HealthySF
OUR HEALTH ACCESS PROGRAM

Healthy San Francisco Program

Annual Report

(Fiscal Year 2019-20)

Prepared by the Office of Managed Care, SF Department of Public Health
March 2023

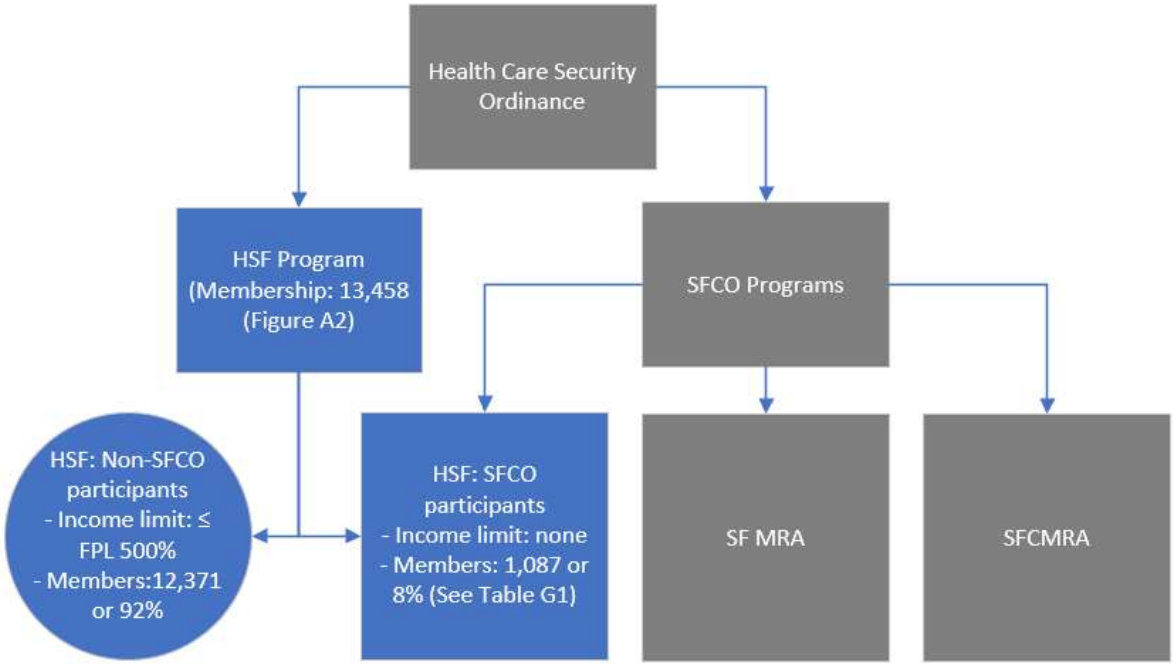
Table of Contents

I. PROGRAM OVERVIEW AND ACCOMPLISHMENTS

The Healthy San Francisco Program (HSF) was designed by the San Francisco Department of Public Health (SFDPH) in 2007 after the passage of the City and County of San Francisco's (the "City") Health Care Security Ordinance (HCSO) in 2006, to make health care services available and affordable to uninsured San Francisco residents. Today, HSF primarily serves to: (1) provide health care services to uninsured San Francisco adults who are ineligible for public full scope coverage; and (2) assist uninsured adult San Francisco residents to enroll in affordable health insurance options when appropriate.

In addition to HSF, the City through SFDPH also created the San Francisco City Option (SFCO) program in the subsequent year to provide a City sponsored way for employers to meet the spending requirements under HCSO. There were three programs under SFCO including HSF, the SF Medical Reimbursement Account (SF MRA) and SF Covered MRA (SFCMRA) programs. SF MRA and SFCMRA were developed to provide financial assistance to San Francisco employees to meet their health and wellness needs. Together, these San Francisco programs complement the federal Patient Protection and Affordable Care Act (ACA) to help make San Francisco a city where nearly 100% of its residents have access to health care coverage. Figure I further illustrates the relationship between HSF and SFCO under HCSO. For example, while HSF had a total of 13,458 participants in FY19-20, only 8% were enrolled under SFCO. For additional program details, such as eligibility requirements, please go to the respective program websites: https://healthysanfrancisco.org/, and https://sfcityoption.org/.

Figure I. Relationship between HSF and SFCO



To manage the daily operation of these two programs, SFDPH has contracted with a third-party administrator San Francisco Health Plan (TPA) to administrate call center, marketing and outreach, data analytics and reporting, and provider contracting.

Amidst evolving healthcare and political landscapes, HSF continues to respond to the changing needs of vulnerable San Francisco residents. This report provides HSF participants, providers, researchers, the general public, and other interested stakeholders with detailed information on how SFDPH operates HSF and monitors and tracks performance. SFCO was discussed here predominantly in the context of its relevancy to HSF. As SFCO continues to growth, in FY20-21 SFDPH's plan is to separate the budget and annual report of SFCO from those of HSF, to provide additional program information, such as program finances, operations and outcomes.

A. HSF and SFCO Policy Changes

There were various policy changes implemented across both programs this fiscal year, both independent of and in response to the COVID-19 pandemic and the Shelter in Place (SIP) and other Public Health Emergency orders by local, state, and federal officials. Accordingly, the HSF and SFCO programs implemented the following measures to ensure continued access to health care services.

HSF Policy Changes (COVID-19 Response)

Due to barriers for participants (interchangeably referred to as "members" or "patients" in this report) to complete renewal resulting from the pandemic and local SIP Orders implemented in March 2020, HSF enacted the following policies to ensure participants' continued health coverage:

- Extended the coverage of 3,207 participants for 90 extra days at no charge starting with participants with termination date of March 17, 2020.
- Implemented a fee waiver program to temporarily stop disenrollments for participants who are experiencing financial hardship and unable to pay quarterly fees.
- Implemented a temporary exception policy for those applicants and participants who are unable to submit supporting documentation for applications and renewals.
- Provided remote appointments for HSF enrollments and renewals with guidance and training, and technical support to all program assistors to ensure uniformity of experience and process for remote appointments.

SFCO Policy Changes (COVID-19 Response)

- A temporary payment method was instituted for employers unable to pay by check or TPA's electronic fund transfer (EFT). SFCO coordinated with TPA's Finance to allow employers to temporarily use their own ACH systems to pay contributions.
- Due to the temporary closure of the TPA's Service Center, the program established remote appointments for SFCMRA enrollment.

SFCO Policy Changes

- In collaboration with TPA Finance, SFCO continued to streamline financial operations in FY19-20. SFCO implemented new financial controls resulting in more accurate reporting including employer spending requirements (ESR) enhancements to better monitor the check processing and refund process.

Other Activities in Support of City's COVID-19 Response

- Assisted in planning and implementing the Mayor's initiative for the one-time $500 cash Grant for over 46,000 SF MRA account holders to use for COVID-19 related expenses.

- In collaboration with the San Francisco Human Services Agency (HSA), distributed $200 grocery gift cards to 2,631 very low-income HSF participants who were not eligible for other types of support for healthy food during the pandemic.

B. HSF Provider and Pharmacy Network Changes

HealthRIGHT 360 Medical Home Off-Boarding

At the start of the first quarter of FY19-20, the HSF program was notified two HealthRIGHT 360 clinics were going to permanently close including Haight Ashbury Free Clinic (HAFC) closing August 1, 2019 and Tenderloin Health Clinic (THC) on October 4, 2019. HSF worked collaboratively with HealthRIGHT 360 to take the following measures to minimize impacts to HSF participants including.

HealthRIGHT 360 led the clinical transition of participants to the HR360 Integrated Care Center (ICC) to ensure the continuity of health care services. All providers from HAFC were also transitioned to Haight Ashbury Integrated Care Center (ICC).

All affected HSF participants were manually reassigned to ICC prior to the official close of the affected clinic. They were allowed to choose another Medical Home by calling HSF Customer Service without having to file a complaint per the HSF policies. All participants were sent new HSF ID cards to reflect their new HSF Medical Home.

HSF enrollment system and other materials was updated to remove HAFC and THS from the medical home directory and St. Francis Memorial Hospital which has an associated relationship with THS.

HSF program notified all impacted participants with information about the clinic closure and next steps. The notice was mailed to over 200 participants, and was translated in Spanish, Chinese and Tagalog.

Walgreens Pharmacy Closures

Three Walgreens Pharmacy locations in the HSF Pharmacy Network were closed in FY19-20 including (1) 3801 3rd Street, (2) 901 Hyde Street, and (3) 1979 Mission Street. HSF has been actively working with Walgreens to explore adding additional locations to minimize the impact of these location closures and to ensure access in priority neighborhoods. Additionally, HSF had notified all impacted participants of such change and their new pharmacy location.

C. SFCO Program Activities

Account Monitoring

Since the first instance of suspicious activity within SFCO in August 2017, SFDPH and TPA have identified protecting SFCO employee identification and contributions as a top priority. In FY19-20 SFCO created a tool within the ESR Admin Portal to track suspicious Program Finder Forms and medical reimbursement accounts (MRAs) that share a bank account. TPA Service Center and SFCO Customer Service use the information provided via such tool to identify and address issues related to suspicious activity on the account.

Program Simplification

Program simplification of SFCO is intended to maximize utilization by eliminating barriers to program engagement and reducing complexity of enrollment and utilization and reimbursement of funds. SFCO will begin implementing the simplification in FY20-21 pending plan finalization. In addition to this major program simplification, SFCO engaged in specific projects to improve its overall communication strategy and increase utilization and engagement with SFCO employers and employees. To ensure program's integrity and compliance with the HCSO, SFDPH also engaged with the Controller's Office this fiscal year to begin its self-audit on the program administration, financials and compliance of the program.

Utilization

During FY19-20, SFCO engaged the American Institutes for Research (AIR) to help better understand SFCO employers and SF MRA participants. AIR used surveys, questionnaires, and interviews to gather information from SFCO employers and employees. Using this data, AIR created a comprehensive set of recommendations to increase utilization of the SF MRA. SFCO will develop a plan for implementation of key findings in FY20-21.

Performance audit of SFDPH and TPA

The Controller's Office and Sjoberg Evashenk Consulting (SEC) conducted a financial and performance audit of SFCO. A generally positive audit report was shared with SFDPH and TPA. SFDPH and TPA are working to respond to the audit findings and recommendations with some to be implementing in FY20-21.

D. Looking Ahead

The COVID-19 pandemic that began in March 2020 destabilized the healthcare environment from the local to the global scale, and the ramifications of this event are likely to be felt for years to come. While local, state, and federal support have been made available including testing and treatment of COVID-19 for patients, it is hard to predict the impacts of future disease course or funding support and associated regulations.

The HSF and SFCO programs have responded to the pandemic via programmatic changes to ensure San Francisco residents are still able to access health services, and this will remain a priority for both programs as we move forward into the next fiscal year.

While HSF and SFCO continue to respond to the changing needs brought by COVID-19, the program also began the process of implementing an audit program and continued strengthening the financial operations and data reporting.

II. PROGRAM ACTIVITIES

A. Communications, Outreach, Applications, and Enrollment

Currently, San Francisco residents have higher health insurance or coverage rates than the national average due to the implementation of the ACA and the maintenance of the HSF. Despite the sustained level of coverage for SF residents, City agencies, non-profit hospitals, and healthcare providers must continue to foster shared responsibility to maintain progress made, particularly in the face of ongoing

affordability concerns and ongoing legal challenges to the ACA. For San Francisco's most vulnerable populations, health care delivery is shifting toward "whole person care" model which consists of care coordination, integration of physical and mental health, and collaboration between medical and social service providers. HSF, as the coverage program for those with no other options, will continue to explore ways to better outreach to potential participants so that coverage remains accessible.

Website Activity

The websites for HSF (http://healthysanfrancisco.org) serves as gateways for program participants. This website provides information about the application process, program fees and resources, and the medical home network amongst other information.

During FY19-20, there were 143,766 visits to the HSF website. This reflected a 10% decrease in web traffic in comparison to the previous year. The most commonly viewed pages on the website included the homepage followed by pages with information about eligibility requirements and information about the HSF fees. Approximately 94% of views were to the English pages, which was consistent with the data observed in the past several years. This suggests that the program explore other media and platforms to communicate and outreach to current and potential participants, particularly the non-English speakers.

Participant Outreach

Certified Application Assistors (CAAs) perform all HSF enrollments in person except when policies allowed for remote enrollment due to COVID-19. HSF has a one-year coverage period, so the need for timely renewals is a primary reason for participant outreach. The program's renewal reminder outreach begins 60 days before participants' current term concludes to encourage continuous enrollment. Renewal notices were turned off to prevent confusion due to automatic enrollment extensions in response to COVID-19. Prior to these COVID-19 enrollment policies, outreach may consist of:

- Mailed notice at 30 and 60 days before term ends;
- Automated phone call at 45 days before term ends;
- Live telephone call between 15-30 days before term ends; and
- E-mail reminder (in lieu of a live phone call if the preferred mode of contact is email).

During the pandemic, the HSF program implemented policies to ensure participants could maintain their health coverage. The program conducted outreach to participants, including notification of no-cost extensions, pause on disenrollments due to non-payment of participant fees, and availability of participant fee waiver programs.

Since the HSF program mainly serves the low-income population not eligible for other federal programs, the City's Human Services Agency partnered with HSF to make available $200 grocery gift cards to 2,631 very low-income HSF participants who were not eligible for other types of support for healthy food during the pandemic.

Assistor Outreach and Training

HSF Application Assistor training is an ongoing aspect of the program to ensure that the CAAs are aware of current policies and best practices that affect their work. In FY19-20, HSF held 15 application assistance orientation and refresher trainings with 26 new application assistors certified and 201 existing CAAs re-trained. In addition to these trainings, the program provides quarterly Assistor Update digitally to ensure

that all CAAs receive updates on changes to programs and share best practices. As of the end of FY19-20, there were 97 active HSF Application Assistors working from 31 HSF enrollment sites.

Applications

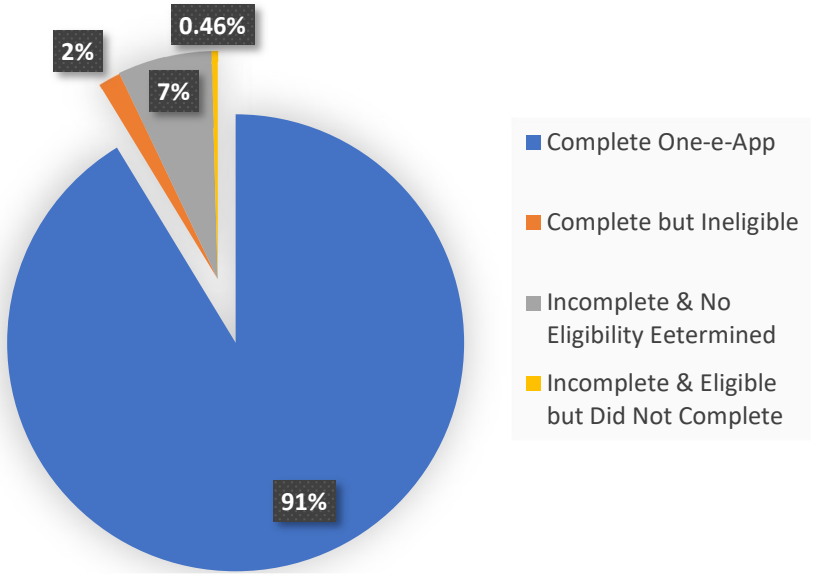
In FY19-20, 9,597 applications were completed successfully in One-e-App enrollment system on behalf of 12,109 unique applicants (Table A1). Of the 12,109 applicants, 11,684 (or 96%) applicants were enrolled into HSF, 405 were referred to Adult Medi-Cal (Restricted) and 20 were referred to Child Health and Disability Prevention (CHDP). All applicants are pre-screened for Medi-Cal and Covered CA before they are considered for any other programs; therefore, One-e-App does not screen for these two programs.

With the implementation of Shelter in Place orders in San Francisco, all the HSF enrollment sites closed, with most sites discontinuing new or renewal applications. Some clinic-based enrollment sites continued to do enrollment to patients. In conjunction with the automated extension of participants' enrollment periods, there was a significant decrease in applications completed in the last quarter of FY19-20. HSF began offering remote appointments, but the volume remained low as participants did not need to complete renewals in the previous quarter.

Table A1:

Total HSF Applications Processed	# of Unique Applicants	% of Total	# of Distinct Applications
Complete One-e-App	12,109	91%	9,597
Complete but Ineligible	211	2%	166
Incomplete & No Eligibility Determined	882	7%	430
Incomplete & Eligible but Did Not Complete	61	0.46%	54
Total	**13,263**	**100%**	**10,247**

Figure A1: Total HSF Applications Processed- Pie Chart



Ninety-one percent (91%) of the HSF Applications processed via One-e-App are complete and eligible.

Nine percent (9%) were either incomplete or ineligible.

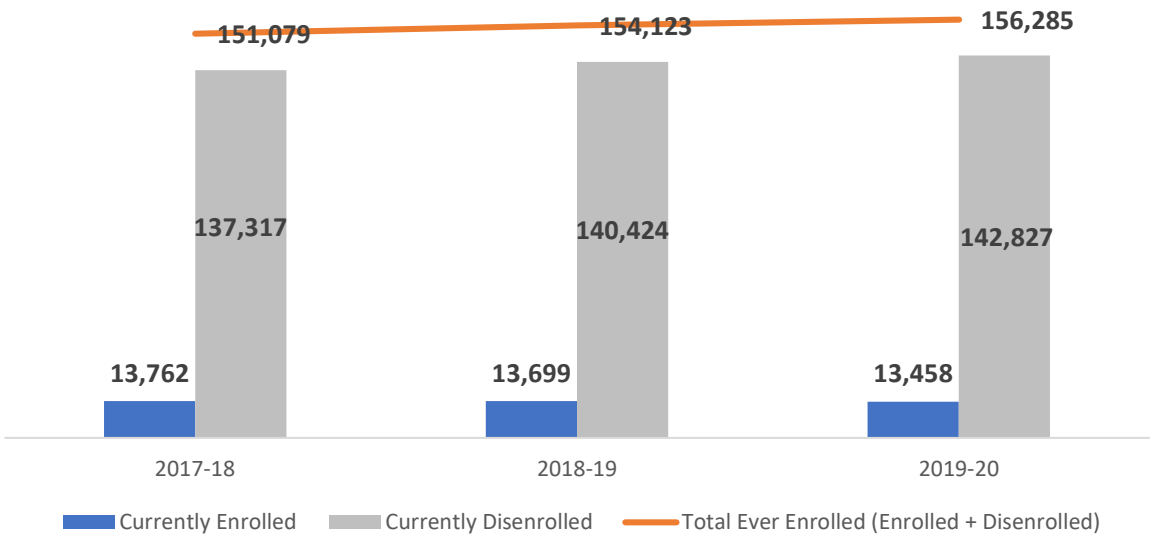
Application Auditing

HSF has been implementing application audits since FY16-17. The goals were to evaluate the completeness and correctness of submitted applications. Internal assessments help ensure that HSF meets audit criteria that make additional assistance programs available to participants, such as patient assistance programs for pharmaceutical products. Specifically, 178 of 1,409 applications were audited and 92 of the applications passed. Applications that did not pass were corrected by assistors who were required to locate missing documents and finalize other incomplete sections that were identified. Each audited application was reviewed based on the following criteria: completeness and accuracy of the application, and a review of verification documents attached to the application, such as proof of residency. HSF Application Assistors receive direct training and guidance for corrective action when errors are found on their applications.

Enrollments, Disenrollments, and Re-enrollments

HSF is a voluntary program with no penalties for failure to enroll or disenroll. It facilitates enrollment to the greatest extent possible by minimizing barriers to enroll. However, some eligible uninsured adults may still elect not to participate. At the end of FY19-20, the program recorded 13,458 active participants and 142,827 disenrolled participants (Figure A2).

Figure A2: Unduplicated Count of Total Ever Enrolled at the End of Fiscal Year



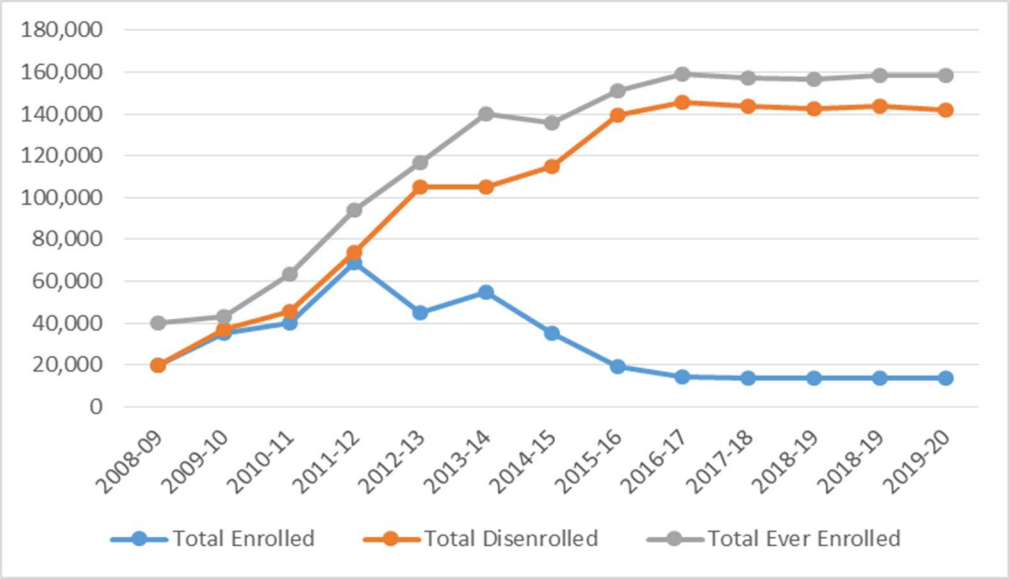
91%

Total Disenrollment Rate for FY 17-18, FY18-19, FY 19-20

Top Reasons for the 91% Disenrollment Rate

1. No longer met program eligibility criteria
2. Voluntarily disenroll
3. Did not pay quarterly participation fees
4. Failed to renew during annual renewal

Figure A3: Enrollment, Disenrollment, and Ever Enrolled (FY07-08 to FY19-20)



At the end of FY19-20, 142,827 (or 91%) HSF participants were disenrolled. Aside from successful transitions to new insurance options, disenrollment occurred for various reasons. These included participants who: (1) no longer met program eligibility criteria; (2) chose voluntarily to disenroll; (3) did not pay quarterly participation fees in a timely manner; or (4) failed to renew enrollment during the annual renewal process.

Pausing Disenrollments Increase the Number of Participants

HSF paused disenrollment by implementing auto extension of participants enrollment dates and pausing disenrollment due to failure to pay participant fees. These policy implemented in FY19-20 had increased the program enrollment as shown in Figure A4. HSF anticipates that in FY20-21 as capacity for remote appointments increases and as program policy support continues, the overall enrollment numbers will climb, reversing the trend of the drop in enrollment due to participants moving to alternative coverage options. However, the full impacts to HSF enrollment cannot be predicted given the changing nature of the pandemic and unknowns of future local, state and federal health care policies.

Multiple Enrollments and Disenrollments

The retention efforts of HSF include monitoring multiple enrollments and disenrollments of program participants. Since the program began in July 2007, 63,108 individuals have been disenrolled at least twice (Table A2). Just under 10% of individuals with multiple enrollments and disenrollments were currently enrolled.

The 63,108 individuals who churned through the program in FY19-20 did so over the course of 163,852 total enrollment periods. An enrollment period is defined as the length of time a member stays enrolled in HSF until disenrollment. Seventy-eight percent (78%) of those enrollment periods lasted between 10-12 months, followed by 15% lasting between one to three months (see Figure A5). This indicates that participants either left HSF soon upon enrollment or elected to remain with the program throughout their coverage.

Figure A4: Pausing Disenrollments Increase the Number of Participants

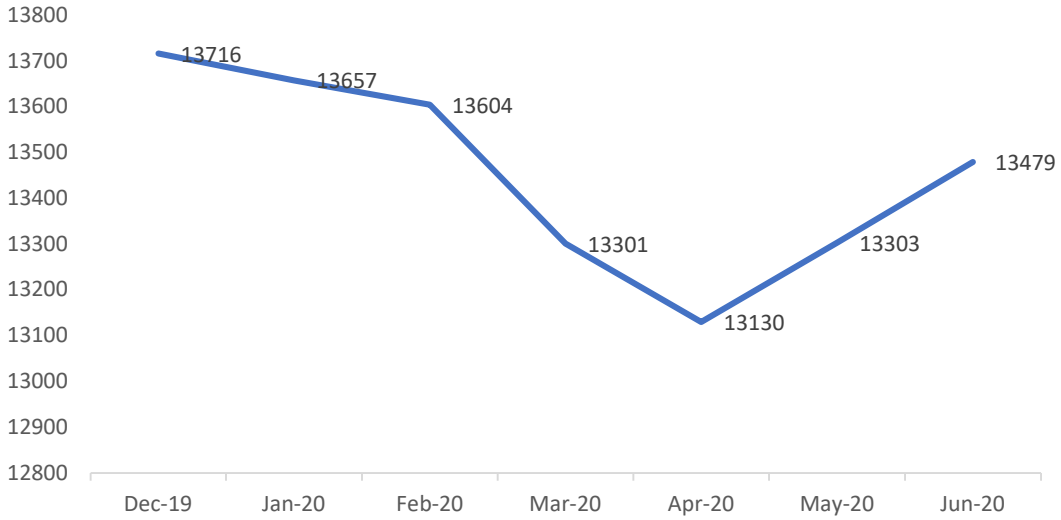


Table A2: Enrollment Status of Individuals with Multiple Enrollments and Disenrollments

	FY16-17		FY17-18		FY18-19		FY19-20	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Currently Enrolled	4,928	8.5%	5,462	9.2%	5,596	9.1%	6,112	9.7%
Currently Disenrolled	52,740	91.5%	54,182	90.8%	55,982	90.9%	56,996	90.3%
Total	**57,668**	**100%**	**59,644**	**100%**	**61,578**	**100%**	**63,108**	**100%**

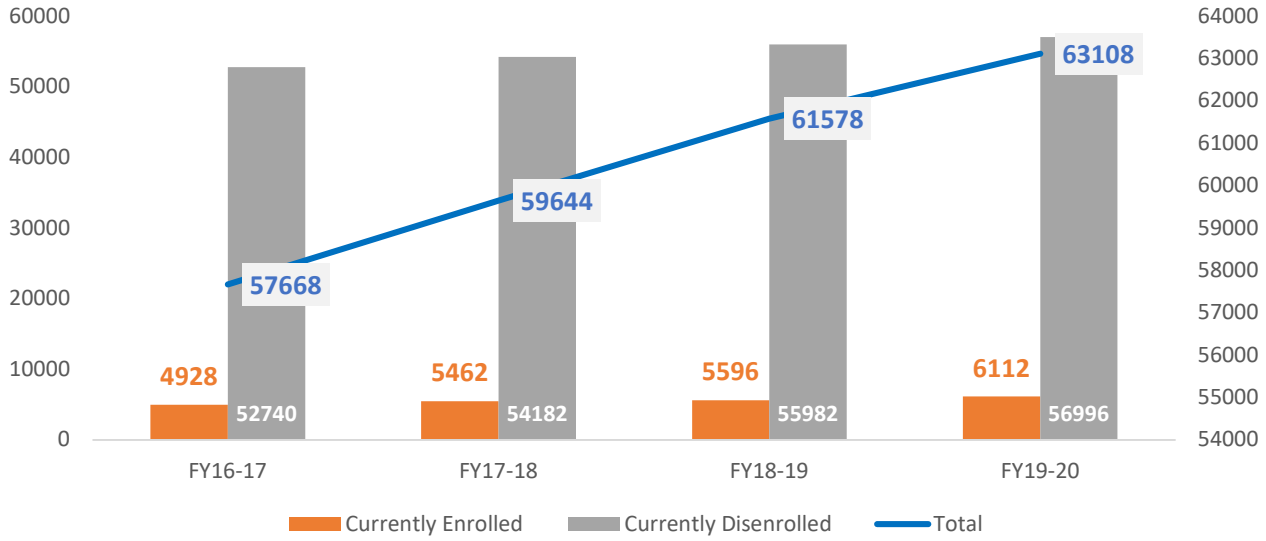
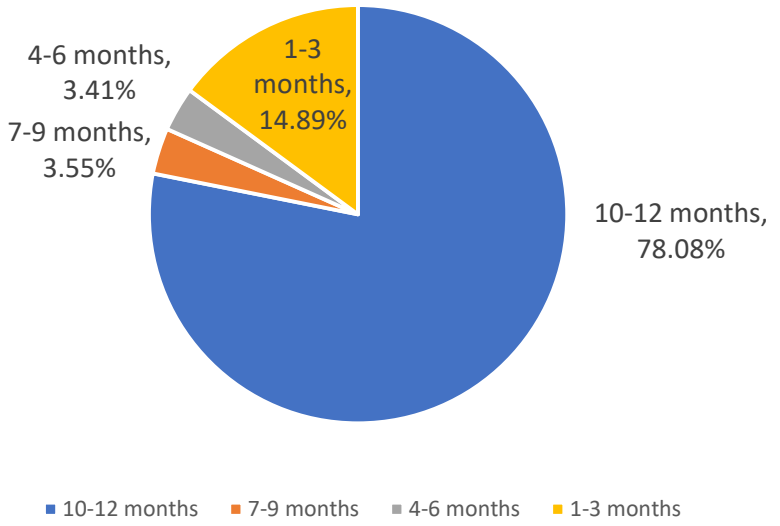


Figure A5: Length of Enrollment for Individuals with Two or More Disenrollments



Seventy-eight percent (78%) of the participants stayed on for 10 to 12 months, and the top reason for multiple disenrollment is failure to complete rescreening

As shown in Figure A5, seventy-eight percent (78%) of the participants stayed on the plan for 10 to 12 months. Further data indicated that they were disenrolling mainly because they did not complete the rescreening process. The second reason was for insufficient payment of participation fees, at 11% (Table A3). Approximately 11% of the participants disenrolled because they enrolled or qualified for other health programs.

Table A3: Reasons for Individuals with Multiple Disenrollments

Disenrollment Reasons	Number	Percent
Did Not Complete Renewal or Failure To Complete Rescreening	46,688	74%
Insufficient Payment of Participation Fees	7,029	11%
Transitioned to SF PATH Program	2,334	4%
Enrolled in Public Coverage	1,473	2%
Determined Eligible for Other Programs During Renewal or Modification	1,075	2%
Enrolled in Employer-Sponsored Insurance	972	2%
Enrolled in Medi-Cal	862	1%
Other	2,675	4%

B. Participant Demographics

Overall, there was just under a 2% in the number of participants enrolled in HSF in FY19-20 compared to the same point in the previous year (FY19-20: 13,458; FY18-19: 13,699). The demographics of the participant pool have remained relatively similar over the last four years. This year immigration status was eliminated as a driving factor in participants' ineligibility for other health insurance programs. The full effect of this policy is anticipated in FY20-21. Latinos continued to make up over 71% of HSF participants.

In FY19-20, participants 65 years of age and older (the "65+") who were eligible for enrollment or renewal with HSF made up 4% of the HSF participant population. Of the 736 participants in this cohort, eighty-eight percent (88%) either enrolled in a San Francisco Health Network (SFHN) or San Francisco Community Clinic Consortium medical home. Fifty-seven percent (57%) of the 65+ had a medical home within SFHN. Additionally, nineteen (19%) participants in this cohort lived in the Excelsior and Outer Mission neighborhoods of San Francisco. Relative to the general HSF population, the 65+ were more likely to:

- have income below 100% Federal Poverty Level (FPL) (77% of 65+ vs. 44% of 18-64);
- be female (55% of 65+ vs. 49% of 18-64); and
- have a known chronic disease (36% of 65+ vs. 13% of 18-64).

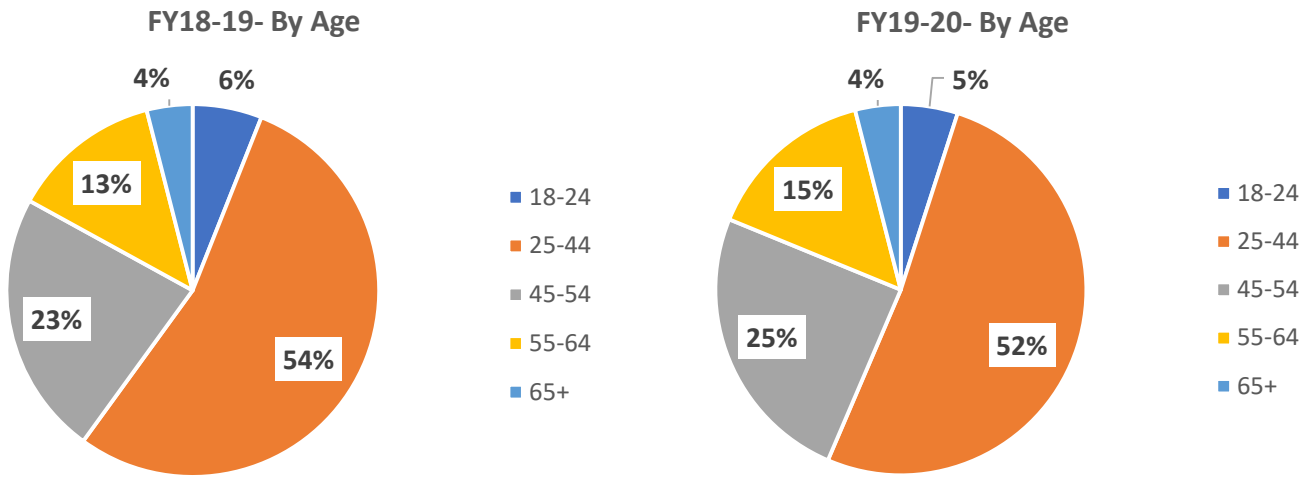
Moving forward, HSF will continue to monitor the distribution and patterns of utilization within this subset of the participant population as compared to that of the program's at-large population.

Key Demographic Figures

Figure B1 compares the primary demographic indicators for the HSF participants between the current and prior year. There was little change in demographics regarding languages spoken. Seventy-one percent (71%) of program participants are Spanish speaking.[1]

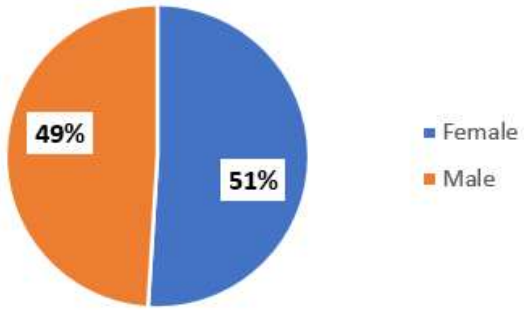
San Francisco's most recent Community Health Needs Assessment identified addressing racial health inequities and increasing access to coordinated, culturally, and linguistically appropriate services across the continuum as key community needs. HSF maintains its commitment to meeting the changing needs of the program participants and aligning with other City departments and community stakeholders to optimize program outreach and provision of services.

Figure B1: Two-Year Demographic Comparison of HSF Participants

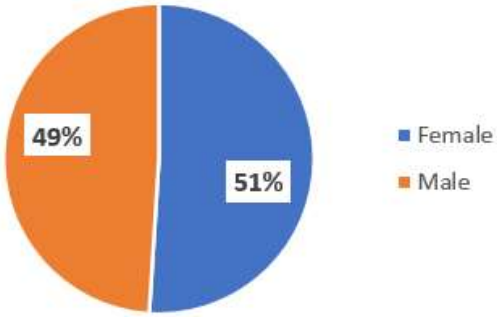


[1] Healthy San Francisco Annual Report Demographics Utilization FY2019-20

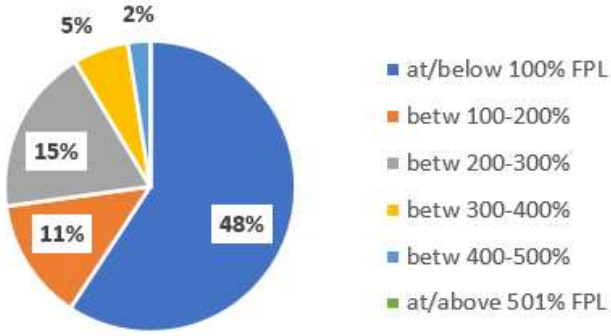
FY18-19 By Gender



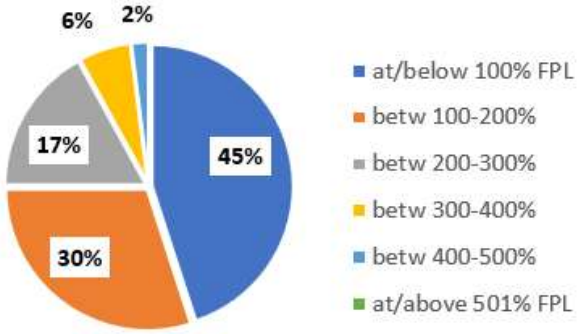
FY19-20 By Gender



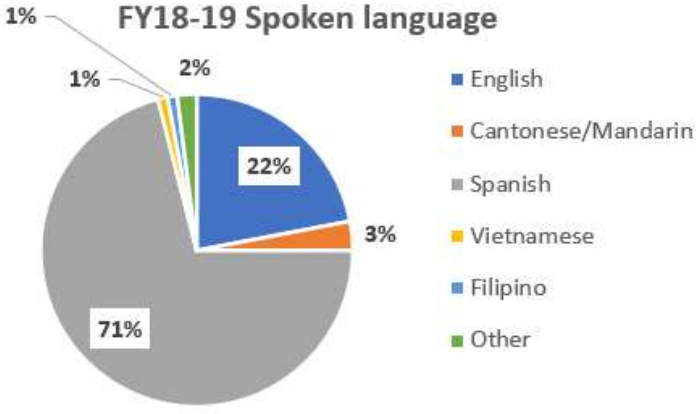
FY18-19 By Income



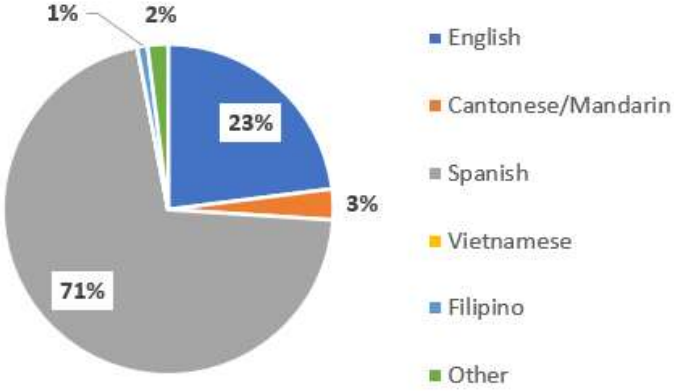
FY19-20 By Income



FY18-19 Spoken language



FY19-20 Spoken language

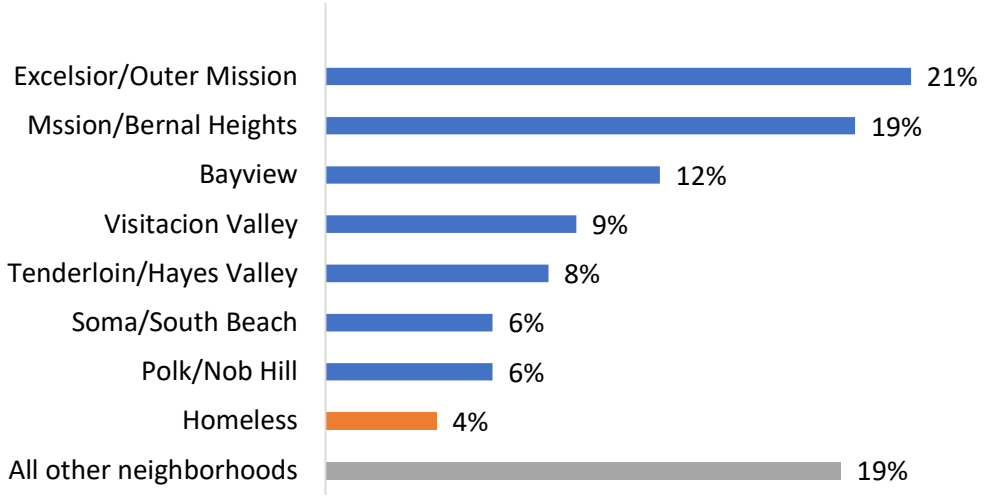


Neighborhood Distribution

The majority (81%) of all HSF participants resided in seven San Francisco neighborhoods in FY19-20 (Figure B2). Specifically, twenty-one percent (21%) of HSF participants resided in the Excelsior/Outer Mission, and 19% in the Mission/Bernal Heights neighborhood. Four percent (4%) reported being homeless. It is possible that this number is underestimated as some homeless individuals may use their medical clinic or a transient housing address when applying for HSF.

Geographically, each of these neighborhoods touch upon another forming a corridor that runs through the middle of San Francisco (Figure B3). HSF utilization by ZIP code data supports this pattern and illustrates that the highest concentrations of participant visits come from these areas as well. ZIP codes 94112 and 94110 account for 40% of the program's member months. The distribution of the program's member months by ZIP code has remained constant from last year.

Figure B2: Healthy San Francisco Participants by Neighborhood



Given their limitations, neither neighborhood nor ZIP code geographic designations cannot serve as perfect indicators of the overall health or utilization patterns of the residents who live there. They are, however, strong approximations that help identify the geographic concentrations of communities' health needs. ZIP code level data limitations can be observed where neighborhood boundaries overlap multiple zip codes. For example, the Tenderloin neighborhood constitutes a significant portion of ZIP code 94102, however, it also blends over into ZIP code 94109. The Nob Hill neighborhood is one of the most affluent in San Francisco; however, it is also designated by ZIP code 94109. The concentration of HSF participants and utilization from 94109 is most likely due to participants who reside in the Tenderloin neighborhood at the southern end of the ZIP code.

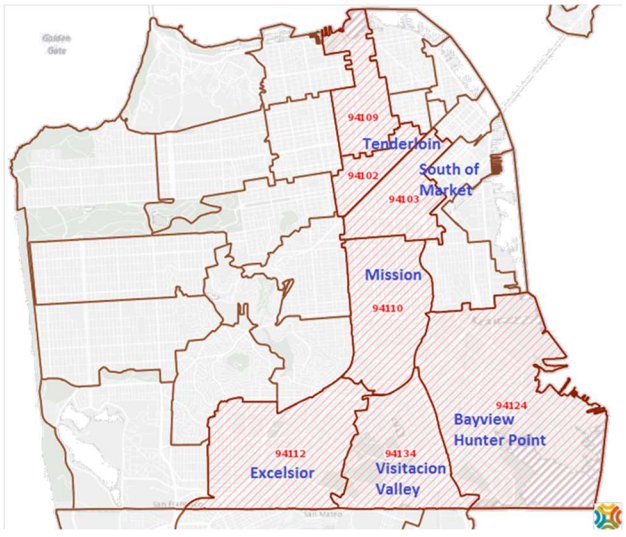
Figures B3 and B4 below further highlight the geographic distribution of these ZIP codes as well as their relation to the census tracts in San Francisco with the highest concentrations of unmet health needs. Neighborhood and ZIP code designations can provide broader insights into access and utilization patterns. Figure B3 illustrates where the highest concentrations of HSF participants reside by ZIP code. Figure B4 depicts the mapping of concentrations of unmet health needs in the City. The orange areas highlight where at least 25% of residents live below the FPL. The purple areas indicate where at least 25% of residents have not completed high school. The dark red areas depict where these two indicators overlap.

Table B1: Healthy San Francisco Participants by Neighborhood and ZIP Code

Neighborhood	Approximate Zip Code	Total Participant Months	% of Total Participant Months	Avg. # of Participants in FY19-20
Excelsior	94112	34009	21%	3,551
Mission	94110	31940	19%	3,330
Bayview Hunters Point	94124	18869	12%	2,040
Visitacion Valley	94134	14392	9%	1,526
Tenderloin	94102	11889	7%	1,278
South of Market	94103	10168	6%	1,072
Nob Hill	94109	10414	6%	1,107
All Other SF Neighborhoods		31067	19%	3,373

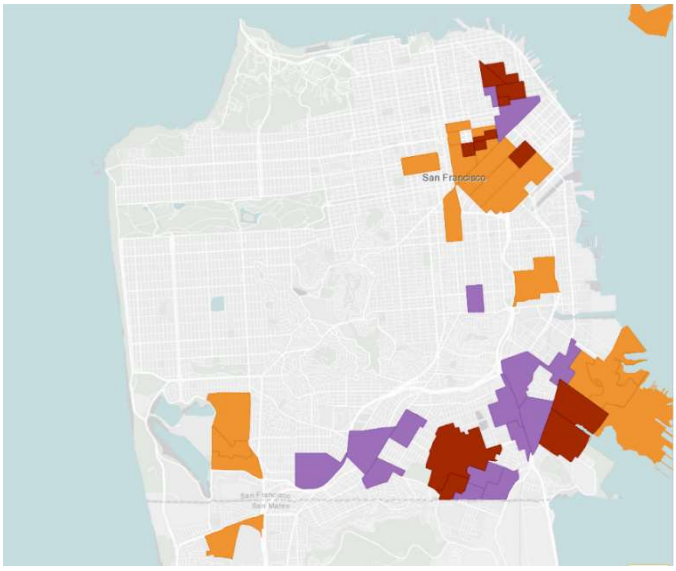
81% of HSF participant's residency

Figure B3:
Highest Concentration of HSF Participants



Source: www.communitycommons.org

Figure B4:
Highest Concentration of Unmet Health Needs



Source: www.communitycommons.org

Mapping census tract-level data such as percentage of residents living below the Federal Poverty Limit or who have not completed high school can provide a gauge of where health needs are greatest in a given region. These maps show that the highest concentrations of HSF participants and the programs highest utilizers largely reside in sections of the city

At least 25% of residents live below FPL
At least 25% of residents have not completed high school
Meets both criteria

where health and social needs are greatest. The City has made increased availability of primary care in low-income areas with documented high rates of health disparities a priority.[2] HSF is committed to dedicating resources to increase access to preventive services and care for the City's most vulnerable populations.

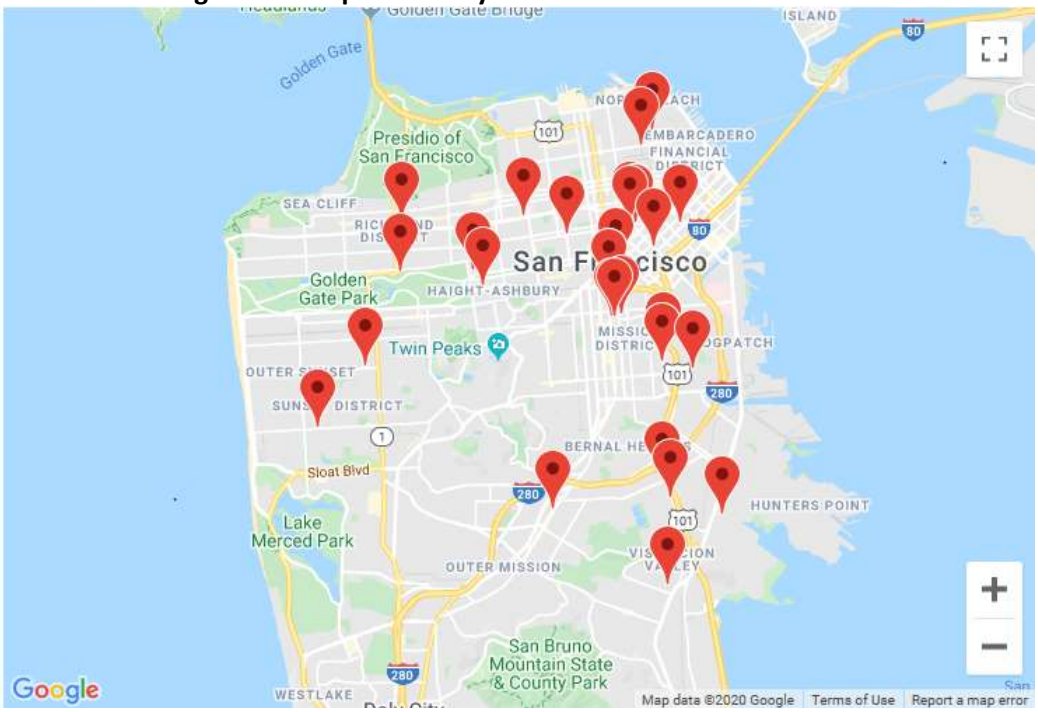
C. Provider and Pharmacy Network

This section provides updates on HSF's delivery system in FY19-20 including medical homes, hospitals as well as behavioral health and pharmacy services.

Medical Home Distribution

At the time of enrollment, HSF participants select a medical home where they will receive primary and preventive care services. The medical home assists participants' navigation through the health care delivery system and coordinates their access to specialty, inpatient, pharmacy, ancillary, and behavioral health services. 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



Source: http://healthysanfrancisco.org/medical-home-map/

At the end of FY19-20, fifty-seven percent (57%) of HSF participants selected a home within the San Francisco Health Network. SFHN is the integrated health delivery system of the SFDPH. It consists of: (1) several primary care and specialty care clinics throughout San Francisco; (2) Zuckerberg San Francisco Hospital and Trauma Center (ZSFG); (3) Laguna Honda Hospital and Rehabilitation Center; and (4) behavioral health and substance abuse services. The next most commonly used medical home system was

[2] Ibid. See footnote #1 above.

the San Francisco Community Clinic Consortium. This network of clinics was home to 30% of HSF participants.

Table C1 provides the distribution of HSF participants across the program's five primary care medical home delivery systems through FY19-20.

Table C1: HSF Participants by Medical Home System

Delivery System	Count	Percent
San Francisco Health Network (SFHN)	9,850	57%
San Francisco Community Clinic Consortium (SFCCC)	5,109	30%
Kaiser Permanente – San Francisco	935	5%
Sister Mary Philippa Health Center (SMP)	353	2%
NEMS (North East Medical Services)	1,030	6%
Total	17,277	100%

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

Hospital Network

ZSFG provides a range of specialty, urgent care, diagnostic, emergency care, home health, pharmacy, durable medical equipment (DME), and inpatient services to all HSF participants enrolled with a SFHN and SFCCC affiliated medical home. ZSFG also provides services to HSF participants with other medical homes for select covered services not offered at their assigned medical home network.

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

- California Pacific Medical Center (CPMC) with four campuses – provides inpatient services to participants with North East Medical Services (NEMS) as their medical home;
- Kaiser Permanente San Francisco Medical Center – provides inpatient and other specialty services to participants with Kaiser as their medical home;
- St. Francis Memorial Hospital (Dignity Health) – provides certain specialty services to participants with Tenderloin Health Services as their medical home; St. Francis Memorial Hospital was off boarded along with Tenderloin Health Services effective October 2019.
- St. Mary's Medical Center (Dignity Health) – provides inpatient and other specialty services to participants with Sister Mary Philippa as their medical home; and
- UCSF Medical Center – provides referral-based diagnostic imaging services at its Mission Bay site as well as services, such as cardiac surgery, that are not provided at ZSFG.

At the end of FY19-20, the HSF provider network had 31 medical homes and participating hospitals.

Behavioral Health Services

Most of the HSF medical homes provide some form of mental health assessment, mental health services, or substance use disorder screening. However, SFDPH's Behavioral Health Service (BHS) provides all contracted mental health and substance use disorder services for the program participants regardless of their medical homes. HSF participants have access to a comprehensive array of community-based services offered by BHS including, but not limited to:

- Information and referral services;
- Prevention services;

- Full range of voluntary behavioral health services, including self-help, peer support, outpatient, case management, medication support, dual diagnosis treatment, and substance use disorder services; and
- 24-hour psychiatric emergency services and a crisis hotline.

Pharmacy Network Change

HSF participant's pharmacy benefit is tied to their medical home, thus participants may have different in network pharmacies and formularies. For participants enrolled with SFHN medical homes, they are able to access a network of Walgreens pharmacies. Three Walgreens Pharmacy locations available for SFHN participants were closed in FY19-20. DPH is working with Walgreens to identify additional pharmacy locations that can be onboarded to reduce the impacts to participants. There were no pharmacy network changes that affected participants enrolled with other medical homes.

D. Clinical Component and Services Utilization

This section examines HSF participants' clinical and service data to explore whether the program is meeting its goals concerning improved health outcomes and appropriate utilization of services. The data represented in this section may have been updated in some instances where additional encounter data from the previous fiscal year became available.

Medical encounters submitted by medical homes and facilities are used to capture the service utilization of HSF participants. Office visits, ED visits, and inpatient stays are primarily defined based on Healthcare Effectiveness Data and Information Set (HEDIS) value definitions. Behavioral health-related encounters reported by BHS. HSF outpatient pharmacy utilization is measured as prescriptions are filled. Medications administered by participants' physicians or related to inpatient stays are not reported here.

It is important to note that these figures only reflect the utilization of services provided through the HSF program. These figures reflect a partial scope of care likely received by program participants, meaning that it excludes care received outside of HSF through other public, private and charity programs.

The encounter data collected by the program to generate the findings here are assessed for completeness and quality on a regular basis. The encounter data helps HSF program management continuously seek operational and data collection improvement opportunities.

Office visits, emergency department (ED) visits, inpatient stays, behavioral health visits, and prescriptions filled are reported as the average number of participant visits per 1,000 member months (per member per month (PMPM) * 1000). In FY16-17, HSF adjusted the methodology used to calculate member months to improve the accuracy of participant monthly enrollment and utilization accounting. The modification allows the program to calculate partial periods of participants' program enrollment and use of services over a month. The PMPM calculation is as follows:

$$\frac{\text{\# of Visits or Prescriptions}}{\text{Total Fraction of Member Months}} \times 1000$$

Overall, service utilization remained relatively consistent with levels from FY2018-19, with a modest decrease in-office visits and a similar increase in inpatient visits. The greatest utilization by service type

is Office Visits at 59%, which has dropped 2% compared to prior year. Followed by Prescriptions Filled, which is stable with 30% utilization. The percentage of ED visits has increased from 9% to 11%. Mental Health Services, Substance Abuse and Inpatient services are all relatively stable and are utilized at 2% or less. (Table D1).

In addition, participants who reported poor health had higher office utilization and lower ED and inpatient utilization than those who reported difficulty. The overall utilization for mental health and substance use disorder appears to have been stable compared to FY18-19. It is worth noting that due to the pandemic and related SIP and other Health Officer Orders implemented to respond to the pandemic, utilization dropped significantly in the fourth quarter of FY19-20. The greatest utilization by service type is Office Visits at 59% utilization rate. This number has dropped 2% compared to the last fiscal year. Followed by Prescriptions Filled, which is stable with 30% utilization. The % of ED visits has increased from 9% to 11%. Mental Health Services, Substance Abuses, and Inpatient Services are all relatively stable and are utilized at 2% or less.

Table D1: Two-Year Comparison of HSF Utilization Rate by Service Type

		FY18-19	FY19-20
Office Visits	Percent Members with Office Visit	61%	59%
	Office Visits PMPY	3.25	2.78
Prescriptions Filled	Percent Members with Prescriptions Filled	30.5%	30.3%
	Prescriptions Filled PMPM*1000	314.19	292.47
Emergency Department	Percent Members with ED Visit	9%	11%
	ED Visits Per 1,000 Members Per Month (PMPM)*1000	16.47	18.86
Mental Health Services	Percent Members with Mental Health Visit	2.10%	2%
	Percentage Change in Number of Mental Health Visits from Previous Year	2.23%	1.77%
Substance Abuse Disorder Services	Percent Members with Substance Use Disorder Visit	0.42%	0.46%
	Percentage Change in Number of Substance Use Disorder Visits from Previous Year	2%	2.1%
Inpatient (IP)	Percent Members with IP Visit	0.7%	1.2%
	Number of IP Visits	140	244

Utilization Rates by Neighborhoods

A neighborhood breakdown of office visits indicates that participants from all neighborhoods had just under three office visits per year on average, 2.78 per member per year (PMPY). Compared to the previous fiscal year (3.25 vs 2.78 visits PMPY), the decrease in Q4 may be driven by the COVID-19 pandemic (office visits decreased by approximately 45% between Q3 and Q4). There were not significant outliers in outpatient service utilization by neighborhood. The Tenderloin and Nob Hill neighborhoods exhibited above-average prescription drug utilization for the fourth year.

Table D2: FY19-20 HSF Neighborhoods with Utilization Rates

	Excelsior (94112)	Mission (94110)	Bayview Hunters Point (94124)	Visitacion Valley (94134)	Tenderloin (94102)	*Nob Hill* (94109)*	So. of Market (94103)	All other neighborhoods (Average data)	Total Utilization HSF Program
# HSF Participants	3551	3330	2040	1526	1278	1107	1072	3373	17277
% of Total HSF Participants	20.6%	19.3%	11.8%	8.8%	7.4%	6.4%	6.2%	19.5%	100.0%
Office Visits PMPY	2.62	2.71	2.50	2.50	3.42	2.75	3.15	2.80	2.90
% Members with ED Visits	10%	12%	11%	9%	13%	11%	14%	15%	13%
ED Visits PMPM*1000	16.90	21.24	17.97	15.99	23.80	19.44	25.39	17.745	20.4795
IP Visits PMPM*1000	1.61	1.65	1.71	1.22	1.22	2.08	1.86	1.33	1.62
Prescriptions Filled PMPM*1000	250.64	257.00	218.62	282.022	480.03	400.48	311.41	248.21	279.85

**Figures reported here are likely skewed by geographic proximity to Tenderloin neighborhood*

Outpatient Office Visits Utilization

HSF participants had a total of 36,408 office visits in FY19-20. The percentages of participants who had an office visit were broken down into categories based on the type of application received by the program. Application types are categorized as either renewed, re-enrolled, or new. Renewed applications indicate that a participant has been enrolled in HSF for an extended period and can serve as a proxy indicator for individuals with consistent access to health care.

New and Re-enrolled applications indicate that the participant has either not accessed services through the program or has yet to do so consistently. There needs to be more certainty about the degree of access to health care these individuals may have before enrollment.

Figure D1 and Table D3 are two different visuals of showing the office visits utilization. Figure D1 shows outpatient visits PMPY across participant categories over the last three years. Table D3 is showing this by the percentage of members with office visits.

The number of office visits made by renewing HSF participants yearly has historically been highest for renewal participants. Figure D1 below shows that FY19-20 was consistent with this trend. Table D3 demonstrates that the renewing population continues to have the highest percentage of participants who had an office visit. This pattern has been consistent in recent years and reflects a greater degree of health needs and utilization by participants who chose to renew with HSF.

Figure D1: Outpatient Office Visits Utilization PMPY by HSF Application Type

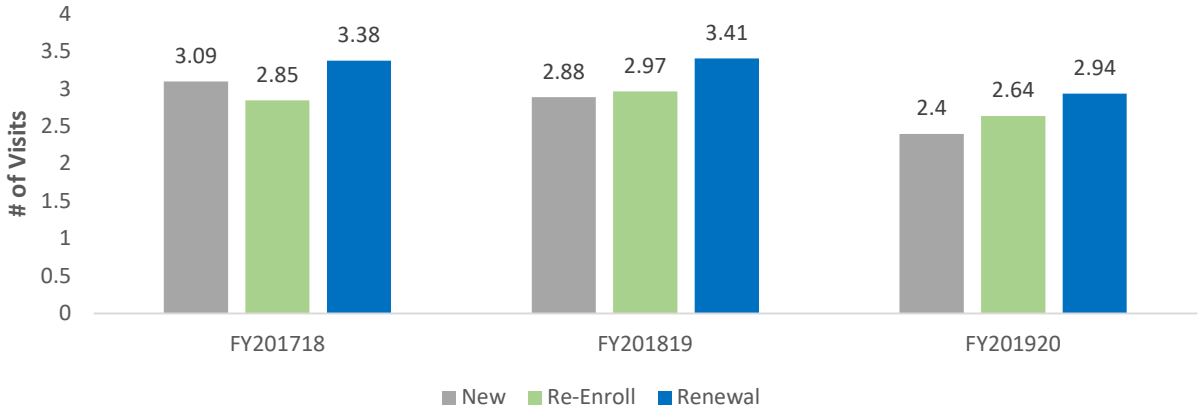


Table D3: Outpatient Utilization by Application Type

	Application Type	FY17-18	FY18-19	FY19-20
% Members with Office Visit	Overall	62%	61%	59%
	New	47%	45%	45%
	Re-Enroll	56%	57%	56%
	Renewal	71%	71%	68%

Outpatient Utilization by Medical Home Organization

Table D4 shows PMPY with at least one office visit within their Medical Homes. Compared to FY17-18, all four of the medical home had a steady decrease in-office visits. Sister Mary Philippa had the highest PMPY among all medical homes and its PMPY has decreased from 6.09 to 5.25. This overall decrease in the outpatient office visits trend is consistent with Figure D2 and Table D3. As mentioned previously, the decreased office visit utilization may be due to various COVID-19 health orders or the reduced number of new applications.

Table D4:
Outpatient Visit PMPY for Participants with at Least One Office Visit by Medical Home Organization

Medical Home Organization	FY17-18	FY18-19	FY19-20
Sister Mary Philippa	6.03	6.09	5.25
SFHN	4.82	4.86	4.22
KAISER	3.19	3.10	2.51
SFCCC (including NEMS)	4.40	4.42	4.28

ED Services Utilization

Healthy SF monitors participants' emergency room utilization because it provides insight into the proportion of participants who may not be accessing primary care services and are looking for treatment in emergency rooms. In FY2019-20, the overall percentage of HSF participants with an ED visit stayed reasonably consistent with the prior year. Still, the average number of visits per 1,000 participants increased by approximately to 18.86 ED visits per month. However, this rate was considerably higher for Healthy SF participants who had at least one office visit within the year than those without office visits

(Table D5). These statistics suggest that ED utilization is driven by individuals with established care, the individuals were not utilizing the ED as their primary source of care. This increase may also be due to individuals seeking services at the ED due to reduced capacity at clinics due to COVID.

Table D5: Comparison of ED Utilization with and without at Least One Outpatient Office Visit

ED Visits PMPM *1000	FY17-18	FY18-19	FY19-20
Total ED Visits PMPM * 1000	13.20	16.47	18.86
Overall with Office Visit	16.27	20.75	25.12
Overall with No Office Visit	5.98	6.63	6.38

Figure D2 shows Sister Mary Philippa (SMP) had the highest overall ED visits, averaging 0.35 PMPY. While SMP and Kaiser had a relatively stable trend, both SFHN and SFCCC had a slight increase with ED visits. This trend is consistent with the higher overall ED utilization seen in the HSF participant population.

Figure D2: ED Visits by Medical Home Per Member Per Year

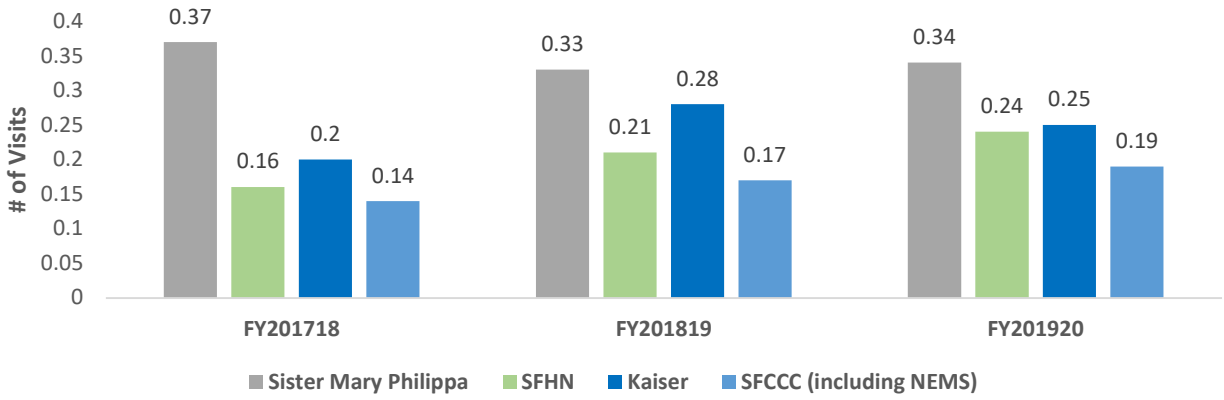


Table D6 shows 11.6% of SFHN participants had at least one ED visit throughout FY19-20. SFCCC reported the lowest percentage of its HSF participants with an ED visit; only 9% visited the ED in FY19-20. All medical home network had experienced a steady uptrend for ED utilization with the exception of Kaiser. SFHN experienced a 2.5% increase in ED utilization. This trend is also consistent with Figure D2.

Table D6: ED Utilization by Medical Home Organization for Participants

Medical Home Organization	FY17-18	FY18-19	FY19-20
Sister Mary Philippa	15.3%	15.3%	15.9%
SFHN	8.3%	9.1%	11.6%
KAISER	10.2%	11.2%	10.9%
SFCCC (including NEMS)	6.9%	7.9%	9%

Inpatient Utilization

Historically, less than one percent (<1%) of all HSF participants were admitted for inpatient care. However, this trend ended in FY19-20 as inpatient utilization nearly doubled (albeit it is still shallow). Inpatient utilization in FY19-20 increased from what was observed in FY18-19 at approximately 1.55 visits per 1,000 members per month (Table D7). Many variables may influence the increase in inpatient utilization, such as COVID-19. Since participants may receive services outside of their HSF-designated

hospital and the program would not capture those visits, it may be the case that in FY19-20, more participants were admitted to their HSF network hospital. Quality of data may also be a factor.

Table D7: Inpatient Utilization Rate

	FY17-18	FY18-19	FY19-20
% Members with IP Visit	0.64%	0.69%	1.24%
IP Visits PMPM*1000	0.80	0.88	1.55

ZSFG is the designated in-network hospital for participants assigned to SFHN and SFCCC medical homes, and rates of inpatient stay vary widely across medical homes. Over the last year, the total number of hospital admissions increased 74%, from 140 to 244, for the entire patient population. Kaiser Permanente has established itself as the leading medical home organization regarding the reduction of its hospitalization rate, which has reportedly remained at 0 per 1000 members for the last four fiscal years. For the fourth year in a row, Kaiser did not report any members who had an IP visit. Given the small number of inpatient admissions for all of the HSF program medical homes and the smaller number of participants enrolled with Kaiser, this likely reflects a particular cohort of HSF participants.

Table D8: Inpatient Utilization by Medical Home Organization for Participants

	Medical Home Organization	FY17-18	FY18-19	FY19-20
% Members with IP Visit	Sister Mary Philippa	2.50%	1.98%	2.57%
	SFHN	0.69%	0.82%	1.55%
	Kaiser	N/A	N/A	0.75%
	SFCCC (including NEMS)	0.54%	0.51%	1.63%
IP Visits PMPM*1000	Sister Mary Philippa	3.47	2.71	4.84
	SFHN	0.86	1.03	1.93
	Kaiser	N/A	N/A	0.88
	SFCCC (including NEMS)	0.68	0.67	1.32

Utilization by Age, Application Type, and Service Type

Effective January 2015, participants age 65 and over (the "65+") can enroll or remain in HSF if they meet all other program eligibility requirements. Through the end of FY19-20, 736 HSF participants 65+ had enrolled or aged into HSF – just under a 3% decrease from FY18-19. Utilization of the 65+ HSF participants continued similar trends across genders in FY19-20. Similar to what was observed the year before, this cohort reported more office visits annually than those age 18-64 (Table D9). Renewing HSF participants who were 65+ were the most likely to have an office visit across all application types from both age groups.

Seventy-five percent (75%) of 65+ HSF participants had an office visit in FY19-20. Seventy-eight percent (78%) of those who renewed their enrollment had at least one office visit. By comparison, fifty-six percent (56%) of continued HSF participants age 18-64 had an office visit in FY19-20. Interestingly, within the 65+ population, inpatient visits had vastly different rates between male and female participants over 65. Participants younger than 65, male participants also had higher rates of inpatient visits. This is dramatically different from FY18-19, where the difference in rate between male and female participants was closer. The effects of COVID-19 in the last quarter may have contributed to the difference, and it will be interesting to see if the difference between gender persists. There was little

change in the inpatient visit per participant per year statistic for the 65+ for FY19-20 compared to last year.

Table D9: FY19-20 Utilization by Age, Application Type and Service Type

	Application Type	18-64			65 and Over		
		Female	Male	Total	Female	Male	Total
Total Office Visits	Overall	18,854	14,882	33,736	1,488	1,184	2,672
% Members with Office Visit	Overall	65%	52%	59%	76%	73%	75%
	New	50%	41%	45%	61%	52%	57%
	Re-Enroll	61%	51%	56%	75%	81%	78%
	Renewal	74%	61%	68%	79%	77%	78%
Office Visits PMPY	New	2.52	2.21	2.35	4.36	4.35	4.35
	Re-Enroll	2.85	2.33	2.59	4.67	3.34	3.96
	Renewal	3.22	2.45	2.85	4.47	4.68	4.56
% Members with ED Visit	New	7%	10%	9%	13%	5%	9%
	Re-Enroll	11%	10%	10%	13%	11%	11%
	Renewal	12%	12%	12%	13%	12%	12%
IP Visits PMPM*1000	New	1.58	2.25	1.95	0.00	13.42	5.97
	Re-Enroll	1.67	1.35	1.51	0.00	4.22	2.25
	Renewal	1.00	1.56	1.27	1.29	5.95	3.30
% Members with Prescriptions Filled	New	18%	16%	17%	31%	25%	28%
	Re-Enroll	29%	25%	27%	31%	32%	31%
	Renewal	41%	35%	38%	47%	43%	45%

Utilization by Chronic Disease Indicator

Table D10 compares HSF participants age 65+ and those ages 18-64 with a chronic disease by service utilization. The data shows that service utilization for the 65+ participants who had chronic conditions was higher than those who did not have a chronic illness for outpatient visits, ED visits, and inpatient visits.

Regardless of age, HSF participants with a chronic disease were more likely to have an office visit when compared to participants with no chronic disease. Participants age 65+ were more likely to have an office visit and made repeat visits per year when compared to participants ages 18-64 for both with or without a chronic disease indicator. HSF participants from the 65+ with a chronic disease group were more likely to have an inpatient visit in FY19-20 and about the same likelihood to have an ED visit when compared to their 18-64 counterparts.

In FY19-20, those with chronic disease and age 65+ also saw a decrease in utilization of office visits with an increase in ED and inpatient services as compared to FY18-19, similar to HSF participants as a whole. Rates of inpatient visit for those 65+ with chronic disease doubled in FY19-20 as compared to FY18-19. This may be the result of overall reduction in utilization due to COVID-19 on preventative services but increase in ED and inpatient services. It will be interesting to observe the utilization rate in FY20-21 to determine if this represents an increased illness due to COVID-19.

Table D10: FY19-20 Utilization by Chronic Disease Indicator, Age Category, and Service Type

		Chronic Disease Indicator	
	Age	**No/No Encounter Data Available**	**Yes**
% Members with Office Visit	18-64	54%	88%
	65 and over	66%	90%
Office Visits PMPY	18-64	2.35	4.79
	65 and over	3.24	6.45
% Members with ED Visit	18-64	10%	18%
	65 and over	7%	19%
IP Visits PMPM*1000	18-64	1.13	3.46
	65 and over	2.24	5.49

HEDIS logic is used to identify the specific types of claim lines and the applicable diagnosis codes (Diagnosis Codes 1-3) and to flag those lines as "inpatient" or "outpatient". A participant is determined to have a chronic disease condition if: (1) an applicable diagnosis code is found on one inpatient encounter within 24 months of when the data was collected; or (2) an applicable diagnosis code is found on two outpatient encounters on different dates of service within 24 months of when the data was collected. The Clinical Classifications Software and the CMS Chronic Conditions Warehouse (CCW) tools can identify disease and condition classifications.

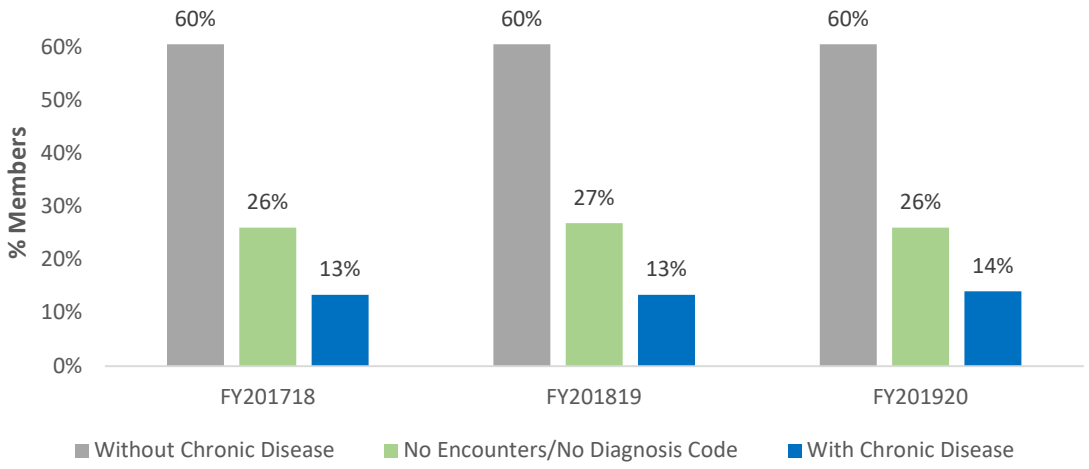
Table D11: Chronic Disease Conditions Identified Using Clinical Classification

Asthma/COPD	Ischemic Heart Disease	Cancer of Male Genital Organs	Cancer of the Breast	Liver Disease
Chronic Kidney Disease	Tobacco Use	Cancer of Lymphatic & Hematopoietic Tissue	Cancer of Bronchus, Lung	Paralysis
Heart Failure	Wounds (Pressure & Chronic Ulcers)	Cancer of the Ovaries & Other Female Genital Organs	Skin Cancer	Epilepsy: Convulsion
Hepatitis C	Alcohol Related Disorder	Cancer of the Urinary Organs	Cancer of Uterus & Cervix	Schizophrenia; Other Psychotic Mood Disorder
HIV/AIDS	Diabetes with Complications	Cancer; Other Primary	Cerebrovascular Disease	Personality Disorders
Hypertension	Diabetes without Complications	Delirium, Dementia, & Other Cognitive Disorders	Suicide & Intentional Self-Inflicted Injury	Substance – Related Disorder

Participants with Chronic Disease by Fiscal Year

The prevalence of HSF participants with a chronic disease diagnosis has remained consistent over the last three years (Figure D3), with 60% of HSF participants who do not have any reported chronic disease, 26% with no encounters or no diagnosis code and 14% with chronic disease. Despite the efforts to collect and report complete participant data, typically, only 70% of participants' diagnosis information is available any given year. As mentioned above, the program has improved its accuracy in calculating service utilization, but this does not offset preexisting data limitations. Therefore, interpreting all findings here must account for the incompleteness of encounter data available to the program.

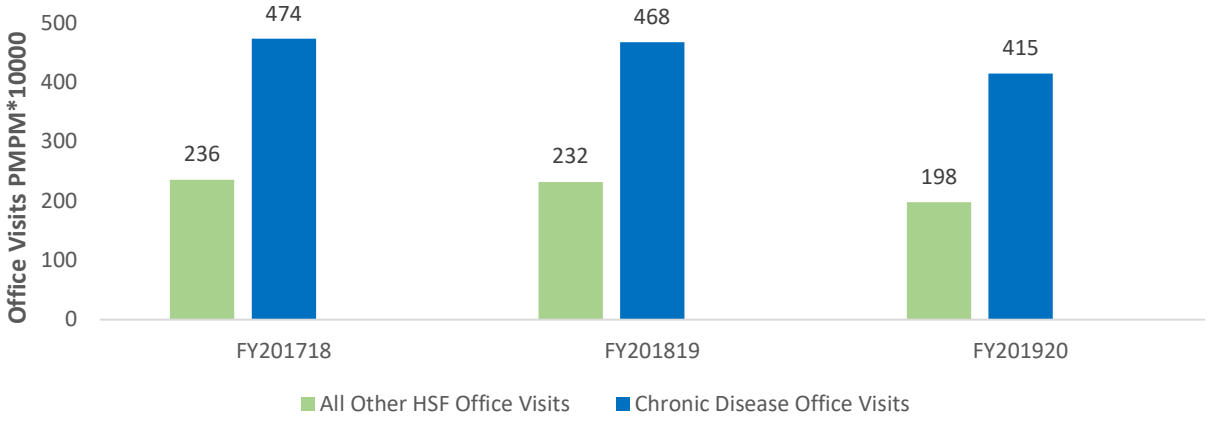
Figure D3: HSF Participants with Chronic Disease by Fiscal Year



Outpatient Utilization by Chronic Disease Diagnosis

Over the past three years, there were two chronic disease office visits to one other office visit, a 2:1 ratio. Figure D4 demonstrates the contrast between the number of office visits per 1,000 participants per month for those diagnosed with a chronic disease as opposed to those who had not. In FY19-20, HSF participants with a chronic disease diagnosis had more than twice as many office visits per 1,000 participants monthly than those without a diagnosis.

Figure D4: Outpatient Utilization by Chronic Disease Diagnosis



Utilization by Service Type and Chronic Disease Indicator for Participants with One or More Office Visits

Table D12 shows the program's three-year trends for utilization of other services by HSF participants. It compares utilization rates of those who had at least one office visit and were diagnosed with a chronic disease to those who had at least one office visit but were not diagnosed with a chronic disease.

HSF participants with one or more chronic disease(s) have more office visits per year than those without. The utilization of ED visits is also higher for those with Chronic Disease. But the overall ED visits PMPY are considerably low and do not represent a significant difference in ED use of participants relative to chronic disease diagnosis. Those with a chronic disease diagnosis continue to have higher rates of inpatient stays

than those without a diagnosis (3.94 compared to 1.75 PMPM*1000, which is 2.25 times more.) Those participants with a chronic disease diagnosis had more than three times the number of prescriptions filled in a fiscal year than their counterparts without a diagnosis (FY19-20- 11.24 to 3.28 PMPY, 3.4 times more).

Table D12: Utilization by Service Type, Fiscal Year, and Chronic Disease Indicator for Participants with One or More Office Visits

Utilization by Service Type	Fiscal Year	No Chronic Disease With Office Visit	Chronic Disease With Office Visit
Office Visits PMPY	FY17-18	4.30	6.02
	FY18-19	4.27	6.21
	FY19-20	3.85	5.37
ED Visits PMPY	FY17-18	0.18	0.26
	FY18-19	0.21	0.40
	FY19-20	0.28	0.39
IP Visits PMPM*1000	FY17-18	0.96	1.69
	FY18-19	0.94	2.28
	FY19-20	1.75	3.94
Prescriptions Filled PMPY	FY17-18	3.30	11.23
	FY18-19	3.40	12.08
	FY19-20	3.28	11.24

Chronic Disease Prevalence by Age Category and Condition

Table D13 shows the prevalence of chronic disease conditions across the program's primary age populations over the last three fiscal years. The table reflects the top conditions HSF participants were diagnosed with.

The highest prevalence of hypertension across all age groups prevails in the 65+ cohort. The participants from the Bayview and South of Market or South Beach neighborhoods in this cohort demonstrated the highest relative percentages of hypertension, Diabetes with complications, and chronic kidney disease. The numbers of HSF participants 65+ within each neighborhood are small, so relative percentages may be affected by small changes in numbers.

The percentage of participants with a chronic disease and an office visit remained very high for both age groups. This data does not include individuals with chronic disease but without visits to an HSF facility.

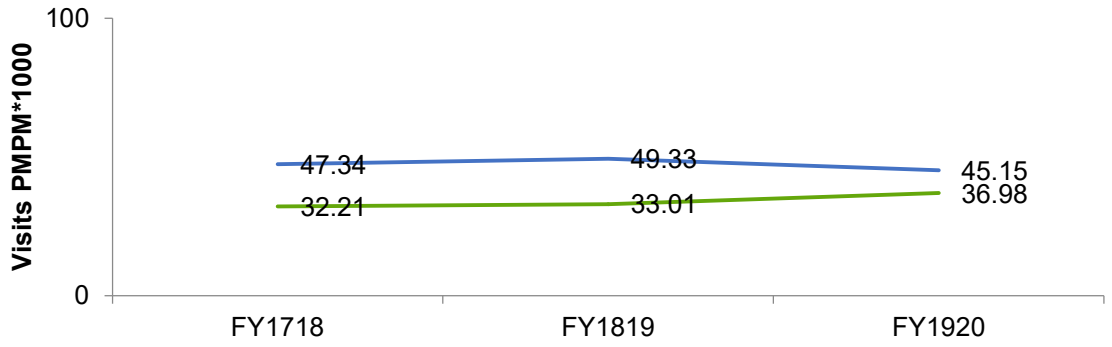
Table D13: Chronic Disease Prevalence by Age Category and Condition

Types of Chronic Disease	Age	Chronic Disease Indicator		
		FY17-18	FY18-19	FY19-20
% Members with Office Visit with Chronic Disease	18-64	91.40%	89.60%	88.30%
	65 and over	87.70%	89.80%	89.70%
Hypertension	18-64	8.90%	8.50%	8.70%
	65 and over	41.25%	41.72%	42.39%
Diabetes (without Complication)	18-64	8.40%	7.70%	7.10%
	65 and over	20.30%	20.40%	19.60%
Diabetes (with Complication)	18-64	2.30%	2.50%	2.80%
	65 and over	8.10%	9.30%	10.70%
Chronic Kidney Disease	18-64	2.20%	2.40%	2.50%
	65 and over	8.30%	8.90%	9.60%
Asthma/COPD and Bronchiectasis	18-64	1.40%	1.20%	1.20%
	65 and over	2.40%	2.90%	2.60%

Mental Health and Substance Use Disorder Services

Behavioral Health Services is the county's mental health plan and provides all mental health and substance use disorder services for HSF participants either at SFDPH facilities or via a network of community-based behavioral health providers. These providers submit encounter information to BHS. As is the case with other data presented in this report, there may be a lag with when BHS receives encounter data from their provider network, which will affect the completeness of the data presented in this report (Figure D5).

Figure D5: Mental Health (blue line) and Substance Use Disorder Services (green line) Utilization



The following table indicates what percentage of HSF participants had a mental health or substance use disorder visit over the last three years. In the last fiscal year, there has been a slight decline in behavioral

health utilization in terms of number of visits. Utilization of BHS services as measured on a number of visits PMPY experienced a slight increase in FY19-20. Within FY19-20, the percentage of participants as well as total visits for substance use disorder marginally increased while those for mental health visits decreased.

Table D14: HSF Mental Health and Substance Use Disorder Services Utilization

	FY17-18	FY18-19	FY19-20
% Members with Substance Use Disorder Visit	0.35%	0.42%	0.46%
Substance Use Disorder Visits PMPY	0.39	0.40	0.44
Total Number of Substance Use Disorder Visits	5,105	5,229	5,816
% Members with Mental Health Visit	2.18%	2.23%	1.77%
Mental Health Visits PMPY	0.57	0.59	0.54
Total Number of Mental Health Visits	7,503	7,815	7,101

In FY19-20, the participants who utilized mental health services and substance use disorder services had eight visits more than just mental health visits per year (9.14 compared to 0.50 visits PMPY) (Table D15). Conversely, in FY19-20 participants who utilized substance use disorder related services and mental health services had two more visits per year than participants without (3.20 visits PMPY compared to 0.39 visits PMPY) (Table D16). Of note, the percentage of participants with substance use disorders remain very low, and thus utilization can vary significantly between years based on small numbers of participants and their utilization patterns. Table D15 shows that the Mental Health Visits PMPY with Substance Use Disorder Visit has increased from 8.05 in FY18-19 to 9.14 in FY19-20. Table D16 shows a similar upward trend where the Substance Use Disorder Visits PMPY with Mental Health Visits has increased from 2.47 in FY18-19 to 3.20 in FY 19-20.

Table D15: Mental Health Visits Per Participant Per Year with and without Substance Use Disorder Visits

	FY17-18	FY18-19	FY19-20
Mental Health Visits PMPY w/Substance Use Disorder Visit	10.61	8.05	9.14
Mental Health Visits PMPY w/o Substance Use Disorder Visit	0.54	0.57	0.50
Mental Health Visits PMPY	0.57	0.59	0.54

Table D16: Substance Use Disorder Visits Per Participant Per Year with and without Mental Health Visits

	FY17-18	FY18-19	FY19-20
Substance Use Disorder Visits PMPY w/ Mental Health Visit	2.39	2.47	3.20
Substance Use Disorder Visits PMPY w/o Mental Health Visit	0.34	0.35	0.39
Substance Use Disorder Visits PMPY	0.39	0.40	0.44

Pharmacy Utilization

Table D17 and Table D18 shows that members in the renewal category consistently had higher utilization for filling prescription, average 39% of the renewal members. An average of 17% new members and 27% re-enrolling members have their prescriptions filled in FY19-20. This trend is steady for the past 3 years, and the overall prescriptions filled has decreased from 49,773 in FY18-19 to 45,999 in FY19-20.

Table D17: Prescription Utilization Rate by Fiscal Year

	FY17-18	FY18-19	FY19-20
Total Prescriptions Filled	47,380	49,773	45,999
% Members with Prescriptions Filled	32%	30%	30%
Prescriptions Filled PMPM*1000	298.97	314.20	292.48
Prescriptions Filled PMPY	3.59	3.77	3.51

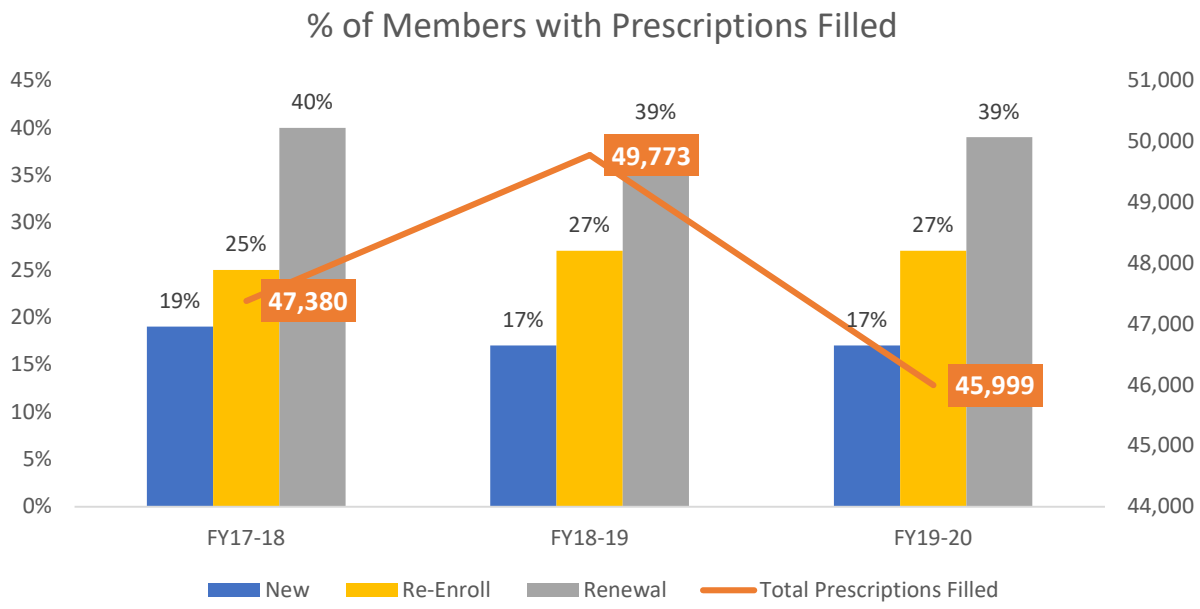


Table D18: Prescription Utilization Rate by Application Type

	Application Type	FY17-18	FY18-19	FY19-20
% of Members with Prescriptions Filled	New	19%	17%	17%
	Re-Enroll	25%	27%	27%
	Renewal	40%	39%	39%
Prescriptions Filled PMPY	New	2.00	1.97	1.80
	Re-Enroll	2.63	3.04	2.97
	Renewal	4.15	4.41	4.23
Prescriptions Filled PMPM*1000	New	166.60	163.80	150.38
	Re-Enroll	218.76	253.40	247.25
	Renewal	345.90	367.23	352.54

Prescriptions Filled by Medical Homes

Sister Mary Philippa reported a decrease in utilization of pharmacy services in FY19-20 while SFHN experienced a slight increase. Kaiser and SFCCC, reported very modest decreases in utilization (Table D19).

Table D19:
Prescription Filled PMPY for participants with at Least One Office Visit by Medical Home Organization

Medical Home Organization	FY17-18	FY18-19	FY19-20
Sister Mary Philippa	0.35	0.28	0.08
SFHN	5.06	5.41	5.44
Kaiser	4.38	3.98	3.88
SFCCC (including NEMS)	4.96	5.25	4.54

E. Participant Experience and Satisfaction

This section describes HSF's efforts to obtain feedback from its participants about their health, healthcare, and program related experiences. Feedback was obtained from the program's call center, medical homes, various other channels that track complaints, and the administration of surveys.

Health Access Questionnaire

HSF administers a Health Access Questionnaire (HAQ) at the point of application and at annual renewals. The survey is available in English, Spanish, and Chinese. Participant responses to this questionnaire enable the program to gauge individuals' experiences prior to enrolling in HSF. The HAQ also serves to capture feedback about the experiences of participants who have either re-enrolled or renewed their enrollment. Responses are used to inform ongoing program improvement and evaluation. In FY19-20, a total of 8,141, approximately 62% of active participants provided survey responses.

Highlights of Participants' HAQ Responses

As depicted in Figure E1,

- Fifty-three percent (53%) of respondents reported that they most often go to a community clinic, health center, or hospital clinic for medical care.
- Fifty percent (50%) of respondents rated the care they received in the last twelve months as either excellent, very good, or good.
- Forty-seven percent (47%) of respondents indicated that it was not difficult or not too difficult to access medical care when needed.
- Seven percent (7%) of those who responded reported difficulty with accessing medical care.
- Three percent (3%) of respondents reported visiting an emergency room in the last twelve months.

Since FY15-16, the percentage of respondents who reported having visited an ED in the past 12 months has declined (Figure E2) according to the HAQs. Please note that the survey data results here was based on what participants remembered and was not backed by factual data, and thus may differ from the other sections of this report.

Figure E1: Highlights from FY19-20 Health Access Questionnaire

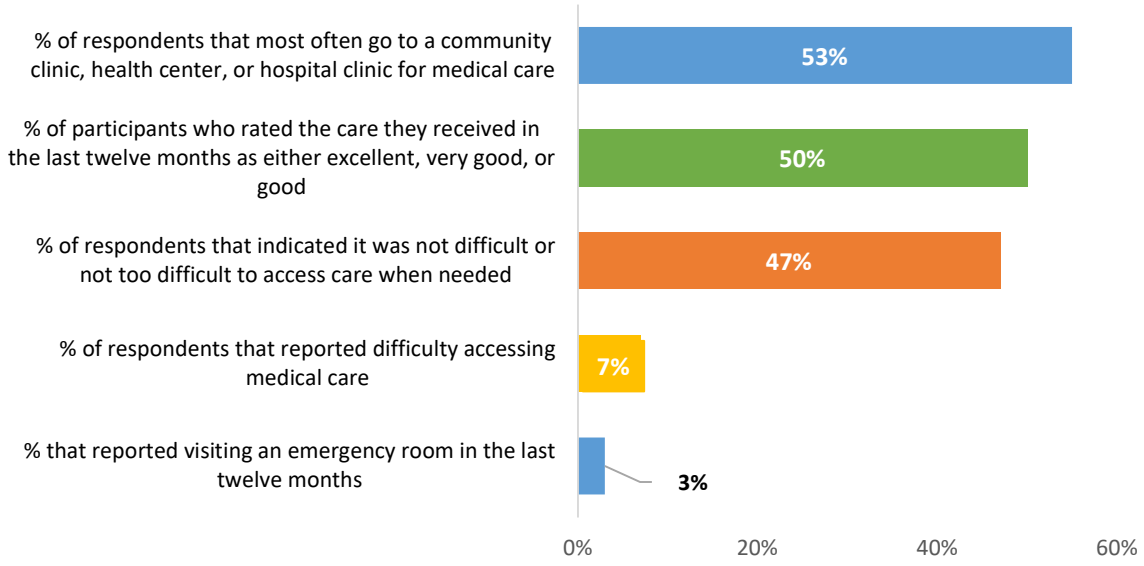


Figure E2

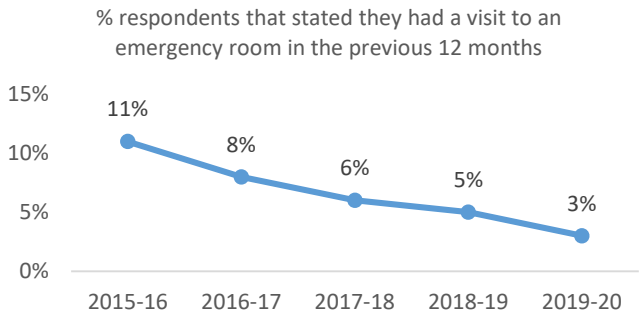


Figure E3

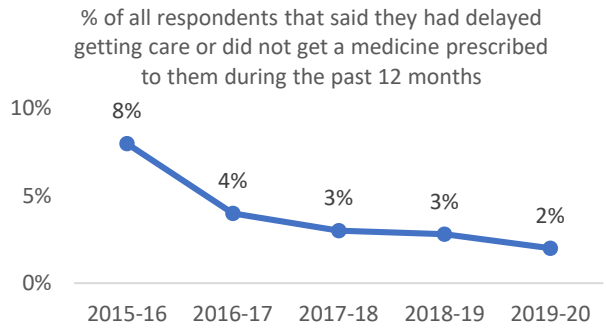


Figure E4

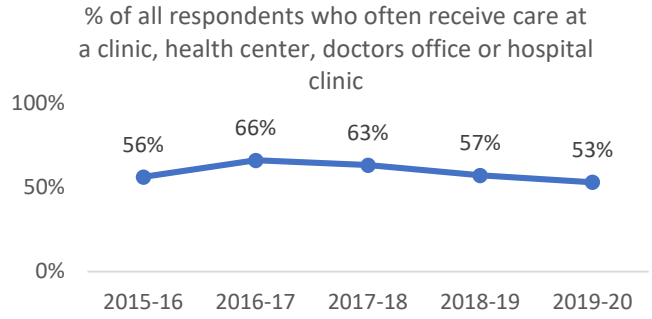
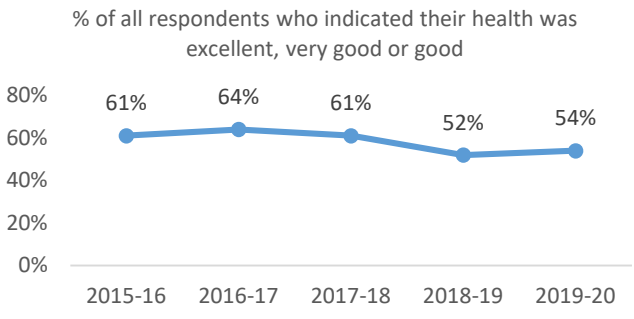


Figure E5



The percentage of respondents who reported delays with getting care or medicine started out as 8% in FY15-16, it is currently 2%. Figure E3 shows that we have been making steady improvements since FY15-16 (Figure E3). Since FY16-17, the percentage of HSF participants who have reported receiving care in an appropriate setting has declined (Figure E4). Since FY15-16, the percentage of HSF participants who have reported good to excellent health has also been declining, however this year it increased by 2% (Figure E5).

HSF Participant Complaints

The HSF Customer Service Department received 193 complaints from participants in FY19-20. Access to care accounted for 32% (or 62 by count) of participant complaints. Access to care complaints may consist of issues regarding lack of care, long wait times for appointments, or long telephone wait times. Twenty-four percent (24%) of all complaints were attributed to issues related to program enrollment; for example, participants who were assigned to the incorrect medical home. Quality of medical care issues accounted for 10% of the participant complaints. Quality of medical care may include dissatisfaction with care coordination or delays in care.

The HSF Customer Service Department received 227 complaints from participants in FY18-19. This indicates that the overall volume of complaints decreased 15% (or 34 by count) from FY18-19.

Table E1: Complaints by Category FY19-20

Category	By Count	By Percentage
Access	62	32%
Enrollment	47	24%
Billing	33	17%
Quality of Service	20	10%
Quality of Medical Care	19	10%
Cultural, Linguistic, and Health Education	5	3%
Other	5	3%
Coverage interpretation	2	1%
Total	**193**	**100%**

F. HSF Revenues and Expenditures

This section provides estimated HSF expenditures and revenues falling under the HCSO for FY19-20.

SFDPH actively tracks expenditures for HSF. Expenditures from each SFDPH division are combined to provide an overview of the program's finances. This year, SFDPH costs and revenue calculations were estimates. The financial data below is comprised of the following components:

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

Revenues

The HSF program had a total revenue $5.155M for FY19-20, which represents a 11.8% decrease, or $689,937 reduction in revenue from the prior year. The HSF revenue includes two main sources: (1) participant fee payments with household incomes at or above 101% FPL, and (2) SFCO Employer Contributions.

Participants with income at or above 101% FPL are billed quarterly for participation fees to remain in the program. As of June 30, 2020, fifty-four percent (54%) of participants were at or above 101% of FPL. In general, SFDPH only collects information on point of service (POS) fees paid by HSF participants accessing services within SFHN. Other medical homes report their POS revenues in their financial reporting and it is counted in the section below where we report their expenditures and revenues. For the fiscal year, SFDPH collected a total of $2.58 million HSF participant and POS fees. HSF participant and SFHN POS fees accounted for 92% and 8% respectively.

Expenditures

System-wide HSF expenditures for FY19-20 totaled nearly $73M for private medical homes and SFDPH (Table F1). The SFDPH expenditure calculation included reimbursement to non-SFDPH HSF medical home providers as well as costs associated with administration and management of the SFCOs program. The average per participant per month expenditure increased to $447 which was an 8% increase from the previous year. There was an $4.37M (or 6%) increase in total program expenditures this year, including a nearly $2.69M increase in SFDPH expenditures coupled with a $1.67M increase in non-SFDPH expenditures. Part of this increase is attributed to how we calculate the SFCO third party administration expenditures. Revenue also decreased by $690,000 in FY19-20.

One may notice the significant increase in TPA expenditures, from $7M for FY18-19 to $12M for FY19-20. Previously, administration and management expenditures of SFCO were not included in the HSF and were managed by TPA separately. As SFCO has grown a larger program, especially in the last decade, and its fund flows and operations are being assessed by SFDPH and the City's Controller's Office, SFDPH has determined that SFCO should be handled as an independent program from HSF moving forward starting next fiscal year. Namely, SFCO will have its own independent annual report, budget including revenues and expenditures, to provide a more accurate accounting and reporting of both programs.

Expenditures by SFDPH

SFDPH reported an estimated total of $66M in expenditures in FY19-20. These costs were due to expenses for administration, services, and information systems. Administration expenditures accounted for approximately $12.5M (or 19% of total SFDPH expenditures) while service costs added up to $54M (or 81% of total SFDPH expenditures). The administration reflects the total administrative costs for both the HSF and SFCO program. Starting FY20-21, DPH will be reporting out the expenditures and revenues separately for each program.

A portion of SFDPH expenditures reflects reimbursement for non-SFDPH medical homes and emergency ambulance transportation, and incremental behavioral health provider funding. A portion of SFDPH service costs at ZSFG supports hospital-based specialty care, urgent care, diagnostic, emergency care, home health, pharmacy, durable medical equipment, and inpatient services to SFDPH clinics and to many other private providers in the network.

Table F1: Estimated Total Revenues and Expenditures

	FY17-18	FY18-19	FY19-20
ENROLLMENT			
Total Participant Months	164,746	165,190	162,848
SFDPH REVENUE			
Participation Fees and SFDPH POS	$2,058,937	$2,767,673	$2,581,152
ESR (Employer Health Care Expenditures)	$1,889,259	$3,077,786	$2,574,370
Transfer of Unused SF MRA Funds	$0	$0	$0
TOTAL REVENUE	**$4,276,491**	**$5,845,459**	**$5,155,522**
SFDPH EXPENDITURES			
HSF Administration	$190,832	$204,189	$214,323
Third-Party Administrator	$6,264,379	$6,956,157	$12,277,347
Services			
Cost of Services (ZSFG, Clinics, UCSF)	$41,049,230	$50,369,578	$46,692,105
Behavioral Health	$2,034,284	$2,800,311	$2,740,254
Non-SFDPH Provider Reimbursement	$2,671,805	$2,859,760	$3,900,733
Eligibility/Enrollment System (One-e-App)	$336,727	$353,546	$412,010
SUBTOTAL SFDPH EXPENDITURES	**$52,547,257**	**$63,543,541**	**$66,236,771**
ESTIMATED SFDPH PMPM EXPENDITURE	**$319**	**$385**	**$407**
NON-SFDPH EXPENDITURES			
Private Medical Homes Net HSF Expenditures	$3,826,224	$3,554,442	$4,521,388
Non-Profit Charity Care Expenditures	$888,233	$1,334,910	$2,042,037
SUBTOTAL NON-SFDPH EXPENDITURES	$4,714,457	$4,889,352	$6,563,425
TOTAL SFDPH AND NON-SFDPH EXPENDITURES	**$57,261,714**	**$68,432,893**	**$72,800,196**
ESTIMATED TOTAL PMPM EXPENDITURE	**$348**	**$414**	**$447**
SFDPH REVENUE LESS SFDPH EXPENDITURES	($48,270,766)	$(57,698,082)	$(61,081,249)
SFDPH PER PARTICIPANT REVENUE PER MONTH	$26	$38	$34
PER PARTICIPANT GENERAL FUND SUBSIDY PER MONTH	($293)	($341)	($375)

Expenditures by Non-SFDPH Providers

Private HSF providers reported that $6.6M worth of health services were rendered to HSF participants this year. This was a 34% increase from the year before (Table F2). It consisted of:

- $4.52M by medical homes, which represents 27% increase from prior year.
- $2.04M in HSF-related hospital charity care expenses, an increase of 53%, from last year.

Table F2: Estimated Expenditures and Revenue for Private HSF Medical Homes

Medical Home	Expenditures	HSF Funding and Other Revenues	Net Costs
Saint Francis Memorial Hospital	$240,474	N/A	($240,474)
Kaiser Permanente	$4,188,412	$1,141,892	($3,046,520)
North East Medical Services	$883,841	$312,741	($571,100)
San Francisco Community Clinic Consortium Affiliated Clinics (includes SFCCC Admin.)	$5,776,486	$5,776,486	$0
Sister Mary Philippa Health Center (affiliation with St. Mary's Medical Center)	$1,001,091	$337,797	($663,294)
All Non-SFDPH Medical Home Health Systems	$12,090,304	$7,568,916	($4,521,388)

G. San Francisco City Option

Health Care Security Ordinance

Passed in 2006, the San Francisco Health Care Security Ordinance (HCSO) (No. 218-06; Chapter 14 of the San Francisco Administrative Code) had two components:

1. Employer Spending Requirement, which requires employers in San Francisco to make health care expenditures on behalf of their employee who works eight or more hours per week in San Francisco; and
2. HSF was launched in 2007 (formerly known as Health Access Program).

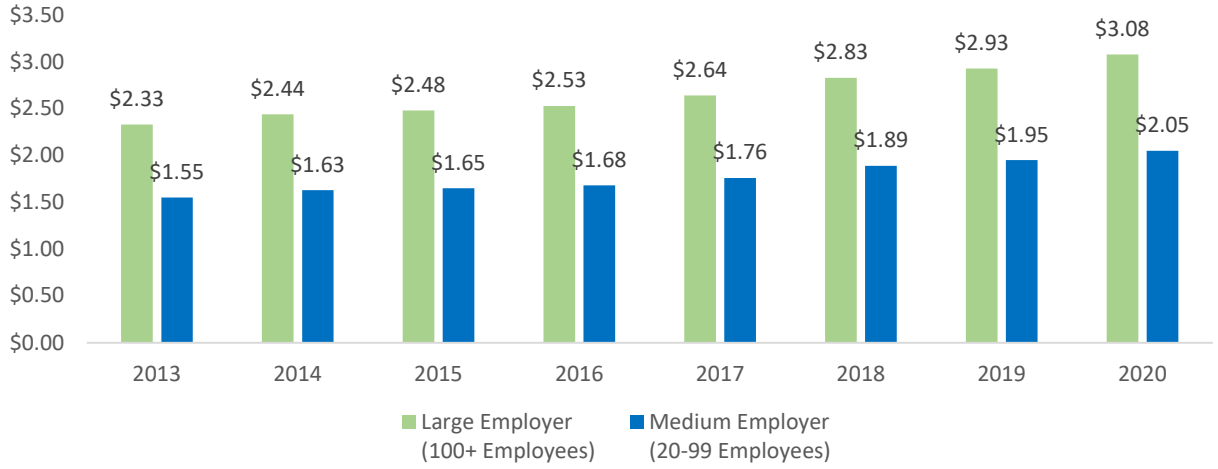
Employer Spending Requirement

The Office of Labor Standards Enforcement (OLSE) oversees the implementation and compliance with the ESR by San Francisco employers. SFDPH oversees administration of HSF and the SFCO programs. In FY19-20, SFCO co-hosted 12 webinars with OLSE to educate interested employers about SFCO, HCSO compliance and the employer spending requirement.

The ESR was implemented for all employers with 50 or more employees on January 2008. As April 2008, the ESR applies to for-profit employers with 20 or more employees and non-profit 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 G1 demonstrates the gradual increase in the required minimum amount to spend per employee per hour since ESR implementation. In FY19-20, the minimum expenditure was $2.05 per hour for medium-sized employers (20-99 employees) and $3.08 per hour for large employers (100+ employees).

Figure G1: Minimum Health Care Expenditures Per Covered Employee Per Hour by Year



Program Structure

It is important to note that while participation in SFCO (SFCO) is a way for employers to meet the employer spending requirement of the HCSO, most San Francisco employers do not participate in SFCO. Most employers demonstrate HCSO compliance to the OLSE outside of the SFCO program, through the provision of insurance to employees. However, SFCO provides a valuable alternative for some employers to satisfy the ESR. Since 2008, 4,020 employers have made at least one contribution to the program. An employer that chooses to contribute to SFCO on behalf of their covered employees will make those employees eligible to either: (1) participate in HSF at a reduced cost; (2) be assigned a Medical Reimbursement Account, namely, a SF MRA; or (3) receive SF Covered MRA premium assistance for Covered CA. Contributions are assigned based on program eligibility criteria as well as the following:

- If the employee is eligible for HSF or SFCMRA, the employee will be notified and must initiate and complete the program's application process in order to participate.
- If the employee is ineligible for either HSF or SFCMRA, a SF MRA will be opened for the employee. All funds contributed on the employee's behalf by the employer(s) are deposited into this account. Subsequently, the employee can access these funds for reimbursement of eligible health care expenses.

When an employer contributes on behalf of an employee who has not enrolled in one of the three available programs, the employee is sent a notification and encouraged to complete an online Program Finder Form, to help determine preliminary eligibility. Employees' contributions are not assigned to a designated program until they have engaged the program.

Employer Program Participation

By the end of FY19-20:

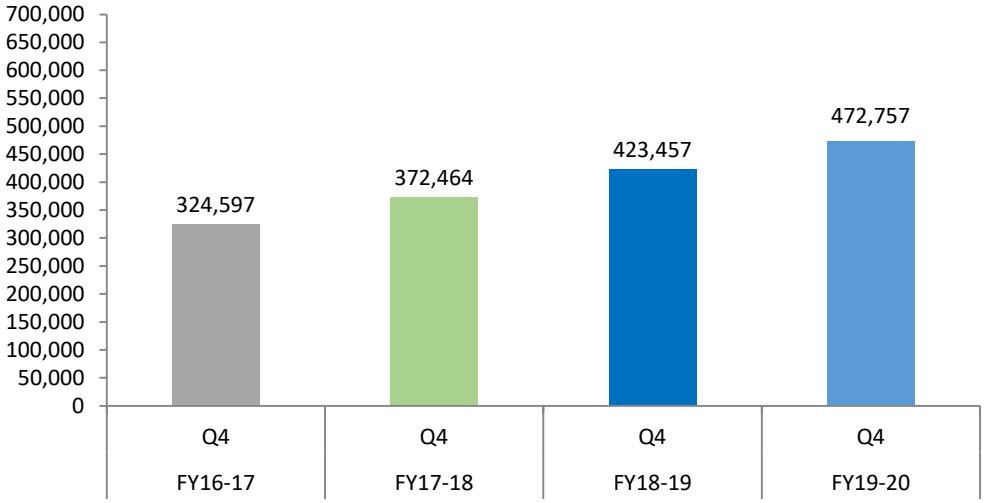
- 2,068 of employers made at least one contribution to HSF to meet the ESR. Of those, 278 employers made their first contributions. Since the program's inception, 4,020 employers made at least one contribution to SFCO. This was a 7% increase from the previous year.
- Employers deposited over $195 million to the program on behalf of their employees, an approximately $9 million increase from FY18-19.

- Of the employer funds contributed to the SFCO this year, fifty-eight percent (58%) were assigned to the pool, forty percent (40%) assigned to SF MRA, one percent (1%) assigned to HSF, and one percent (1%) assigned to SFCMRA (Table G1).
- The number of SFCO employees increased to 472,757, a 11.6% increase from the year before (Figure G2).

Table G1: SFCO Employer Contributions, FY19-20

Pool	$ 113,398,067.25	58%
SF MRA	$ 78,478,203.89	40%
HSF	$ 2,574,370.62	1%
SFCMRA	$ 1,362,259.59	1%
Total	**$ 195,812,901.35**	**100%**

Figure G2: Program-to-Date Count of Employees Receiving Employer Contributions



As of June 30, 2020, over 96% of active SFCO participants or employees are enrolled in SF MRA, three percent (3%) in HSF, and less than 1% in SFCMRA. 2,068 employers made SFCO contributions on behalf of (59,105) employees. This number includes those employees who were counted more than once because they received contributions from multiple employers.

SF MRA Deactivation or Reactivation

SFCO deactivates SF MRAs that have no claims or employer deposits for 24 months or more. SF MRAs with no activity receive three outreaches prior to deactivation. After deactivation, funds are no longer available to the employee and the account administrative fees charged by WageWorks are no longer deducted from the account. SFCO restores the balance and reopens the account for employees who contact the program after deactivation.

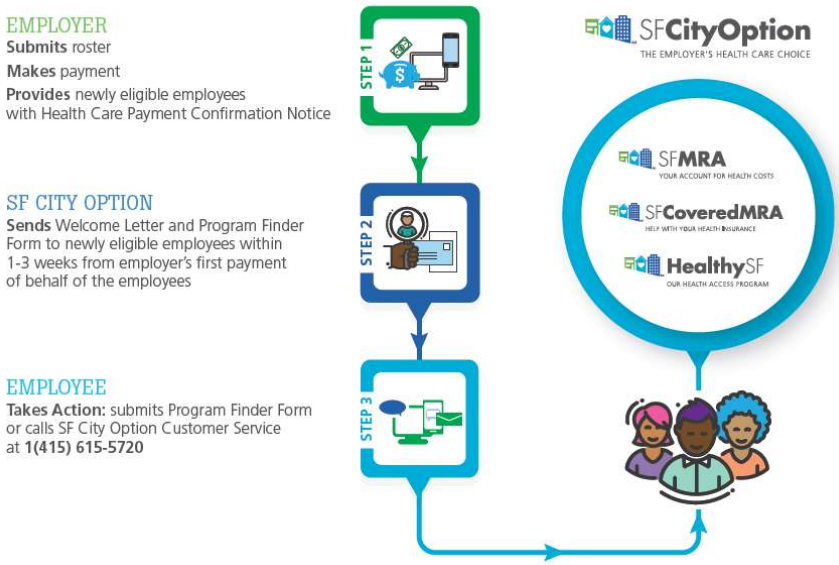
This deactivation policy was suspended for a portion of FY18-19 due to data quality issues in properly identifying accounts for potential deactivation. In FY19-20, these data quality issues were addressed, and

the deactivation process was resumed. In December 2019, 16,886 MRA's were identified for deactivation and account holders were notified of pending deactivation. However, the program did not deactivate these accounts identified in December due to COVID-19 and Shelter in Place occurring during the deactivation response period considering that Employees would be unlikely to engage in deactivation outreach during the pandemic. Program resources were subsequently assigned to work on the SF MRA COVID-19 Cash Grant program. This fiscal year, 1,157 SF MRAs were reopened with a total of nearly $1.9M added back into the impacted accounts. Program to date, the overall reopen rate is 4.4%.

Program Finder Form Overview

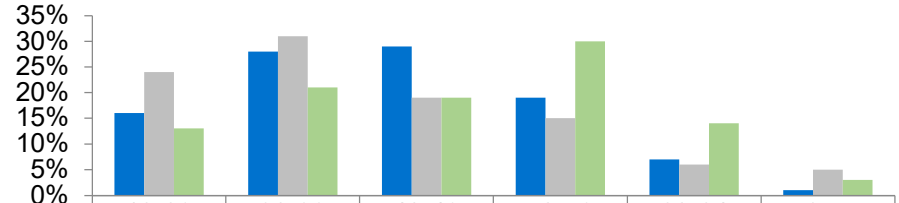
The Program Finder Form was created in 2016 as a screening tool for participants and a mechanism to enroll in SF MRA (Figure G3). An employee takes actions by submitting the Program Finder Form and based on the information provided, can be determined for one of the three SFCO programs—HSF, SF MRA and SFCMRA. In FY19-20, SFCO received a total of 12,239 Program Finder Forms, with 92% submitted online and 8% submitted by mail or fax. The majority of participants that completed a Program Finder Form during this fiscal year were determined to be eligible and 69% were enrolled into SF MRA, consistent with the trend established in previous years.

Figure G3: Enrollment Flowchart



The data collected from the Program Finder Form showed that 55% of the SF MRA participants and 48% of the HSF participants were under age 39. For SFCMRA, 30% of the participants in the age 50-59 age category (Figure G4).

Figure G4: Age Distribution of Active HSF, SF MRA, and SFCMRA Participants, as of June 30, 2020



	18-29	30-39	40-49	50-59	60-64	65+
HSF	16.0%	28.0%	29.0%	19.0%	7.0%	1.0%
SF MRA	24.0%	31.0%	19.0%	15.0%	6.0%	5.0%
SF Covered MRA	13.0%	21.0%	19.0%	30.0%	14.0%	3.0%

SF Covered MRA

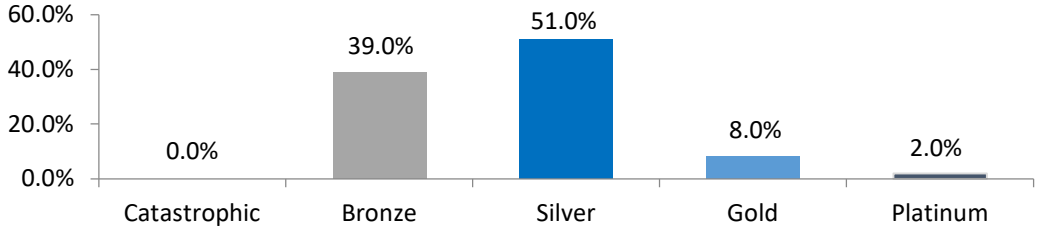
SFCMRA was launched through SFCO in response to legislation requiring SFDPH to establish a program to assist San Franciscans in purchasing affordable health insurance through Covered CA and in maintaining access to HSF for individuals unable to afford other health coverage options. SFCMRA was approved by the San Francisco Health Commission in 2015. SFDPH proposed increasing access to affordable health care for all low- and moderate-income residents of San Francisco by leveraging existing SFCO and HSF infrastructures for two purposes: (1) to make health insurance more affordable for City residents and (2) to ensure that HSF remains available to individuals who cannot afford other options.

SFCMRA offers premium assistance with out-of-pocket costs for insurance purchased through Covered CA and other eligible health care expenses. To be eligible for the program, a SFCO employee must meet all of the following requirements:

- San Francisco resident;
- Age 18 or over;
- Income at or below 500% FPL;
- Not eligible for Medi-Cal or Medicare;
- Required by law to carry health insurance;
- Purchased health insurance through Covered CA; and
- Two employer contributions made to SFCO in the past six months.

At the end of FY19-20, there were 283 participants enrolled in the SFCMRA program. On average, an employee enrolled in this program received a subsidy amount of $3,878 annually or $323.16 per month. Figure G5 shows Covered CA plan tier by SFCMRA participants. Over half of SFCMRA participants (51%) purchased a Silver Covered CA plan as seen in Figure G5.

Figure G5: Covered California Plan Tier Purchased by SF Covered MRA Participants, FY19-20



Employee Data

At the end of this year, SFCO had 58,749 SF MRA accounts and 283 SFCMRA accounts. And of these 58,749 accounts, 32,405 unique individuals with at least one SF MRA claim within the prior 12 months (defined as "active SF MRA participants"), and 1,087 unique individuals enrolled in HSF who were receiving an ESR contribution. This was a 3% increase from the year before.

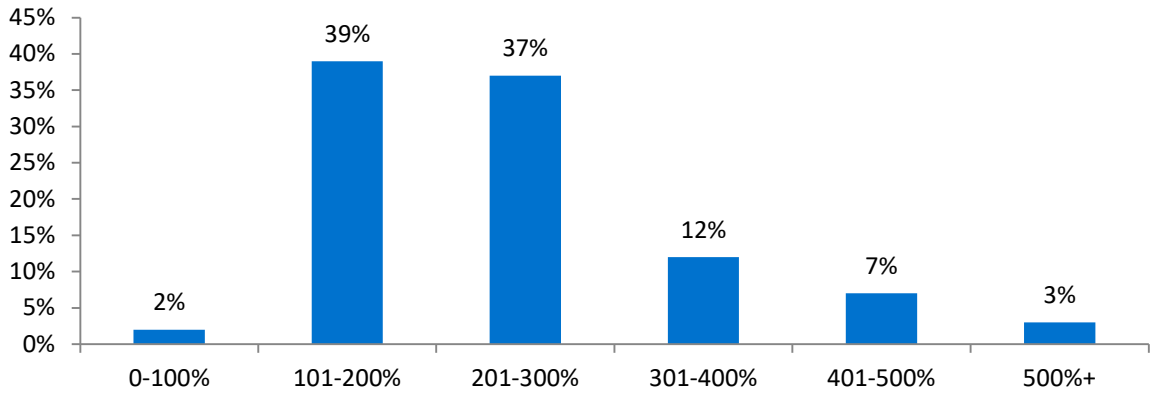
Table G2: SFCO Employees by Program Eligibility in FY19-20

Category	Description	Number
HSF-Eligible Employees	SFCO employee who is a resident of San Francisco, is not insured, age 18 or over, not eligible for public insurance programs such as Medi-Cal or Medicare and living in a household with an income at or below 500% of FPL.	1,087
SF MRA Employees	An employee who works in San Francisco and their employer pays into SFCO.	58,749
SFCMRA Employees	SFCO employee who is a resident of San Francisco, has purchased insurance coverage through Covered CA, and meets income and other eligibility guidelines.	283

As previously discussed, only 3% of the SFCO participants enrolled in HSF this year. Most of these participants (39%) had incomes between 101% - 200% of the FPL. Two percent (2%) were between 0 - 100% FPL while 37% were between 201 - 300% FPL (Figure G6). Compared to the general HSF population, SFCO employees enrolled in HSF had relatively higher incomes.

Given these modest incomes relative to the overall cost of health insurance, affordable health insurance remains a pressing issue for the City. Additionally, with the burden of obtaining affordable health care even with available subsidies, Employees who are eligible for SFCMRA subsidies may continue to elect to remain in HSF.

Figure G6: SFCO Participants Enrolled in HSF by FPL, as of June 30, 2020



Employer Data

Figure G7 summarizes the SFCO employers' information by company size, as of June 2020. Forty-one percent (41%) of the employers had more than 500+ employees. The second largest group is 100-499 employees at 25%. These two groups alone account for 66% of all the employees by company size. The count by company size over the past three years also indicated that the 500+ employees' category has the greatest increase in count while the other company sizes are relatively stable (Figure G8).

Figure G7: FY19-20 by Company Size

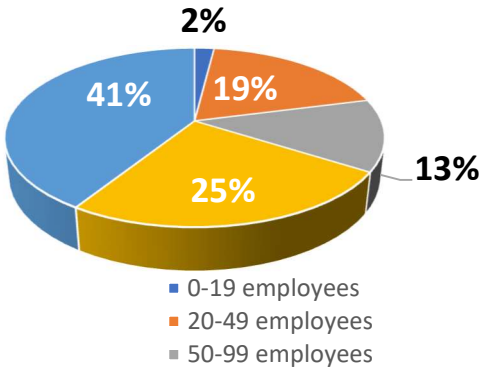
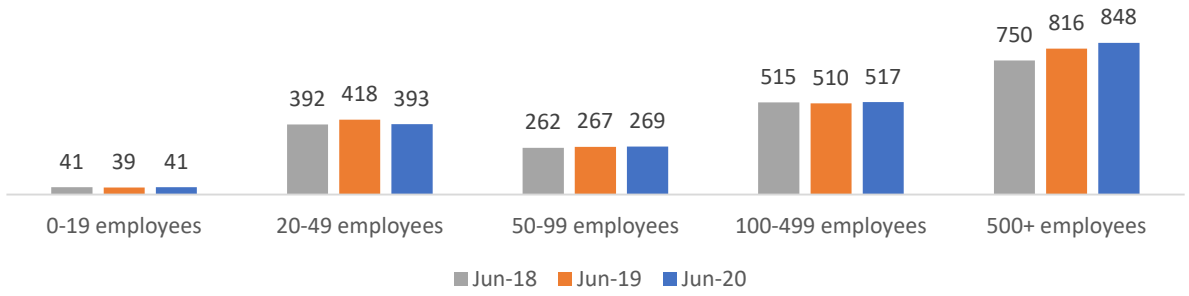


Table G3: Counts of SFCO Employers by Number of Employees

Number of Employees	Jun-18	Jun-19	Jun-20
0-19	41	39	41
20-49	392	418	393
50-99	262	267	269
100-499	515	510	517
500+	750	816	848
Total	**1960**	**2050**	**2068**

Figure G8: Count by Company Size



SFCO Website and Eligibility

The SFCO website (http://sfcityoption.org) is a key source of information for San Francisco employers and their employees to learn more about the program resources available to them. The SFCO site is a resource for frequently asked questions, program resources, documentation, and materials. It also serves as a portal to employers' SFCO accounts and employees' SF Medical Reimbursement Accounts. The SFCO Program Finder form is an online tool used to determine and inform SFCO employees' program eligibility.

III. FY20-21 ANTICIPATED PROGRAM ACTIVITIES

A. SFCO Program Audit Recommendation Implementation

The San Francisco Department of Public Health, with support from the Controller's Office, conducted and completed its first in-depth program and financial audit of the administration of the SFCO for its TPA, San Francisco Health Plan. The following recommendations were derived with the goal of implementation over the next three fiscal years:

1. Enhanced participation outreach for the purposes of burgeoning enrollment and reenrollment and increasing utilization of employer contributions
2. Overall outreach analysis to determine whether the TPA requires additional resources to conduct necessary outreach to increase enrollment
3. Enrollment simplification efforts intended to increase overall access for participants
4. Development of written policies addressing unused fund in the contribution pool for an extended period
5. Regular outreach activities focused on participants with deactivated accounts
6. Policies and procedures to guide replenishment of deactivated funds in the event that enough participants exercise their right to reactivate their accounts resulting in insufficient funds to cover additional requests

B. Streamlining SFCO

In a continuation of last year's efforts, SFCO modernization will remain a priority for SFDPH in the next fiscal year. Many of the audit recommendations will be implemented with the goal of streamlining employee enrollment and increasing utilization of employer contributions. In FY19-20, SFCO engaged with American Institutes for Research (AIR) to better understand SFCO employers and SF MRA participants. The findings and recommendations from this engagement will begin to be implemented in the coming year as well.

C. Continued COVID-19 Support

While it is difficult to predict what additional challenges and programmatic needs may arise for the HSF and SFCO programs due to the ongoing pandemic, the programs will continue to provide health access to those who do not have other options. In FY19-20, HSF and SFCO made operational policy decisions to ensure that participants continued to have coverage and partnered with other City agencies to provide additional support to residents impacted by COVID-19. It is anticipated that HSF and SFCO programs will continue those collaborations as the City adopts new response measures, including vaccination campaigns, community engagement, and financial support.

FY19-20 was a year that brought many new and unexpected challenges to the programs. Still, it was also a year that demonstrated these programs' value to the community's overall health. The HSF program, including all the participating medical homes, relaxed certain policies regarding network services and point-of-service fees to ensure that participants could access free COVID testing services. When COVID-19 response measures reduced the capacity of enrollment sites to see participants, the program took action to prevent participants from losing coverage. Specifically, sites that were better equipped to conduct remote enrollments took over the enrollment efforts for sites that were not. These unexpected shifts in the program's work plan, along with the reduction of staff across the programs to shift to COVID-

19 response work impacted the efforts and planned work to streamline and strengthen the SFCO program. However, the programs continued to make progress in these efforts. Next year, both the HSF and SFCO programs will continue to face unknown changes that require the programs to reprioritize work. Regardless, the programs will undoubtedly continue its implementation of the streamlining of SFCO and its support to HSF participants' access to low-barrier health care, including COVID-19 testing, treatment, and vaccination once available.

IV. DATA SOURCES AND LIMITATIONS

Data Sources

The data used to generate the figures and findings in the FY19-20 HSF Annual Report was drawn from two primary sources:

- HSF Participant Encounter and Prescription Drug Data and HSF Participant Enrollment Data from San Francisco Department of Public Health
- Health Access Questionnaire from TPA, HSF Network Providers and County Behavioral Health Services

Limitations

This HSF Annual Report provides a snapshot of available data that characterizes participants' health care services utilization as of June 30, 2020. In order to accomplish this, HSF relies on partner agencies to furnish the participant encounter and prescription drug utilization data needed to generate the report. To note, the data received is not independently audited by HSF.

While processing utilization data, some providers and partner agencies may encounter delays when validating and reporting the data to the program. Thus, historically all relevant encounter and prescription drug-related data has not been available at the time of writing this report. In addition, a variable percentage of the encounter data received by HSF may be incomplete due to errors in recording or reporting the service utilization. The lack of complete data may have resulted in underreporting of these utilization data at the time the annual report is written. However, in years past, comparative analysis of the partial to the complete encounter datasets has shown few discrepancies.

Another noteworthy limitation of the program's capacity to examine its services utilization is the inability to determine utilization outside of participants' medical home or the program's provider network. Many participants have potential access to Medi-Cal, charity care, and health care outside of the City. Many of the program's non-profit hospital partners confront this reality as well when reporting possible utilization by HSF participants from other medical homes.

HSF is not able to determine where participants may seek care and it is possible that a segment of the participant population may only use HSF for access to discrete services. The likelihood of participants seeking care in other settings obscures HSF's ability to fully account for the utilization patterns of HSF participants. Therefore, the program's analysis of the utilization data is inherently limited to describing the use of services within the program.

V. ACKNOWLEDGEMENTS

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Thank You to Our Key Community Stakeholder Partners:
San Francisco Health Plan
San Francisco Community Clinic Consortium Clinics
St. Francis Memorial Hospital and St. Mary's Medical Center
Kaiser Foundation Hospital, San Francisco
University of California, San Francisco Medical Center
Alluma (Formerly known as Social Interest Solutions)

VI. APPENDIX A

HSF maintains a clinical data warehouse managed by the program's third-party administrator. The TPA defines encounter data submission standards, ensures the quality of data collected and processed, and analyzes and reports the data received by the SFDPH annually. Collection and analysis of encounter data is key to determining the extent to which HSF meets its goals.

The source data for this report came from the HSF data warehouse that includes records for all medical and pharmacy services, as well as from the Health Access Questionnaire. The HAQ is administered during the HSF application process and incorporates membership data from the One-e-App system. Data for this report accounts for all services that were incurred from July 2011 through June 2020. It should be noted that the completeness of service and encounter data reported is not uniform across all participating HSF providers. Services that are provided to HSF participants but are billed to those participants directly or to other insurers are not captured within the encounter data.

TPA monitors HSF encounter data submissions by service category and total submissions received by providers on a monthly basis. Ongoing monitoring facilitates a better understanding of the total submissions received, loaded, and used for the development of utilization analysis.

Nonprofit hospitals might also provide charity care services to HSF participants. Since FY09-10, SFDPH has worked with these hospitals to obtain utilization data about the HSF population that receives charity care services. In some cases, these hospitals do not consistently submit encounter data for HSF participants. This means that it is likely that the encounter data for all services provided to this population has not been captured.

VII. APPENDIX B

10,055 health access questionnaires (HAQ) were completed during FY19-20. Of these surveys, 8,141 were active applications and the HAQ analysis was limited to this number.

#	Questions:	% of Respondents Who Indicated That:	FY 19-20	FY 18-19	FY 17-18	FY 16-17	FY 15-16	FY 14-15	FY 13-14	FY 12-13
1	Would you say that in general your health is excellent, very good, fair, or poor?	their health was excellent, very good or good	49	52	61	64	63	60	62	64
2	During the past 12 months, was there any time you had no health insurance at all?	they did not have health insurance for some time in the past 12 months	21	24	29	43	36	37	33	46
3	What is the main reason why you did not have health insurance?	the most common reason for not having health insurance was HSF	NA	NA	0.5	0.5	NA	31	36	33
4	In the last 12 months, did you visit a hospital emergency room for your own health?	they had a visit to an emergency room in the previous 12 months	3	5	6	8	11	10	8	8
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?	most often receive care at a clinic, health center, doctors office or hospital clinic	53	57	64	66	56	63	67	70
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?	it was not at all difficult or not too difficult to access care when they needed	47	46	47	47	44	39	46	46
7	How do you rate the medical care that you received in the past 12 months – excellent, very good, good, fair, or poor?	the medical care they received in the past 12 months as excellent or very good	19	25	30	27	26	27	24	23
8	During the past 12 months, did you either delay getting care or not get a medicine that a doctor prescribed for you?	they had delayed getting care or did not get a medicine prescribed to them during the past 12 months	2	3	2	4	5	5	6	8

#	Questions:	% of Respondents Who Indicated That:	FY 19-20	FY 18-19	FY 17-18	FY 16-17	FY 15-16	FY 14-15	FY 13-14	FY 12-13
9	Was cost or lack of insurance a reason why you delayed getting care or did not get a prescription?	cost or lack of insurance was a reason why they had delayed care	0.4	0.5	3	5	8	7	10	10
10	Do you now smoke cigarettes every day, some days, or not at all?	smoked (every day or some days)	2	2	3	5	9	10	9	11
11	Which of the following had the greatest influence in your decision to come in today to renew? Renewal notice, phone call from HSF, reminded when visited medical home, reminded when called medical home, or you remembered?	the renewal notice as the reason for coming in for a renewal	15	21	27	34	43	46	43	35