File No. 141097 Committee Item No. 2
Board Item No. 15

COMMITTEE/BOARD OF SUPERVISORS

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Committee: Budget & Finance Committee **Date** November 5, 2014

Board of Supervisors Meeting **Date** November 18, 2014

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Completed by: Linda Wong **Date** October 31, 2014
Completed by: L.W. **Date** 11/10/14

AMENDED IN COMMITTEE
11/5/14

FILE NO. 141097 ORDINANCE NO.

[Administrative Code - Department of Public Health Managed Care Contracts]

Ordinance amending the Administrative Code to authorize the Director of Health to enter into managed care contracts for the provision of services to individuals covered under federal and state programs including subsidized health coverage for low income populations.

NOTE: **Unchanged Code text and uncodified text** are in plain Arial font.
Additions to Codes are in *single-underline italics Times New Roman font*.
Deletions to Codes are in ~~*strikethrough italics Times New Roman font*~~.
Board amendment additions are in double-underlined Arial font.
Board amendment deletions are in ~~strikethrough Arial font~~.
Asterisks (* * * *) indicate the omission of unchanged Code subsections or parts of tables.

Be it ordained by the People of the City and County of San Francisco:

Section 1. The Administrative Code is hereby amended by adding Section 21.44, to read as follows:

SEC. 21.44. DEPARTMENT OF PUBLIC HEALTH MANAGED CARE CONTRACTS.

(a) Findings.

(1) The federal government and state government continue to increase the proportion of safety net health care services provided under a managed care model, by, among other things, transitioning Seniors and Persons with Disabilities to Medi-Cal managed care, expanding Medi-Cal managed care eligibility to individuals below 138 percent of the federal poverty level, establishing pilot programs to transition those persons who are dually eligible for Medicare and Medicaid into managed care, and establishing state health exchanges to provide federally-subsidized health insurance for persons with incomes up to 400 percent of the poverty level.

(2) The Department of Public Health's ("DPH") mission includes the provision of high-quality health care to all San Franciscans, including the uninsured and low-income individuals who access health care through federally- and state-subsidized programs. Historically, DPH has fulfilled its mission by providing services through a fee-for-service structure or in partnership with the San Francisco Health Authority, also known as the San Francisco Health Plan ("SFHP") authorized by California Welfare & Institutions Code § 14087.36, and Administrative Code Chapter 69.

(3) Under the shift to a managed care-focused system for delivery of health care services, to participate as a provider in certain programs, DPH will need to be a contracted partner with insurers. Otherwise, current and prospective DPH clients will not have the option of selecting DPH as a provider. If DPH cannot offer itself as a contracted provider, continuity of care will be disrupted for those who have long histories with DPH health care providers, and DPH will lose revenue due to reduced patient care.

(4) Both the federal and state governments acknowledge through policy and legislative actions that county health care providers are expected to increase services to individuals newly eligible for insurance under the Affordable Care Act ("ACA") (see, 42 U.S.C.A §18091 and 26 U.S.C.A.§5000A). In 2016, the federal government plans to reduce the Disproportionate Share Hospital program, which has been a source of funding for safety net providers, like DPH, for many years. Similarly, under AB85 (June 27, 2013), the State of California will recoup indigent health care realignment allocations, funds that formerly went to counties. In both cases, providers such as DPH are expected to replace those revenues by increasing enrollment of persons who are newly eligible for managed care insurance programs.

(5) Shortly after the passage of the ACA, DPH entered into a year-long Integrated Delivery System planning process, which concluded that to remain financially viable under ACA, DPH must transition from a "provider of last resort" to become a "provider of choice" to retain clients newly enrolled in insurance under the ACA.

(6) In February 2013, DPH and the Controller's Office jointly launched a Health Reform Readiness Assessment project and engaged Health Management Associates, a consulting firm specializing in healthcare. The Controller's summary report of that effort, on file with the Clerk of the Board of Supervisors in File No. 141097, concluded that in order to maintain excellence in patient care and financial health, DPH should focus on increasing "the number of insured and covered clients, by maximizing the current Medi-Cal expansion," and "contracts with health plans." The Health Reform Readiness Assessment also recommended that DPH increase the number of insured patients in its network by 30,000 over the next five years. The timely ability to enter into and modify managed care contracts is critical to achieving these goals.

(7) In July 2013, the City convened the 41-member Universal Healthcare Council ("UHC"), engaging a wide range of stakeholders to examine San Francisco's implementation of the ACA. The UHC Final Report 2013, on file with the Clerk of the Board of Supervisors in File No. 141097, adopted guiding principles, including: a commitment to "full implementation of the ACA in San Francisco;" "maximizing enrollment of San Franciscans into the new insurance opportunities created by the ACA;" and sharing responsibility among all sectors of society, including City government, to "reduc[e] the number of uninsured residents and ensur[e] access to care." To meet these expectations, DPH must be given the administrative tools to fully engage in implementation of the ACA.

(8) The ACA requires the creation of state health exchanges to provide options for insurance coverage, including for the formerly uninsured. To meet this mandate, the State of California established Covered California, which provides a marketplace where individuals can purchase health insurance. Health insurers providing coverage under Covered California must offer health plans compliant with federal and state regulations under the ACA and subsequent legislation.

(9) Covered California provides the key means for individuals to comply with the individual mandate in the ACA. Through Healthy San Francisco and other programs, DPH has

historically provided health care for a large number of individuals, who are now required to have health insurance under the ACA's individual mandate. For many of these individuals, obtaining insurance through Covered California is the only affordable way to comply.

(10) The only way to become a health care provider to individuals insured under Covered California is to enter into contractual arrangements with one or more of the state-authorized insurance providers. DPH currently serves approximately 5,000 individuals who will be eligible for Covered California subsidized insurance in 2015. If those individuals choose to enroll in insurance under Covered California, they will no longer be able to receive primary care, preventative care, specialty care, and other services from DPH, and will be forced to move to another provider, unless DPH enters into contracts with those insurance companies.

(11) To participate in the new health care markets, DPH will need flexibility to enter into and modify managed care contractual arrangements. Most insurers operate with an annual open enrollment period. Time between these open enrollment periods is limited and health care contracts are often negotiated and executed in a relatively short time period. Under current City procedures for approving such contracts, DPH will struggle to meet timelines expected in the industry, which could limit its ability to retain patients and revenue.

(b) Acting under Charter section 9.118, the Board of Supervisors authorizes the Director of Health to enter into contracts anticipated to generate over $1 million in reimbursements or revenue to the City to provide health care services at DPH facilities, including, but not limited to, primary care, specialty services, hospital services, and behavioral health services. These contracts may include fee-for-service arrangements, fully capitated arrangements where DPH receives fixed monthly payments per individual and is financially responsible for managing health care costs of its patients, or a hybrid of the two. The term of any *such contracts* ~~may not exceed three years and~~ shall terminate no later than December 31, 2017 and *shall be subject to the review and approval of the Controller for*

consistency with the terms of this Section 21.~~14~~4. The DPH annual budget shall show the revenues from the contracts as capitation rates or patient fees (collectively "Rates of Reimbursement").

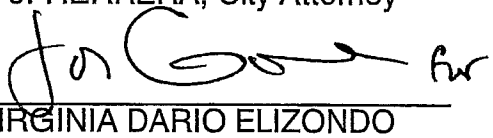
(c) Rates of Reimbursement for health services in contracts entered into under this Section 21.14, shall be equal to or higher than either (1) Fee for Service: the California Department Health Care Services (DHCS) published Medi-Cal fee for service rates, which are updated monthly and posted at http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp; or (2) Capitated Rates: the average of per-member-per month rates for Medi-Cal managed care for Aid Codes Family and Medi-Cal Expansion, or successor provisions, set by DHCS as authorized by federal and state law and posted at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDFinancialReports.aspx. For the purposes of determining whether the Capitation Rates in contracts are equal to, or exceed the minima specified in this Section 21.44, the Controller shall consider net payments the City will receive for health services provided by DPH after removing administrative fees and other amounts that state law allows the San Francisco Health Authority or other provider to withhold.

(d) No later than January 1, 2016, ~~and every two years, thereafter,~~ *the Controller, in coordination with DPH, shall conduct an analysis of health care services payment rates to ensure that the rates in the DPH contracts are within a reasonable range of the industry standard or that of comparable health systems, and identify opportunities to improve contract terms.*

(e) The Director of Health shall provide quarterly reports, ~~commencing on~~ between *September 1, 2015* and December 1, 2017, *to the Health Commission of the contracts approved under this Section 21.44, and the aggregate amount of reimbursement and revenue generated. The Director of Health shall provide* ~~an~~ *annual report*s, *no later than July 1, 2015,* July 1, 2016, and July 1, 2017 ~~and each July first, thereafter,~~ *to the Mayor and the Board of Supervisors, indentifying*~~ies~~ *the contracts approved and the aggregate amount of reimbursement and revenue generated.*

Section 2. Effective Date. This ordinance shall become effective 30 days after enactment. Enactment occurs when the Mayor signs the ordinance, the Mayor returns the ordinance unsigned or does not sign the ordinance within ten days of receiving it, or the Board of Supervisors overrides the Mayor's veto of the ordinance.

APPROVED AS TO FORM:
DENNIS J. HERRERA, City Attorney

By: 
VIRGINIA DARIO ELIZONDO
Deputy City Attorney

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AMENDED IN COMMITTEE
11/5/14

FILE NO. 141097

LEGISLATIVE DIGEST

[Administrative Code - Department of Public Health Managed Care Contracts]

Ordinance amending the Administrative Code to authorize the Director of Health to enter into managed care contracts for the provision of services to individuals covered under federal and state programs including subsidized health coverage for low income populations.

Existing Law

Charter Section 9.118 requires the Board of Supervisors to approve, by resolution, all contracts entered into by a department, board or commission having anticipated revenue to the City and County of one million dollars or more, or the modification, amendment or termination of any contract which when entered into had anticipated revenue of one million dollars or more.

Amendments to Current Law

Through this ordinance, the Board will delegate authority to the Director of Health to enter into managed care contracts where the City will be reimbursed for health care services provided at Department of Public Health (DPH) facilities by insurance companies and other health care providers. It is anticipated that these reimbursements will exceed one million dollars.

The rates of reimbursement will be equal to or higher than either:

(1) Fee for Service: the California Department Health Care Services (DHCS) published Medi-Cal fee for service rates, which are updated monthly and posted at http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp; or

(2) Capitated Rates: the average of per-member-per month rates for Medi-Cal managed care for Aid Codes Family and Medi-Cal Expansion, or successor provisions, set by DHCS as authorized by federal and state law and posted at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDFinancialReports.aspx.

These contracts must expire by December 31, 2017. They will reviewed and approved by the Controller. Additionally, by July 2016, the Controller and DPH will conduct an analysis of health care services payment rates to ensure that the rates in the DPH contracts are within a reasonable range of the industry standard or that of comparable health systems, and identify opportunities to improve contract terms.

The Director of Health will provide quarterly reports until 2017 to the Health Commission regarding the contracts approved under this ordinance and the aggregate amount of reimbursement and revenue generated, and an annual report to the Mayor and the Board of Supervisors, indentifying the contracts approved and the aggregate amount of reimbursement and revenue generated.

Background Information

The federal government and state government continue to increase the proportion of safety net health care services provided under a managed care model. The DPH's mission includes providing high-quality health care to all San Franciscans, including the uninsured and low-income individuals who access health care through federal and state-subsidized programs. Historically, DPH has fulfilled this mission by providing services through a fee-for-service structure or in partnership with the San Francisco Health Authority, also known as the San Francisco Health Plan, a separate governmental entity.

Under the shift to a managed care-focused system for delivery of health care services, to participate as a provider in certain programs, DPH will need to be a contracted partner with insurers. Otherwise, current and prospective DPH clients will not have the option of selecting DPH as a provider. If DPH cannot offer itself as a contracted provider, continuity of care will be disrupted for those who have long histories with DPH health care providers, and DPH will lose revenue due to reduced patient care.

As the federal and state governments reduce previous forms of health care reimbursement to counties, those counties are expected to replace those revenues by the increasing enrollment of persons newly eligible for managed care insurance programs.

To participate in the new health care markets, DPH will need flexibility to enter into and modify managed care contractual arrangements. Most insurers operate with an annual open enrollment period. Time between these open enrollment periods is limited and health care contracts are often negotiated and executed in a relatively short time period. Under current City procedures for approving such contracts, DPH will struggle to meet timelines expected in the industry, which could limit its ability to retain patients and revenue.

This legislative digest reflects amendments made by the Budget and Finance Committee on November 5, 2014 to require that the term of any contracts approved under this ordinance expire by December 31, 2017.

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Item 2 File 14-1097	Department: Department of Public Health (DPH)

EXECUTIVE SUMMARY

Legislative Objectives

The proposed ordinance would amend the City's Administrative Code to add subsection 21.44, wherein the Board of Supervisors authorizes Department of Public Health (DPH), under City Charter Section 9.118(a), to negotiate and enter into managed care contracts without additional Board of Supervisors approval provided that such contracts are: (1) for a term of less than three years, (2) approved by the Controller's Office, and (3) equal to or greater than the reimbursement rates used by the State Medi-Cal Authority as published by the California Department of Health Care Services.

Key Points

- With the passage of the Federal Affordable Care Act (ACA), more people are enrolling for health insurance through either their employer or directly through the State's health exchange. As a result, the funding model for DPH is changing and requires that DPH focus more on a managed care model of service delivery, for which DPH would be reimbursed by a third-party insurance company.
- Currently, there are five insurance companies that offer plans through Covered California and none of these plans allow the insured persons to select DPH as a health care provider. According to Mr. Greg Wagner, DPH Chief Financial Officer, DPH did not enter into any contracts with these insurance companies to be a health care provider during the 2014 open enrollment period in part because DPH was not able to quickly move the necessary contracts through the City's Charter-required approval process. DPH is requesting the proposed ordinance to prevent such a delay for future contracts that are currently being negotiated.

Fiscal Impact

- The value of the four potential managed care contracts to be entered into by DPH cannot be accurately estimated at this time. However, Mr. Wagner estimates DPH would receive up to $30 million of new revenues per year starting in 2019.

Policy Consideration

- Since DPH request is based on a need that is more significant in the short-term than it may be in three to five years, amend the proposed ordinance to allow DPH to enter into managed care contracts for up to three years, or through December 31, 2017.

Recommendations

- Amend the proposed ordinance on page 4 lines 16-18 to read "authorizes the Director of Health to enter into contracts *through December 31, 2017* anticipated to generate over $1 million in reimbursements or revenue to the City".
- Approve the proposed ordinance as amended.

MANDATE STATEMENT / BACKGROUND

Mandate Statement

City Charter Section 9.118(a) states that contracts entered into by a department, board or commission that will generate revenue in excess of $1 million or any modification of that contract is subject to Board of Supervisors approval.

Background

The San Francisco Department of Public Health (DPH) provides various health care services to people in San Francisco through the San Francisco General Hospital, Laguna Honda Hospital, and the primary care clinics. In order to recover costs for these services, DPH charges fees to individuals or to their insurance providers.

With the passage of the Federal Affordable Care Act (ACA), more people are enrolling for health insurance through either their employer or directly through the State's health exchange (Covered California[1]). As a result, the funding model for DPH is changing and requires that DPH focus more on a managed care model of service delivery, for which DPH would be reimbursed by a third-party insurance company.

Currently, DPH has managed care contracts with two State-designated Medi-Cal managed care plans, including the San Francisco Health Authority and Anthem Blue Cross. Any person who has health insurance through these two plans, can select DPH as his or her health care provider and can receive health care services from DPH, with the costs of such services reimbursed to DPH by those two plans.

Under the ACA, additional San Franciscans will enroll for health insurance through Covered California. According to Mr. Greg Wagner, DPH Chief Financial Officer, unless DPH enters into managed care contracts with these other non-Medi-Cal plans that offer coverage in San Francisco prior to the open enrollment period, which is from November 15, 2014 through February 15, 2015, then persons enrolling for health insurance through these other plans would not be able to select DPH as a health care provider. Consequently, DPH would forgo the revenues associated with those newly insured persons.

Currently, there are five insurance companies[2] that offer plans through Covered California and none of these plans allow the insured persons to select DPH as a health care provider. According to Mr. Wagner, DPH did not enter into any contracts with these insurance companies to be a health care provider during the 2014 open enrollment period in part because DPH was not able to quickly move the necessary contracts through the City's Charter-required approval process. DPH is requesting the proposed ordinance to prevent such a delay for future contracts that are currently being negotiated.

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[1] Covered California is the ACA-required State health exchange. People enrolling for health care can compare and enroll in competing State-authorized health insurance plans, through Covered California.

[2] Anthem, Blue Shield, Chinese Community Health Plan, Health Net, and Kaiser Permanente offer health plans in San Francisco.

DETAILS OF PROPOSED LEGISLATION

The proposed ordinance would amend the City's Administrative Code to add subsection 21.44, wherein the Board of Supervisors authorizes DPH, under City Charter Section 9.118(a), to negotiate and enter into managed care contracts without additional Board of Supervisors approval provided that such contracts are: (1) for a term of less than three years, (2) approved by the Controller's Office, and (3) equal to or greater than the reimbursement rates used by the State Medi-Cal Authority as published by the California Department of Health Care Services.

According to Mr. Wagner, DPH has had discussions with four[3] of the five third-party insurance companies that offer plans in San Francisco with the goal of being a listed health care provider under those plans. According to Mr. Wagner, the terms and provisions of the various contracts will vary based on the structures of the individual contracts (capitated rate[4], fee-for-service, or a combination), the term of the contracts, and the specific services to be covered or excluded by the contracts.

Mr. Wagner estimates that the first managed care contracts with each of the four health care plans will be for a term of approximately one year so that DPH and the plans can negotiate more appropriate contracts that are informed by the first years' experience. However, according to Mr. Wagner, after a few years of experience, DPH and the plans may enter into two-year or three-year contracts that are annually adjusted. As noted above, the proposed ordinance would limit such contracts to a term not-to-exceed three years.

As noted above, the proposed ordinance would authorize the Board of Supervisors to pre-approve managed care contracts entered into by DPH and third-party insurance plans provided that such contracts are (1) for a term not-to-exceed three years, (2) approved by the Controller's office, and (3) equal to or greater than the reimbursement rates used by the State Medi-Cal Authority as published by the California Department of Health Care Services.

Under the proposed ordinance, DPH is required to submit (1) quarterly updates to the Health Commission about these managed care contracts identifying the amount of revenues received, (2) annual reports to the Board of Supervisors and the Mayor, and (3) biennial analyses with the Controller's Office to guarantee that the rates and reimbursements are within an appropriate range of costs.

FISCAL IMPACT

According to Mr. Wagner, the value of the four potential managed care contracts to be entered into by DPH cannot be accurately estimated at this time. Mr. Wagner notes that the value of such contracts will depend on (1) the number of insured persons who select DPH as their

[3] DPH was unable to provide the names of the four insurance companies since these discussions are confidential and since the details of the discussions are highly sensitive.

[4] A capitated rate model of service assumes that the health care provider is responsible for all treatment under a plan and is reimbursed a flat, monthly amount per insured person. By contrast, under a fee-for-service model, the insurance plan sets individual rate for each service and reimburses the health care provider on per-use basis.

health care service provider, (2) the State's reimbursement rates, (3) whether the contract is based on a fee-for-service model, a capitated rate model, or a combination of the two, (4) the length (one-, two-, or three-years) of the contracts, and (5) the services covered or excluded by the individual plans. According to Mr. Wagner, the annual amount of revenues received by DPH are anticipated to be less initially, but will grow over time as more insured persons select DPH as their health care provider. Mr. Wagner estimates DPH would receive up to $30 million of new revenues per year starting in 2019.

Additionally, not all persons who receive care through DPH will be covered by one of the plans in Covered California or will have insurance. In such situations, DPH will not recover costs from third-party insurers but will charge the individuals directly, or will subsidize the cost of services through the City's General Fund. Alternatively, if DPH is not a contracted provider under a patient's designated managed care health plans, those patients would not be authorized to receive services through DPH (except for emergency services) and DPH would not be reimbursed for those patients.

POLICY CONSIDERATION

Deferring Charter-Required Approvals

The proposed ordinance would allow DPH to enter into revenue-generating managed care contracts that could potentially generate significant revenues for the City without future Board of Supervisors approval of these contracts, as currently required under the City Charter.

As noted above, DPH is requesting this authority to more quickly enter into managed care contracts in order to be an eligible health care provider under health insurance plans and therefore to recover costs.

Since DPH request is based on a need that is more significant in the short-term than it may be in three to five years, the Budget and Legislative Analyst's Office recommends amending the proposed ordinance to allow DPH to enter into managed care contracts for up to three years, through December 31, 2017. Mr. Wagner concurs with the Budget and Legislative Analyst's Office's recommendation.

RECOMMENDATIONS

1. Amend the proposed ordinance on page 4 lines 1618 to read "authorizes the Director of Health to enter into contracts *through December 31, 2017* anticipated to generate over $1 million in reimbursements or revenue to the City".
2. Approve the proposed ordinance as amended.

File # 141097

San Francisco
Universal Healthcare Council 2013

FINAL REPORT

San Francisco Universal Healthcare Council 2013
FINAL REPORT - EXECUTIVE SUMMARY

On July 25, 2013, Mayor Lee asked Director of Health Barbara Garcia to reconstitute the Universal Healthcare Council (UHC) to engage stakeholders in a data-driven process to examine San Francisco's implementation of the federal Affordable Care Act (ACA) and its integration with the City's Health Care Security Ordinance (HCSO or Ordinance). The work of the original UHC, convened in February 2006, ultimately resulted in the enactment of the HCSO. The Ordinance imposes an Employer Spending Requirement, which requires some employers to make health care expenditures on behalf of their San Francisco employees, and establishes a public health benefit program that includes Healthy San Francisco, a health care access program for the uninsured. The reconstituted 41-member UHC reviewed in-depth analyses of the ACA, the HCSO, and the impact of these laws on individuals and employers in San Francisco. Council members held an open dialogue to share views and concerns, and collected suggestions for final submission to the Mayor in this report.

Two key findings emerged during the UHC's deliberations:

- **The HCSO remains intact alongside the ACA.** While the ACA's insurance market reforms remove one option for compliance with the HCSO (the medical stand-alone health reimbursement account), the Ordinance itself remains intact. This means that for the large majority of San Francisco employers covered by the HCSO, the ACA does not present hurdles to compliance with either law.
- **Potential affordability concerns remain for some.** Due to the high cost of living and doing business in San Francisco compared to other places in the state and the nation, the UHC identified a number of categories of people or entities (particular populations of individuals, certain types of employers, and the City public health system) that may face affordability concerns beginning in 2014.

The UHC did not seek consensus and, as such, a diversity of opinion is expressed in the 30 suggestions offered by UHC members, which fall generally into the following categories:

- Maintain the Current Status
- Modify the HCSO to Mirror the ACA
- Modify the HCSO Employer Spending Requirement
- Modify the City Option
- Address Carryover HRA Balances
- Conduct Outreach & Research
- Other

On July 25, 2013, Mayor Lee asked Director of Health Barbara Garcia to reconstitute the Universal Healthcare Council (UHC) to engage stakeholders in a data-driven process to examine San Francisco's implementation of the federal Affordable Care Act (ACA) and its integration with the Health Care Security Ordinance (HCSO). The work of the original UHC, convened in February 2006 by then-Mayor Newsom, ultimately resulted in the enactment of the HCSO, which requires employers to make health care expenditures on behalf of their employees and established a public health benefit program that includes Healthy San Francisco, a health care access program for the uninsured. This report details the work and recommendations of the 2013 UHC.

THE 2013 UNIVERSAL HEALTHCARE COUNCIL

The 2013 Universal Healthcare Council (UHC) was an inclusive group of stakeholders brought together to analyze, identify, and assess key issues underlying the intersection of the HCSO and ACA. The reconstituted 41-member UHC was co-chaired by Director Garcia and Dr. Sandra Hernandez, CEO of The San Francisco Foundation. The membership largely mirrored that of the 2006 UHC and included representation from the city's labor, business, health care, and government sectors. A list of 2013 UHC members is included as **Attachment 1.**

The UHC met five times from September to December 2013. Research support was provided by the City's Department of Public Health, Office of the Controller, and the Office of Labor Standards Enforcement. All meetings were open to the public and time was allotted for public comment. Complete meeting materials, including issue briefs, presentations, and minutes, can be accessed through the Department of Public Health website, at http://www.sfdph.org/dph/comupg/knowlcol/uhc/default.asp.

UHC members reviewed in-depth analyses of the ACA, the HCSO, and their impact on individuals and employers. A summary of the key data examined by the UHC is included in **Attachment 2.** They held an open dialogue to share views and concerns and to collect suggestions. The group did not seek consensus and, as such, the array of suggestions offered in this report reflects a diversity of opinion. The various suggestions have not been tested for their legality or practicality, nor have they been evaluated for the extent to which they reflect the UHC's guiding principles (set out below). Rather, this document presents the complete list of individual UHC members' suggestions in order to provide the Mayor with a full accounting of the many possibilities and considerations generated by the UHC to inform the City's policy deliberations going forward.

UHC Guiding Principles

The UHC unanimously adopted the following guiding principles, adapted from the 2006 UHC and updated to reflect the charge of the 2013 UHC in the post-ACA environment.

1. **Support the Affordable Care Act** – The UHC supports the ACA and is committed to full implementation of the ACA in San Francisco. The ACA builds on what San Francisco began and presents an opportunity for San Francisco to continue to lead the way in health care access.

2. **Maximize Enrollment into Health Insurance** – Health insurance is better than uninsurance and the UHC is committed to maximizing enrollment of San Franciscans into the new insurance opportunities created by the ACA.

3. **Leverage State and Federal Funding** – All available state and federal funds that support enrollment of San Franciscans into health insurance should be utilized and encouraged.

4. **Maintain Healthy San Francisco** – Though Healthy San Francisco is not health insurance, it provides access to health care services for San Francisco's most vulnerable uninsured. At a minimum, Healthy San Francisco should be preserved for individuals who do not qualify for publicly-funded health insurance, but also should not be an impediment to full implementation of the ACA.

5. **Maximize Affordability** – Health insurance options must be affordable for San Franciscans to maximize enrollment.

6. **Shared Responsibility** – Fundamental to the UHC's vision and goal is the notion of collective responsibility. All sectors of society – individuals as well as public, private, and non-profit entities – must take a role in reducing the number of uninsured residents and ensuring access to care. Shared responsibility increases affordability and should continue to form the basis of creative local solutions to provide access to health insurance and care.

BACKGROUND

Health Care Security Ordinance

The Health Care Security Ordinance (HCSO) requires employers with 20 or more total employees (50+ for non-profit) to make health care expenditures on behalf of covered employees working a minimum of 8 hours per week in San Francisco. Employers comply by providing health insurance, allocating funds to health reimbursement accounts (HRAs), or paying into the City Option. Under the City Option, the City subsidizes eligible employees' membership fees for Healthy San Francisco or sets up a medical reimbursement account, known as the City MRA. Healthy San Francisco is operated by

the City's Department of Public Health and provides program participants access to a medical home, which is a health care facility (in most cases, a clinic) through which participants access their medical care. To be eligible, one must be: a San Francisco resident, uninsured, earning less than 500% of FPL ($57,450/year), and not eligible for state or federally subsidized coverage. The City MRA reimburses employee account holders for eligible health care expenditures.

The HCSO requires health care expenditures in an hourly dollar amount, but the employer controls how it makes its expenditures. Employers may use a single compliance strategy for all of its employees, multiple compliance strategies to cover different employees, or use multiple strategies to cover one employee. Each year, HCSO-covered employers report their compliance strategies and expenditures to the City's Office of Labor Standards Enforcement (OLSE). Through the HCSO's Employer Spending Requirement (ESR), employers have contributed an average of $1.2 billion for health expenditures to cover on average 235,000 employees each year.[1]

Since its enactment in 2007, the HCSO has served an important role in increasing access to health care and is a contributing factor to the declining rate of uninsurance in San Francisco, which dropped from 15.2% in 2009 to 13.6% in 2012.[2] Healthy San Francisco has won national acclaim and has provided medical homes to over 116,000 uninsured San Franciscans during the past five years. The program currently serves an estimated 70% of the City's uninsured population.

The HCSO has also helped to put San Francisco ahead of the curve in implementing the ACA. Healthy San Francisco has provided uninsured San Franciscans regular access to health care services since 2007. In addition, Healthy San Francisco currently serves more than 70 percent of San Francisco's uninsured, who can now easily be contacted to tell them of the changes that are coming with Health Reform and help them enroll into insurance.

Affordable Care Act

The Affordable Care Act (ACA) was enacted in March 2010. Over the past three years, local health systems and City Departments have developed implementation strategies to comply with the phase-in process of the federal law. Over the next two years, several more important reforms and provisions directly affecting San Franciscans will take effect. The individual mandate, which requires most individual taxpayers to carry health insurance for themselves and their dependents, and health insurance market reforms go into effect January 1st, 2014. The employer mandate, which requires employers with 50+ full-time employees to offer affordable health insurance to full-time

[1] San Francisco Office of Labor Standards, Analysis of Annual Reporting Forms, 2010-2012.
[2] United States Census Bureau, American Community Survey, 2009-2012.

employees, is effective January 1st, 2015. To assist with these mandates, the ACA makes new health insurance options available through Covered California and expands eligibility for Medi-Cal, beginning January 1st, 2014. It also creates a health insurance exchange and limited subsidies for small businesses that wish to offer health insurance.

UHC FINDINGS ON THE INTERSECTION OF THE HCSO AND ACA

At the intersection of the HCSO and the ACA, the UHC identified two key issues that have implications for individuals, employers, and the City: the compatibility of the HCSO with the ACA, and the affordability of health care coverage.

HCSO Remains Intact Alongside the ACA

Insurance market reforms under the ACA affect one market-based option for compliance with the HCSO but leave the Ordinance itself intact. This means that for the large majority of San Francisco employers covered by the HCSO, the ACA does not present hurdles to compliance with either law. Eighty-eight percent of the City's employers meet their HCSO Employer Spending Requirement by offering insurance to some or all of their employees, a trend that is particularly evident among large employers and further incentivized under the ACA. Employers who currently pay into the City Option can also continue to do so unaffected, and their covered employees will continue to have access to Healthy San Francisco or the City MRA, which the employees can use to purchase individual insurance on Covered California.

However, the ACA does make changes to the third commonly used method of HCSO compliance, the health reimbursement arrangement (HRA). HRAs are accounts created by employers on behalf of employees to reimburse employees for their health care expenditures. Typically, HRAs are structured such that employer contributions expire and the unused funds revert to the employer. Under the HCSO, contributions are treated as employer health care expenditures only if the contribution remains available for at least 24 months from the date of the contribution or 90 days from separation. The HCSO also requires HRA contributions to be "reasonably calculated to benefit the employee" to ensure that eligible expenses are not subject to restrictions that make it unreasonable to believe that the employee will be able to benefit fully from the employer's contributions.

HRAs have been a cost-effective way for some businesses to comply with the HCSO because the average employee expenditure rate is 24.6%, meaning that roughly 75 cents of every dollar contributed to an HRA reverts to the employer. In comparison, dollars paid for insurance premiums and to the City Option do not revert to the employer. The use of HRAs to make health care expenditures (HCE) is highest among small businesses and those with many part-time employees. OLSE estimates that a minimum of 658 employers (16%) subject to the HCSO allocated funds to at least one

stand-alone HRA in 2012. Per the HCSO 2012 annual reporting forms, 190 employers (5%) used stand-alone HRAs exclusively.

The ACA market reforms affect HRAs such that they will no longer be available as a complete HCSO compliance strategy for employees who work more than 20 hours per week. As of January 1st, 2014, the ACA requires most HRAs to be integrated with comprehensive, employer-sponsored health insurance plans.[3] HRAs that are not coupled with an insurance plan, known as stand-alone HRAs, are disallowed unless they reimburse only for "excepted benefits."[4] "Excepted benefits" is a term used in the Affordable Care Act to describe a limited number of health benefits that are "excepted" from some of the market reform requirements, so employers can still provide excepted benefits whether or not they also provide health insurance. But the scope of such benefits is extremely limited in comparison to the full range of health care benefits that stand-alone HRAs could provide prior to January 1st, 2014. Because the excepted benefits will be so limited, OLSE has correspondingly limited the HCSO credit an employer receives for contributing to an excepted benefits HRA to the amount of the employer's spending requirement for an employee who works an average of 20 hours per week. Contributions to stand-alone HRAs that were not limited to excepted benefits did not have this limit.

This change will affect how some employers comply with the HCSO and will likely have financial impacts for both employers and employees. Employers who relied exclusively on HRAs to make health care expenditures for employees working more than 20 hours per week can no longer do so and will have to choose a different type of expenditure for any additional hours. Because providing insurance and paying into the City Option are more expensive than HRAs, this will create additional costs for affected businesses in 2014. Employees will also have additional burdens, because their non-excepted medical expenses, including health insurance premiums, will not be eligible for reimbursement.

In addition, the City has confirmed with federal officials that beginning January 1st, 2014, individuals who have carryover balances in stand-alone HRAs that provide

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[3] U.S. Departments of Treasury and Labor. IRS Notice 2013-54: Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements. September 13, 2013.

[4] Section 9832(c) of the Internal Revenue Code and its accompanying regulations contain the full list of excepted benefits and place some limits on how they can be offered. But only some of those excepted benefits also qualify as "health care services" under the HCSO. Those benefits are:

- dental benefits limited to treatment of the mouth;
- vision benefits limited to treatment of the eye;
- medical indemnity insurance;
- long-term, nursing home, home health, or community-based care; and
- coverage limited to a specific disease or illness.

reimbursements for health care expenditures other than excepted benefits will not be eligible for federal subsidies on Covered California for any month they carry an HRA balance. Employees may still spend down their accounts, including by using it toward unsubsidized purchase of plans on Covered California (if the terms of the HRA allow), or they may permanently opt out and waive the balance in the account in order to qualify for a subsidy sooner. This rule affects HCSO covered employees, who are guaranteed access to their HRA funds for 24 months from the date of the allocation. OLSE estimates that a minimum of 35,469 employees (13%) had stand-alone HRAs in 2012, many of which will have rollover balances in 2014. These employees are likely to be part-time and/or low-wage employees. The carryover rule also affects employers who have employees with HRA balances. Under the ACA, these employers must allow employees to opt out of their HRAs at least once per year; and under the HCSO, these employers will need to use another strategy to make the required expenditures on behalf of employees who opt out.

It is important to note that the non-excepted benefit stand-alone HRA issue is a temporary one. Employers can continue to comply with the HCSO in other ways, and employees become eligible for premium subsidies as soon as they spend down their accounts or permanently opt out. Any remaining carryover accounts will expire by their own terms by the end of 2015.

Potential Affordability Concerns Remain for Some

The cost of living and doing business in San Francisco is high compared to other places in the state and the nation. Health insurance can also be expensive, with small businesses and part-time employees at high risk for not being able to afford coverage. While the ACA provides new coverage options through Medi-Cal and Covered California's individual and small business insurance exchanges, and offers federal subsidies in some cases, the high cost of living in San Francisco may keep health insurance out of reach for low- and middle-income individuals and families. Meanwhile, ACA changes to HRAs potentially increase the cost of complying with the HCSO for small businesses. Such affordability concerns could translate to a lack of coverage, which ultimately becomes a financial concern for the City.

The UHC identified the following populations and entities as potentially facing affordability concerns beginning in 2014.

	Potential Affordability Concern
Individuals	• Undocumented immigrants • Part-time employees • Employees of small business • Families • Individuals with Carryover Balances in Existing Stand-alone HRAs • Individuals choosing to pay penalties
Employers	• Small businesses (20-49 employees) • Businesses relying on stand-alone HRAs • Businesses choosing to pay penalties
City	• Public health care system

Undocumented immigrants are ineligible to purchase insurance through Covered California and eligible only for limited Medi-Cal benefits. While low-income undocumented persons below age 65 will continue to have health care access through Healthy San Francisco or Healthy Kids, those whose income or age does not qualify them for these programs may not have access to affordable health care.

Part-time employees are less likely to have offers of employer-sponsored insurance, and are also more likely to be low- and middle-wage earners. ACA employer provisions do not extend employer-sponsored coverage to part-time workers. Employees working 8-29 hours per week are covered by the HCSO, but those benefits may not cover the full cost of insurance. The ACA provides financial assistance for individuals with incomes between 138-400% of FPL ($15,856-$45,960 per year) when purchasing insurance on Covered California. The amount of the subsidy declines sharply between 250-400% of FPL, meaning that a person earning $45,000 pays nearly the full price of premiums, which may be a deterrent to buying insurance.

Employees of small business are less likely than employees of large business to have insurance and are likely to pay more for premiums and deductibles than employees working for large businesses. Small business employees currently comprise a large number of enrollees in stand-alone HRAs.

Families may face financial and coverage concerns depending on an employer-sponsored offer of coverage. The ACA considers employer–sponsored coverage as affordable if an employee's contribution for self-only coverage is less than 9.5% of household income. However, family coverage can cost three to four times more than individual coverage, which could in practice be unaffordable for the family. Should a

family decide to decline employer coverage and purchase on Covered California, all family members covered under the employer's plan are barred from accessing federal subsidies on Covered California.

Employees with carryover stand-alone HRA balances will be considered to have satisfied the individual mandate during the months they retain a balance. If otherwise eligible for federal tax subsidies on Covered California, these employees will lose access to those subsidies during the months they carry a balance.

Individuals choosing to pay ACA penalties rather than purchase health insurance would remain uninsured and liable for all health related costs.

Small businesses with 20-49 employees have difficulty financing insurance for their employees for various reasons, including high cost and low employee participation in insurance, especially if the employees are low-wage earners. A small business also may not have the requisite number of full-time employees or a large enough workforce to negotiate affordable health insurance rates. Small employers generally operate on low profit margins and it is unclear whether Covered California's small business exchange will put health insurance within their reach.

Businesses relying on stand-alone HRAs as a mode of compliance with the HCSO anticipate the reversion of allocations that go unused for 24 months. These may be small businesses relying solely on HRAs, or larger businesses that offer HRAs to part-time or low-wage employees.

Having built the HRAs into their business strategy, these businesses face an increase in costs to the extent that they will have to move a portion of their HCSO spending to insurance or the City Option.

Businesses choosing to pay ACA penalties rather than provide health insurance would do so to save health insurance costs, but this may not be a cost-effective option for businesses that would still be required to comply with the HCSO.

The City's public health care system, operated by the Department of Public Health (DPH), absorbs the cost of care for those who are uninsured and/or indigent through its hospitals and clinics and the Healthy San Francisco program. To recover revenue losses related to caring for the uninsured, DPH draws from the City's General Fund. In the last three years, DPH has required $248.7–336.5 million per year in General Fund support; these numbers reflect revenue shortfalls related to patient care only and do not include General Fund support for DPH's other programs and services. Currently, DPH projects that 49,000-53,000 San Franciscans will remain residually uninsured in 2014. A higher rate of insurance among San Franciscans may help to reduce DPH's revenue shortfall.

SUGGESTIONS OFFERED BY MEMBERS OF THE 2013 UHC

The UHC's suggestions for the City, collected throughout the process, are listed below. Like ideas were combined and grouped for ease of understanding and numbered for ease of reference. The order in which they are presented is not a reflection of priority. Each suggestion stands on its own and, as the UHC process did not require members to reach consensus, some suggestions may directly or indirectly conflict with others.

Maintain the Current Status

1. **Maintain the HCSO** in its current form with robust monitoring and enforcement.
2. **Maintain Healthy San Francisco and Healthy Kids** for those left out of the ACA.

Modify the HCSO to Mirror the ACA

3. **Align HCSO employer obligations with ACA employer provisions**, and eliminate the Employer Spending Requirement for businesses with fewer than 50 employees.[5]
4. **Deem** large and small **employers that offer full- or part-time employees ACA-compliant health insurance as compliant with the HCSO** and provide a "safe harbor" from any financial obligations that may remain under the HCSO.
5. For large employers that choose to pay the ACA penalty, **credit the amount of the ACA penalty toward compliance with HCSO.**

Modify the HCSO Employer Spending Requirement

6. **Lower the health care expenditure rate** (e.g., to reflect the current average health reimbursement account reimbursement rate of 24.6%.)[6]
7. **Tether** health care expenditure **rates to costs on Covered California**, rather than to the 10-County Survey rate.
8. **Remove requirement** for employers to make health care expenditures **for employees who decline insurance.**[7]

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[5] The HCSO requires employers with 20+ employees to make health care expenditures on behalf of employees working a minimum of 8 hours per week in San Francisco. The ACA requires employers with 50+ full-time equivalent employees to offer affordable health insurance to employees working at least 30 hours per week.

[6] The health care expenditure (HCE) rate is currently set to 75% (for large employers) and 50% (for small and medium employers) of the average contributions made by the 10 most populous California counties to their employees' health insurance. The 2014 rates are $1.63/hour worked per employee for businesses with 20-99 employees, and $2.44/hour worked per employee for businesses with more than 100 employees.

9. **Credit** as valid health care expenditures **only those funds that are irrevocably spent by employer.**

10. **Approve a method of HCSO compliance that allows for direct reimbursement of employee health expenses** that does not require fully irrevocable, upfront expenditures for small businesses and does not jeopardize employee eligibility for ACA subsidies, **such as excepted benefit health reimbursement accounts.**

11. **Restrict** the amount of funds that can be allocated to **excepted benefits health reimbursement accounts to a level that can reasonably be spent by an average employee in a year,** and require employers to make remaining expenditures through another option.

Modify the City Option

Medical Reimbursement Accounts

12. **Allow unused City medical reimbursement account funds to revert to employers** after a certain time.

13. **Petition Covered California to accept direct payments from City medical reimbursement accounts,** saving employees the need to pay for premiums up-front.

14. Enforce the HCSO policy that **allows unclaimed City medical reimbursement account funds to be transferred to the Department of Public Health** to help defray the costs of indigent care.

Healthy San Francisco

15. **Expand Healthy San Francisco eligibility to cover San Francisco residents not eligible for ACA coverage,** including seniors without coverage, people exempt from the individual mandate, immigrants not eligible for publicly-subsidized coverage, individuals barred from subsidies due to the "family glitch," and those for whom insurance would cost more than eight percent of family income.

16. **Delay the disenrollment of current Healthy San Francisco participants** until after confirming that they have enrolled through Covered California.

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[7] The HCSO allows employees to waive HCEs made on their behalf only if they have employer-sponsored coverage, either from another employer or through a spouse's employer. Individual coverage, whether purchased through Covered California or through the individual market, does not qualify for a waiver.

Create a New City Option

17. **Create a wrap-around program** funded by health care expenditures **to pay for services not covered by Medi-Cal or Covered California plans** (e.g., dental, vision).

18. **Create a public benefit program** that pools health care expenditures **to support Healthy San Francisco** for those ineligible for ACA coverage **and to assist with premiums and out-of-pocket costs** to assure the affordability of health insurance for those eligible for ACA coverage.

Address Carryover HRA Balances

19. Work with employers to **convert carryover health reimbursement accounts to City medical reimbursement accounts.**

20. Work with employers to **modify policies to keep carryover health reimbursement accounts from interfering with employee eligibility for health insurance subsidies** on Covered California.

21. Work with employers to **amend restricted carryover health reimbursement accounts to allow employees to spend down the balance to purchase insurance** on Covered California.

22. **Do not require** employers to make **additional health care expenditures for employees who opt out of carryover health reimbursement accounts.**[8]

Conduct Outreach & Research

23. **Conduct** an **extensive outreach** campaign **to educate employees about** the consequences of and options for use of **carryover health reimbursement account balances.**

24. **Disseminate educational materials highlighting the** difference that City **medical reimbursement accounts** could make to the affordability of health insurance on Covered California.

25. **Promote the City Option to employers** as a means of complying with the HCSO for employees for whom they do not provide health insurance.

26. **Aggressively market availability of unused City medical reimbursement accounts funds to account holders,** in conjunction **with a campaign to help enroll account holders into insurance** on Covered California.

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[8] Under HCSO regulations, if an employee opts out of the HRA and waives his/her carryover funds, the employer is not considered to have met its HCSO obligations and is required to make valid health care expenditures in the amount of the waived funds.

27. **Conduct further research and data analysis on affordability concerns** for San Franciscans under the ACA.

28. **Educate the community at large about** continued access to health care services through **existing charity care and sliding fee scale programs** at health care providers throughout the City.

Other

29. **Continue the UHC into 2014.**

30. **Indemnify employers if they face federal penalties** for following City's guidance on HCSO.

PUBLIC INPUT

The following were suggestions offered by members of the public.

1. Small businesses that purchase insurance through the Small Business Health Options Program (SHOP) on Covered California should not be required to make the full amount of HCE for insured employees. The cost of SHOP plans is likely to be less than the annual HCE for a full-time employee, while providing comprehensive ACA-approved coverage.
2. Create a non-MRA HCSO compliance option specifically for small businesses.
3. Because California law extends insurance to employees regularly working 20 hours per week, the focus should be on solutions that provide insurance to employees working 20-30 hours/week.

Attachment 1

2013 UNIVERSAL HEALTHCARE COUNCIL MEMBERS

Last Name	First Name	Organization
Adams	Steve	President, San Francisco Small Business Commission
Black	Rob	Executive Director, Golden Gate Restaurant Association
Browner, MD	Warren	Chief Executive Officer, California Pacific Medical Center
Chan, PharmD	Eddie	President/Chief Executive Officer, Northeast Medical Services
Chung	Anni	President/Chief Executive Officer, Self Help for the Elderly
Fields	Steve	Co-Chair, Human Services Network
Fung, MD, PhD	Gordon	Member, San Francisco Medical Society Board of Directors
Garcia	Estela	Chicano Latino Indigena Health Equity Coalition; Executive Director Instituto Familiar de la Raza
Garcia, Co-Chair	**Barbara**	**Director of Health, San Francisco Department of Public Health**
Gressman	John	President/Executive Director, San Francisco Community Clinic Consortium
Grumbach, MD	Kevin	Professor & Chair of Family Practice, UCSF/SFGH; Co-Director, UCSF Clinical Translational Science Community Engagement and Health Policy Program; Co-Director, UCSF Center for Excellence in Primary Care
Hauge	Scott	President, CAL Insurance & Associates; Founder, Small Business California
Heilig	Steve	Policy Director, SF Medical Society
Hernandez, MD, Co-Chair	**Sandra**	**Chief Executive Officer, The San Francisco Foundation**
Jacobs	Ken	Chair, UC Berkeley Center for Labor Research and Education
Lang	Perry	African-American Community Health Equity Council; Executive Director, Black Coalition on AIDS
Laret	Mark	Chief Executive Officer, UCSF Medical Center
Lewis	Ian	Research Analyst, Unite Here Local 2
Lazarus	Jim	Senior Vice President, SF Chamber of Commerce
Melara	Sonia	President, San Francisco Health Commission
Miller	Rebecca	Director, Workforce Development, United Healthcare Workers - West
Muscat	Bob	Chair, Public Employees Committee, San Francisco Labor Council
Naranjo	Fred	Principal, Scarborough Insurance Agency

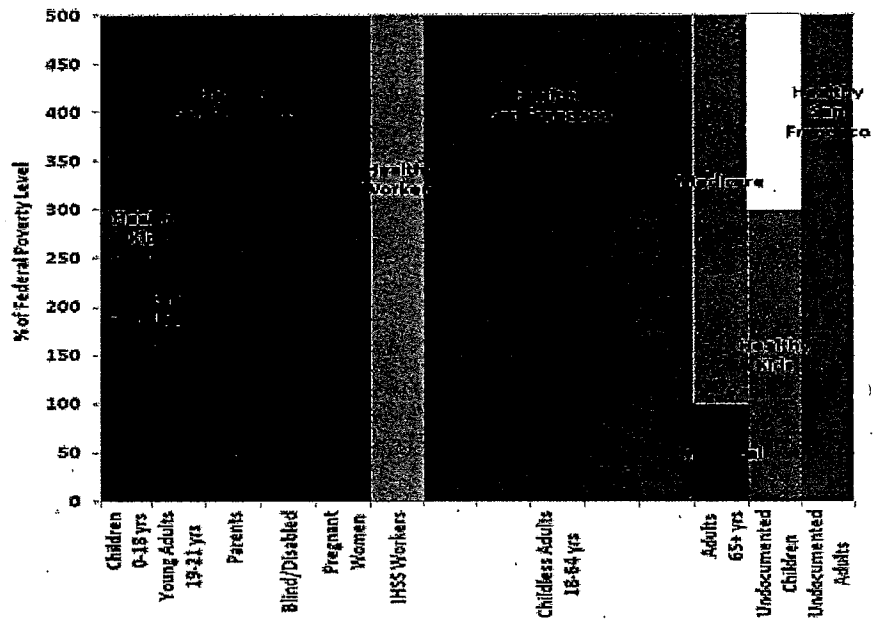
2013 UNIVERSAL HEALTHCARE COUNCIL MEMBERS		
Last Name	**First Name**	**Organization**
Pappas	Michael	Executive Director, Interfaith Council
Paulson	Tim	Executive Director, Labor Council
Rhorer	Trent	Executive Director, San Francisco Human Services Agency
Robisch	Christine	Senior Vice President & Area Manager, Kaiser Foundation Hospitals and Health Plan
Rose	L. Wade	Vice President, External & Government Relations, Dignity Health
Rosenfield	Ben	Controller, City and County of San Francisco
Santiago, DPM	Amor	Asian & Pacific Islander Health Parity Coalition; Executive Director, APA Family Support Services
Smith	Ron	Regional Vice President, Hospital Council of Northern and Central California
Snay	Abby	Executive Director, Jewish Vocational Services
Stead-Mendez	John	Deputy Executive Director, Field & Programs, SEIU Local 1021
Storey	Brenda	Executive Director, Mission Neighborhood Health Center
Thomas	Laurie	Rose Pistola & Rose's Café
Thomason	Richard	Director, Health Care and Coverage, Blue Shield of California Foundation
Valdes, MD	Ana	Medical Director, St. Anthony's Clinic
Wright	Chris	Executive Director, Committee on Jobs
Wulsin, Jr	Lucien	Executive Director and Founder, Insure the Uninsured Project
Wunderman	Jim	President/Chief Executive Officer, Bay Area Council
Yee	Brenda	Chief Executive Officer, Chinese Hospital

Attachment 2

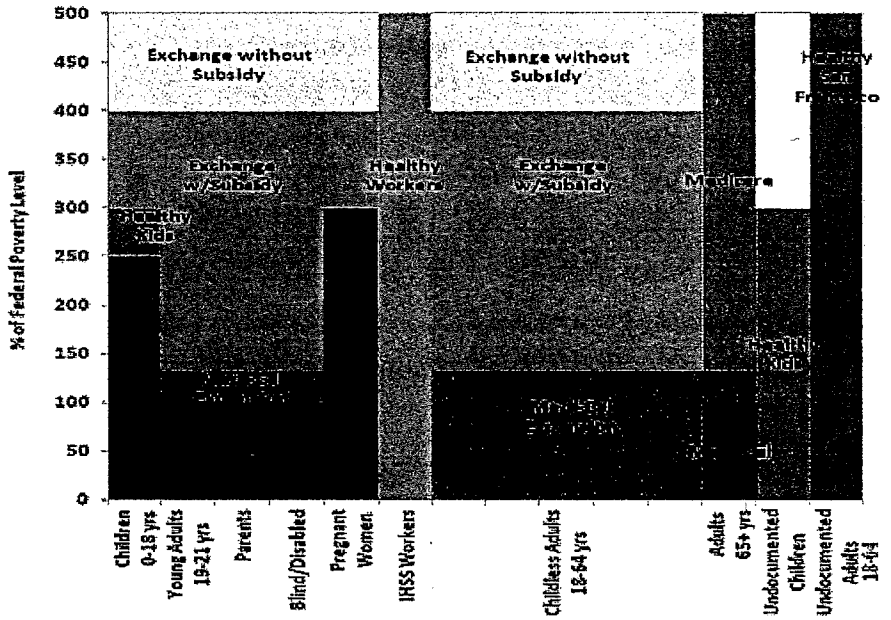
The following is a compilation of key data examined by the 2013 Universal Healthcare Council. Some of the content has been updated to reflect information that became available during the course of the UHC deliberations. More context and detail can be found in the full issue briefs and follow-up materials presented at UHC meetings. The information contained herein represents the City's best understanding to date of a dynamic situation, and some graphs and charts have been updated to reflect changes since the data's original presentation. This information is not intended to serve as legal advice regarding the ACA or the HCSO.

Attachment 2A. State and Federal Programs Available in San Francisco
With full implementation of the Affordable Care Act, new state and federal health coverage options will be created for many San Franciscans.

Current



2014



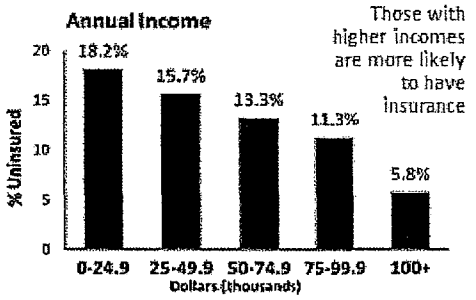
Attachment 2B. Insurance Status in San Francisco

The graphs below detail the characteristics of San Franciscans with and without health insurance. Data reported are from the 2011 American Community Survey for the City and County of San Francisco.

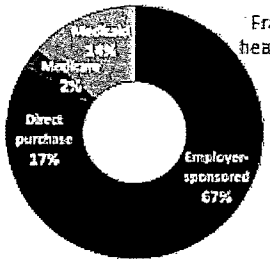
Insured

Most San Franciscans have private insurance

Type of Insurance	Age % of San Franciscans			
	Under 18	18-34	35-64	65+
Private	65.2%	72.4%	71.4%	2.9%
Public	26.4%	8.4%	14.1%	51.9%
Public & Private	4.3%	1.1%	2.7%	44.3%
None	4.1%	18.1%	11.8%	0.9%

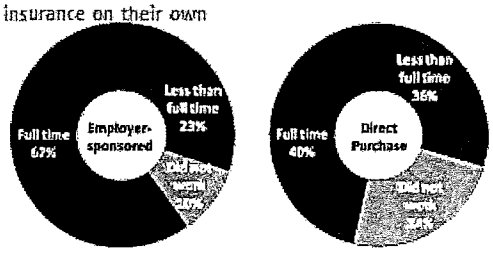


Those with higher incomes are more likely to have insurance



Most San Franciscans get health insurance through employment

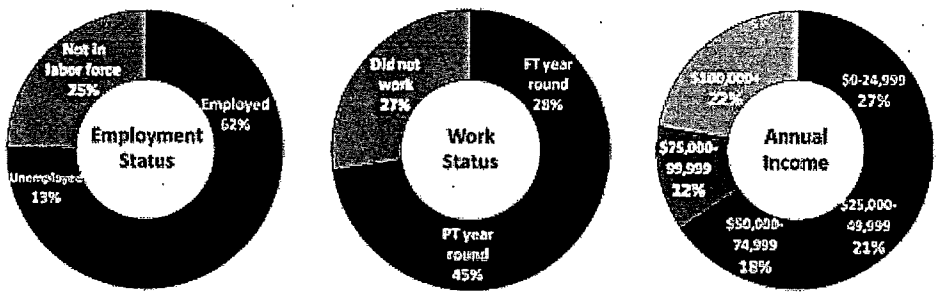
Those working less than full time are more likely to buy insurance on their own



Uninsured

Among all San Franciscans, 18-64 year olds, those who are unemployed, and those who work part time have the highest rates of uninsurance

Among those without insurance, the majority are employed, work part-time, and earn less than $50,000 per year

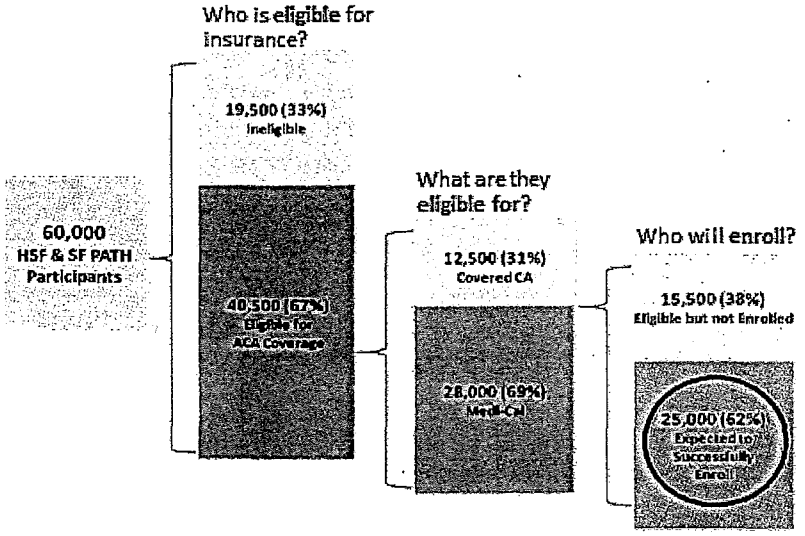


Attachment 2C. Residually Uninsured

a) Of the ~84,700 uninsured San Franciscans, ~60,000 are served by Healthy San Francisco (HSF) and SF PATH, which is a program that will automatically transition enrollees into Medi-Cal in 2014. Given historical uptake rates and experience with the HSF population, approximately 25,000 of current HSF/SF PATH participants are expected to successfully enroll in ACA coverage.

b) Using UC Berkeley's CalSIM model to estimate insurance uptake rates among ~24,700 uninsured persons non enrolled in HSF/SF PATH, DPH estimates that a total of ~49,000 – 53,000 San Franciscans are likely to remain residually uninsured in 2014. The total residually uninsured number reflects persons ineligible for ACA coverage, as well as those who may be eligible but are unlikely to enroll for a variety reasons.

a. Expected Transitions Among Healthy San Francisco (HSF)/SF PATH Participants:

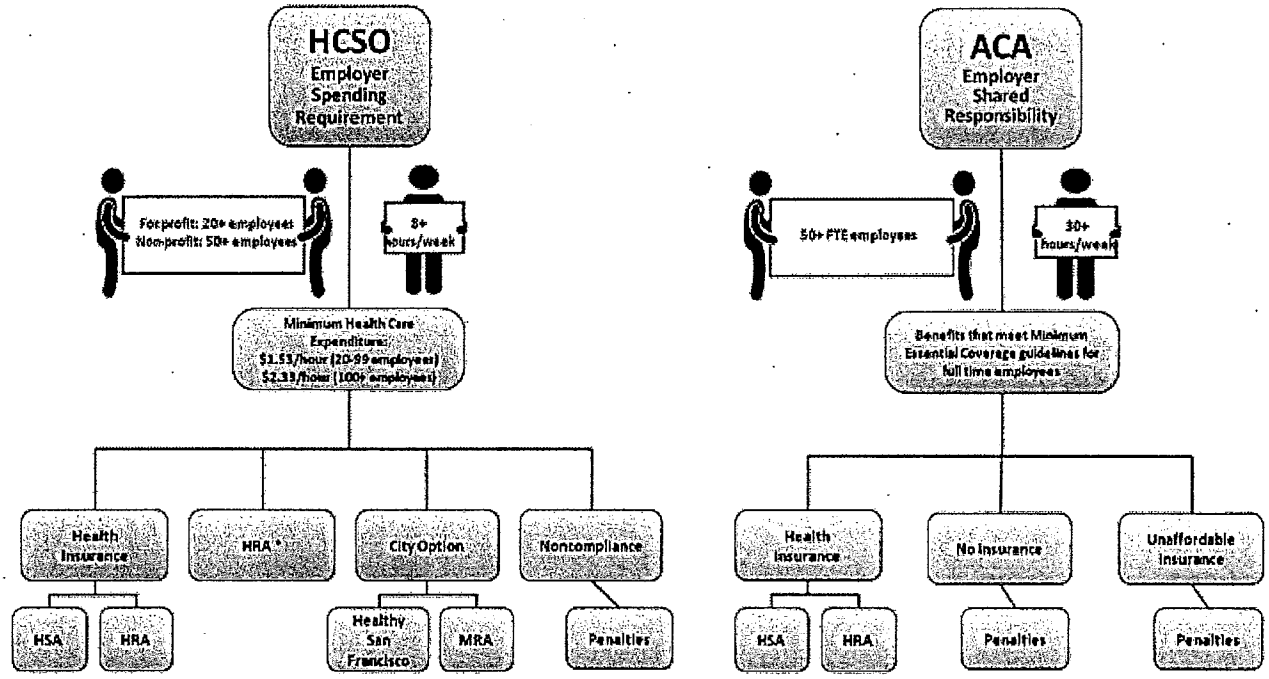


b. Total Residually Uninsured Estimates

	Insurance Uptake Scenario Among Non-HSF Uninsured Population		
Healthy San Francisco Uninsured + non-Healthy San Francisco Uninsured	**Low**	**Mid**	**High**
Total Eligible for ACA	58,722	58,722	58,722
Eligible–Expected to Enroll	31,395	33,607	35,362
Eligible–Likely not to Enroll	27,327	25,115	23,360
Total Ineligible	25,975	25,975	25,975
# of all San Franciscans Residually Uninsured (Ineligible + Eligible Likely not to Enroll)	**53,302**	**51,090**	**49,335**
Residually Uninsured as % of Total Uninsured	**63%**	**60%**	**58%**
Residually Uninsured as % of San Francisco Population aged 18-64	**9.1%**	**8.7%**	**8.4%**

Attachment 2D. Key Employer Provisions under the Health Care Security Ordinance (HCSO) and the Affordable Care Act (ACA)

The HCSO covers a broader range of employers and employees than the ACA, and does not require health insurance as the only mode of compliance.



= Covered Employer

= Covered Employee

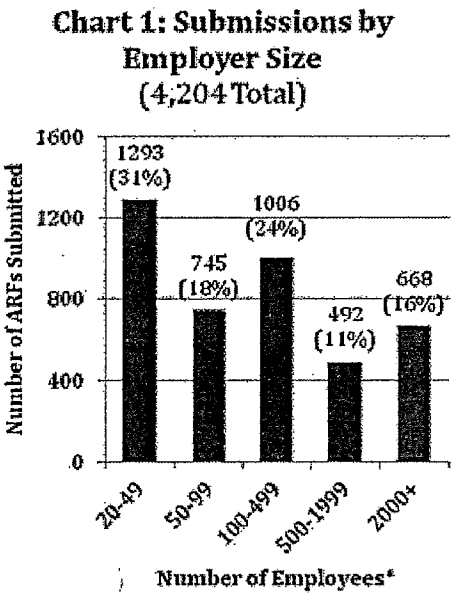
HRA = Health Reimbursement Account
HSA = Health Savings Account
MRA = Medical Reimbursement Account

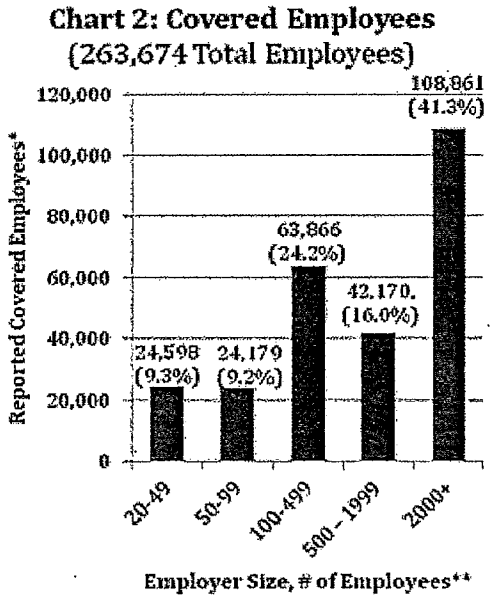
*Effective January 2014, the ACA disallows HRAs that are not integrated with group health insurance.
*Effective January 2014, excepted benefit HRAs will be allowed under the HCSO.

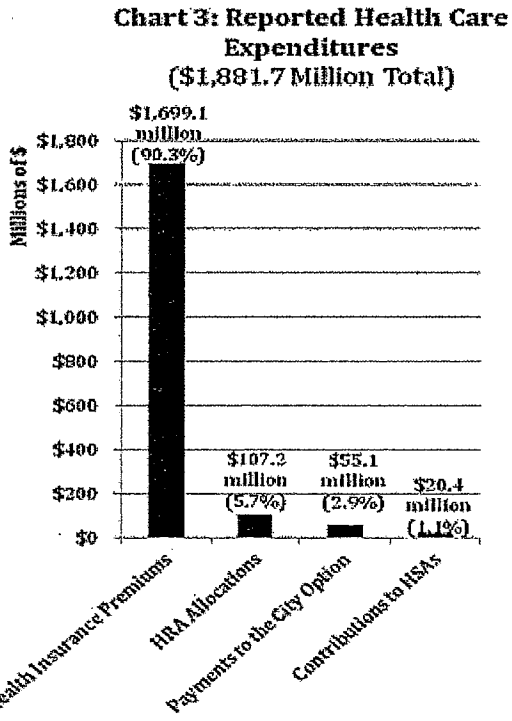
Attachment 2E. Comparison of ACA Employer Provisions and HCSO Employer Spending Requirement

	Large Employer Shared Responsibility under the ACA	Employer Spending Requirement under the HCSO
Effective Date	January 1, 2015	January 9, 2008
Covered Employer	Businesses with 50+ full-time equivalent (FTE) employees	Employers with: one employee working at least 8 hours in SF and: • 20+ employees (medium, for-profit) • 50+ employees (medium, non-profit) • 100+ employees (large, regardless of profit status)
Covered Employee	Working an annual average of 30 hours/week	• Employed for 90+ days; and • Working at least 8 hours/week in SF
Employer Responsibility	• Offer affordable self-only health insurance (defined as covering at least 60% of health costs with employee contribution <9.5% of household income) to all covered employees (defined as at least 95% of FTEs) • Employers with 200+ employees must automatically enroll employees in health coverage. Employee may refuse.	Make minimum Health Care Expenditures (HCE) for all covered employees via: • Health insurance • Health reimbursement accounts • Payments to the City Option • Any combination of the above, or • By any other means that provides health care or reimburses health care costs for covered employees
Minimum Contribution	• Cost of affordable health coverage to 95% of full-time employees; or • Possible penalties	For 2014: • $1.63/hour paid (20-99 employees); $2.44/hour paid (100+ employees) • Capped at 172 hours/month per covered employee • Expenditures must be made w/in 30 days of end of each quarter
Penalties	• For no coverage: $2,000 annually/FTE beyond the first 30 • For unaffordable coverage, lesser of: • $2,000 annually/FTE beyond the first 30; or • $3,000 annually/employee purchasing subsidized coverage on Covered CA	• Failure to make HCE: full compensatory payment to employee and $100/employee/quarter • Failure to submit annual reporting form: $500/quarter • Retaliation against employees: $100/targeted employee/day • Not allowing City access to records: $25/employee with missing records/day • Failure to maintain accurate or complete records: $500/quarter
Reporting Requirement	Annual	Annual
Enforcement Agency	United States Internal Revenue Service (IRS)	San Francisco Office of Labor Standards Enforcement (OLSE)

Attachment 2F. HCSO Compliance: The Numbers
The charts below are taken from the Analysis of the 2012 Healthy Care Security Ordinance Annual Reporting Forms, conducted by the Office of Labor Standards Enforcement.







In 2012, 4,204 employers made $1.88 billion in health care expenditures to cover 264,674 employees. While 49% of covered employers are small/medium businesses (20-99 employees), 82% of covered employees work for large businesses with more than 100 employees. 90% of all health care expenditures made by employers are for health insurance premiums.

Attachment 2G. HCSO Compliance: The Numbers

The charts below are taken from the Analysis of the 2012 Healthy Care Security Ordinance Annual Reporting Forms, conducted by the Office of Labor Standards Enforcement.

88% of HCSO covered employers offer health insurance to some or all of their employees (a), and use of HRAs is highest among businesses with 20-99 employees (b).

a. COMPLIANCE STRATEGIES

COMPLIANCE STRATEGY	NUMBER OF EMPLOYERS	% OF TOTAL
Health Insurance Only*	2407	57.3%
Health Insurance* + City Option	590	14.0%
Health Insurance* + HRA	720	17.1%
City Option Only	143	3.4%
HRA Only	190	4.5%
Other Strategy	154	3.7%
Total Employers	4204	100.0%

b. EMPLOYERS UTILIZING HEALTH REIMBURSEMENT ACCOUNTS (HRA)

Number of Employees (EEs)	20-49 EEs	50-99 EEs	100-499 EEs	500+ EEs	Total
Employers with HRAs in 2012 (#)	336	212	223	225	996
Employers with HRA in 2012 (%)	26.0%	28.5%	22.2%	19.4%	23.7%
Employers with HRA in 2011 (%)	22.0%	24.9%	17.6%	17.7%	20.3%

By cross referencing the number of Covered Employees receiving Health Insurance with the number participating in HRAs, OLSE estimates that a minimum of 658 employers subject to the HCSO (16% of all) allocated funds to at least one stand-alone HRA in 2012.

c. EMPLOYEES WITH HEALTH REIMBURSEMENT ACCOUNTS (HRA) BY EMPLOYER SIZE

Number of Employees (EEs)	20-49 EEs	50-99 EEs	100-499 EEs	500+ EEs	Total
Employees with HRAs (includes both stand-alone and integrated)	6,112	6,589	11,723	21,627	46,051

By cross referencing the number of Covered Employees receiving Health Insurance with the number participating in HRAs, OLSE estimates a minimum of 35,469 HCSO covered employees (13% of all) had stand-alone HRAs in 2012.

d. EMPLOYEES RECEIVING CITY OPTION CONTRIBUTIONS BY EMPLOYER SIZE

Number of Employees (EEs)	20-49 EEs	50-99 EEs	100-499 EEs	500+ EEs	Total
Employees Receiving City Option Contributions	1,401	1,092	2,874	14,335	19,701

Attachment 2H. Comparison of Health Reimbursement Account (HRA) and City Option Medical Reimbursement Account (City MRA)

This chart represents the City's best understanding and interpretation of available federal guidance. It does not constitute legal advice or opinion.

	Health Reimbursement Account (HRA)	SF City Option Medical Reimbursement Account (MRA)
Contribution	Employer	Employer
End of year funds	May roll over. (HCSO requires HRA funds to be available for 24 months from the date of distribution. Employee may opt out of rollover HRA.)	Roll over. (City MRA funds technically revert to the City after 18 consecutive months of non-use. However, in practice, the funds roll over in perpetuity and administratively closed accounts are reactivated at employee's request.)
Considered by ACA to be a group health plan	Yes	No
Funds at termination of employment	Revert to employer. (HCSO requires HRA funds to be available to employees for 90 days after separation from employment.)	Remain available to employee
Restrictions	Employer may restrict benefits	Unrestricted; qualifying expenses defined more broadly than tax-exempt expenses
Types	• Carryover Health Care HRAs • Excepted Benefit HRAs	N/A

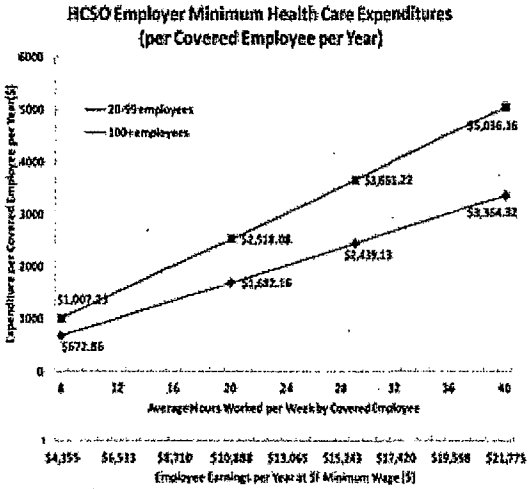
After ACA Market Reforms	• Carryover Health Care HRAs:
	  • qualify as minimum essential coverage
	  • disqualifies individual for premium subsidies on Covered CA
	  • Some disallow insurance premium reimbursements
	• Excepted Benefits HRAs:
	  • Allowable as stand-alone HRA only for excepted benefits (e.g., vision, dental)
	  • Does not qualify as minimum essential coverage
	  • Does not disqualify from individual for premium subsidies on Covered CA
		• Does not qualify as minimum essential coverage
		• May be used toward premiums for individual coverage on Covered CA
		• Does not disqualify employee from accessing income-based subsidies on Covered CA

Attachment 2I. Impact of ACA Insurance Market Reforms on HCSO Compliance Choices

	Employer Impact	Employee Impact
Group health insurance	• Large employer may meet shared responsibility requirement through HCSO if insurance is "affordable" for FT employees • Small employer may be able to leverage tax credit and ESR to provide insurance • May not be available option for some part-time employees • May not be sufficient to meet ESR • Tax favored • Premium payments may be irrevocable	• Employer-sponsored health insurance will be more widely available to employees • Will satisfy individual mandate • May meet ACA definition of affordability without being affordable in practice
HRA	• Employer must also offer health insurance unless employee is covered by spouse's insurance or HRA only covers excepted benefits • Excepted benefits HRA may stand alone • Must be "reasonably calculated to benefit employee" • Tax favored • Unused funds may be returned to employer after 24 months.	• 2013 carryover balances are considered minimum essential coverage • Unrestricted carryover HRA funds may be used to buy unsubsidized insurance on Covered CA • Eligible for subsidies month after spend down or permanent opt out • Excepted Benefits HRA provides only limited benefits to employee
City Option	• No change to employer • Doesn't satisfy shared responsibility provisions under ACA for employers required to offer group health insurance	• Neither HSF nor MRA is minimum essential coverage • Does not satisfy individual mandate • Does not disqualify from premium subsidies • MRA can be used to purchase insurance on Covered CA

Attachment 2J. Financial Considerations-Individuals and Families

The total cost of health care includes insurance premiums and out-of-pocket costs, which include deductibles, co-pays, and co-insurance. For individuals and families, age, income, household size, and employment status are key determinants of the availability and affordability of health care coverage. The ACA imposes limits on annual out-of-pocket costs for individuals and families; however, these costs vary greatly depending on a person's rate of utilization and health status.



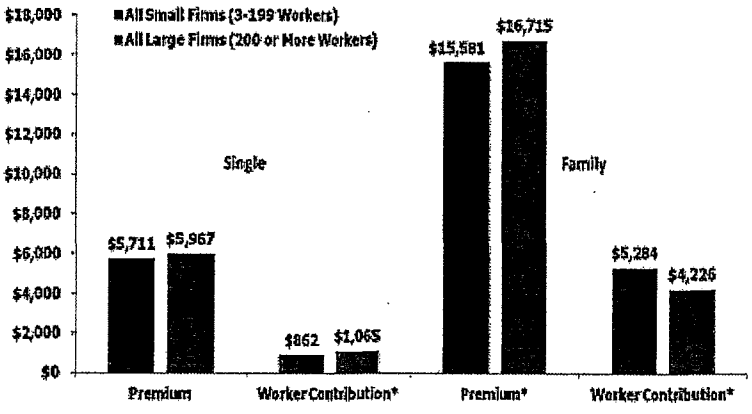
Using 2014 expenditure rates, a person employed full-time in San Francisco can expect between $3,300 and $5,000 in annual health care expenditures from his/her employer, depending on employer size.

Individual Eligibility for Publicly-Subsidized Insurance

	40 hrs/wk	36 hrs/wk	30 hrs/wk	25 hrs/wk	20 hrs/wk
Min Wage	[illegible]	$14,976	$12,480	$10,400	$8,320
$9/hr	[illegible]	[illegible]	$14,040	$11,700	$9,360
$10/hr	[illegible]	[illegible]	$15,600	$13,000	$10,400
$11/hr	[illegible]	[illegible]	[illegible]	$14,300	$11,440
$12/hr	[illegible]	[illegible]	[illegible]	$15,600	$12,480
$13/hr	[illegible]	[illegible]	[illegible]	[illegible]	$13,520
$14/hr	[illegible]	[illegible]	[illegible]	[illegible]	$14,560
$15/hr	[illegible]	[illegible]	[illegible]	[illegible]	$15,600
$16/hr	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$17/hr	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$18/hr	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$19/hr	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
$20/hr	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Medi-Cal

Depending on wages and work schedule, low- and middle-income persons are eligible for no cost Medi-Cal or for federally subsidized coverage on Covered CA.



* Estimates are statistically different between All Small Firms and All Large Firms (p<.05).
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013.

Family coverage can cost two to three times more than single coverage. For out-of-pocket costs, participants in employer-sponsored insurance face average annual deductibles of $1,107/year for individuals and $1700-$4,000/year for families. Other out-of-pocket costs, such as co-pays and co-insurance vary widely by the type of plan.

Attachment 2J. Financial Considerations-Individuals and Families

Costs of health insurance on Covered CA can be greatly mitigated for persons who are eligible for subsidized coverage (earning between 138-400% of FPL). Subsidies are tethered to the cost of the second-lowest cost silver plan, but may be used to purchase any plan. However, persons earning less than 250% of FPL are eligible for additional cost-sharing subsidies if they purchase the silver plan.

Cost of Plan Premiums on Covered CA by Household Size and Income

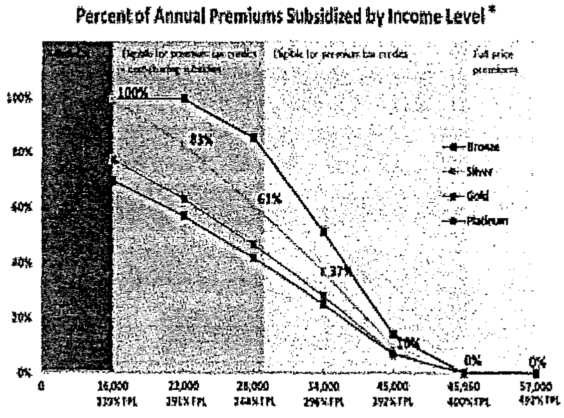
Household Size: 1 Age: 42 Annual Income	Premium Tax Credit ($/month)	Final Cost ($/month)			
		Bronze	Silver	Gold	Platinum
$16,000 (139% FPL)	$243-346	$1	$1-93	$101-179	$150-283
$22,000 (191% FPL)	243-282	1-42	59-157	165-242	213-347
$28,000 (244% FPL)	206	35-116	132-231	239-317	288-421
$34,000 (296% FPL)	125	118-199	215-314	322-400	371-504
$45,000 (392% FPL)	34	209-290	306-405	412-490	461-595
$57,000 (496% FPL)	0	243-324	340-439	447-524	496-629

Household Size: 3 Ages: 36, 36, 5* Annual Income	Premium Tax Credit ($/month)	Final Cost ($/month)			
		Bronze	Silver	Gold	Platinum
$28,000 (143% FPL)	$451-651	$2	$2-$174	$189-$333	$279-$527
$37,000 (189% FPL)	451-546	2-56	86-269	284-428	374-622
$46,000 (235% FPL)	435**	15-166	195-339	394-538	484-732
$57,000 (292% FPL)	472**	96-285	322-553	571-753	695-997
$76,000 (359% FPL)	310	257-446	484-715	733-914	847-1159
$94,000 (481% FPL)	0	568-757	794-1025	1043-1227	1157-1471

*Child may be eligible for Medi-Cal for incomes up to 250% of FPL.
**The subsidy in this case is higher at the higher income because it now includes the subsidy for the child, who was eligible for Medi-Cal at lower incomes.

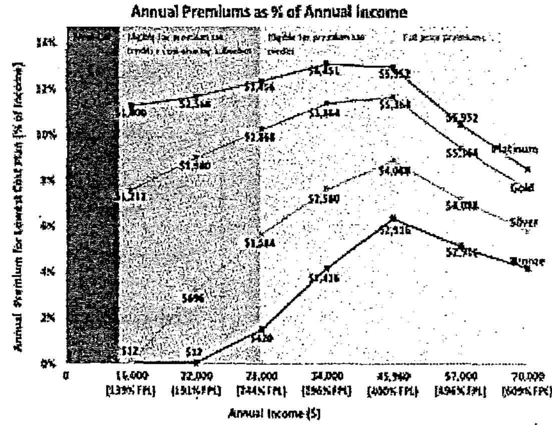
At incomes below 250% of FPL, the combination of premium assistance tax credits and cost-sharing subsidies significantly reduces enrollee costs.

Percent of Annual Premiums Subsidized by Income Level*



*Curves based on maximum allowable annual tax credit and price of lowest cost plan in each tier, for a 42 year-old San Francisco resident. Out-of-pocket costs are not accounted for. Values are shown for the Silver plan, to which the subsidies are tethered.

Annual Premiums as % of Annual Income



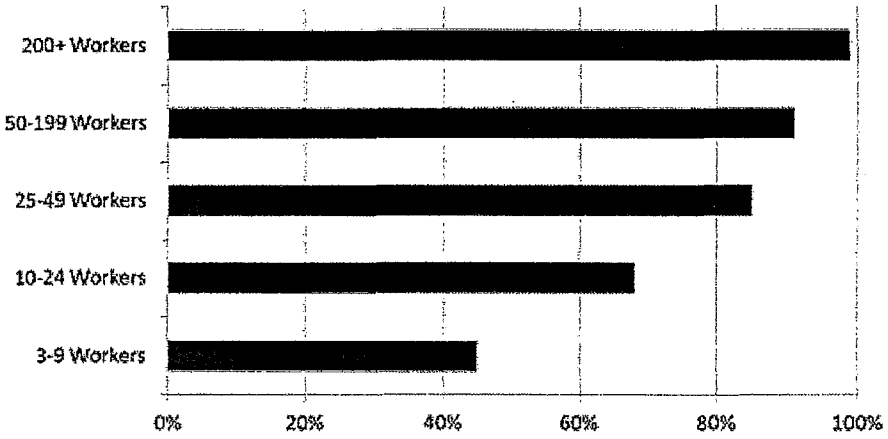
*Curves based on maximum allowable annual tax credit and price of lowest cost plan in each tier for a 42-year old San Francisco resident. Dollar values reflect annual price of premiums only; out-of-pocket costs are not included.

As household income surpasses 250% of FPL, the amount of the subsidy declines sharply and cost-sharing assistance is no longer available (left graph). Effectively, this means that persons earning near 400% of FPL are likely to pay a higher percent of their annual income toward premiums than persons earning more or less than 400% of FPL (right graph). Below 400% of FPL, subsidies reduce cost, and above 400% of FPL, the cost is mitigated by higher incomes.

Attachment 2K. Financial Considerations-Employers

For employers, the ability to offer health insurance depends largely on business size and employee demographics. Larger businesses often have more full-time employees and the strength of numbers to negotiate lower rates than small businesses.

Percentage of Firms Offering Health Benefits, by Firm Size, 2013



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2013

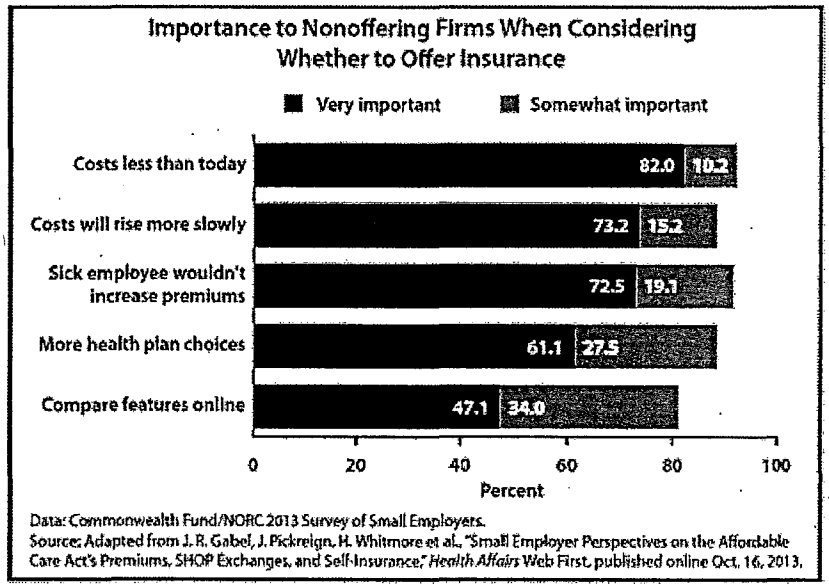
The larger an employer is, the more likely it is to offer health insurance to its employees.

Health insurance for small business has:

Higher admin costs

More volatile pricing

Lower value products

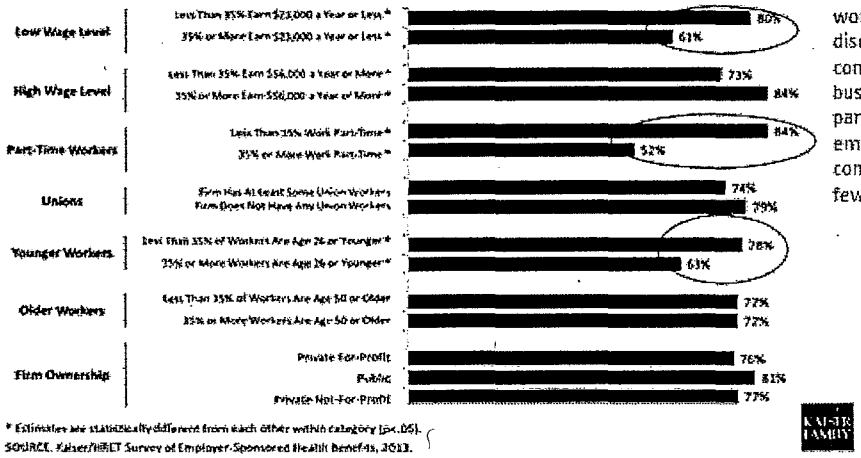


Data: Commonwealth Fund/NORC 2013 Survey of Small Employers.
Source: Adapted from J. R. Gabel, J. Pickreign, H. Whitmore et al., "Small Employer Perspectives on the Affordable Care Act's Premiums, SHOP Exchanges, and Self-Insurance," *Health Affairs* Web First, published online Oct. 16, 2013.

Small businesses cite cost as the most important consideration in offering insurance.

Attachment 2K. Financial Considerations-Employers
Employee demographics strongly affect whether employees are eligible for insurance (as deemed by the insurance plan) and whether employees participate in an employer-sponsored plan.

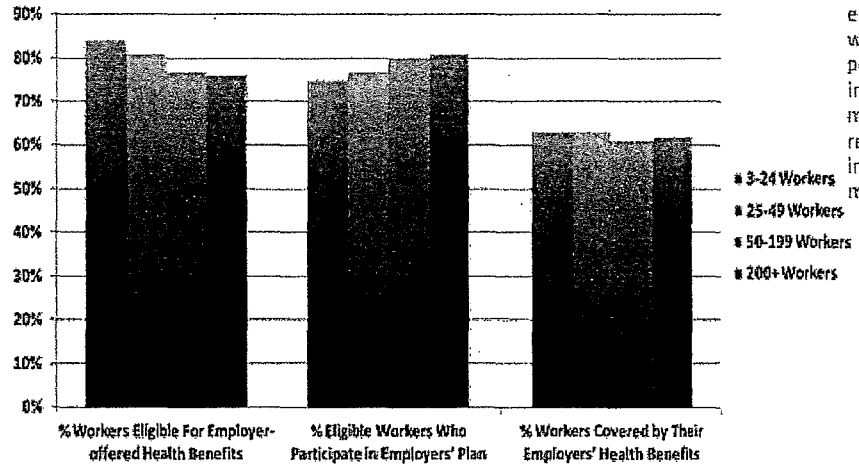
Exhibit 3.3
Among Workers in Firms Offering Health Benefits, Percentage of Workers Eligible for Health Benefits Offered by Their Firm, by Firm Characteristics, 2013



* Estimates are statistically different from each other within category (p<.05).
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013.

Fewer employees are eligible for health benefits at firms that have high proportions (35% or more) of low-wage workers, part-time workers, and younger workers. The discrepancy is most evident when considering part-time employees: at businesses that have more than 35% part-time workers, only 52% of employees are eligible for insurance, compared to 84% at businesses with fewer part-time workers.

Eligibility, Take-Up Rate, and Coverage in Firms Offering Health Benefits by Firm Size, 2013



SOURCE: Kaiser Family Foundation, Employer Health Benefits Survey 2013, Exhibit 3.2

Although more employees are eligible for insurance at businesses with fewer than 49 employees, the percent of employees participating in the plan is higher at firms with more than 49 employees. This is a reflection of higher costs for insurance in the small business market.

Attachment 2L. Financial Considerations-Public Health Care System

The cost of providing care to uninsured persons is passed on to the local public health system. The San Francisco Department of Public Health (DPH) is the largest department in the City and draws heavily from the General Fund (GF). The largest proportion of DPH expenditures is allocated to delivering care to patients, including those who are seen through Healthy San Francisco and DPH hospitals and clinics. In the last three years, DPH has required $248.7-$336.5 million per year from the General Fund to cover shortfalls resulting from the cost of delivering health care services.

DPH Direct Patient Costs FY 2010-11 to FY 2012-13

	FY 2010-11 ($)	FY 2011-12 ($)	FY 2012-13 ($)
Expenses	1,382,649,481	1,482,827,765	1,596,688,969
Revenues	1,096,922,204	1,234,116,532	1,260,184,512
GF Support	**285,727,277**	**248,711,233**	**336,504,457**

File # 141097

City and County of San Francisco

Office of the Controller – City Services Auditor

DEPARTMENT OF PUBLIC HEALTH

A Summary of Health Reform Readiness

March 5, 2014

OFFICE OF THE CONTROLLER
CITY SERVICES AUDITOR

The City Services Auditor (CSA) was created in the Office of the Controller through an amendment to the Charter of the City and County of San Francisco (City) that was approved by voters in November 2003. Under Appendix F to the Charter, CSA has broad authority to:

- Report on the level and effectiveness of San Francisco's public services and benchmark the City to other public agencies and jurisdictions.
- Conduct financial and performance audits of city departments, contractors, and functions to assess efficiency and effectiveness of processes and services.
- Operate a whistleblower hotline and website and investigate reports of waste, fraud, and abuse of city resources.
- Ensure the financial integrity and improve the overall performance and efficiency of city government.

Project Team: Peg Stevenson, Director
Michael Wylie, Project Manager
Michelle Schurig, Performance Analyst
Jennifer Tsuda, Performance Analyst

415-554-7500 City Hall • 1 Dr. Carlton B. Goodlett Place • Room 316 • San Francisco CA 94102-4694 FAX 415-554-7466

City and County of San Francisco

Office of the Controller – City Services Auditor

Department of Public Health
Summary of Health Reform Readiness

March 5, 2014

Project Purpose

The purpose of this report is to educate and provide engaged stakeholders and city policymakers with a summary of the 2013 consultant engagement between the Department of Public Health (DPH) and Health Management Associates (HMA), which the Controller's Office funded and provided contract and project management assistance. This report highlights the resulting recommendations and strategies for the City and County of San Francisco (City) to achieve a fully integrated delivery system and to succeed under the Affordable Care Act (ACA). The report aims to inform readers of the identified external factors as well as key internal milestones that will significantly impact DPH's fiscal sustainability and ability to continue to provide high quality services under the community safety net.

Health Care Reform Overview

The mission of DPH is to protect and promote the health of all San Franciscans. In October 2013, DPH re-organized its healthcare delivery system into the San Francisco Health Network ("the Network") as a step toward achieving the goal of a fully integrated delivery system. The Network must cover more people, improve quality, and rein in costs, in order to remain a competitive provider in the new environment outlined below.

- Federal Health Care Reform: ACA requires individuals have insurance, provides additional options to obtain coverage, and changes reimbursement mechanisms.
- State Implementation of the ACA: The roll-out of the state's insurance exchange, Covered California, provides the new options, and expansion of Medi-Cal increases revenues. This is coupled with reductions in historical state and federal payments that support the safety net.
- Local Implementation of the ACA: The City passed a health care access solution four years before the ACA, called the Health Care Security Ordinance (HCSO), which requires employers to make health care expenditures on behalf of their employees and established a program for the uninsured. The intersection of the HCSO with ACA continues to be investigated by the City, DPH, and engaged stakeholders.

DPH Implementation & the HMA Engagement

ling on a two-year planning effort, DPH engaged HMA, a firm with experience in public ...alth delivery systems, to assist in integrating its service delivery system and to:

- Prepare DPH to effectively compete for clients as the environment changes and financial reimbursement moves from fee-for-service toward capitation (fixed monthly payment)
- Transform DPH's delivery system and its corresponding support systems in order to become a "provider of choice," going beyond being "provider of last resort"

Key Network Challenges

- Provide timely access to care now that there are provisions ensuring clients have a right to care within a reasonable time
- Capitation which creates a greater incentive to reduce unnecessary use of high cost care and to invest in prevention and care management
- Competition since more providers are interested in the same clients as DPH and traditional clients will have more choice

Recommendations

The report groups recommendations into three topic areas:

1. Patient Care Access and Quality Improvement: Achieve quality patient care and efficient service delivery through improved access, capacity, coordination, and client flow
2. Managed Care: Develop and manage a new managed care network through focus on operational accountability, utilization, and new contracts
3. Financial Sustainability: Strive for financial sustainability through exploitation of financial opportunities and key cost management efforts

Additional supplemental recommendations include:

- Investments: Clinic, HR, and IT infrastructure investments required to implement the above recommendations
- Partnerships: Strategic partnerships and collaborations required in the new healthcare environment to achieve the above recommendations

See the summary of all strategies and key milestones on next page

Copies of the full report may be obtained at:
Controller's Office • City Hall, Room 316 • 1 Dr. Carlton B. Goodlett Place • San Francisco, CA 94102 • 415.554.7500
or on the Internet at http://www.sfgov.org/controller

Key Strategies for Adapting to Health Reform Change

	Highlighted Accomplishments	Key Strategies	Short Term Milestones	Long Term Milestones
Patient Access & Improvement	☐Combined direct services under the SF Health Network ("Network") ☐Created a plan to ensure Network client care is accessible and coordinated	☐Increase primary care access and capacity (e.g., centralized call center, increased productivity) ☐Establish a central care management database to identify high-risk clients ☐Track unnecessary or inappropriate utilization of health services	☐Increased client enrollment and decreased wait times ☐Improved client experience scores ☐Reduced inappropriate utilization ☐Reduced unreimbursed hospital days ☐Increased mental health clients receiving primary care	☐Access to high quality and timely care ☐Continuous quality improvement ☐High client and staff satisfaction scores
Managed Care	☐Identified the Network's "vision" to continuously increase quality and value of services to clients, staff, and partners ☐Created an Office of Managed Care	☐Reinforce the plans and vision statement for the new Network through internal and external education with staff and partners ☐Staff the new Office of Managed Care ☐Select appropriate metrics to manage risk and increase accountability	☐Developed Network metrics tracking clients and utilization ☐Developed automated reports ☐Established process for dissemination and use of metrics reports	☐Full Network implementation and culture change ☐Fiscal stewardship Network-wide ☐Clear accountabilities via reporting and metrics
Financial Sustainability	☐Developed detailed labor and productivity reporting tools to improve expense tracking at SF General Hospital (SFGH) ☐Reduced the amount of time for state reimbursement at Laguna Honda Hospital (LHH)	☐Increase managed care revenue and continue to seek new state and federal funding ☐Improve cost management through improved contract management and expense tracking and analysis	☐Increased client, state, and federal revenues ☐Reduced cost growth through regular, proactive reporting and corrective action ☐Completed the new SFGH facility budget	☐Reduced fiscal uncertainty ☐Clear fiscal accountabilities ☐Financial sustainability achieved
Investments	☐Hired key Network leadership ☐Began hiring process improvements	☐Increase staffing flexibility and continue to resolve hiring barriers ☐Develop a strategic short and long term information technology and financing plan ☐Invest in clinic facilities to help the Network become a provider of choice	☐Staffing matched to appropriate volume/client demand ☐Staff satisfaction measured and improved during Network implementation ☐Established a financially feasible information technology strategy	☐Necessary assets obtained to improve client access and achieve financial sustainability
Partnerships	☐Evaluated the UCSF physician group partnership in light of health reform ☐Identified community partners ☐Engaged key stakeholders on the Network's structure, vision, plans ☐Began strategizing with the SF Health Plan in light of reform	☐Strengthen and manage partnerships to improve quality, increase revenue, and manage costs (e.g., SF Health Plan, Covered CA health plans, UCSF, labor) ☐Continue to engage and inform key stakeholders (e.g., SF Clinic Consortium, state leaders, local leaders, business)	☐Developed the SF Health Plan relationship to increase enrollment ☐Established contracts with one or more Covered CA health plans ☐Developed shared financial incentives with UCSF ☐Developed strategy to strengthen labor partnership in light of health reform ☐Engaged, educated, and sought input from key stakeholders and leaders	☐Continuous improvement of the Network's strategic position ☐Successfully competing to retain and attract clients in the new healthcare environment

CITY AND COUNTY OF SAN FRANCISCO
OFFICE OF THE CONTROLLER

Ben Rosenfield
Controller
Monique Zmuda
Deputy Controller

March 5, 2014

Barbara Garcia
Director of Health
Department of Public Health, City and County of San Francisco
101 Grove Street, Room 308
San Francisco, CA 94102

Dear Ms. Barbara Garcia:

The Controller's Office is pleased to provide this summary of recent planning and steps needed to prepare for federal health care reform. Our office contributed by supporting DPH's engagement of a health care consulting firm, Health Management Associates (HMA), and provided contract monitoring and other assistance during the process.

This report aims to summarize key highlights and recommendations from the consultant engagement and related work occurring in 2013. This is not a comprehensive list of all HMA activities and products but our office's attempt to provide the major results to city policymakers and the public, placed in context of the new healthcare environment and DPH's achievements already underway.

The report organizes the many recommendations and strategies into three broad topic areas, listed below. From a citywide perspective, some of the key takeaways of the work are:

1. **Patient Care Access and Quality Improvement.** For DPH and its current network of direct health services to sustain itself in the new healthcare environment, it must implement numerous critical strategies and changes to transform into a "provider of choice" for its clients, going beyond "provider of last resort." Key changes include:
   - Increasing primary clinic and ambulatory care access, capacity, and productivity
   - Improving patient care quality and resulting client satisfaction
   - Continued integration of services and improved coordination of care
   - Increasing patient flow through DPH's institutions, including reduced length of stays and unreimbursed patient days

2. **Managed Care.** The provisions of the Affordable Care Act (ACA) have altered the operating environment for healthcare especially for public systems. To sustain DPH's network of services in the era of managed care and capitated payments for our insured clients, the system must attain a high level of accountability and success regarding quality, utilization, and cost management. Key changes include:
   - Implementing a Managed Care Office to provide needed focus on performance reporting, efficiency, and new contracts with health plans in the state insurance exchange ("Covered California")
   - Implementation of network-wide metrics and accountabilities

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3. **Financial Sustainability**. As a result of this engagement, the City has a revised five-year projection of the City's health system clients, costs, and revenues. The new ACA environment introduces a higher level of revenue uncertainty. Assuming DPH's current level of service without increases in enrollment or capitated revenue, the financial outlook is not sustainable, with the City's general fund contribution projected to increase to $831 million by FY18-19. Some of the strategies to achieve financial stability include:
   - Increasing the number of insured and covered clients, by maximizing the current Medi-Cal expansion, contracts with health plans, and other enrollment efforts
   - Actively pursuing targeted opportunities for additional state and federal funding
   - Better controlling spending through improved cost center tracking, as well as new reporting and shared financial incentives in the UCSF contract

We have greatly valued the opportunity to work with DPH staff on this project. The department and its partners continue to show a high level of professionalism and commitment to protecting and promoting the health of all San Franciscans. We specifically appreciate the collaboration and support from Colleen Chawla, Greg Wagner, Roland Pickens, Tangerine Brigham, Lindsey Angelats, and all Action Team members. Lastly, we acknowledge your vital leadership as director, in proactively addressing the dramatic change coming in health care and leading the agency to thrive in the challenging environment ahead.

Respectfully,

Ben Rosenfield
Controller

cc: Mayor's Office
Board of Supervisors

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INTRODUCTION

Purpose

The evolving healthcare operating environment increases the number of insured individuals and changes the payors of health care services. Prior to the implementation of the Affordable Care Act (ACA), there were 84,000 uninsured San Franciscans. However, the implementation of the ACA on January 1, 2014, provided 56,000 of these individuals with access to health insurance.[1] The challenge for DPH is that the newly insured can choose to elect private and non-profit providers for their health care. At the same time, reimbursement for services is moving away from fee-for-service and toward capitation; meaning instead of receiving reimbursement for every service provided or "fee-for-service", systems are reimbursed a set amount per member per month or "capitation". These factors bring about a major change for county health care systems because they must move from being a "provider of last resort" to a "provider of choice" to compete with other providers for clients and revenue.

To adapt to the new healthcare environment, DPH like many public health systems is being challenged to become the provider of choice, not the provider of last resort.

The purpose of this report is to educate and provide engaged stakeholders and city policymakers with a summary of the 2013 consultant engagement between the Department of Public Health (DPH) and Health Management Associates (HMA). This report highlights the resulting recommendations and strategies for the City and County of San Francisco (City) to achieve a fully integrated delivery system and to succeed under the Affordable Care Act (ACA). The organization of this report aims to inform readers of the major environmental healthcare factors as well as key DPH operational milestones identified. Addressing the external environmental issues and timely meeting implementation milestones will significantly impact DPH's fiscal sustainability and ability to continue to provide high quality care within the community safety net.

Background

The mission of DPH is to protect and promote the health of all San Franciscans. To achieve this, DPH must adapt to the changing healthcare operating environment brought about by the ACA, which represents the most significant social policy change in a generation. The ACA requires individuals have insurance and provides additional options to obtain coverage. The State of California implemented the ACA and continues to support the ACA's goals through the implementation of the state's health insurance exchange, Covered California (Covered CA), and the expansion of the state's Medicaid program, Medi-Cal. At the local level, the City and County of San Francisco (City) passed an innovative, local solution four years before the ACA was enacted called the Health Care Security Ordinance (HCSO), which required employers to make health care expenditures on behalf of their employees and established a public health benefit program that included Healthy San Francisco (HSF), a health care access program for the uninsured.

[1] There will still be a significant number of residually uninsured San Franciscans for two reasons: (1) due to the ACA provisions, there will be individuals ineligible for coverage (e.g., undocumented, etc.) and (2) there will be individuals who are eligible but do not enroll.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACA	Affordable Care Act
ALOS	Average Length of Stay
BHC	Behavioral Health Center
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCMS	Coordinated Case Management System
City	City and County of San Francisco
CMS	Centers for Medicare & Medicaid
Covered CA	Covered California or the Exchange
CPG	Clinical Practice Group
CPMC	California Pacific Medical Center
DHR	San Francisco Department of Human Resources
DOFR	Division of Financial Responsibility
DPH	San Francisco Department of Public Health
eCW	eClinicalWorks
EHR	Electronic Health Record
ESR	Employer Spending Requirement
FPL	Federal Poverty Level
HCSO	Health Care Security Ordinance
HMA	Health Management Associates, Inc.
HMA Engagement	2013 DPH-HMA Health Reform Readiness Engagement
HSA	Human Services Agency
HSF	Healthy San Francisco
HUMS	High Users of Multiple Systems
HUSS	High Users of Single Systems
IDS	Integrated Delivery System
IRS	Internal Revenue Service
ISC	Integration Steering Committee
LHH	Laguna Honda Hospital
LLOC	Lower Level of Care
MEC	Minimum Essential Coverage
NEMS	North East Medical Services
OC	Nurse Orientation Clinics
OON	Out of Network
PCBH	Primary Care Behavioral Health
PCMH	Patient-Centered Medical Home
SF PATH	San Francisco Provides Access to Health Care
SFGH	San Francisco General Hospital
SFHN-UMC	San Francisco Health Network – Utilization Management Committee
SFHP	San Francisco Health Plan
SPA	State Plan Amendment
The Network or SFHN	San Francisco Health Network
Transitions	Formerly Community Placement Division
UCSF	University of California, San Francisco
UHC	Universal Healthcare Council

DPHs' goals align with the intent of the policies enacted at the federal, state, and local levels to: cover more people, improve quality, and rein in costs. Internally, DPH has undergone a three-year transformation to adapt to this new healthcare landscape by reorganizing, revamping business processes, implementing new technologies, hiring and retraining staff, and more efficiently serving new and existing clients. HMA was hired in February 2013 to assist DPH in this effort; additional information about HMA is in Appendix I.

New Healthcare Environment

Federal Level: The Affordable Care Act

Federal health reform or the Affordable Care Act (ACA), passed in 2010, has two primary components (1) it requires individuals have health insurance (the "individual mandate") and (2) it provides additional options to obtain health insurance. Many of the major provisions went into effect on January 1, 2014.[2]

Individual Mandate. The Individual Shared Responsibility provision of the ACA (aka Individual Mandate), requires most U.S. residents to obtain health insurance that meets minimum essential coverage (MEC) guidelines for themselves and their dependents, per federal income tax guidelines or pay a penalty, beginning in 2014. There are some exceptions to the mandate, such as undocumented individuals, the incarcerated, and those experiencing hardship, among other exceptions, but most U.S. residents will be subject to the mandate. Penalties for not complying with individual mandate are $95 or one percent of income in 2014 and will increase incrementally on an annual basis, to $695 or 2.5 percent of income in 2016.

Additional Health Insurance Options. The second component of the ACA provides additional options to obtain qualified health insurance in three ways.[3]

1. State Implemented Reforms: The ACA expands public insurance for low income citizens through the Medicaid program, called Medi-Cal in California, and creates an online insurance marketplace where individuals can compare and buy insurance; these provisions are further described in the section below.
2. Employer Incentives & Penalties: The ACA does not explicitly mandate that employers offer their employees acceptable health insurance. However, it does provide tax benefits for small businesses that offer affordable insurance and imposes penalties on certain "large employers" that do not offer affordable insurance.
3. Market Reforms: The final way in which health reform is making health insurance more accessible, is through health insurance marketplace reforms. Examples of these new health insurer standards are below.
    - Coverage of essential benefits for small group and individual plans
    - Ensures that all plans offer a baseline of benefits
    - Enables comparisons across plans
    - Guarantees issue and renewal or prohibits insurers from refusing to renew a policy because of the amount of health care services used in the previous year
    - Eliminates pre-existing condition exclusions
    - Extends dependent coverage up to age 26
    - Eliminates cost-sharing for prevention

[2] Additional information regarding the Affordable Care Act and its provisions can be found on the IRS website.

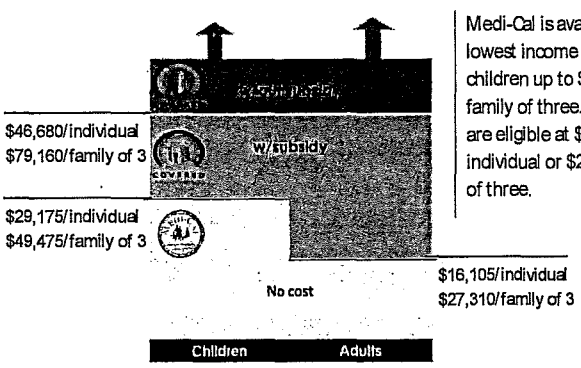
[3] "Qualified" health insurance is insurance that meets the minimum essential coverage (MEC) outlined in the ACA and on the IRS website.

State Level: Medi-Cal Expansion & Covered California

The State of California now has two expanded options for health insurance: Medi-Cal and Covered CA.[4] Figure 1 shows, by income, how Medi-Cal and Covered CA expand health insurance coverage.

Figure 1: Post-ACA Expanded Eligibility for Health Insurance

Covered CA takes over where Medi-Cal stops. Individuals with incomes up to 400% of federal poverty level, or $47k for an individual and $79k for a family of three, are eligible for sliding scale subsidies for insurance purchased through Covered CA. Individuals with incomes above 400% of poverty can purchase insurance through Covered CA without a subsidy.



Medi-Cal is available for the lowest income and for children up to $49k for a family of three. Now adults are eligible at $16k for an individual or $27k for a family of three.

Source: Department of Public Health.

Medi-Cal Expansion. Previously, single healthy low-income adults were not eligible for Medi-Cal, yet this population comprises a significant portion of the uninsured.[5] On January 1, 2014, adults aged 18-64 with incomes below 138% of the federal poverty level (FPL), which is about $16,105 for a single person, became eligible for Medi-Cal, named the "Medi-Cal Expansion" population. Existing and new Medi-Cal clients will enroll into one of the two San Francisco managed care plans – Anthem Blue Cross or the San Francisco Health Plan (SFHP). Although more individuals are eligible, enrollment is not automatic. Prior to expansion, approximately 1.3 million Californians were already eligible for Medi-Cal but did not enroll. Individuals can apply for Medi-Cal any time during the year, but joint enrollment efforts between DPH and the Human Services Agency (HSA) will be key to successful implementation of Medi-Cal expansion at the local level.

As of January 1, 2014, approximately 14,000 individuals have been transitioned from the low income health plan (LIHP) to Medi-Cal.

Covered California. The second option for health insurance is the state Health Insurance Exchange created by the ACA, called Covered California (Covered CA), an online marketplace where individuals can purchase health insurance. Individuals who have incomes that are above Medi-Cal eligibility and small businesses can purchase insurance on the exchange. More than five million Californians are eligible for Covered CA. Plans are standardized so that they are

[4] California is one of 26 states that chose to expand Medicaid in 2014 and one of only 17 states that chose to operate a state-based health insurance exchange marketplace in 2014. Kaiser Family Foundation, State Decisions on Health Insurance Marketplaces and the Medicaid Expansion.

[5] Medi-Cal was previously only for low-income individuals who are children, in families, over age 65, or disabled.

easily compared across insurers. There are four tiers from lowest to highest monthly premiums based on the actuarial value of the plan[6] – bronze, silver, gold, and platinum. There are sliding scale subsidies available to low income individuals up to 400 percent FPL. Currently, there are five plans approved for San Francisco: Anthem Blue Cross, Blue Shield, Chinese Community Health Plan, HealthNet, and Kaiser. Like many insurance offerings, enrollment can only occur in a specified period – October to March for the initial open enrollment, and October to December annually thereafter.

Local Level: Health Care Security Ordinance

At the local level, the San Francisco Health Care Security Ordinance (HCSO) was passed unanimously by the Board of Supervisors in July 2006, four years before federal health reform, and codified as Chapter 14 of the San Francisco Administrative Code. The two main components are: the Healthy San Francisco program and the Employer Spending Requirement.

Healthy San Francisco. A health access program – called "Healthy San Francisco" (HSF) – created by the DPH. HSF will still be available to those who need it, but insurance through Covered CA or Medi-Cal is better for clients as it provides access to affordable medical care when and where needed, covers routine care that prevents illness and improves health, and protects families from high costs in the event of major injury or illness.

Employer Spending Requirement. An Employer Spending Requirement (ESR), which mandates that employers subject to the HCSO "make required health care expenditures to or on behalf of their covered employees each quarter."[7] The City's Office of Labor Standards Enforcement (OLSE) enforces the ESR and annually collects employer data regarding compliance with the health care expenditure requirement.

On July 25, 2013, the Mayor asked the Director of Health to reconstitute the Universal Healthcare Council to engage stakeholders in a data-driven process to examine the intersection of the ACA and HCSO.[8] Two findings emerged: the HCSO to remain intact alongside the ACA and potential affordability concerns remain for some.

DPH Preparedness

DPH is focused on transitioning the uninsured to health insurance by (1) exiting or reducing DPH health coverage programs (SF PATH and HSF enrollees), (2) providing outreach to specific, vulnerable, but eligible populations (i.e., homeless, public housing residents, jail inmates, etc.), and (3) growing partnerships with community-based organizations and city departments. The Network must transition to become a provider of choice and achieve the following goals to remain a competitive provider of care in the new healthcare environment: (1) cover more people, (2) improve quality of care, and (3) rein in costs.

Figure 2 provides the new integrated delivery system's vision. For additional information on the development of this structure and the new DPH organizational structure, please refer to Appendix I.

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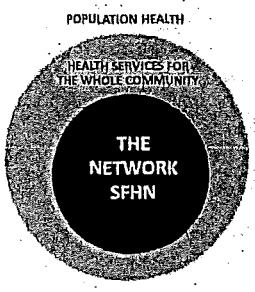
[6] Actuarial values are estimates of how much the insurance plan will pay of an average person's medical expenses. California Healthcare Foundation, "Health Reform in Translation: What is Actuarial Value?" August 2013.

[7] The HCSO is codified in Chapter 14 of the San Francisco Administrative Code, and is available via the HCSO website: www.sfgov.org/olse/hcso.

[8] More information regarding the Universal Healthcare Council (UHC) can be found at http://www.sfdph.org/dph/comupg/knowlcol/uhc/default.asp.

Figure 2: DPH's IDS Vision



The Network (SFHN) provides direct health care services to insured or covered clients whose care is managed through the Network, from primary to acute to long term care.

Health services for the whole community include services for those clients outside of the Network but still in the safety-net, for example, undocumented immigrants and homeless/ transient populations. Includes community behavioral health and trauma services.

Population health aims to improve the health of the entire population through environmental health, disease control, assessment, and housing.

Source: Department of Public Health.

Report Organization

This report aims to provide engaged stakeholders and city policymakers with the major recommendations and strategies that resulted from the HMA engagement. Implementation of these recommendations and strategies will ensure that DPH is prepared to address the challenges of the new healthcare environment. The report is organized around three topic areas below. Each chapter begins with the predicted impact of ACA and includes key strategies to achieve the recommendations.

- Chapter 1: Patient Care Access and Improvement
  - Goal: Achieve Quality Patient Care and Efficient Service Delivery, through improved access, capacity, coordination, and flow
- Chapter 2: Managed Care
  - Goal: Development and Management of the Network, through focus on operational accountability and utilization
- Chapter 3: Financial Sustainability
  - Goal: Strive for Financial Sustainability, through exploitation of financial opportunities and key cost management efforts in the ACA environment

Further background information and additional areas of HMA analysis are included in the Appendices.

- Appendix I: IDS History, HMA Engagement, and Action Teams
  - Provides a brief history of the IDS development, HMA engagement, and key achievements to date
- Appendix II: Investments
  - Provides additional details on the investments required in clinic, HR, and IT infrastructure to implement the changes described in Chapters 1 through 3
- Appendix III: Partnerships
  - Provides additional information on the strategic partnerships and collaborations required in the new healthcare environment

CHAPTER 1: PATIENT CARE ACCESS AND QUALITY IMPROVEMENT

Background

The Affordable Care Act (ACA) strives to make healthcare more affordable, increase the quality of patient care, and make service delivery more efficient. For example, to increase access to preventive care, the ACA provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost. In addition, to increase quality of care, a new provision by the ACA, effective in January 2015, will tie physician payments to the quality of care provided.

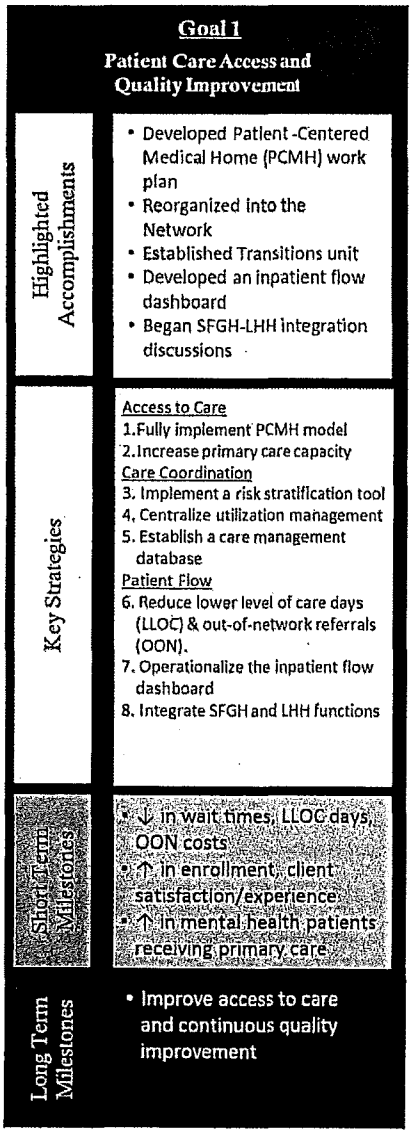
As a result of recent health reform readiness efforts by the San Francisco Health Network (referred to as "the Network" in this report), and recommendations resulting from the Health Management Associates (HMA) engagement, the Network began and continues to implement several strategies to achieve higher quality patient-centered care and more efficient service delivery aimed to increase access to care, improve care coordination, and improve patient flow.

Access to Care

The new healthcare environment creates additional demand for high quality, efficient care since individuals are required to have health insurance and will now have a broader choice in their providers. Internally at DPH this means the Network must effectively compete with other providers and transform into a provider of choice rather than a provider of last resort through increasing access to care. This can be achieved by:

- better integrating and coordinating services,
- improving quality of care,
- increasing their capacity for providing care, and
- improving the client experience by decreasing wait times, increasing efficiency, and improving customer service.

DPH continues to expand its efforts to improve access to care, these include the addition of a nurse advice line,



improvements in scheduling appointments, the use of nurse practitioners to improve team access and continuity of care, and the integration of behavioral health and primary care. However, there is significant additional work to be done to improve access to care.

Strategy 1: Fully Implement the Patient-Centered Medical Home (PCMH) Model of Care

The Network's commitment to the implementation of the Patient-Centered Medical Home (PCMH) model of care aligns with the goal to improve access to care. This model, as described to the right, provides patient-centered, comprehensive, team-based, coordinated, and accessible care focused on quality and safety. PCMH also emphasizes an integrated approach to care. DPH continues to implement integrated care in its clinics, including staffing primary care clinics with behavioral health staff (Behaviorists and Behaviorist Assistants).

The Patient-Centered Medical Home

In this model, a patient can visit a primary care or mental health clinic and be seen on the same day for both their behavioral health and physical health needs. As opposed to a system which is fragmented and lacks coordination, patients receive coordinated care through their medical home and designated primary care physician. The patient-centered medical home model moves towards a less costly and more preventative approach to care, through integrated health services, team-based care, and enhanced communication.

HMA conducted assessments of three hospital-based primary care health centers, four community health centers, and one behavioral health center. In addition, HMA analyzed data on clients, payers, staff, and providers. HMA also performed site assessments and interviews with central primary care leaders in administration, medicine, nursing, behavioral health, care management, and finance. HMA used this quantitative and qualitative analysis to make findings and recommendations to fully implement the PCMH Model of Care within the Network.

Key recommendations:

- Clearly define the role of Behaviorist and Behaviorist Assistants through the standardization of job descriptions, core competencies, and performance evaluation.
- Review billing practices, including the charge master and encounter forms, for behavioral health services within PCMH. Provide ongoing training to ensure the capture of all available revenue utilizing the work completed by the Revenue Generation Committee to inform this effort.
- Identify and empower on-site supervisors of Behaviorists and Behaviorist Assistants to support and ensure accountability of all PCMH team members in integrated care.
- Utilize lessons learned from behavioral health integration in primary care to inform future integration efforts.

In the medium and long term, the Network will continue to work toward achieving the PCMH model via the strategies listed throughout Chapter 1. DPH is also in the process of piloting four health homes as an additional longer term strategy towards achieving the PCMH Model of Care. A description of health homes is to the right. DPH intends to submit a state plan amendment (SPA) for federal funding by the Centers for Medicare & Medicaid Services (CMS) to support this effort. To date, the Network has implemented one health home and plans to implement three more by the end of 2014. These four pilot health homes will focus on client populations with serious and persistent mental health conditions.

Defining Health Homes under Medicaid's State Plan Option

Health Homes are a new integrated model of care that allows states to provide comprehensive care coordination for Medicaid beneficiaries with two or more chronic conditions, one chronic condition and risk of another, or one serious and persistent mental health condition. States that meet the health home criteria can receive enhanced federal funding during the first two years of implementation.

Source: Centers for Medicare & Medicaid Services

Strategy 2: Increase Primary Care Capacity

Another critical component to ensure timely access to care is the availability and efficiency of scheduling primary care visit appointments available to new and returning clients. HMA identified several priority areas for increasing primary care capacity:

- Meet panel size and productivity targets
- Implement a call center
- Implement nurse orientation clinics and chronic disease visits
- Increase capacity for specialty care
- Hire qualified staff to fill all vacant primary care provider positions

Strategy 2A: Meet Panel Size and Productivity Targets

The Network developed and utilizes a robust methodology for predicting the number of future visits. However, until recently, the Network's primary care clinics did not set panel size targets. Determining primary care panel size targets is a complicated process that must take into account several variables including the number of visits per client per year, the number of provider visits per day, and the number of provider days per year. The challenge is to estimate the optimal panel size to effectively care for a client population. A panel size that is too large can result in service delays and interruptions in care, whereas a panel that is too small can be unsustainable since there are not enough clients to support the Network.

Defining Panel Size

Panel size is the number of individual patients under the care of a specific provider (e.g., physician). An appropriate panel size is necessary to effectively manage primary care workloads and optimize patient access to care.

HMA assisted the Network in conducting a provider full time equivalent (FTE) staffing analysis to develop sustainable targets. The results of the analyses indicated the primary care system must retain the current client

population of 54,000. While primary care provider FTEs are adequate, the addition of patients with complex health issues may strain capacity. And, although staffing ratios are near-adequate, some redistribution is needed. With an average panel size of 826 patients per FTE in October 2013, the Network set a target panel size goal of 1350 patients per FTE. As of December 2013, the panel size targets were implemented at the Network's primary care clinics for primary care providers and reports are being sent to the San Francisco Health Plan (SFHP) monthly to improve accountability.

HMA evaluated current visit productivity levels. Currently it is estimated that providers have a current visit productivity level of 1.5 visits per hour. This is far beneath national standards. HMA recommends that the Network increase visit productivity levels by 50 percent from the October 2013 calculated level of 1.5 visits per hour to 2.25 per hour. To achieve this, HMA recommends incorporating the no show rate into the scheduling system.

The Network aims to achieve a panel size target of 1350 patients per FTE. Currently, the Network's panel size is 826 patients per FTE.

The Network's target provider productivity rate is 2.5 patient visits per hour. This is a 50 percent increase in provider productivity from the current rate of 1.5 patient visits per hour.

Strategy 2B: Implement a Centralized Call Center

Planning for a centralized call center is underway at the Network. As identified during the HMA engagement, the Network's primary care clinics need an improved phone system by which clients can request and schedule appointments. The reasons for implementing a centralized call center are to:

- Improve telephone response for appointments and ensure timely access to care
- Help coordinate the appropriate use of healthcare providers and facilities
- Reduce emergency room and urgent care visits
- Reduce no-show rate
- Increase customer satisfaction scores; by providing excellent customer service and increasing loyalty, the Network can maintain and grow the market share of its primary care members[9]

Since December 2013 a subcontractor was hired to provide expert technical assistance in call center design and product purchase. To date the Network has completed a preliminary return on investment analysis for call center options and begun to determine the factors that will impact staffing (e.g., call duration, number of calls, etc.).

The Network is currently evaluating the feasibility of implementing an internal or externally-hosted call center across 16 outpatient clinics. Depending on the results of this evaluation and departmental priorities, the Network goal is to develop a clear call center plan by late 2014.

[9] DPH Primary Care customer satisfaction has historically been very low with the CAHPS Clinician & Group Survey scores of 35 percent, significantly below the National Research Corporation average rating of 62.6 percent. Source: Presentation by the SFDPH Centralized Call Center Workgroup, January 30, 2014.

Strategy 2C: Implement Nurse Orientation Clinics and Chronic Care Visits

Long patient wait times can negatively impact the client experience and challenge effective access to care. In December 2013, the Network began implementing nurse orientation clinics (OC) with the goal of eliminating wait lists. To date, the Network standardized the OC scheduling template and routinely scheduled OCs at all Network primary care clinics.

Nurse orientation clinics (OCs) provide an individual with a health care screening, an opportunity to discuss information about their primary care appointment, and a scheduled visit with their primary care provider. Effective implementation of OCs can reduce the work load of primary care providers.

Another strategy to increase access to care is chronic care visits for individuals with chronic illnesses. Chronic care management is a major focus of the ACA and an essential benefit. In many ways, chronic care management is dependent on a client's ability to manage their own condition and to know when to seek help from their primary care provider. Managing a chronic disease is dependent on a client motivation to adhere to medication, engage in physical activity, eat healthfully, and manage stress. As part of the HMA engagement, the Network developed a standard set of nurse competencies in self-management support and tools. Nurses received training tailored to these competencies. Chronic disease visits are essentially group visits by registered nurses and pharmacists to help patients better control their disease and provide a safe environment for clients to ask questions and express concerns. To date, the Network has implemented chronic disease visits at one SFGH clinic and three Network primary care clinics. The goal is continue ongoing development for chronic disease visits with pilots through 2014, and Network-wide implementation in 2015.

Strategy 2D: Increase Capacity for Specialty Services

To ensure adequate access to specialty services, the Network must assess staff and space requirements in light of demand for specialty care services. Major specialty services include cardiology, dermatology, endocrinology, gastroenterology, hematology, nephrology, oncology, pulmonary, and rheumatology. As a result of the HMA engagement, the Network accomplished the following.

- Identified units requiring additional space and/or staff to meet necessary standards
- Identified key ambulatory procedures to reduce wait times to target
- Confirmed operational standards and prepared business plans for staff expansion
- Developed and implemented discharge criteria in an additional two to four priority specialty clinics

For 2014, the Network is working to establish sufficient specialty capacity and aim to achieve these milestones.

- Ensure that 60 percent of specialists have a wait time of less than 45 calendar days; 20 percent have 45-60 days; and only 20 percent have more than 60 days
- Identify specialty capacity at Laguna Honda Hospital (LHH)
- Develop a system to anticipate and backfill absences
- Begin collecting patient satisfaction data for all specialty clinics
- Develop accountability mechanisms for specialty care with UCSF
- Identify targets for increased specialty care capacity and implement plan

Strategy 2E: Make Necessary Clinic Facility Investments

To further increase access to care, HMA recommended expanding clinic facility space to accommodate team-based care and to ensure that providers have a minimum of two exam rooms for clinical sessions with clients.

HMA conducted an environmental assessment that indicated the need for investment and improvements in clinic facilities to attract and retain patients. Staff suggested improving health center aesthetics by increasing the size of waiting rooms, increasing privacy in reception areas, adding new furniture in waiting rooms, applying fresh paint, and other improvements.

Care Coordination

Effective care coordination ensures quality patient care and efficient service delivery. Care coordination aims to facilitate beneficial, efficient, safe and high quality client experiences, prevent avoidable health care-related costs, and improve the health, functional status, wellness, and social outcomes for Network clients. As a result of the HMA engagement, the Transitions Division, formally Community Placement, was created and is responsible for the movement and coordination of patients between health care providers and settings as their condition and care needs change. An example of care coordination is illustrated to the right.

A Day in the Life of Effective Care Coordination*

George, a 62 year old man with severe diabetes and depression, was admitted to SFGH with uncontrolled diabetes leading to amputation of his left foot. After receiving inpatient care during his SFGH hospitalization, the Network's Transitions Team assisted in his placement and transfer to Laguna Honda (LHH). Once rehabilitated at LHH, the Transition Team assisted his transfer to a lower level of care at an assigned medical home ("PCMH"). Here, his primary care physician identified depression as a key barrier to self-managed care of his diabetes. In addition to receiving chronic care visits from a nurse, he was referred to a Behaviorist within his PCMH to work with him on his depression. George is now able to better self-manage his diabetes to prevent re-occurrences of uncontrolled diabetes.

*Note: This is a fictitious example used to illustrate Network care coordination.

Strategy 3: Implement a Risk Stratification Tool

Risk stratification can enhance care coordination. It is used to identify and predict which clients are at high risk or likely to be at high risk and enables the care team to prioritize the management of their care in order to prevent worse outcomes.[10] Globally assessing and understanding client risk is necessary for the Network to more efficiently identify high cost clients and better manage the entire Network population. A risk stratification tool will enable the Network to achieve the following:

- Develop a systematic process for identifying and predicting patient risk levels relating to health care needs, services, and coordination

[10] On a technical level, risk stratification is a periodic and systematic assessment utilizing detectable criteria and characteristics associated with an increased chance of experiencing unwanted outcomes. By identifying factors before the occurrence of an event, it is possible to personalize a client's care plan and develop targeted interventions to mitigate their impact. Source: American Academy of Family Physicians, http://bit.ly/1fWxfg6.

- Utilize algorithms involving registries, payer data, physician/provider judgment/input, and patient self-assessments and experiences to assess each client's health risk status to develop an individualized care plan
- Identify those at the highest risk or likely to be at high-risk and prioritizing the management of their care to prevent poor health outcomes
- Maximize use of limited time and resources to prioritize needs of their patient population

To conduct appropriate risk adjustment for clients, the Network researched various algorithms for risk stratification. While the Network identifies the appropriate risk stratification tool, the Transitions team is currently using the Coordinated Case Management System (CCMS), a compilation of several health and social service databases, to identify high users of multiple systems (HUMS) and high users of single systems (HUSS) to prioritize high risk clients in need of care coordination.[11]

Strategy 4: Centralize Utilization Management

Utilization Management (UM) is the ability to ensure that health care services are medically appropriate, necessary, and aligned with clinical best practices. This is a key component to effective care coordination. At SFGH, utilization management reviews are performed to ensure a client is receiving clinically appropriate care for their needs using the InterQual Criteria for Adult and Pediatrics. The Network Utilization Management Committee (SFHN-UMC) has now been created to monitor utilization throughout the Network.

The DPH-HMA Care Coordination Action Team identified the utilization management indicators to collect across the Network and accompanying quality improvement processes. In the long term, Network analysts will track data metrics and assemble standardized reports related to utilization, outcome measures, and quality. Please see Chapter 2 for additional information regarding the development of Network Performance Metrics.

Strategy 5: Establish a Care Management Database

The term care management and care coordination are often used interchangeably. At the Network, the care manager improves care coordination by providing direct care management to clients with a combination of health, functional, and social challenges. The goal of effective care management is to improve clients' health, while at the same time, reduce the need for expensive health care services. To achieve this, however, current and accurate access to client information is necessary.

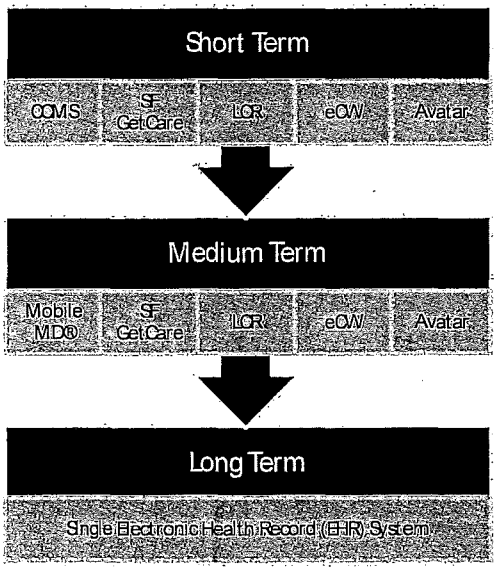
HMA conducted an assessment of the Network's information technology (IT) and information systems (IS). While there are many information systems used within the Network to view client clinical data, most systems operate in isolation from one another. This negatively impacts client care processes and limits the amount of financial and utilization data available for quality and efficiency purposes. These data are essential for a managed care environment.

During the HMA engagement, the Network identified the following systems that contain key information for care coordination. Primary care is in the process of implementing eClinical Works (eCW). ECW has some reporting capabilities, but the Network is determining the best strategy for enhancing its reporting capabilities

[11] Within the HUMS population, the top one percent of users of urgent/emergent services comprises about 25 percent of the costs. The top five percent comprises over 50 percent of the costs. Source: Department of Public Health.

further so that it can readily produce actionable data for care coordination. Additional information regarding the Network's information technology and the factors that must be taken into consideration as the Network begins to plan for a single electronic health record (EHR) is in Appendix II.

Figure 3: Steps Toward a Single Electronic Health Record System



The Network's Information Systems

- Coordinated Case Management System (CCMS) An integrated electronic charting, reporting, and communication tool for teams working with vulnerable adult served across multiple systems of care.
- SF GetCare A countywide, integrated web-based information system focused on older and disabled adults
- Life Time Clinical Record (LCR) An EHR utilized by various partners, including local hospitals, the San Francisco Community Clinics Consortium (SFCCC), the Department of Housing, and the county jail system.
- eClinicalWorks (eCW) A unified electronic medical records and practice management system for Ambulatory Services being implemented in Community and Hospital-based Primary Care and Specialty Clinics.
- Avatar The behavioral health electronic record system.
- MobileMD® An outsourced health information exchange for health systems, hospitals, physicians, labs and ancillary healthcare providers with secure messaging, analytic solutions, and an electronic medical record system to physician practices. Connects healthcare providers and patients through secure clinical and patient portals.

Source: Department of Public Health, Care Coordination Action Team Final Report.

Client Flow

An important aspect to improve the quality and efficiency of health care is to optimize client flow, or, the movement of clients through the health care system ensuring the most appropriate level of care is achieved.

Strategy 6: Reduce Lower Level of Care Days and Out-of-Network Referrals

The Network has developed key strategies to improve client flow. One of the primary goals is to reduce non-acute lower level of care (LLOC) inpatient days and out-of-network (OON) referrals. Reducing LLOC days can reduce costs and increase capacity by effectively transferring clients that no longer need acute care to an outpatient setting, and, thereby freeing up additional capacity in inpatient care. To accomplish this, processes need to be in place to be able to effectively transfer clients from inpatient to other services (e.g., their primary care medical home, LHH, community beds, etc.). Below is a table of recent achievements and future goals.

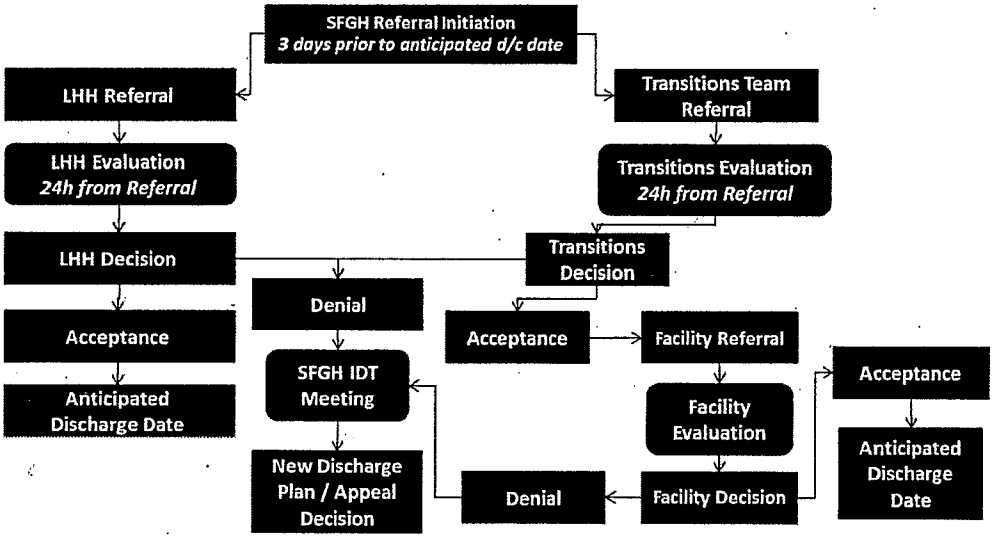
Figure 4: Lower Level of Care and Out-of-Network Key Achievements and Goals

	2012-2013 Achievements	2013-2014 Goals
SFGH	Reduced the percentage of Medical/Surgical LLOC days from 14 to 11 percent of total days Increased the percent of utilization management reviews performed within 24 hours from 30 percent to 64 percent	Reduce LLOC days by 60 percent of its FY12 level and increase acute admissions by 640 per year □ 10 LLOC patients per day for Medical/Surgical; reduction of 51 percent from current average of 20.5 patients per day □ 18 LLOC patients per day for Psychiatry; reduction of 49 percent from current average of 35 patients per day
LHH	Reduced the average wait time from referral to admission from 9.4 to 7.5 days via internal and external relationship development	Reduce the average length of stay (ALOS) by 12.4 percent, from 629 days to 551, and increase DPH referrals by an additional 140 per year
Transitions Division	Formally established the Transitions Division (formerly Community Placement)	Reduce ALOS in community placements by 50 percent to increase capacity for SFGH and LHH referrals

Source: Department of Public Health, Institutional/ Post-Institutional Action Team Final Report.

In addition, the Institutional and Post-Institutional Care Action Team closely reviewed the current client flow process between SFGH and LHH and began work on streamlining client flow, as illustrated below.

Figure 5: Revised Client Flow from SFGH to LHH and Transitions



Source: Department of Public Health, Institutional/ Post-Institutional Action Team Final Report.

Strategy 7: Develop and Operationalize an Inpatient Flow Dashboard

To achieve the above targets for improvements to client flow, the Network developed a set of metrics on inpatient flow, access, and post-institutional follow-up for inpatient clients.

Figure 6: Key Inpatient Flow Metrics

SFGH	LHH	Transitions Division
Daily LLOC days	Average length of stay (ALOS) – Bed Turnover Rate	Number of clients
Barriers to Discharge	Barriers to Discharge	ALOS
Discharge Destinations	Discharge Disposition	
30 Day Related Readmissions	Readmissions	

Source: Department of Public Health.

The Network plans to develop a dashboard to be able to easily view and review metrics data on a regular basis. The dashboard will allow Network staff and leadership to drill down to more detailed levels of information, depending on need and level of access. Dashboard reports are intended to be used by three different staffing levels within the Network: (1) Network leadership, (2) Network Management, and (3) Frontline or Point of Care Staff. The reports will be a useful tool for guiding discharge planning decisions, monitoring progress or areas for improvement, and creating a culture of accountability across the Network.

The Controller's Office is assisting the Network to complete an interim dashboard tool. The Network will also continue to create an automated dashboard in a data visualization tool and operationalize this across the Network.

Strategy 8: Pursue Opportunities for SFGH and LHH Integration

To become a fully integrated system and improve client flow across the system, the Network is exploring the integration of certain functions of SFGH and LHH. A Joint Hospital Executive Council was developed and is responsible for approving an integration performance improvement program that will enhance care delivery, client flow, and communication between the hospitals, ambulatory, and community sites. The HMA engagement identified opportunities and high priority areas to further pursue integration, listed below.

Figure 7: SFGH-LHH Areas Identified for Integration

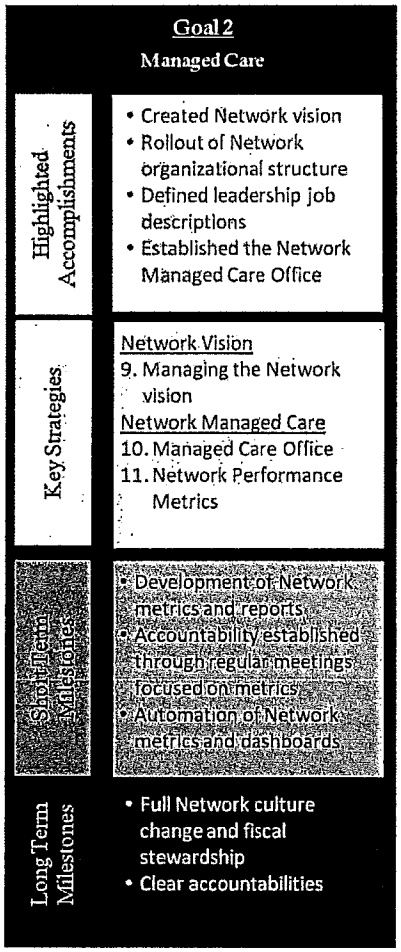
- ☐ Cafeteria
- ☐ Food Services Management
- ☐ Clinical Nutrition
- ☐ Electrocardiogram
- ☐ Electroencephalogram
- ☐ Chronic Dialysis
- ☐ Interpreter Services
- ☐ Clinical Laboratories
- ☐ Pharmacy
- ☐ Radiology
- ☐ Rehabilitation
- ☐ Respiratory Therapy
- ☐ Telecommunication
- ☐ Biomedical
- ☐ Utilization Management
- ☐ Social Services
- ☐ Performance Improvement

CHAPTER 2: MANAGED CARE

The Birth of the San Francisco Health Network (The Network)

As mentioned in the background section, the provisions of the Affordable Care Act (ACA) altered the operating environment for healthcare, particularly for public health systems. For DPH, health care reform requires a major transformation of the patient delivery system to become a fully integrated delivery system (IDS) that will facilitate improved patient care and the more effective use of resources. A major accomplishment that resulted from the HMA engagement was the development of the San Francisco Health Network (referred to as "the Network" in this report), which combines the patient delivery services under one system (see Figure 16).

The new healthcare environment requires the Network to become a provider of choice. Therefore, to remain competitive, creation of the Network includes development of a Managed Care Office aimed at managing risk and increasing the number of clients seen at Network clinics.



The Network Vision

HMA interviewed key leadership and staff throughout DPH and underwent an intensive, collaborative process to develop a detailed and clear vision for the Network and the necessary components, in particular the Managed Care Office. The Network's vision is to continuously increase the quality and value of services to clients, staff, and partners.

The Network is unique to other private and public systems as it has a robust set of key services needed to build a seamless continuum of care: patient-centered medical homes (PCMH), outpatient specialties and diagnostics, inpatient acute services, long term care (both institutional and home and community-based), and comprehensive behavioral health services. In addition, because the Healthy San Francisco program covered the City's uninsured, the Network was able to predict with fair precision the number of clients that would need coverage after health reform. These two elements, having a full complement of health care services and a defined population, served as the starting point for the development of the Network.

Strategy 9: Managing the Network Vision

As mentioned above, the Network centralizes the service delivery side of DPH. The new organizational structure in Figure 16 was informed by six DPH-HMA Action Teams, HMA consultants, and DPH key staff and physicians of all levels. The DPH vision for the Network is summarized below.

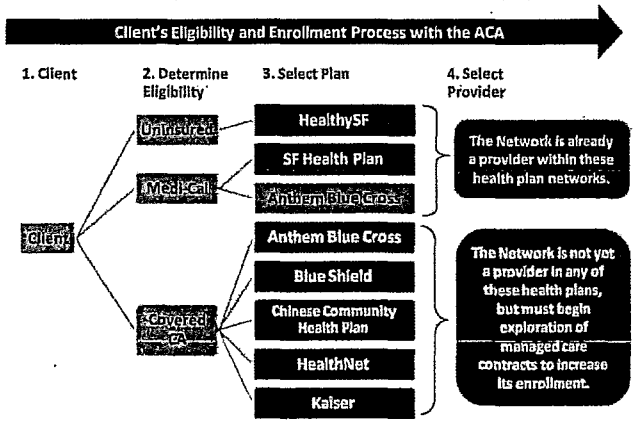
- Provide and manage the care for a defined number of new and existing clients
- Organize elements of the delivery system into one Network which will work together to assure that gaps are filled, duplication is eliminated, quality is enhanced, and the health of the population is improved
- Build an integrated operational infrastructure (including the necessary elements of a managed care structure) that supports the delivery of care in a way that maximizes efficiency, consistency, and quality
- Assure that all patients are cared for timely and at the most appropriate level of care
- Collaborate with other providers, partners, and health plans to assure the long term sustainability of the Network, which is the core of DPH and broader San Francisco safety net

Managed Care under the Network

With the implementation of the ACA, a critical part of the overall business strategy for a financially sustainable Network is managing financial risk. In contrast to the fee-for-service model, managed care and capitation will make the Network accountable for cost, utilization, quality, and health of its clients. Therefore, unnecessary or preventable health care expenditures are problematic to DPH.

Also, in managed care, acute services transitions from a revenue source in fee-for-service to a cost in capitation, if over the monthly capitated rate. With the implementation of the ACA and Covered CA, clients now have additional choices in the health plan they choose to enroll in. To sustain the Network and grow the number of Network clients, it will be necessary to pursue and secure managed care contracts with the qualified Covered CA health plans, as depicted in the figure below. Please refer to Appendix III for additional information.

Figure 8: Network Managed Care Contracting Opportunities



Note: Anthem Blue Cross is a product line under Medi-Cal and a separate product line under Covered CA.

Strategy 10: Operationalize the Managed Care Office

Broadening the managed care base, retaining enrolled members, and successfully competing with other healthcare providers and delivery systems, requires a restructuring and realignment of critical operational and business development activities, including contract management and provider relations, performance data analysis and reporting, beneficiary relationship management, business development, marketing, and outreach. A key recommendation that emerged as part of the HMA engagement was the establishment of a Network Managed Care Office. The multifaceted roles of the Managed Care Office are described below.

- Contract management and provider relations includes the development and compliance monitoring of standards for Medi-Cal managed care, as well as contracting with and monitoring community providers and services that serve Network clients.
- Performance reporting and analysis is critical to the successful managed care cost, quality, and population health outcomes. Managed care performance reporting and analysis provides management information to evaluate performance against required managed care business metrics.
- Beneficiary relations management includes serving as a liaison to the health plans customer service department complaints and grievances, assuring quality client care, assuring access to primary care and medically necessary service within required timeframes, assisting in enrollment and reenrollment assistance, and communicating with beneficiaries.
- Business development, marketing, and outreach includes the development of current and future business opportunities to position the organization to expand market share, development and distribution of internal and external marketing and collateral materials, and strategic outreach to community and business organizations.

Strategy 11: Network Performance Metrics

To ensure that the Network vision is being implemented in alignment with DPH and ACA goals (to increase enrollment, quality of care, reduce out of network expenditures, and maximize revenues, etc.), HMA recommended and Network leadership agreed to the development of performance metrics to regularly measure, evaluate, and improve performance to deliver the highest-quality healthcare and maximize efficiencies. Performance measurement will promote transparency, open communication, and accountability across the Network.

In the short term, the goal is to develop Network metrics and associated reports from existing systems to share at regular meetings with key staff to promote knowledge-sharing and accountability. The Controller's Office is assisting the Network with initial development of key performance metrics that resulted from the HMA engagement in:

- Patient Flow
- Finance
- Quality and Safety
- Patient Satisfaction
- Staff Satisfaction

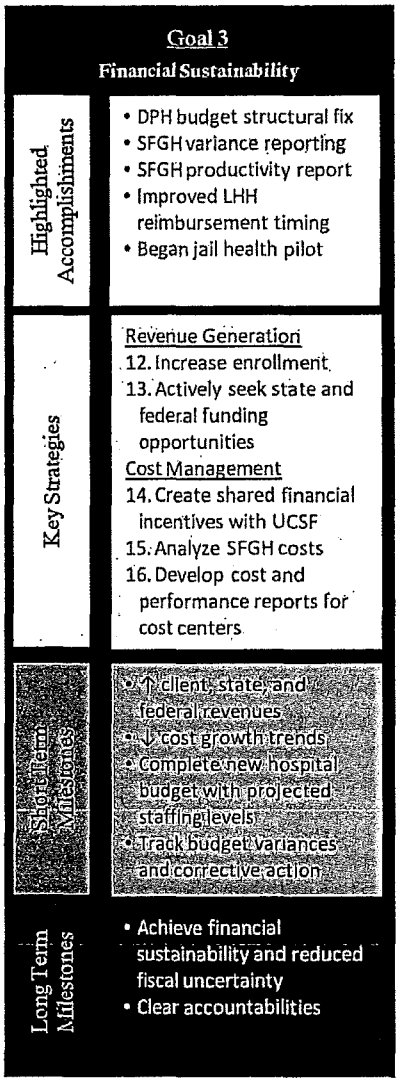
In the future, the Network aims to transform these metrics into automated dashboards viewable to key leadership and staff to monitor trends and continue to hold appropriate personnel accountable.

CHAPTER 3: FINANCIAL SUSTAINABILITY

ACA Impact on DPH Financial Sustainability

Financial management in many sectors is challenging, from healthcare to technology to financial services, but one financial goal remains the same - to manage risks and increase predictability in cost and revenue. The Affordable Care Act (ACA) made a giant leap forward for health care access, but the unpredictability of a provider's patients and the ever-changing healthcare regulatory and reimbursement landscape makes financial planning and management of risk even more challenging. This is particularly true for public health departments facing an historically complex safety net patient population and a financial system built around finding dollars to cover costs. The HMA engagement and the two year integrated delivery system planning process began the shift toward improving internal efficiencies while maintaining care excellence and quality.

In light of the new healthcare environment, which aims to increase coverage for more people, improve quality, and control costs, DPH must strive for financial sustainability through (1) delivery of coordinated quality preventative care as described in previous sections of this report, (2) exploitation of financial opportunities, and (3) cost control and management strategies. At DPH, the increased number of insured individuals as a result of the ACA provides current and potential San Francisco Health Network (the Network) clients with a choice regarding where to access care. Each Network client retained or newly enrolled helps maintain or increase revenues to sustain the Network. On the other hand, if Network clients choose to get their health care elsewhere and move out of the Network, DPH will lose revenue to support its current system of care. During the HMA engagement, DPH underwent an intensive internal process to develop a model to project future revenue streams in light of health reform and clear strategies to achieve cost containment and revenue generation. The next two sections provide the Network's key financial strategies and a rough timeline of intended outputs and outcomes as health reform and its impacts continue to unfold.



Revenue Generation Strategies

Revenue Outlook

As a result of the ACA, it is projected that DPH will realize a 16 percent decrease in the historical state and federal safety net dollars. Capitated revenues are anticipated to partially offset this loss. The impact of health reform on DPH's financial sustainability is broken down into four main categories: Primary Care Capacity, Change in Reimbursement Mechanism, Insurance Status, and State and Federal Revenues.

- Primary Care Capacity. As discussed in the Chapter 1 and Appendix II, increasing primary care capacity to meet demand directly impacts quality of care as well as managed care revenues. Not only is the Network currently challenged to meet demand and in need of additional capacity but also the ACA requires that clients have timely access to care. Therefore, the Network must strengthen its primary care system to increase capacity to ensure timely access to care. This will allow DPH to provide patients preventative and early interventions to keep its patients healthy, improve quality outcomes, and minimize avoidable hospital admissions.

- Change in Reimbursement Mechanism. To incentivize more efficient use of services and as a means to manage risk, the reimbursement mechanism in the new healthcare environment is moving away from fee-for-service and towards capitated payments. Fee-for-service is a payment for each service provided. There is predictability in payment for services, but also fewer incentives to reduce costs. Medi-Cal is moving away from the fee-for-service model to a capitated rate. Capitation provides a fixed amount of money to care for each patient, regardless of utilization or cost. There is predictability in payment for patients, but it requires better cost control mechanisms to ensure financial sustainability. As an emerging practice in the public sector identified by HMA, the Network must become more efficient and cost conscious at all levels of client delivery and educate clients about the Network's new managed system of care. Medi-Cal expansion and Covered CA have moved to a fixed per member per month (PMPM) rate to manage the care of clients regardless of how frequently or infrequently they use services. This new reimbursement environment will be challenging as a large proportion of the Network's clients are multi-diagnosed and complex. However, the Network has a broader, deeper system of care than many competing managed care systems; therefore, if care is well coordinated and managed, the Network's full continuum of care can help retain clients and ensure the viability of the Network and DPH.

- Insurance Status. Network clients' insurance status is essential to DPH's revenues as these revenues fund the many vital health services for the whole community as illustrated in Figure 2. Therefore, to continue to provide a viable safety net, the City must increase the number of Network clients and increase revenue.

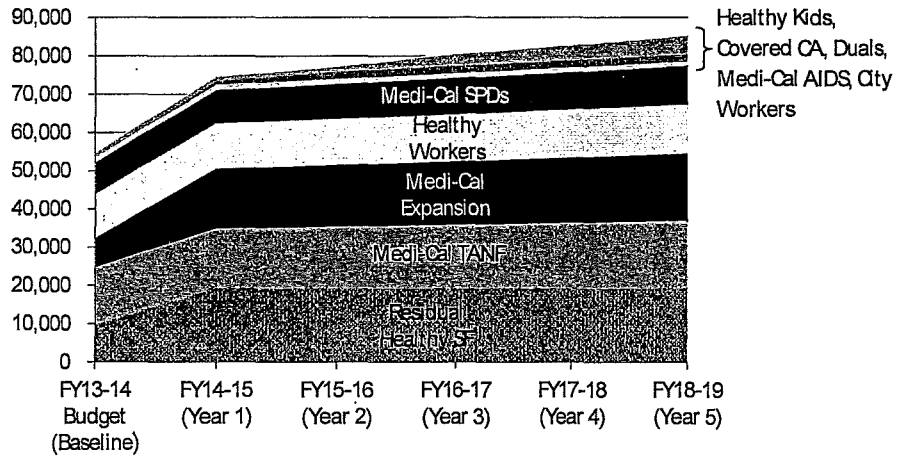
  As intended, ACA's impact will result in an increase in the number of insured and a decrease in the number of uninsured. A majority of the state's insured will gain coverage through Medi-Cal as a result of Medi-Cal expansion while the remainder will gain coverage through Covered CA. Programs that historically served the uninsured in San Francisco will shrink as more clients are covered under the ACA.

For example, SF PATH (San Francisco Provides Access to Health Care)[12] ended on December 31, 2013 and its clients transitioned into the newly expanded Medi-Cal. The remaining uninsured, who are not eligible for Medi-Cal or Covered CA, will remain in Healthy San Francisco.

Based on the HMA engagement five-year projection model, the figure below illustrates the forecasted trend of Network clients by program over the five year period from FY14 to FY19. The key drivers of the increase from FY14 to FY15 are the Medi-Cal expansion and Covered CA clients. The major assumptions within this projection are listed below:

- Total Projected Client Increase: Network clients are forecasted to increase from approximately 57,000 to 85,500 clients over a five year period. Key assumptions are listed below.
  - Medi-Cal Expansion: Network to enroll nearly 15,000 individuals eligible for the Medi-Cal expansion around January 2014. The monthly ("PMPM") capitation rate for the new Medi-Cal expansion population as of January 2014 is assumed to start at approximately $400.
  - Covered CA: Network to enroll 2,000 individuals eligible for Covered California (insurance exchange) in or around January 2015.
  - Dual Eligibles[13]: State's transition of dual eligibles (Duals) into managed care is anticipated around 2016 resulting in a one-time increase in the number of Duals clients within the Network.

Figure 9: Projected Trend of Network Clients by Program FY14-FY19



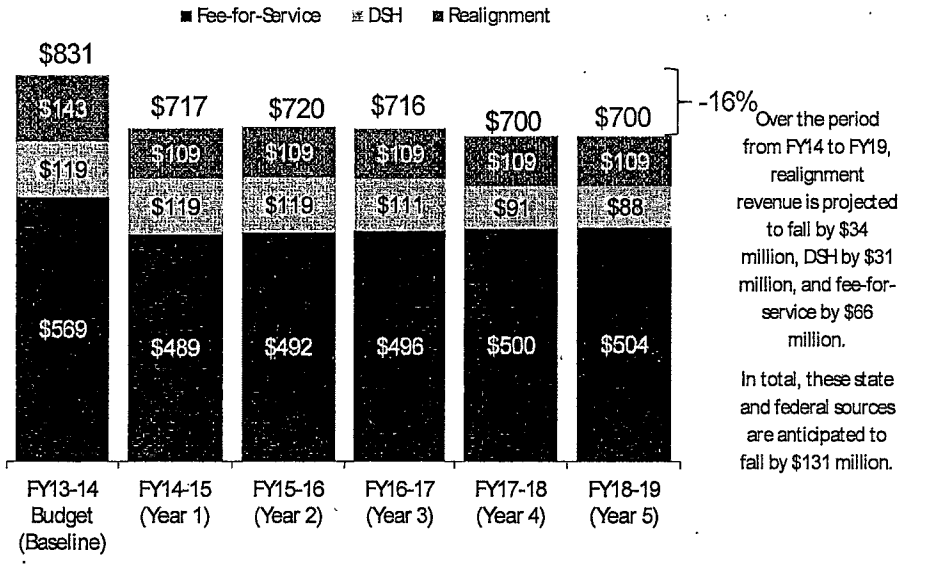
Source: Department of Public Health via the HMA Financial Projection Model. Note: Projections are based on HMA and DPH assumptions regarding estimated client membership.

[12] SF PATH: The City and County of San Francisco's Low Income Health Program (LIHP) was created by the state in July 2011 as a temporary program for certain Californians eligible for free or low cost health insurance as a part of the federal health reforms that took effect in 2014.

[13] Dual eligibles are those eligible for both Medicare and Medi-Cal.

- State and Federal Revenue. Under the ACA, there are major changes in how counties receive state and federal revenues. The historical state and federal "lump sum" payments to support the uninsured and safety net services will be reduced with the expectation they will be partially offset by an increase in Medicaid revenue and earned managed care revenues. The three major losses of historical revenues include federal Disproportionate Share Hospital (DSH) payment reductions ($31 million), state "realignment" funds for indigent health ($34 million), and traditional fee-for-service patient revenues ($66 million). These losses amount to a 16 percent reduction in revenues from FY14 to FY19. The figure below illustrates the net reduction of these three revenue streams over this period.

Figure 10: Projected Reductions in Three Major State and Federal Revenues FY14-FY19 (in millions)



Source: Department of Public Health via the HMA Financial Projection Model.

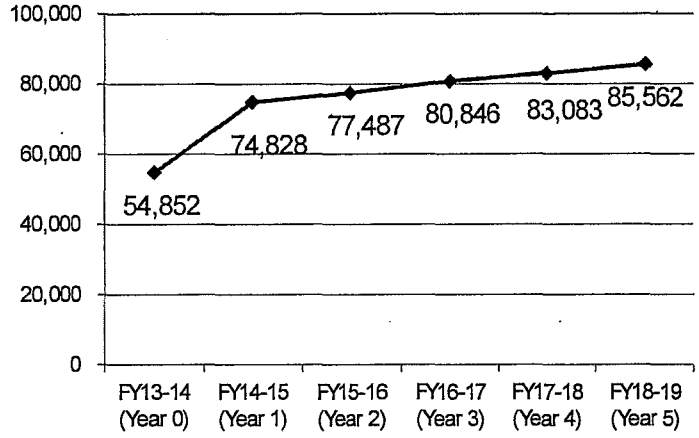
Strategy 12: Increase Network Clients by Strengthening the Ambulatory Care System

During the HMA engagement, the Network developed a detailed work plan to improve the Ambulatory Care system. It is imperative the Network increase the number of insured clients to create adequate and stable funding to the Network. Chapter 1 describes the strategies aimed at strengthening the Ambulatory Care system to achieve this increase, such as increasing panel sizes, implementing a call center, and improving the physical appearance of clinic sites to attract and retain Network clients.

The Network projects that over the next five year period there will be an average 10 percent increase in Network clients each year, reaching approximately 85,500 clients by FY19. A key assumption is that the number of Network clients will increase by 36 percent in health reform's first year, from approximately 54,900 to 74,800 clients by June 30, 2015. Attaining this year-over-year increase is imperative to DPH's financial sustainability as a

result of the anticipated state and federal revenue losses. Over time, successful increases in Network clients will reduce revenue uncertainty.

Figure 11: Projected Monthly Network Clients FY14-FY19



Over the period from FY14 to FY19, Network clients are projected to increase 36 percent in FY14 and increase by an average of three percent each of the following years.

Source: Department of Public Health via the HMA Financial Projection Model. Note: Projections are based on HMA and DPH assumptions regarding estimated client membership.

Strategy 13: Actively Seek Additional State and Federal Funding Opportunities

DPH has recently increased its work with state and federal officials on targeted opportunities to support San Francisco's innovative programs. This dialogue led to the prioritization, achievements, and next steps listed below.[14]

- Timeliness of LHH Supplemental Payment Calculation. The Network recently worked with state officials to assure the timeliness of supplemental payment calculations for Laguna Honda Hospital (LHH) in terms of both amounts received and the timing of that receipt. By utilizing more current cost data, which represents higher costs, the amount of settlement costs increased. In addition, the use of more current cost data will now result in the more timely settlement and therefore payment for LHH.
- Health Homes. The Network, with HMA expertise, monitored developments regarding ACA Section 2703, the Medicaid Health Home State Plan Option, and began to explore options to establish Health Homes within the Network. In the future, the Network will attempt to garner additional funding for Health Homes through a SPA or Medicaid 1115 Waiver project. See Chapter 1 for more information on the establishment of Health Homes.
- FQHC Clinic Visit Reimbursements. HMA identified current State Plan Amendments (SPAs) that allow supplemental Federally Qualified Health Center (FQHC) payments as a way to increase the rate of

[14] These opportunities were not incorporated into the HMA five-year financial forecast model as these strategies are additional revenue opportunities yet to be realized.

reimbursement from the Federal government. After additional exploration, DPH discovered the current California SPA cannot be used for this. However, DPH found the state may be supportive of an effort to allow for certified public expenditures (excluding intergovernmental transfers or IGTs) to draw down federal financial participation for unreimbursed FQHC costs.

- Jail Health Enrollment. The Network initiated implementing a Jail Health pilot enrollment project to ensure enrollment of the jail population into a coverage program prior to release from jail. Ensuring the jail population has coverage and access to care prior to or when being released from jail will further decrease the uninsured rate in our community and reduce pressures on the safety net. If these newly enrolled individuals choose to access care at a Network clinic or hospital, then this is also another source of client revenue for the Network. The Network is currently working with the Human Services Agency (HSA), the Sheriff's Department, and Jail Health staff to ensure health care enrollment occurs at, or just after, release.

Over the next five year period, these opportunities could increase state and federal funding to help offset projected decreases in revenues.

Cost Control & Management Strategies

Expenses Outlook

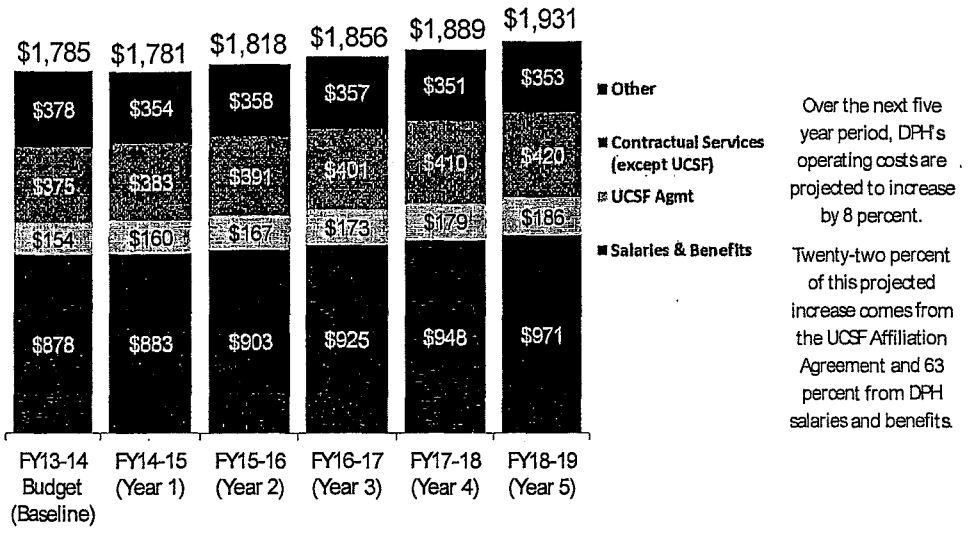
As stated at the beginning of this section, one of the major financial impacts of the ACA is an approximately 16 percent reduction in revenues (DSH, fee-for-service, realignment). These reductions can be offset with increases in managed care (capitated) revenues; however, expenditures must be managed carefully to ensure financial stability.

Capitated revenues will only partially offset the anticipated state and federal revenue losses.

Cost management and control strategies must also be used to curb expense growth.

As illustrated below, over the next five year period DPH's current operating expenses are projected to increase by eight percent, to approximately $2 billion. DPH's costs can be broken down into four main categories: salaries and benefits comprise 50 percent, UCSF comprises nine percent, and other contractual services and other costs together comprise 41 percent. Twenty-two percent of the eight percent increase in costs is attributed to the UCSF Affiliation Agreement and 63 percent of the increase is from DPH salaries and benefits. These expense projections include inflationary factors outlined in the City's Three-Year Budget Projection ("Joint Report"), but do not reflect any new initiatives or programs above the FY13-14 budget nor the operating budget for the new San Francisco General Hospital.

Figure 12: Projected Increase in Total DPH Operating Expenses FY14-FY19 (in millions)



Over the next five year period, DPH's operating costs are projected to increase by 8 percent.

Twenty-two percent of this projected increase comes from the UCSF Affiliation Agreement and 63 percent from DPH salaries and benefits.

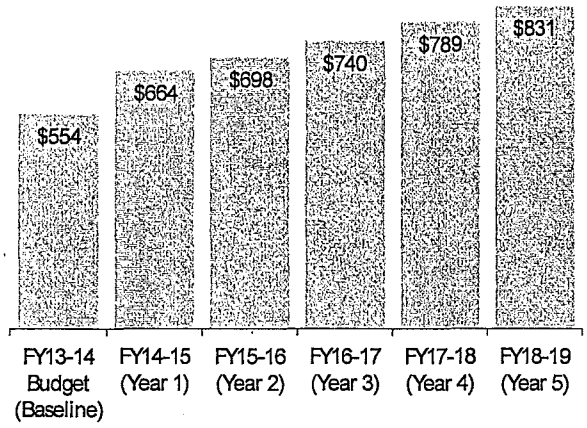
Source: Department of Public Health via HMA Financial Projection Model.

One of the fiscal challenges facing public health departments as a result of health reform is accurately projecting capitated revenue as this is based on enrollment projections, depicted in Figure 9. The level of uncertainty for projected revenue remains high. However, over time and with greater market experience DPH will continue to refine and should be able to more accurately predict enrollment numbers.

To estimate DPH's general fund subsidy for its baseline operating costs in FY15 through FY19, the department utilized the HMA financial model provided during the engagement, updating it with more recent information and to reflect DPH's current operating budget. Based on this update, the City's net general fund contribution to DPH is anticipated to increase by 50 percent from FY14 to FY19, as illustrated below. During its engagement, HMA pointed out that historical cost trends must be reversed or otherwise mitigated for DPH to attain the goal of long term financial sustainability.

This projection assumes the aforementioned 16 percent revenue loss from DSH, realignment, and fee-for-service, the forecasted eight percent cost increase, the current FY14 baseline general fund subsidy, general-funded capital and project dollars are constant, and the same level of service in other DPH programs. In addition, the methodology used to project the estimated general fund subsidy does not include increases in enrollment or capitated revenues.

Figure 13: Projected General Fund Subsidy Increases FY14-FY19 (in millions)



These cost growth rates, coupled with the impact of the ACA, will be unsustainable unless historical cost trends are reversed or otherwise mitigated.

Absent any interventions, the general fund contribution by the City is projected to reach $831 million in FY19, for a total of $4.3 billion over the period from FY14-FY19.

Source: Department of Public Health via HMA Financial Projection Model.

Given DPH's main cost drivers and HMA's fiscal recommendations, the following are three key areas to control costs: the UCSF Affiliation Agreement, SFGH operating costs, and cost reporting. This section will identify the actions already accomplished and strategies for cost control and management.

Strategy 14: Create Shared Financial Incentives with UCSF

The UCSF relationship is a long standing, mutually beneficial partnership that has served the San Francisco community for more than one hundred years, formalized in a written Affiliation Agreement since 1959. However, with health reform and a new managed care environment, public health systems around the country are working to better measure and rein in costs. The UCSF Affiliation Agreement is at $154 million in FY14 and comprises approximately ten percent of the annual DPH budget and 15 percent of the annual SFGH budget. Through the HMA engagement, the Network identified key areas around fiscal management of the UCSF agreement to improve data collection and accountability for both parties. The next section identifies these strategies to improve tracking, accountability, and fiscal management. Additional information regarding the UCSF partnership can be found in Appendix III.

Health reform and the managed care environment require tracking, measuring, and reporting for regulatory compliance and achieving a competitive edge.

As a large portion of SFGH staff and the DPH budget, the UCSF Agreement must be restructured and new measures enforced to remain competitive.

To move forward under this new managed care environment, DPH is exploring additional accountability and tracking measures throughout Network operations as described in Chapter 2. Therefore, one key strategy for the Network to control costs is data-

driven management of the UCSF Affiliation Agreement as well.

- By the end of FY14 the Network intends to support a benchmarking study to identify best practices in hospital-academic institution affiliation agreements across the country to understand key reporting and accountability measures.
- By the end of FY15 the Network intends to utilize the best practice research when evaluating the Agreement, in particular the addition of key reporting requirements, risk-reward provisions, billing expectations, and regular review of non-faculty costs and leases.

Through the implementation of these strategies, DPH, in particular the Network, will centralize all UCSF contract management and decision making to ensure transparency and, most importantly, realize improved productivity and reduced cost growth. This year-over-year management of the UCSF Affiliation Agreement and associated costs will help DPH achieve financial sustainability and increase mutual accountability.

Strategy 15: Analyze SFGH New Facility Costs

SFGH operating costs comprises approximately one-third of DPH's annual General Fund subsidy and more than 50 percent of DPH expenses. Furthermore, in the new managed care, capitated environment, services provided to a Network client will not be reimbursed on a fee-for-service basis, but costs must be within the capitated rate for the Network to remain financially sustainable. So, there are opportunities to prevent acute admissions through a strengthened ambulatory system (as discussed in Chapter 1), as well as opportunities to control costs in the acute setting at SFGH. As a result of the HMA engagement, there have been three key financial achievements at SFGH: (1) implementation of salary and fringe variance reporting by cost center, (2) development of an SFGH productivity report, and (3) a re-evaluation of the new SFGH operating budget via data gathering and assessment of proposals.

In the next year, the following three strategies will be pursued to continue to manage SFGH costs.

- SFGH will continue to evaluate one-time transition costs and ongoing new facility costs to ensure that new equipment and FTEs are justified by volumes.
- Staffing costs comprise approximately 50 percent of SFGH's operating expenses; therefore, a detailed examination of staffing levels against similar hospitals and benchmarks coupled with a study of the client population and volumes is needed by the end of FY15.
- SFGH will also operationalize a benchmark database so SFGH can compare productivity and volumes against similar academic teaching hospitals across the nation.

These strategies will be used to refine the operating budget for the new SFGH. This updated budget coupled with proactive budget variance reporting will provide SFGH with tools to better manage and control costs. SFGH's ability to manage costs is imperative to the overall financial sustainability of the Network, DPH, and the City as many of the services provided in an acute setting are now capitated. Close management of costs against volumes is a key strategy to achieve financial sustainability in the long term.

Strategy 16: Develop Cost and Performance Reports for Cost Centers

In recent years, DPH has required supplemental funding from the General Fund or new revenues to cover actual expenses. The FY14 adopted budget added funding to address the previous structural gap with SFGH staff funding. In addition, DPH leadership implemented expanded financial reporting to the Health Commission to hold DPH accountable to the Commission and City leaders if overruns occur. If overruns occur, DPH will present a corrective action plan.

To allow managers to make effective decisions on resources, DPH aims to develop cost and performance tools for all Network units and cost centers. DPH has committed to use these reports to hold the appropriate staff accountable. It is anticipated these reports will be produced for all units and cost centers over the next few years.

In sum, the Network must not only increase the number of clients served to help offset state and federal revenue losses, but also effectively manage costs to ensure the Network, DPH, and the City remain financially sustainable over the long term. Additional investment and partnership strategies can be found in Appendix II and III.

APPENDIX I: IDS HISTORY, HMA ENGAGEMENT, AND ACTION TEAMS

DPH has worked toward integrating patient delivery for nearly three years and developed the following definition for DPH's integrated delivery system (IDS): a comprehensive system of care that is clinically and financially accountable to provide coordinated health services to the individuals it serves and improve the health of the community. The IDS vision is based on the local history of healthcare delivery and the changing healthcare landscape described in the introduction.

History of IDS at DPH

The initial planning and implementation efforts were and continue to be rooted in the contention that DPH is critical to the populations and communities it serves. Between June 2011 and May 2012, an internal IDS planning and visioning effort took place that resulted in over 40 recommendations aligned with the Health Commission's priorities. This significant effort involved over 100 staff and community partners in the IDS planning groups.[15] Between July 2012 and March 2013, initial implementation efforts took place in which five work teams were created to begin implementation of the recommendations.[16]

HMA Engagement

To further the transformation of DPH into a fully integrated delivery system, DPH engaged Health Management Associates (HMA), a consulting firm with experience in public healthcare delivery systems, in February 2013 through a formal solicitation process. The Controller's Office funded and provided contract and project management support for the engagement. In line with the changing healthcare environment, HMA's two main objectives were:

1. Prepare DPH to compete for clients as the healthcare environment changes and financial reimbursement moves away from fee-for-service and towards capitation
2. Transform and integrate DPH's delivery system and corresponding support systems into a provider of choice and away from the provider of last resort

HMA's work took place in three main stages: visioning, prioritization, and implementation.

Visioning

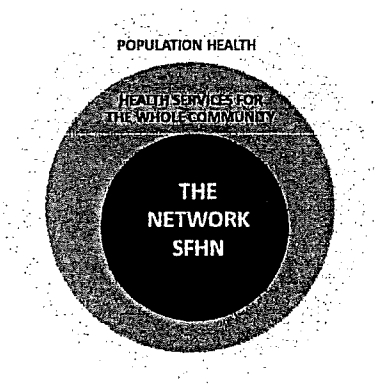
Building upon the previous IDS work, HMA began the engagement with a series of key internal and external stakeholder interviews and intensive document review. HMA developed an environmental assessment and clear statement of the vision for DPH as depicted in Figure 14. This graphic illustrates DPH's relationship between the health of our community's population and the importance of a strong integrated delivery system. The core of public health must be strong for the greater San Francisco system to have and maintain a healthy population.

[15] Department of Public Health. Presentation of the Integrated Delivery System Planning Project, May 15, 2012. Retrieved January 15, 2014 from http://bit.ly/1pWU3kk.

[16] The teams were Care Management, Clinical Leadership, Health Promotion and Disease Prevention, Innovations in Health Care, and Quality and Utilization Management. Department of Public Health.

The two primary roles of DPH in this new healthcare environment are to (1) externally, improve the health of the population by maximizing enrollment into new health insurance options and (2) internally, DPH must prepare the health care delivery system to become the provider of choice for clients.

Figure 14: DPH's IDS Vision



The Network (SFHN) provides direct health care services to insured or covered clients whose care is managed through the Network, from primary to acute to long term care.

Health services for the whole community include services for those clients outside of the Network but still in the safety-net, for example, undocumented immigrants and homeless/transient populations. Includes community behavioral health and trauma services.

Population health aims to improve the health of the entire population through environmental health, disease control, assessment, and housing.

Source: Department of Public Health.

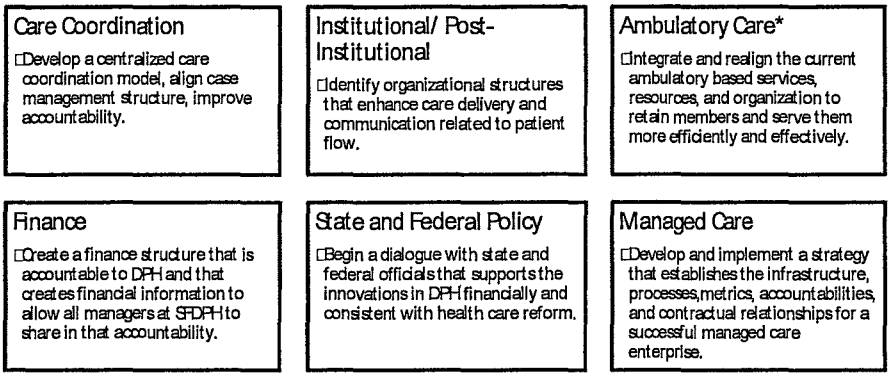
Prioritization

The intensive DPH IDS development, prioritization, and planning effort took place over the summer of 2013 via DPH-HMA Action Teams. The process aimed to (1) establish broad areas for attention, (2) develop Action Teams or work groups to prioritize actions and develop champions within DPH, and (3) move the two years of IDS planning into the implementation phase. Figure 15 depicts the six Action Teams developed and the main objective of each team. Throughout the process, the leaders of the Action Teams formed the Integration Steering Committee (ISC), which served as the key planning and monitoring group for health reform readiness activities and IDS development.

The output of this three-month, joint DPH-HMA effort from June to September 2013 included strategic and intensive intra-departmental collaboration, and a priority list of key recommendations for improved systems change in light of health reform. On October 1, 2013, the planning phase ended and implementation began with the launch of the City's public health integrated delivery system, called the San Francisco Health Network (referred to as "the Network" in this report).

Figure 15: DPH-HMA Action Team Objectives

From June to September 2013, DPH and HMA worked intensely via six Action Teams on specific objectives, all aimed to turn DPH's integrated delivery system into a reality.

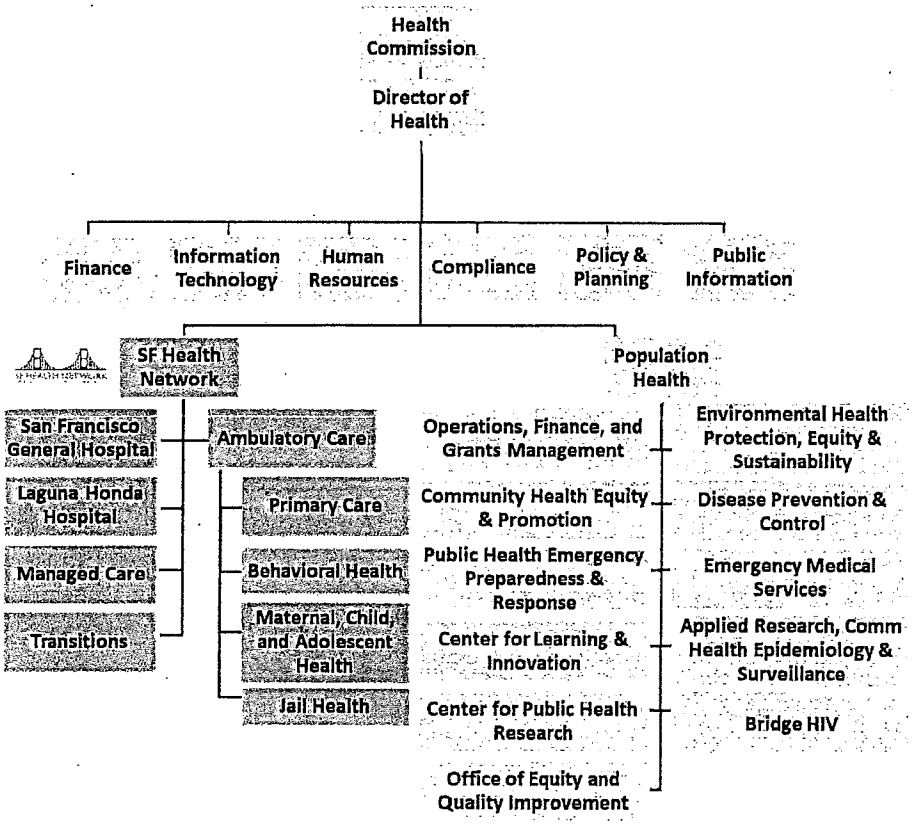


Source: Department of Public Health. *The ambulatory care sub-groups included the following: 1. Panel Sizes, 2. Operational Issues, 3. Organizational Structure, 4. Critical Capital and HR Investments, 5. Health Homes, 6. Specialty Services

Implementation

HMA assisted DPH to reorganize management and reporting structures to be able to fully support an integrated delivery system. This significant effort resulted in a new organizational chart for DPH. The reorganization and integration of DPH's patient delivery system into the San Francisco Health Network is depicted in Figure 16. As Figure 14 illustrates, the core of the public health system (the Network) must be strong in order for the greater San Francisco system to maintain a healthy population.

Figure 16: San Francisco Department of Public Health Organizational Structure



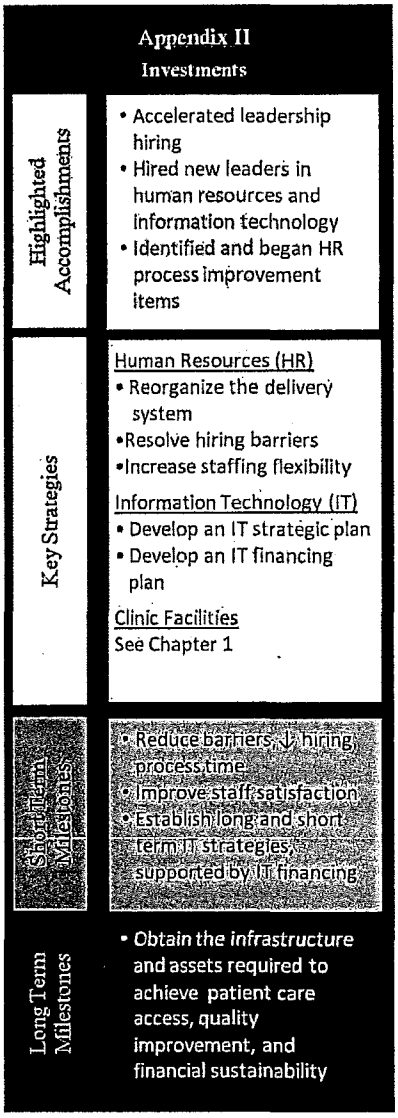
Source: Department of Public Health.

APPENDIX II: INVESTMENTS

ACA Impact on Investments

As the Background and Chapter 3 state, the provisions of the Affordable Care Act (ACA) and resulting changes to the healthcare environment are challenging the San Francisco Health Network (the Network) to improve efficiency of care while also improving quality. The three main challenges facing the Network are: (1) timely access to care (with ACA, clients have a right to care within a reasonable time), (2) adapting to capitation payments, which create greater incentives to reduce unnecessary high cost care and invest in prevention and care management, and (3) increased competition, since clients now have more choice in choosing their provider. The Network must move from a "provider of last resort" to a "provider of choice."

To meet these new challenges and succeed in the new environment, the City and the Network must quickly identify and strategically increase investments in its health system infrastructure; in particular, investments in human resources, information technology, and clinic facilities. Please refer to Chapter 1 for a discussion of clinic facility investments important to improving access to care and patient flow. The next two sections discuss key strategies coming out of the HMA engagement regarding human resource and information technology investments.



Human Resource Strategies

For organizations in direct patient care such as hospitals, clinics, and public health systems, the ACA and the managed care setting require quality, cost-effective, and cost-conscious care. There are several key steps to achieve this; for public health systems, these include: (1) reorganize and restructure into an integrated delivery system, (2) identify and resolve barriers to expedite hiring, and (3) increase staffing flexibility based on demand for services and the number of staff available based on client volume. Discussed more below, these strategies are needed to help the Network improve wait times, provide more efficient care, and more effectively compete with other providers.

Reorganize and Restructure the Delivery System

The DPH IDS planning process and the HMA engagement, including the work of the 2013 Action Teams, resulted in the development and adoption of the San Francisco Health Network on October 1, 2013. The rollout of the Network and reorganization of the delivery system as depicted in Figure 16 is a crucial first step towards becoming a "provider of choice." Informed by HMA's experience integrating other county public health systems, the Network developed job descriptions for key leadership positions in 2013. These key positions include the Network Director and Ambulatory Care Director. In addition, the reorganization established a Managed Care Office for the Network which aims to hire a Managed Care Director by the end of FY14. For more information on new leadership positions and the Managed Care Office, see Chapter 2. For more information on additional Ambulatory Care human resource strategies, see Chapter 1. In addition to the Network leadership positions, DPH also hired key leadership positions, including the Human Resources Director and Chief Information Officer.

Throughout FY14 and continuing into FY15, the Network needs to continue to develop its integrated structure and staffing strategies among Ambulatory Care, Finance, Managed Care, and Transitions (formerly Community Placement). The Network has pledged to monitor the impact of organizational and culture changes on staff through a quality improvement process, including a staff satisfaction survey. In the long term, staff satisfaction will be an indicator of the Network's effectiveness.

Identify and Resolve Barriers to Hiring

A key HMA recommendation was to develop effective strategies as soon as possible to reduce recruitment and hiring barriers. This includes streamlining the DPH and City recruiting and hiring processes to reduce the time to hire.

The hiring of DPH's Director of Human Resources in August 2013 was a major milestone. As a result of the HMA engagement, DPH identified and started to implement 14 action items to improve personnel processes in conjunction with the City's Department of Human Resources (DHR). This includes a secured agreement from DHR to accelerate hiring of key DPH and Network leaders, and ongoing weekly meetings with DPH divisions to identify and accelerate hiring of key positions. DPH has committed to continue to identify and resolve barriers to hiring to appropriately and flexibly staff the Network.

> To meet the human resource challenges of ACA, the Network must strategically and successfully engage DHR and other City partners to remove hiring barriers and increase staffing flexibility.

Increase Staffing Flexibility

The third human resource strategy identified during the HMA engagement is staffing flexibility through redeployment of staff; that is, redeployment based on client demand, cross-training, and professional development. HMA's early assessment of DPH included a lack of front-line workers, over-staffing in certain areas, and inefficient staffing structures that have led to uncertainty regarding accountability. HMA emphasized the need to sufficiently and appropriately staff the front-end of the network (i.e., primary care) in order to retain its clients. HMA also identified a lack of clear messaging to contract and labor partners regarding the future need for staffing flexibility as a result of the new environment.

Recent achievements to improve staffing flexibility, efficiency, and hiring include:

- Implementing LEAN at SFGH: To improve efficiency in select hospital units, SFGH adopted the process and quality improvement method known as "LEAN" in 2012. Through August 2013, 35 staff have taken LEAN certification training, four units have undergone a value stream mapping process to increase efficiency, and 11 "Kaizen," or rapid improvement events, have taken place.
- Hiring Key Leadership and Messaging: Prior to January 1, 2014, DPH began to hire and staff key leadership and staff positions described in Chapter 1, Strategy 1, who have begun to educate and inform key partners of the impacts of ACA on staffing.
- Measuring Staff vs. Volume. DPH has prioritized the measurement of staffing needs. HMA developed a productivity measurement tool as a first step in helping SFGH leadership identify staffing compared to volume, with high-level comparisons to select hospital systems across the country.
- Identifying Physician Recruitment Issues. HMA identified the high cost of living in San Francisco compared to relative salaries offered at DPH as a key barrier to primary care physician recruitment and retention. Refer to Appendix III for information regarding physician pay-for-performance incentives.
- Creating an HR Strategy for PCMH. HMA recommended the creation of a human resources strategy specific to the Network's adoption of the Patient-Centered Medical Home (PCMH) model. This includes developing the competencies, job descriptions, performance evaluation, and identifying essential positions specific to PCMH teams. HMA recommended closely linking competencies in training programs and ongoing competence building for PCMH practices. See Chapter 1, Strategy 1 for more information.

In sum, the Network must continue to track staffing and patient volume while proactively and creatively recruiting, training, and redeploying its staff and physicians, with a focus on matching supply to demand (clients and volume).

Information Technology Strategies

The new healthcare environment must be accompanied by robust data and reporting systems that enable identification of key issues and trends. The backbone to creating a fully integrated delivery system within DPH is to integrate information systems containing client clinical records. Currently, the Network has over 50 systems that contain medical and psychosocial information, however many of the systems are not integrated with each other which can lead to misunderstandings and inefficiencies (refer to Figure 3).

In addition, HMA found there is a lack of useable data across the system. The Network is hampered by the multiplicity of data sources, a lack of financial data (granularity or matching operations properly), and often a distrust of the validity of the data produced. There currently is an inability to combine data sources to facilitate accountability and effective planning. At the same time, DPH staff and partners are overwhelmed with the amount of data currently required to be collected and reported (e.g., regulatory, research, grant program evaluation).

DPH has made strides integrating its approach to information technology (IT) development through home-grown innovative approaches to connectivity and the recent on-boarding of DPH's Chief Information

Among many IT needs of the Network, implementing system-wide electronic health records and financial management solutions will be critical to success under the ACA.

In the short term this requires significant planning and identification of sustained financial resources.

Officer (CIO), but is still significantly behind other delivery systems in the establishment of an effective and integrated IT system. DPH is committed to the long term implementation of a system-wide electronic health record system (EHR)[17], but in the short term, immediate solutions are needed to support connectivity, client management, and financial accountability. To accomplish this, DPH must as soon as possible (1) develop an overarching IT strategic plan and (2) identify and implement a sustainable financing strategy to support the long term plan. Otherwise, the adoption of fragmented systems without linking each new system to the overall strategy leads to inefficiencies.

Develop a Short Term and Long Term IT Strategic Plan

DPH's hiring of its CIO was a key step in reorganizing and integrating the IT organizational structure. For the short term, HMA provided strategies and helped the Network to approach interim solutions.

1. Assessment. Prior and during the HMA engagement, a preliminary assessment of the existing IT systems took place. Moving forward DPH must immediately conduct a formal assessment of the IT system options and identify a system-wide, interim solution in lieu of an expensive, stand-alone EHR
2. Interim Interfaces. Using the formal assessment results, the second, complimentary approach is the strategic implementation of interfaces and updates to software and hardware, including the IT recommendations for ambulatory care discussed in Chapter 1. The Network is now exploring the following options prior to the identification and purchase of a large EHR or financial solution:
    - Reporting. Reporting tools that provide standardized reports across multiple systems. These tools, including data visualization, may cost in the thousands of dollars per license annually.
    - Business Intelligence/ Decision Support. Tools aimed at providing a means to aggregate, analyze, and report key financial information. In some cases, these tools can cost hundreds of thousands of dollars, and relies on feeds from existing systems in lieu of a larger integrated solution. The Controller's Office provided DPH with some benchmarking information in this area.

However, in the long term the Network must assess, develop, and implement a robust and sustainable IT infrastructure, including a single EHR solution, to support the comprehensive services provided. Through Controller's Office benchmarking interviews, a single EHR may cost approximately $200-$300 million to develop and implement, and requires significant ongoing staff commitment and support. DPH is already exploring the implementation and ongoing maintenances costs for a single EHR solution with a technology consultant.

Regardless of the specific solution obtained, an integrated IT system and strategy must include:

- An application that provides dashboards and reports client information using a data warehouse
- Standardization and interoperability, enabling the quality measurement, coordinated care, and financial rigor required by the new ACA environment
- Population care management tools that allow for tracking and optimization of key prevention and disease management outcomes
- An integrated, county-wide health information system for clinical, quality, and financial measures
- Training and staff support

[17] Electronic Health Record: a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR has the ability to generate a complete record of a clinical patient encounter including evidence-based decision support, quality management, and outcomes reporting.

Identify and Implement an IT Financing Strategy

A diverse and sustainable financing strategy must be developed to support the resulting long term IT Strategic Plan. The Mayor's Office, Controller's Office, and the Committee on Information Technology (COIT) will be key stakeholders in supporting the final strategy. Purchasing and implementing a network-wide EHR is not only a significant financial commitment but there is also a resource commitment for leaders and staff to utilize the system to its full potential. HMA recommended two strategies to finance this large commitment.

1. Partnerships. During the HMA engagement the following stakeholders were identified as highly interested or proceeding with EHR implementation. The key to this recommendation is to engage stakeholders in the planning process to determine the type of partnership and mutual investments that could help offset the cost of EHR implementation. Examples of these benefits include the following:
   - For the UCSF Medical Center, a shared EHR would significantly improve communication and the sharing of information between SFGH and UCSF providers and UCSF residents, resulting in better care coordination.
   - For the UCSF Medical School, training residents and performing research may be easier and more cost effective with quick access to client data through a shared EHR.
   - For the San Francisco Health Plan (SFHP), an EHR will result in higher levels of compliance and a higher ranking among health plans.

2. Self-Financing. Of the numerous financing options explored through the HMA engagement, HMA recommended self-financing as a possible sustainable option. This option could improve long term financial performance and operations and would reinforce the cost-conscious culture created by health reform.

   In the long term, self-financing can be achieved through a change in DPH's control over surplus funds. During its engagement, HMA pointed out that when annual surpluses are available to an enterprise organization, they can be used for needed investments in information technology, infrastructure, or other needs. In this arrangement, there is an incentive to find innovative, cost-effective solutions to challenges so that surpluses can be carried over and utilized for long term projects.

   Currently, SFGH is listed as an enterprise fund within the City budget. SFGH and DPH overall are still supported by and reliant on the City's general fund. Conversely, the City can sweep any remaining funds at year-end back to the general fund. Since any surplus monies if they occurred would be returned, the desire to find innovative solutions to operational and reimbursement challenges is muted since there is a lack of incentive to save or increase revenue.

> DPH and the City will need to commit to significant investments in human resources, information technology, and clinic facilities in order to meet the ACA requirements for patient care access and quality improvement, and to achieve financial sustainability.

In sum, the Network and DPH should develop a clear IT strategy and sustainable IT financing plan, which include exploring potential partnerships and engaging the major financial stakeholders of the City.

APPENDIX III: PARTNERSHIPS

ACA Impact on Partnerships

In light of the new healthcare environment which aims to cover more people, improve quality, and rein in costs, partnerships will become all the more important. DPH and the Network must build and strengthen its strategic partnerships and collaborations to increase revenue and manage costs.

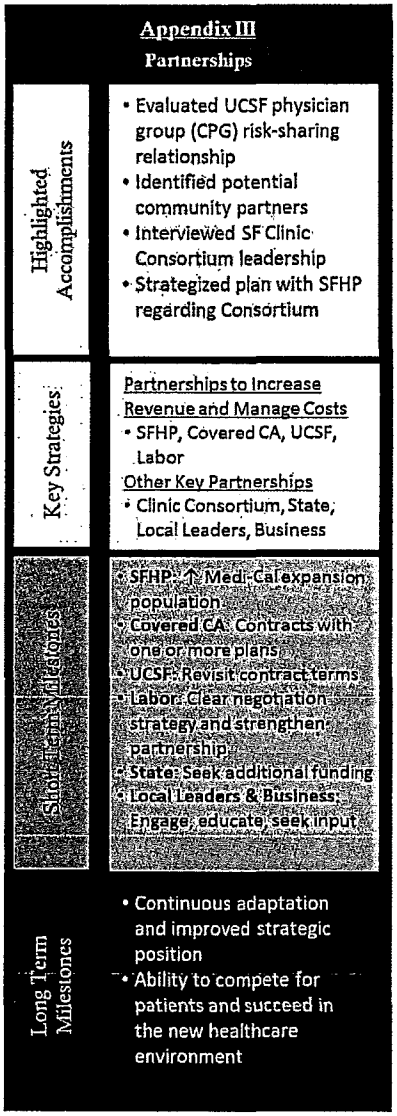
Partnerships to Increase Revenue and Manage Costs

As discussed in Chapter 2, the recent DPH reorganization and development of the San Francisco Health Network (the Network) has established a new Managed Care Office. Although the recruitment of a Managed Care Director is still pending (who would lead much of this work), the HMA engagement identified key partnerships and risk arrangements to help increase revenue and manage costs.

San Francisco Health Plan

With HMA's expertise, the Network worked closely with the San Francisco Health Plan (SFHP)[18] to create a plan to contractually to set up contracts for sharing capitation payments with consortium clinic partners. Moving forward, the Network must next work closely with SFHP to accomplish the following strategies.

1. Medi-Cal Expansion Population Enrollment Strategy. The Network should work with SFHP to continue to reach out to the potential Medi-Cal expansion population.
2. Assess Division of Financial Responsibility. The Network should re-assess the current division of financial responsibilities with SFHP. This is spelled out in a contract exhibit used by health plans and providers to identify payment obligations. By describing all service categories and designating the entity fiscally responsible, the agreement governs the risk arrangement between the organizations.



[18] San Francisco Health Plan: SFHP is a licensed community health plan that provides affordable health care coverage to over 80,000 low and moderate-income families. It is one of the two Medi-Cal plans offered in SF County and also acts as the Healthy San Francisco program's third party administrator.

3. Explore Future Collaborations and Plans. The Network must assess the current services received as part of the four percent administration fee to SFHP for Medi-Cal administration and determine additional mutually beneficial investments and collaborations, such as the investment in an EHR system discussed in Appendix II. SFHP would benefit from a continued close partnership due to the expansive set of services and providers offered through the Network. The Network would also benefit due to the large number of Medi-Cal enrollees and potential Covered CA enrollees (if SFHP decides to become a qualified health plan on the Exchange).

In the future, a successful partnership and enrollment strategy with SFHP will result in an increased share of the Medi-Cal expansion currently underway and its related client revenues.

Covered California Health Plans

As described in the background section and in Chapters 2 and 3, Covered CA currently offers five qualified health plans for San Francisco residents. During the HMA engagement, the Network explored contracting with one of the five plans. As of the end of 2013, the Network still is not currently a provider within any of the qualified health plans. In the medium and long term, the Network should continue to pursue this possibility and Network leadership has committed to doing so through its new Managed Care Office.

University of California, San Francisco

As described in Chapter 3, the Affiliation Agreement with UCSF is a critical partnership to providing the system's quality patient care, but it is also a growing cost that cannot be sustained over the long term, with an increase of more than seven percent alone from FY13 to budgeted FY14 costs. In addition, UCSF physicians possess a significant amount of control over operational efficiency in the Network but HMA found without a clear and structured mechanism for accountability. Thus there is an opportunity for expense control through the successful management of this Agreement.

During its engagement with DPH, HMA recommended the Network re-evaluate, and through negotiations, build a stronger and more strategic collaboration with UCSF via these strategies:

- Reduce SFGH operating costs and make the Network more cost-effective and market competitive
- Encourage UCSF and its faculty to support the goals of the Network through better accountability
- Encourage UCSF to support the DPH operationally and financially (i.e., in the implementation or sharing of an Electronic Health Record (EHR) as described in Appendix II)

An extensive delay in obtaining valid and reliable UCSF physician cost data was a major challenge in HMA's analysis.

To solve this, additional contractual reporting requirements will be added to the UCSF Affiliation Agreement over the next two years.

Through the HMA engagement, DPH has already recommended the use of utilization rates as a strategy to refine and simplify risk-sharing under the capitated contracts between UCSF's Clinical Practice Group (CPG) and SFGH. In the medium term, the Network plans to continue to work with SFHP and UCSF to develop a clear payment methodology and incentive structure for the CPG.

As a result of the HMA engagement and the lack of data necessary for tracking and analysis of UCSF expenses at the hospital and Network level, HMA recommended the following strategies to bring the UCSF Affiliation Agreement in line with more recent affiliation agreements across the country.

- Physician Pay-for-Performance. Physician compensation based on performance metrics is growing across the country and is now more common than not in group practices. At-risk compensation amounts to about 7 percent of physician pay, on average. Public hospitals have been generally slower to adopt "pay for performance" for physicians. Even fewer public hospitals that contract with universities utilize this practice; however, several notable public hospitals have begun such incentive programs and more are considering their implementation, including New York City Health and Hospitals, Minneapolis/Hennepin County, and Denver Health. Common components of compensation goals for physicians include productivity, quality of care, and other institutional goals related to operations and finance.
- Metric Requirements, Risk-Reward Provisions, and Contract Management. In the medium term, additional risk-reward provisions through the use of metrics should be explored, as well as closer contract monitoring and management.
- Restructuring for Accountability. In the long term, a re-assessment and potential restructuring of the Agreement to ensure a clear mechanism for accountability.
- Benchmarking Assessment. In the short term, additional benchmarking of affiliation agreements between hospitals and academic institutions is needed to inform the types of reporting requirements for the Agreement.

Labor

In health care markets, employee organizations and their agreements with health provider organizations significantly impact the cost of doing business. The City values its employees as the most important asset in providing quality health care to its residents. However, according to HMA many of the Network's private and non-profit competitors, as well as other public health systems across the country, have the ability to change faster than in San Francisco. To meet the goal of adapting to the new environment, therefore, DPH and the City must identify and effectively strategize for the outcomes most important to the Network's success in its labor agreements.

During the HMA engagement and during DPH's roll-out of the new Network, DPH leadership reached out to its employee organizations regarding the updated changes. DPH and the Network have committed to continue this outreach and partnership, which will be crucial to facing the health care changes together and making the Network and the greater health system viable into the future.

During the HMA engagement, some benchmarking data on staffing and volumes was gathered, as available. This will help the Network assess staffing needs (supply) versus volume (demand), as described in Appendix II. SFGH has committed by the end of FY14 to begin to supply data to a shared database sponsored by the University Healthcare Consortium and will have the ability to receive benchmark staffing and volume data from peer hospitals. An additional product is still pending from HMA regarding budgeting and staffing for the new building at SFGH. This improved information, combined with planned collection of Network performance metrics, will aid in developing a clear strategy and attaining a strengthened relationship with the Network's labor partners.

Other Key Partnerships

Clinic Consortium

The San Francisco Clinic Consortium is a group of community-based, non-profit health clinics, inclusive of a select number of the Network's community clinics. During the HMA engagement, DPH interviewed and informed Clinic Consortium leadership to discuss and share the new Network's strategy. In the medium and long term, the Network and its Ambulatory Care leadership need to continue to engage the Clinic Consortium, assessing this partnership and the associated opportunities and risks.

State of California

As discussed in Chapter 3, it is essential that the Network maintain a positive working relationship with the state, pursuing opportunities for improved reimbursement and new programs. The state will remain a critical, ongoing source of funding in the new environment, playing a central role in key revenues such as Medi-Cal rates and Realignment funding. Please refer to Chapter 3 for specific initiatives and strategies.

Local Leaders and Decision Makers

The City and County of San Francisco's departments, the Board of Supervisors, the Health Commission, and the Mayor's Office have historically provided strong financial support for the DPH mission. In the short term, DPH must educate local leaders and decision makers on the impact of health reform on DPH and the entire health care system in the city. DPH leadership in conjunction with the Health Commission has committed to look to target support to the areas that will have the most profound and positive impact on the health system's operational and fiscal future.

Business Community

As a key provider of health care coverage, the business community is a key stakeholder that DPH must continue to have an open dialogue and partnership with for ACA to succeed in San Francisco.

The Mayor's Universal Healthcare Council (UHC), a diverse group of public, business, health and education stakeholders, was re-convened in 2013 to identify and assess issues resulting from the intersection of the ACA and the City's Health Care Security Ordinance (HCSO). The 41-member UHC was co-chaired by Director Barbara Garcia and Dr. Sandra Hernandez, former CEO of The San Francisco Foundation. The data-driven process did not seek consensus from all members, but did examine San Francisco's implementation of the federal ACA and provided a summary report with collected recommendations from the group.

As health reform and its impact on the business and labor communities unfold over the next few years, DPH and the City must remain engaged in the issues and challenges that arise. Additional information regarding the UHC can be found at http://www.sfdph.org/dph/comupg/knowlcol/uhc/default.asp.

Print Form

Introduction Form

By a Member of the Board of Supervisors or the Mayor

Time stamp
or meeting date

I hereby submit the following item for introduction (select only one):

☒ 1. For reference to Committee. (An Ordinance, Resolution, Motion, or Charter Amendment)

☐ 2. Request for next printed agenda Without Reference to Committee.

☐ 3. Request for hearing on a subject matter at Committee.

☐ 4. Request for letter beginning "Supervisor [ ] inquires"

☐ 5. City Attorney request.

☐ 6. Call File No. [ ] from Committee.

☐ 7. Budget Analyst request (attach written motion).

☐ 8. Substitute Legislation File No. [ ]

☐ 9. Reactivate File No. [ ]

☐ 10. Question(s) submitted for Mayoral Appearance before the BOS on [ ]

Please check the appropriate boxes. The proposed legislation should be forwarded to the following:

☐ Small Business Commission ☐ Youth Commission ☐ Ethics Commission

☐ Planning Commission ☐ Building Inspection Commission

Note: For the Imperative Agenda (a resolution not on the printed agenda), use a Imperative Form.

Sponsor(s):

Supervisor Mark Farrell; Supervisor David Chiu, Supervisor David Campos

Subject:

Administrative Code - Department of Public Health Managed Care Contracts

The text is listed below or attached:

Attached.

Signature of Sponsoring Supervisor: _____

For Clerk's Use Only: