Healthy San Francisco

*Our Health Access Program*

# Annual Report to the San Francisco Health Commission (Fiscal Year 2013-14)

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# *I. SUMMARY AND OVERVIEW OF PROGRAM ACCOMPLISHMENTS: HEALTHY SAN FRANCISCO AND HEALTH CARE REFORM*

The Healthy San Francisco Program (HSF) was designed by the San Francisco Department of Public Health (DPH) in 2007 to make health care services available and affordable to uninsured San Francisco residents. HSF has served a dual purpose: (1) providing health care services to San Francisco uninsured adults as the program of last resort for those ineligible for public coverage and (2) preparing DPH, other providers, and HSF participants for the federal Patient Protection and Affordable Care Act's (ACA) key implementation components. The ACA implementation on January 1, 2014 expanded Medi-Cal to single healthy adults, ages 19 to 64, and created California's Health Benefit Exchange, Covered California. This is a marketplace where individuals can purchase health insurance and potentially qualify for income-based subsidies.

Fiscal Year 2013-14 was pivotal for HSF and the populations it serves. HSF leveraged its history, experience and connections with community-based organizations, providers, and key stakeholders to assist participants in making a smooth transition into new health care options available through the ACA. Well positioned and trusted within the community, HSF conducted vigorous and comprehensive outreach, informed, and educated participants and stakeholders about ACA options and requirements. Outreach was organized in a variety of settings and included distributing informational materials to encourage participants to enroll in or purchase health insurance. The program has continued to provide care for uninsured adults ineligible for health insurance while encouraging ACA eligible participants to enroll in newly created insurance options.

**Program Activities to Support ACA Implementation**

*LIHP Transition*

The statewide Low Income Health Program (LIHP) is known as San Francisco Provides Access to Health (SF PATH) in San Francisco. HSF administered SF PATH and facilitated the transfer of eligible HSF participants to SF PATH. SF PATH participants were successfully transitioned to Modified Adjusted Gross Income (MAGI) Medi-Cal, California's free comprehensive health insurance program. SF PATH was funded locally through the City General Fund subsidies and federally as California's 1115 Waiver program.

The SF PATH Program ended on January 1, 2014 when all enrolled participants meeting eligibility requirements were administratively transitioned to MAGI Medi-Cal without requiring participant action. HSF took proactive steps to maximize the number of participants eligible for this automatic transition process**:**

- HSF conducted outreach to potential participants, including underserved populations. For example, HSF worked with the Homeless Outreach Team to expedite enrollment of homeless individuals. The combination of targeted outreach and administrative transition of eligible HSF

participants into SF PATH increased enrollment by 5,202 or 53% from July 2013 through Dec 2013. Enrollment reached 9,844 in July 2013 and increased to 15,046 by December 31, 2013 (last date of the SF PATH program).

- HSF implemented the State's option to suspend redetermination for SF PATH participants with program termination months from September 2013 to December 2013 for one year. This allowed a greater number of participants to be eligible for automatic transition to MAGI Medi-Cal. This approach also enabled HSF Application Assistors to focus on Covered California's first open enrollment period.
- HSF's efforts to enroll participants in SF PATH resulted in the successful transition of 13,680 SF PATH participants to Medi-Cal. Some SF PATH participants did not transition for various reasons including no longer being eligible for Medi-Cal or living out of the county.

*Application Process Includes ACA Options*

HSF developed a new application process to incorporate the addition of the CalHEERS to determine eligibility for Medi-Cal and subsidies for Covered California plans consistent with program eligibility rules.

- HSF encouraged medical homes to become Covered California Certified Enrollment Entities (CEEs) so Application Assistors at those sites could become Certified Enrollment Counselors (CECs) and enroll participants into Medi-Cal or Covered California plans in addition to HSF.
- HSF developed a standardized application process flow to ensure that applicants are screened for HSF only if they are ineligible for public coverage programs (Medi-Cal and subsidized insurance through Covered California).
- HSF made several changes to One-e-App, the HSF eligibility and enrollment system, to streamline the application process and to align the system with changes in program eligibility.

*HSF Transition Period*

Covered California's first open enrollment period posed many challenges to the general public in accessing health insurance and coverage. For example, California Healthcare Eligibility Enrollment and Retention System (CalHEERS), the eligibility and enrollment system for Covered California, was not prepared to process the large volume of applications that were submitted through the Statewide Automated Welfare System (SAWS), causing a backlog of potential Medicaid applications. The backlog caused confusion among applicants who avoided seeking healthcare services while they waited to be processed and admitted to expanded Medi-Cal. Additionally, continuity of care was a primary concern for both participants whose HSF medical home was not an available option through the statewide marketplace, and providers who strived to maintain treatment plans during patients' transition to other providers or coverage plans. In response to the concerns faced by the public and key stakeholders, HSF created the Transition Period.

The Transition Period allows individuals eligible to purchase subsidized coverage through Covered California to continue participation or newly enroll in HSF, provided all other HSF eligibility criteria are

met. In keeping with HSF program goals of transitioning participants to health insurance, which is better than HSF, the Transition Period features:

- An effective date until December 31, 2014
- A required acknowledgment document for individuals enrolling in HSF under the Transition Period to sign, confirming that they understand the terms and have been counseled on the potential consequences of enrollment. Specifically, individuals are informed that HSF is not health insurance, HSF does not meet the ACA individual mandate requirement, and they may be subject to a tax penalty for failure to comply with the individual mandate.

*Expanded Education and Outreach*

In order to facilitate the transition of eligible HSF participants to new health insurance options, HSF led and participated in outreach efforts targeting the existing HSF population, while expanding outreach to the general public. HSF employed a variety of successful outreach and communications strategies to engage, inform, and educate participants on the value of Health Care Reform, including:

- Participation in ACA education forums throughout the City sponsored by several Supervisors, a Congressman, various community organizations and colleges
- Coordination of a program website update (October 2013) to feature added content on Health Care Reform
- Fall 2013 edition of *HeartBeat*, the HSF participant newsletter, focused on Health Care Reform and its positive implications for HSF participants
- Addition of HSF renewal notices and acknowledgement forms that include information on program changes due to ACA implementation

HSF took a lead role in citywide initiatives to raise visibility for health care reform by collaborating with the City and County of San Francisco to educate and enroll residents into new health insurance options through participation in a citywide ACA communication workgroup. This integrated partnership brought together multiple stakeholders to produce the City's first Health Care Reform website and informational flyers on how to enroll in ACA health insurance options. The success of the workgroup's collaborative effort to outreach to the general public was exemplified by the enrollment fair held on March 22, 2014. HSF took the lead in coordinating the event, along with the Human Services Agency, the Mayor's Office, SEIU- United Healthcare Workers West, and National Association for the Advancement of Colored People (NAACP), among others. Specifically, the program was responsible for developing and mailing flyers to approximately 15,000 participants to market the event. Over 220 individuals attended the event, and 103 health insurance applications were initiated or submitted to both Covered California and Medi-Cal.

To supplement direct participant communication, HSF provided training and resources to Application Assistors and customer service staff to enable accurate, comprehensive, and helpful responses to participant inquiries. This effort included the development of an HSF and Health Care Reform Frequently

Asked Questions (FAQ) guide, refresher training and webinars for Application Assistors, as well as the inclusion of a new "Health Care Reform Corner" section in the monthly newsletter.

**Health Care Reform Impact**

*Enrollment*

The majority of HSF participants became eligible for new public insurance options when ACA was implemented on January 1, 2014, decreasing the number of eligible HSF participants. The HSF and SF PATH programs reached peak enrollment in September 2013 with 65,650 participants. Due to participants transitioning to Medi-Cal, Covered California, other insurance options, and the SF PATH, HSF enrollment dropped to 46,302 participants by January 2014. As of June 30, 2014, enrollment was 31,965. This represents a 51% reduction from the combined HSF and SF PATH peak enrollment. Most of the remaining HSF population is exempt from ACA's individual mandate requirement or is enrolled under the Transition Period provision.

*Eliminating Duplicate Enrollment*

HSF continues to identify participants who have enrolled in health insurance programs, dedicating resources to validating the accuracy of enrollment information in order to serve those who truly need the health access provided by the Healthy San Francisco Program. In June 2013, HSF identified approximately 3,200 HSF participants who had concurrent Full-Scope Medi-Cal coverage through a validated third party vendor. These individuals were notified and administratively dis-enrolled. Additionally, since HSF cannot obtain proprietary enrollment data from Covered California and other commercial insurers, HSF regularly conducts phone outreach to participants who are due for renewal, determining if participants have enrolled in other health insurance, See Section III A for details.

**Financial Summary**

In FY2013-14, DPH's estimated HSF expenditures totaled nearly $112 million. Of this amount, $28.76 million was covered by revenue and $83.12 million was provided by a City & County of San Francisco General Fund subsidy. Private community HSF providers reported incurring an estimated $46.85 million in net HSF expenditures. In total, the estimated program expenditures reached $158.74 million in FY2013-14 or a per participant per month (PMPM) expenditure of $296 based on a total of 537,045 participant months.

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.

HSF's reputation as a well-trusted source of information for participants, made HSF an integral part of citywide efforts to enroll residents into new health insurance options. However, the expansion of health coverage options does not guarantee access to health services for all. There will be individuals who are barred, exempt, or otherwise unable to purchase health insurance under the ACA. The program's mission remains the same: making health care services available and affordable to uninsured San Francisco

residents. HSF will continue to use the new health care options and tools available through the ACA to assist eligible San Francisco residents to obtain coverage and will continue to provide comprehensive health care access to any remaining uninsured and underserved San Francisco residents.

# *II. LOW INCOME HEALTH PROGRAM AND SF PATH*

The Healthy San Francisco administration created the San Francisco Provides Access to Healthcare (SF PATH) program in response to California's "Bridge to Reform" Demonstration 1115 Medicaid Waiver. SF PATH allowed for the development of a new statewide health care program, the Low Income Health Program (LIHP). SF PATH 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. DPH's participation in LIHP is an extension of its participation in California's former 1115 Waiver program, the Health Care Coverage Initiative (HCCI). HCCI provided DPH with federal reimbursement to cover a portion of the cost of care for former HSF participants who met eligibility requirements.

SF PATH is one of the legacy LIHPs, having served low-income uninsured San Franciscans since the beginning of the program on July 1, 2011. DPH's participation in the State LIHP enabled the administrative transition of SF PATH participants into Medi-Cal on January 1, 2014 without requiring additional effort by the participant. Those eligible for health insurance through Covered California must proactively apply to enroll.

**Program Eligibility and Provider Network**

Since LIHP was designed to facilitate the seamless transition of eligible uninsured individuals to Medi-Cal on January 1, 2014, the program eligibility rules closely mirror those of Modified Adjusted Gross Income (MAGI) Medi-Cal. However, each participating county's LIHP determined the maximum eligible income for participation in the program. In San Francisco, SF PATH eligibility rules were:

- San Francisco resident
- Between 19 and 64 years old
- Not eligible for full-scope public coverage program
- Meet citizenship requirements (US Citizen or Legal Permanent Resident for a minimum of five years)
- Below maximum income (see below)

Existing HCCI participants were allowed to participate in SF PATH up to 200% federal poverty level (FPL) if they had continuous enrollment and met all other eligibility requirements. The HCCI Program's income eligibility requirement was 133-200% FPL. In November 2011, the maximum income for SF PATH participants was 25% FPL. To enable more eligible San Francisco residents to be eligible for automatic transition to Medi-Cal effective January 1, 2014, DPH raised the maximum income limit for SF PATH to 133% FPL on June 28, 2013. Similar to HSF, SF PATH had an income-based participation and point-of-service fee. Participants above 150% FPL paid a quarterly participation fee.

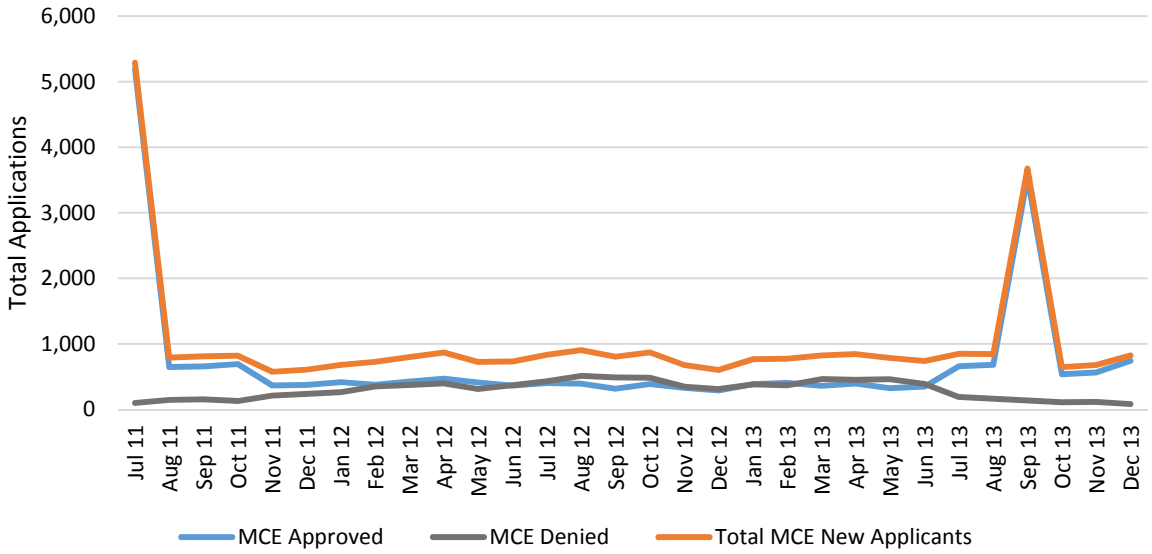
SF PATH's provider network consisted of DPH's network of primary care clinics and hospitals. However, unlike HSF, out-of-network emergency services were covered under SF PATH, regardless of the service location.

**Application and Enrollment**

DPH utilized one eligibility and enrollment system, One-e-App, for both HSF and SF PATH. At the time of closure, the SF PATH Program served 15,046 individuals and had served 25,564 unique individuals since the Program's inception in July 2011. Participants enrolled in SF PATH by completing an application in One-e-App with an HSF Application Assistor, or by meeting SF PATH eligibility and being administratively transitioned from HSF to SF PATH. DPH conducted two administrative participant transitions from HSF to the SF PATH Program, which accounted for the majority of new SF PATH enrollees. At the beginning of the SF PATH Program, HSF administratively transitioned over 10,000 participants from HSF to SF PATH. On September 28, 2013, DPH conducted a second administrative transition of HSF participants meeting SF PATH eligibility rules into the SF PATH Program. A total of 2,926 participants were enrolled in SF PATH as part of this second administrative transition.

Figure II-1 illustrates two administrative enrollments accounting for the sharp increase in SF PATH enrollment, once at the beginning of the program and once in September 2013.

**Figure II-1**
**SF PATH Program Medi-Cal Expansion (MCE) Applications Processed**




Since HCCI enrollees were only allowed to continue participation in SF PATH if they had continuous enrollment, participants who allowed their enrollment to end were no longer eligible for SF PATH when they came back for renewal, but they were eligible for HSF. Participants whose income levels (up to 133% FPL) were within program eligibility requirements could re-enroll into SF PATH.

**Table II-1**
**SF PATH Program Enrollment by Program**

| SF PATH Program Category | Cumulative Enrolled | Program End Enrolled |
|---|---|---|
| MCE (0-133% FPL) | 23,706 | 14,290 |
| HCCI (133-200% FPL) | 1,858 | 756 |
| **Total** | **25,564** | **15,046** |

**Figure II-2**
**SF PATH Program Enrollment Trend**

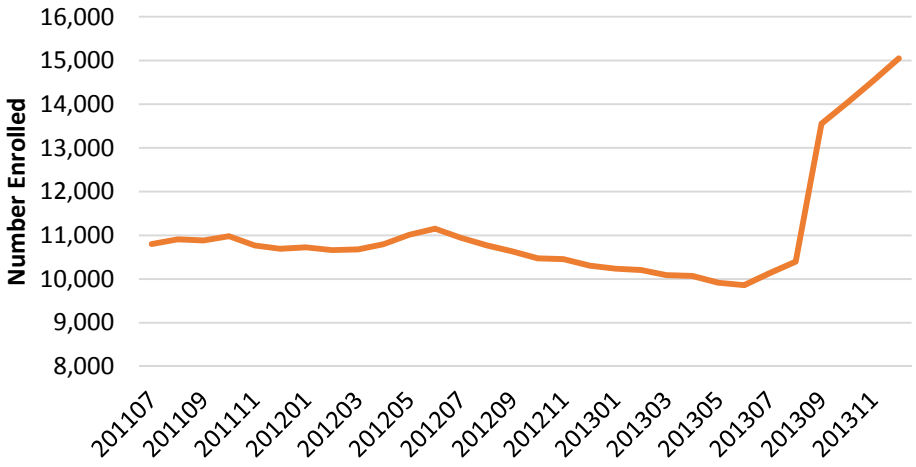
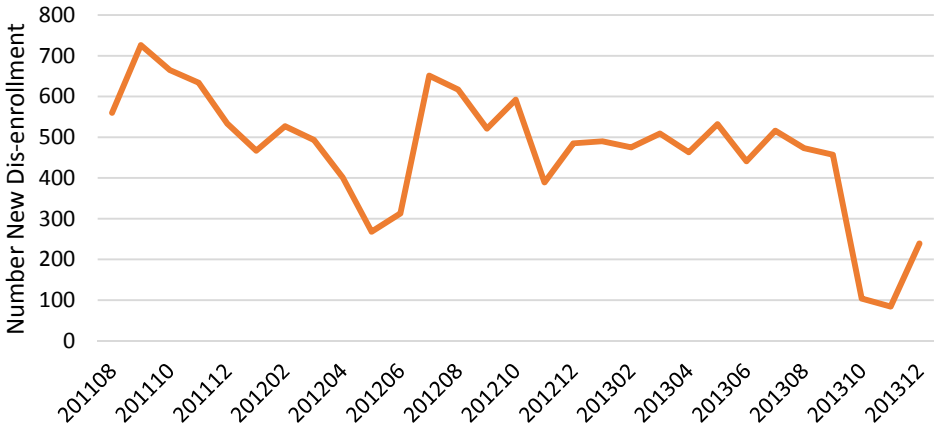



**Figure II-3**
**SF PATH Program Dis-enrollment Trend**



**Participant Demographics**

The following figures compare SF PATH population demographic characteristics at the end of the program with the cumulative program. Demographic characteristics were very similar, with the exception of gender. Cumulatively, 60% of enrollees were male, but at the end of the program, only 40% of participants were male. This might indicate that while more male participants enrolled in the program, they did not take the necessary actions to remain in SF PATH. The proportion of participants enrolled in each medical home remained constant throughout the program.

There were some notable differences in HSF and SF PATH population demographics due to different program eligibility rules, including income limits. While only 19% of HSF participants were 55 or older at the end of FY2013-14, 30% of SF PATH participants were 55 or older. For HSF, 12% self-identified as Caucasian and 3% identified as African American, but in SF PATH, 29% self-identified as Caucasian and 19% were African American. Due to racial makeup differences, the overwhelming majority (76%) identified English as the preferred language. While only 8% of SF PATH participants said Spanish was their preferred language, 42% of HSF participants preferred Spanish. 95% of SF PATH participants had income levels that were eligible for Medi-Cal expansion.

**Figure II-4**

**Demographic Comparison of SF PATH Participants, Program Cumulative and Program End***

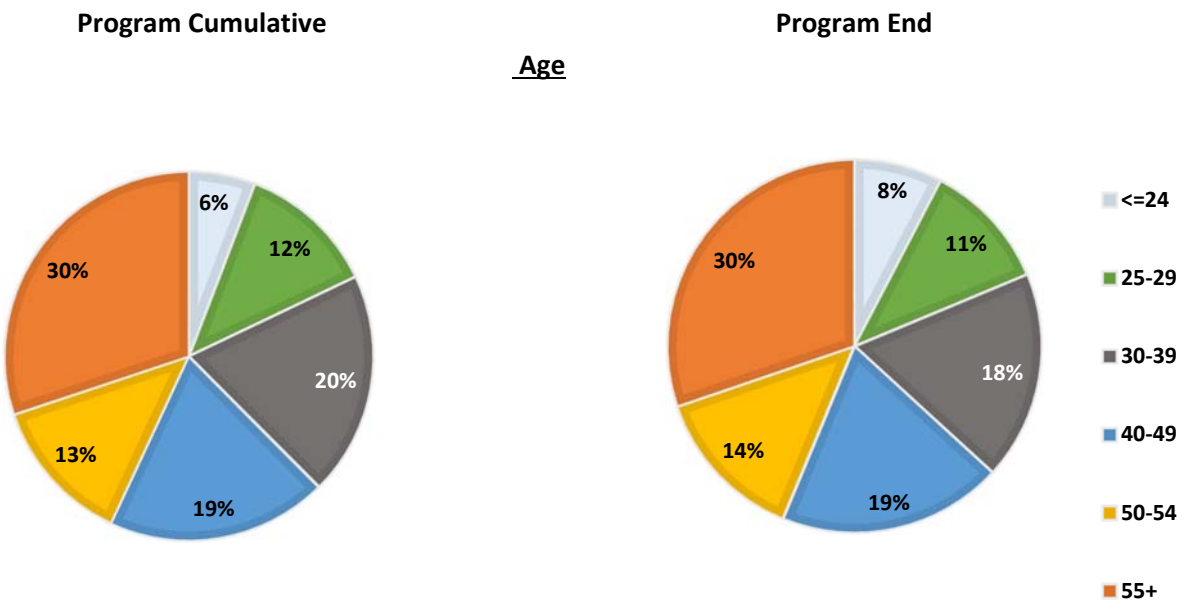
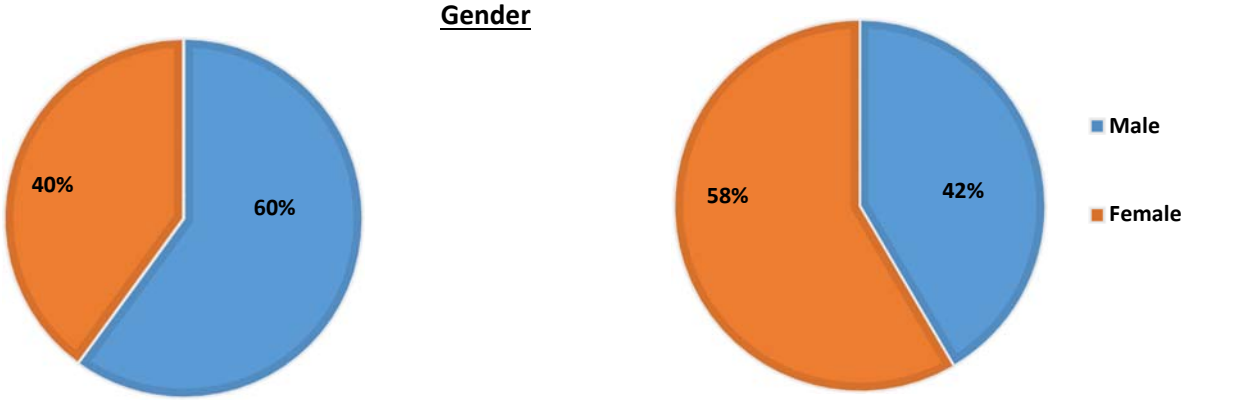


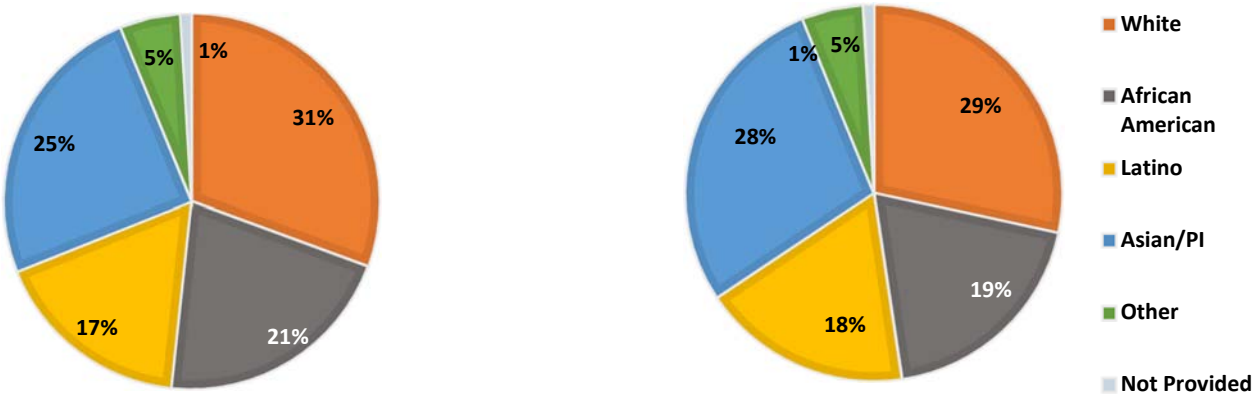
**Figure II-4 (cont.)**

**Program Cumulative** | **Program End**

**Gender**




**Race/Ethnicity**




**Spoken Language**

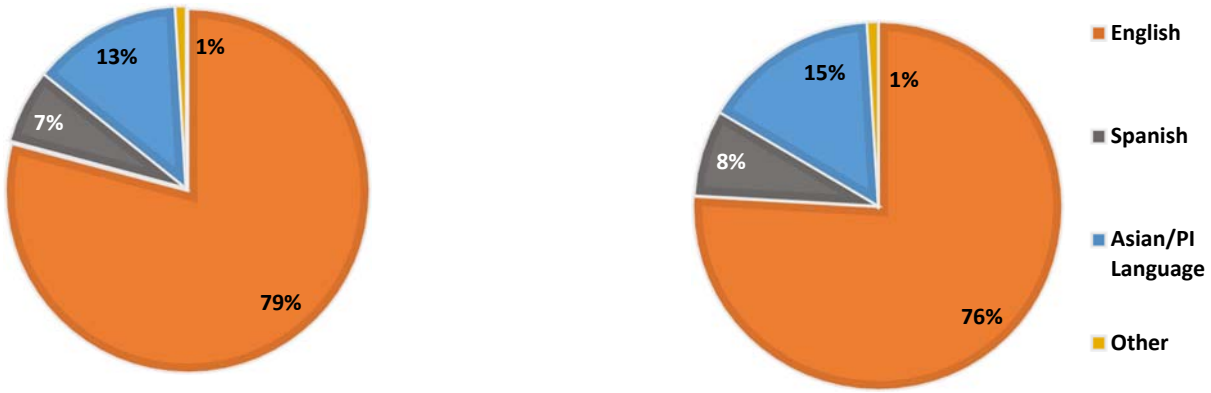
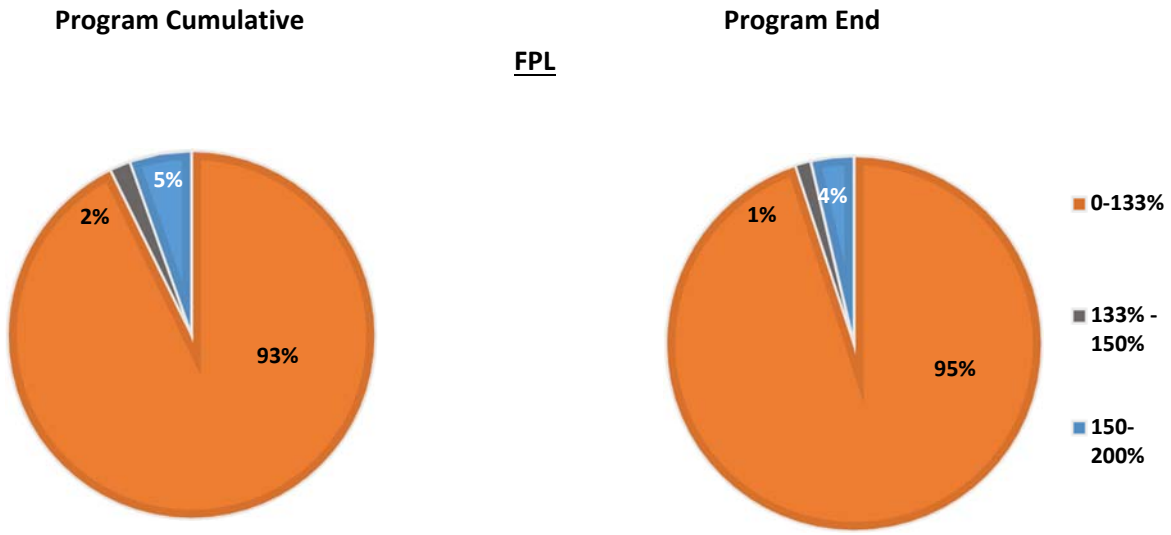
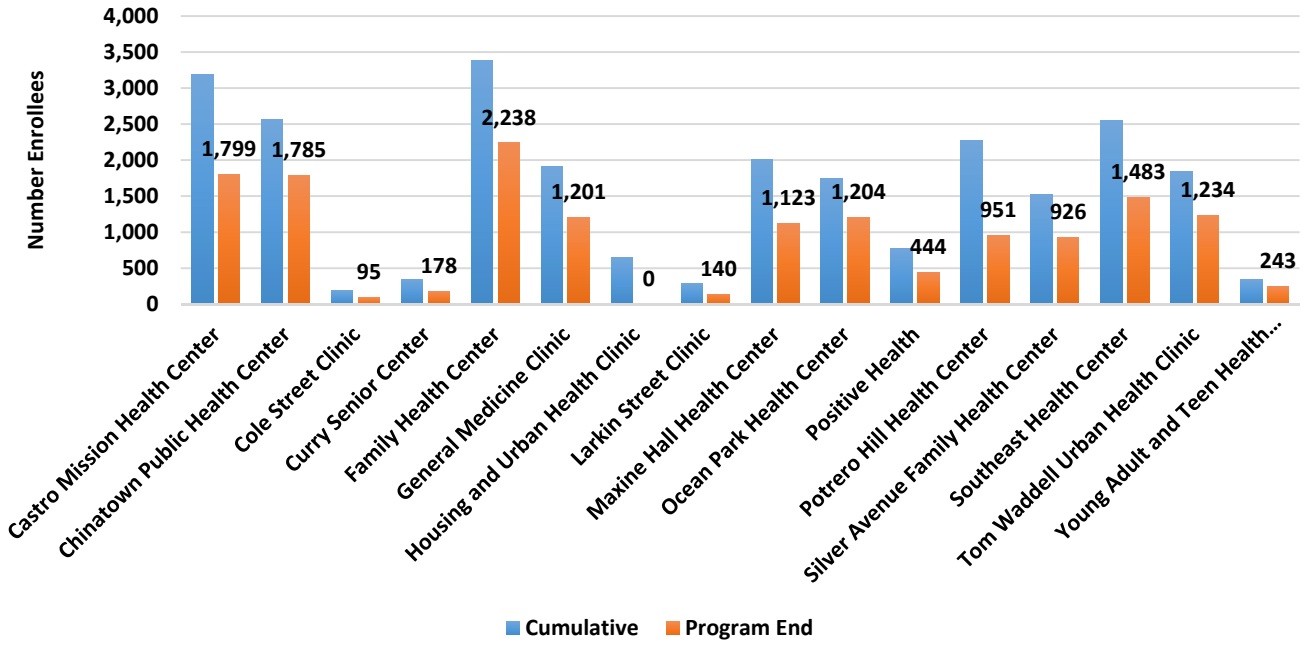


**Figure II-4 (cont.)**




** Note that the sum of percentages per chart may not equal exactly to 100% due to rounding.*

**Figure II-5**
**Comparison of SF PATH Medical Home Enrollment Cumulative and Program End**



Since most of the SF PATH population became eligible for transition to Medi-Cal starting January 1, 2014, this population will likely continue to be DPH's responsibility under the Medi-Cal managed care program.

**Clinical Utilization**

While SF PATH's key purpose was to provide eligible low income uninsured individuals with an option for administrative transition to Medi-Cal starting January 1, 2014, the program also sought to improve program participants' health by enrolling them into coordinated care during SF PATH's duration. This section reviews SF PATH participants' clinical and service data to determine whether the program met its goals with respect to improved health outcomes and appropriate utilization of services. Since the majority of SF PATH participants were automatically enrolled into Medi-Cal managed care, appropriate utilization and overall health outcomes impacts the DPH's managed care programs after January 1, 2014.

In general, the SF PATH population utilized services at a higher rate than the HSF population, both compared to the entire HSF population and compared to HSF participants with a DPH medical home. Compared to the HSF population, the SF PATH population had a higher total percentage of participants who utilized at least one primary care or specialty service, had a prescription, outpatient emergency department (ED) visits, and inpatient admissions.

*Utilization Summary*

SF PATH Program participants actively used services throughout the program's duration. During June 2013 to Dec 2013, 42.29% of SF PATH participants visited a provider within 60 days of enrollment. During 2013, 6,218 participants were continuously enrolled for at least 12 months. Of those participants, 77% had at least one primary care or specialty care visit, 1% had at least one inpatient admission and 68% utilized a prescription. Compared to the HSF population, 72% of HSF participants utilized at least one primary care or specialty service and 43% had a prescription. Since Medi-Cal members are required to have an Initial Health Assessment within 120 days of enrollment unless the provider can document a qualifying service provided to the patient in the last 12 months, a number of participants who rolled over to DPH's Medi-Cal managed care program will need to have a qualifying visit. Inpatient admission encounter data presented in the table below is primarily from DPH and may not capture utilization at hospitals outside of San Francisco General Hospital (SFGH).

**Table II-2**

**SF PATH Program Utilization Summary January – December, 2013**

| Service Category | Number of Participants Continuously Enrolled | Number of Participants Utilizing at Least One Service | Percentage |
|---|---|---|---|
| Primary / Specialty Care | 6,218 | 4,797 | 77.15% |
| Inpatient Admission | 6,218 | 92 | 1.48% |
| Prescription | 6,218 | 4,250 | 68.35% |

DPH also tracks utilization among participants who have and do not have a chronic disease. Participants with a chronic condition had a higher rate of ED utilization and inpatient admission frequency, as well as prescriptions, compared to those without a chronic condition. During July 2013 to Dec 2013, participants with a chronic disease had ED visit per 1,000 rate of 696.34 and those who did not have a chronic condition had a rate of 201.88 visits per 1,000. However, both rates decreased from FY2012-13. For HSF, during FY2013-14, the rate of ED visits per 1,000 was 251.36 for those with chronic disease and 82.83 for those without. During the same period, SF PATH participants with chronic diseases had 57.14 total admissions per 1,000 with an average length of stay (ALOS) of 3.87 days (a 40.57% decrease from FY2012-13) and those without chronic disease had 8.94 admissions per 1,000, with an average length of stay of three days. During FY2013-14, HSF participants with chronic diseases had 26.10 total admissions per 1,000 and those without chronic diseases had an admission rate of 4.03 per 1,000. The data suggests that while SF PATH participants with chronic diseases had over six times more admissions than those without chronic conditions, the average length of stay was less than a day's difference.

**Table II-3**

**SF PATH Program Utilization Comparison Between Participants With and Without Chronic Disease**

| | Data periods | ED Visits per 1,000 | Total Admissions per 1,000 | ALOS | Readmission Rate | Average Prescriptions |
|---|---|---|---|---|---|---|
| **With Chronic Disease** | Jul 11 - Jun 12 | 509.10 | 86.29 | 4.44 | 19.44% | 2.00 |
| | Jul 12 - Jun 13 | 726.01 | 61.05 | 6.51 | 19.62% | 20.79 |
| | Jul 13 - Dec 13 | 696.34 | 57.14 | 3.87 | 15.69% | 18.49 |
| **Without Chronic Disease** | Jul 11 - Jun 12 | 218.47 | 29.09 | 4.07 | 9.55% | 0.32 |
| | Jul 12 - Jun 13 | 237.74 | 8.46 | 2.89 | 5.56% | 3.63 |
| | Jul 13 - Dec 13 | 1.88 | 8.94 | 3.00 | 3.85% | 2.74 |

**Appropriate Utilization of Services**

*Emergency Department*

Emergency department utilization (ED) from Jul 2013 to Dec 2013 was 474.39 per 1,000 participants, a 9.67% decrease from FY2012-13. This is higher than the State average of 294[1] visits per 1,000. Participants aged 45 to 54 had the highest percentage of outpatient ED visits (three or more) in 2013. Among high frequency ED utilizing participants, the most common diagnoses were: (1) abdominal symptoms, (2) respiratory symptoms, (3) general symptoms, (4) nondependent abuse of drugs and (5) other non-organic psychoses. This is similar to the top diagnoses for ED visits for the entire SF PATH population, where abdominal symptoms, respiratory symptoms, general symptoms, and nondependent abuse of drugs are among the top five reasons for ED visits for FY2013-14.

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

Table II-4 shows high frequency ED utilizers for FY2013 by medical homes. In June 2013, Tom Waddell and Housing and Urban Health (HUH) Clinic combined to form the Tom Waddell Urban Health Clinic. The individuals represented in the HUH Clinic are participants who had the HUH Clinic as their medical home before the consolidation, and they were moved to Tom Waddell after.

**Table II-4**
**SF PATH Outpatient ER Visits 3 or More by Medical Home**
**January – December, 2013**

| Medical Home | Participants Continuously Enrolled | Participants Had 3 or More ER | Percentage |
|---|---|---|---|
| Tom Waddell Health Center | 518 | 50 | 9.65% |
| Castro Mission Health Center | 898 | 30 | 3.34% |
| Southeast Health Center | 549 | 25 | 4.55% |
| Potrero Hill Health Center | 437 | 18 | 4.12% |
| General Medical Clinic at SFGH | 475 | 14 | 2.95% |
| Family Health Center at SFGH | 852 | 12 | 1.41% |
| SFGH Positive Health Practice | 211 | 10 | 4.74% |
| Maxine Hall Health Center | 461 | 9 | 1.95% |
| Housing and Urban Health Clinic | 13 | 7 | 53.85% |
| Silver Avenue Family Health Center | 397 | 4 | 1.01% |
| Ocean Park Health Center | 563 | 3 | 0.53% |
| Chinatown Public Health Center | 667 | 2 | 0.30% |
| Children's Health Center at SFGH | 52 | 1 | 1.92% |
| Larkin Street Youth Clinic | 47 | 1 | 2.13% |
| Curry Senior Center | 59 | 1 | 1.69% |
| Cole Street Youth Clinic | 19 | 0 | 0.00% |
| **TOTAL** | **6,218** | **187** | **3.01%** |

DPH also tracks avoidable ED utilization to analyze appropriate ED utilization. From Jul 13 to Dec 13, 220 out of 3,073 ED visits (7.16%) were determined as avoidable. During 2013, among participants who were continuously enrolled for 12 months, 98.07% did not have an avoidable ED visit, and among the 2% of participants who had an avoidable ED visit, 96.7% had only one or two visits.

*Inpatient Admissions*

SF PATH experienced a decrease in the admission rate and the average length of stay in FY2013-14. The SF PATH population had 35.51 acute admissions per 1,000 from Jul 2013 to Dec 2013. This is a reduction

of 9.93% from FY2012-13 (39.42 admissions per 1,000) and a 38.5% reduction (57.76 admissions per 1,000) from FY2011-12, the first year of the program. During FY2013-14, HSF participants with DPH medical homes had an acute admission rate of 12.51 per 1,000. The SF PATH average length of stay from Jul 2013 to Dec 2013 was 3.77, a decrease of 39.09% (6.19 days) from FY2012-13 and 13.3% (4.35 days) from FY2011-12. In 2013, over 98% of SF PATH participants continuously enrolled for 12 months did not have an inpatient admission, an increase of 1.93% from 2012.

In 2013, the top five diagnoses for participants with inpatient admissions were: (1) alcohol withdrawal, (2) cellulitis and abscess of leg, (3) unspecified septicemia, (4) acute on chronic systolic heart and (5) acute pancreatitis.

*Out-of-Network Utilization*

Unlike HSF, SF PATH covered the cost of out-of-network emergency visits. Per LIHP requirements, hospitals that provide emergency and post-stabilization services to LIHP participants may seek reimbursements from the LIHP if they meet LIHP requirements. Out-of-network hospitals providing services to SF PATH participants must notify the SFGH Utilization Management (UM) Department within 24 hours to be eligible for reimbursement for services provided. Following is an analysis of out-of-network claims for SF PATH participants submitted to SFGH's UM Department. These visits may not be captured in the previous emergency and inpatient analysis since the clinical utilization analysis is from data encounters that are submitted to the San Francisco Health Plan (SFHP), who served as the Third Party Administrator (TPA) for the SF PATH Program.

SFGH UM received a total of 6,367 claims for 2,793 members through December 31, 2013. Of these, 1,236 claims were accepted for 252 members; 347 (5.4%) claims were from providers outside of San Francisco. Through December 2013, the total paid amount for out-of-network claims for SF PATH participants was $228,538.11. Since providers may submit claims several months after an encounter, some claims may not have been received at the time of this analysis and are not reflected in this report.

**Table II-5**
**SF PATH Program Out of Network Utilization**
**July 2011 – December 2013**

| | Members | Claims | Outside SF |
|---|---|---|---|
| Accepted | 252 | 1,236 | 41 |
| Rejected | 2,541 | 5,131 | 306 |
| **Total** | **2,793** | **6,367** | **347** |

**Transition to Medi-Cal**

The LIHP Program ended after December 31, 2013 with the administrative transition of all SF PATH enrollees to MEDS, California's Medi-Cal system of records. To maximize the number of uninsured San Franciscan residents eligible for automatic transition to Medi-Cal expansion, DPH took steps to increase SF PATH enrollment.

*Suspension of Redetermination*

SF PATH participated in the State option to suspend redetermination for LIHP enrollees who had termination dates between September 1 and December 31, 2013, extending their termination date by one year. DPH enacted this option to minimize the number of participants who would need to see an Application Assistor to re-determine their program eligibility. This ensured that more people would be eligible for transition to Medi-Cal, while increasing the HSF enrollment site's capacity to enroll individuals in ACA insurance options. In total, 2,467 participants had their renewal dates deferred by one year.

*BlueShield of California Foundation Grant – Direct to MEDS Transition*

In late 2012, the State of California offered all LIHPs two options for transferring LIHP enrollee case information to the Department of Healthcare Services (DHCS). One option was to transfer all case information to the County Human Services Agency (HSA), the local agency with delegated authority to determine Medi-Cal eligibility, and for HSA to send these case files to MEDS, the State's Medi-Cal systems of record. The second option was for local LIHPs to send the case information of LIHP enrollees directly to MEDS and then subsequently send the case information to HSA, which is needed for redetermination or renewal of these participants once they have been transitioned into Medi-Cal. In order to avoid any discrepancies between what the SF PATH program has and what information is ultimately received by DHCS and MEDS, DPH chose to send information of SF PATH enrollees directly to MEDS.

While a direct to MEDS approach provided SF PATH control over the information that DHCS received on SF PATH participants and those eligible for transition to Medi-Cal, it necessitated the creation of two data transfer pathways: one from One-e-App to MEDS and one from One-e-App to CalWIN (San Francisco's HSA system of records). Partnering with Alameda County and San Mateo County, the three Bay Area counties applied for and received a grant from the Blue Shield of California Foundation to complete these projects. San Francisco served as the grant administrator on behalf of the three counties. By June 30, 2014, all LIHP participant data was successfully transferred to both MEDS and CalWIN.

*SF PATH Enrollment Efforts*

In order to increase the number of individuals eligible for automatic transition, DPH took steps to maximize enrollment. On September 28, 2013, HSF transitioned 2,926 HSF participants who met SF PATH eligibility to the SF PATH Program. In addition, HSF partnered with several DPH Divisions and community-based organizations to conduct targeted outreach utilizing a streamlined application process for those who met certain criteria. These included working with those serving mental health and substance abuse clients, homeless individuals, and other residential facilities. As a result of these targeted enrollment efforts, 4,646 participants were enrolled in SF PATH from September, 2013 to December 31, 2013.

*Continuity of Care for LIHP/SF PATH Participants*

During the transition, continuity of care for existing SF PATH participants as they transitioned into Medi-Cal was a primary concern for DPH. In order to ensure continuity of care, DPH worked closely with both Medi-Cal Managed Care Plans (SFHP and Anthem Blue Cross) to ensure that open authorizations for SF PATH participants were communicated so that there were minimal interruptions to services and prescriptions. Since SFHP was also the TPA for the SF PATH Program, SF PATH participants who enrolled into their Medi-Cal plan were assigned their SF PATH medical home if they did not select a different medical home. In addition, DPH retained SF PATH pharmacy benefits through March, 2014 so that participants could continue to access their prescriptions if they experienced problems transitioning to Medi-Cal.

**Program Termination**

When the SF PATH Program ended on December 31, 2013, all participant information was successfully transmitted to the Department of Health Care Services (DHCS) and SF PATH was successfully closed in One-e-App. At its conclusion, SF PATH had 15,046 participants: 14,290 were preliminarily determined eligible for expansion Medi-Cal and 756 were not eligible for Medi-Cal but were eligible to purchase subsidized health insurance through Covered California. As of May 31, 2014, all SF PATH participants were dispositioned in MEDS and 13,680 individuals were transitioned to Medi-Cal with coverage effective January 1, 2014. There were 430 individuals who were not transitioned. There are several reasons that a person could have been identified by the SF PATH program as eligible for transition but ultimately determined not eligible by DHCS, including already being enrolled in Medi-Cal, exceeding the age limit by January 1, 2014 and so forth.

All individuals enrolled in Medi-Cal as a part of the SF PATH termination will go through a full eligibility determination by HSA during their annual redetermination. During 2014, renewals for those with term dates between January and May, 2014 were delayed in anticipation of the increased demand for HSA services due to Covered California open enrollment. DPH continues to track the status of SF PATH participants after their transition to understand their behavior in Medi-Cal Managed Care programs and to ensure that DPH continues to meet their health care needs after the transition.

# *III. FY2013-14 PROGRAM ACTIVITIES*

## A. COMMUNICATIONS, OUTREACH, APPLICATIONS AND ENROLLMENT

This section discusses HSF outreach, application, and enrollment trends.

### Communications and Outreach

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

HSF updated its website *(www.healthysanfrancisco.org*) with more user-friendly features in October 2013. The updated website features an enhanced user experience on an easily navigable site containing valuable Health Care Reform content. The HSF website continues to be an accessible and versatile program communications tool, attracting a total of 155,857 visitors during FY2013-14, despite a decrease in utilization with an average of 7,677 visits per month. Although the HSF website is available in English, Chinese and Spanish, the overwhelming majority of visits were to the English site (97.7%) followed by Chinese (1.44%) and Spanish (.86%). New visits comprised 67.9% of all visits. The new City Option website created separation from HSF, providing comprehensive information for the City Option on a separate site. The City Option is a program that was formed by San Francisco for employers to meet the Employer Spending Requirement portion of the Health Care Security Ordinance, if they do not elect to pay into HSF (discussed in Section III-G).

In addition to the website, the general public can also obtain information on HSF and SF PATH by calling the City and County of San Francisco's 3-1-1 System. Call volumes to 3-1-1 increased through December, rising from 329 in the first quarter to 467 in the second quarter, and falling to levels that were similar with the last quarter of the previous year, ending the year with 214 people calling during the last quarter of FY 2013-14. 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 program regularly posts health education materials on the HSF Facebook page (*http://www.facebook.com/HealthySF*).

In April 2014, the City and County of San Francisco certified Tagalog as a threshold language and all public-facing departments will provide all available materials in Tagalog. HSF will provide all communications in Tagalog to participants, including website, notices, applications, and other materials. This effort will be implemented within 18 months, beginning in July 2014.

### Applications

HSF enrollment begins with a trained Application Assistor, As of June 30, 2014, HSF had 165 Application Assistors who helped San Francisco residents apply for the program at 33 different enrollment sites throughout San Francisco. In FY2013-14, Application Assistors processed 39,792 applications through the web-based eligibility and enrollment system, One-e-App, a 35% decrease from FY2012-13. This decrease is due to Application Assistors using CalHEERS, the application system for new health care options,

including Medi-Cal and subsidized insurance through Covered California, to screen applicants for new health care options since open enrollment began on October 1, 2013. Since most HSF participants are eligible for these new options, and no longer eligible for HSF, they will not complete an application in One-e-App.

The HSF program continues to offer trainings for new Application Assistors and refresher trainings for new and current Application Assistors throughout the year, including a series of trainings for Community Behavioral Health Services (CBHS) and two refresher webinars covering the HSF Transition Period in FY2013-14 described in Section I.

In FY2013-14, applicants were determined to be eligible for HSF or SF PATH, preliminarily eligible for another public program, or ineligible for any program. Of the 39,792 applications processed, 96.4% of applicants were determined by One-e-App to be eligible for and submitted to a health program, 1.5% did not have an eligibility determination made or did not complete an application and about 1.5% were determined ineligible for any program. An eligibility determination may not be made if the application is still in process or if the application is cancelled before a final eligibility determination is made. Applicants are ineligible if they exceed the income eligibility threshold, are not within the eligibility age range, are enrolled in health insurance or are not San Francisco residents.

There were 47,105 unique applicants from the 39,792 applications processed, with an average of approximately 1.5 people applying per household.[2] A total of 38,947 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)**

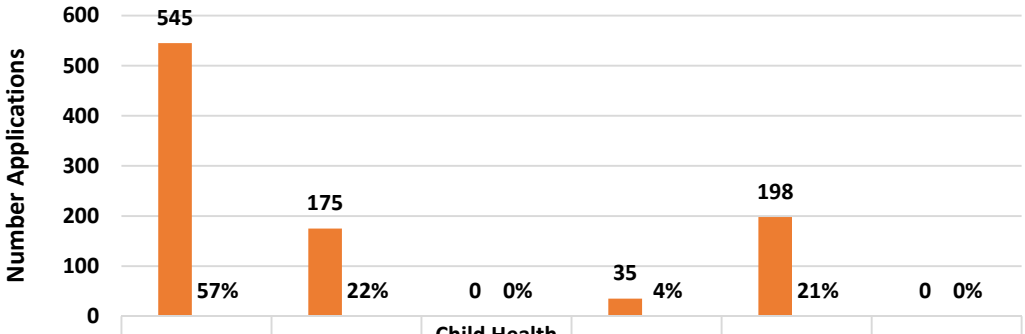
| One-e-App Applications by Type | % of Applications | # of Applications |
|---|---|---|
| New | 24% | 9,320 |
| Renewal | 35% | 13,706 |
| Modification | 41% | 15,917 |
| Other | 0% | 4 |
| **Total** | **100%** | **38,947** |

Of the 45,811 applicants who had an application submitted, 44,171 (96%) were applicants who were found eligible for either HSF or SF PATH. In addition, a total of 953 (2%) applicants were determined preliminarily eligible for other health programs (Figure A1). Of these applications, 79% 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

[2] 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.

into the appropriate program with the use of One-e-App. These do not represent applicants who were identified as eligible for Medi-Cal by Application Assistors using the CalHEERS system.

**Figure A1**
**Number of Applications Processed for Other Health Programs and Percentage of all Applicants (FY2013-14)**




| | Adult Medi-Cal, Full Scope | Adult Medi-Cal, Restricted | Child Health and Disability Prevention (CHDP) | Healthy Kids | Healthy Families | Medical for Children and Pregnant Woman |
|---|---|---|---|---|---|---|
| Count | 545 | 175 | 0 | 35 | 198 | 0 |
| Percent | 57% | 22% | 0% | 4% | 21% | 0% |

**Enrollments, Dis-enrollments and Percentage of Uninsured**

Since HSF is a voluntary program, some eligible uninsured adults may elect not to participate, even though HSF facilitates enrollment to the greatest extent possible and does not have any penalties for failure to enroll or dis-enroll. According to the 2008-2010 American Community Survey (ACS) 3-Year Estimates, there were an estimated 87,000 uninsured adults age 18 to 64 in San Francisco. According to the 2011-12 California Health Interview Survey (CHIS) released in August 2013, there were an estimated 69,000 uninsured adults age 18 to 64 in San Francisco[3]. However, the implementation of the Affordable Care Act (ACA) in January 1, 2014, should have reduced the number of uninsured.

At the end of FY2013-14, there were 45,482 participants enrolled in HSF, representing approximately 52% of the ACS's estimated uninsured adults age 18-64 residing in San Francisco. This is a 7% decrease in HSF's enrollment of the estimated uninsured compared to the end of FY2012-13 (51,158 participants).

[3] Prior to FY2012-13, the Department utilized the biennial (now continuous) California Health Interview Survey (CHIS) estimates produced by the 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 and 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.

**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% |
| 2011-12 | 46,822 | 64,000 | 73% |
| 2012-13 | 51,158 | 87,000 | 59% |
| 2013-14 | 45,482 | 87,000 | 52% |

There were 15,046 SF PATH enrollees at the termination of the program. An estimated 70% 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. |
|---|---|---|---|---|---|
| 2013-14 | 45,482 | 15,046 | 60,528 | 87,000 | 70% |

Enrollment fluctuates daily as new people enroll, existing participants renew eligibility and participants dis-enroll. At the end of FY2013-14, 91,109 HSF participants were dis-enrolled. Dis-enrollments can occur because participants no longer meet the HSF Program eligibility criteria, no longer choose to remain in the program and voluntarily dis-enroll, do not pay the quarterly participation fee and so forth. The number of participants currently dis-enrolled include individuals who transitioned into SF PATH. During FY2013-14, HSF administratively transitioned 2,926 eligible individuals into SF PATH, dis-enrolling them from HSF.

**Table A4**
**Unduplicated Count of Total Ever Enrolled by Fiscal Year**

| Fiscal Year | Currently Enrolled at end of FY | Currently Dis-enrolled at end of FY | Total Ever Enrolled at End of FY (Enrolled + Dis-enrolled) | Dis-enrollment Rate (%) |
|---|---|---|---|---|
| 2007-08 | 24,210 | 1,059 | 25,269 | 4% |
| 2012-13 | 51,158 | 79,850 | 131,008 | 61% |
| 2013-14 | 31,965 | 113,299 | 145,264 | 78% |

At the end of the FY2013-14, the HSF dis-enrollment rate was 78%. During FY2013-14, the dis-enrollment rate increased due to the administrative dis-enrollments of HSF participants who met SF PATH eligibility

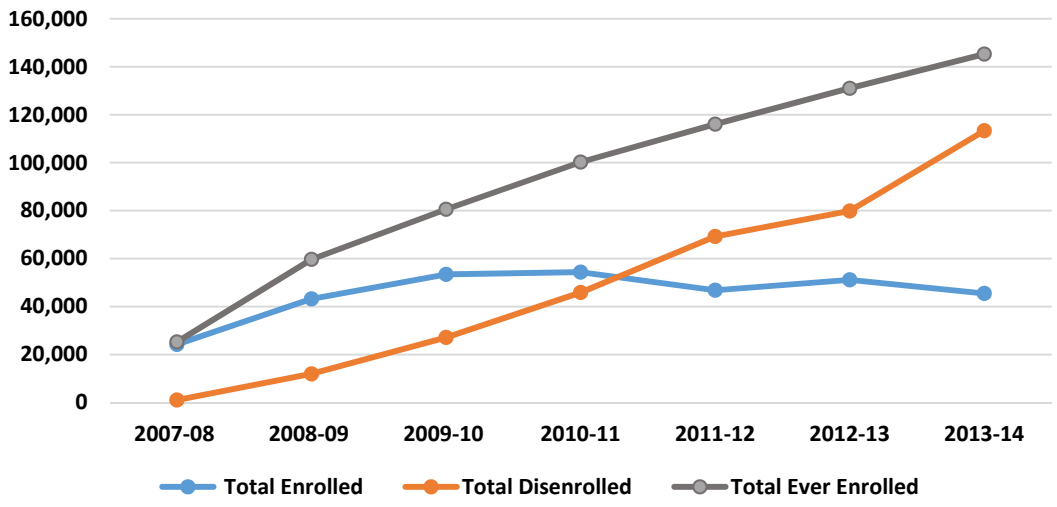
criteria, administrative dis-enrollment of HSF participants who were identified as active Medi-Cal enrollees and the transition of participants to new options under the ACA during open enrollment. Since the majority of HSF participants will be eligible for insurance options through the ACA, dis-enrollments are expected to increase as participants transition from HSF to available insurance programs.

**Table A5**
**HSF Dis-enrollment Rate**

| Total Ever Dis-enrolled | Less Re-enrolled | Equals Currently Dis-enrolled | Plus Currently Enrolled | Equals Ever Enrolled | Dis-enrollment Rate = (113,299 ÷ 145,264) |
|---|---|---|---|---|---|
| 118,602 | 5,303 | 113,299 | 51,158 | 145,264 | 78% |

As HSF participants increase over time, the number of dis-enrolled participants also increases. As more participants enroll, 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 or voluntarily dis-enroll. In addition, given that HSF is a voluntary program and individuals can re-enroll after a dis-enrollment without penalty, DPH expects that there will always be a certain level of enrollment mobility within the program. Figure A2 shows the enrollment, dis-enrollment and ever enrollment trends since HSF's inception.

**Figure A2**
**Enrollment, Dis-enrollment, and Ever Enrolled (FY2007-08 to FY2013-14)**



**Dis-enrollment Analysis**

DPH regularly monitors and analyzes participant dis-enrollments. By June 2014, 113,299 individuals were dis-enrolled from HSF for the following reasons:

**Table A6**

**Dis-enrollments By Reason**

| Current Dis-enrollments by Reason | Number | Percent |
|---|---|---|
| Transitioned to SF PATH Program | 11,328 | 10% |
| Program Eligibility | 28,904 | 26% |
| Participation Fee | 8,910 | 8% |
| Annual Renewal | 63,770 | 56% |
| Other/Voluntary | 387 | <0.1% |

*Dis-enrollments Due to Transition to SF PATH Program* (10% - 11,328 participants)

Ten (10%) of HSF participants transitioned into SF PATH in preparation for the Medi-Cal Expansion in January 2014 as a result of ACA implementation.

*Dis-enrollments Due to Program Eligibility* (26% - 28,904 participants)

Twenty-Six (26%) of those dis-enrolled no longer met the HSF eligibility requirements. Table A7 lists specific program eligibility dis-enrollment reasons. In FY2013-14, HSF identified and administratively dis-enrolled 3,178 participants who actively enrolled in Medi-Cal**.**

**Table A7**

**Program Eligibility Dis-enrollments**

| Dis-enrollment Reason | Number | Percent |
|---|---|---|
| Enrolled in Public Coverage (including Medi-Cal and PCIP) | 11,839 | 41% |
| Exceeds Program Age Requirements | 4,777 | 17% |
| Enrolled in Employer or Private Insurance | 4,607 | 16% |
| Determined Eligible for Other Programs During Renewal or Modification | 2,781 | 10% |
| Not a San Francisco Resident | 1,830 | 6% |
| Ineligible for City & County Program | 325 | 1% |

*Dis-enrollments Due to Participation Fee* (8% - 8,910 participants)

Dis-enrollments due to insufficient payment of the quarterly participation fee comprised 8% of all program dis-enrollments at the end of FY2013-14. These dis-enrollments indicated the following:

- Participant communicates that they could no longer afford the participation fee – 402 dis-enrollments
- Insufficient payment of the participation fee – 8,508 dis-enrollments

Dis-enrollments due to participation fees occur for reasons other than inability to pay and may mask other dis-enrollment reasons. For example, an HSF participant at or 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 dis-enrollment is erroneously coded as failure to pay the participant fee when the correct code should be dis-enrollment due to eligibility – receipt of health insurance.

DPH analyzed the utilization of services among those with a participation fee related dis-enrollment from the time period July 2007 to June 2014. Analysis on 4,996 (59% of 8,508) of these dis-enrolled individuals was based on the fact that the individual sought services from DPH after HSF dis-enrollment. These 4,996 individuals had a total of 87,646 clinical encounters after a HSF participation fee related dis-enrollment. Because there is no program penalty for re-enrollment after a dis-enrollment, the majority of encounters (67%) were either HSF (9%) or SF PATH (58%); that is, 48% of the people with HSF participation fee-related dis-enrollments eventually re-enrolled and received health care services under HSF or SF PATH. Twenty-three percent (23%) of the encounters were paid for by health insurance (public or private) or other payer sources after HSF dis-enrollment. This supports the notion that some dis-enrollments coded as "insufficient payment" are in actuality dis-enrollments due to obtaining health insurance.

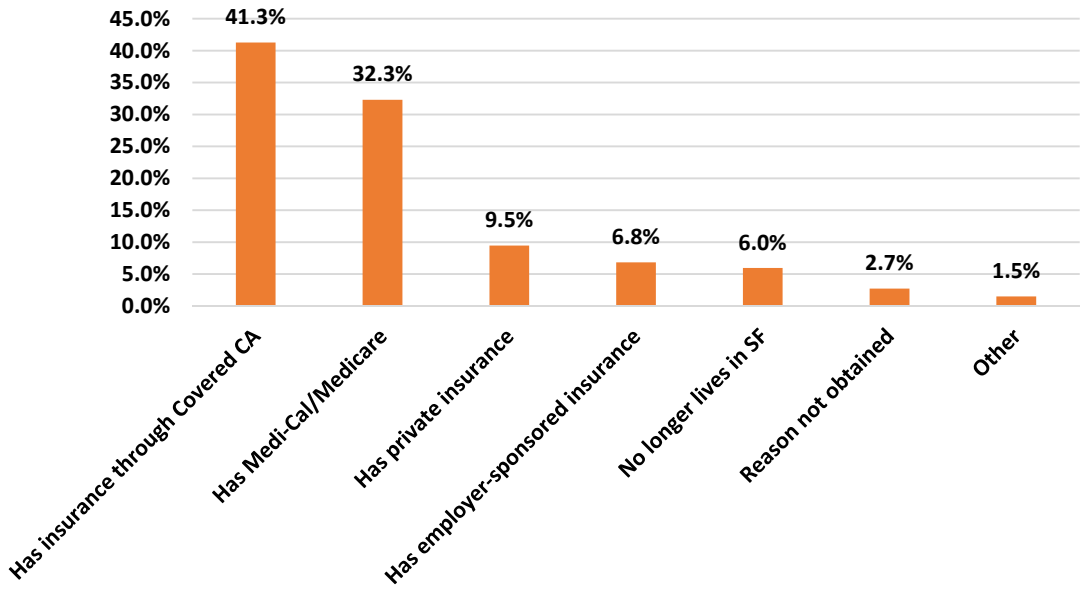
*Dis-enrollments Due to Incompletion of Annual Renewal* (56% - 63,770 participants)
HSF eligibility is for a 12-month period and the program requires participants to renew their eligibility in-person annually. If the renewal is not completed before the 12-month period expires, the participant is dis-enrolled from the program. HSF participants receive notices and telephone calls to remind them to renew before the end of their eligibility period.

Similar to FY2012-13, the majority of dis-enrollments in FY2013-14 were due to failure to complete annual renewal (56%). However, just as dis-enrollments due to failure to pay participation fees can mask different dis-enrollment reasons, the same holds true for dis-enrollments due to an incomplete annual renewal. DPH has implemented new program components to promote on-time renewal and to identify true dis-enrollment for participants who do not renew. During FY2013-14, the program discontinued the HSF renewal lottery program. HSF attempted to outreach to 25,251 participants who were approaching their enrollment termination date. The program's call center reached 11,063 (43.3%) of the participants on the call lists and left messages for 4,822 (34.8%) participants.

In FY2013-14, there was a dramatic increase in the number of participants indicating they did not want to renew their HSF coverage, primarily due to having enrolled in another insurance program. Of note, the top reason was due to coverage through Covered California.

**Figure A3**

**HSF Participant Non-Renewal Reasons FY2013-14**




The "Other" category includes the following reasons:

- Over age 64
- Cannot afford participation fee
- Dissatisfied with medical home
- Thinks they are not eligible due to income

This information is provided to One-e-App so that we can more accurately capture participant's dis-enrollment reasons.

*Dis-enrollments Due to Other or Voluntary Reasons* (<0.1% - 387 participants)

The remaining dis-enrollments are voluntary or involuntary due to dissatisfaction with the program, death, or false or misleading information provided on the program application. The majority of dis-enrollments due to other or voluntary reasons were due to program dissatisfaction (Table A8).

**Table A8**

**Dis-enrollments Due to Other Reasons**

| Dis-enrollment Reasons | Number | Percent |
|---|---|---|
| Program Dissatisfaction (administration, services, medical home, etc.) | 202 | 52% |
| Participant is Deceased | 82 | 21% |
| False or Misleading Information on HSF Application | 33 | 9% |
| Other | 70 | 18% |

**Re-enrollments**

HSF dis-enrolled individuals have the option to re-enroll at any time with no penalty or wait period, provided that they meet eligibility criteria. As of June 30, 2014, 5,303 dis-enrolled individuals re-enrolled into HSF and were current participants at the end of the FY2013-14. The data indicates that:

- The initial dis-enrollment reasons for the majority of re-enrollments were incomplete annual renewal (77%)
- Forty- three (43%) of those dis-enrolled for failure to renew re-enrolled within 60 days of the end of their original enrollment end date.
- Five (5.8%) of those dis-enrolled 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 FY2012-13, there has been a 48% 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 ACA implementation.

**Table A9**

**Re-Enrollments by Original Dis-enrollment Reasons (July 2007 – June 2014)***

| | **Total Re-enrollment** | | **Re-enroll in 0-30 Days** | **Re-enroll in 31-60 days** | **Re-enroll in 61-90 days** | **Re-enroll in 91-180 days** | **Re-enroll in 181-365 days** | **Re-enroll After 365 days** | **Total Percent** |
|---|---|---|---|---|---|---|---|---|---|
| **Type** | # Individuals | % of Total Re-enroll-ment | % of Dis-enroll Group Total | % of Dis-enroll Group Total | % of Dis-enroll Group Total | % of Dis-enroll Group Total | % of Dis-enroll Group Total | % of Dis-enroll Group Total | % of Dis-enroll Group Total |
| **Program Eligibility** | 310 | 5.8% | 7.4% | 3.7% | 1.4% | 3.9% | 15.2% | 68.3% | 100.0% |
| **Participation Fee Related** | 883 | 16.7% | 15.1% | 13.2% | 8.4% | 16.8% | 17.1% | 29.4% | 100.0% |
| **Incomplete Renewal** | 4101 | 77.3% | 28.7% | 13.9% | 7.0% | 11.3% | 12.2% | 26.9% | 100.0% |
| **Other** | 9 | 0.2% | 5.6% | 11.1% | 0.0% | 5.6% | 33.3% | 44.4% | 100.0% |
| **Total** | **5,303** | **100.0%** | **24.6%** | **12.7%** | **6.6%** | **11.2%** | **13.2%** | **31.8%** | **100.0%** |

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

**Churn (Multiple Enrollments and Dis-enrollments)**

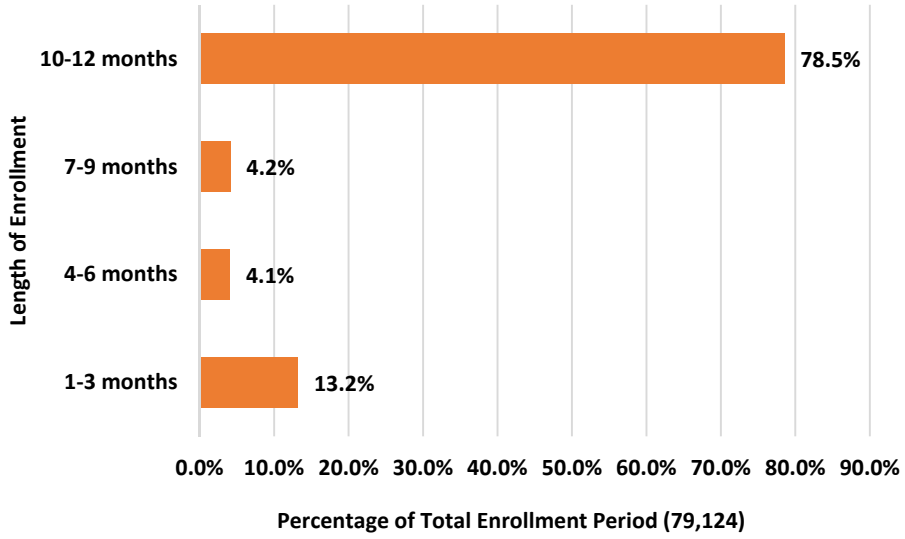
In an effort to determine the impact of the program's eligibility and enrollment provisions on participant retention, DPH examines the frequency of multiple enrollments and dis-enrollments by program participants (known as "churn" for the purposes of this report). DPH defines churn as a program participant with two or more dis-enrollments. Specifically, a participant has enrolled in the program at least twice and has been dis-enrolled from the program at least twice. Since the program's inception in July 2007 and up to June 30, 2014, 47,239 individuals have had at least two dis-enrollments, a 36% increase from June 2013. The program has witnessed an increase in participants with multiple dis-enrollments, which reflects the increased enrollment over time.

**Table A10**
**Enrollment Status of Individuals with Multiple Enrollments and Dis-enrollments**
**(FY2010-11 to FY2013-14)**

| | As of June 30, 2011 | | As of June 30, 2012 | | As of June 30, 2013 | | As of June 30, 2014 | |
|---|---|---|---|---|---|---|---|---|
| | **Number** | **Percent** | **Number** | **Percent** | **Number** | **Percent** | **Number** | **Percent** |
| **Currently Enrolled** | 2,388 | 27% | 4,258 | 25% | 9,251 | 27% | 5,916 | 13% |
| **Currently Dis-enrolled** | 6,380 | 73% | 13,082 | 75% | 25,530 | 73% | 41,323 | 88% |
| **Total** | **8,768** | **100%** | **17,340** | **100%** | **34,781** | **100%** | **47,239** | **100%** |

By virtue of churning through the program, these individuals will all have more than one enrollment period. For instance, an individual with two dis-enrollments will have two enrollment periods. A high-level enrollment analysis was conducted on the 47,239 individuals and found that, collectively, there were 111,946 enrollment periods, namely, the period of time between an enrollment and dis-enrollment. The data further indicated that most of individuals with multiple enrollments (78.5%) had enrollment periods lasting from 10 to 12 months. As a result, those with multiple dis-enrollments are generally not short-term participants.

**Figure A4**
**Length of Enrollment Periods of Individuals with Two or More Dis-enrollments**
**(Currently Enrolled and Dis-enrolled Participants)**




Churn analysis on 34,781 participants with multiple dis-enrollments revealed the following distribution:

- 33,715 (71%) had two dis-enrollments,
- 10,265 (22%) had three dis-enrollments,
- 2,676 (6%) had four dis-enrollments,
- 495 (1%) had five dis-enrollments,
- 88 (<1%) had six or more dis-enrollments,

The analysis below examines those who had two dis-enrollments (77% of the churn population). Dis-enrollments are grouped by dis-enrollment type. The data indicates that the majority of HSF participants with two dis-enrollments were dis-enrolled for two instances of failure to renew, two instances of program eligibility, or one instance of failure to review and one instance of program eligibility (70% total). Ten (10%) were in instances in which one of the dis-enrollments was related to the participation fee and 4% were cases in which both of the dis-enrollments related to the participation fee.

**Table A11**
**Churn Analysis of Multiple Dis-enrollments -- Those with Two Dis-enrollments (July 2007 – June 2014)**

| ***Dis-enrollment Reasons*** | ***Number*** | ***Percentage*** |
|---|---|---|
| Two Failure to Complete Renewals | 17,760 | 53% |
| One Failure to Complete Renewal and One Program Eligibility | 5,538 | 17% |
| One Failure to Complete Renewal and One Participation Fee | 2,684 | 8% |
| One Participation Fee and One Program Eligibility | 770 | 2% |
| Two Participation Fees | 1,328 | 4% |
| Two Program Eligibility | 5,245 | 16% |
| Two Other Dis-enrollments or One Dis-enrollment Coded Other & One Dis-enrollment Coded Another Reason | 350 | 1% |

## B. PARTICIPANT DEMOGRAPHICS

This section provides an overview of uninsured adult residents enrolling in HSF.

### Demographic Characteristics

Figure B1 below compares the demographic characteristics of the HSF population at the end of FY2012-13 to demographics at the end of FY2013-14. Previously, HSF participant demographics had been relatively stable. However, FY2013-14 had some changes in the demographics of HSF participants, which could be attributed to people acquiring new health insurance under the ACA and dis-enrolling from HSF. Compared to the end of FY2012-13, the end of FY2013-14 saw a slight increase in the proportion of participants who are between the ages of 25 and 44, and this age group now makes up more than half of the HSF population. The percentage of participants age 55 to 64 decreased from 27% to 19%. Latinos now make up almost half of the HSF population, previously representing just one quarter one year ago.

The percentage of Asian or Pacific Islander (PI) participants decreased by 18%. In addition, the percentage of Cantonese or Mandarin-speaking participants decreased by almost half, while the percentage of Spanish-speaking participants nearly doubled. The decrease in the Asian population is consistent with the efforts of the Chinese Community Health Care Association (CCHCA) and North East Medical Services (NEMS) medical homes. These two organizations were very active in determining the eligibility of patients for other coverage programs and have a high Asian patient population (at the end of FY2013-14, 98% and 92%, respectively, reported their race as Asian). During Covered California's first open enrollment, officials noted that Latino enrollment in health insurance was lagging, so as continued education and outreach reaches individuals, the demographic characteristics of the HSF population may further change. The male to female ratio has consistently been nearly equal. In June 2014, 156 participants reported being transgender.

**Figure B1**
**Demographic Comparison of HSF Participants, End of FY2012-13 and FY2013-14***

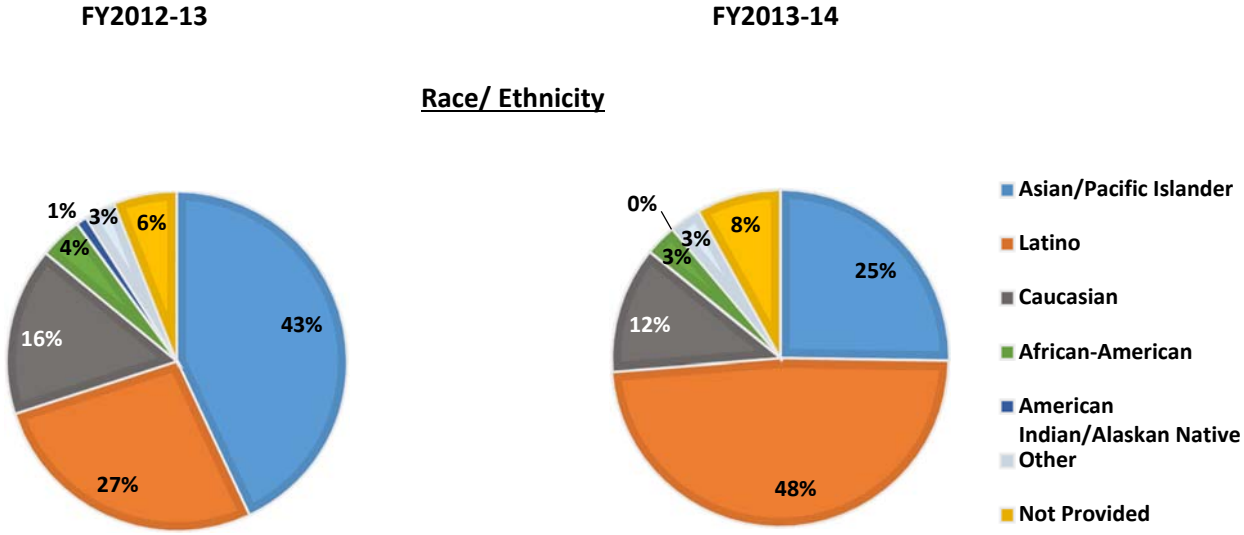
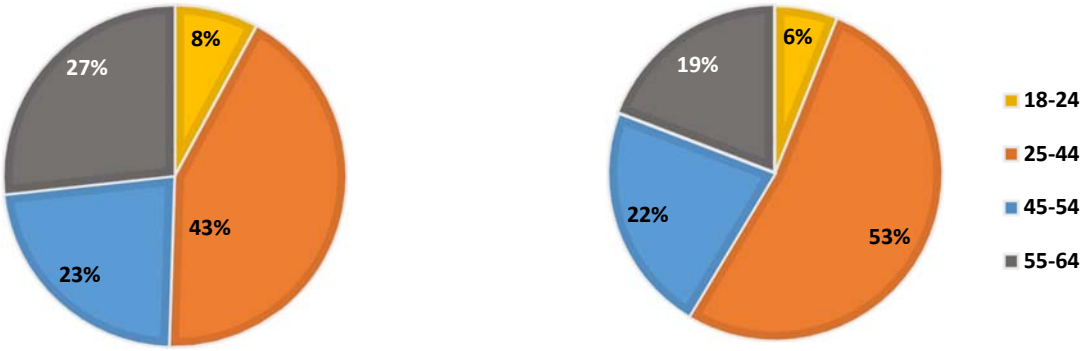


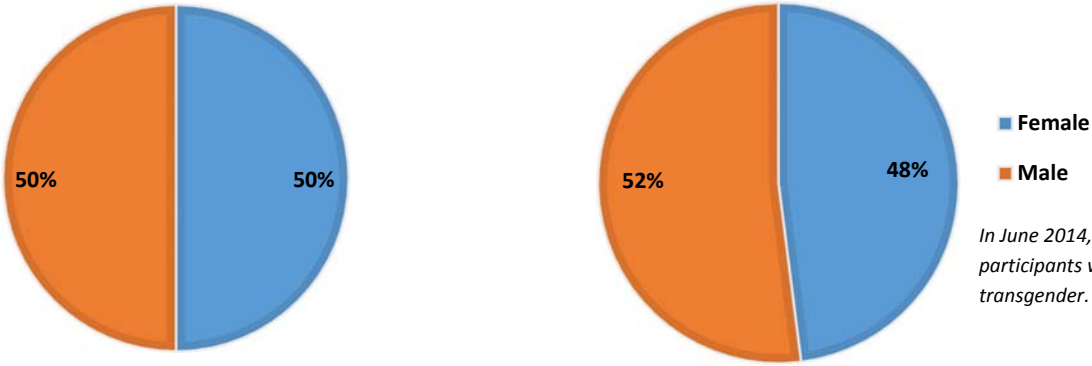
**Figure B1 (cont.)**

**FY2012-13** **FY2013-14**

## Age




## Gender




*In June 2014, there were 156 participants who indicated being transgender.*

## Income

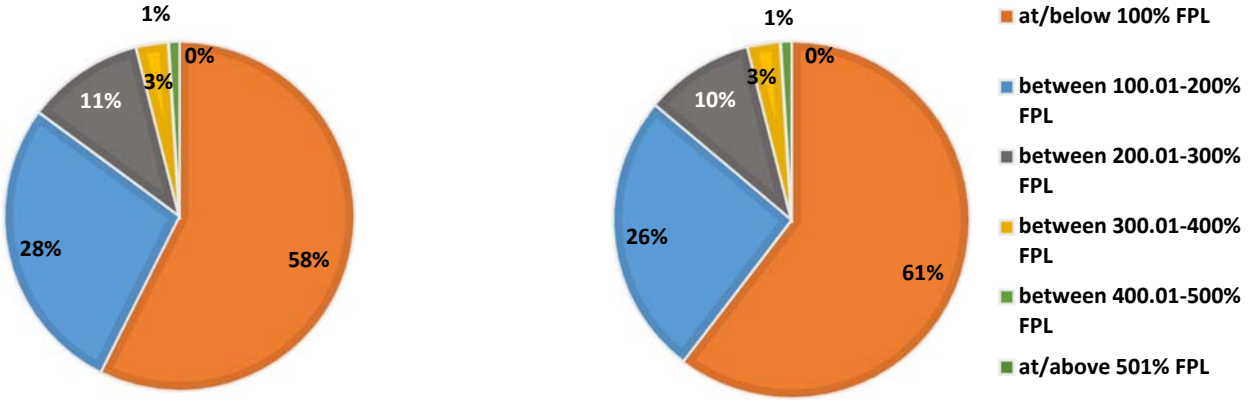
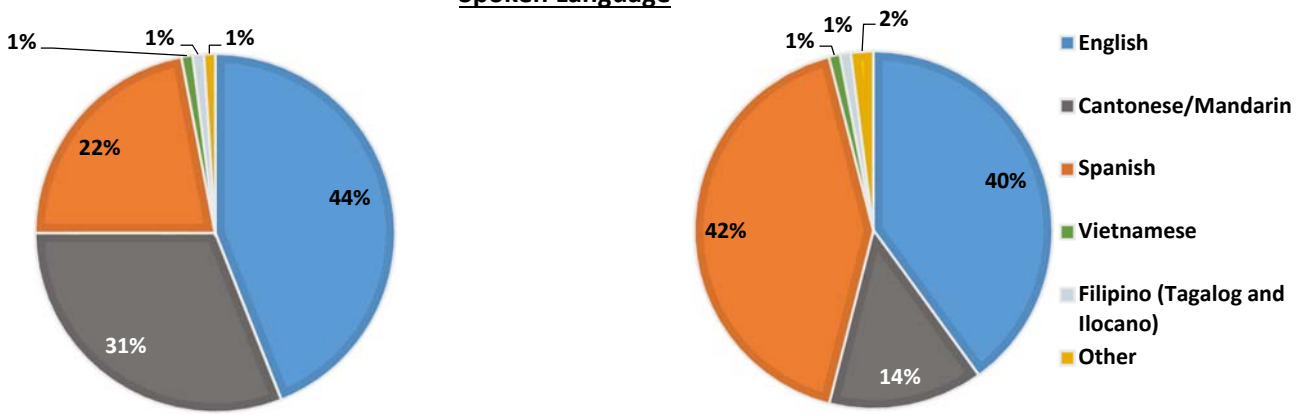


**Figure B1 (cont.)**

**FY2012-13** **FY2013-14**

**Spoken Language**




**Note that the sum of percentage per chart may not equal exactly to 100% due to rounding.*

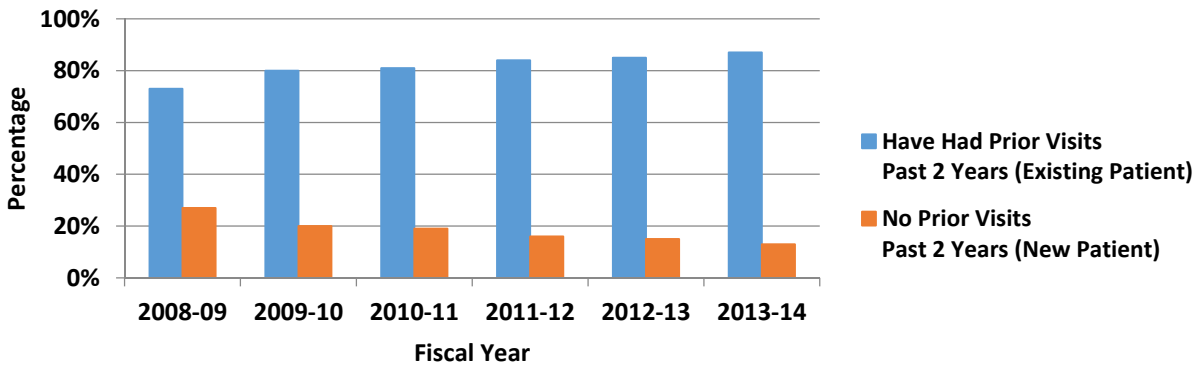
In compliance with the City and County Refuge Ordinance (also known as the Sanctuary City Ordinance), the DPH does not collect demographic information on an applicant's immigration status, employment status, or pre-existing medical conditions. This is consistent with the San Francisco Health Care Security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

**HSF Population – New versus Existing**

At the end of FY2013-14, 85% of HSF enrollees were existing patients and 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 who 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 obtain health insurance coverage through ACA. Figure B2 illustrates the gradual decline of "new" participants in the HSF Program.

**Figure B2**

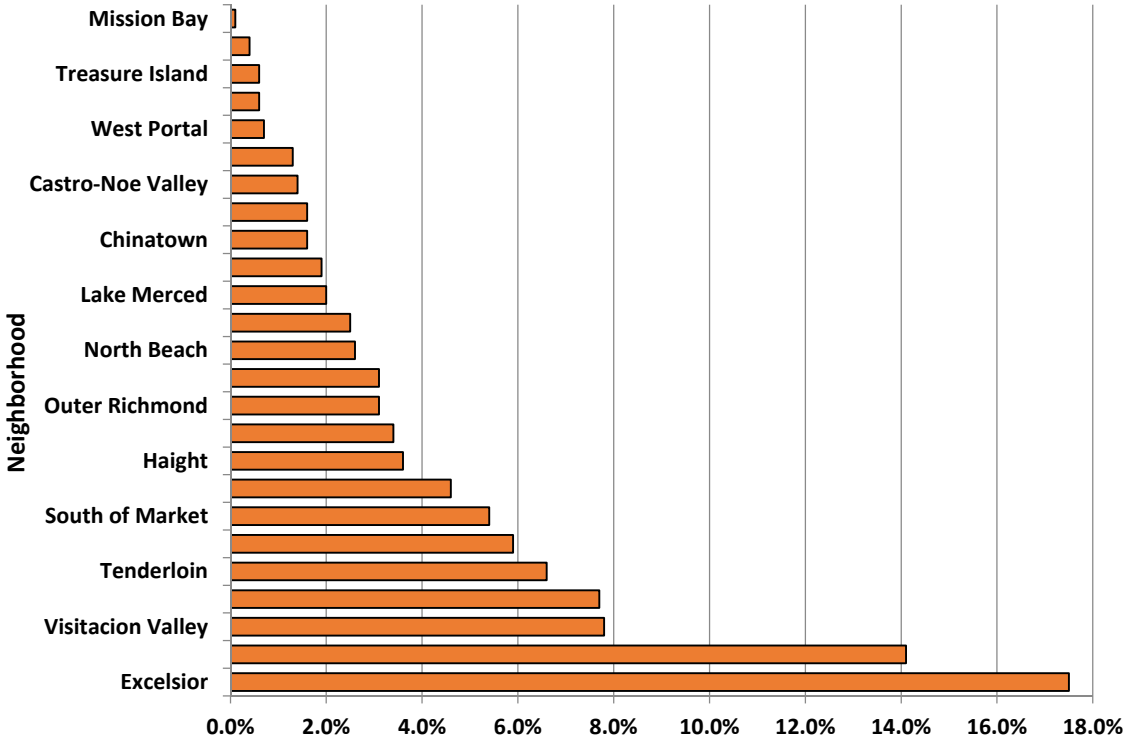
**New vs. Existing Participation in Healthy San Francisco**



**Neighborhood Distribution**

At the end of FY2013-14, 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's address when applying for HSF.

**Figure B3**
**Healthy San Francisco Participants by Neighborhood**



## C. PROVIDER NETWORK (DELIVERY SYSTEM)

This section describes HSF's delivery system including medical homes, hospitals and behavioral health services.

### Medical Home Expansions and Capacity

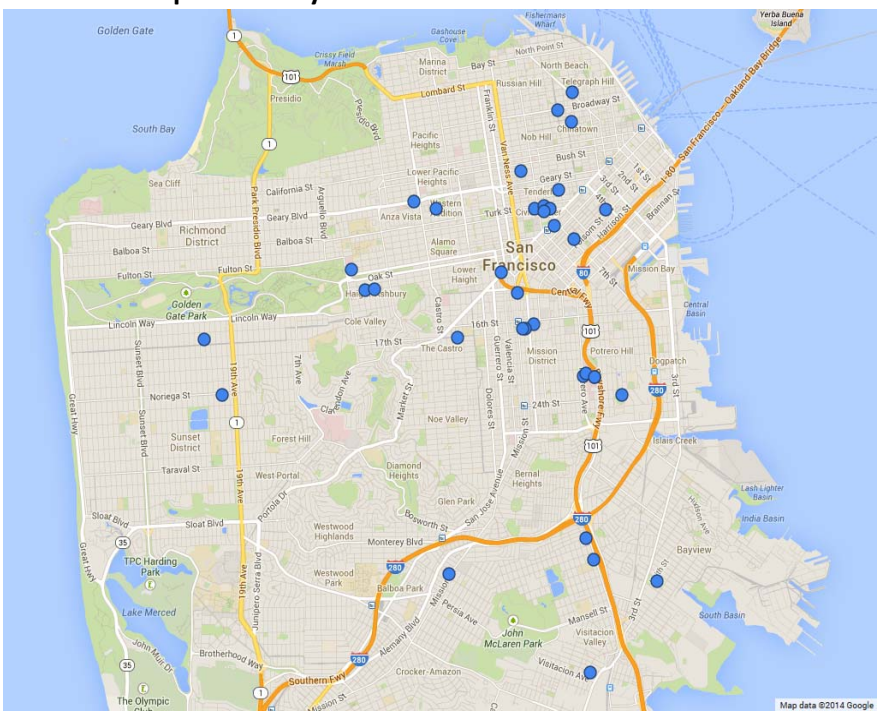
HSF ended FY2013-14 with 36 medical homes, one fewer than FY2012-13. On July 9, 2013, Tom Waddell Health Center and Housing & Urban Health Center merged to form the Tom Waddell Urban Health Clinic. Tom Waddell Health Center's old site became the Tom Waddell Urgent Care Center.

To ensure sufficient capacity to serve both new and existing HSF participants, HSF tracks each medical home's capacity twice a month, as "open" or "closed" status. HSF medical home capacity is determined by factors including appointment availability and total number of patients (from all payer sources including Medi-Cal, Healthy Kids, Healthy Workers, sliding scale, and self-pay) seen at each medical home. As of July 1, 2014, 18 HSF medical homes were open to new and existing patients.

### Medical Home Distribution

At the time of enrollment, HSF participants select a medical home where they will receive all of their primary care and preventive care services. The medical home also coordinates a participant's access to specialty, inpatient, pharmacy, ancillary, and behavioral health services and assists a participant in navigating through the health care delivery system. Figure C1 below illustrates the distribution of HSF medical homes throughout San Francisco using Google Maps.

**Figure C1**
**Map of Healthy San Francisco Medical Homes***



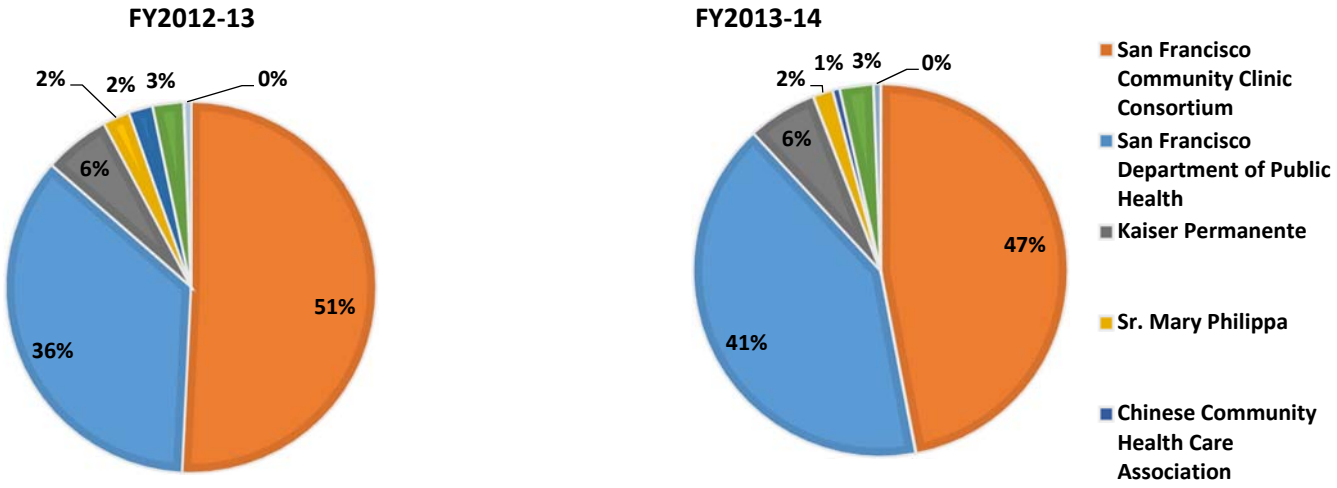

**Brown & Toland Physicians – CPMC is not on this map; actual physician locations for this medical home vary.*

There were seven delivery systems at the end of FY2013-14:

- BAART Community HealthCare
- Brown & Toland Physicians – California Pacific Medical Center (CPMC)
- Chinese Community Health Care Association (CCHCA) – Chinese Hospital
- Department of Public Health (DPH)
- 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 serve HSF patients is a collaborative achievement for the City and County of San Francisco, reinforcing the mission of providing coordinated health care to all San Francisco residents. The variety of possible medical homes provides HSF participants with the autonomy to select a medical home that best fits their needs. At the end of FY2013-14, almost half of HSF participants had a medical home that was part of the SFCCC, and the next most popular medical home system was DPH. Compared to the last fiscal year, there has been a slight increase in the proportion of HSF participants with a DPH medical home, and a slight decrease in the proportion of HSF participants with a SFCCC medical home. Despite declines in overall enrollment, there was little change in the proportions for the remaining medical homes (Figure C2).

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




** Note that the sum of percentages per chart may not equal exactly to 100% due to rounding.*

**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 DPH medical home. In addition, SFGH provides all or some of these 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 (NEMS) (SFCCC-affiliated)
- Remaining SFCCC-affiliated clinics

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

- CPMC (four campuses) – inpatient services to those with NEMS as their HSF medical home and 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 their HSF medical home
- Saint Francis Memorial Hospital (Dignity Health) –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 to which all hospitals (public, non-profit or for-profit) must adhere. In the case of emergency services, HSF participants will receive services at the nearest available hospital with clinical capacity, which 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, DPH's Community Behavioral Health Services (CBHS) provides all contracted behavioral health services for HSF participants at all medical homes, especially mental health and alcohol and drug abuse care. HSF participants have access to the comprehensive array of community-based services offered by DPH's CBHS including, but not limited to:

- Information and referral services
- Prevention services
- 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
- 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 an HSF participant needs access to behavioral health services that are not provided at their HSF medical home, 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 AND SERVICES UTILIZATION

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

HSF analyzed clinical services data in areas related to the use of primary care services, quality of care and effectiveness of care. As DPH has noted in the past, analysis of service utilization is dependent upon completeness of data from all HSF providers – hospitals and medical homes. For this report, 52% of the hospital data came from San Francisco General Hospital (SFGH) and 48% came from non-SFGH hospitals and clinics. While all non-profit hospitals provided clinical data for HSF participants, DPH believes that this data may be incomplete due to variation of reporting mechanisms of each organization and known gaps in receiving encounter data. In addition, services such as office visits are reported on a calendar year basis and not a program year basis. Therefore, emergency department visits, inpatient admissions, and hospital days are likely underreported for FY2013-14. For FY2012-13, 49% of the hospital data came from San Francisco General Hospital (SFGH). The variation of hospital data reporting from non-profit hospitals makes it difficult to analyze year-to-year comparisons of certain medical services utilization. Appendix A contains a description of the HSF data warehouse and data source submission. Utilization rates may have changed as more HSF participants became eligible for expanded Medi-Cal and ineligible for the HSF Program. From January 2013 through December 2013, HSF made substantial efforts to prepare participants for the transition to full health insurance through the ACA) implementation. Section I on Health Care Reform offers details on participants' transition to health insurance.

When possible, the data in this summary contains a comparison between HSF's first stable reporting year (FY2009-10) and this fiscal year. As program eligibility policies change to align with Health Care Reform, the remaining HSF population will vary in demographics and medical needs from that of previous years.

**Key Utilization Summary**

The following data indicates the percentage of participants who were continuously enrolled in HSF from July 2011 to March 2014 and utilized at least one service for each service type. This data reflects the most recent calendar year with complete data available.

**Table D1**
**Summary of Utilization Data – Percentage of Participants Utilizing at Least One Service**
**(January 2013- December 2013)**

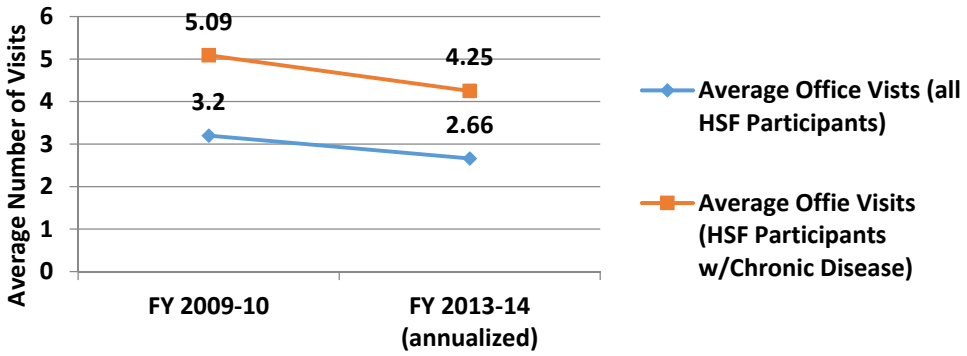
| Service | Percent |
|---|---|
| Primary / Specialty Care | 71.59% |
| Inpatient Admission | 0.95% |
| Prescription | 48.26% |

**Preventive and Primary Care Services**

HSF participants' average office visits decreased slightly in FY2013-14 to 2.66 per participant per year, which is slightly below the National Medicaid Average of three 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 (4.25) is slightly lower than the U.S. rate, which averages five visits per year for patients with chronic conditions *(Division of Health Care Statistics, U.S. Department of Health and Human Services, 2009)*.

**Figure D1**

**Average Office Visits (Including Well Visits) Per Participant (All Participants)**




Preventive services utilization 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 following table displays information contained in the graph above by medical home system. Historically, most medical homes, with the exception of BAART and DPH, experience relatively small changes in the average number of office visits for their HSF population.

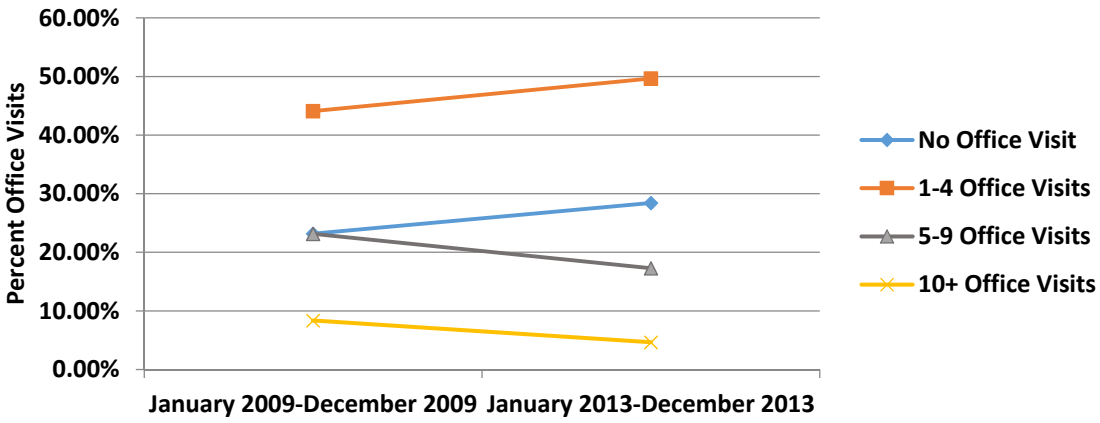
**Table D2**
**Average Office Visit Utilization by Delivery System**

| Medical Home System | July 2009 - June 2010 | July 2013 - Mar 2014 |
|---|---|---|
| BAART | 9.00 | 1.49 |
| Brown & Toland | N/A | 2.60 |
| CCHCA | 4.20 | 3.91 |
| DPH | 3.57 | 2.79 |
| Kaiser | 1.86 | 2.60 |
| SFCCC | 2.78 | 2.52 |
| SMP | 3.98 | 3.26 |
| **Total** | **3.20** | **2.66** |

*CCHCA = Chinese Community Health Care Association*
*DPH = Department of Public Health*
*SFCCC = San Francisco Community Clinic Consortium*
*SMP = Sister Mary Philippa*

Almost 28.42% of HSF participants did not have an office visit after 12 months of continuous enrollment. This has increased over the past four calendar years. During this same time, there was a slight decrease in the percentage of participants with five or more office visits per year, a decrease in the percentage of participants with 10 or more visits, and an increase in the number with one to four visits per year. The figure below demonstrates the changes in office visit frequency from 2009 and 2013.

**Figure D2**
**Office Visit Frequency (Including Well Visits)**



DPH cannot reliably use HSF data to analyze the utilization of some preventive services, due to HSF's position as a payer of last resort. Since participants are required to apply to any available public programs, low-income women may be able to obtain mammograms and pap smears through State programs such as the Every Woman Counts and the State Family Planning Program, and this data is not available for analysis. Therefore, although encounter data indicates that only 19.24% of women received mammograms and 18.84% of women received cervical cancer screening, it is highly likely that the actual screening rate is much higher.

In FY2013-14, HSF met the national Medicaid average for colorectal cancer screening among women at 54.30%. The colorectal cancer screening rate for men in HSF was 45.72%, below the national target of 54.5%. However colorectal screening for men has increased in the past year. The first quarter rate was 57% and it has steadily increased each quarter. In the program's fourth quarter, the rate was 64%, which is above the national average. The data is cumulative from July 2011 to March 2014 and the lower overall rate may reflect lower rates at the beginning of the reporting period. Improving colorectal cancer screening rates is a priority of the Strength in Numbers Program (discussed in Section III-E).

**Table D3**

**Percentage of Women's Health Preventive Screening (July 2011 – March 2014)**

| Women's Preventive Screening | Participants Received Screening | Eligible Participants | Percentage | National Medicaid Average |
|---|---|---|---|---|
| Cervical Cancer | 5,124 | 27,200 | 18.84% | 64.80% |
| Colorectal Cancer | 6,107 | 11,247 | 54.30% | 54.50% |
| Mammogram | 3,333 | 17,321 | 19.24% | 50.00% |

**Table D4**

**Percentage of Men's Preventive Screening for Colorectal Cancer (July 2011 – March 2014)**

| Men's Preventive Screening | Participants Received Screening | Eligible Participants | Percentage | National Medicaid Average |
|---|---|---|---|---|
| Colorectal Cancer | 4,975 | 10,881 | 45.72% | 54.50% |

**Appropriate Utilization**

*Emergency Department*

Since FY 2009-2010, emergency department (ED) utilization has decreased for overall HSF participants and for participants with DPH clinics as their medical homes. DPH participants' ED utilization from July 2013 to March 2014 was 157.11 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*). The FY2009-10 rate was 217.56 ED visits per 1,000. The FY2013-14 ED visit per 1,000 rate is 28% lower than FY2009-10. For the HSF Program as a whole, the rate decreased from 166.91 ED visits per 1,000 in FY 2009-10 to 153.52 ED visits per 1,000 in FY2013-14 representing an 8% decrease.

**Table D5**

**HSF Participants ED Visits Per 1,000 Participants Per Year**

| Data Period | ED Visits | Participant Months | ED Visits/1,000 |
|---|---|---|---|
| **DPH Only** | | | |
| July 2009-June 2010 | 5,602 | 308,993 | 217.56 |
| July 2013-March 2014 | 1,835 | 140,154 | 157.11 |
| **Total HSF Total Program** | | | |
| July 2009 – June 2010 | 8,628 | 620,320 | 166.91 |
| July 2013 – March 2014 | 5,517 | 431,231 | 153.52 |

Ninety-one (91%) of HSF participants had no emergency department visit in calendar year 2013.[4]

Overall, HSF participants with chronic conditions utilized the ED more frequently than those without chronic conditions (251.91 visits per 1,000 participants compared to 82.67 visits per 1,000 participants). Consistent with previous years, the top diagnostic categories for outpatient ED visits were: (1) respiratory symptoms, (2) abdominal symptoms, (3) general symptoms, (4) cellulitis and abscess, and (5) symptoms of the head and neck. The distribution of ED visit frequency is similar in 2009 compared with 2013 (see Table D6 below).

**Table D6**

**All HSF Participants ED Visit Frequency**

| ED Visit | January 2009 – December 2009 Percent | January 2013- December 2013 Percent |
|---|---|---|
| No ER Visit | 89.83% | 91.17% |
| 1-4 ER Visits | 9.80% | 8.56% |
| 5-9 ER Visits | 0.28% | 0.20% |
| 10+ ER Visits | 0.09% | 0.07% |
| **Total** | **100%** | **100%** |

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

During calendar year 2013, 262 HSF participants had three or more ED visits. The top five outpatient diagnoses for participants with three or more ED visits were: (1) general symptoms, (2) abdominal and pelvic symptoms, (3) respiratory symptoms, (4) non-dependent abuse of drugs, and (5) alcohol-induced medical disorders. A review of demographic data reveals that the following have a higher incidence of frequent ED utilization:

- Homeless (10.32%) rather than housed (0.79%)
- Men (1.06%) compared to women (0.59%)
- American Indian (25%), Laotian (14.29%), American Indian (4.08%), Black (3.63); the high rate of American Indians' ED utilization may be explained by the low number of American Indian HSF participants (n=8) continuously enrolled
- Participants with a chronic disease (1.40%) relative to those without a chronic disease (0.30%)
- Participants aged 45 – 54 (1.07%) and 25-44 (.93%) compared to all age groups (1.1%)

*Avoidable Emergency Department Visit Frequency*

From July 2013 to March 2014, the avoidable ED visit rate for HSF was approximately 8.99%, using conditions defined by the "Medi-Cal Managed Care ER Collaborative Avoidable Emergency Room (AED) Conditions." This rate is below the rate for all participants in the San Francisco Health Plan (18.2%), which serves a large portion of San Francisco's Medi-Cal adults. The AED saw a steady decrease from FY2008-09 (9.31%) through FY2012-13 (6.78%), but saw an increase in FY 2013-14 (8.99%). During calendar year 2013, 99% of participants did not access ED care for avoidable conditions. This has been consistent over the past four years.

**Table D7**
**Average Avoidable ED (AED) Rate**

| Data Period | AED Rate |
|---|---|
| July 2009-June 2010 | 8.00% |
| July 2013-March 2014 | 8.99% |

**Table D8**
**Avoidable ED (AED) Visit Frequency**

| AED Visit | Jan. 2009 – Dec. 2009 Percent | Jan. 2013 – Dec. 2013 Percent |
|---|---|---|
| No AED Visits | 98.61% | 99.08% |

*Hospitalization*

Lack of reporting from non-profit hospitals can result in under-representation of true admission rates. Since the Program's inception, the rate of acute admits has decreased steadily, in particular for those with a DPH medical home, as evidenced by the comparison of admission rates between DPH and all clinics in FY2009-10 and FY2013-14. In FY2013-14, the acute admission rate for DPH clinics was 12.50 admits per 1,000, compared to the rate for all clinics, 13.30 admits per 1,000. From FY2009-2010 to FY2013-14, the

admit rate per 1,000 for DPH participants decreased by over 68%, while the rate decreased by 54% for the entire program.

**Table D9**
**Acute Hospital Admits Per 1,000 HSF Participants Per Year**

| Data Periods | Admits | Acute Admits/1,000 |
|---|---|---|
| **DPH Only** | | |
| July 2009-June 2010 | 1,003 | 38.95 |
| July 2013-March 2014 | 146 | 12.50 |
| **Total HSF Program** | | |
| July 2009 – June 2010 | 1,492 | 28.86 |
| July 2013 – March 2014 | 478 | 13.30 |

*Behavioral Health*

Mental health and substance abuse service utilization increased for participants with and without a chronic disease in FY2013-14. Substance abuse utilization was higher than mental health utilization. In this analysis, data after March 2014 is likely to be incomplete due to claims lag and was therefore excluded.

**Table D10**
**Average Mental Health Visits Per Participant (CBHS and Encounter Data)**

| | Data Periods | Mental Health Visits | Average Visits |
|---|---|---|---|
| **With Chronic Disease** | July 2009-June 2010 | 16,211 | 0.90 |
| | July 2013-March 2014 | 30,914 | 2.05 |
| **Without Chronic Disease** | July 2009-June 2010 | 39,960 | 1.18 |
| | July 2013-March 2014 | 10,731 | 0.52 |

**Table D11**
**Average Substance Abuse Visits Per Participant (CBHS and Encounter Data)**

| | Data Periods | Substance Abuse Visits | Average Visits |
|---|---|---|---|
| **With Chronic Disease** | July 2009-June 2010 | 5,197 | 0.29 |
| | July 2013-March 2014 | 60,084 | 4.38 |
| **Without Chronic Disease** | July 2009-June 2010 | 10,433 | 0.31 |
| | July 2013-March 2014 | 26,559 | 1.27 |

**Quality of Care**

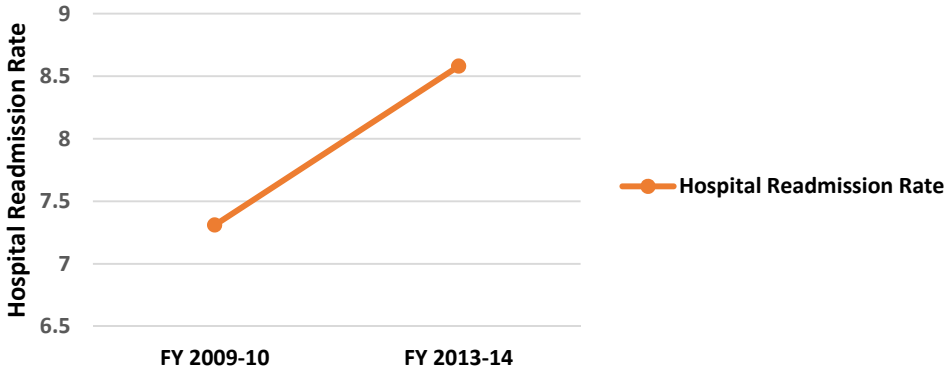
Analyzing hospital readmissions and diabetes testing rates helps measure quality of care for HSF participants.

*Hospital Readmissions*

Readmission data is a good quality of care indicator. HSF's 30-day readmission rate of 8.58% is 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 FY2013-14 does not represent the full fiscal year, but the HSF rate is still much lower than the Medi-Cal 30-day readmission rate.

**Figure D3**

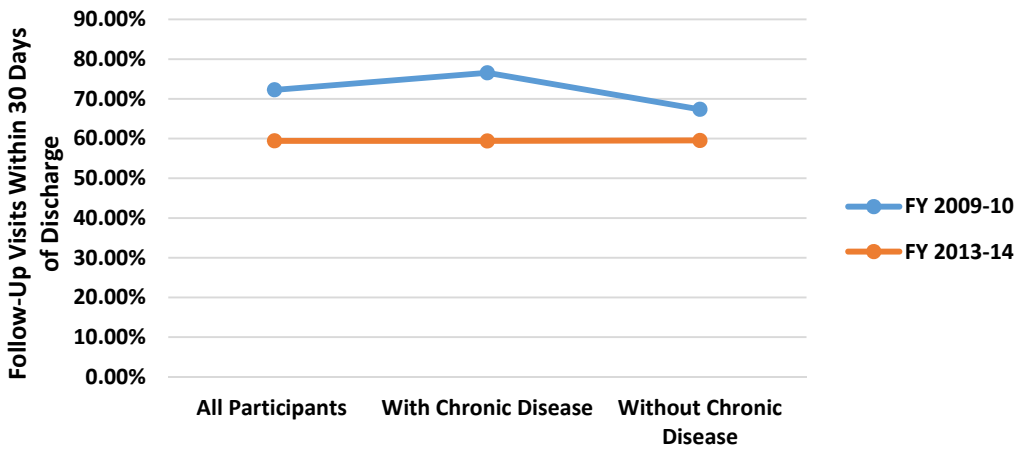
**30-Day Hospital Readmission Rate for HSF Participants**




Data also indicates that follow-up office visits within 30 days of discharge decreased to about 59.41% for all participants. For those with chronic disease, the rate decreased to 59.39% and for those without chronic disease the rate decreased to 59.52%. However, it is important to note that this data does not represent the full FY2013-14. By comparison, the Center for Medicare and Medicaid Services (CMS) 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 D4**

**Percentage of Participants with Follow-Up Office Visits within 30 Days of Discharge**



*HEDIS Measures*

DPH monitors the quality of care for all HSF participants, particularly those with chronic disease. HSF uses indicators 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 2013 indicates that the percentage of participants with diabetes receiving HbA1c tests is almost 67.61%, which is lower than the national Medicaid average of 83%. The percent of diabetics getting LDL (cholesterol) testing is 55.75%, lower than the National Medicaid Average at 76%. HSF is engaged in active programs to encourage better diabetes management as described in Section III-E.

**Table D12**
**Percentage of Participants Receiving Tests Compared to Medicaid**
**(January 2013 – December 2013)**

| Measure | HSF Percentage | National Medicaid Average |
|---|---|---|
| Diabetic Care Test - HbA1c | 67.61% | 83.0% |
| Diabetic Care Test - LDL | 55.75% | 75.5% |

**Out-of-Network Utilization**

HSF's health care delivery model is based on the premise that participants receive care through the network of providers affiliated with the medical home they have selected. HSF requires applicants to select a medical home when they enroll in HSF. This ensures that the participant has a usual source of care, minimizing episodic care. Out-of-network is defined as utilizing services at a facility that is not part of the participant's network, including a hospital not affiliated with the participant's medical home. Since HSF does not provide out-of-network coverage, facilities may not report a HSF participant visit to the program, especially facilities outside of San Francisco. Therefore, the reported utilization will be an under-reporting of true out-of-network utilization by HSF participants.

From July 2011 to March 2014, a total of 5,632 ED visits, including inpatient ED to inpatient visits, were reported for HSF participants with 4,220 (75%) visits occurring in a facility that was the affiliated hospital of the medical home. Out of 5,632 total visits reported, 63% (3,571) were seen at San Francisco General Hospital (SFGH), including 416 (12%) visits that were out-of-network due to the participants' medical homes being affiliated with a different hospital. St. Francis Memorial Hospital reported the second highest number of ED visits for HSF participants for July 2011 to March 2014 with 954 total visits including 546 (57%) visits considered as out-of-network. During the same period, 866 (20%) of the 4,429 visits for HSF participants with SFGH as their network hospital occurred at an out-of- network facility.

Out-of-network ED visits, including those resulting in an inpatient admission, can occur for a variety of unavoidable reasons, such as the nature of the emergency and emergency transport. This is a major

program limitation; 25% of visits from July 2011 to March 2014 were not covered under HSF. These participants would have had to apply for charity care and other programs for assistance to cover the cost of those visits.

**Health Care Utilization among Participants with Multiple Enrollments and Dis-enrollments**

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

This analysis calculated length of enrollment in months; this is important to determine whether participants were enrolled in the program for a sufficient period of time to receive a service. An enrollment period will range in length of days.[5] As indicated in Section III-A of this report, 33,715 individuals have had at least two HSF dis-enrollments and collectively had 111,946 enrollment periods (i.e., the period of time between an enrollment and dis-enrollment). Of the 111,946 enrollment periods, 79% had enrollment periods lasting 10 to 12 months.

An examination of utilization data for 33,715 individuals suggests 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 determined that there were 67,290 patients in the enrollment periods. The number of patients (67,290) is greater than the number of unique individuals (33,715) because a participant can be a patient (i.e., receive a service) in more than one enrollment period (i.e., duplicated). Each time a participant receives one service in an enrollment period, they are counted as a patient. Data indicates that 61% of the patients had their initial office visit within the first 60 days of enrollment with almost half (44%) making their first visit within 30 days. Data does not suggest that those with multiple enrollment periods are enrolling in HSF and not receiving services.

**Table D13**
**Length of Days to Initial Office Visit for Individuals with Two or More Dis-enrollments**

| First Initial Office Visit (Days After Enrollment) | No. of Patients (Duplicated) | Rate |
|---|---|---|
| 01-30 Days | 29,651 | 44% |
| 31-60 Days | 11,529 | 17% |
| 61-90 Days | 6,803 | 10% |
| >90 Days | 19,307 | 29% |
| **Total** | **67,290** | **100%** |

[5] For example, individuals dis-enrolled for program eligibility or failure to pay participation fee can be dis-enrolled mid-year while individuals dis-enrolled for failure to renew will have 365 days of enrollment before being dis-enrolled. 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.

## E. HEALTH IMPROVEMENT INITIATIVES

This section highlights the HSF Health Improvement Program. Health improvement initiatives focus on promoting preventive services, improving the quality of chronic care, facilitating the HSF Quality Improvement Committee, and providing quality and utilization data reporting.

HSF Quality Improvement Program functions include:

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

**Health Education**

HSF participant health improvement projects planning takes demographic characteristics, methods of delivery and appropriate cultural and linguistic competencies into consideration when developing the necessary education materials and tools for each project. In response to positive feedback and input from both providers and patients, HSF continued the following projects into FY2013-14:

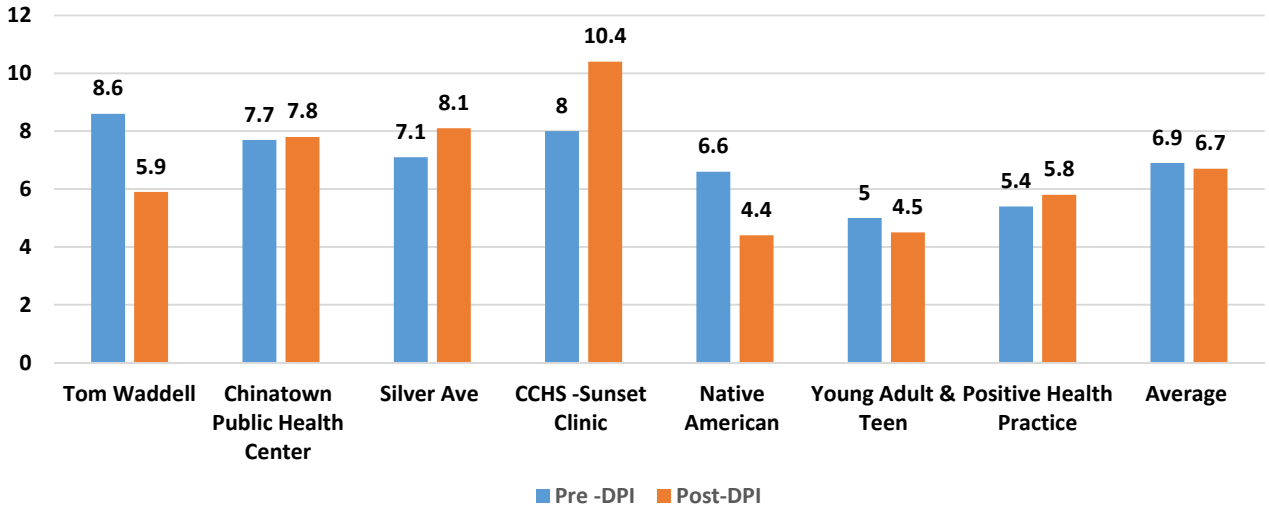
- *Well Woman and Well Man Mailings:* HSF continues to send participants "Well Man" and "Well Woman" health education materials during their birth month. These materials provide preventive care reminders, such as immunizations, recommended exams and screenings, and health care management tips, dependent on the participant's age and gender.
- *HeartBeat Newsletters:* Quarterly newsletters are mailed to HSF participants to provide program updates, promote relevant health and wellness events or other opportunities, and offer tips on maintaining health through nutrition and exercise.
- *Diabetes Text Messaging Campaign:* After its first year, the Diabetes Text Messaging campaign delivered positive results. Of the 169 program participants, 83% have maintained participation. While there is no data to show an improvement in screening trends, participants have self-reported improved efficacy in their diabetes care and satisfaction with the program. When asked to rate their confidence level from one to 10 in diabetes self-care, participant response averages increased from 7.3 in March 2013 to 8.2 in February 2014, indicating an improvement in confidence levels. In addition, 89% of respondents who took a satisfaction survey indicated that they would recommend the program to a friend or family member.
- *Diabetes "Passport" Brochure:* In its second year, diabetes "passport" brochure mailings continue to be sent to all HSF participants with diabetes. The brochure is an educational tool encouraging participants to become informed partners in their treatment through providing pages for them to document medication, treatment, and provider visit history.

**Care Experience**

In FY2013-14, HSF continued efforts and launched new initiatives to improve patients' experiences with HSF and its medical home network.

- *Coleman Associates' Rapid Dramatic Performance Improvement (DPI) Program:* In FY2013-14, HSF sponsored eight clinics into Coleman Associates' Rapid DPI Program. In this two-month intensive 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. As demonstrated in the chart below, half of the participating clinics increased the amount of patients seen per session. Clinics that did not improve on operational metrics were able to make progress across other measures in the manner of increasing patient flow and experience. For example, Tom Waddell Health Center redesigned of the front office flow to improve the registration process. A simplified registration process made a noticeable difference in the patients' calm demeanors when they sat in the waiting room. As a result of the program, clinics expanded their capacity to see more patients within a clinic session.

**Figure E1**
**Average Number of Patients Seen Per Clinic Session**




- *Provider-Patient Improvement:* This year, HSF provided scholarships for 14 staff members to attend a motivational interviewing training hosted by the California Quality Collaborative. The two-day training was followed by webinars and continual check-ins to ensure that staff was utilizing the average 15-minute primary care visit to educate patients on self-care.
- *Design on a Dime:* This new program seeks to improve the cultural relevance, aesthetic, and overall comfort of clinic ambiance. All seven Community Oriented Primary Care (COPC) clinics and several other clinics were sponsored to participate in this redesign effort. SGPA Architecture and Planning consulted with the clinics and offered cost-effective recommendations to improve

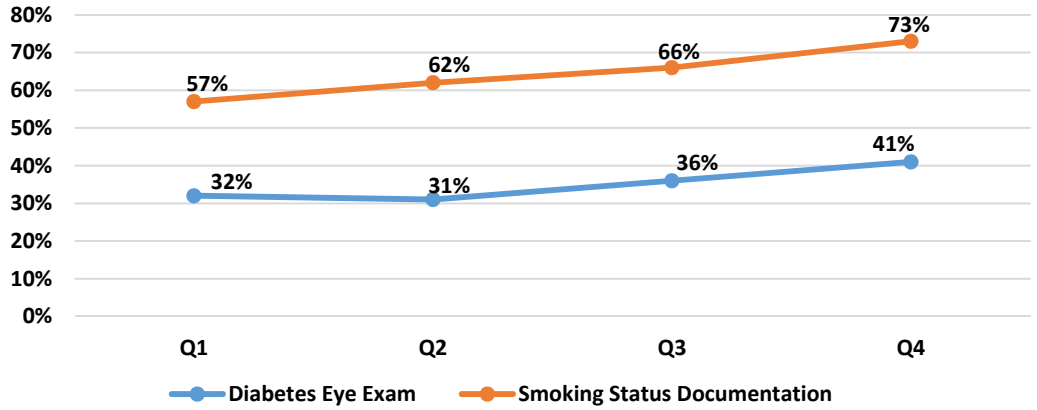
patient experience. The clinics invited patient input by interviewing at least three patients on identifying areas of improvement. The program will grant awards of up to $5,000 to SFCCC clinics who submit project plans and budgets for their redesign projects.

- *Phone Service Improvement:* DPH's COPC clinics standardized phone scripts and phone trees to ensure that participants receive comprehensive service across the board. In October 2013, over 100 COPC staff participated in a Sullavin Luallin Group training on phone etiquette. COPC initiated secret shopper calls every three months to monitor progress protocols learned in the trainings. The performance was based on eight measures including: friendly greeting, asking "how can I help?" and ending the conversation with a kind salutation. DPH clinics (COPC included) averaged a 62% on the mystery calls, and scored a 72% in April 2014, when the mystery calls were repeated. The program treated clinic phone operators to Target gift cards to celebrate this improvement.
- *Building a Better Workplace:* This program analyzes staff satisfaction as a component of patient experience improvement. The Center for Excellence in Primary Care (CEPC) conducted a satisfaction survey for sites to assess staff experience and identify areas of improvement. With 22 participating sites, the average response rate for the DPH clinics was 70%, and 72% for SFCCC Clinics. The survey also allowed for qualitative comments to elicit the most salient issues encountered by staff members at each participating site. The most reported comment was: "Communication with/from leadership: consistent mission/policies and appreciation/recognition for hard work," with 18 sites reporting this comment 188 times. The second highest concern was staffing, specifically sufficient hiring and reducing turnover, reported by 16 sites 62 times.

**Strength in Numbers**

The *Strength in Numbers* Program is designed 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. This fiscal year, the program made significant changes to improve performance and increase high quality outcomes for Clinical Quality, Data Quality, System Improvement, and Patient Experience. Highlights of the 2013 program year include the introduction of two new measures: the Diabetes Eye Exam and Smoking Cessation Counseling.

**Figure E2**
**Average Rates Across All Participating Medical Homes on New Measures**




The graph demonstrates 13% improvement for eye exams and 37% for smoking status documentation for the program while highlighting room for growth. The program will continue its efforts in meeting the 70% threshold for the eye exams and 90% threshold for smoking status documentation. The six core diabetes measures: Hb1C, HbA1c<8, HbA1c>9, LDL, LDL<100 screenings, and Blood Pressure Control <140/90 all remained stable throughout the year, showing no significant changes.

The 2014 year focused on merging the Strength in Numbers program into SFHP's Practice Improvement Program (PIP), which took place on January 1, 2014. The immersion includes grouping Strength in Numbers measures into the PIP Clinical Quality program. This new program focuses on Healthcare Effectiveness Data Information Set (HEDIS) measures and other measures that target issues impacting medical homes: access, patient experience, and quality and quantity of data.

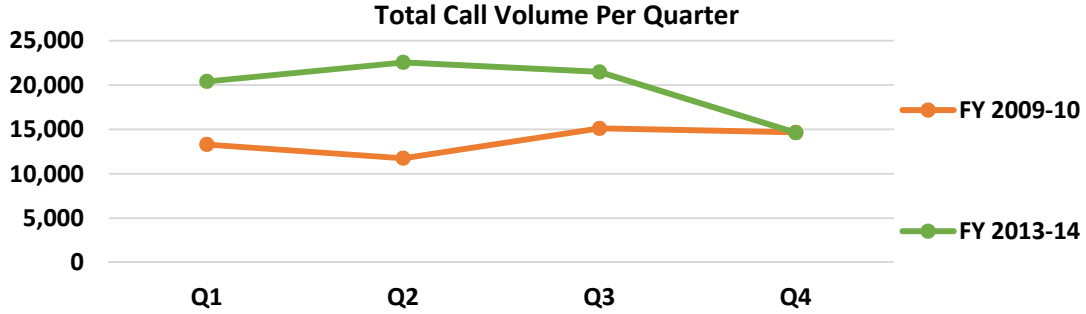
## F. PARTICIPANT EXPERIENCE AND SATISFACTION

This section highlights HSF's mechanisms to obtain feedback from participants about their experiences. This includes the call center, tracking of complaints and survey administration.

### Customer Service Call Center

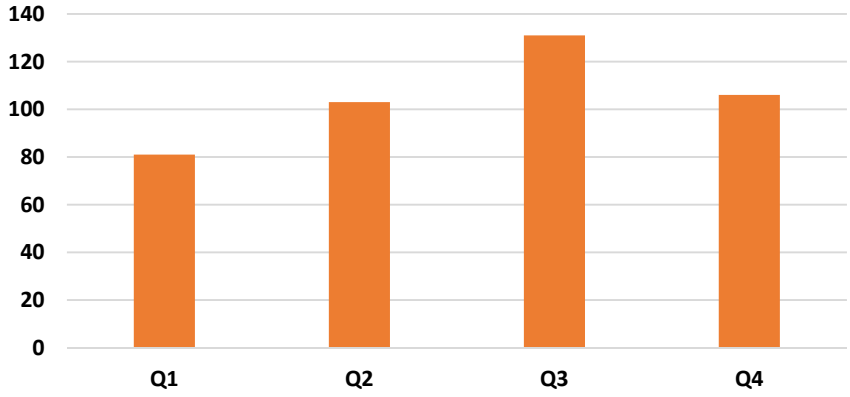
The HSF Customer Service Center supports all HSF customers, including participants, potential participants, medical homes, City Option employers and City Option employees. Functions include providing telephone assistance to participants, providers, and employers; scheduling enrollment appointments for the HSF enrollment site at San Francisco Health Plan and handling participant complaints. HSF Customer Service Center received a total 79,055 incoming calls (applicants, participants, providers, employers, others) in FY2013-14–very similar to FY2012-13's total of 79,229 calls. This is despite the fact that the number of HSF participants enrolled dropped by approximately half; call volume was very high during Covered California's open enrollment period, then dropped greatly in the fourth quarter of FY2013-14 (see graph below).

**Figure F1**
**Total Call Volume Per Quarter**




The call rate for FY2013-14 averaged 105 calls per 1,000 participants compared to 78 calls per 1,000 participants during FY2012-13.

**Figure F2**
**Average HSF Participant Calls (per 1000 Participants)**

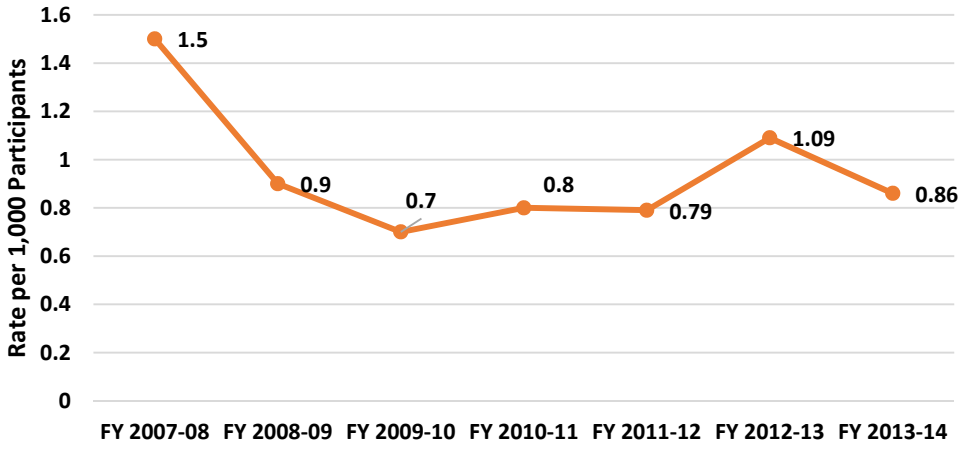


**Participant Complaints**

The HSF Customer Service Center receives all customer complaints and is responsible for resolving all non-clinical complaints. HSF Quality Improvement handles the resolution of all clinical complaints, as well as complaints oversight and reporting. During FY2013-14, the HSF Customer Service Center received a total of 356 complaints and the key trends include the following:

- The complaint rate per 1,000 participants[6] for FY2013-14 was 0.86, a 21% decrease from the FY2012-13 rate of 1.09.
- Access issues were 27.1% of the total complaints received in the FY2013-14, a decrease from FY2012-13, where access issues comprised 47.4% of total complaints.
- Quality of service issues were 24.9% of the total complaints received in FY2013-14, compared to 16.6% of the total complaints received in FY2012-13.

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




Following is a description of top complaints:

- *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 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

[6] 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.

physicians or staff, the hospital or other providers or (5) service interactions with customer service staff, participant billing or HSF Application Assistor.

- *Other:* This category includes complaints about the medical home that deal with a myriad of issues, such as when a participant prefers a specialized treatment or provider that is only available at another medical home or a participant has general complaints about a medical home that are not related to a specific service or a specific appointment, such as a medical home serves too many homeless people from participant's perspective.

The remaining complaints represent 47.75% of all complaints.

**Table F1**
**HSF Participant Complaints by Category (FY2013-14)**

| Attribute | Number | Percent |
|---|---|---|
| Access Issue | 97 | 27.25% |
| Quality of Service | 89 | 25% |
| Other | 55 | 15.45% |
| Enrollment Issue | 54 | 15.17% |
| Billing | 37 | 10.39% |
| Coverage Interpretation | 9 | 2.53% |
| Cultural, Linguistic & Health Education | 9 | 2.53% |
| Quality of Medical Care | 6 | 1.69% |
| **Total** | **356** | **100%** |

**Health Access Questionnaire**

HSF administers a Health Access Questionnaire (HAQ) at the point of application and at annual renewals.[7] HSF participant responses to this questionnaire enables DPH to gauge individuals' pre-HSF (if participant is a first time applicant) and post-HSF (for those who have renewed) experiences with health care in a quantifiable manner. The questionnaire is useful in helping capture participant experience for ongoing program monitoring and evaluation purposes.

Application Assistors ask HSF participants designated questions and responses to the questionnaire represent self-reported data. HSF eligibility 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.

During FY2013-14, HSF administered 33,795 questionnaires to first-time HSF enrollees and renewing or and re-enrolling members. The survey responses of those who were new to HSF reflect those participants' experiences with health care access before HSF enrollment, while renewal applicants' responses should reflect the HSF experience with health care access.

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

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

- An analysis of 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 33,795 questionnaires administered to 33,697 participants in FY2013-14.
- A year-to-year analysis, since the program initiated the questionnaires, for those participants who have taken four questionnaires and have been continually enrolled in HSF without breaks in participation.
    - This examines the responses of the 6,405 participants who have been enrolled in HSF for four consecutive years without breaks in coverage.

*FY2013-14 HAQ Responses*

Appendix B provides detailed information on all participant responses to the 11 survey questions in FY2013-14. Participant self-reported data continues to suggest that patient experience with HSF is improving. Compared to FY2011-12 and FY2012-13, questionnaire responses in FY2013-14 indicated the following:

- A maintained decline of respondents (5%) delayed getting care or a medicine prescribed to them in the past 12 months (FY2012-13 and FY2011-12 were 5% and 6% respectively)
- A low percentage of respondents (8%) visiting a hospital or emergency room for their own health (FY2012-13 and FY2011-12 were 7% and 9% respectively)
- A steady decline in the percentage of participants (8%) claiming to smoke cigarettes over time (9% in FY2012-13 and 9% in FY2011-12)

*Year-to-Year HAQ Comparison*

By the end of the FY2013-14, the following number of participants had taken the questionnaire for consecutive years with no disruption in enrollment:

- 32,228 participants - two times,
- 10,731 participants - three times,
- 6,405 participants - four times.[8]

Information on the medical home selection of the individuals taking multiple questionnaires reveals that the majority of HSF participants continuously enrolled had either a DPH or a San Francisco Community Clinic Consortium (SFCCC) medical home, which is consistent with data that shows these two medical homes had 92% of HSF enrollment (for those who took two questionnaires). The data indicates that those who were continuously enrolled were less likely to change medical homes during their enrollment. Specifically, for individuals who took four questionnaires and were continuously enrolled, 4.03% changed

[8] 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 dis-enrollment and re-enrollment period of less than 15 days.

their medical home by the second questionnaire, 2.03% changed their medical home by the third questionnaire, and 1.33% 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.

With respect to the ethnicity, data reveals that Asian or Pacific Islanders are more likely to be continuously enrolled (Table F2).

**Table F2**
**Ethnic Distribution of HAQ1, HAQ2, HAQ3 and HAQ4 Participants**

| | HAQ1 | | HAQ2 | | HAQ3 | | HAQ4 | |
|---|---|---|---|---|---|---|---|---|
| **Ethnicity Group** | # PID | % Total | # PID | % Total | # PID | % Total | # PID | % Total |
| Asian/Pacific Islander | 3,309 | 51.7% | 3,336 | 52.1% | 3,348 | 52.3% | 3,345 | 52.2% |
| Black/African American | 109 | 1.7% | 107 | 1.7% | 115 | 1.8% | 116 | 1.8% |
| Hispanic | 1,927 | 30.1% | 1,989 | 31.1% | 1,997 | 31.2% | 2,008 | 31.4% |
| Native American/Alaskan Native | 6 | 0.1% | 7 | 0.1% | 6 | 0.1% | 6 | 0.1% |
| Other | 152 | 2.4% | 153 | 2.4% | 151 | 2.4% | 152 | 2.4% |
| White | 590 | 9.2% | 625 | 9.8% | 638 | 10.0% | 637 | 9.9% |
| Not Provided | 312 | 4.9% | 188 | 2.9% | 150 | 2.3% | 141 | 2.2% |
| ***Total*** | ***6,405*** | ***100.0%*** | ***6,405*** | ***100.0%*** | ***6,405*** | ***100.0%*** | ***6,405*** | ***100.0%*** |

For this analysis, DPH examined those completing 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 2009 and 2014. The analysis examines responses in the aggregate and the variance calculation in Table F4 below is the difference between the HAQ1 and HAQ4 responses.

Of the 11 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*

Data 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 58% at HAQ1 and 55% at HAQ4). There was a consistent reduction in the percentage who indicated that they were in poor general health.

**Table F3**

**General Health**

| General Health | HAQ1 | HAQ2 | HAQ3 | HAQ4 | Variance |
|---|---|---|---|---|---|
| Excellent | 7.1% | 4.9% | 4.1% | 4.1% | -3.0% |
| Very Good | 16.9% | 13.6% | 16.5% | 19.3% | 2.4% |
| Good | 41.2% | 46.8% | 48.0% | 44.0% | 2.9% |
| Fair | 17.2% | 13.4% | 12.0% | 10.8% | -6.4% |
| Poor | 2.4% | 1.9% | 1.7% | 1.6% | -0.8% |
| Don't Know or Refused | 15.3% | 19.3% | 17.6% | 20.0% | 5% |

*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 F4**

**Hospital Emergency Department Use**

| ED Visit in Last 12 Months | HAQ1 | HAQ2 | HAQ3 | HAQ4 | Variance |
|---|---|---|---|---|---|
| Yes | 9.8% | 7.8% | 6.3% | 5.0% | -4.8% |
| No | 74.5% | 73.1% | 76.2% | 74.6% | 0.1% |
| Don't Know or Refused | 15.7% | 19.0% | 17.5% | 20.4% | 4.7% |

*Medical Care Location*

Survey data demonstrated 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 F5**
**Medical Care Location**

| Medical Care Location | HAQ1 | HAQ2 | HAQ3 | HAQ4 | Variance |
|---|---|---|---|---|---|
| Some Other Place | 0.9 | 0.3 | 0.1 | 0.2 | -0.7% |
| Refused, Don't Know | 16.9 | 18.9 | 16 | 17.8 | 0.9% |
| No One Place | 7.4 | 1.3 | 0.7 | 0.6 | -6.8% |
| Clinic/Health Center/Hospital | 64.3 | 70.5 | 73.4 | 70.0 | 5.7% |
| Doctor's Office | 9.0 | 8.4 | 9.5 | 11.1 | 2.1% |
| Emergency Room | 1.6 | 0.6 | 0.4 | 0.4 | -1.2% |

*Medical Care Access*

The data reveals that respondents reported a reduction in the level of difficulty in receiving care from HAQ1 to HAQ2. This trend was reversed in HAQ3 when 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 F6**
**Medical Care Access**

| Medical Care Access | HAQ1 | HAQ2 | HAQ3 | HAQ4 | Variance |
|---|---|---|---|---|---|
| Extremely Difficult | 1.6% | 1.3% | 2.4% | 2.7% | 1.1% |
| Very Difficult | 7.0% | 3.3% | 4.0% | 3.4% | -3.6% |
| Somewhat Difficult | 16.8% | 14.3% | 15.8% | 15.7% | -1.1% |
| Not Too difficult | 32.9% | 36.2% | 37% | 35.6% | 2.7% |
| Not Difficult At all | 18.5% | 23.8% | 21.9% | 21.6% | 3.1% |
| Don't Know, Refused | 23.1% | 21% | 19% | 21% | -2.1% |

*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 rated their care as poor.

**Table F7**

**Medical Care Rating**

| Medical Care Rating | HAQ1 | HAQ2 | HAQ3 | HAQ4 | Variance |
|---|---|---|---|---|---|
| Excellent | 9.0% | 8.7% | 7.9% | 7.5% | -1.5% |
| Very Good | 16.7% | 18.9% | 23.0% | 25.0% | 8.3% |
| Good | 39.3% | 42.9% | 44.0% | 41.0% | 1.7% |
| Fair | 6.7% | 7.2% | 5.3% | 4.7% | -2% |
| Poor | 0.9% | 0.6% | 0.2% | 0.4% | -0.5% |
| Don't Know, Refused | 27.3% | 21.7% | 19.6% | 21.3% | -6% |

*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 F8**

**Delays in Getting Care**

| Delay in Care | HAQ1 | HAQ2 | HAQ3 | HAQ4 | Variance |
|---|---|---|---|---|---|
| Yes | 8.3% | 3.3% | 2.8% | 2.3% | -6% |
| No | 69.3% | 75.5% | 77.5% | 75.7% | 6.4% |
| Don't Know, Refused | 22.4% | 21.3% | 19.6% | 21.9% | -0.5% |

*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 F9**

**Delays in Care Due to Costs**

| Delay in Care-Cost Reasons | HAQ1 | HAQ2 | HAQ3 | HAQ4 | Variance |
|---|---|---|---|---|---|
| Yes | 11.1% | 7.3% | 5.4% | 4.6% | -6.5% |
| No | 62.4% | 69.4% | 73.7% | 72.0% | 9.6% |
| Don't Know, Refused | 26.5% | 23.3% | 20.8% | 23.4% | -3.1% |

**Participant Perception of Health Status Compared to Utilization**

DPH's review of participant experience included a desire to assess how an 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 2013 and March 2014. 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 41% 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 section III D, Clinical Component-Services Utilization.

**Table F10**

**Does ED Utilization Response Match Information in Database**

| ED Visit in HAQ Response | ED Visit in Utilization Database | Percent HAQ Responses w/ Visit |
|---|---|---|
| 2,440 Participants | 1,008 Participants | 41% |

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 or very good, and good.

**Table F11**

**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 | 10,479 | 2.89 | 0.10 |
| Good | 16,871 | 3.40 | 0.13 |
| Fair | 3,626 | 4.85 | 0.21 |
| Poor | 575 | 6.87 | 0.40 |

Those participants who reported that access to medical care was "extremely or very difficult" had the same ED utilization than those who reported that access was "not that difficult."

**Table F12**

**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 (PM/PM) |
|---|---|---|
| Extremely/Very Difficult | 9,209 | 0.01 |
| Not That Difficult | 21,584 | 0.01 |

Renewing participants were asked about their interactions with the system and perception of care and access to services. Responses revealed that 45% of participants who rated their health as excellent or very good or good have a chronic condition, compared to 55% of those who rate their health as poor.

**Table F13**
**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 with Chronic Disease | Proportion without Chronic Disease |
|---|---|---|---|
| Excellent/Very Good/Good | 27,350 | 45.11% | 54.89% |
| Fair | 3,626 | 63.65% | 36.35% |
| Poor | 575 | 74.96% | 25.04% |

There was no difference in the incidence of chronic conditions among participants who rated their medical care as excellent or very good or good (48%), compared to those who rated it as poor (48%).

**Table F14**
**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 with Chronic Disease | Proportion without Chronic Disease |
|---|---|---|---|
| Excellent/Very Good/Good | 28,523 | 48.29% | 51.71% |
| Fair | 1,923 | 51.53% | 48.47% |
| Poor | 172 | 48.26% | 51.74% |

Results indicated that smokers had nearly twice as many emergency department visits per person as non-smokers, and about 11% higher incidence of chronic disease.

**Table F15**
**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 with Chronic Disease | Proportion without Chronic Disease |
|---|---|---|---|---|---|---|
| Smokers | 3,375 | 3.27 | 0.05 | 0.24 | 57.13% | 42.87% |
| Non-Smokers | 27,789 | 3.47 | 0.8 | 0.12 | 46.31% | 53.69% |

## G. HEALTH CARE SECURITY ORDINANCE AND THE EMPLOYER SPENDING REQUIREMENT

This section focuses on the Health Care Security Ordinance (HCSO) and the Employer Spending Requirement (ESR) resulting from the HCSO. The City Option, Healthy San Francisco (HSF), and Medical Reimbursement Accounts (MRAs) were formed to assist employers in meeting the ESR.

### Health Care Security Ordinance

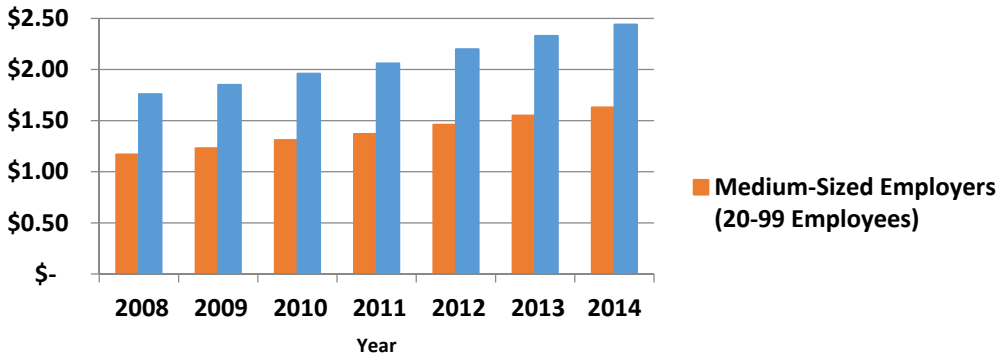
The San Francisco HCSO (No. 218-06; Chapter 14 of the San Francisco Administrative Code) created two City and County programs:

1. Employer Spending Requirement (ESR), which requires employers in San Francisco to make health care expenditures on behalf of their employees
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 DPH oversees the implementation of HSF.

The ESR was implemented 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 to spend a minimum monetary amount on health care expenditures for their eligible employees; Figure III-1 below demonstrates the gradual increase in the required minimum amount to spend per employee per hour since ESR implementation. In FY2014, the minimum expenditure was $1.63 per hour for medium-sized employers (20-99 employees) and $2.44 per hour for large employers (100+ employees).

**Figure G1**
**Health Care Security Ordinance Minimum Health Care Expenditures Per Covered Employee Per Hour by Year**



**City Option**

*Program Description*

The ESR Portal at *www.sfcityoption.org* is the mechanism by which employers identify 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 enroll 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 an 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.

*Program Updates*

In FY2013-14, the City Option program created and improved resources to assist all users with navigating the program's features:

- User and service guides were created to assist both employers and employees to address common questions and provide instructions on how to use the ESR Administration Portal.
- A new City Option website was launched in October 2013 to provide comprehensive program information and resources for both employers and employees.
- Automated calls are made to employees within one week of their employers' first payment to welcome them to the program and if applicable, explain new health care options that participants may be eligible for.
- At the end of FY2013-14, the Welcome Letter for new participants was updated to include information about new health care options that participants may be eligible for.

*Program Activities*

For FY2013-14:

- Approximately 66% (1,347) of employers made at least one contribution to the City Option to meet the ESR. A total of 417 of these employers made their first contribution during FY2013-14. The increase in the number of employers contributing to the City Option is probably due to the elimination of standalone Health Reimbursement Accounts (HRAs) as a result of ACA's implementation.
- Employers deposited $64.6 million to provide the City Option for their employees, approximately $13.9 million more compared to FY2012-13. This increase is partially due to the ban on standalone HRAs and employers opting to fulfill the ESR through the City Option.
- Of the funds contributed to the City Option by employers in FY2013-14, 63% ($41 million) was distributed to employees' MRAs and 37% ($23.6 million) was for employees potentially eligible for HSF.

For the City Option Program, as of June 30, 2014:

- A total of 2,042 employers have made at least one contribution to the City Option.
- For the Program overall, 56% of employees had their contributions assigned to a MRA, and 44% had their contributions assigned to HSF program participation.
- Since the implementation of the ESR, $102.9 million in employer contributions (including $23.6 million in FY2013-14) have been transferred from SFHP to the City & County of San Francisco for potentially eligible HSF participants.

Employer payments are submitted to the San Francisco Health Plan, the Third Party Administrator of the City Option, for Processing. SFHP transfers employer payments for the HSF component to DPH quarterly. DPH submits these funds to the City Controller's Office for processing and deposit. In accordance with the HCSO, these 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 since the Program's inception.

**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. | 58,692 |
| 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. | 84,820 |
| HSF and MRA Employees | City Option employee whose contributing employer(s) has previously submitted contributions designating this employee as both HSF-eligible and MRA-eligible. These individuals are counted as either the "HSF-Eligible Employees" or "MRA Employees;" therefore, this figure is negative to eliminate duplicate counting of employees. | -9,071 |
| **All City Option Employees** | **Total number of employees with HSF contributions and employees with MRA contributions, less employees with both HSF and MRA contributions.** | **134,441** |

The status of the 58,692 employees who have been determined potentially eligible for HSF based on employer-submitted information follows:

**Table G2**
**City Option HSF-Eligible Employees by Disposition**

| HSF Eligibility Disposition | Number | Percent |
|---|---|---|
| HSF Enrollment (Ever Enrolled) | 14,044 | 24% |
| Employee-Initiated Request for Fund Transfer from HSF to MRA | 6,776 | 11% |
| HSF to MRA Transfers Due to Incorrect Employer-Provided Information | 20,352 | 35% |
| Disposition Determination in Process, Inadequate Date or Unresponsive Outreach | 17,520 | 30% |
| All Employees (Potential Duplication re: HSF & MRA Individuals) | 58,692 | 100% |

For the 84,820 employees whose employer-contributed funds went to a MRA, the reasons for MRA designation based on HSF program eligibility follow:

**Table G3**
**MRA Designation Reasons for HSF Ineligibility**

| Reasons for MRA | Number | Percent |
|---|---|---|
| Not a San Francisco Resident | 44,690 | 53% |
| Not Between the Ages of 18 and 64 | 912 | 1% |
| Has Health Insurance | 18,801 | 22% |
| Combination of One or More Eligibility Reasons | 20,417 | 24% |
| All Employees with MRAs | 84,820 | 100% |

At the end of FY2013-14, there were 54,730 active MRAs with approximately $1.4 million in MRA contributions. The average rate of participant claims for reimbursement was 52%; in FY2008-09, the rate was 17%, indicating that a greater percentage of City Option MRA employees are successfully utilizing the accounts. MRAs comprise more than half of City Option employee inquiries to customer service.

**Employer Data**

The following summarizes information on employers electing to use the City Option for all or some of their employees, as of June 30, 2014. Note that an employer may use the City Option to supplement any existing health care expenditures they are making which are below the required ESR expenditure levels. Data indicates:

- 38% 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
- 85% employers are for-profit and 9% are non-profit (remaining employers are either public or did not report their profit status)

- Using the *North American Industry Classification System* (NAICS) code for classifying occupations, 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 (12%).

**Table G4**
**City Option Employers by Company Size**

| Count by Company Size | Number | Percent |
|---|---|---|
| 0-19 employees | 39 | 2% |
| 20-49 employees | 399 | 20% |
| 50-99 employees | 246 | 12% |
| 100-499 employees | 453 | 22% |
| 500+ employees | 786 | 38% |
| Not reported | 119 | 6% |

**Health Care Security Ordinance Updates**

On June 17, 2014, the San Francisco Board of Supervisors passed several amendments to the Health Care Security Ordinance (HCSO), relating to DPH's administration of the Health Access program (HAP), which is comprised of two components: Healthy San Francisco and Medical Reimbursement Accounts.
These amendments include the following requirements:

- All health care expenditures made to satisfy the ESR shall become irrevocable over a phase-in period of three years.
- DPH is charged with creating a plan to maximize HAP participants' enrollment into health insurance options while addressing the affordability of insurance, in time for the 2016 plan year.

As a result of these amendments, DPH is studying and assessing its long-term options for maximizing health insurance enrollment. In the short-term, DPH is conducting outreach to current MRA holders, notifying them of the availability of MRA funds for use towards insurance premiums. DPH has also identified mechanisms to make City MRAs more readily available for covered employees who are San Francisco residents. Currently, San Francisco residents are defaulted to HSF unless they can show proof of insurance. DPH has proposed to remove this requirement, which will facilitate the covered employee's choice of setting up an MRA. This proposed change will be presented to the San Francisco Health Commission in October and, if passed, is scheduled to take effect on November 1, 2014.

## H. EXPENDITURES AND REVENUES

This section provides estimated HSF expenditures and revenues in FY2013-14. As noted in previous sections, the HSF-SF PATH transition expenditures and revenues are not included in HSF financial estimates.

DPH tracks expenditures through a financial class created for HSF. Expenditures from each DPH division are combined to provide an overview of HSF finances. FY2013-14 DPH costs and revenue calculations are estimates. The financial data that follows is comprised of the following components:

- Total HSF revenues and expenses
- DPH expenditures
- Non-DPH expenditures
- Per participant per month expenditures, revenues and subsidy
- Estimated DPH costs of serving the indigent and uninsured

*HSF Revenues*

HSF revenues totaled $28.76 million. This includes contributions from employers using the City Option to fulfill the Employer Spending Requirement (ESR) and participant fees (both participation and DPH point-of-service (POS) fees). ESR funding in FY2013-14 increased close to $7 million (40%) from the prior year. Participants with income at or above 101% of the Federal Poverty Level (FPL) are billed quarterly for pay participation fees to remain in the program. As of June 30, 2014, approximately 38% of participants were at or above 101% of FPL. DPH only collects information on POS fees paid by HSF participants accessing services within DPH. For the fiscal year ending June 30, 2014, DPH collected $5.2 million in HSF participant fees ($4.87 million) and point-of-service fees ($324 thousand).

**HSF Expenditures**

System-wide HSF expenditures for FY2013-14 added up to around $158.74 million for private medical homes and DPH. Since the DPH expenditure calculation includes reimbursement to non-DPH HSF medical home providers and to avoid potential double-counting of expenditures, the net HSF expenditure for private medical homes is applied in the tables to illustrate expenditures.

**Table H1**
**Summary of Estimated System-Wide FY2013-14 HSF Expenditures (All HSF Providers)**

| Delivery System | Estimated Cost |
|---|---|
| Total DPH HSF Expenditures | $111,883,631 |
| Private Provider Net HSF Expenditures | $20,078,342 |
| Non-Profit Hospital Charity Care Expenditures | $26,775,327 |
| **All HSF Provider Expenditures** | **$158,737,300** |

**Table H2**

**Estimated Total Revenues and Expenditures**

| | 2008-09 | 2012-13 | 2013-14 |
|---|---|---|---|
| **ENROLLMENT** | | | |
| Total Participant Months | 420,878 | 612,462 | 537,045 |
| **REVENUE** | | | |
| Health Care Coverage Initiative | $19,199,749 | $0 | $0 |
| Participation Fees and DPH POS | $3,208,577 | $7,499,428 | $5,196,074 |
| ESR (Employer Health Care Expenditures) | $18,236,251 | $16,807,439 | $23,567,891 |
| Reserve for Unearned Rev. (Enrollee & ESR) | ($4,559,063) | $0 | $0 |
| Philanthropic Grants (Evaluation) | $450,000 | $0 | $0 |
| **TOTAL REVENUE** | $36,535,514 | $24,306,867 | $28,763,965 |
| **DPH EXPENDITURES** | | | |
| *Administration* | | | |
| HSF Administration | $752,122 | $506,273 | $874,025 |
| Third-Party Administrator (SFHP) | $5,132,291 | $7,000,103 | $6,671,181 |
| *Services* | | | |
| Cost of Services (SFGH, Clinics, UCSF) | $91,431,700 | $76,316,179 | $77,563,729 |
| Behavioral Health | $20,099,554 | $21,070,330 | $13,031,805 |
| Non-DPH Provider Reimbursement | $6,683,671 | $15,792,251 | $13,192,357 |
| *Information Systems* | | | |
| Eligibility/Enrollment System (One-E-App) | $240,702 | $301,977 | $316,626 |
| Siemens Information Technology | $200,000 | $233,908 | $233,908 |
| **SUBTOTAL DPH EXPENDITURES** | **$124,540,040** | **$121,221,021** | **$111,883,631** |
| **ESTIMATED DPH PER PARTICIPANT PER MONTH EXPENDITURE** | **$296** | **$198** | **$208** |

**Table H2 (cont.)**
**Estimated Total Revenues and Expenditures**

| | 2008-09 | 2012-13 | 2013-14 |
|---|---|---|---|
| **NON-DPH EXPENDITURES** | | | |
| Private Medical Homes Net HSF Expenditures | -- | $16,101,659 | $20,078,342 |
| Non-Profit Charity Care Expenditures | -- | $21,534,961 | $26,775,327 |
| **SUB-TOTAL NON-DPH EXPENDITURES** | | $37,636,620 | $46,853,669 |
| **TOTAL DPH AND NON-DPH EXPENDITURES** | **$124,540,040** | **$158,857,641** | **$158,737,300** |
| **ESTIMATED TOTAL PER PARTICIPANT PER MONTH EXPENDITURE** | **N/A** | **$259** | **$296** |
| **DPH REVENUE LESS DPH EXPENDITURES = GENERAL FUND SUBSIDY** | ($88,004,526) | ($96,914,154) | ($83,119,666) |
| **ESTIMATED DPH PER PARTICIPANT EXPENDITURE** | $296 | $198 | $208 |
| **DPH PER PARTICIPANT REVENUE** | $87 | $40 | $54 |
| **PER PARTICIPANT GF SUBSIDY** | ($209) | ($158) | ($155) |

*DPH Expenditures*

DPH expenditures, which totaled an estimated $111.88 million in FY2013-14, are categorized into major categories of administration, services and information systems. Administration (including information technology) was roughly 7% of total estimated DPH expenditures at $7.55 million. Service costs were 93% of total estimated DPH expenditures at $103.79 million.

A portion of DPH expenditures reflects reimbursement for non-DPH medical homes and emergency ambulance transportation, incremental University of California San Francisco (UCSF) reimbursement for services professional specialty rendered at San Francisco General Hospital (SFGH), and incremental behavioral health provider funding. In addition, as noted in Section III-C, a portion of DPH service costs at SFGH support hospital-based specialty care, urgent care, diagnostic, emergency care, home health, pharmacy, durable medical equipment and/or inpatient services to DPH clinics, as well as many other private providers in the network.

DPH behavioral health services expenditure estimates for HSF participants are reported through Community Behavioral Health Services. Providers have until August 20, 2014 to submit data and final costs for FY 2013-14 will not be available until January, 2015. At the time of this report, behavioral health and substance abuse expenditures listed are based on nine (9) months of data from July 2013 to March 2014. Pharmacy costs are based on twelve (12) months data, from July 2013 to June 2014.

**Estimated Private HSF Provider Costs and Revenue for Serving HSF Participants**

It is estimated that health services to HSF participants cost private HSF providers $46.78 million:

- $20.08 million by medical homes after revenues of $24.37 million are deducted from total expenses of $44.45 million
- $26.78 million in hospital charity care expenses

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

| Medical Home | Expenditures | HSF Funding and Other Revenues | Net Costs |
|---|---|---|---|
| BAART | $98,529 | $76,126 | (22,403) |
| Brown & Toland Physicians | $929,968 | $693,500 | (236,468) |
| CCHCA & Chinese Hospital | $1,617,769 | $151,800 | (1,465,969) |
| Glide Health Services (specialty affiliation with St. Francis Memorial Hospital) | $ 4,676,280 | $449,375 | (4,226,905) |
| Kaiser Permanente | $12,064,569 | $4,285,275 | (7,779,294) |
| North East Medical Services | $9,645,487 | $5,262,191 | (4,383,296) |
| San Francisco Community Clinic Consortium Affiliated Clinics (includes SFCCC Administration) | $10,929,592 | 10,929,592 | 0 |
| Sister Mary Philippa Clinic (affiliation with St. Mary's Medical Center) | $4,489,450 | $1,160,443 | (3,329,007) |
| **All Non-DPH Medical Home Health Systems** | $44,451,644 | $24,373,302 | ($20,078,342) |

Of the reported $24.37 million in revenues available to private medical homes, about $13.85 million (57%) was funded by DPH. DPH funding to private HSF providers is not intended to cover the costs of care delivery to HSF participants. DPH does not have sufficient funding to provide reimbursement at that level. 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. HSF providers have worked to enroll their existing uninsured patients in the HSF Program. Through HSF, these providers are now receiving some reimbursement for a population that they previously provided services to without any City and County reimbursement.

Charity care services by non-profit hospitals are estimated at $26.78 million. Hospitals count these expenses in different ways these expenses may include services to HSF participants affiliated or not affiliated with the hospital's medical home partners.

In examining 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 provided information to DPH using its own established processes and procedures for estimating costs. In addition, in the area of charity care, some hospital providers report costs on a calendar year, not a fiscal year basis.

Therefore, the hospital financial data included the most recent fiscal year, which in some cases was FY2012-13 (July 1, 2012 – June 30, 2013).

*General Fund Subsidy*

A City and County General Fund subsidy covered the difference between expenditures and revenue. It is represented as a negative number to show the shortfall between revenues and expenditures. The FY2013-14 General Fund subsidy was $83.12 million. The General Fund subsidy decreased $3 per participant per month (PMPM), a 2% decrease from FY2012-13. Although revenue increased due to ESR contribution increases, overall costs increased from $259 PMPM to $296 PMPM, a 14% increase.

**Estimated DPH Costs of Serving the Indigent and Uninsured**

DPH provides services to uninsured individuals who are not eligible for HSF or not yet enrolled in HSF, and provides services beyond the HSF scope of benefits such as dental and long-term care on a sliding scale basis to uninsured individuals at its hospitals and primary care clinics. The costs of providing services to this population was approximately $58.25 million in FY2013-14. The SF PATH Program, which ended on December 31, 2013, provided services to participants estimated at $27.44 million in expenditures.

DPH's estimated costs of serving the indigent and uninsured reached $163.25 million in FY201314. This excludes behavioral health expenditures for the non-SF PATH and non-HSF population.

**Table H4**
**Estimated Costs of Serving Indigent and Uninsured (FY2013-14)**

| Uninsured Patient Population | Estimated Cost |
|---|---|
| HSF Uninsured Population | $77,563,729 |
| Non-HSF Uninsured Population (not including SF-PATH) | $58,246,526 |
| LIHP/SF PATH Population | $27,440,304 |
| Entire Uninsured Population | $163,250,559 |

# IV. FY2014-15 ANTICIPATED PROGRAM ACTIVITIES

During the next fiscal year, HSF will build on last year's successful transition of participants to health insurance options through the ACA. HSF will continue focusing on enrolling uninsured individuals in health insurance.

DPH will propose several HSF and City Option Program policy changes for approval by the Health Commission in October 2014. These changes are based on the 2013 Universal Healthcare Council (UHC) Final Report and the June 2014 Board of Supervisors approved amendments to the Health Care Security Ordinance (HCSO). These proposed changes are:

*Remove HSF's 65-year-old age limit*

Participants who will be aging out of HSF (turning 65 years old) during the latter part of 2014 will be informed of the opportunity to be eligible for HSF after January 1, 2015. The vast majority of participants turning 65 will be eligible for either Medicare or Medi-Cal (some will be eligible for both). However those who are age 65 and older and who are ineligible for public coverage currently do not have a program that offers comprehensive coordinated health care services. The UHC specifically requested to add this population to those eligible for Healthy San Francisco. Consistent with current HSF eligibility, only those seniors who are ineligible for Medi-Cal or Medicare would be eligible for HSF. About 400 Healthy San Francisco participants will turn 65 in 2015 and about 1,200 individuals in the city may be eligible for HSF if the age limit is removed.

*Decrease HSF's income eligibility limit from 500% FPL to 400% FPL (does not apply to participants receiving an employer contribution towards HSF participation)*

The current income limit for HSF and public coverage (including subsidized coverage through Covered California) are not aligned. This change will align the HSF income limit with that of subsidies for Covered California. Individuals receiving an employer contribution will not be affected by any income limit for participation in HSF. Currently less than 175 individuals are affected by this policy change. Those individuals will be notified and provided with information about their health insurance options such as Covered California.

*Extend the HSF Transition Period until December 31, 2015*

The current HSF Transition Period was established in response to barriers faced by San Franciscans during the first Covered California Open Enrollment period. It also gave DPH an opportunity to explore options to adequately address identified barriers. These options are to be researched under a plan to be brought to the Health Commission in August 2015, which would help make Covered California more affordable for eligible individuals who have an employer contribution under the Health Care Security Ordinance. The extension of the HSF Transition Period through 2015 will provide residents who continue to face barriers transitioning to ACA programs a health access program until that new proposed program is implemented in 2016. Currently an estimated 4,500 HSF participants are eligible for this transition period. HSF will

counsel Transition Period participants about their health care coverage options. These participants will be informed that HSF participation does not meet the federal individual mandate and that they may have to pay a penalty for not having health insurance. The penalty for 2014 is 1% of household income or $95 per person. In 2015 the penalty increases to 2% of household income or $325 per person.

These HSF eligibility changes, if approved by the Health Commission will become effective January 1, 2015.

*City Option Policy Change*

The City Option policy change is to streamline the process for transferring contributions from HSF to MRA, including removing the requirement to show proof of program ineligibility. The City Option eligibility changes are designed to facilitate employees who receive employer contributions through the program to access and utilize those funds to purchase health insurance, including paying insurance premiums, co-payments, deductibles and so forth.

The City Option eligibility change is targeted for implementation on November 1, 2014.

**Continue Transitioning Eligible Participants to ACA Options**

Medical homes will be encouraged to continue as Certified Enrollment Entities and have Application Assistors renew as Certified Enrollment Counselors. This will enable most HSF enrollment sites to continue serving as a central place for health insurance information and enrollment for those who are eligible, and for enrollment in HSF for those who are not eligible for insurance. HSF will continue to monitor dis-enrollments, outreach and educate individuals on available options.

HSF will focus on assisting participants to enroll in Covered California health insurance options during the upcoming open enrollment from November 15, 2014 – February 15, 2015. HSF is again participating in citywide communication efforts to educate San Franciscans about ACA health insurance options. This includes continuing to encourage people to enroll and renew their Medi-Cal coverage. It is critical for HSF to clearly communicate expected program changes and the options available (including the Transition Period) to participants and Application Assistors so that individuals can make an informed choice about their health care options.

**Maintain Medical Home Network**

HSF will focus on maintaining the stability of the medical home network. HSF is able to offer participants a choice of several providers throughout the city. This public-private partnership of medical homes provides participants options to access to healthcare. Maintaining such medical home options becomes more challenging as some medical homes may be concerned about the financial risk of providing care to a smaller and smaller number of participants due to ACA implementation.

While HSF continues to focus on transitioning eligible participants to new health insurance options, DPH recognizes that San Franciscans who are not eligible for these new options will continue to rely on HSF for their health care needs. In addition, the new options available remain unaffordable for many San Franciscans. DPH will again explore ways to address these concerns in the upcoming year and HSF will

participate in these planning efforts. HSF will maintain fulfilling its mission of providing eligible San Francisco residents with affordable health care options regardless of immigration status, employment, or pre-existing conditions. HSF will remain a solid support for uninsured San Franciscans who need assistance in obtaining health care services, working to find the right option for each individual.

## ***APPENDIX A***

## *Data Source and Submission*

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 encounter data submission standards, ensures quality data is collected and processed, and analyzes and reports the data received by the DPH annually. Collection and analysis of encounter data is key to ascertaining the extent to which HSF is meeting its goals.

The source data for this report came from the HSF data warehouse, including all medical and pharmacy services, the Health Access Questionnaire (HAQ), which is administered during the HSF application process, and membership data from the One-e-App system. Data reported includes all services incurred from July 2008 through March 2014. For FY2013-14, the analysis allows for a three-month lag for data completion. Therefore, the analysis does not use actual data for the months of April 2014 to June 2014. This 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, July 2011 to June 2012, and July 2013 to June 2013.

SFHP monitors HSF submissions by service category and total submissions received by providers on a monthly basis. This ongoing monitoring facilitates a better understanding of the total submissions received, loaded, and used for the development of utilization analysis. Service utilization analysis is dependent upon having data as complete as possible from all HSF providers. In FY2013-14, over 52% of institutional service data was from San Francisco General Hospital. In addition, at any given time, a non-profit hospital can provide charity care services to an HSF participant. Since FY2009-10, DPH has worked with hospitals to obtain utilization data on this population. For some hospital systems, the data has not been consistently submitted and may not capture all services provided. DPH 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 FY2013-14 Health Access Questionnaire Responses (New Applicants and Continuing Participants)*

The 33,795 questionnaires were administered to 33,397 participants:

- 33,301 participants took the survey only one time during the year,
- 394 participants took the survey twice during the year (i.e. new applicant who renewed eligibility before the end of his/her 12-month term)
- 2 participants took the survey three times (likely due to dis-enrollment and re-enrollment)

| No. | Question | Key FY2013-14 Responses | 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? | 62% 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. | 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? | 33% of all respondents indicated that they did not have health insurance for some time in the past 12 months | 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 HSF" 36% cited HSF as the reason they did not have health insurance | The most common reason notes was "enrollment in HSF" 36% cited HSF as the reason they did not have health insurance | The most common reason noted was "enrollment in HSF." 33% cited HSF as the reason they did not have health insurance. | The most common reason noted was "enrollment in HSF." 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 FY2013-14 Responses | 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. | 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? | 67% 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. | 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. | 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. |

| | Question | Key FY2013-14 Responses | Key FY2012-13 Responses | Key FY2011-12 Responses | Key FY2010-11 Responses | Key FY2009-10 Responses | Key FY2008-09 Responses |
|---|---|---|---|---|---|---|---|
| 7 | How do you rate the medical care that you received in the past 12 months – excellent, very good, good, fair, or poor? | 26% rated the medical care they received in the past 12 months as Excellent or Very Good. | 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. |
| 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. | 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, 8% of respondents said cost or lack of insurance was a reason why they had delayed care | 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. |

| | Question | Key FY2013-14 Responses | Key FY2012-13 Responses | Key FY2011-12 Responses | Key FY2010-11 Responses | Key FY2009-10 Responses | Key FY2008-09 Responses |
|---|---|---|---|---|---|---|---|
| 10 | Do you now smoke cigarettes every day, some days, or not at all? | Overall, 9% of respondents smoked (either every day or some days). | Overall, 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-three percent (43%) of respondents stated the lottery offer as the reason for coming in for renewal. | 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 |