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To: LeAnn Monfredini, President and
Members of the San Francisco Health Commission

Through: Mitchell Katz, M.D.
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From: Gregg Sass
Chief Financial Officer

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Re: Health Access Program Proposed 2007-08 Budget and Project Update

Date: May 1, 2007

This memorandum provides the proposed 2007-08 Health Access Program (HAP) and a project update.

Proposed 2007-08 Budget -- Incremental HAP Expenditures
On March 30, 2007, DPH received notice that it had been awarded funding under the Health Care Coverage Initiative (HCCI). HCCI is funded by the federal government via a State pass-through. Funding is part of California's five-year Section 1115 Medi-Cal Hospital/ Uninsured Care Demonstration. The HCCI award provides funding for both services and administrative costs for a three-year period beginning September 1, 2007 and terminating August 31, 2010.

The City and County of San Francisco applied for funding to support HAP participants receiving services within the public sector safety net. Specifically is supports approximately 16,000 HAP participants a year over the three year period. San Francisco's services funding totals $73.12 million (or $24.37 million a year) and allowable administrative funding totals $5.66 million over the three-year period (administrative funding also covers the planning period prior to program implementation). Services and administrative funding under HCCI are provided to the Department based on a claiming mechanism. Specifically, DPH incurs and documents health services and administrative expenditures that are subsequently reimbursed at 50% of costs. Therefore, to receive $73.12 million in services funding, DPH must document that it has incurred $146.24 million in expenses.

While DPH has received its HCCI award letter from the State Department of Health Services, the notification provides only the services allocation and does not provide the administrative cost allocation. Confirmation of the administrative funding level will come at a later date. As a result, DPH chose to be prudent and did not include any HCCI administrative funding in the proposed 2007-08 HAP revenue budget at this time.

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In 2007-08, the Department anticipates that the HCCI will provide revenue of $18.28 million (time period September 2007 – June 2007 with an assumption that 90% of allowable services funding will be received given that this is the first year of this State initiative). The HAP budget is comprised of City and County General Fund, State Health Realignment, Health Care Coverage Initiative dollars, fees from participants and any contributions from employers that elect to participate in the HAP. The HCCI funds are in addition to the funding that is currently used to provide health services to uninsured persons. Combined, these revenues will enable the Department to expand clinical services, enhance registration, information systems and other systems to better serve uninsured persons. As a result, the figures below represent the incremental increase in HAP expenditures tied to HCCI funding for 2007-08; they do not represent the entire HAP budget for 2007-08.

The incremental budget increases are as follows:

Health Access Program -- Proposed 2007-08 Incremental Cost Increases
(in millions of dollars)

Clinical Expansions	
DPH Primary Care Clinic Hours	3.1
Hospital Services (Ancillary/Diagnostic, Inpatient, Specialty)	4.4
Pharmacy Services	1.5
Behavioral Health Services	2.2
Other (Video Medical Interpretation, Clinical IS)	0.5
Clinical Expansions Sub-Total	11.7
Delivery System Innovations	
General Medicine Clinic Redesign	0.7
Family Medicine Clinic Redesign	0.8
Delivery System Innovations Sub-Total	1.5
Patient Access	
Eligibility and Registration	1.2
Centralized Access to Services	0.3
Private Providers	3.2
Patient Access Sub-Total	4.7
Administration	
San Francisco Health Plan	4.2
Information Systems	0.7
General Administration	0.1
Administration Sub-Total	5.0
ALL COST CATEGORIES	**23.0**

Detailed information on each cost category can be obtained in Attachment A. The proposed budget factors in an additional 20,000 primary care medical homes with 7,000 new medical homes within DPH and 13,000 medical homes with private providers (2,000 with participating health plans and 11,000 with participating San Francisco Community Clinic Consortium clinics). The 13,000 medical homes with private providers are for both new and existing clients.

In reviewing the budget detail with respect to the number of people served in a clinical setting, it is important to note that the figures are not the same in each expansion area. For example, if

the budget stated that an additional 10,000 new primary care medical homes were being developed for 10,000 new individuals, this would not necessarily result in 10,000 additional inpatient stays, 10,000 specialty visits, 10,000 mental health consultations, etc. A subset of the population will need services beyond the primary care setting. The budget and utilization estimates take this into account. In addition, it is important to remember that clinical expansions within a setting will benefit not only new persons entering the delivery system, but also existing patient populations irrespective of their payor source. For example, improvements in the redesign of a clinic will benefit all patients using that clinic and the overall clinic system, not just uninsured patients using the clinic. As a result, the number of people that can be served or additional visits provided may be greater than the number of new persons seen in the system. Finally, in some cases, DPH provides services to not only those within its system, but to those who have primary care homes in other delivery systems (e.g., San Francisco Community Clinic Consortium) and number of persons served attempts to take this account.

The following is designed to clarify information on the number of persons served:

- Primary Care (Clinic Expansion within DPH and Private Providers) – Of the 20,000 primary care medical homes allocated in the budget, at least 9,000 are for new individuals (DPH and private providers who serve health plans). The budget assumes that the remaining 11,000 individuals will have primary care medical homes with San Francisco Community Clinic Consortium member clinics. At this time, the exact distribution of these 11,000 individuals between new and existing clientele cannot be determined – the budget assumes 30% new /70% existing. Of the private providers, the budget assumes that those serving as health plans would accept capitation for the full range of health services provided and those functioning as health centers/clinics would accept capitation for primary care services.

- Hospital Services (i.e., ancillary/diagnostic, inpatient and specialty) -- Factors in increased utilization from new clients within DPH and SFCCC member clinics (new and existing) for a total of 18,000 (of which 10,000 are estimated to be new). The budget assumes that private providers who are health plans will ensure provision of hospital-based services within a capitated rate. In the area of ancillary and diagnostic services, the budget assumes providing this service to 65% of 10,000 new individuals (or 6,500). An additional 1,100 inpatient days are budgeted. Specialty access improvement is tracked via a reduction in appointment wait times.

- Pharmacy Services – Services to 10,000 new individuals (DPH and SFCCC).

- Behavioral Health – Assumes that behavioral health services are delivery via the Department's Community Behavioral Health Services division. Budget anticipates that a fewer than 3,000 new persons will need mental health or substance abuse services.

- Delivery System Redesign (Family Health Clinic and General Medicine Clinic) – Anticipates expanded capacity to serve chronic care patients (both new and existing within DPH and referrals from SFCCC). Total patient encounters will increase by 21,000. Improvements in delivery system redesign will facilitate access to entire patient population, not just HAP participants.

The Department has identified revenue of $23 million to cover the increased $23 million in costs. This is in keeping with the Department's previous statements that ongoing expenses of HAP would be budget neutral. Below is a summary of the projected revenue:

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Revenue Category	Total Amount
Health Care Coverage Initiative Funds	$18.28 million
Participation Fees (individuals and employers)	$4.75 million
Point of Service Fees (DPH only)	$0.05 million
Estimated New Revenues	$23.09 million

Project Update
The Health Access Program (HAP) is being designed to address some of the critical problems inherent in the current safety net delivery system (e.g., fragmentation, duplicative eligibility screening and enrollment processes, insufficient emphasis on efficiency and customer service, inability to document and track utilization and to improve quality). DPH is working towards a common vision whereby the existing health care safety net (public and non-profit) is restructured to function as a coordinated whole, enabling uninsured residents to have knowledge of and improved access to comprehensive services and delivery of care in clinical and community settings appropriate to their health needs. Under such a vision, the health care safety net system focuses on primary care and prevention and functions in an integrated manner by adopting a common eligibility and enrollment system, and by virtue of incorporating providers in an all-inclusive network. Providers have access to health data and information that facilitate the monitoring, evaluation and improvement of health care utilization and quality of care. To ensure financial sustainability, the system optimizes financial resources from all available payor sources.

Since the January 30, 2007 update to the Health Commission, the Department of Public Health (DPH) has worked collaborative with the San Francisco Health Plan (SFHP), the Health Access Program Advisory Committee, the Office of Labor Standards and Enforcement and other key stakeholders to develop the HAP. As noted previously, implementation of HAP involves addressing policy, program, finance, operational and technical issues. The project is now entering the operational phase having outlined many of the critical program design issues. As the project proceeds to the operating phase, DPH recognizes that unknown policy or program issues may surface and has developed a process and structure to address these issues.

From the outset, the DPH has stressed to need to phase-in HAP. Phasing is required to ensure that the project is implemented successfully. It enables DPH to address any needed modifications before the program is expanded to a wider population. In addition to populations being phased-in, program components will also be phased-in. As a result, it is important to recognize that all aspects of the program will not be operational on July 1, 2007. DPH and SFHP are taking a critical look at the comprehensive set of functions and program features and will work to ensure that all necessary program features are in place when the program has is launched.

The following provides an update on major activities within the project:

Program Name
A new name has been developed for HAP:
<div align="center">

Healthy San Francisco
Our Health Access Program

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The rationale for the name change is based on the following:
1. Confusion with existing San Francisco Health Plan Identity

2. "Health Access Program" name already used by the State
3. Importance of consumer/public appeal of name

The new name, along with graphic logos, was presented to the Health Access Program Advisory Committee, the SFHP Member Advisory Committee and the Ocean Park Health Center Advisory Board for consideration and input. To maintain a link to the project and all the work that has been done to date, *Our Health Access Program* will be used as the program tag line.

Eligible participants will become members of Healthy San Francisco (HSF).

Planning Structure
DPH/SFHP have created an cross-agency committee to address all policy decisions related to the development and implementation of the program and to ensure that sufficient resources (i.e., time, funding, staff) are allocated to the implementation. Key committee objectives (not listed in priority order) include, but are not limited to:
- clarifying current delivery systems issues that HSF is intended to resolve,
- coming to consensus on the vision and design of HSF,
- finalizing the functional responsibilities of DPH, SFHP, providers and others critical to the successful implementation of HSF,
- empowering staff to develop design and operational work plans tied to the vision of the program,
- approving a common glossary of key terms and communications plan for all staff involved in the HSF.

The overall vision, policies and key decisions will be communicated to internal staff, governing bodies (San Francisco Health Commission and San Francisco Health Plan Governing Board), elected officials (Mayor's Office and Board of Supervisors), advisory bodies (Health Access Program Advisory Committee), other City and County agencies and the general public. The overall planning structure is described in Attachment C.

HSF Implementation Timeline
The following are critical dates in the implementation of the HSF:
July 2007
- HSF will be phased-in incrementally. HSF will "debut" on July 2, 2007 at Chinatown Public Health Center for a two-month period – during the months of July and August 2007.
- Because HSF is in "debut-phase" during this period, neither DPH nor SFHP will market and actively solicit participation in the program.

September 2007
A broader roll-out of HSF will take place with point-of-service enrollment. The following individuals would be eligibilized for HAP:
- Current and new DPH clients
- Current and new SFCCC Clients (timeframe may vary from this date depending upon the private provider network discussions and negotiations)

January 2008
Employer Spending Requirement goes into effective for employers with 50 or more employees on January 1, 2008. DPH anticipates any potential HSF enrollment from this sector to occur after this date.

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Enrollment Phase-In

A joint DPH/SFHP Population Phase-In Strategy Committee developed enrollment projections after deriving uptake rates (see Attachment B). Monthly enrollment projections are based on the time period July 2007 to November 2008 with an average enrollment of 4,300 per month over this period. The analysis segmented the HAP participant population into the following broad categories:

1) DPH sliding scale participants (those transitioned from the Sliding Scale Program to HSF),
2) uninsured San Francisco Community Clinic Consortium (SFCCC) patients at participating sites and
3) new participants/patients (those who are new to both the SFCCC and DPH safety net systems and new employer-sponsored participants via the Employer Spending Requirement).

Cumulative monthly participation figures assumed that 10% of HSF participants will elect not to re-enroll on the anniversary of their initial enrollment month.

By August 2008, a year after the launch of HAP enrollment at DPH and participating SFCCC sites, 66% (54,000) of the estimated 82,000 uninsured eligible for participation will be enrolled in HAP. Historical DPH Sliding Scale enrollment figures, OSHPD data on uninsured SFCCC patients, and uptake rates for other public programs informed the Committee's projections.

DPH will balance its need to develop realistic and attainable enrollment projections with its need to fulfill its enrollment and/or services expenditures requirements to receive HCCI funding.

Communications, Outreach and Marketing

DPH continues to do general outreach on HSF; this includes making community presentations and meeting with interested parties. With respect to (insert from March 23rd HAP Advisory memo). A DPH/SFHP committee was formed to oversee these activities. With respect to program enrollment, the Committee recognizes that marketing and outreach can have a significant impact on the number of HAP participants who enroll in the program. The Committee further recognizes that general outreach can create a demand for the program absent active marketing for enrollment and participation. The committee recommends the following marketing outreach approach:

- July 2008: Given that July to August 2007 is a "debut" period, DPH recommends that public/ media communication of debut be limited and announce the initial phase-in of HSF.
- September 1, 2007: A broader marketing, communications and outreach strategy is developed tied to the expansion of HSF to other primary care clinical settings.

Provider Network

HSF is a city-wide effort and therefore its provider network should be broader than DPH (e.g., community clinics, private providers, non-profit hospitals). DPH strongly believes that having a comprehensive network of safety net providers will improve access to care reduce barriers to access. Non-DPH provider interest in participating in HSF will be based on reimbursement rates, method of reimbursement and risk (i.e., expected utilization compared with adequacy of reimbursement). The HSF private provider network has not been finalized and it is being developed by SFHP. DPH has provided SFHP with the context (i.e., programmatic, financial and policy guidelines) for entering into discussions and negotiations with potential private providers. This is important to note because the CCSF and not SFHP is the payor of any service provided under HAP. As stated previously, CCSF is the payor of last resort for HSF and SFHP will not be at financial risk for services provided.

One-E-App

One-e-App (OEA) is a key feature of Healthy San Francisco; specifically, in San Francisco OEA will:

1. screen eligibility for Medi-Cal, Healthy Families Program, Healthy Kids & Young Adults, and Childrens' Health and Disability Program,
2. determine eligibility and enroll eligible persons into HSF and
3. serve as the system of record (or enrollment database) for the HSF.

Eligibility determination and/or enrollment will be facilitated by a certified application assistor who has been trained in both OEA and Health-e-App (web-based system for coverage programs for children and pregnant women).

It is important to note that OEA will not enroll eligible persons into any of the programs listed in number one above. It will only determine whether the person is eligible. The following will occur for anyone who is determined eligible for any of the programs:

- Medi-Cal (children or pregnant women) and Healthy Families Program (children): The certified application assistor will log eligibility information from OEA into Health-e-App. From that point, the information is gathered and sent to the State's Single Point of Entry system which coordinates enrollment for these two programs. The State will provide the applicant with confirmation of Healthy Families program enrollment via mail in conjunction with member program information and materials. The County Medi-Cal Office (HSA) will provide Medi-Cal applicants of confirmation of enrollment via mail.
- Childrens' Health and Disability Program: Serves as the gateway for uninsured children to temporary Medi-Cal or Healthy Families Program enrollment through an automated pre-enrollment process. The certified applicant assistor submits a CHDP application online via the CHDP gateway and receives confirmation of temporary CHDP eligibility.
- Medi-Cal (adult): The person is referred to the Human Services Agency Medi-Cal Program for enrollment. If person presents at DPH, then efforts are made to arrange a Medi-Cal eligibility appointment for the person on the same day.
- Healthy Kids & Young Adults: The person is informed of their eligibility and instructed to submit their enrollment fee to the San Francisco Health Plan to finalize their enrollment. The San Francisco Health Plan will confirm enrollment and send member program participation information.

To ensure that OEA is launched successfully, a project team has been assembled with eligibility, program and information technology staff from DPH and SFHP. The OEA vendor also participates in these meetings. DPH will involve the SFCCC in this process as the project moves forward. Implementing OEA is a complex project given all of the various interfaces that are needed. The projected project start date is May 1, 2007 with a September 1, 2007 OEA "go live" date. Initially, OEA will be available in clinical settings. In year two of the project the goal is to expand OEA to certified application assistors in community settings. At this time, the Human Services Agency's participation in OEA has focused on using this web-based tool to identify potential individuals and families eligible for, but not participating in the USDA Foods Stamps Program.

As part of its consultant engagement with The Lewin Group, DPH asked the firm to provide a qualitative analysis on the benefits of OEA based on the experience of counties that have implemented the system. A more quantitative return on investment analysis could not be undertaken because few of the counties that have implemented OEA have done similar analyses. Lewin identified primary benefits, challenges, and limitations of One-e-App based on

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interviews with One-e-App counties. Overall, counties were very pleased with One-e-App, despite some challenges experienced (generally in implementation). Lewin's findings were:

Category	Findings
Benefits Of One-e-App	• Improved eligibility flow process for users • Smoother enrollment process for applicants; one-stop shopping effective • Increased administrative efficiency • Increased enrollment • Improved reporting capacity • Data and documentation stored centrally • Increased collaboration among county agencies and organizations • Highly invested vendor (Center to Promote Healthcare Access)
Challenges Of One-e-App	• Process change for users requires time and extensive training • Some "bugs" may need to be worked out during implementation • Updates are needed to keep up with eligibility and other policy changes
Limitations	• Dispositions for Healthy Families and Medi-Cal are not automatically recorded in One-e-App due to policy issues with the State, but these can be manually entered by users on an ongoing basis • Barriers to enrollment may still exist, such as compliance with documentation requirements • Enrollment increases in State-funded programs may be limited by other eligibility factors such as citizenship status

Based on preliminary findings, Lewin offered the following OEA implementation recommendations:
- create/foster partnerships (San Francisco is doing),
- visit multiple counties (San Francisco has done and will continue to do),
- visit potential user sites and conduct a "needs assessment," (San Francisco will do)
- focus on user training and review ongoing training needs (San Francisco is doing),
- implement new programs concurrently (San Francisco is doing),
- document the implementation process (San Francisco is doing) and
- review ongoing training needs (San Francisco will do).

Contingency Planning
To date, a contingency proposal has been developed if the eligibility enrolment and premium billing systems are up and operational. This proposal was outlined as part of the HSF design development process by the Eligibility Rules and Enrollment Workgroup. Specifically the workgroup recommended the following:

Systems	Enrollment Strategy
1. Central Eligibility Unit operational 2. OEA operational 3. Premium Billing System not operational	Transition only the Sliding Scale patients with incomes between 0% to 100% FPL to the HAP program and continue to offer the Sliding Scale program to patients above 100% FPL
1. Central Eligibility Unit operational 2. OEA not operational 3. Premium Billing System not operational	Limit HAP enrollment to selected clinics DPH clinics and continue to parallel the Sliding Scale Program to cover indigent patients seen at other non-HAP selected CHN clinics

In addition to the contingency proposal in this area, DPH and SFHP will determine the need to develop additional contingency plans via its joint committee structure.

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The Lewin Group Consulting Engagement

Since February 2007, The Lewin Group has been working with DPH on various programmatic aspects of the HAP. Specifically, the consultation is to support DPH in efficiently and effectively implementing HAP through timely analysis and recommendations. The engagement is part of a larger municipal healthcare assessment project overseen by the City Controller's Office. In addition to the qualitative analysis with respect to One-e-App, Lewin has provided its recommendations on the phase-in strategy. It proposed phasing in HSF by starting at one DPH clinic (either Curry Senior Center or Silver Avenue Health Center). This approach was similar to the recommendation made by the DPH/SFHP internal planning committee. The internal committee recommended Chinatown Public Health Center. Lewin is currently in the process of completing a demand and capacity analysis. DPH anticipates that all aspects of this engagement will be completed by June/July 2007.

Health Care Coverage Initiative

DPH is awaiting information from the State regarding the HCCI claiming mechanism and evaluation/reporting requirements. DPH is participating in an informal work group comprised of all HCCI awardees to collaborate on common issues and leverage our collective strength in working with the State.

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