-5.39%
July 2012-March 2013	6,325	456,966	166.10	19.50%

91% of participants had no emergency room visit in calendar year 2012.[8]

Table D6
ED Visit Frequency

ED Visit	January 2009 – December 2009 Percent	January 2010 – December 2010 Percent	January 2011 – December 2011 Percent	January 2012- December 2012 Percent
No ER Visit	89.83%	90.81%	92.59%	91.25%
1-4 ER Visits	9.80%	8.81%	7.21%	8.53%
5-9 ER Visits	0.28%	0.30%	0.16%	0.16%
10+ ER Visits	0.09%	0.08%	0.03%	0.06%
Total	**100%**	**100%**	**100%**	**100%**

During calendar year 2012, there were 243 HSF participants with three or more ED visits. The top five outpatient diagnoses for participants with three or more ED visits were: (1) abdominal and pelvic symptoms, (2) non-dependent abuse of drugs, (3) respiratory symptoms, (4) general symptoms and (5) disorders of back. A review of demographic data reveals that the following have a higher incidence of frequent ED utilization:

- homeless (7.59%) rather than housed (0.45%)
- men (0.93%) compared to women (0.64%)
- African-Americans (6.68%), Samoans (6.90%) and Whites (5.37%) in comparison to all ethnic groups (0.78%); the high rate of Samoans' ED utilization may be explained by the low number of Samoan HSF participants (29) continuously enrolled
- participants with a chronic disease (1.36%) relative to those without a chronic disease (0.16%)
- participants aged 25-44 (0.95%) and 45 – 54 (.93%) compared to all age groups (0.78%)

In comparison to all medical homes, on average, in which 0.78% of the continuously enrolled HSF population would have three or more ED visits, 17 medical homes had a higher than average percentage of participants with 3 or more ER visits. The following medical homes had the highest percentages of HSF participants with three or more ED visits: Glide Health Services (5.82%), Mission Neighborhood Resource Center (4.44%), Children's Health Center at SFGH (3.45%), BAART Community Healthcare (2.86%), and Tom Waddell Health Center (2.78%).

Avoidable Emergency Department Visit Rate

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

From July 2012 to March 2013, the avoidable ED visit rate for HSF was approximately 7% using conditions defined by the "Medi-Cal Managed Care ER Collaborative Avoidable Emergency Room Conditions". This rate is below the rate for all members of the San Francisco Health Plan (SFHP) (18.2%), who serves a large portion of San Francisco's Medi-Cal adults. During the calendar year 2012, 99% of participants did not access emergency department care for avoidable conditions. This has been consistent over the past four years.

Table D7
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	7.62%	-4.76%
July 2011-June 2012	7.72%	1.39%
July 2012-March 2013	6.78%	-12.17%

Table D8
Avoidable ED (AED) Visit Frequency

AED Visit	Jan. 2009 – Dec. 2009 Percent	Jan. 2010 – Dec. 2010 Percent	Jan. 2011 – Dec. 2011 Percent	Jan. 2012- Dec. 2012 Percent
No AED Visits	98.61%	98.96%	99.21%	99.10%

Hospitalization

Overall hospital admissions for all HSF participants were reported to have decreased (from roughly 25 to 14 per 1,000 participants). The data indicate that HSF participants with a Department medical home now have a similar hospital admission rate to all HSF participants (15 and 14 per 1,000 participants, respectively). Acute days were 63 per 1,000 participants with an average length of stay of 4.6 days. The cause for the sharp decrease in hospital utilization data is being investigated. The data reveals that in FY2012-13, the top five diagnoses for hospitalization were unspecified psychosis, acute pancreatitis, unspecified septicemia, alcohol withdrawl, and unspecified episodic mood disorder.

Figure D4
Acute Hospital Admissions Per 1,000 Participants Per Year

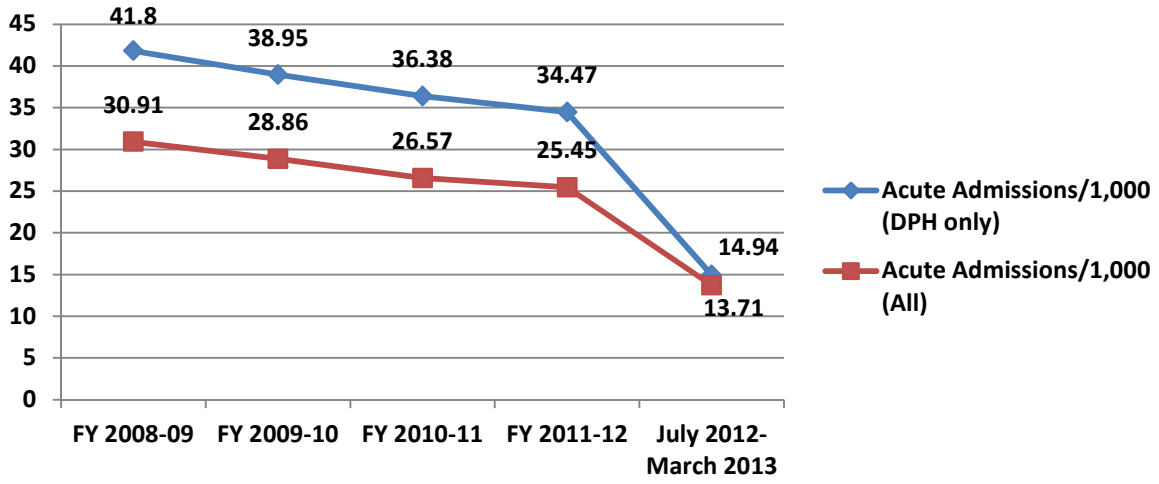


Table D9
Acute Hospital Days Per 1,000 Participants Per Year and Average Length of Stay (ALOS)

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	1,520	5,931	103.69	3.90
July 2011-June 2012	1,214	5,009	105.01	4.13
July 2012-March 2013	522	2,396	62.92	4.59

Behavioral Health

Mental health utilization increased and substance abuse service utilization increased both for those with and without a chronic disease from FY2012-13. This may be due to the HSF SF PATH transition. Mental health utilization continues to be higher than substance abuse utilization. Data is only shown from July 2012 to December 2012 because data after December 2012 is likely incomplete due to a claims processing delay.

Table D10
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	0.9	-22%
	July 2010-June 2011	18,452	0.95	6%
	July 2011-March 2012	9,535	0.87	-8%
	July 2012-December 2012	20,006	1.9	118%
Without Chronic Disease	**July 2008-June 2009**	35,404	1.5	N/A
	July 2009-June 2010	39,960	1.18	-21%
	July 2010-June 2011	46,504	1.24	5%
	July 2011-March 2012	19,065	0.78	-37%
	July 2012-December 2012	8,474	0.58	-26%

Table D11
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	-26%
	July 2010-June 2011	5,654	0.29	0.00%
	July 2011-March 2012	3,952	0.36	24%
	July 2012-December 2012	39,459	3.75	942%
Without Chronic Disease	**July 2008-June 2009**	13,313	0.56	N/A
	July 2009-June 2010	10,433	0.31	-45%
	July 2010-June 2011	11,325	0.3	-3%
	July 2011-March 2012	9,005	0.37	23%
	July 2012-December 2012	14,809	1.01	173%

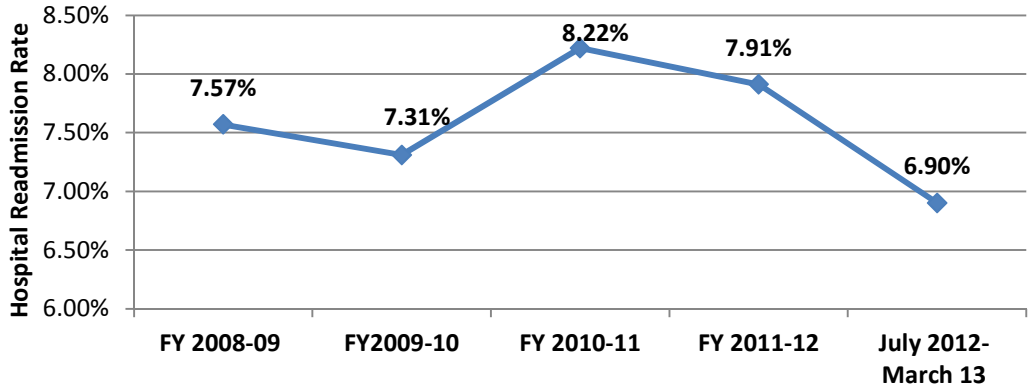
Quality of Care

Rates of hospital readmissions and diabetes and asthma testing help to measure the quality of care that HSF participants receive.

Hospital Readmissions

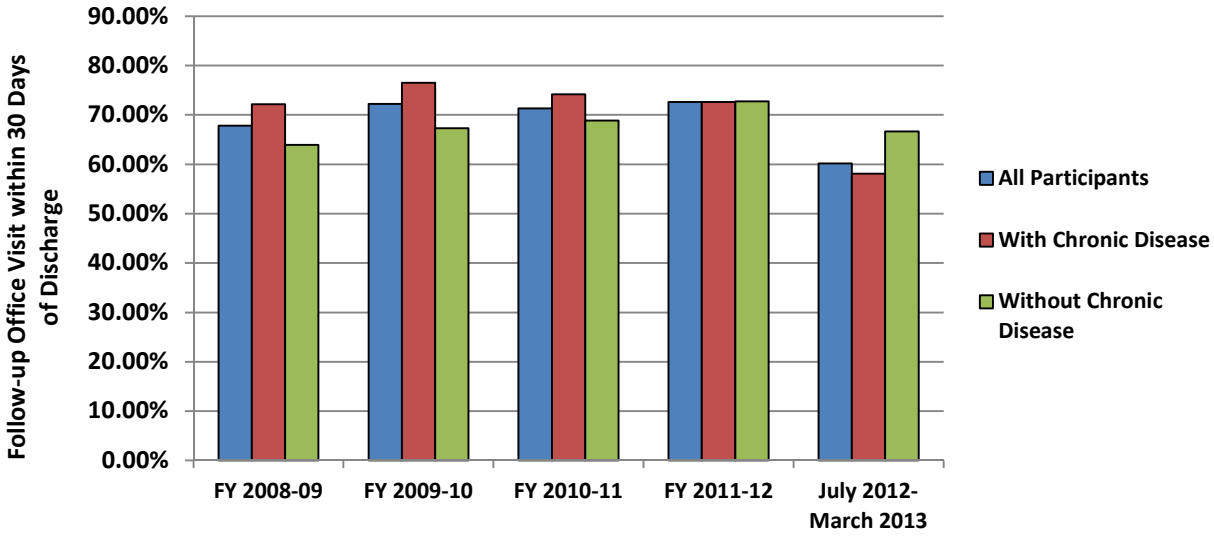
Readmission data is a good indicator for quality of care. HSF's 30-day readmission rate of 7% is almost 12% lower than the 18.7% 30-day hospital readmission rate for Medi-Cal members (Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data, 2011). It is important to note that the data from 2012-13 does not represent the full fiscal year, but is still much lower than the Medi-Cal 30-day readmission rate.

Figure D5
30-Day Hospital Readmission Rate for HSF Participants



The data also indicates that the follow-up office visits within 30 days of discharge decreased to about 60% for all participants. For those with chronic disease, the rate decreased to 58% and for those without chronic disease the rate decreased to 66%. However, it is important to note that this data does not represent the full FY2012-13. By comparison, the Center for Medicare and Medicaid Services reported in a Medicare beneficiary claim study that 50% of patients readmitted within 30 days of discharge did not have a bill for a physician visit between hospital discharge and readmission.

Figure D6
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 the National Committee for Quality Assurance (NCQA). Participants enrolled for 12 months with asthma and diabetes were measured against HEDIS benchmarks.

The data for calendar year 2012 indicates that the percentage of participants with diabetes getting HbA1c tests is almost 79%, lower than the national Medicaid average of 83%, and the percent of diabetics getting LDL (cholesterol) testing is 73%, slightly lower than the National Medicaid Average at 76.%. For asthma, the data shows that 75% of participants with asthma are getting the medication they need to control their asthma, higher than the National Medicaid average of 74%.

Table D12
Percentage of Participants Receiving Tests Compared to Medicaid
(January 2012 – December 2012)

Measure	HSF Percentage	National Medicaid Average
Diabetic Care Test - HbA1c	78.71%	83.0%
Diabetic Care Test - LDL	73.25%	75.5%
Asthma Test - Medication	75.22%	73.9%

Out of Network Utilization

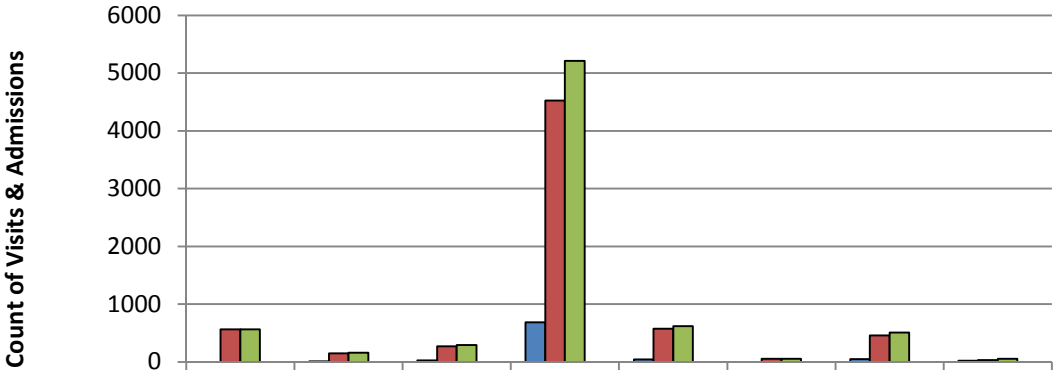
HSF is based on the premise that participants receive their care through a network of providers affiliated with the medical home they have selected. HSF requires the selection of a medical home by the applicant at the time of program enrollment to help ensure that the participant has a usual source of care and to minimize episodic care.

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 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 SFGH. Figure D7 provides summary information on the count of HSF participants with hospital-based ED visits and inpatient stays by hospital system. SFGH provided 70% of the care. As noted previously in this report, SFGH provides ED services for the Department, SFCCC and BAART medical homes.

Figure D7
Emergency Department Utilization Across the HSF Hospital Systems for HSF Participants*



	CPMC	Chinese	Kaiser	SFGH	St Francis	St Luke	St Mary's	UCSF
ED Inpatient	0	11	24	687	45	0	51	22
ED Outpatient	563	149	269	4524	577	56	460	32
Total	563	160	293	5211	622	56	511	54
Percent of Total	8%	2%	4%	70%	8%	1%	7%	1%

**Due to rounding, percentage totals may not exactly equal to 100%.*

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 Hospital as their medical home had 81 ED outpatient visits of which 66 were within the network and 15 were outside of network. These participants also had 14 ED inpatient visits of which 11 were within the network and 3 were outside of network."

Table D13
Emergency Department Outpatient Utilization – Within and Outside Medical Home Network

Medical Home and Affiliated Hospital	Within Medical Home Network	Outside Medical Home Network	Total	Percentage Outside Medical Home Network
BAART - SFGH	76	11	87	13%
Brown & Toland - CPMC	215	49	264	19%
CCHCA - Chinese Hospital	66	15	81	19%
DPH Clinics - SFGH	1945	223	2168	10%
Glide - St. Francis	556	419	975	43%
9 SFCCC Clinics - SFGH	1360	142	1502	9%
Kaiser - Kaiser Medical Center	268	20	288	7%
NEMS - SFGH	696	116	812	14%
Sr. Mary Philippa - St. Mary's	421	32	453	7%
TOTAL	**5549**	**1081**	**6630**	**16%**

Table D14
Emergency Department Inpatient Utilization – Within and Outside Medical Home Network

Medical Home and Affiliated Hospital	Within Medical Home Network	Outside Medical Home Network	Total	Percentage Outside Medical Home Network
BAART - SFGH	11	3	14	21%
Brown & Toland - CPMC	0	6	6	100%
CCHCA - Chinese Hospital	11	3	14	21%
DPH Clinics - SFGH	331	7	338	2%
Glide - St. Francis	40	46	86	53%
9 SFCCC Clinics - SFGH	159	8	167	5%
Kaiser - Kaiser Medical Center	24	3	27	11%
NEMS - SFGH	126	4	130	3%
Sr. Mary Philippa - St. Mary's	48	10	58	17%
TOTAL	**750**	**90**	**840**	**11%**

Finally, further analysis revealed that of the 1,081 out-of-network ED outpatient visits, 41.4% occurred at SFGH. Out of 90 out-of-network inpatient admissions, 66.7% were at SFGH.

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 IV-A of this report, 34,781 individuals have had at least two HSF disenrollments and collectively had 79,124 enrollment periods (i.e., the period of time between an enrollment and disenrollment). Of the 79,124 enrollment periods, 80% had enrollment periods lasting 10 – 12 months.

An examination of utilization data for the 34,781 individuals suggest that these participants 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 51,934 patients. The number of patients (51,934) is greater than the number of unique individuals (34,781) 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 61% of the patients had their initial office visit within the first 60 days of enrollment with almost half (44%) having their first visit within 30 days. Thus, the data does not suggest that those with multiple enrollment periods are enrolling in HSF and not receiving services.

Table D15
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	22,690	44%
31-60 Days	8,728	17%
61-90 Days	5,068	10%
>90 Days	15,448	30%
Total	**51,934**	**100%**

E. HEALTH IMPROVEMENT INITIATIVES

This section of the report focuses on the Healthy San Francisco (HSF) Health Improvement Program, overseen by the Department of Public Health's third-party administrator, the San Francisco Health Plan (SFHP), and focuses on promoting preventive services, improving the quality of chronic care, facilitating the HSF Quality Improvement Committee, and providing quality and utilization data reporting.

Functions handled by the HSF Quality Improvement Program include:

- Producing and disseminating health education materials for HSF participants
- Accepting and resolving complaints from HSF participants about their health care
- Delivering training on customer service, provider-patient communications, appointment access and other topics to participating providers
- Monitoring and improving HSF participant clinical outcomes and access through the *Strength in Numbers* program
- Coordinating and hosting the quarterly Quality Improvement Committee of the HSF provider network

Health Education

During planning for HSF participant health improvement projects, demographic characteristics, methods of delivery, as well as appropriate cultural and linguistic competencies are considered when developing the necessary education materials and tools that are integrated into each project. In response to positive feedback and input from both providers and patients, there are existing projects that have continued into FY2012-13 as well as new projects:

- *Well Woman and Well Man Mailings:* HSF participants are mailed "Well Man" and "Well Woman" health education materials during their birth month. These materials provide preventive care reminders (e.g. immunizations, recommended exams and screenings) and health care management tips, dependent on the participant's age and gender. Wellness information is also provided on HSF's Facebook page.
- *HeartBeat Newsletters:* Newsletters are mailed out quarterly to HSF participants to provide program updates, promote relevant health-promotion events or other opportunities, and offer tips on maintaining health through methods such as nutrition and exercise.
- *Diabetes Text Messaging Campaign:* In FY2012-13, HSF and SFHP launched DMTxt, a text messaging program for HSF patients with diabetes that allows them to communicate with health educators and physicians who monitor the messages coming through to DMTxt. This program is available in English, Spanish, and Chinese. As of June 2013, there were 92 HSF participants participating in the program.
- *Diabetes "Passport" Brochure:* Continuing from FY2011-12, diabetes "passport" brochure mailings are a health education outreach campaign that goes out to all HSF participants with diabetes. The brochure contains guided pages for both the patient and provider to complete to appropriately monitor and manage each patient's diabetes.
- *Cultural Awareness Training:* In order to expand cultural competency among all providers and their staff, HSF offers cultural awareness trainings, which review topics such as Limited English Proficiency and examine certain cultural groups and their traditional beliefs and practices around health and wellness. HSF also monitors patients' preferred languages and identifies cultural groups whose needs should be addressed and services need to be expanded.

Care Experience

In FY2012-13, HSF continued and launched new initiatives to improve patients' experiences with HSF and its medical home network.

- *Coleman Associates' Rapid Dramatic Performance Improvement (DPI) Program:* In FY2011-12, HSF sponsored four clinics into Coleman Associates' Rapid DPI Program. This fiscal year, five additional clinics were added to the Program. In this program, consultants worked alongside clinic staff for one week with the goals of breaking down barriers to promote improving teamwork, patient access, and visit efficiency through the redesign of clinics' work flows. Afterward, the consultants coach, monitor and report performance measures, and continuously find areas for quality improvement for a period of two months. As a result of the Program, the nine San Francisco clinics that participated, on average, decreased their no-show rate by 3% and reduced cycle time by 21 minutes within three months after the clinics' start in the Program. In qualitative interviews, participating clinic staff reported an improvement in understanding the clinic experience from the patient's perspective, an increase in medical assistants' expertise and responsibility level, and a greater sense of unity among their clinic colleagues.
- *Appointment Access Improvement Action Series:* From November 2012 to March 2013, HSF implemented an Appointment Access Improvement Action Series. This Series started with a half-day training and was followed by six monthly webinars which went into detail on specific access improvement topics. At the end of the Series, the two medical homes that participated reduced their no-show rates by 7% combined.
- *Provider Patient Communication Action Series:* This Series featured a three-day provider training on improving communication and maintaining focus on the patient while using an Electronic Health Record system. Seven clinics implemented activities to reinforce the skills learned in the training, and in a six-month follow-up survey, all who responded to the survey reported still using at least two techniques that were taught at the training. Also from this survey, 47% of providers reported that they thought their patients had a better understanding of their health conditions.
- *Customer Service Action Series:* In FY2012-13, 11 clinics went through this Series that provided protocols for caring for challenging patients and dealing with patients' concerns, all the while providing patient-centered customer service. 94% of those who participated reported that the training was "useful" and "high-quality". In addition, certain units of the Department received phone etiquette trainings in order to learn how to provide better and effective responses to patients.
- *Building Blocks Coaching:* Under the 10 Building Blocks Practice Coaching Program, 13 HSF medical homes have had practice coaches placed at their clinics to offer training, support, facilitation, and planning. More coaches are expected to be placed in medical homes later in the calendar year. The project is a collaboration between SFHP and the Center for Excellence in Primary Care (CEPC).

Strength in Numbers

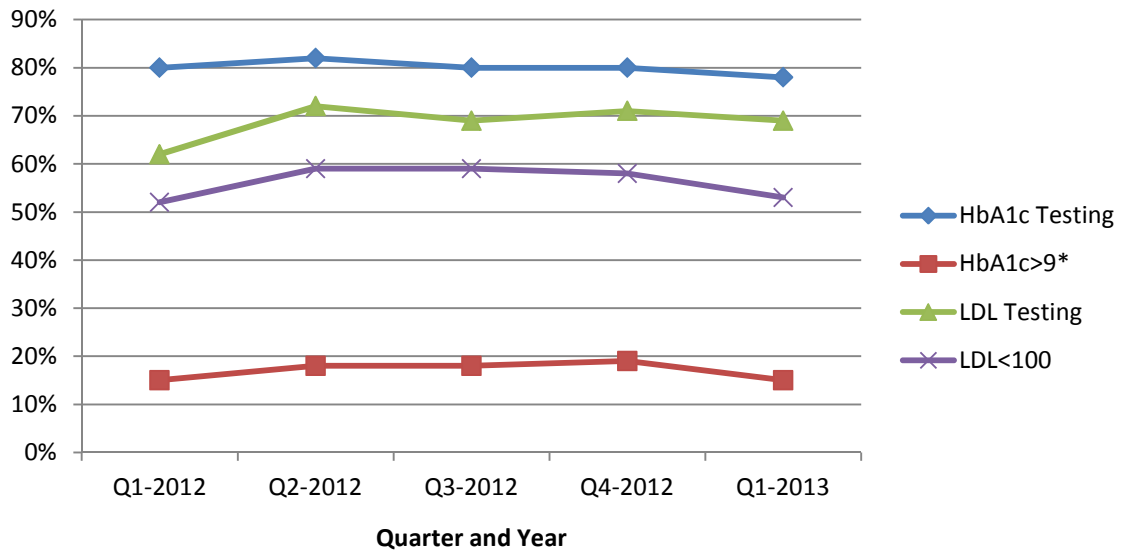
The *Strength in Numbers* Program aims to improve chronic care and prevention services for HSF participants, invest in chronic care registries, and create standardized measurement and improvement structure across the San Francisco safety net. Medical homes that provide care to at least 350 HSF participants are eligible to participate in the program. Program data is self-reported on a quarterly basis and is sent back to participating clinics in a quarterly newsletter. Since the start of the 2012 program, *Strength in Numbers* has provided un-blinded comparative reports to all participating clinics. These

reports highlight an individual clinic's highest and lowest performance within a measure as compared to the most recent quarter. The program operates on a calendar year.

At the end of the 2012 program year, program participants participated in a survey to assess how they have integrated panel management, a provider-team approach to meet the needs of patients with chronic diseases using disease registries to identify unmet needs of patients. The Program has resulted in registry usage that has grown by 12% since 2009, registry maintenance that has increased by 18%, and a 31% increase in site with more than 2 staff members who are trained to generate reports.

For example, 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. The first quarter of the 2013 Program year saw a slight decrease in the overall performance in four core diabetes measures (HbA1c testing, HbA1c>9, LDL testing, and LDL<100) in the first quarter of 2013, but this may likely be due to the implementation of eClinicalWorks (the Department's ambulatory electronic health record system) which resulted in a decrease in clinic capacity, as well as the fact that as performance improves, the increments of positive gains decrease. However, for the controlled diabetes measure HbA1c>9, lower is better so the decrease is a positive improvement.

Figure E1
Diabetes Measures for Participating *Strength in Numbers* Clinics



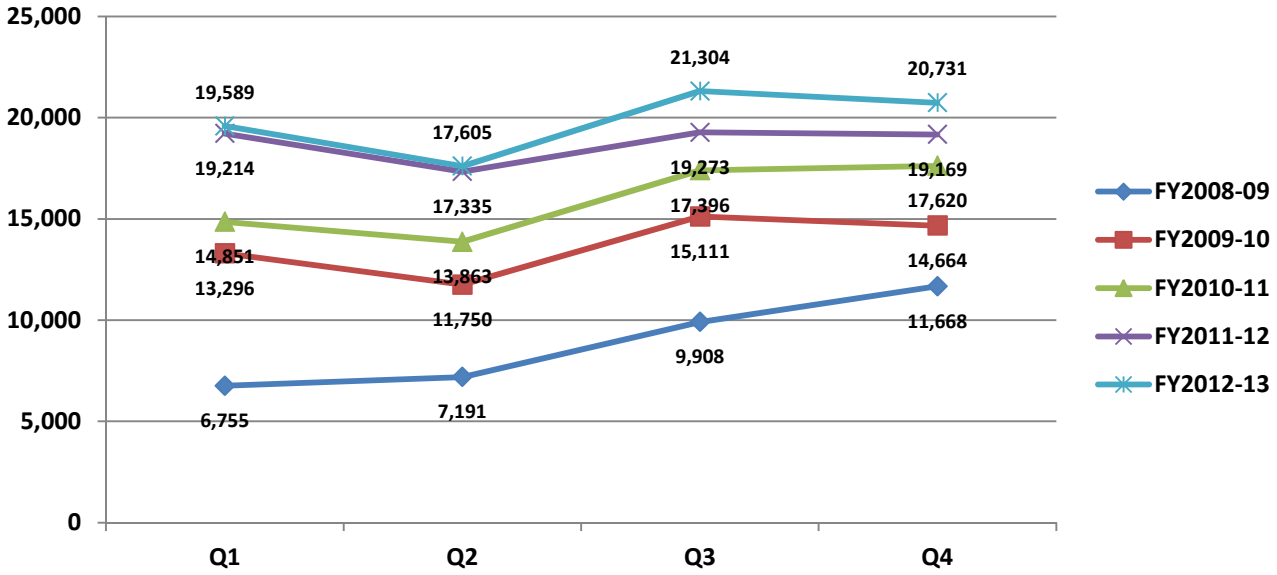
F. PARTICIPANT EXPERIENCE AND SATISFACTION

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.

Customer Service Call Center

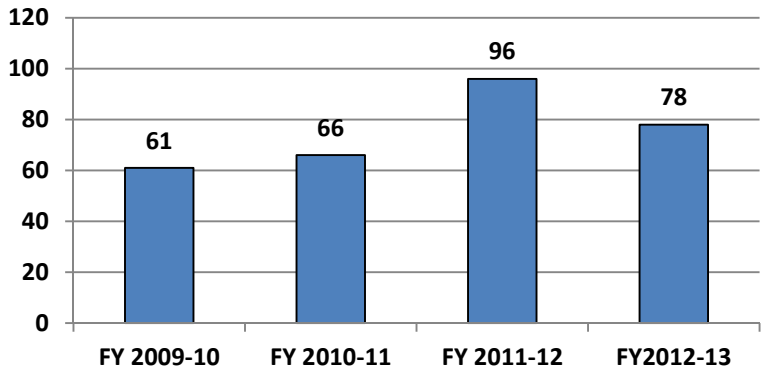
The HSF Customer Service Center supports all HSF customers, including participants, potential participants, medical homes, City Option employers and City Option employees. These activities are performed by the Department of Public Health's third-party administrator, the San Francisco Health Plan (SFHP). Functions include providing telephone assistance to participants, providers, and employers, scheduling enrollment appointments for the HSF enrollment site at SFHP and handling participant complaints. HSF Customer Service Center received a total 79,229 incoming calls (applicants, participants, providers, employers, others) in FY2012-13–a 6% increase from FY2011-12's total of 74,991 calls.

Figure F1
Total Call Volume Per Quarter



The call rate for FY2012-13 averaged 78 calls per 1,000 participants compared to 96 calls per 1,000 participants during FY2011-12.

Figure F2
Average HSF Participant Calls (per 1000 Participants)

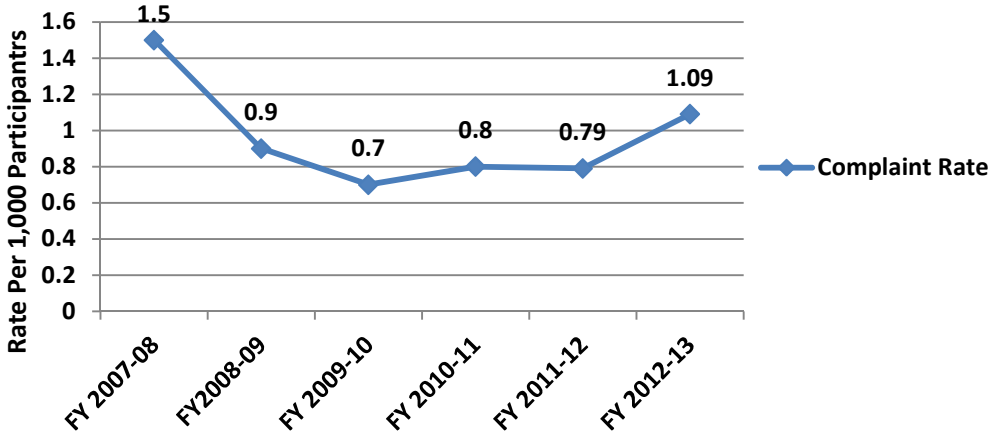


Participant Complaints

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 FY2012-13, the HSF Customer Service Center received a total of 652 complaints and the key trends were:

- The complaint rate per 1,000 participants[10] for FY2012-13 was 1.09, a 38% increase from the FY2011-12 rate of 0.79.
- Access issues were 48% of the total complaints received in the FY2012-13, a 130% increase from FY2011-12, where access issues comprised 20.9% of total complaints.
- Quality of service issues were 14% of the total complaints received in the FY2012-2013, compared to 20.2% of the total complaints received in FY2011-12.

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



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

[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.

not related to a specific service or a specific appointment (e.g., a medical home serves too many homeless people from participant's perspective, etc.).

The remaining complaints represent 20% of all complaints.

Table F1
HSF Participant Complaints by Category (FY2012-13)

Attribute	Number	Percent
Access Issue	309	47%
Quality of Service	108	17%
Other	104	16%
Enrollment Issue	58	9%
Billing	38	6%
Coverage Interpretation	16	2%
Cultural, Linguistic & Health Education	12	2%
Quality of Medical Care	7	1%
Total	**652**	**100%**

Health Access Questionnaire

HSF administers a Health Access Questionnaire (HAQ) at the point of application and at annual renewals.[11] HSF participant responses to this questionnaire allows the Department to gauge individuals' pre-HSF (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.

During FY2012-13, HSF administered 53,189 questionnaires to first-time HSF enrollees and renewing or and reenrolling members. The survey responses of those who were new to HSF reflect those participants' experiences with healthcare access before HSF enrollment, while renewal applicants' answers should reflect the HSF experience with healthcare access.

Two 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 55,230 questionnaires administered to 53,189 participants in FY2012-13.
- A year-to-year analysis for those participants who have taken four questionnaires and have been continually enrolled in HSF without breaks in participation.

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

- This examines the responses of the 5,049 participants who have been enrolled in HSF for four consecutive years without breaks in coverage.

FY2012-13 HAQ Responses

Appendix B provides detailed information on all participant responses to the 11 survey questions in FY2012-13. Participant self-reported data continues to suggest that patient experience with HSF is improving. Compared to FY2010-11 and FY2011-12, questionnaire responses in FY2012-13 indicated the following:

- A lower percentage of respondents (4.8%) delayed getting care or a medicine prescribed to them in the past 12 months than in FY2011-12 and FY2010-11 (6% and 8%, respectively).
- A steady decline in the percentage of respondents (7%) visiting a hospital or emergency room for their own health over the years (9% in FY2011-12 and 10% in FY2010-11).
- A continued decline in the percentage of respondents (9%) claiming to smoke cigarettes over time (9% in FY2011-12 and 11% in FY2010-11).

Year-to-Year HAQ Comparison

By the end of the FY2012-13, the following number of participants had taken the questionnaire for consecutive years with no disruption in enrollment:

- 29,366 participants - two times,
- 10,696 participants - three times,
- 5,049 participants - four times.[12]

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 San Francisco Community Clinic Consortium (SFCCC) medical home which is consistent with data that shows these two medical homes have 87% of HSF enrollment. The data indicates that those who were continuously enrolled were less likely to change medical homes during their enrollment. Specifically, for individuals that took four questionnaires and were continuously enrolled, 3.5% changed their medical home by the second questionnaire, 1.2% changed their medical home by the third questionnaire, and 1.3% changed medical homes by their fourth questionnaire.

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.

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	2,743	9.34%	N/A	N/A	N/A	N/A
3 Questionnaires	11,256	Baseline	Baseline	466	4.36%	289	2.70%	N/A	N/A
4 Questionnaires	3,283	Baseline	Baseline	174	3.45%	62	1.23%	64	1.27%

[12] There were individuals that had more than one continuous enrollment period. For those, 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 re-enrollment period of less than 15 days.

With respect to the ethnicity, data reveals that Asian/Pacific Islanders are more likely to be continuously enrolled (Table F3).

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	2,860	57%	2,872	57%	2,878	57%	2,880	57%
Black/African American	75	2%	73	1%	76	1%	77	1%
Hispanic	1,454	29%	1,483	30%	1,490	29%	1,496	30%
American Indian/ Alaskan Native	3	0%	4	0%	4	0%	4	0%
Other	94	2%	95	2%	93	2%	90	2%
White	420	8%	429	8%	438	9%	442	9%
Not provided	143	3%	93	2%	70	1%	60	1%
Total	5,049	100%	5,049	100%	5,049	100%	5,049	100%

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 2013. The analysis examines responses in the aggregate and the variance calculation is the absolute difference between the HAQ1 and HAQ4 responses.

Of the eleven HAQ 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	7.5%	4.6%	3.9%	3.7%	-3.8%
Very Good	15.9%	11.6%	12.5%	14.0%	-1.9%
Good	35.4%	48.2%	51.9%	49.0%	13.6%
Fair	12.5%	15.6%	14.0%	12.6%	0.1%
Poor	2.8%	1.9%	2.1%	2.0%	-0.8%
Don't Know or Refused	25.9%	18.1%	15.6%	18.7%	-7.2%

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	9.2%	7.3%	6.9%	5.3%	-3.9%
No	76.8%	75.0%	77.5%	75.9%	-.9%
Don't Know or Refused	13.9%	17.7%	15.6%	18.8%	4.9%

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	8.7%	9.1%	10.2%	11.7%	3.0%
Clinic/Health Center/Hospital Clinic	69.2%	71.2%	74.2%	70.8%	1.6%
Emergency Room	1.4%	0.4%	0.2%	0.2%	-1.2%
Some Other Place	0.6%	0.5%	0.2%	0.1%	-0.5%
No One Place	5.5%	1.2%	0.5%	0.4%	-5.1%
Don’t Know, Refused	14.5%	17.5%	14.7%	16.8%	2.3%

Medical Care Access

The data reveals that from HAQ1 to HAQ2, respondents reported a reduction in the level of difficulty receiving care. However, this trend was reversed in HAQ3 as there was an increase in respondents who reported extreme or very difficult access to care. Respondents who had little to no difficulties increased from HAQ1 through HAQ3, but by HAQ4 had similar percentages as were reported in HAQ1.

Table F7
Medical Care Access

Medical Care Access	HAQ1	HAQ2	HAQ3	HAQ4	Variance
Extremely Difficult	1.3%	0.9%	2.1%	2.4%	1.1%
Very Difficult	5.8%	3.2%	3.7%	2.8%	-3.0%
Somewhat Difficult	16.0%	15.9%	15.1%	18.4%	2.4%
Not Too difficult	35.5%	36.6%	39.3%	35.1%	-0.5%
Not Difficult At all	21.1%	23.7%	23.2%	21.6%	0.5%
Don't Know, Refused	20.3%	19.7%	16.6%	19.8%	-0.5%

Medical Care Rating

A review of the questionnaire data reveals that over time, participants are more likely to rate their medical care as good or very good (combined percentages) and less likely to rate it as excellent or fair. 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	9.4%	8.0%	6.9%	7.5%	-1.9%
Very Good	18.8%	18.40%	21.4%	23.7%	4.9%
Good	41.6%	44.7%	47.9%	43.7%	2.1%
Fair	6.4%	7.8%	6.1%	4.8%	-1.6%
Poor	1.0%	0.6%	0.3%	0.3%	-0.7%
Don't Know, Refused	22.8%	20.3%	17.5%	20.0%	-2.8%

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	6.5%	3.3%	4.2%	1.8%	-4.7%
No	74.5%	77.1%	78.7%	77.9%	3.4%
Don't Know, Refused	19.0%	19.7%	17.1%	20.3%	1.3%

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	8.6%	7.4%	7.0%	3.4%	-5.2%
No	67.6%	70.4%	74.0%	74.5%	6.9%
Don't Know, Refuse	23.8%	22.2%	19.0%	22.1%	-1.7%

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 HAQ between July 2012 and March 2013.

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 42% 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
1,420 Participants	601 Participants	42%

Predictably, participants who reported their health status as poor had more than three times as many ED visits as those who reported their health status as excellent/very good, and 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	5,884	3.00	0.10
Good	9,801	3.54	0.12
Fair	2,258	4.93	0.18
Poor	361	6.92	0.36

Those participants who reported that access to medical care was "extremely or very difficult" had the same emergency room utilization than those who reported that access was "not that difficult." This is a great improvement from last year's rate of 1.1% average avoidable ED visits for those who responded that it was extremely 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	5,499	0.01%
Not That Difficult	12,248	0.01%

Renewing participants were asked about their interactions with the system and perception of care and access to services. The data revealed that 42% of participants who rated their health as excellent/very good/good have a chronic condition, compared to 73% 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	15,685	42.38%	57.62%
Fair	2,258	61.91%	38.09%
Poor	361	72.85%	27.15%

There was very little difference in the incidence of chronic conditions among participants who rated their medical care as excellent/very good/good (47%), compared to those who rated it as poor (45%).

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	16,405	47.44%	52.56%
Fair	1,126	51.60%	48.40%
Poor	94	44.68%	55.32%

Results showed that smokers had nearly twice as many emergency department visits per person as non-smokers, and about 10% higher 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	2,052	3.38	0.06	0.21	54.68%	45.32%
Non-Smokers	16,171	3.62	0.8	0.11	44.00%	56.00%

G. EMPLOYER SPENDING REQUIREMENT

This section focuses on employer selection of the City Option (Healthy San Francisco (HSF) and Medical Reimbursement Accounts (MRAs)) to meet the mandate of the Employer Spending Requirement (ESR) as outlined in the San Francisco Health Care Security Ordinance (HCSO). Information regarding the HCSO can be found in Section III of this report.

City Option Activity

The ESR Portal at www.sfcityoption.org is maintained by the San Francisco Health Plan (SFHP), HSF's third-party administrator. The portal is the mechanism by which employers identify their employees for whom they would like to meet the ESR via the City Option. When an employer chooses the City Option, their employees will receive either HSF program participation or a MRA, 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 initiate and complete the HSF application process in order to become a HSF participant.
- If the employee is ineligible for HSF, a MRA will be opened for the employee. 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 eligible health care expenses.

For FY2012-13:

- 989 employers had made at least one contribution to the City Option to meet the ESR. 197 of these employers made their very first contribution during FY2012-13.
- Employers deposited $50.7 million to provide the City Option for their employees, approximately $9.745 million more compared to FY2011-12.
- Of the funds contributed to the City Option by employers in FY2012-13, 63% ($32.016 million) were for employees receiving a MRA and 37% ($18.684 million) were for employees potentially eligible for HSF.

For the whole City Option program, as of June 30, 2013:

- A total of 1,625 employers have made at least one contribution to the City Option.
- For the program overall, 57% of employees had their contributions assigned to a MRA, and 43% had their contributions assigned to HSF for program participation.
- Since the initiation of the ESR, $81.644 million in employer contributions (including $18.684 million in FY2012-13) have been transferred from the SFHP to the City & County of San Francisco.

Employer payments are submitted to the SFHP for processing. SFHP transfers the HSF component of the employer payments to the Department of Public Health on a periodic basis. The Department then submits these funds to the City Controller's Office for processing and deposit. In accordance with the HCSO, those funds are used for the HSF program.

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

Employee Data

The following tables present employers' distributions to employees with respect to program eligibility as of June 30, 2013:

Table G1
City Option Employees by Potential Program Eligibility

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.	46,555
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"; other insurance flag as "yes"; age between 0-17 inclusive; or age greater than or equal to 65.	63,746
HSF and MRA Employees	City Option employee whose contributing employer(s) has 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"; therefore, this figure is negative to eliminate duplicate counting of employees.	-7,547
All City Option Employees	**Total number of employees with HSF contributions and employees with MRA contributions, less employees with both HSF and MRA contributions.**	**102,754**

Of the 46,555 employees who have ever been determined potentially eligible for HSF based on employer-submitted information, their status is as follows:

Table G2
City Option HSF-Eligible Employees by Disposition

HSF Eligibility Disposition	Number	Percent
HSF Enrollment (Ever Enrolled)	11,167	24%
Employee-Initiated Request for Fund Transfer from HSF to MRA	5,546	12%
HSF to MRA Transfers Due to Incorrect Employer-Provided Information	16,780	36%
Disposition Determination in Process, Inadequate Date or Unresponsive Outreach	13,062	28%
All Employees (Potential Duplication re: HSF & MRA Individuals)	46,555	100%

Of the 63,746 employees whose employer-contributed funds went to a MRA, the reasons for MRA designation based on HSF program eligibility are listed on the following page:

Table G3
MRA Designation Reasons for HSF Ineligibility

Reasons for MRA	Number	Percent
Not a San Francisco Resident	35,464	56%
Not Between the Ages of 18 and 64	763	1%
Has Health Insurance	13,240	21%
Combination of One or More Eligibility Reasons	14,279	22%
All Employees with MRAs	63,746	100%

Employer Data

The following is summarized information on employers electing to use the City Option for all or some of their employees. Note that an employer may use the City Option to supplement any existing health care expenditures that they are making which are below the required ESR expenditure levels. The data indicate that:

- 40% of participating employers have 500+ employees, and 2% of participating employers are not subject to the mandate because they have less than 20 employees, but are still participating in the City Option.
- 83% are for-profit and 9% are non-profit (remaining employers are either public or did not report their profit status).
- The majority of employers who have elected the City Option are either in the other services (25%), retail trade (14%), or professional/scientific/technical services (13%).

Table G4
City Option Employers by Company Size

Count by Company Size	Number	Percent
0-19 employees	32	2%
20-49 employees	278	17%
50-99 employees	189	12%
100-499 employees	350	22%
500+ employees	644	40%
Not reported	132	8%

Table G5
City Option Employers by Tax Status

Count by Tax Status	Number	Percent
For-profit	1,348	83%
Non-profit	141	9%
Public (Publicly-traded)	4	0%
Not reported	132	8%

Table G6
City Option Employers by Industry Type

Count by Industry (*North American Industry Classification System* **(NAICS) code)**	**Number**	**Percent**
Accommodation and Food Services (72)	108	7%
Administrative & Support and Waste Management & Remediation Services (56)	8	0%
Agriculture, Forestry, Fishing and Hunting (11)	3	0%
Arts, Entertainment, and Recreation (71)	65	4%
Construction (23)	31	2%
Educational Services (61)	45	3%
Finance and Insurance (52)	130	8%
Health Care and Social Assistance (62)	90	6%
Information (51)	33	2%
Management of Companies and Enterprises (55)	8	0%
Manufacturing (31-33)	35	2%
Mining, Quarrying, and Oil and Gas Extraction (21)	2	0%
Other Services (except Public Administration) (81)	404	25%
Professional, Scientific, and Technical Services (54)	208	13%
Public Administration (92)	3	0%
Real Estate and Rental and Leasing (53)	38	2%
Retail Trade (44-45)	228	14%
Transportation and Warehousing (48-49)	24	1%
Utilities (22)	4	0%
Wholesale Trade (42)	26	2%
Unreported	132	8%

H. EXPENDITURES AND REVENUES

This section provides estimated expenditures and revenues for the HSF in FY2012-13. As noted in previous sections, the HSF-SF PATH transition expenditures and revenues are not included in HSF financial estimates.

The Department of Public Health 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 FY2012-13 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 $159.17 million in FY2012-13. Department-specific HSF expenditures totaled $121.22 million and of that amount, $24.3 million in expenses were covered by revenue and almost $97 million was covered by a City and County General Fund subsidy. Private HSF medical homes and non-profit hospitals reported that they incurred approximately $38 million in HSF net expenditures. Overall, Department expenditures for uninsured individuals (those enrolled in HSF, those enrolled in SF PATH and others) in FY2012-13 is estimated at $178.2 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 FY2012-13 are estimated at $159.17 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 Tables H1 and H2.

Table H1
Summary of Estimated System-Wide FY2012-13 HSF Expenditures (All HSF Providers)

Delivery System	Estimated Cost
Total Department HSF Expenditures	$121,221,021
Private Provider Net HSF Expenditures	$16,409,559
Non-Profit Hospital Charity Care Expenditures	$21,534,961
All HSF Provider Expenditures	**$159,165,541**

Table H2
Healthy San Francisco Estimated Total Expenditures and Revenues (Up to FY2012-13)

	FY2008-09	FY2009-10	FY2010-11	FY2011-12	FY2012-13
ENROLLMENT					
Total Participant Months	420,878	596,647	656,361	549,525	612,462
REVENUE					
General Fund	$0	$0	$0	$0	$0
Health Care Coverage Initiative	$19,199,749	$22,855,381	$27,400,000	$0	$0
Participation Fees and DPH POS	$3,208,577	$5,046,830	$5,791,742	$8,067,498	$7,499,428
ESR (Employer Health Care Expenditures)	$18,236,251	$13,970,440	$12,966,266	$15,587,137	$16,807,439
Reserve for Unearned Rev. (Enrollee & ESR)	($4,559,063)	($1,563,176)	$0	$0	$0
Transfer of Unused MRA Funds	--	--	$3,565,831	$0	$0
Philanthropic Grants (Evaluation)	$450,000	$140,000	$210,000	$105,190	$0
TOTAL REVENUE	**$36,535,514**	**$40,449,475**	**$49,933,839**	**$23,759,825**	**$24,306,867**
DPH EXPENDITURES					
Administration					
HSF Administration	$752,122	$697,757	$788,742	$766,497	$506,273
Evaluation	--	--	$719,088	$105,190	$0
Third-Party Administrator (SFHP)	$5,132,291	$6,180,527	$6,567,316	$6,656,012	$7,000,103
Services					
Cost of Services (SFGH, Clinics, UCSF)	$91,431,700	$97,374,760	$106,295,039	$61,989,030	$76,316,179
Behavioral Health	$20,099,554	$23,440,070	$20,375,732	$16,168,695	$21,070,330
Non-DPH Provider Reimbursement	$6,683,671	$11,516,867	$14,396,117	$14,942,338	$15,792,251
Information Systems					
Eligibility/Enrollment System (One-E-App)	$240,702	$282,636	$267,810	$270,449	$301,977
Siemens Information Technology	$200,000	$203,578	$223,936	$233,908	$233,908
Capital					
Capital Projects	$0	$562,280	$0	$0	$0
SUBTOTAL DPH EXPENDITURES	**$124,540,040**	**$140,258,475**	**$149,633,780**	**$101,132,119**	**$121,221,021**
ESTIMATED DPH PER PARTICIPANT PER MONTH EXPENDITURE	**$296**	**$235**	**$228**	**$184**	**$198**
NON-DPH EXPENDITURES					
Private Medical Homes Net HSF Expenditures	--	$23,629,093	$16,328,385	$21,436,106	$16,101,659
Non-Profit Charity Care Expenditures	--	--	$11,812,682	$17,297,376	$21,534,961
SUBTOTAL NON-DPH EXPENDITURES		**$23,629,093**	**$28,141,067**	**$38,733,482**	**$37,636,620**
TOTAL DPH AND NON-DPH EXPENDITURES	**$124,540,040**	**$163,887,568**	**$177,774,847**	**$139,865,602**	**$158,857,641**
ESTIMATED TOTAL PER PARTICIPANT PER MONTH EXPENDITURE	**N/A**	**$275**	**$271**	**$255**	**$259**
DPH REVENUE LESS DPH EXPENDITURES = GENERAL FUND SUBSIDY	($88,004,526)	($99,809,000)	($99,699,941)	($77,372,294)	($96,914,154)
ESTIMATED DPH PER PARTICIPANT EXPENDITURE	$296	$235	$228	$184	$198
DPH PER PARTICIPANT REVENUE	$87	$68	$76	$43	$40
PER PARTICIPANT GENERAL FUND SUBSIDY	($209)	($167)	($152)	($141)	($158)

Note that due to the HSF-SF PATH transition that occurred in FY2011-12, there was an absolute reduction in HSF participant months, revenues, and expenditures in FY2011-12. Data for HSF-SF PATH transition members is not included for FY2012-13 as well.

Department Expenditures

Department expenditures totaled an estimated $121.22 million in FY2012-13. Department expenditures are categorized into the major categories of administration, services, information systems and capital. Key expenditures highlights are:

- Service costs were 93.4% of total estimated Department expenditures at $113.18 million
- Administration (including information technology) was roughly 6.2% of total estimated Department expenditures at $7.5 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 (SFGH), and incremental behavioral health provider funding. In addition, as noted in Section IV-C, a portion of Department service costs at SFGH 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 many other private providers in the network.

Department Revenues

Non-General Fund revenues totaled $24.3 million. This includes contributions from employers using the City Option to fulfill the Employer Spending Requirement (ESR) and participant fees (both participation and Department point-of-service fees). 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, 2013, approximately 42% of participants were at or above 101% of FPL. The Department only collects information on point-of-service fees paid by HSF participants accessing services within the Department. For the fiscal year ending June 30, 2013, the Department collected an estimated $424,354 in HSF point-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.[13]

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 FY2012-13 General Fund subsidy was close to $97 million.

Estimated Private HSF Provider Costs and Revenue of Serving HSF Participants

It is estimated that health services to HSF participants cost private HSF providers $37.94 million:

- $16.41 million by medical homes after revenues of $26.72 million are deducted from total expenses of $37.94 million, and
- $21.53 million in hospital charity care expenses

[13] 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.

Table H3
Estimated Expenditures and Revenue for Private HSF Medical Homes*

Medical Home	Expenditures	HSF Funding and Other Revenues	Net Expenditures
BAART	($131,210)	$109,853	($21,357)
Brown & Toland Physicians	($1,149,424)	$826,650	($322,774)
CCHCA & Chinese Hospital	($1,499,647)	$1,466,400	($33,247)
Glide Health Services (specialty affiliation with Saint Francis Memorial Hospital)**	($5,235,987)	$575,000	($4,660,987)
Kaiser Permanente	($11,176,160)	$4,425,779	($6,750,381)
North East Medical Services	($5,786,890)	$5,288,298	($498,592)
San Francisco Community Clinic Consortium Affiliated Clinics (includes SFCCC Administration)	($12,868,031)	$12,868,031	$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	**($42,819,477)**	**$26,717,818**	**($16,101,659)**

** Figures in parentheses indicate negative numbers.*
***The provided figures for this medical home are actually from FY2011-12 but are expected to be similar to FY2012-13 expenditures and revenues; this medical home did not provide requested financial information.*

Of the reported $26.72 million in revenues available to private medical homes, about $15.79 million (59%) 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 provide reimbursement at that level. In addition, prior to HSF, the majority of HSF providers were providing services to their HSF participants through their specific sliding scale clinic programs for uninsured patients. To the fullest extent possible, HSF providers have worked to enroll their existing uninsured patients 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.[14]

Charity care services by non-profit hospitals are estimated at $21.53 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.

[14] Prior to HSF, Healthright 360, Lyon-Martin Health Center and Mission Neighborhood Health Center had contracts with the Department to provide health services to medically indigent adults.

In examining the HSF private community provider expenditure data, it is important to emphasize 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 SFGH and in Community Oriented Primary Care. It is estimated that the costs of providing services to this population was approximately $57.10 million in FY2012-13. The LIHP/SF PATH population is estimated at $47.50 million in expenditures.

As a result, the Department's estimated cost of serving the indigent and uninsured in FY2012-13 is $178.18 million. This does not include behavioral health expenditures for the non-SF PATH and non-HSF population.

Table H4
Estimated Costs of Serving Indigent and Uninsured (FY2012-13)

Uninsured Patient Population	Estimated Cost
HSF Uninsured Population	$76,316,179
Non-HSF Uninsured Population (not including LIHP)	$56,045,066
LIHP/SF PATH Population	$45,816,201
Entire Uninsured Population	$178,177,447

V. FY2013-14 ANTICIPATED PROGRAM ACTIVITIES

Since its inception, the Healthy San Francisco (HSF) program has transformed the way the City meets California Welfare and Institutions Code Section 17000 and its responsibility to provide medical care for the indigent population. Built on the Department of Public Health's existing Sliding Scale Fee program, it provides low cost coordinated care through the medical home for uninsured San Francisco residents regardless of their employment status, immigration status, or pre-existing medical conditions. In the first six years of the program, the program has grown from 24,210 participants at the end of the first year to the current membership of 51,158 and another 9,844 in the San Francisco Provides Access to Health Care (SF PATH) program, San Francisco's Low Income Health Program (LIHP). Thus, HSF has served over 131,000 unique individuals in a city with a population of slightly more than 800,000.

To ensure ready access to care for the program's growing membership, HSF has expanded the network from its initial 2 medical homes to 37 medical homes spread throughout the city at the end of FY2012-13. This represents a city-wide collaboration between the Department and private medical care providers. In addition to provider collaboration, HSF also represents a financial collaboration between the City and private partners through the provision of general fund dollars, private employers through contributions to the City Option and private healthcare providers' expenditures.

While HSF and SF PATH provide access to affordable health care for uninsured residents of San Francisco, the implementation of the Patient Protection and Affordable Care Act (ACA) on January 1, 2014 has major implications for HSF and SF PATH. The majority of HSF participants will be eligible for new health insurance options through the ACA. About 41,000 (68%) of all HSF and SF PATH participants will be eligible for insurance post-ACA. It is estimated that of those eligible, 28,000 (68%) of HSF/SF PATH participants are eligible for expanded Medi-Cal while 13,000 (32%) may be eligible for Covered California subsidies. An estimated 19,000 participants will be ineligible for insurance through the ACA and will remain in HSF post-ACA. The Department and HSF program fully support the implementation of the ACA and have already taken many steps to prepare the program to support the ACA.

In getting ready for ACA implementation, the Department and the HSF program have already engaged with other City & County of San Francisco departments, especially the Human Services Agency (HSA) and the Mayor's Office to facilitate the development of a coordinated City-wide ACA outreach and enrollment strategy. To that end, since an estimated 70% of uninsured individuals in San Francisco are enrolled in one of the two health coverage program (HSF and SF PATH), the program is poised to provide subject matter expertise on communication and outreach efforts to encourage enrollment in health insurance through the ACA.

The HSF program continues to closely monitor activities of Covered California, California's Health Benefit Exchange regarding the process for HSF enrollment sites to become Certified Enrollment Entities, so HSF can build the capacity to assist individuals with enrolling in new healthcare coverage when appropriate. Since enrollment for both expanded (MAGI) Medi-Cal and Covered California benefit plans will be through Covered California's CalHEERS enrollment system, it is critical that HSF Application Assistors become certified to enroll individuals. The Department also plans to take advantage of the administrative transition of SF PATH participants to Medi-Cal expansion on January 1, 2014. The HSF program will also make changes to its existing eligibility system to further streamline the application process for applicants.

The FY2013-14 will be a time of a transformation for San Franciscans as thousands will have health insurance for the first time through new options such as expanded Medi-Cal and Covered California health insurance. HSF will work collaboratively with stakeholders to ensure maximum enrollment in newly available health insurance options for both HSF participants and the general public by leveraging the existing infrastructure of enrollment sites, communication channels, and partnerships within the community. However, we recognize that not all individuals will be eligible for these new options and HSF will continue to be needed to meet the healthcare needs of many San Franciscans.

HSF membership is expected to decrease as current participants become eligible and enroll in new insurance options. During the first year of ACA implementation, the Covered California open enrollment period will be from October 1, 2013 – March 31, 2014. While the program will focus on transitioning or enrolling individuals in new health insurance options, we will continue to monitor program activities to identify best practices and lessons learned so that Department can continue to successfully meet the healthcare needs of participants.

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 2013. For FY2012-13, the analysis allows for a three month lag for data completion. Therefore, the analysis does not use actual data for the months of April 2013 to June 2013. The data has been trended comparing 12 months of actual data from July 2008 to June 2009, July 2009 to June 2010, July 2010 to June 2011, and July 2011 to June 2012.

SFHP monitors HSF submissions by service category and total submissions received by providers on a monthly basis. 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 as complete of data as possible from all HSF providers. In FY2012-13, over 49% of institutional service data was from San Francisco General Hospital.

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. 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 FY2012-13 Health Access Questionnaire Responses (New Applicants and Continuing Participants)

The 55,230 questionnaires were administered to 53,189 participants:

- 51,167 participants took the survey only one time during the year,
- 2,004 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 re-enrollment) and
- 1 participant took the survey four times (likely due to disenrollment and re-enrollment).

No.	Question	Key FY2012-13 Responses	Key FY2011-12 Responses	Key FY2010-11 Responses	Key FY2009-10 Responses	Key FY2008-09 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.	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?	46% of all respondents indicated that they did not have health insurance for some time in the past 12 months	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 notes was "enrollment in Healthy San Francisco" 36% cited HSF as the reason they 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." 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." 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." 20% cited it as the reason they did not have health insurance.

No.	Question	Key FY2012-13 Responses	Key FY2011-12 Responses	Key FY2010-11 Responses	Key FY2009-10 Responses	Key FY2008-09 Responses
4	In the last 12 months, did you visit a hospital emergency room for your own health?	8% of all respondents stated that they had visited a hospital emergency room in the previous 12 months.	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?	70% 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.	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?	46% of all respondents said it was Not At All Difficult or Not Too Difficult to access care when they needed it.	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?	27% rated the medical care they received in the past 12 months as Excellent or Very Good.	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.

No.	Question	Key FY2012-13 Responses	Key FY2011-12 Responses	Key FY2010-11 Responses	Key FY2009-10 Responses	Key FY2008-09 Responses
8	During the past 12 months, did you either delay getting care or not get a medicine that a doctor prescribed for you?	5% of all respondents said they had delayed getting care or did not get a medicine prescribed to them during the past 12 months.	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.
9	Was cost or lack of insurance a reason why you delayed getting care or did not get a prescription?	Overall, 7% 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, 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, 10% of respondents smoked (either every day or some days).	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-six percent (46%) of respondents stated the lottery offer as the reason for coming in for renewal.	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