SAN FRANCISCO HEALTH PLAN
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Joint Meeting of the San Francisco Health Authority (SFHA)
and the San Francisco Community Health Authority (SFCHA)

Governing Board Agenda
Wednesday, November 4, 2020 12 pm-2 pm

- CHANNEL NAME: ***Governing Board Team*** > ***Open Session Meetings*** *channel*
- TIME: **12pm to 2pm**
- LINK: Click here to join the Governing Board meeting

SPECIAL NOTICE: Coronavirus COVID-19

Due to the COVID-19 public health emergency and in accordance with Governor Newsom's Executive Order N-29-20, San Francisco Health Authority (SFHA) and San Francisco Community Health Authority (SFCHA) Governing Board Members will be attending this meeting via video conference. The meeting will be closed to in-person public attendance. This precaution is being taken to protect members of the Governing Board, staff and the public. All of the Board members will attend the meeting by video conference and will participate in the meeting to the same extent as if they were present.

Members of the Governing Board and public may connect to the meeting with the following links:

- TIME: **12pm to 2pm**
- LINK: Click here to join the Governing Board meeting
- CHANNEL NAME: ***Governing Board Team*** > ***Open Session Meetings*** *channel*

**********OPEN SESSION **********

Public Comment on any matters within SFHA/SFCHA purview

1. (V) Approval of Consent Calendar
   a. Minutes from September 2, 2020 Meeting
   b. Quality Improvement Committee (QIC) Minutes
   c. Appointments to QIC
   d. Credentialing and Recredentialing Recommendations
   e. Update to FY 20-21 Organizational Goals
   f. Payment of CalPERS Unfunded Liability
2. (V) Review and Approval of the Annual Independent Auditor's Report for FY 2019-20 (Chris Pritchard and Rianne Suico, Moss Adams, LLP)

3. (V) Review and Approval of Unaudited Monthly Financial Statements and Investment Reports (Skip Bishop and Rand Takeuchi)

4. (D) Federal and State Updates (Sumi Sousa)

5. (D) Member Advisory Committee Report (Maria Luz Torre & Irene Conway)

6. Chief Medical Officer's Report (Jim Glauber, MD, MPH)

   (D) a. HEDIS and CAHPS Results Report (Jim Glauber, MD, MPH and Amy Petersen, MPH)

7. (D) CEO Report (John F. Grgurina, Jr.) - Highlighted Items – SFHP Department Updates, SFCCC Personal Protective Equipment grants and distribution, Compliance Report

**********CLOSED SESSION **********

8. (D) Discussion of the Chinese Community Health Care Association (CCHCA) Managed Services Organization Change from North East Medical Services to In-House within CCHCA (Kaliki Kantheti and Nina Maruyama)

   Pursuant to Welfare and Institutions Code Section 14087.36(x)

**********OPEN SESSION **********

9. (D) Chair's Report on Closed Session Items (Chair, Steve Fugaro, MD)

10. Adjourn

The San Francisco Health Authority and San Francisco Community Health Authority will meet concurrently.

(V) Denotes an Action Item Requiring A Vote (D) Denotes A Discussion Item

Next meeting: January 6, 2021
12:00 pm to 2:00 pm

Please Note These Upcoming SFHA/SFCHA Meetings:

- Member Advisory Committee: November 13, 2020 (1:00 pm-3:00 pm)
- Quality Improvement Committee: December 10, 2020 (7:30 am-9:00 am)
- Member Advisory Committee: December 11, 2020 (1:00 pm-3:00 pm)
- Finance Committee: January 6, 2021 (11:00 am-12:00 pm)
- Governing Board: January 6, 2021 (12:00 pm-2:00 pm)

Public Comment:
Please note that members of the public will be allowed to make public comments. If a person wishes to make a public comment during the meeting, they may either 1) use Microsoft Teams and will have the option to notify San Francisco Health Plan (SFHP) staff by alerting them via the "Chat" function or they can 2) contact SFHP staff via email at vhuggins@sfhp.org, in which staff would read the comment aloud during the public comment period. Public comments will be limited to two (2) minutes per comment.

If you plan to attend, please contact Valerie Huggins at (415) 615-4235.

If you plan to attend and need to request disability-related modification or accommodation, including auxiliary aids or services, in order to participate in the public meeting, please contact Valerie Huggins at (415) 615-4235.

Agenda Item 1

Action Item

Approval of Consent Calendar:

a. Minutes from September 2, 2020 Meeting
b. Quality Improvement Committee (QIC) Minutes
c. QIC Appointments
d. Credentialing and Recredentialing Recommendations
e. Update to FY 20-21 Organizational Goals
f. Payment of CalPERS Unfunded Liability

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119

MEMO

Date: October 27, 2020

To	**SFHP Governing Board**
From	**John F. Grgurina, Jr.**
Regarding	**Consent Calendar Items for Approval**

Consent Calendar
All matters listed hereunder constitute a Consent Calendar and are considered to be routine by the Governing Board of the San Francisco Health Authority and San Francisco Community Health Authority Board and will be acted upon by a single vote of the Board. There will be no separate discussion of these items unless a member of the Board so requests, in which event the matter shall be removed from the Consent Calendar and considered as a separate item.

Item 1a. Recommendation to Approve Board Minutes
It is recommended that the Governing Board approve the minutes from the Governing Board meeting held on September 2, 2020. The minutes are attached for review.

Item 1b. Recommendation of the Quality Improvement Committee (QIC) Minutes
It is recommended that the Governing Board approve the attached minutes from the August 2020 QIC meeting, as approved and recommended by the QIC.

Item 1c. QIC Appointments
It is recommended that the Governing Board approve the nominations of two appointments, Dr. Claire Horton and Dr. Thomas Kravis, to the QIC as recommended and approved by the QIC.

Item 1d. Recommendation of Credentialed and Recredentialed Providers
It is recommended that the Governing Board approve the attached list of providers that have been approved and recommended by the Physician Advisory and Peer Review Committee.

Item 1e. Review and Approval of the Organization Score for the Board-Approved FY 20-21 Organizational Goals
It is recommended that the Governing Board approve one update to the organizational performance goals and success criteria for fiscal year 2020-2021 (FY 20-21) to define the metric for Goal 3.2 to increase telehealth utilization by 25% as the stretch goal.

Item 1f. Review and Approval of Payment of CalPERS Unfunded Liability

It is recommended that the Governing Board approve to pay the entire projected amount of SFHP's CalPERS pension unfunded accrued liability estimated to be $478,512, which is projected forward to June 30, 2021. The projected unfunded accrued liability as of June 30, 2021 is as follows:

• Classic Miscellaneous Plan	$ 349,346
• PEPRA Miscellaneous Plan	$ 129,166
Total unfunded accrued liability	$ 478,512

Agenda Item 1

Action Item

Approval of Consent Calendar:

a. Minutes from
   September 2, 2020 Meeting

Joint San Francisco Health Authority/San Francisco Community Health Authority
Governing Board
September 2, 2020
Meeting Minutes

Chair:	Steven Fugaro, MD
Vice-Chair:	Roland Pickens
Secretary-Treasurer:	Reece Fawley

Members Present: Dale Butler, Edwin Batongbacal, Eddie Chan, PharmD, Lawrence Cheung, MD, Irene Conway, Steve Fields, Steven Fugaro, MD, Sabra Matovsky, Maria Luz Torre, Emily Webb, David Woods, PharmD, and Jian Zhang, DNP, MS, FNP-BC

Members Absent: Reece Fawley, Roland Pickens, MHA, FACHE, and Greg Wagner

Due to the ongoing COVID-19 public health emergency and in accordance with Governor Newsom's Executive Order N-29-20, San Francisco Health Authority and San Francisco Community Health Authority Governing Board Members attended this meeting via teleconference. The meeting was closed to in-person public attendance, but the conference line information was provided on the publicly-posted agenda. This precaution was taken to protect members of the Governing Board, staff and the public. All of the Board members, staff and public attended the meeting telephonically.

Nina Maruyama, Officer, Compliance and Regulatory Affairs, took the roll call of the Board members and San Francisco Health Plan (SFHP) staff and provided a quick demonstration for raising hands to vote using the Microsoft Teams video conference tool.

Steven Fugaro, MD, Chair, called the meeting to order. He asked if there was anyone from the public in attendance and if there were any public comments. In attendance from the public was Eunice Majam-Simpson, DSR Health Law, the law firm for SFHP. There were no public comments.

John F. Grgurina, Jr., CEO, announced a few Board members promotions. Emily Webb was promoted to Vice President, External Affairs at Sutter Health, and Greg Wagner was promoted to Chief Operations Officer at the Department of Public Health.
Mr. Grgurina also highlighted Jian Zhan, DNP, MS, FNP-BC, Board member and CEO, Chinese Hospital, was featured on the PBS NewsHour show for the successful efforts to control COVID-19 in San Francisco's Chinatown District.

1. Approval of Consent Calendar

The following Board items were on the consent calendar for the Board's approval:

a. Minutes from June 10, 2020 Governing Board Meeting
b. Quality Improvement Committee (QIC) Minutes
c. Appointment of Member to the QIC
d. Credentialing and Recredentialing of Practitioners and Ancillary Providers
e. Review and Approval of the Organization Score for the Board-Approved FY 19-20 Organizational Goals and No Cash Bonus Payments to SFHP Employees for FY 19-20
f. Review and Approval of Staff Salary Ranges and no Merit Increase for FY 20-21

The Board unanimously approved the consent calendar without any issues.

2. Federal and State Legislative and Budget Updates

Sumi Sousa**,** Officer, Policy Development and Coverage Programs, provided the Board with the following updates. (Detailed PowerPoint was provided in the Board packet.)

Ms. Sousa started with a comprehensive federal update. She stated that negotiations on the additional COVID-19 relief bill were still at an impasse. She also reported that President Trump signed the following four executive orders:

- Delay on payroll tax collection for those making less than $104,000 until December 31, 2020.
- Replaces $600 supplemental unemployment insurance (UI) payment with $300 supplemental payment using Federal Emergency Management Agency (FEMA) disaster funds; currently subject to litigation.
- Defers federal student loan payments and waives interest until December 31, 2020.
- Directs Health and Human Services and Center for Disease Control to consider whether an eviction ban is needed; Treasury and Housing and Urban Development to determine whether funds are available.

She stated that the highest priority for California, however, is another federal relief bill with state funds.

Ms. Sousa than provided an update on the California budget which is heavily impacted by potential federal funding. California faces $11 billion in reductions or deferrals depending on whether CA receives $14 billion in federal funding by October 15th. Education at all levels are particularly impacted. Medi-Cal, however, is spared from these federal "trigger" cuts. However, if California's revenues remain below expenditures, California will automatically suspend the

Proposition 56 enhanced provider payments and Medi-Cal optional benefits in FY 21-22.

Ms. Sousa then reviewed the impact of COVID-19 on the national election and health care policy. Health care was key issue in the 2018 election and will be the focus of November election strategy as well. She stated that COVID-19 has brought focus and attention to multiple health care systemic failures and opportunities for reform. The unprecedented unemployment levels/income loss and loss of employer coverage has increased support for Medicaid, Exchanges and broader health reform efforts. These issues will not only impact the upcoming election but will also be the subject of future legislation and regulation, impacting SFHP, our providers and members.

Ms. Sousa discussed the Affordable Care Act (ACA) case, Texas vs CA, still pending review by the U.S. Supreme Court. Oral arguments are scheduled for the week after the election on November 3rd. This case could strike down the entirety of the ACA. If struck down, the ruling could impact over 20 million Americans. If struck down, a major Congressional effort and debate to reinstate ACA is expected.

Ms. Sousa also provided updates on two key changes in State leadership. Dr. Sonia Angell resigned as the California Public Health Officer in August and Dr. Erica Pan, former Director of Public Health for Alameda County, is now the interim Public Health Officer. Sandra Shewry, former Director of the DHCS, and recently with the California Health Care Foundation, is interim Director, Public Health. Lastly, Ms. Sousa stated that the two-year legislative session is wrapping up and the focus on COVID-19 and its impact on the State's budget will continue in the next legislative session.

3. Review and Approval of Year-End 2019-20 Unaudited Financial Statements and Investment Reports

Recommendation: Review and Approval of Year-End 2019-20 Unaudited Financial Statements and Investment Reports.

Skip Bishop, CFO, and Rand Takeuchi, Director, Accounting, reviewed the financial statements for the period ending June 30, 2020. Mr. Bishop discussed the following highlights:

1. June 2020 reported a loss of ($8,166,000) versus a budgeted loss of ($864,000). After removing Strategic Use of Reserves (SUR) activity, the actual loss from operations would be ($7,888,000) versus a budgeted loss of ($586,000).

   In the month of June, SFHP recorded a $6.0 million decrease in revenue due to the impact of the 1.5% Medi-Cal rate reduction that was implemented by the Department of Health Care Services (DHCS) retroactive to July 1, 2019. DHCS took this rate action in response to the COVID-19 pandemic that has significantly impaired the state budget. The $6.0 million revenue loss covers

the period of July 2019 through June 2020. The 1.5% rate reduction also applies to the period from July 1, 2020 through December 31, 2020. The impact is estimated to be $3.3 million and has been built in to the FY 20-21 budget.

The month of June also includes additional claims accruals needed to maintain adequate reserves for Incurred But Not Reported (IBNR) claims as required by our auditors, Moss Adams. In addition, June administrative expenses were slightly higher than normal because of extending the June month-end closing to capture all expenses related to FY 19-20.

2. On a year-to-date basis, SFHP had a loss of ($10,443,000) versus a budgeted loss of ($8,928,000). After removing SUR activity, the actual loss from operations would be ($5,020,000) versus a budget of break even. If the unexpected, retroactive 1.5% Medi-Cal rate reduction was excluded, SFHP would have reported a positive margin of $1.0 million.

3. Variances between June actual results and the budget include:

   a. A net decrease in revenue of $2.6 million due to:
      i. $6.0 million decrease in premium revenue due to the 1.5% rate reduction in Medi-Cal described in #1 above.
      ii. $294,000 less in Hepatitis C revenue as the result of 108 fewer treatment weeks.
      iii. $102,000 less in third-party administrative fees which can be attributed the phase-out of the Healthy Kids line of business.

   b. A net increase in medical expense of $4,577,000 due to:
      i. $2.9 million more in capitation expense as the result of gaining 8,536 member months.
      ii. $700,000 in accruals to reach an adequate IBNR reserve level at year end as required by the annual audit.
      iii. $600,000 more in accrued medical expenses related to the expansion of the Proposition 56 programs and Ground Emergency Medical Transportation (GEMT) activity.
      iv. $300,000 grant to the San Francisco Community Clinic Consortium (SFCCC) to be used for the purchase of Personal Protective Equipment (PPE) for SFCCC and non-SFCCC providers. This grant will help providers as they continue to deal with the ongoing impact of COVID-19.

   c. A net increase in administrative expenses of $98,000 due to:
      i. Additional professional services in the areas of evaluating and enhancing system security and for executive training/coaching.

The chart on the next page highlights the key income statement categories for June with adjustments for SUR activity in order to show margin or loss from ongoing operations.

This chart reflects the impact of $6.0 million revenue loss as the result of the 1.5% Medi-Cal rate reduction.

	JUN 2020				FYTD 19-20 THRU JUN			
CATEGORY	ACTUAL	BUDGET	FAV (UNFAV)	% FAV (UNFAV)	ACTUAL	BUDGET	FAV (UNFAV)	% FAV (UNFAV)
MEMBER MONTHS	144,308	135,772	8,536	6.3%	1,666,675	1,659,144	7,531	0.5%
REVENUE	$ 43,988,000	$ 46,587,000	$ (2,599,000)	-5.6%	$ 737,385,000	$ 718,481,000	$ 18,904,000	2.6%
MEDICAL EXPENSE	$ 47,866,000	$ 43,288,000	$ (4,578,000)	-10.6%	$ 698,339,000	$ 677,988,000	$ (20,351,000)	-3.0%
MLR	110.5%	94.4%			95.8%	95.6%		
ADMINISTRATIVE EXPENSE	$ 4,427,000	$ 4,330,000	$ (97,000)	-2.2%	$ 52,058,000	$ 51,421,000	$ (637,000)	-1.2%
ADMINISTRATIVE RATIO	8.7%	7.8%			6.0%	6.0%		
INVESTMENT INCOME	$ 139,000	$ 167,000	$ (28,000)	-16.8%	$ 2,569,000	$ 2,000,000	$ 569,000	28.5%
MARGIN (LOSS)	$ (8,166,000)	$ (864,000)	$ (7,302,000)		$ (10,443,000)	$ (8,928,000)	$ (1,515,000)	
ADD BACK: SUR PAYMENTS AND ACCRUALS	$ 278,000	$ 278,000			$ 5,423,000	$ 8,928,000		
MARGIN (LOSS) FROM OPERATIONS	$ (7,888,000)	$ (586,000)	$ (7,302,000)		$ (5,020,000)	$ -	$ (5,020,000)	

On a year-to-date basis through June and after the removal of SUR activity, SFHP reported a loss of ($5,020,000). As mentioned earlier, SFHP absorbed a $6.0 million reduction in revenue due to the DHCS decision to implement a 1.5% premium rate reduction retroactive to July 2019. If the impact of the 1.5% rate reduction were to be excluded, SFHP would have reported a $1.0 million positive margin.

- Overall net revenue is above budget by $18.9 million. After removing the impact of Directed Payments and intergovernmental transfer (IGT) funding, net revenue is up $2.6 million even with the $6.0 million adjustment for the rate reduction. Additional member months and the 1.7% population acuity adjustment helped to offset the 1.5% rate reduction.
- Overall medical expense is above budget by $20.3 million. After removing the impact of Directed Payments, IGT funding and SUR activity, medical expense is $7.6 million above budget due mainly to additional capitation expense related to higher member months, the impact of accrued claims related to the expanded Proposition 56 program and All Patients Refined Diagnosis Related Groups (APR-DRG) inpatient claims.
- Overall administrative expense is above budget by $637,000. This is primarily due to GASB 68 adjustments required by the rules that outline the recording of net pension costs for the full fiscal year.

PROJECTIONS

Mr. Bishop reviewed the following financial projections through December 2020:

1. As of June 2020, SFHP added $5.0 million to the PIP program related to the FY 18-19 Strategic Use of Reserves (SUR) program. Unpaid SUR commitments of $7.6 million will carry over to future fiscal years, i.e., $5.8 million for FY 20-21, $1.0 million for FY 21-22 and $800,000 for FY 22-23.

2. Due to the impact of the COVID-19 pandemic, SFHP anticipates an increase in Medi-Cal membership between July and December. After working with our actuary, sister plans and the county of San Francisco to gather information to help us develop estimates for the upcoming months, SFHP expects to add approximately 22,000 new members over the next twelve months. These new members would be spread across the Adult, Child and Adult Expansion categories of aid.

3. In response to the COVID-19 pandemic and the effect it is having on state of California finances, the State Legislature approved the implementation of a 1.5% rate reduction retroactive to July 2019. This rate reduction is effective for the entire Bridge Period which runs through December 2020. The rate reduction applies to all categories of aid except dual eligible members. SFHP estimates the impact of this rate reduction to be $3.3 million for the period of July through December 2020. At this time, SFHP does not plan to adjust provider rates and plans to absorb the $3.3 million loss of revenue, pending approval by the Finance Committee and Governing Board.

4. At the Governing Board meeting in March 2020, a recommendation to decrease capitation rates for the Dual member category of aid was approved. This rate decrease became effective July 1, 2020. The overall impact of this rate decrease will be 0.9%.

5. Proposition 56 – This program provides enhanced payments to medical groups for qualifying physician services and supplemental payments for developmental screenings, adverse childhood experiences screenings, trauma screenings and value-based payments related to a variety of health care quality measures. Due to the impact of COVID-19 on the state budget, the Governor proposed to eliminate Proposition 56 programs effective July 1, 2020. The State Legislature, however, did not approve the Governor's proposal and the Proposition 56 programs will continue.

HIGHLIGHTED IMPACTS TO THE HEALTH PLAN AND/OR PROVIDERS

$2.6 Million Receivable from the City of San Francisco Department of Human Resources

The Healthy Workers program has approximately 12,000 members enrolled with SFHP. This block of membership consists of two groups - 11,800 In-Home Supportive Services (IHSS) workers with the Public Authority for IHSS and approximately 200 As-Needed Workers, part-time employees with the Department of Human Resources (DHR). The Public Authority for IHSS funds the premiums for the IHSS Workers and the DHR funds the premiums for the As-Needed Workers.

Due to excessive delays with DHR issuing a previous amendment and new contract to continue enrollment and health care benefits for the As-Needed Workers, SFHP is carrying a $2.6 million receivable from DHR for unpaid premiums dating back to August 2017. During this time, SFHP has continued to keep the As-Needed Workers enrolled in Healthy Workers based on the understanding that both SFHP and the DHR intended to continue the contractual relationship. SFHP understood that formal contract extensions documenting the new rates to which the parties agreed and payment of premiums owed were imminently forthcoming.

To fulfill its contractual obligations and ensure As-Needed Workers would have uninterrupted access to primary care, hospital, mental health, and vision services, SFHP has paid monthly capitation to the San Francisco Department of Public Health, Community Behavioral Health Services, and Vision Service Plan. In addition, as SFHP is at risk for the pharmacy benefits available to the As-Needed Workers, SFHP has continued to cover the cost for prescription drugs for these individuals. SFHP has continued to make these monthly capitation payments and pay for prescription drugs since August 2017. The DHR, however, has not paid any premiums owed from and after August 1, 2017.

During this period of nonpayment, SFHP has made ongoing inquiries with the DHR regarding the status of the contract extension and the plans to pay all premiums owed. While representatives of the DHR would engage in conversations, there has been no movement. On July 24, 2020, SFHP sent a formal letter to the Deputy Managing Director of the DHR requesting a definitive timeline for when premium payments will be made and when a formal contract extension will be executed. If the DHR does not provide SFHP with the requested timelines, incorporating reasonable and satisfactory commitments, SFHP will be forced to cancel the parties' agreement and terminate coverage for the As-Needed Workers. SFHP will also formally pursue a claim with the City and County of San Francisco for all premiums owed to date.

On August 3, 2020, SFHP received a response from the Deputy Managing Director of the DHR. In the response, the DHR committed to sending a draft of the contract to the City Attorney by August 7, 2020 with a further expectation that the draft contract would be provided to SFHP by late August. Both SFHP and the DHR have agreed to participate in weekly update meetings until this issue is resolved.

Investment Report

Mr. Takeuchi then reviewed the investment reports that were provided to the Finance Committee in the packet.

With the Finance Committee recommendations, the Board unanimously approved the year-end 2019-20 unaudited financial statements and investment reports without any issues.

4. Review and Approval of Year-to-Date July 2020 Unaudited Financial Statements and Investment Reports

Recommendation: Review and Approval of Unaudited Monthly Financial Statements and Investment Reports

Mr. Bishop and Mr. Takeuchi next reviewed the financial statements for the period ending July 30, 2020. Mr. Bishop discussed the following highlights:

1. July 2020 reported a loss of ($236,000) versus a budgeted loss of ($1,677,000). After removing SUR activity, the actual loss from operations would be ($236,000) versus a budgeted loss of ($1,114,000). The budget assumed five claims disbursement cycles in July. FY 19-20 accruals pushed the majority of the claims expense in June.

2. Variances between July actual results and the budget include:
    a. A net increase in revenue of $510,000 due to:
        i. $785,000 increase in premium revenue due to 2,395 more member months when compared to the budget. Membership has been on an upward trend mostly due to members not placed on hold. Due to the COVID-19 pandemic, the DHCS has ceased negative eligibility actions during the pandemic. Adult Expansion member months were 3,786 more than budget.
        ii. $275,000 less in Hepatitis C revenue as the result of 107 fewer treatment weeks.

    b. A net decrease in medical expense of $440,000 due to:
        i. $563,000 less in SUR activity. This is a timing issue as it is expected that SUR disbursements will align with the budget as we get deeper into the fiscal year.
        ii. $406,000 less in Pharmacy expense. Of this amount, $275,000 was related to 107 fewer Hepatitis C treatment weeks. The remainder of $131,000 was related to slightly lower utilization than expected.
        iii. $529,000 more in capitation expense as the result of 2,395 more member months.

c. A net decrease in administrative expenses of $439,000 due to:
    i. $186,000 more in Compensation and Benefits. SFHP assumed a 12% attrition factor for FY 20-21. Due to the COVID-19 pandemic, we are seeing less staff turnover and therefore a greater percentage of positions remained filled on a month-to-month basis.
    ii. $625,000 less in professional services as well as in systems maintenance, telecommunications, and system support costs. The month of July followed the typical pattern for administrative expenses, i.e., the carryover of expenses from June was virtually eliminated and expenses tend to be budgeted a little heavier in the early months of the fiscal year.

The chart below highlights the key income statement categories for July with adjustments for SUR activity in order to show margin or loss from ongoing operations.

	JUL 2020				FYTD 19-20 THRU JUL			
CATEGORY	ACTUAL	BUDGET	FAV (UNFAV)	% FAV (UNFAV)	ACTUAL	BUDGET	FAV (UNFAV)	% FAV (UNFAV)
MEMBER MONTHS	144,252	141,857	2,395	1.7%	144,252	141,857	2,395	1.7%
REVENUE	$ 49,068,000	$ 48,558,000	$ 510,000	1.1%	$ 49,068,000	$ 48,558,000	$ 510,000	1.1%
MEDICAL EXPENSE	$ 45,093,000	$ 45,533,000	$ 440,000	1.0%	$ 45,093,000	$ 45,533,000	$ 440,000	1.0%
MLR	93.1%	95.1%			93.1%	95.1%		
ADMINISTRATIVE EXPENSE	$ 4,305,000	$ 4,744,000	$ 439,000	9.3%	$ 4,305,000	$ 4,744,000	$ 439,000	9.3%
ADMINISTRATIVE RATIO	7.5%	8.5%			7.5%	8.5%		
INVESTMENT INCOME	$ 94,000	$ 42,000	$ 52,000	123.8%	$ 94,000	$ 42,000	$ 52,000	123.8%
MARGIN (LOSS)	$ (236,000)	$ (1,677,000)	$ 1,441,000		$ (236,000)	$ (1,677,000)	$ 1,441,000	
ADD BACK: SUR PAYMENTS AND ACCRUALS	$ -	$ 563,000			$ -	$ 563,000		
MARGIN (LOSS) FROM OPERATIONS	$ (236,000)	$ (1,114,000)	$ 878,000		$ (236,000)	$ (1,114,000)	$ 878,000	

PROJECTIONS

Mr. Bishop reviewed the following financial projections through January 2021:

1. Due to the impact of the COVID-19 pandemic, SFHP anticipates an increase in Medi-Cal membership over the next six months. After working with our actuary, sister plans and the county of San Francisco to gather information to help us develop estimates for the upcoming months, SFHP expects to add approximately 22,000 new members during FY 20-21. These new members would be spread across the Adult, Child and Adult Expansion categories of aid. July membership was 2,395 members greater than budget projections.

2. In response to the COVID-19 pandemic and the effect it is having on state of California finances, the State Legislature approved the implementation of a 1.5% rate reduction retroactive to July 2019. This rate reduction is effective for the entire Bridge Period which runs through December 2020. The rate reduction applies to all categories of aid except dual eligible members. SFHP estimates the impact of this rate reduction to be $3.3 million for the period of July through December 2020. This revenue loss was built into the FY 20-21 budget.

3. Beginning January 2021, the pharmacy benefit will be carved out of Medi-Cal managed care. The State will take on this benefit and has selected Magellan as its Pharmacy Benefits Manager (PBM). For the period of January through June 2021, SFHP will see a revenue reduction of $44 million and an expense reduction of $43 million. This carve-out of the pharmacy benefit was built into the FY 20-21 budget.

4. It is expected that SFHP will receive preliminary CY 2021 rates in September or October 2020. DHCS and Mercer plan to use multiple efficiency factors when developing the rates which, when combined with the ongoing impact of COVID-19 on state finances, make it difficult to predict what will happen to our rates. To take a conservative approach, SFHP assumed a 2% rate reduction effective January 2021.

5. Proposition 56 – This program will continue for FY 20-21 and will provide enhanced payments to medical groups for qualifying physician services, supplemental payments for developmental screenings, adverse childhood experiences screenings, trauma screenings, family planning services and value-based payments related to a variety of health care quality measures.

6. Directed Payments – SFHP projects to receive $136 million in Directed Payments funding during FY 20-21. These funds will be disbursed to Zuckerberg San Francisco General, UCSF as well as private hospitals. 50% of this funding is expected to be received in September.

7. See income statement charts on subsequent pages. Due to the impact that pass-through funding and the disbursement of SUR have on projections, we have included graphs with and without this activity. It is important to note the anticipated decline in revenue and medical expense effective January 2021. This reflects the impact of carving out the pharmacy benefit.

HIGHLIGHTED IMPACTS TO THE HEALTH PLAN AND/OR PROVIDERS

$40 Million Increase in Line of Credit

Due to the uncertainty created by the COVID-19 pandemic, potential delays with Medi-Cal payments and upcoming Managed Care Organization (MCO) tax obligations, SFHP approached City National Bank (CNB) with a request to increase the current $40 million line of credit to $80 million. After much due diligence on the part of CNB, our request was approved. CNB agreed to allow

our line of credit to flex to as much as $80 million if warranted by negative changes in cash flow.

In a worst-case scenario where delays could occur with the monthly Medi-Cal premium payments as well as SFHP having to make $38 million in MCO tax payments before receiving the tax funding from DHCS, SFHP projected it would need approximately $72 million to bridge the gap created by timing delays. Should SFHP need to access funds through the line of credit, the interest rate would be 2.5%.

SFHP is cautiously optimistic that it will not be necessary to draw down on the additional $40 million. The June Medi-Cal premium payment was received on schedule (mid-July). DHCS has indicated it intends to include the MCO tax component in health plan rates before health plans are required to make the first tax payment by September 15, 2020. DHCS must receive CMS approval before disbursing the tax component to the health plans.

City National Bank has been SFHP's banking partner since July 2012. Not long after establishing this new relationship, SFHP was able to secure a $40 million line of credit to help cover potential delays in Medi-Cal premium payments. Only once has SFHP needed to access line of credit funding in the last eight years. In 2019, it was necessary to use a portion of the line of credit for five days to cover an unanticipated delay in Medi-Cal payments.

Investment Reports

Mr. Takeuchi then reviewed the investment reports that were provided to the Finance Committee in the packet.

With the Finance Committee recommendation, the Board unanimously approved the unaudited monthly financial statements and investment reports without any issues.

5. Review and Approval of Modifications to Practice Improvement Program Payments to Providers During the COVID-19 Public Health Emergency

Recommendation: Review and Approval of Modifications to Practice Improvement Program (PIP) Payments to Providers during the COVID-19 Public Health Emergency.

SFHP recommends the Governing Board approve the recommendation to modify the Practice Improvement Program (PIP) payment structure for FY 20-21 during the COVID-19 public health emergency:

1. Allocate 50% of capitation withhold to traditional PIP payments.
2. Allocate 50% of capitation withhold to Quality Improvement Projects (QIP) aimed at increasing primary care visit utilization to pre-COVID levels (face-to-face plus telehealth), use of telehealth modalities, engagement with high-risk COVID members, identifying care disparities caused by

race-based clinical algorithms, review SFHP-provided list of members on multiple chronic medications for whom continuity of care may be impacted by the Medi-Cal Rx transition, or another quality-related project of the participants' choosing.

Dr. Jim Glauber, Chief Medical Officer, provided the Governing Board with some background. (Detailed memo was provided in the packets.)

Dr. Glauber stated that COVID-19 has significantly impacted the way care is delivered in the health care system. Mandates from Governor Newsom, changes in individual behavior, and shifting provider priorities have not only limited PIP's influence on provider clinical priorities and motivation but have also had severe financial impacts on the network.

Furthermore, the DHCS financial incentives and Pay-for-Performance payment policy for federally qualified health centers (FQHCs) requires PIP payments to enumerate specific metrics and/or performance terms for FQHCs attain the FQHC payment.

Dr. Glauber states he recommends the following PIP programmatic adjustments to ease the PIP reporting burden for FY 2020-21:

1. Decrease measure set from 28 total measures to 13 total measures based on clinical importance. See attached for list of measures.
2. Update quarterly scoring methodology:
    a. Reduce performance requirements of Priority Five Continuous Quality measures as described in the table on the next page.
    b. Maintain scoring methodology of non-priority five measures.
    c. Pay for reporting on new measures (Breast Cancer Screening and Depression Screening).

With the Finance Committee recommendation to approve the changes to the PIP, the Board unanimously approved the modifications to PIP payments to Providers during the ongoing COVID-19 public health emergency.

6. Member Advisory Committee Report

Due to Governor Newsom's Executive Order N-29-20, "stay at home" order, the Member Advisory Committee did not meet in July or August.

The Committee is scheduled to meet on September 11, 2020 via Skype.

7. Chief Medical Officer Report

a. Review and Approval of Pharmacy Benefit Management Services for Healthy Workers and Healthy San Francisco

Recommendations: Approval of a six-month contract extension with PerformRx, with a termination date of June 30, 2021.

Approval of a three-year contract with MagellanRx, effective July 1, 2021 with financial terms of no more than a 0% increase or better.

Lisa Ghotbi, PharmD, Director, Pharmacy Services, reviewed the recommendations with the Governing Board. (PowerPoint slides were provided in the Board packets.)

PerformRx, Pharmacy Benefit Management (PBM) Company

- Contracted with SFHP since July 2013.
- Contract is set to terminate December 31, 2020.
- Contact extension will support close-out activities for the Medi-Cal Rx transition and on-going services for Healthy Workers and Healthy San Francisco members.

MagellanRx, Pharmacy Benefit Management (PBM) Company

- Selected by DHCS for Medi-Cal Rx PBM services on January 1, 2021.
- One of four finalists in our 2018 PBM request for proposals (RFP).
- Scored highest in five of six domains and ranked first overall in the 2020 RFP process.

The Board unanimously approved a six-month contract extension with PerformRX, with a termination date of June 30, 2021. In addition, the Board also unanimously approved a three-year contract with MagellanRx, effective July 1, 2021, with financial terms of no more than a 0% increase or better.

8. CEO Report – Highlighted Items – SFHP Employees Work from Home Status

Mr. Grgurina provided an update regarding SFHP employees' work-from-home status. (Detailed overview of the CEO report was provided in the Board packet.)

Mr. Grgurina stated that the CEO report provides a detailed overview of all SFHP departments and our ability to work successfully on a remote basis. We continue to operate at normal capacity on a remote basis without a decrease in service levels. Each area continues to report minimal issues with the telecommuting change and any identified issues are quickly managed by our ITS staff. He stated that we are pleased to report that SFHP departments have adapted, made adjustments and continue to serve our members, participants, providers, regulators and employees at the same service levels pre-pandemic.

The transition to remote work within SFHP has been critical in minimizing the risk of COVID-19 exposure to our employees and keeping them safe since most employees rely on public transportation to commute to work to a 24-story building on Beale Street. We have also successfully held two Board meetings on a remote basis, which may have helped to protect our Governing Board members since during the past two months, at least two construction workers in the Beale building tested positive for COVID-19.

The Board Adjourned to Closed Session.

9. Review and Approval of Recommendation Not to Impose a 1.5% Rate Reduction for Medi-Cal Providers and Not to Pursue Litigation Against the Department of Health Care Services

This item was discussed in closed session.

10. Review and Approval of Annual Performance Evaluation of CEO

This item was discussed in closed session.

The Board resumed in open session.

11. Report on Closed Session Action Items

Dr. Fugaro reported that the Governing Board approved the recommendation not to adjust provider rates retroactively or prospectively related to the 1.5% Medi-Cal rate reduction SFHP received from DHCS. SFHP will absorb the $9.3 million loss of revenue. The Governing Board agreed that reducing provider rates at this time would place an undue burden on providers as they continue to deal with the severe impacts of the ongoing pandemic. The Governing Board agreed that this action would not be precedent setting. The Governing Board also approved the recommendation not to sue DHCS.

12. Oral Report and Vote on Governing Board's Annual Performance Evaluation of CEO

Dr. Fugaro reported that the Governing Board approved the Annual Performance Evaluation of CEO with a rating of Exemplary/Outstanding and no change in salary.

13. The meeting was adjourned.

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Reece Fawley, Secretary/Treasurer

Joint San Francisco Health Authority/San Francisco Community Health Authority
Governing Board
September 2, 2020
Closed Session Meeting Minutes

1. **Review and Approval of Recommendation Not to Impose a 1.5% Rate Reduction for Medi-Cal Providers and Not to Pursue Litigation Against the Department of Health Care Services**

   Recommendation: San Francisco Health Plan (SFHP) recommends not adjusting provider rates retroactively or prospectively and will absorb the $9.3 million loss of revenue. Reducing provider rates at this time would place an undue burden on providers as they continue to deal with the severe impacts of the COVID-19 pandemic. This recommendation is not intended to be precedent-setting.

   John F. Grgurina, Jr., CEO, provided the Governing Board with some background.

   In response to the COVID-19 pandemic and the effect it has had on the state of California finances, Governor Newsom proposed, and the Legislature approved, a 1.5% Medi-Cal rate reduction for Medi-Cal managed care plans retroactive to July 1, 2019. This rate reduction will be effective for the entire 18-month Bridge Period, which runs through December 31, 2020.

   The rate reduction will apply to all categories of aid except dual eligible members. SFHP estimates the Department of Health Care Services (DHCS) will take back a total of $9.3 million from SFHP for the full Bridge Period. SFHP recorded a $6.0 million reduction in revenue in the month of June 2020, which covered the period from July 1, 2019 through June 30, 2020. SFHP projects another $3.3 million reduction in revenue for the remainder of the Bridge Period, from July 1 through December 31, 2020. This revenue loss has been built into the FY 20-21 budget.

   Although SFHP will be losing $9.3 million as a result of DHCS' retroactive rate reduction, we do not recommend adjusting provider rates retroactively or prospectively, but instead recommend absorbing the $9.3 million loss of revenue. Reducing our providers' rates at this time would place an undue burden on our provider network as they continue to deal with the severe impacts of the COVID-19 pandemic. This recommendation, however, is not intended to be precedent-setting. Recommendations regarding future recoveries of retroactive rate adjustments implemented by DHCS will be based on each unique set of circumstances.

   The table on the next page shows the impact to providers if SFHP were to implement a 1.5% capitation and fee-for-service rate reduction for the entire 18-month Bridge Period.

PROVIDER	1.5% RATE REDUCTION JUL 2019 - DEC 2020
HOSPITALS	
ZUCKERBERG SAN FRANCISCO GENERAL	$ 1,991,442
UCSF MEDICAL CENTER	$ 757,563
CPMC	$ 679,370
CHINESE HOSPITAL	$ 221,421
CPMC MISSION BERNAL	$ 195,700
	$ 3,845,496
MEDICAL GROUPS	
NORTH EAST MEDICAL SERVICES	$ 1,106,095
CLINICAL PRACTICE GROUP	$ 847,700
UCSF MEDICAL GROUP	$ 298,756
CHINESE COMMUNITY HEALTHCARE ASSOCIATION	$ 97,984
JADE MEDICAL GROUP	$ 76,363
BROWN & TOLAND MEDICAL GROUP	$ 31,756
HILL PHYSICIANS	$ 29,717
	$ 2,488,370
SFCCC	
MISSION NEIGHBORHOOD HEALTH CENTER	$ 61,118
HEALTHRIGHT 360	$ 41,445
SOUTH OF MARKET HEALTH CENTER	$ 26,290
ST. ANTHONY MEDICAL CLINIC	$ 7,476
SAN FRANCISCO COMMUNITY HEALTH CENTER	$ 7,256
NATIVE AMERICAN HEALTH CENTER	$ 5,797
BAART	$ 3,115
	$ 152,498
UNAFFILIATED	
DR. TRAN	$ 3,502
MARIN CITY HEALTH AND WELLNESS	$ 3,439
	$ 6,941
TOTAL	$ 6,493,305

Litigation Against DHCS

In the past, similar rate reductions were litigated by health plans against DHCS. SFHP does have the option to file a Notice of Dispute (NOD), which would effectively sue DHCS for implementing this 1.5% rate reduction retroactively to July 2019. SFHP, however, does not recommend pursuing this legal option as 1) it would result in the loss of the AB 85, 25% component of our Medi-Cal Adult Expansion rate, which is currently worth $4.0 million annually; and 2) it would take years to settle the NOD, incur legal fees, and there would be no guarantee of a successful outcome.

With the recommendation from the Finance Committee, the full Governing Board approved the recommendation not to reduce provider rates and agreed that this action would not be precedent setting. The Governing Board also approved the recommendation not to sue DHCS.

2. Review and Approval of Annual Performance Evaluation of CEO

The Governing Board approved the Personnel Committee's recommendation for the CEO's annual performance evaluation with an Exemplary/Outstanding

rating. In addition, the Governing Board approved the following recommendations from the Personnel Committee:

- **No Merit Increase.** Due to the economic conditions the Board approved the staff recommendation of no merit increases for the CEO and staff.

- **No Performance Based Cash Bonus.** Due to a $5 million loss for the fiscal year, the Finance Committee and Governing Board agreed with the staff recommendation to not pay the annual performance-based cash bonus, even though the staff achieved an 89% score on the FY 19-20 Governing Board approved goals.

- **Alternative to the Cash Bonus.**

For all SFHP staff, the Governing Board approved an alternative to the cash bonus of paid time off. While the recommendation is no cash bonus, we also acknowledge the fact that that if it were not for the Medi-Cal 1.5% retroactive rate decrease SFHP would have had a positive bottom line leading to a performance-based cash bonus for staff. Because of this the Governing Board approved an alternative proposal for time off for staff to acknowledge the successful year towards achieving Governing Board approved goals. This proposal is the same as the action the Governing Board took for the staff in FY 11-12 when the State underpaid for the addition of Seniors and Persons with Disability which caused a multi-million dollar loss and no cash payment for the bonus.

The proposal is as follows: 1) additional time off up to 5 days as provided in the table below, 2) performance based on each employees individual goals for FY 19-20 and subject to SFHP bonus parameters (e.g. must be employed on the date hours are provided, must have achieved satisfactory performance review and have not have been on a Performance Improvement Plan) and 3) pro-rated based on the time of the year the employee was with SFHP.

	2019-20 Individual Goal Score		
Date of Hire	**80 - 100%**	**60 - 79%**	**< 60%**
Prior to 8/31/19	5 Days	4 Days	0
9/1/19 - 10/31/19	4 Days	3 Days	0
11/1/19 - 12/1/19	3 Days	2 Days	0
1/1/20 - 2/29/20	2 Days	1 Day	0
3/1/20 - 3/31/20	1 Day	0	0
Post 4/1/20	0	0	0

- **Increase the 2021 and 2022 CEO Retention Payments and add one for 2023.** Last year the Governing Board updated the following “cliff vesting” retention payments to be paid on specified dates as long as John remains as

CEO with SFHP. These were added incentives to retain John up to September 1, 2022.

- $95,000 to be paid on September 1, 2020, if John is still CEO
- $120,000 to be paid on September 1, 2021, if John is still CEO
- $100,000 to be paid on September 1, 2022, if John is still CEO

In order to retain John and since we are not compensating him for his performance relative to the market, we have approved the following changes to the Retention Payments:

- $145,000 to be paid on September 1, 2021, if John is still CEO
- $145,000 to be paid on September 1, 2022, if John is still CEO*****
- $165,000 to be paid on September 1, 2023, if John is still CEO*****

*****The 2022 and 2023 payments include the flexibility for the Governing Board to either decrease or increase the amounts depending on economic conditions and the financial stability of SFHP.

These changes reflect the Governing Board's efforts and intent to retain John as SFHP's CEO for three more years

Agenda Item 1

Action Item

Approval of Consent Calendar:

b. Quality Improvement Committee (QIC) Minutes

SAN FRANCISCO HEALTH PLAN
Here for you

Quality Improvement Committee Minutes

Date: August 13, 2020
Meeting Place: SKYPE: +1 (628) 220-4855,,2078349
Meeting Time: 7:30AM - 9:00AM

Members Present: Edwin Batongbacal, LCSW, Kenneth Tai, MD; Joseph Woo, MD; Irene Conway, Jackie Lam, MD; James Glauber, MD, MPH (Chief Medical Officer, SFHP) Jamie Ruiz, MD; Lukejohn Day, MD; Ellen Chen, MD; Edward Evans; Ann Valdes, MD; Idell Wilson; Albert Yu, MD

Staff Present: Yves Gibbons; Grace Dadios; Jose Mendez; Ravid Avraham, MD; Joel Nellis; Suu Htaung; Jessica Shost; Abby Ealy; Se Chung

Topic		Follow-up [if Quality Issue identified, Include Corrective Action]	Resolution, or Closed Date [for Quality Issue, add plan for Tracking after Resolution
Call to Order	• Meeting called to order at 7:30 AM with a quorum. • Dr. Glauber: announced that this meeting will transition from Skype to MS Teams for October QIC/PAC. • Starting with introductions because there are guests and potential QIC members once approved by the Governing Board. - SFHP: Jim Glauber, Chief Medical Officer (CMO); Yves Gibbons, Program Manager – Access and Care Experience; Grace Dadios, Associate Program Manager- Appeals and Grievances; Jose Mendez- Senior Program Manager-HEDIS; Dr. Ravid Avraham, Associate Medical Director; Joel Nellis, NCAQ Project Manager; Suu Htaung, Policy Analyst-Compliance; Jessica Shost, Care Coordination		

	Pharmacist; Abby Ealy, Credentialing Coordinator; Se Chung, Health Services Administrative Specialist. - Committee member introductions: Ken Tai, CMO -North East Medical Services (NEMS); Jackie Lam, Medical Director/QI Director -NEMS; Albert Yu, San Francisco Health Department; Ellen Chen, Director of Population Health and Quality -San Francisco Health Network (SFHN); Jaime Ruiz, CMO -Mission Neighborhood Health Center; Luke Day, CMO -San Francisco General Hospital (ZSFG); Joe Woo, Director of Community Relations – Chinese Community Health Care Association (CCHCA); Ana Valdes, Chief Healthcare Officer -HealthRight 360; Edwin Batongbacal, Director of Behavioral Health – Department of Public Health (DPH). - MAC committee member introductions: Irene Conway, member of Member Advisory Committee (MAC) and SFHP Governing Board; Ed Evans; Idell Wilson, newest QIC participant. - Dr. Glauber: Since Idell hasn't not been formally approved by the Governing Board, which should occur next month; she will not be vote on any of the items. - Dr. Glauber: Today's voting will be done by consensus and we will document anyone specifically voting against an item.		
Follow Up Items	• Opiate Audit Tool -Dr. Glauber: SFHP will be undergoing triennial NCQA national committee for quality assurance accreditation survey in October. It	• Jessica Shost to email Dr. Valdes • Dr. Chen to email primary care group	

	has already been three years since SFHP received its initial accreditation. -The accreditation process this time around will be a bit simpler because of COVID. There are usually three components: meeting numerous accreditation standards that fall into different areas of the organization; HEDIS measures scores; CAPS survey. Combination of three scores results in health plan rating which is publicly available. Rating is measured on a scale of 1 to 5. -Currently, SFHP has a rating of 4 - commendable. SFHP is 1 of 5 Medi-Cal plans out of 26 in California to have a commendable rating. -Since COVID has had such an impact on both quality and member experiences and our ability to conduct quality audits and member satisfaction surveys; NCQA will surveying health plans just based on accreditation standards so will not be providing a health plan rating. It is important to maintain our NCQA accreditation and assuming SFHP passes the survey; SFHP will just be listed as "accredited" instead of having a plan rating.		
Consent Calendar	• Dr. Glauber: motion to approve Consent Calendar. • Committee Member: motion to approve • Dr. Glauber: All in Favor? • Committee Members: Ayes. • Dr. Glauber: Does anyone oppose? No? Thank you.		
Quality Improvement	<u>CAHPS Report & Interventions</u> • Yves Gibbons, Program Manager, Access and Care Experience, presented member experience survey results, analysis, and next steps. • Accomplishments: Rating of All Healthcare maintained higher performance. Improvement projects included: Teladoc registration campaign- registered approximately 1,100 more Teladoc members. Virtual care guides- SFHP website tailored to		

	each provider group so members can find out how to receive care, mental health care, etc. • Challenges for CAHPS Improvement o COVID19 - Perceived barriers to accessing routine care. - Phone survey were cancelled due to call centers closing. Last year phone surveys contributed to higher scores and higher response rates. o SFHN - EPIC transition may have caused challenges in receiving care. - Decrease in PCP utilization. Members with PCP visits tend to rate the health plan higher. - Service metrics at call center shows member poor experience. o Transition of members from Hill and BTP to NEMS. That might have caused some confusion and member dissatisfaction. -Dr. Chen: What kind of messaging can be done in terms of PCP utilization? Can the service metrics of the call center be shared? -Dr. Glauber: SFHP oversampled at medical group level so SFHP can provide tailored feedback to each medical group. Results are expected shortly and will be shared with each group specific to your patients. • Key Drivers for Performance: 3 Questions with most room for improvement: o Rating of specialist seen most often; o Ease of getting needed care, tests, or treatment; o Customer service provided needed help or information		

	• Key Drivers are mapped to main finding from late 2019 Market Research -Specialty Care: Better communicate to members the process and time expectations for wait time to see a specialist. Market research showed that people were confused on how to access a specialist, specialists had different practices, people were really getting help to navigate. -Access to Care: Better communicate other options besides primary care. Nurse advise line, Teladoc and Urgent Care. Talk about online symptom checkers. -Customer Service: Support doctors' offices to offer advices lines and other messaging platforms, and portals. -Irene Conway: Input on member communication. Messaging platform used by Ocean Park Health Center was helpful in resolving issue. -Ed Evans: It is more stressful for pregnant women, especially black women? Especially with their higher mortality rate. -Dr. Glauber: There is this article focusing on the potential that the pandemic will worsen disparities and mortality among African American women. With hospitals restricting the number of people who can participate in a women's labor, women of color who may need their partner and birth coach/doula are more negatively impacted. • Next Steps: -Planning 2021 market research: Information gathering to see what types of questions or stimuli, ask more questions about access to specialty care. - Providing feedback to member experience projects. - Organizational goals: Improve member engagement-cross departmental group from to discuss improvements; try to lessen the impact that the Medi-Cal Rx transition will have on member experience.		

	-Improve primary care utilization to pre pandemic levels, and increase telehealth usage. -Dr. Glauber: Just to clarify by the end of this this fiscal year, Q2 2021, with the uncertainty of the pandemic, but what percentage of your overall primary care visits do you envision delivering via telehealth whether that's video or telephonic relative to in-person? -Dr. Horton: There are two parts to the question. What do we think is reasonable given the flux of surges? Secondly, what is the optimal mix in the long run? If 50/50 (in person vs. telephone) it would be hard to reduce in-person if there is another surge. I think the peak would be right around there. Curious to find out Kaiser does since they have been using telehealth for a long time and to see if they have hit an optimal formula for their patients. -Dr. Ruiz: Women's department has been hit the hardest and that requires in office visits. Challenges getting patients in office. Hopefully health plans can still advocate for telehealth at the State level. We do video but people also still use the phone. -Dr Glauber: Cautiously optimistic that the State will continue support telehealth flexibilities. The new DHCS Director said last month that this is one of his priorities. Amy Petersen is participating in a State workgroup to look at telehealth and particularly to see if it is worsening disparities among various groups within the Medi-cal population. <u>HEDIS Results</u> • Jose Mendez, Senior Program Manager, Health Services Product Management, presented summary of HEDIS Reporting Year 2020. • Highlights:		

	○ SFHP met organizational goal of ½ rating increase in Prevention and Treatment Composites of NCQA Health Plan Rating. SFHP also met DHCS minimum performance level (MPL) for all Managed Care Accountability Set (MCAS) measures except Chlamydia Screening which did still have a 19.81% absolute improvement. ○ Other key HEDIS measures meeting MPL included: Adolescent Well-Care Visits (AWC) 60.40%, Well-Child Visits in the First 15 Months of Life (W15) 69.34%, and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) 80.80%. -Dr. Glauber: Comment about MCAS. It used to be until this year, we had to hit the 25th % but DHCS has raised the bar and said they will financially sanction any health plan for each measure that doesn't met the 50th %. Hence the focus on the 50th %. ○ HEDIS Chronic Measures (asthma, diabetes, and heart disease) rates were comparable to Reporting Year 2019 rates meeting MPL. Improvement in Diabetes Blood Pressure control (CDC-BP) 82.11% and Statin Therapy for Patients with Cardiovascular Disease (SPC) 79.53%. ○ Key measures with a 5-point increase in performance included: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis/Bronchiolitis (AAB) 65.40% and Pharmacotherapy Management of COPD Exacerbation-Systemic Corticosteroid (PCE) 61.26%. ○ Key measures with a 5-point decrease in performance included: Childhood Immunization Status Combo 10 (CIS) 61.11%, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) 51.35%, and		

	Appropriate Testing for Pharyngitis (CWP) 63.87%. o Notable NCQA changes for Reporting Year 2021 include: measure revisions to Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC) from hybrid to admin measures and updates to measure specifications. o Telehealth guidance updated for 40 HEDIS measures to support increased use of telehealth caused by COVID-19. o Expected COVID-19 impacts include decrease in preventative care visits, chronic disease care and increase in behavioral health needs. -Dr. Glauber: there seems to still be a lot of reticence among patients to come in for a face to face visit due to safety concerns; is that still a barrier you're seeing among patients with chronic illnesses? -Dr. Horton: Yes, it is still a barrier. What has been helpful is approval of home blood pressure cuffs. Home management tools will continue to become important. -Dr. Chen: Yes, it is very true, especially with the older adults that are higher risk, but younger families are showing up for more appointments. Urgent care is more complicated because any symptom can lead to COVID testing that creates a barrier to the flow of the clinics and able to handle the volume. -Dr. Ruiz: Transportation is also an issue. Since it has not be restored to normal. Patients are late to appointments or challenges getting to the appointment.		

	-Ed Evans: Can Seniors with Medi- Medi go anywhere not governed by the medical group? -Dr. Glauber: That is true because we're providing their wrap Medicaid benefit around their Medicare benefit. Even though SFHP nominally assigns them to a SFHP PCP and medical group, that's for SFHP administrative and financial purposes to know who to pay for the wrap care. A Medi-Medi can go to any participating provider and get services. -Ed Evans: Right before my surgery, I was told that the hospital was not covered by Brown and Tolland. So, I had to find a new provider. I am being told different information by different people. -Dr. Glauber: I think this is a larger issue to be tackled. Mis-information. We have received grievances in the past of Medi-Medi member's challenges to access to care. In SFHP's response, we try to educate members about not having to stay within medical groups, etc. <u>Annual Grievance Report</u> Grace Dadios, Associate Program Manager, Appeals and Grievances, presented the report. • A grievance is a formal complaint a member can make when they are not happy with the health care services they received. • An appeal is a request for a denied service or medication to be reviewed again by a different provider. • SFHP monitors grievances through the Annual Grievance and Appeals Report and monthly grievance trending. • SFHP received 352 grievances in 2019 compared to 265 in 2018. The most common types of grievances filed were grievances involving Quality of Care and Quality of Service. • SFHP's performance threshold for each NCQA grievance category is < 1.00 per 1,000 members. If any category exceeds a rate of 1.00 for either grievances or appeals, SFHP determines		

	appropriate improvement activities for SFHP and its broader provider network. SFHP met the performance threshold for all categories in 2019. • SFHP received 77 appeals in 2019 compared to 61 in 2018. SFHP met the performance threshold for appeals in 2019. 2019 Grievance Trends: • A grievance trend is identified if SFHP receives three or more grievances filed by unique members, within a rolling three-month period, that have the same grievance subcategory and involve the same provider and/or clinic. • SFHP identified a trend involving SFHN Centralized Call Center (CCC): o Issues included long telephone wait times, difficulty coordinating appointments, and poor attitude from staff. o SFHP learned through grievance investigations that issues arose due to the implementation of EPIC. o Interventions included implementing a message while members are on hold that stated there may be longer wait times, discussing the trend at Joint Operations Committee (JOC), and assigning additional staff to improve wait times. • SFHP identified a trend at UCSF regarding new patient appointment access: • Members were having difficulty scheduling new patient appointments. • Interventions included obtaining UCSF's New Patient Appointment wait time report and closing one UCSF clinic to new patients for one month. • UCSF reopened the clinic to new patients because additional staff hired and because of the reduction of primary care appointments due to the COVID-19 pandemic. COVID-19 Impact on Appeals and Grievance Volume:		

	• Appeal and grievance volume in Q2 2020 were lower compared to previous quarters. SFHP attributed this decrease to fewer members visiting the hospital or going to appointments due to the COVID-19 pandemic.
	• SFHP received approximately 70 clinical grievances and 10 non-clinical grievances since Q1 2019. In Q2 2020, SFHP received 54 clinical grievances and 7 non-clinical grievances. The volume of appeals remained the same.
	• Telehealth visits during the COVID-19 pandemic increased while utilization rates decreased.
	• SFHP received grievances from members regarding negative experiences related to changes that have been made due to the COVID-19 pandemic.
	
	Provider Responses for Grievances Involving Discrimination
	• SFHP members have filed grievances alleging discrimination. In FY 2018/2019, most discrimination-related grievances involve a member's clinic and/or PCP.
	• Members describe their experiences in different ways including feeling lack of respect, devaluation, suspicion, scapegoating, and dehumanization.
	• SFHP categorized provider responses to grievances involving discrimination. The three categories include:
	  ○ Dismissive responses
	  ▪ "The medical record doesn't show that anyone discriminated against the member."
	  ○ Denial or deflective responses
	  ▪ "We treat all patients equally." "The patient was [yelling, not letting me speak, hung up on me]"
	  ○ Reflective responses
	  ▪ "After reading Mr. A's description of our interaction, I will work to be mindful of what behaviors I might exhibit, unintentionally, that can lead to someone feeling dismissed."		

	▪ SFHP encourages providers/clinics to provide reflective responses however understands it may be difficult to do so. • Ed Evans inquired about grievances regarding access to African American doctors and Tom Waddell Urban Health Clinic. o SFHP's provider directory does not have information about sex and race as SFHP is not required to publish nor ask providers to disclose this information. o SFHP will revisit this topic to see if this information can be included. In addition, SFHP will gather provider input to see if this is information that can be shared. • SFHP developed templated language that is included in resolution letters to grievances involving discrimination: o "SFHP apologizes for your negative experience. SFHP acknowledges the unequal treatment of people of color in health care settings. We are working to create a more just health care system and your feedback helps us know where we can do better." o SFHP developed generic language to acknowledge members' experience of discrimination when providers/clinics provide dismissive or deflective responses. o Dr. Glauber invited committee members to share feedback on how to improve the generic language via e-mail. • Dr. Glauber: Introduced potential new member and guest: Dr. Claire Horton, new CMO of SFHN.		

QI Committee Chair's Signature & Date _____

Minutes are considered final only with approval by the QIC at its next meeting.

Agenda Item 1
Action Item
Approval of Consent Calendar:

c. QIC Appointments

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119

MEMO

Date: October 27, 2020

To	**Governing Board**
From	**Jim Glauber, MD, MPH, Chief Medical Officer**
Regarding	**Quality Improvement Committee Nominations**

Recommendation:
The Quality Improvement Committee (QIC) recommends the Board approve the appointments of Claire Horton, MD, and Thomas Kravis, MD to the QIC.

Background:

Claire Horton, MD, MPH, received her Doctor of Medicine from Duke University and Masters in Public Health from University of North Carolina Chapel Hill. She is the Chief of Staff at Zuckerberg San Francisco General Hospital and Clinical Professor at UCSF. Prior to these positions, Dr. Horton was the Associate Medical Director at Richard Fine People's Clinic and La Clinica de la Raza. Please see attached curriculum vitae.

Thomas Kravis, MD, received his Doctor of Medicine from Thomas Jefferson University. He is currently the Medical Director of Chinese Community Health Care Association (CCHCA). Prior to CCHCA, Dr. Kravis was the Medical Director at Chinese Community Health Plan and has previously worked at 3M Health Information Systems, UnitedHealth Group, Milliman Care Guidelines, Arthur Andersen, and Patient Care, Inc. Please see attached curriculum vitae.

The QIC recommends approval of the appointments of Dr. Horton and Dr. Kravis to the QIC.

University of California, San Francisco

CURRICULUM VITAE

Name: Claire K Horton, MD, MPH

Position: Clinical Professor, UCSF School of Medicine
Chief of Staff, Zuckerberg San Francisco General Hospital

Address:

EDUCATION

1988 - 1992	Duke University	B.A.	Cum Laude, History
1993 - 1997	Duke University Medical School	M.D	
1996 - 1997	University of North Carolina-Chapel Hill School of Public Health	MPH	Maternal / Child Health
1998 - 2001	University of California, San Francisco	Resident	Medicine (SFPC)

LICENSES, CERTIFICATION

2000	Medical licensure, California (A71387)
2001	Board Certification, Internal Medicine

PRINCIPAL POSITIONS HELD

2001 - 2008	La Clinica de la Raza, Oakland, CA	Primary Care Clinician, 2001-2008; Associate Medical Director for Quality, 2006-2008
2008 - 2018	San Francisco General Hospital	Associate Medical Director, Richard Fine People's Clinic, 2008-2011; Medical Director, 2011-2018

2018-present	Chief of Staff	Zuckerberg San Francisco General
2008 - present	University of California/San Francisco	Clinical Professor, Internal Medicine

OTHER POSITIONS HELD CONCURRENTLY

2001 - 2008	Alta Bates / Summit Medical Center	Admitting / Treating Physician
2002 - 2008	Clinical Preceptor	UCSF Family Nurse Practitioner Program
2010 - 2016	Senior advisor / leadership coach	UCSF Center for Health Professions Institute for Physician Leadership

HONORS AND AWARDS

1993	Fulbright-Swyers Memorial Scholarship	Duke University
1997	North Carolina Albert Schweitzer Fellow	University of North Carolina/Chapel Hill
2001	Award for Excellence in Community Service	UCSF Medicine Residency
2002	Clinician of the Year Award	La Clinica de la Raza
2006	California Health Care Foundation Health Leadership Fellowship	UCSF Center for Health Professions
2010	Gage Award for Patient Experience	National Association of Public Hospitals
2011	Rick Haber Excellence in Teaching Award	San Francisco General Hospital Primary Care Residency
2011	AME Excellence in Teaching Award	UCSF Academy of Medical Educators
2012	Friends of Medicine Award	UCSF Department of Medicine
2012	Gage Award Honorable Mention: RFPC's Care Management Program	National Association of Public Hospitals
2012	UCSF Department of Medicine's Friends of Medicine Award	UCSF Friends of Medicine

2015	Innovations Award in Education	UCSF Academy of Medical Educators
2015	Election to membership	UCSF Academy of Medical Educators

PROFESSIONAL ORGANIZATIONS

Memberships

2018-present California Association of Public Hospitals
2008 - present Society of General Internal Medicine
1997 - present American Association of Public Health

INVITED PRESENTATIONS

NATIONAL

2004	Robert Wood Johnson Advancing Diabetes Self-Management Conference	presenter
2004	National Public Health Initiative on Women and Diabetes (CDC)	presenter
2005	American Liver Foundation Conference on Hepatitis	presenter
2006	Conference on Diabetes and Obesity (CDC)	presenter
2007	American Public Health Association Annual Conference	presenter
2011	National Patient Safety Forum Annual conference	presenter
2011	AAMC "Integrating Quality" National Forum	presenter
2012	National Patient Safety Forum Annual Conference	presenter
2015	Institute for Healthcare Improvement	presenter
2017	Society for General Internal Medicine	presenter

REGIONAL AND OTHER INVITED PRESENTATIONS

2006	University of CA / Irvine, Bi-national Conference on Diabetes in Mexicans and Mexican-Americans	presenter
2007	Community Clinics Initiative Medical Directors Session	presenter
2008	California Healthcare Foundation "Better Ideas in Chronic Care" conference	panel facilitator

2015	UCSF Teaching Scholars half-day session: Using QI tools to improve workplace professionalism	presenter
2016	Division of Hospital Medicine, UCSF, leadership series	presenter

UNIVERSITY AND PUBLIC SERVICE

UNIVERSITY SERVICE

UCSF CAMPUS-WIDE

2008 - present	Intern selection committee, San Francisco Primary Care Internal Medicine Residency	committee member
2013 - 2014	Search committee, Clinical Service Chief, SFGH Division of Opthalmology	committee member
2014 - 2015	Search committee, faculty, UCSF Division of Family and Community Medicine	committee member
2014 - 2017	Search committee, clinical pharmacists, San Francisco Health Network	committee member

SCHOOL OF MEDICINE

2014 - 2015	Bridges planning committee (Leadership, Inquiry)	Attend Bridges retreats and planning sessions, advise on areas of expertise

DEPARTMENTAL SERVICE

2008 - 2010	Formulary committee, San Francisco General Hospital	committee member
2010 - 2014	No-show task force, San Francisco General Hospital	co-chair
2012 - 2012	SFGH Department of Medicine Clinical Effort Task Force	task force member
2011 - 2018	Search committee, faculty, Division of General Internal Medicine, Zuckerberg San Francisco General	committee chair

PUBLIC SERVICE

2000 - 2001	California Association of Interns and Residents	co-chair
1998 - 2001	Women's Needle Exchange Clinic, San Francisco	physician volunteer and volunteer coordinator
2006 - 2008	Community Advisory Board, Research Program on Genes, Environment and Health, Kaiser Permanente Division of Research, Oakland, CA	board member

2006 - 2008	Medi-Cal Managed Care Advisory Board, Department of Health Services, CA	board member
2002 - 2010	St. Elizabeth's Community Health Fair, Oakland, CA	volunteer physician, volunteer coordinator
2008 - 2012	Healthy San Francisco QI Advisory Committee	clinician adviser
2008 - 2018	Primary Care QI Committee, San Francisco DPH	committee member
2011 - 2014	San Francisco Health Plan QI Committee	committee member
2011 - 2013	San Francisco Health Plan Piaget committee	clinician adviser
2015 – 2018	San Francisco General Hospital Medical Executive Committee	at-large member
2020	California Association of Public Hospitals	Policy and Technical Advisory Committee

TEACHING AND MENTORING

TEACHING

POSTGRADUATE AND OTHER COURSES

2008 – present	San Francisco General Hospital Primary Care Internal Medicine Residency QI curriculum	Course co-director
2008-present	RFPC and Zuckerberg San Francisco General inpatient wards	Preceptor

GRANTS AND AWARDS

(Principle Investigator)	10/01/05 - 01/01/08
Advancing Diabetes Self-Management Program	$385,000 direct/yr1
Advancing Diabetes Self-Management Program	$765,000 total

(Principle Investigator)	01/01/07 - 12/31/07
California Department of Health Services	$200,000 direct/yr1
Best Practices in Childhood Asthma	$200,000 total

(Physician Lead)	01/01/07 - 01/01/08
	$100,000 direct/yr1

Behavioral Health Integration Project, La Clinica de la Raza $100,000 total

PUBLICATIONS: JOURNALS

1. **Horton C, Huang L, Gooze L. Pseudallescheria boydii sinusitis in AIDS (letter). Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 1999; Vol. 20: 209.**
2. **Anderson D, Horton C, O'Toole M, Brownson C, Fazzone P, and Fisher E. Integrating Depression Care with Diabetes Care in Real-World Settings: Lessons from the Robert Wood Johnson Foundation Diabetes Initiative. Diabetes Spectrum. 2007; 20:10-16.**
3. **Thompson J, Horton C and Flores C. Advancing Diabetes Self-Management in the Mexican American Population: A Community Health Worker Model in a Primary Care Setting. The Diabetes Educator, Vol. 33, No. Supplement 6, 159S-165S (2007)**
4. **Horton C; Thompson, J; Flores, C. Evolution of a Diabetes Quality Improvement Program at an Urban Community health Center. Clinical Diabetes, 2008; Volume 26 (3), 128-129**
5. **Dowdy DW, Horton CK, Lau B, Ferrer R, Chen AH. Patient Follow-up in an Urban Resident Continuity Clinic: An Initiative to Improve Scheduling Practices. J Grad Med Educ. 2011 Jun; 3(2):256-60. PMID: 22655154. PMCID: PMC3184901 [View in Pubmed]**
6. **Baxi S, Lakin J, Lyles CR, Berkowitz S, Horton C, Sarkar U. Points for improvement: performance measurement for glycemic control in diabetes patients in a safety-net population. Jt Comm J Qual Patient Saf. 2013 Mar; 39(3):109-13. PMID: 23516760 [View in Pubmed]**
7. **Brenner S, Detz A, López A, Horton C, Sarkar U. Signal and noise: applying a laboratory trigger tool to identify adverse drug events among primary care patients. BMJ Qual Saf. 2012 Aug; 21(8):670-5. [View in Pubmed]**
8. **Newbold E, Schneidermann M, Horton C. The bridge clinic. Am J Nurs. 2012 Jul; 112(7):56-9. [View in Pubmed]**
9. **Gupta R, Davis E, Horton C. Interval examination: building primary care teams in an urban academic teaching clinic. J Gen Intern Med. 2013 Nov; 28(11):1517-21. PMID: 24043568 [View in Pubmed]**
10. **Hines JZ, Sewell JL, Sehgal NL, Moriates C, Horton CK, Chen AH. "Choosing wisely" in an academic department of medicine. Am J Med Qual. 2015 Nov-Dec;30(6):566-70. PMID: 24970279 [View in Pubmed]**
11. **Horton C, Sarkar U, Fernandez A. Applying Principles and Practice of Quality Improvement for Better Care of the Underserved. Book chapter in The Medical Management of Vulnerable and Underserved Patients 2016**
12. **Zapata C, Wistar E, Lum H, Horton C, Sudore R. Using A Video-Based Advance Care Planning (ACP) Website to Facilitate Group Visits for Diverse Older Adults in Primary Care Is Feasible And Improves ACP Engagement. Journal of Pain and Symptom Management. February 2017; Volume 53 (2) 318–319**
13. **Lee SY, Cherian R, Ly I, Horton C, Salley A, Sarkar U. Designing and Implementing an Electronic Patient Registry to Improve Warfarin Monitoring in the Ambulatory Setting. Jt Comm J Qual Saf 2017; 43:353–360**

PUBLICATIONS: OTHER

1. **Brindis C and Horton C. Promising Opportunities: An evaluation of Healthy Start adolescent health services. Internal document for the national Healthy Start Evaluation Project, August 1996**
2. **Janisse, Tom: "Innovations in our Nation's Public Hospitals: Three-year follow-up interview with five CEO's and medical directors." The Permanente Medical Journal**

PUBLICATIONS: BOOK CHAPTERS

1. **Horton C, Sarkar U, Fernandez A. Applying Principles and Practice of Quality Improvement for Better Care of the Underserved. Book chapter in The Medical Management of Vulnerable and Underserved Patients 2016**
2. **Fondahn E, Horton C. Patient Safety and Risk Management. Book Chapter in Leading an Academic Medical Practice, Springer, in publication.**

POSTER PRESENTATIONS

1. **Emergency Contraception: Knowledge and Barriers Harleman B; Horton C; Schneiderman M. Society for General Internal Medicine Conference San Diego, CA**
2. **Promotoras' role in improving health outcomes and data collection: Findings from a diabetes self-management program among Latino patients. Flores C, Thompson J, Horton C APHA Annual Conferenc**
3. **What's Good for the Goose is Good for the Gander?... Community Health Workers and Self-Management Support in Latino patients. Horton C, UCSF Health Disparities Conference**
4. **Immersing Residents in Clinic Quality Improvement Horton C; Jain S; Chen A. Institute for Healthcare Improvement International Summit on Improving the Office Practice**
5. **Team-based care in GMC: Evaluation of a Resident Continuity Nurse Practitioner Program Horton C; O'Sullivan P; Chen A. Society for General Internal Medicine Annual Conference**
6. **Boosting tetanus vaccine rates in an urban underserved resident clinic: A team approach. Hanson et al. Safety Net Institute's Summit on Quality Improvement in Graduate Medical Education**
7. **The Healthy San Francisco Chronic Care Redesign Project. Horton C; Ofman D; Hammer H. National Association of Public Hospitals Annual Conference**
8. **The Healthy San Francisco Chronic Care Redesign Project: An innovative role for nurse practitioners Grundland H, Tang A, Kuo, C, Flores-Byrne L, Hammer H, Heuerman D, Horton C, Kanenaga J, Nierman J, Robbins D, Siegel R, Sobel V, Tsao S, Ofman D California Association for Nurse Practitioners 34th Annual Educational Conference**
9. **All Aboard: Creating a culture of teamwork in an urban resident clinic Horton C, Ratanawongsa N, Chen A. AAMC Integrating Quality Conference, June 2011**
10. **Health Care Disparities and Quality Improvement in the Safety Net: Uniting educational and operational missions at San Francisco General Hospital Horton C, Fernandez A, Chen E, Hammer H. AAMC Integrating Quality Conference, June 2011**

11. **Addressing Disparities in Colorectal Cancer Screening at San Francisco General Hospital Horton C, Chen E, Phengrasamy L, Viloria J, Hammer H. Society for General Internal Medicine Annual Conference 2012.**
12. **Primary care-based care management for high risk patients: Implementing evidence-based practice in a real-world clinic Davis E, Janssen J, Johnson A, Horton C. Society For General Internal Medicine Annual conference 2012**
13. **Continuity Clinic Makeover: An Ambulatory Education Needs Assessment for Residents Practicing in an Urban Safety-Net Clinic Laponis R, Horton C, Julian K, Jain S, Gupta R. Society for General Internal Medicine Annual Conference 2012**
14. **Creation of a Controlled Substance Review Committee for Patients on Chronic Opioids at General Medicine Clinic: Implementation & Challenges Soraya Azari, Claire Horton, MD; Ghezal Saffi; Bren Turner, Melissa Kirkpatrick, Lindsay Evans. UCSF Department of Medicine Quality and Safety Innovations Challenge.**
15. **Eyes on the Prize: Improving diabetic retinal screening at San Francisco General Hospital. Horton C, Society for General Internal Medicine National conference**
16. **Assessment of time in therapeutic range for anticoagulation patients on warfarin therapy Christina Wang, Dhruv Kazi, MD, Shin-Yu Lee, Irene Ly, Claire Horton, Urmimala Sarkar. UCSF Department of Medicine Quality and Safety Innovations Challenge.**
17. **PREPARE Advance Care Planning Group Visits for Elderly Primary Care Patients Emily Wistar, Carly Benner, Claire Horton, Rebecca Sudore, Antonella Jimenez. UCSF Department of Medicine Quality and Safety Innovations Challenge**
18. **The heart of the team in team-based care: Improving provider-medical assistant pairing in primary care. Braden Mogler, David Lee, Claire Horton. Society for General Internal Medicine Annual Conference**

Contact

thomas.kravis@comcast.net

www.linkedin.com/in/thomas-kravis-5534565 (LinkedIn)
mendocinohotel.com (Company)

Top Skills

Healthcare
Leadership
Strategy

Languages

English (Native or Bilingual)
French (Professional Working)

Publications

"Emergency Medicine a Comprehesive Review" editions 1,2 and 3

Topics of Emergency Medicine, Editorial Board, Aspen Systems Corporation, Rockville, Maryland, 1982 - 1989

Thomas Kravis

Medical Director of a medical group in San Francisco with extensive experience as a Physician Executive at Milliman, Arthur Anderson, United Health Group and 3M corporation.
San Francisco

Summary

Medical Director CCHP Health Plan, San Francisco, Ca. March 2016-November, 2018
Improved performance relying on best practices and lessons learned as a hospital executive at Scripps/Mercy, founder and an owner and Medical Director of Vibra San Diego a 110 bed Acute Rehabilitation hospital ; executive at Arthur Andersen, Milliman USA, 3M Health Information Systems and VP of United Healthcare. In less than three years developed collegial relationships with physicians and contracted providers which contributed to improved performance across the continuum of care: members at risk, inpatient, and outpatient, post-acute and ambulatory care. Developed and implemented continuous quality improvement and efficient care initiatives for members in the Commercial and Medicare lines of business and improved HEDIS scores and the Medicare Stars from 3.5 to 4.5 for 2018 and 2019 resulting in significant increased revenue; led the medical management team in the rigorous application of analytic tools, claims-based software solutions and focused physician group and 1 on 1 case and medical record reviews and evidence based guidance and mentoring; reduced readmissions, Medicare inpatient admits per 1000 members and ER visits for Covered California members was reported as the third best performance of all health plans in California. Developed and implemented innovative solutions for the appropriate documentation, coding and reporting of CPT and ICD-10 diagnostics codes, DRGs/APR-DRGs, HCCs and risk scores in support of CMS and ACA contracts. Created actionable dashboards with risk adjusted member and provider- specific profiles to drive P4P and other value based initiatives; reversed a several year unfavorable trend of leakage of members to non-preferred providers by $5.5M per year; identified over $20M in annual cost savings measures.

Experience

Asian American Medical Group (AAMG)
Medical Director CCHCA
May 2019 - Present (1 year 4 months)
San Francisco Bay Area

Medical Director of CCHCA, San Francisco, California. June 2019- current.

Medical Director of CCHCA an MSO and its affiliated multidisciplinary medical group AAMG. Responsible for Utilization Management, Quality Assurance and improving HEDIS and Stars performance measures in support of full risk arrangements with a focus on the Medicare Advantage line of business.

CCHP
Medical Director
April 2016 - November 2018 (2 years 8 months)
San Francisco, California, United States

Improved performance relying on best practices and lessons learned as a hospital executive at Scripps/Mercy, founder and an owner and Medical Director of Vibra San Diego a 110 bed Acute Rehabilitation hospital ; executive at Arthur Andersen, Milliman USA, 3M Health Information Systems and VP of United Healthcare. In less than three years developed collegial relationships with physicians and contracted providers which contributed to improved performance across the continuum of care: members at risk, inpatient, and outpatient, post-acute and ambulatory care. Developed and implemented continuous quality improvement and efficient care initiatives for members in the Commercial and Medicare lines of business and improved HEDIS scores and the Medicare Stars from 3.5 to 4.5 for 2018 and 2019 resulting in significant increased revenue; led the medical management team in the rigorous application of analytic tools, claims-based software solutions and focused physician group and 1 on 1 case and medical record reviews and evidence based guidance and mentoring; reduced readmissions, Medicare inpatient admits per 1000 members and ER visits for Covered California members was reported as the third best performance of all health plans in California. Developed and implemented innovative solutions for the appropriate documentation and reporting of CPT and ICD-10 diagnostics codes, DRGs, HCCs and risk scores in support of CMS and ACA contracts. Created actionable dashboards with risk adjusted member and provider specific profiles to drive P4P and other value based initiatives; reversed a several year unfavorable trend of leakage of members to non-preferred

providers by $5.5M per year; identified over $20M in annual cost savings measures.

3M Health Information Systems

3M Health Information Systems
April 2010 - May 2016 (6 years 2 months)
San Francisco Bay Area

Strategic thought leader for the design and implementation of tools and solutions for the successful management of populations at risk and across the continuum of care. Served as the medical content and policy expert for current and new solutions including real time evidenced-based decision support tools utilizing Natural Language Processing (NLP) designed for providers and payers; DRG Assurance and APR-DRG severity adjusted tools to optimize quality and value-based outcomes for the health plan, employer, and patient and construction of web based dashboards that provided clear concise reports for stakeholders; deployment of proprietary solutions that identify stratify and manage HCCs and RAF scores, Potentially Preventable Complications (“PPCs”) Potentially Preventable Readmissions (“PPRs”) and Potentially Preventable Events (“PPEs”) including emergency department visits (“PPVs) by specific condition and physician ; Clinical Risk Groups (“CRGs”) for managed care risk arrangements (Medicare Advantage /Medicaid, Medical Groups, IPAs,and ACOs) and evidence based models to predict clinical and economic outcomes and ROI based on targeted interventions; developed produced and featured in 18 specialty videos and on line training modules for physicians and hospitals for ICD-10 documentation and coding with over 60,000 users; developed severity adjusted evidence based decision support tools for the “two midnight rule” and the appropriate documentation required to optimize appropriate DRG assignment for hospitals and to support risk scores for entities at risk under CMS and ACA arrangements; led a cadre of 3M physicians that conducted training of physicians, hospital and health plan executives and consulting services for over 1500 client organizations; actively engaged in development and deployment of marketing and sales initiatives for national clients.

UnitedHealth Group

Vice President Clinical Operations
March 2002 - November 2005 (3 years 9 months)
Minneapolis Minnesota

Served as Vice President, Clinical Operations Health Economics and participated in the development and implementation of solutions based on the APR-DRGs and other risk adjusters to identify and improve health plan physician and hospital quality performance, efficiency, quality and cost across the continuum of care; created tools to identify overuse, underuse Fraud and Abuse and best practices and medical content expert in major litigation and recovery projects;participated in the use of severity adjusted models that were used to identify and designate United Health Centers of Excellence; a medical content expert for the Ingenix “Technology Pipeline” which provided an analysis of new pharmaceutical agents, devices and technology and their medical appropriateness and safety and assessed proposed legislation and projected potential future utilization, safety costs and the “value” to the stakeholders: the health plan, beneficiaries, and providers. Participated in the strategic design and response to TRICARE and other RFPs.

Milliman Care Guidelines
Lead Clinical Consultant and Editor
February 1999 - April 2002 (3 years 3 months)

Served as the lead clinical consultant working collaboratively with clinicians and actuaries in providing performance improvement services to health plans, hospitals and physician groups.Editor of the Milliman Care Guidelines and implemented these across national and regional health plans and hospitals.

Arthur Andersen (1985 -> 2002) Official
Director of Patient Care Solutions
1999 - April 2002 (3 years)
Greater Chicago Area

Led a national health care practice which was focused on auditing and provided Continuous Process Improvement consulting services to publicly traded health care companies, PBMs, pharmaceutical and technology companies national regional and local health plans, hospitals, physicians and affiliated networks.

Patient Care Inc
Founder and CEO
January 1986 - May 1999 (13 years 5 months)

Founder and CEO of Patient Care Inc. which operated a multi-specialty physician provider organization based in San Diego and a leader in the design development for novel successful risk and other contracts in California and other states. Contracted with Aetna Government Health Plans and initiated

the first pilot program (CHAMPUS Reform Initiative) that was a precursor for TRICARE; contracted with QualMed in a successful response to a TRICARE RFP (later lost in an appeal); consulted and provided services to Humana Military Services TRICARE.
Founding Member, planned constructed and served on the Board of Directors and as the Medical Director of a 110 bed acute care hospital, San Diego; entered into a number of successful risk contracts.

Education

The Scripps Research Institute
Experimental Immunology · (1972 - 1973)

University of California, San Diego
Internal Medicine and Pulmonary · (1968 - 1973)

Thomas Jefferson University
Doctor of Medicine (MD) · (1964 - 1968)

Fairfield University
Bachelor's degree, Biology, General

Agenda Item 1

Action Item

Approval of Consent Calendar:

d. Credentialing and Recredentialing Recommendations

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
www.sfhp.org

MEMO

Date: October 27, 2020

To	Governing Board
From	James Glauber, MD, MPH Chair, Physician Advisory/Peer Review/Credentialing Committee
CC	Sean Dongre, Manager, Provider Network Operations
Regarding	Summary of SFHP Credentialing Activities (August 2020 to September 2020)

Recommendation:

San Francisco Health Plan (SFHP) completed the credentialing and recredentialing of the following practitioners and ancillary providers. SFHP's Physician Advisory/Peer Review/Credentialing Committee recommends the Governing Board approve the following providers for participation in the SFHP provider network.

PRACTITIONERS

NAME	DEGREE	BOARD	INITIAL / RECRED	LICENSE
Adam Francis	MD	Family Medicine	Initial	A122054
Nancy Myrick	CNM	N/A	Initial	1595
Carla Stern	OT	N/A	Initial	972
Sarah Jourdin	PT	N/A	Initial	15295
Charles Edwards	MD	Pediatrics	Initial	G81670
Frederick Adler	MD	Family Medicine	Initial	G50673
Deirdre O'Bryan	PT	N/A	Initial	16361
Min Suk Jun	DO	N/A	Initial	18386
Angela Solleder	NP	N/A	Initial	95006024

ANCILLARY

ORGANIZATION NAME	# OF SITES	TYPE OF SERVICE	INITIAL / RECREDENTIALED
Lifewatch Services, Inc	1	Independent Diagnostic Testing Facility	Recred
San Francisco Birth Center	1	Birth Center	Initial
Jewish Home and Rehab Center	1	Skilled Nursing Facility	Initial
Health At Home	1	Home Health	Initial
Crossroads Home Health and Hospice	1	Home Health and Hospice	Initial
Pathways Home Health and Hospice (Sunnyvale and South San Francisco)	2	Home Health and Hospice	Initial
Pathways Home Health and Hospice (Oakland)	1	Home Health and Hospice	Initial
Optum Infusion Services 401, LLC (Marina)	1	Home Infusion Pharmacy	Initial
Optum Infusion Services 401, LLC (Sacramento)	1	Home Infusion Pharmacy	Initial
Optum Infusion Services 403, LLC (Rohnert Park)	1	Home Infusion Pharmacy	Initial
24-7 MedTransport	1	Non-Emergency Medical Transportation	Initial
First Aid Transportation	1	Non-Emergency Medical Transportation	Initial

Agenda Item 1

Action Item

Approval of Consent Calendar:

e. Update to FY 20-21 Organizational Goals

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
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MEMO

Date	**October 27, 2020**
To	**Governing Board**
From	**John F. Grgurina, Jr., Chief Executive Officer**
Regarding	**FY 2020-21 Organizational Goals and Success Criteria- Update**

Recommendation

San Francisco Health Plan (SFHP) recommends the Governing Board approve one update to the organizational performance goals and success criteria for fiscal year 2020-2021 (FY 20-21) to define the metric for Goal 3.2 to increase telehealth utilization by 25% as the stretch goal.

Update to the FY 20-21 Goals

The following is an excerpt of the FY 20-21 organizational goals that were approved by the Governing Board in June 2020. There is one update to the second goal of Goal 3.2. There is no change to the Goal 3.1, which was passing the NCQA renewal survey.

Strategic Anchor 3:
Exemplary Service to Members and Stakeholders – 20 points

We are committed to providing exemplary service and support to our members, participants, purchasers, physicians and other health care providers, and each other. SFHP fosters a culture of ownership, accountability and continuous improvement (CI) within SFHP.

Goal 3.2: Maintain primary care utilization and support ongoing transition to telehealth modalities.

The pandemic caused a dramatic reduction in primary care visits, despite increased flexibilities afforded for telehealth care. It is critical to our providers' financial viability and our members' health that primary care utilization is restored to pre-pandemic levels. Given the need for continuing social distancing and evolving member experience with and preference for telehealth, we will transition primary care utilization to telehealth.

- Restore primary care utilization to pre-pandemic levels.

  Goal: By Q2 2021, restore overall primary care utilization (visits/1000mm) to pre-pandemic level in Q2 2019.

  Minimum (**3 points**): PCP visits/1000mm >80%-90% of Q2 2019 rate
  Meets (**4 points**): PCP visits/1000mm >90%-100% of Q2 2019 rate
  Stretch (**5 points**): Q2 2021 PCP visits/1000mm greater than or equal to rate in Q2 2019

- **The following goal has been updated to include the targets for the minimum, meets and stretch goals.**

  Goal: Increase percentage of primary care visits delivered by telehealth modalities.

  Minimum (**3 points**) – 15% to 19.99%
  Meets (**4 points**) – 20% to 24.99%
  Stretch (**5 points**) – 25% or more

FY 20-21 Organizational Goals and Success Criteria

SFHP Strategic Anchors	FY 20-21 Success Criteria Measures	Score
3. Exemplary Service to Members and Stakeholders - We are committed to providing exemplary service and support to our members, participants, purchasers, physicians and other health care providers, and each other.	**3.1. Achieve Renewal accreditation with the National Committee for Quality Assurance (NCQA) by January 31, 2021.** All points will be awarded if the Renewal survey is passed by January 31, 2021; zero points will be awarded accreditation is not achieved. Pass/No Pass - **10 points**	10
	3.2 Maintain primary care utilization and support ongoing transition to telehealth modalities. The pandemic caused a dramatic reduction in primary care visits, despite increased flexibilities afforded for telehealth care. It is critical to our providers' financial viability and our members' health that primary care utilization is restored to pre-pandemic levels. Given the need for continuing social distancing and evolving member experience with and preference for telehealth, we will transition primary care utilization to telehealth. • Restore primary care utilization to pre-pandemic levels. Goal: By Q2 2021, restore overall primary care utilization (visits/1000mm) to pre-pandemic level in Q2 2019. Minimum (**3 points**): PCP visits/1000mm >80%-90% of Q2 2019 rate Meets (**4 points**): PCP visits/1000mm >90%-100% of Q2 2019 rate Stretch (**5 points**): Q2 2021 PCP visits/1000mm greater than or equal to rate in Q2 2019 • Goal: Increase percentage of primary care visits delivered by telehealth modalities. Minimum (**3 points**) – 15% to 19.99% Meets (**4 points**) – 20% to 24.99% Stretch (**5 points**) – 25% or more	10
	Total	**20**

Agenda Item 1

Action Item

Approval of Consent Calendar:

f. Payment of CalPERS Unfunded Liability

SAN FRANCISCO HEALTH PLAN
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Finance Committee & Governing Board

MEMO

Date:	**October 27, 2020**
To:	**Finance Committee and Governing Board**
From:	**Skip Bishop, Chief Financial Officer** **John F. Grgurina Jr., Chief Executive Officer**
Regarding:	**Review and Approval of Payment of CalPERS Unfunded Accrued Liability**

Recommendation:
San Francisco Health Plan (SFHP) recommends approval to pay the entire projected amount of SFHP's CalPERS pension unfunded accrued liability estimated to be $478,512, which is projected forward to June 30, 2021.

If approved, payment will be made by November 15, 2020.

Background:
The Government Accounting Standards Board (GASB) Statement number 27 (GASB 27) is in reference to an accounting standard for pension by State and Local Government Employers. It specifies that an employer's fiscal years ending on or after 2015 must accrue for unfunded pension liabilities.

SFHP is a government employer in the CalPERS Miscellaneous Pooled Plans for the defined benefit pension plan known as 2% @ 55 for employees with hire dates prior to January 1, 2013 (Classic Miscellaneous Plan) and 2% @ 62 for employees with hire dates after December 31, 2012 (PEPRA Miscellaneous). According to CalPERS letters attached to this memo, SFHP's projected unfunded accrued liability as of June 30, 2021 is as follows:

• Classic Miscellaneous Plan	$ 349,346
• PEPRA Miscellaneous Plan	$ 129,166
Total unfunded accrued liability	$ 478,512

When projecting how future year pension obligations will be met, CalPERS assumed a 7.0% annual rate of return on its investment portfolio. CalPERS achieved an 6.7% return for the year ending June 30, 2019. As CalPERS missed the target of 7.0%, our pension accounts now have unfunded liability balances.

This payment will be treated as Prepaid Pension Expense for FY 20-21. The Prepaid Pension Expense will be amortized and recorded as an administrative expense during FY 21-22.

CalPERS is offering the following options to pay off the unfunded accrued liability:

1) Pay it back over a 20-year period with annual interest payments of 7.0% (this is the assumed annual investment rate of return CalPERS is using for all pension funds). This would mean total payments of $911,158 (interest payments would be $411,911 of this total amount).
2) Pay it back over a 15-year period with annual interest payments of 7.0%. This would mean total payments of $794,869 (interest payments would be $295,622 of this total amount).
3) Pay it all in one payment now.

SFHP is recommending to the Finance Committee and the Governing Board to pay off the entire amount now. The reasons are:

1) It is financially advantageous to pay the entire amount to avoid the annual 7.0% interest payments totaling $295,622 over 15 years versus keeping the cash in our Liquid Management Portfolio account at a current annual investment return of 0.10%.
2) Because of SFHP's strong financial balance sheet, we currently have the cash to pay off the entire amount now.
3) Paying off the unfunded accrued liability would place SFHP's CalPERS pension funding level at approximately 100% (currently at 97.4%).

CalPERS has reported a preliminary 4.7% net return on investments for the 12-month period ending June 30, 2020. The next annual valuation reports are expected to be available in July 2021, at which time CalPERS will provide an update of pension funding levels.

California Public Employees' Retirement System
Actuarial Office
400 Q Street, Sacramento, CA 95811 |Phone: (916) 795-3000 | Fax: (916) 795-2744
888 CalPERS (or **888**-225-7377) | TTY: (877) 249-7442 | **www.calpers.ca.gov**

September 21, 2020

CalPERS ID: 1822494442
Employer Name: SAN FRANCISCO HEALTH AUTHORITY
Rate Plan: MISCELLANEOUS PLAN [3251]

Re: Lump Sum Payment to reduce the Unfunded Accrued Liability

Dear Requestor:

As requested, information on the fiscal year 2021-22 employer contribution requirement following your lump sum payment is shown below.

If you are aware of others interested in this information (i.e. payroll staff, county court employees, port districts, etc.), please inform them.

The information is based on the most recent annual valuation and assumes payment by *November 13, 2020* and no further contractual or financing changes taking effect before June 30, 2021. The Unfunded Accrued Liability (UAL) will be eliminated by a lump sum payment in the amount of **$349,346**.

There will be no change to your FY 2020-21 contributions.

Valuation as of June 30, 2019	Pre-Payment	Post-Payment
Projected 6/30/2021 Total Unfunded Liability	$ 364,484	
Payment on November 13, 2020	$ 349,346	
Revised 6/30/2021 Total Unfunded Liability		**$ 0**
FY 2021-22 Employer Contributions		
Base Total Normal Cost for Formula	17.25%	17.25%
Surcharges for Class 1 Benefit		
None	0.00%	0.00%
Phase out of Normal Cost Difference	0.00%	0.00%
Plan's Total Normal Cost	17.25%	17.25%
Formula's Expected Employee Contribution Rate	6.91%	6.91%
Employer Normal Cost Rate	10.34%	10.34%
Employer Unfunded Liability Payment	$ 19,268	$ 0

The attached schedule of the plan's amortization bases includes the additional discretionary payment(s) listed above.

		Fiscal Year
Required Employer Contribution		**2021-22**
Employer Normal Cost Rate		**10.34%**
Plus Either		
1) Monthly Employer Dollar UAL Payment	**$**	**0.00**
Or		
2) Annual UAL Prepayment Option*	**$**	**0**

*The total minimum required employer contribution is the **sum** of the Plan's Employer Normal Cost Rate (expressed as a percentage of payroll) **plus** the Employer Unfunded Accrued Liability (UAL) Contribution Amount (billed monthly in dollars).*

** Only the UAL portion of the employer contribution can be prepaid **(which must be received in full no later than July 31)**. Any prepayment totaling over $5 million requires a 72-hour notice email to FCSD_public_agency_wires@calpers.ca.gov. Plan Normal Cost contributions will be made as part of the payroll reporting process. If there is contractual cost sharing or other change, this amount will change.*

In accordance with Sections 20537 and 20572 of the Public Employees' Retirement Law, if a contracting agency fails to remit the required contributions when due, interest and penalties may apply.

To initiate this payment, the enclosed Lump Sum Payment Request must be completed and returned to the CalPERS Fiscal Services Division with payment by Electronic Funds Transfer (EFT) or wire transfer by November 13, 2020. A copy should be sent to us.

If you have questions, please call (888) CalPERS (225-7377).

SHELLY CHU, ASA, MAAA
Senior Pension Actuary, CalPERS

Schedule of Amortization Bases

Reason for Base	Date Established	Ramp Up/Down 2021-22	Escalat-ion Rate	Amorti -zation Period	Balance 6/30/19	Expected Payment 2019-20	Balance 6/30/20	Expected Payment 2020-21	Balance 6/30/21	Scheduled Payment for 2021-22
FRESH START	06/30/18	No Ramp	2.75%	1	$647,213	$669,482	$0	$0	$0	$0
NON-INVESTMENT (GAIN)/LOSS	06/30/19	No Ramp	0.00%	20	$142,229	$0	$152,185	$157,421	$0	$0
INVESTMENT (GAIN)/LOSS	06/30/19	20% ↗	0.00%	20	$176,125	$0	$188,454	$194,939	$0	$0
TOTAL					**$965,567**	**$669,482**	**$340,639**	**$352,360**	**$0**	**$0**

This schedule assumes an additional discretionary payment is made in the amount and by the date stated on page 1 of this letter.

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LUMP SUM PAYMENT REQUEST

Please complete and return this form by either mail or e-mail.

Mail	CalPERS – FRAS Cash and Payments Processing Unit P.O. Box 942703 Sacramento, CA 94229-2703
E-mail	FCSD_public_agency_wires@calpers.ca.gov

Payment may be made by EFT through myCalPERS or wire transfer.

EFT through myCalPERS	E-mail *FCSD_public_agency_wires@calpers.ca.gov* at least two business days prior to the payment date. A receivable in the amount of the payment will be established. Once you are notified that the receivable has been established, sign in to your my|CalPERS account and submit payment via Electronic Funds Transfer (EFT).
Wire	ABA#0260-0959-3 Bank of America Sacramento Main 555 Capitol Mall, Suite 1555 Sacramento, CA 95814 For credit to State of CA, CalPERS Account # 01482-80005 E-mail *FCSD_public_agency_wires@calpers.ca.gov* and your actuary on the day of the wire to ensure timely crediting to your account. **Any individual wire totaling over $5,000,000 requires 72-hour notice.**

Employer Name: SAN FRANCISCO HEALTH AUTHORITY
CalPERS ID: 1822494442
Member Group or Plan: MISCELLANEOUS PLAN
Rate Plan ID: 3251

Amount: **$ 349,346**

Purpose:	UAL Payoff
Base(s) to which payment is applied:	N/A

In recognition of our payment please revise our required employer contribution effective July 1, 2021:

Name and Title: (Please Print): _____

Signature: _____Date: _____

Mailing Address: _____

City/State/Zip: _____

Telephone Number: _____Fax Number: _____

E-mail Address: _____

California Public Employees' Retirement System
Actuarial Office
400 Q Street, Sacramento, CA 95811 |Phone: (916) 795-3000 | Fax: (916) 795-2744
888 CalPERS (or **888**-225-7377) | TTY: (877) 249-7442 | **www.calpers.ca.gov**

September 21, 2020

CalPERS ID: 1822494442
Employer Name: SAN FRANCISCO HEALTH AUTHORITY
Rate Plan: PEPRA MISCELLANEOUS PLAN [27238]

Re: Lump Sum Payment to reduce the Unfunded Accrued Liability

Dear Requestor:

As requested, information on the fiscal year 2021-22 employer contribution requirement following your lump sum payment is shown below.

If you are aware of others interested in this information (i.e. payroll staff, county court employees, port districts, etc.), please inform them.

The information is based on the most recent annual valuation and assumes payment by *November 13, 2020* and no further contractual or financing changes taking effect before June 30, 2021. The Unfunded Accrued Liability (UAL) will be eliminated by a lump sum payment in the amount of **$129,166**.

There will be no change to your FY 2020-21 contributions.

Valuation as of June 30, 2019	Pre-Payment	Post-Payment
Projected 6/30/2021 Total Unfunded Liability	$ 134,763	
Payment on November 13, 2020	$ 129,166	
Revised 6/30/2021 Total Unfunded Liability		**$ 0**
FY 2021-22 Employer Contributions		
Base Total Normal Cost for Formula	14.34%	14.34%
Surcharges for Class 1 Benefit		
None	0.00%	0.00%
Phase out of Normal Cost Difference	0.00%	0.00%
Plan's Total Normal Cost	14.34%	14.34%
Formula's Expected Employee Contribution Rate	6.75%	6.75%
Employer Normal Cost Rate	7.59%	7.59%
Employer Unfunded Liability Payment	$ 7,183	$ 0

The attached schedule of the plan's amortization bases includes the additional discretionary payment(s) listed above.

		Fiscal Year
Required Employer Contribution		**2021-22**
Employer Normal Cost Rate		**7.59%**
Plus Either		
1) Monthly Employer Dollar UAL Payment	**$**	**0.00**
Or		
2) Annual UAL Prepayment Option*	**$**	**0**

*The total minimum required employer contribution is the **sum** of the Plan's Employer Normal Cost Rate (expressed as a percentage of payroll) **plus** the Employer Unfunded Accrued Liability (UAL) Contribution Amount (billed monthly in dollars).*

** Only the UAL portion of the employer contribution can be prepaid **(which must be received in full no later than July 31)**. Any prepayment totaling over $5 million requires a 72-hour notice email to FCSD_public_agency_wires@calpers.ca.gov. Plan Normal Cost contributions will be made as part of the payroll reporting process. If there is contractual cost sharing or other change, this amount will change.*

In accordance with Sections 20537 and 20572 of the Public Employees' Retirement Law, if a contracting agency fails to remit the required contributions when due, interest and penalties may apply.

To initiate this payment, the enclosed Lump Sum Payment Request must be completed and returned to the CalPERS Fiscal Services Division with payment by Electronic Funds Transfer (EFT) or wire transfer by November 13, 2020. A copy should be sent to us.

If you have questions, please call (888) CalPERS (225-7377).

SHELLY CHU, ASA, MAAA
Senior Pension Actuary, CalPERS

Schedule of Amortization Bases

Reason for Base	Date Established	Ramp Up/Down 2021-22	Escalat-ion Rate	Amorti -zation Period	Balance 6/30/19	Expected Payment 2019-20	Balance 6/30/20	Expected Payment 2020-21	Balance 6/30/21	Scheduled Payment for 2021-22
FRESH START	06/30/18	No Ramp	2.75%	1	$585,750	$605,904	$0	$0	$0	$0
NON-INVESTMENT (GAIN)/LOSS	06/30/19	No Ramp	0.00%	20	$53,333	$0	$57,066	$59,030	$0	$0
INVESTMENT (GAIN)/LOSS	06/30/19	20% ↗	0.00%	20	$64,374	$0	$68,880	$71,250	$0	$0
TOTAL					**$703,457**	**$605,904**	**$125,946**	**$130,280**	**$0**	**$0**

This schedule assumes an additional discretionary payment is made in the amount and by the date stated on page 1 of this letter.

LUMP SUM PAYMENT REQUEST

Please complete and return this form by either mail or e-mail.

Mail	CalPERS – FRAS Cash and Payments Processing Unit P.O. Box 942703 Sacramento, CA 94229-2703
E-mail	FCSD_public_agency_wires@calpers.ca.gov

Payment may be made by EFT through myCalPERS or wire transfer.

EFT through myCalPERS	E-mail *FCSD_public_agency_wires@calpers.ca.gov* at least two business days prior to the payment date. A receivable in the amount of the payment will be established. Once you are notified that the receivable has been established, sign in to your my|CalPERS account and submit payment via Electronic Funds Transfer (EFT).
Wire	ABA#0260-0959-3 Bank of America Sacramento Main 555 Capitol Mall, Suite 1555 Sacramento, CA 95814 For credit to State of CA, CalPERS Account # 01482-80005 E-mail *FCSD_public_agency_wires@calpers.ca.gov* and your actuary on the day of the wire to ensure timely crediting to your account. **Any individual wire totaling over $5,000,000 requires 72-hour notice.**

Employer Name: SAN FRANCISCO HEALTH AUTHORITY
CalPERS ID: 1822494442
Member Group or Plan: PEPRA MISCELLANEOUS PLAN
Rate Plan ID: 27238

Amount: **$ 129,166**

Purpose:	UAL Payoff
Base(s) to which payment is applied:	N/A

In recognition of our payment please revise our required employer contribution effective July 1, 2021:

Name and Title: (Please Print): _____

Signature: _____Date: _____

Mailing Address: _____

City/State/Zip: _____

Telephone Number: _____Fax Number: _____

E-mail Address: _____

Agenda Item 2
Action Item

- Review and Approval of the Annual Independent Audit Report for FY 2019-20 (Moss Adams Consultants, LLP)

MOSSADAMS

San Francisco Health Authority and San Francisco Community Health Authority

Report of Independent Auditors

Report of Independent Auditors

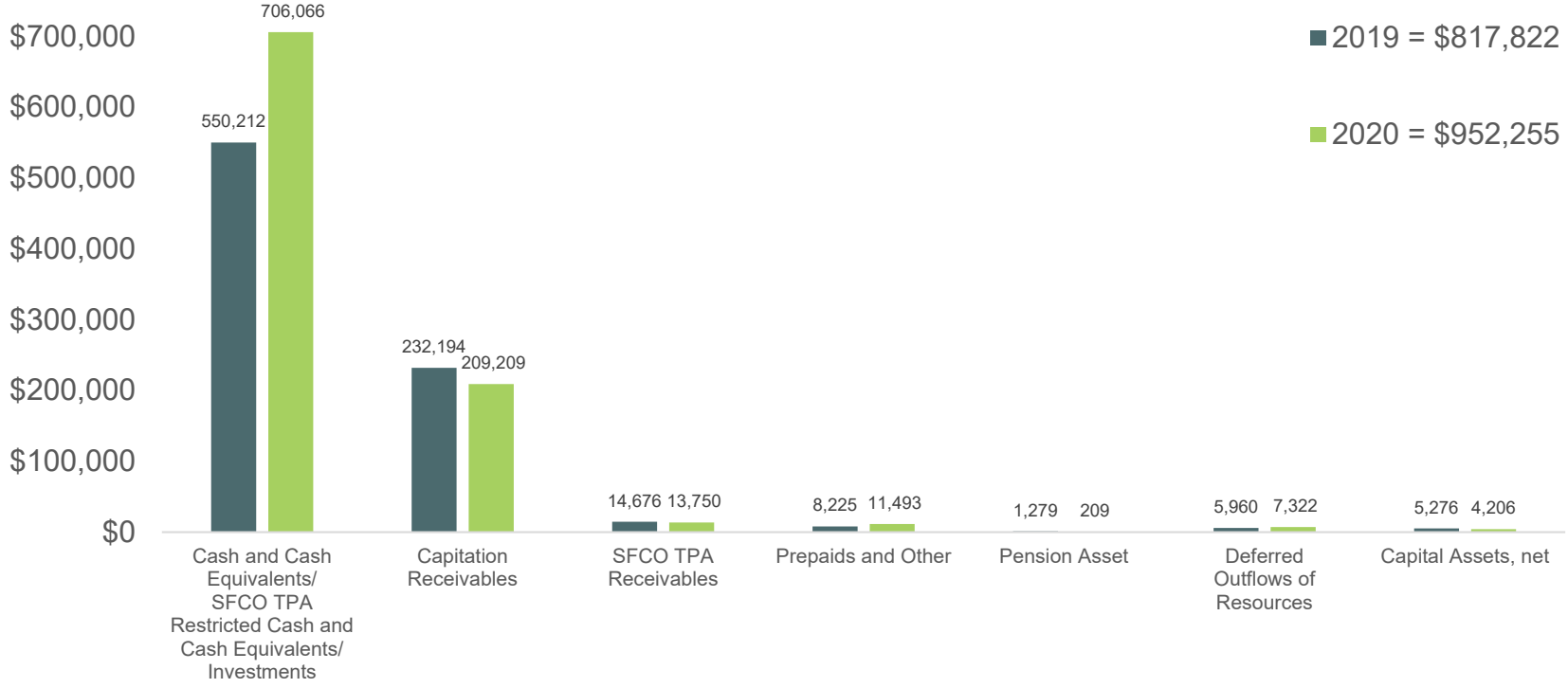
Unmodified Opinion

Combined financial statements are fairly presented in accordance with generally accepted accounting principles.

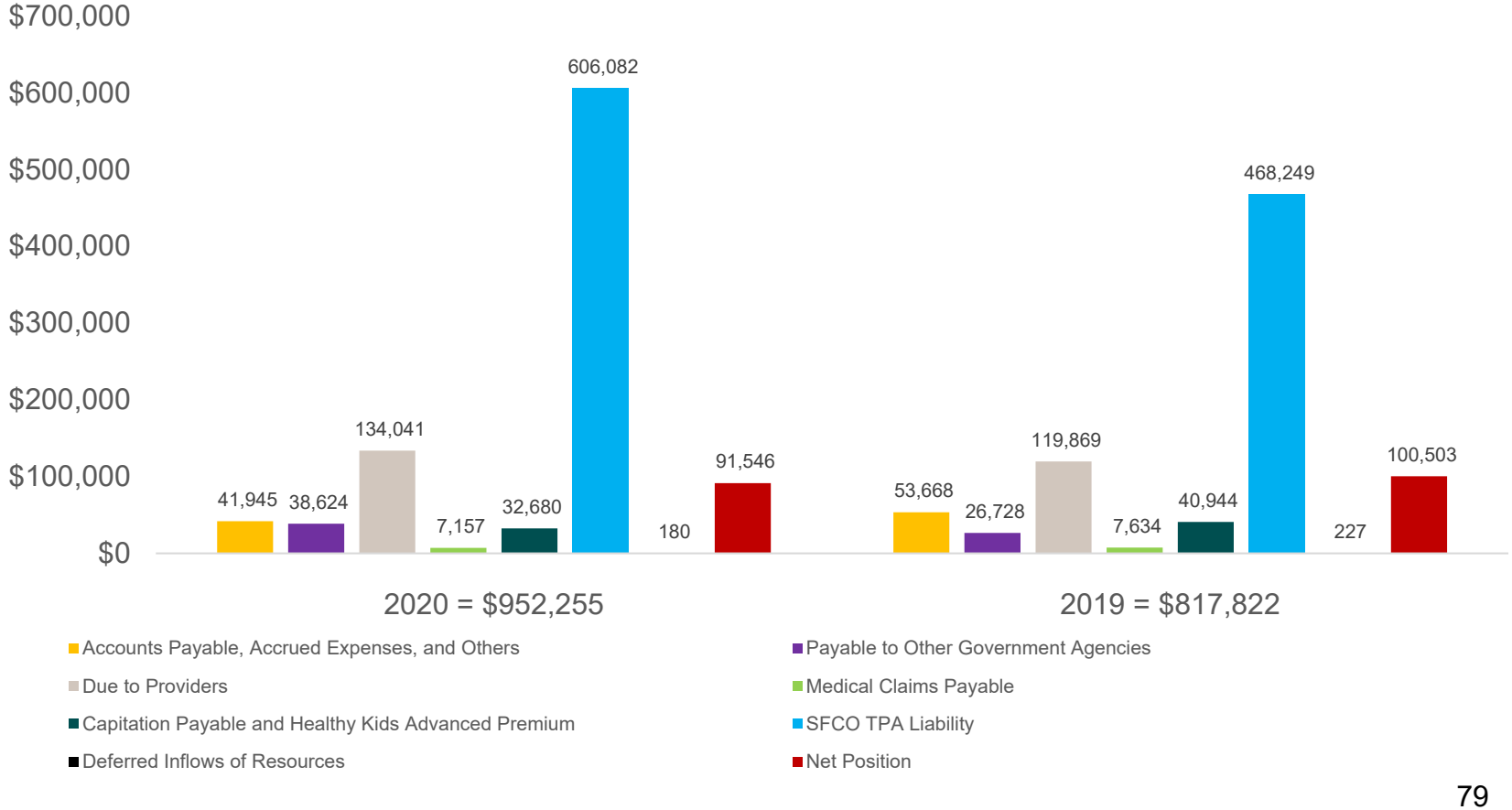
1

Combined Statements of Net Position

Assets and Deferred Outflows and Resources (in thousands)



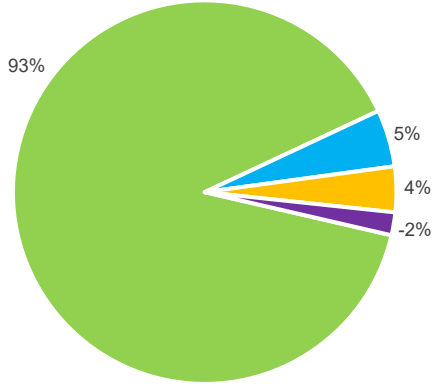
Liabilities, Deferred Inflows of Resources, and Net Position (in thousands)

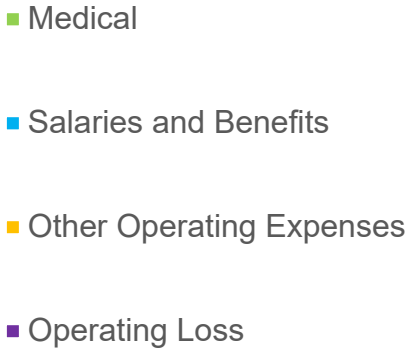


Operations

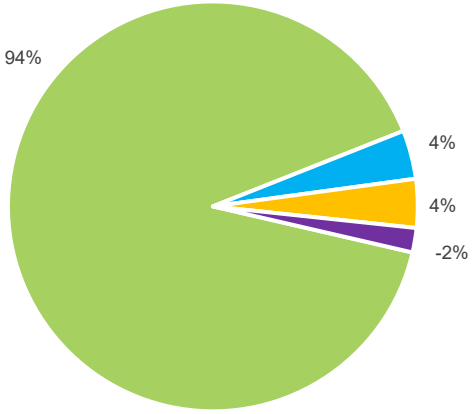
Operating Expenses as a Percentage of Total Revenues (without SFCO TPA) (in thousands)

June 30, 2020
$600,865



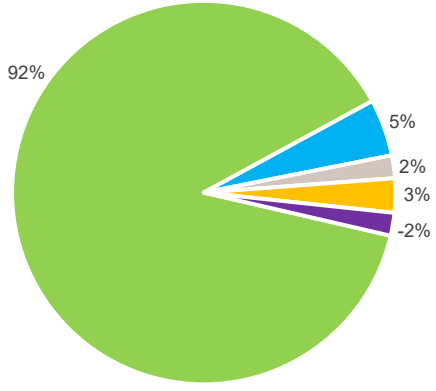


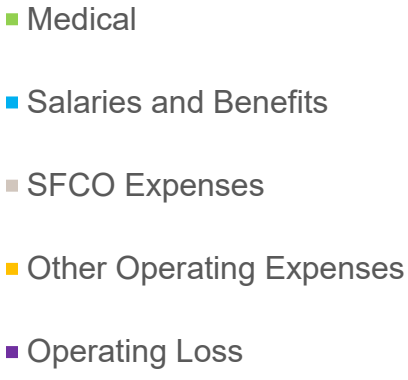
June 30, 2019
$607,073



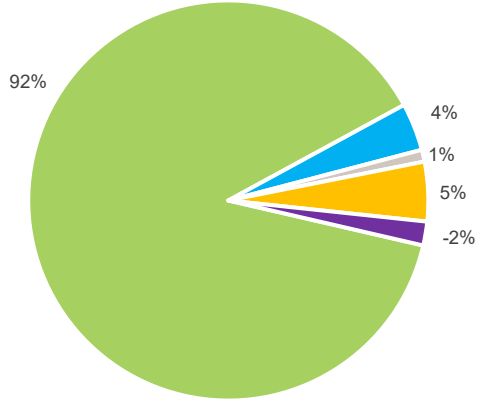
Operating Expenses as a Percentage of Total Revenues (with SFCO TPA) (in thousands)

June 30, 2020
$610,850

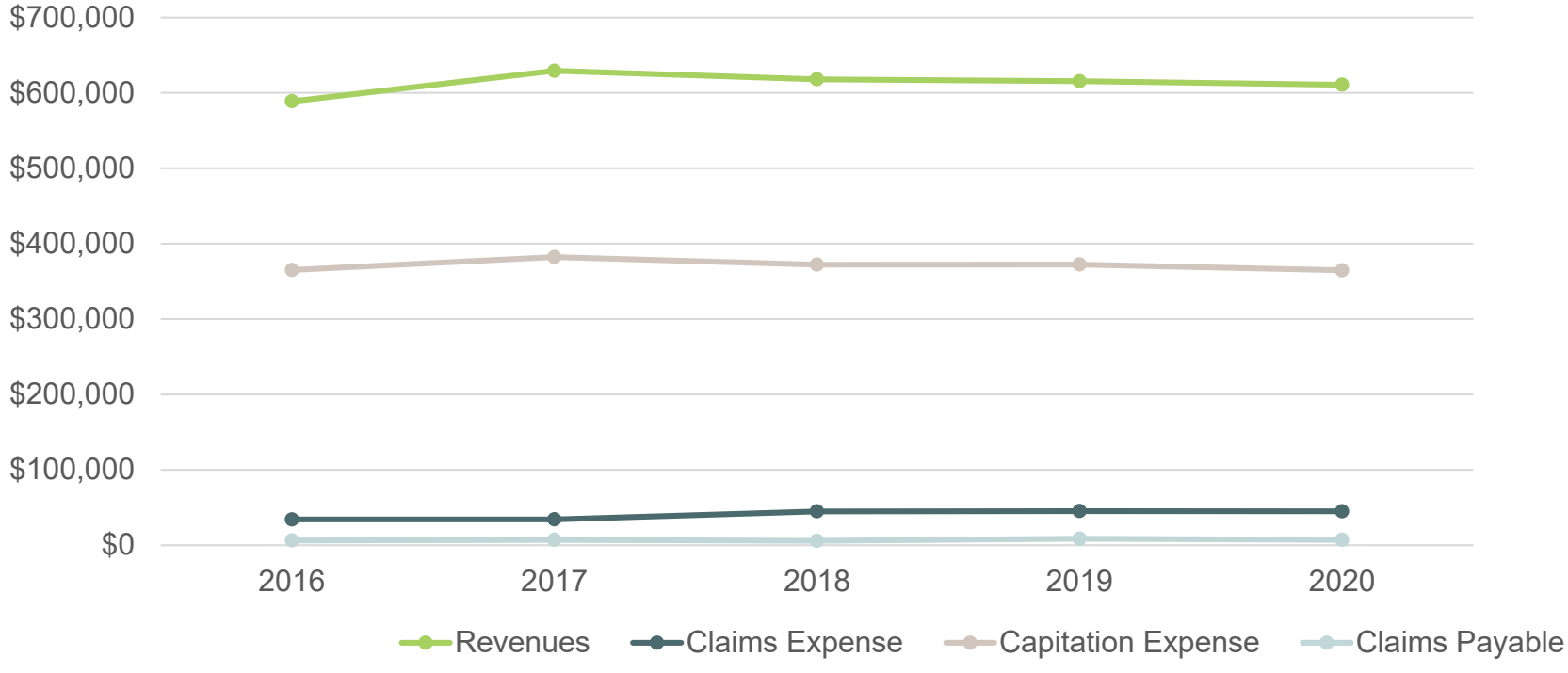




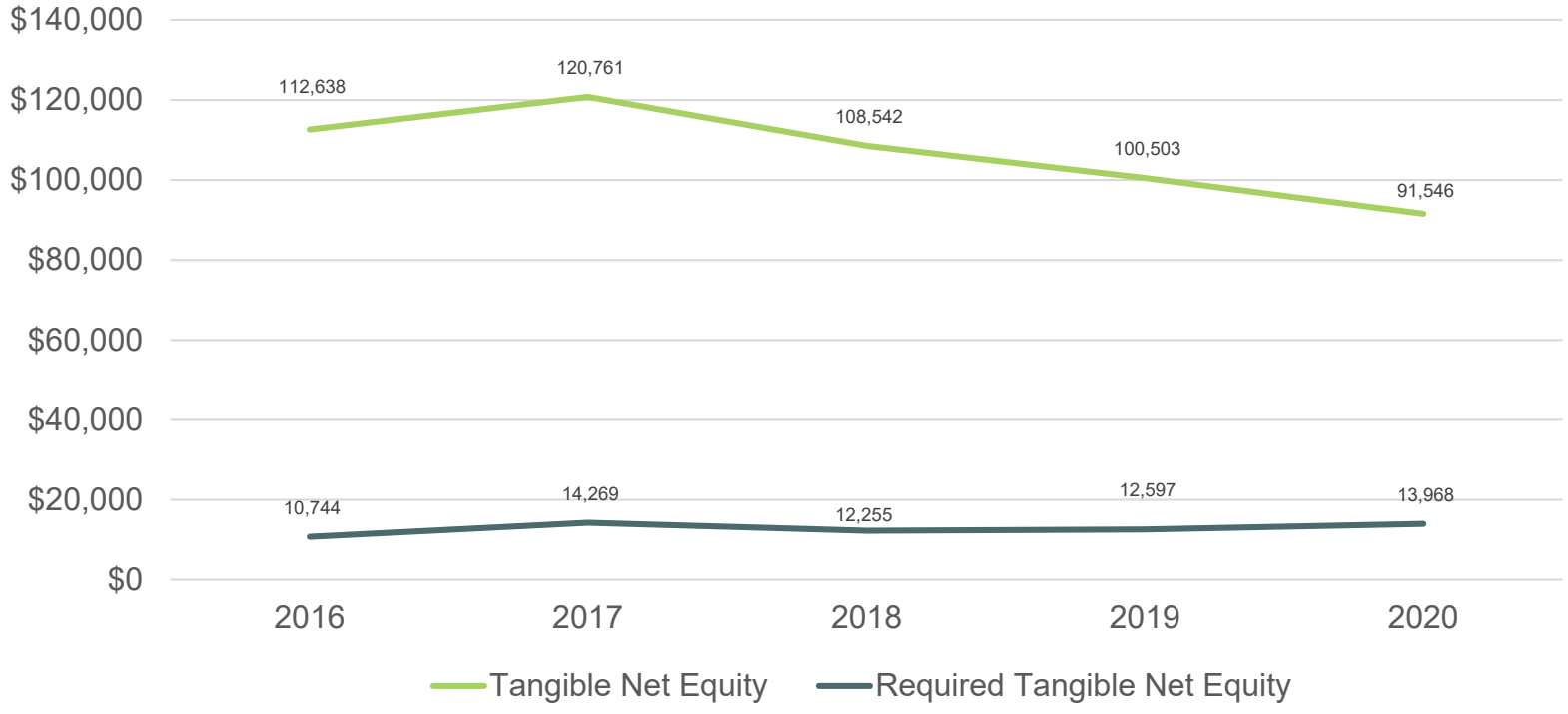
June 30, 2019
$615,519



Revenues, Claims Expense, Capitation Expense, and Claims Payable (in thousands)



Tangible Net Equity (in thousands)



Source: Annual Department of Managed Health Care Filing

Important Board Communications

- AU-C Section 260 – *The Auditor's Communication with Those Charged with Governance*
- AU-C Section 265 – *Communication of Internal Control Related Matters*
- Significant accounting policies
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of instances of fraud or noncompliance with laws and regulations

Questions?

THANK YOU

Communications with Those Charged with Governance

San Francisco Health Authority and San Francisco Community Health Authority

June 30, 2020

MOSSADAMS

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Communications with Those Charged with Governance

To the Governing Board
San Francisco Health Authority and San Francisco Community Health Authority

We have audited the combined financial statements of San Francisco Health Authority and San Francisco Community Health Authority (collectively the "Plan"), as of and for the year ended June 30, 2020, and have issued our report thereon dated October 26, 2020. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated July 20, 2020, our responsibility, as described by professional standards, is to form and express an opinion about whether the combined financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Our audit of the combined financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2 Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts, and to design the audit to obtain reasonable, rather than absolute, assurance about whether the combined financial statements are free from material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control over financial reporting. Accordingly, we considered the Plan's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the combined financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated July 20, 2020, and our planning meeting with management on July 22, 2020.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Plan are described in Note 2 to the combined financial statements. There were no changes in the application of existing policies during 2020. We noted no transactions entered into by the Plan during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the combined financial statements in a different period than when the transactions occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the combined financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the combined financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the combined financial statements were:

- Management recorded an estimated liability for incurred but unreported claims expense. The estimated liability for unreported claims is based on management's estimate of historical claims experience and known activity subsequent to year end. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

- Management recorded an estimated capitation receivable. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon a historical experience methodology. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

- Management recorded an estimated payable to governmental agencies. The estimated payable for eligible Medi-Cal program beneficiaries is based upon estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

- Management's estimate of the fair market values of investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.

- The useful lives of capital assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America.

- Management's estimate of the net pension asset is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

Combined Financial Statement Disclosures

The disclosures in the combined financial statements are consistent, clear, and understandable. Certain combined financial statement disclosures are particularly sensitive because of their significance to combined financial statement users. The most sensitive disclosures affecting the Plan's combined financial statements relate to medical claims payable, fair value of investments, and capitation revenues.

Significant Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected or uncorrected misstatements whose effects, as determined by management, are material, both individually and in the aggregate, to the combined financial statements as a whole.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the combined financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the attached management representation letter dated October 26, 2020.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Plan's combined financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Independence

We are required to disclose to those charged with governance, in writing, all relationships between the auditors and the Plan that in the auditor's professional judgment, may reasonably be thought to bear on our independence. We know of no such relationships and confirm that, in our professional judgment, we are independent of the Plan within the meaning of professional standards.

Other Significant Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Plan's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of the Governing Board and management of San Francisco Health Authority and San Francisco Community Health Authority, and is not intended to be, and should not be, used by anyone other than these specified parties.

Moss Adams LLP

San Francisco, California
October 26, 2020

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
sfhp.org

October 26, 2020

Moss Adams LLP
101 Second Street, Suite 900
San Francisco, CA 94105

We are providing this letter in connection with your audits of the combined financial statements of San Francisco Health Authority and San Francisco Community Health Authority (collectively "the Plan"), which comprise the related combined statements of net position, statements of revenues, expenses, and changes in net position, and cash flows as of June 30, 2020 and 2019 and for the years then ended and the related notes to the combined financial statements for the purpose of expressing an opinion as to whether the combined financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $900,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the combined financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of the date of this letter.

Combined Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated July 20, 2020, for the preparation and fair presentation of the combined financial statements in accordance with U.S. GAAP.
2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.
3. We acknowledge our responsibility for the design, implementation and maintenance of internal controls to prevent and detect fraud.
4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
5. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.
6. All events subsequent to the date of the combined financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.
7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.
8. The following, if any, have been properly recorded or disclosed in the combined financial statements:
    a. Related-party transactions, including sales, purchases, loans, transfers, leasing arrangements, and guarantees, and amounts receivable from or payable to related parties.
    b. Guarantees, whether written or oral, under which the Plan is contingently liable.
    c. Significant estimates and material concentrations known to management that are required to be disclosed in accordance with the Government Account Standards Board ("GASB") Codification Section C50, *Claims and Judgments* [Significant estimates are estimates at the balance sheet date that could change materially within the next year. Concentrations refer to volumes of business, revenues, available sources of supply, or markets or geographic areas for which events could occur that would significantly disrupt normal finances within the next year.]

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9. There are no estimates that may be subject to a material change in the near term that have not been properly disclosed in the combined financial statements. We understand that *near term* means the period within one year of the date of the combined financial statements. In addition, we have no knowledge of concentrations existing at the date of the combined financial statements that make the Plan vulnerable to the risk of severe impact that have not been properly disclosed in the combined financial statements. We understand that concentrations include individual or group concentrations of payers, members, suppliers, lenders, products, services, sources of labor or materials, licenses or other rights, or operating areas or markets. We further understand that *severe impact* means a significant financially disruptive effect on the normal functioning of the Plan.

Information Provided

10. We have provided you with:
    a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the combined financial statements such as records, documentation and other matters;
    b. Minutes of the meetings of the Board of Governors, directors, and committees of directors, or summaries of actions of recent meetings for which minutes have not yet been prepared;
    c. Additional information that you have requested from us for the purpose of the audit;
    d. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
11. We acknowledge our responsibility for the design and implementation of programs and controls to prevent and detect fraud. We understand the term “fraud” includes misstatements arising from fraudulent financial reporting and misstatements arising from misappropriation of assets. Misstatements arising from fraudulent financial reporting are intentional misstatements, or omissions of amounts or disclosures in the combined financial statements to deceive financial statement users. Misstatements arising from misappropriation of assets involve the theft of an entity’s assets where the effect of the theft causes the condensed interim combined financial information not to be presented in conformity with accounting principles generally accepted in the United States of America.
12. All transactions have been properly recorded in the accounting records and are reflected in the combined financial statements.
13. Receivables recorded in the combined financial statements represent valid claims for charges arising on or before June 30, 2020 and 2019.
14. We have disclosed to you the results of our assessment of the risk that the combined financial statements are not materially misstated as a result of fraud.
15. We have no knowledge of any fraud or suspected fraud that affects the entity and involves—
    a. Board of Governors,
    b. Management,
    c. Employees who have significant roles in internal control, or
    d. Others when the fraud could have a material effect on the combined financial statements.
16. There are no—
    a. There are no violations or possible violations of laws or regulations that exist, such as those related to Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the combined financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the combined financial statements. This is including, but not limited to, the antikickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law), and the False Claims Act.
    b. Possible illegal acts brought to the attention of management.

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c. Unasserted claims or assessments that our lawyer has advised us are probable of assertion and must be disclosed in accordance with GASB 62 section 1500, *Reporting Liabilities*, paragraph .114 and section C50, *Claims and Judgments*, paragraph .115.

d. Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB 62 section 1500 paragraph .114 and section C50 paragraph .115.

17. We have no knowledge of any allegations of fraud or suspected fraud, affecting the entity's combined financial statements communicated by employees, former employees, analysts, regulators or others.
18. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing combined financial statements.
19. The Plan has no plans or intentions that may materially affect the carrying value or classification of assets and liabilities.
20. The Plan has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral.
21. We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the combined financial statements.
22. We have disclosed to you the identity of the Plan's related parties and all the related party relationships and transactions of which we are aware.
23. The Plan has complied with all aspects of contractual agreements that would have a material effect on the combined financial statements in the event of noncompliance.
24. There have been no internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the combined financial statements or on the disclosure in the notes to the combined financial statements.
25. We have disclosed to you any change in the Plan's internal control over financial reporting that occurred during the Plan's most recent fiscal year that has materially affected, or is reasonably likely to materially affect, the Plan's internal control over financial reporting.
26. There have been no oral or written communications from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction, including those related to Medicare and Medicaid antifraud and abuse statutes; deficiencies in financial reporting practices; or other matters that could have a material adverse effect on the combined financial statements.
27. The liability for health unpaid claims and claims adjustment expenses, including amounts for incurred but not reported claims, has been determined using appropriate estimated ultimate costs of settling the claims (including the effects of inflation and other societal and economic factors), considering past experience adjusted for current trends and any other factors that would modify past experience. The estimated liability is to the best of our knowledge and belief, an accurate estimate of our incurred but unreported health claims liability as of June 30, 2020 and 2019. The data used in projecting the ultimate unpaid claims and claims adjustment expense is complete and accurate, and is reconciled to the underlying accounting records.
28. We have determined the liability for health unpaid claims and claims adjustments expenses related to Community-Based Adult Services ("CBAS") members are immaterial to the combined financial statements as of June 30, 2020 and 2019. As such, no liability is recorded in the combined financial statements at year-end.
29. We agree with the findings of specialists in evaluating the liability for health unpaid claims and claims adjustment expenses and have adequately considered the qualifications of the specialist in determining the amounts and disclosures used in the combined financial statements and underlying accounting records. We do not give or cause any instructions to be given to specialists with respect to values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have an impact on the independence or objectivity of the specialist.
30. We believe that the actuarial assumptions and methods used to measure pension liabilities and costs for financial accounting purposes are appropriate in the circumstances. We agree with the findings of CalPERS (specialist) in evaluating our pension liabilities and costs and have adequately considered the qualifications of CalPERS (specialist) in determining the amounts and disclosures used in the combined financial statements and underlying accounting records. We did not give or cause any instructions to be given to CalPERS

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(specialist) with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of CalPERS (specialists).

31. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by third-party organizations or other regulatory agencies.

32. All reinsurance transactions entered into by the Plan are final and there are no side agreements with reinsurers, or other terms in effect, which allow for the modification of term under existing reinsurance arrangements. Furthermore, the Plan's reinsurance arrangements meet the risk transfer provisions of GASB Codification Section P20, *"Public Entity Risk Pools"*, or are accounted for as deposits.

33. The Plan has been in compliance with the requirements of licensure under the Knox-Keene Health Care Service Plan Act of 1975 at June 30, 2020 and 2019.

34. The Plan has appropriately reconciled its books and records (e.g., general ledger accounts) underlying the combined financial statements to their related supporting information (e.g. sub ledger or third-party data). All related reconciling items considered to be material were identified and included on the reconciliations and were appropriately adjusted in the combined financial statements. There were no material unreconciled differences or material general ledger suspense account items that should have been adjusted or reclassified to another account balance. There were no material general ledger suspense account items written off to a statement of net position account, which should have been written off to an income statement account and vice versa.

35. In regards to your assistance with drafting the combined financial statements, we have:

    a. Made all management decisions and performed all management functions.

    b. Designated an individual with suitable skill, knowledge, or experience to oversee the services.

    c. Evaluated the adequacy and results of the services performed.

    d. Accepted responsibility for the results of the services.

    e. Established and maintained internal controls, including monitoring of ongoing activities

36. We acknowledge that U.S. GAAP presents premium tax fees in the combined financial statements as an administrative, operating expense. However, management has elected to present the premium tax fee as a contra revenue item in the combined statements of revenues, expenses and change in net position. This approach is an alternative presentation that we confirmed to be acceptable by the Department of Health Care Services who regulates the current industry financial reporting.

37. Risk sharing, quality improvement, provider incentive, and other arrangements with providers wherein the Plan is obligated to provide for a settlement of accounts with providers have been calculated in accordance with the existing arrangements and are included in the combined financial statements at net realizable value, giving consideration to all amounts due under arrangements. We believe these liabilities are fairly stated as of June 30, 2020 and 2019.

38. We have the intent and ability to commit the necessary resources to become compliant with the laws and regulations contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") by the required compliance deadlines. We have no information that indicated that a significant vendor may be unable to sell to the Plan; a significant customer may be unable to purchase from the Plan; or a significant service provider may be unable to provide services to the Heath Plan, in each case because of their respective inability to comply with HIPAA.

39. We are not aware of any reason that Moss Adams LLP would not be considered to be independent for purposes of the Plan's audit.

40. To our knowledge, there are no instances where any officer or employee of the Plan has an interest in a company with which the Plan does business that would be considered a "conflict of interest." Such an interest would be contrary to the Plan's policy.

41. We acknowledge our responsibility for presenting the Management's Discussion and Analysis required by GASB 62 section 1500 paragraph .114 and section C50 paragraph .115, in accordance with accounting principles generally accepted in the United States of America and we believe the Management's Discussion

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and Analysis is measured and presented in accordance with the prescribed guidelines. The methods of measurement and presentation of the Management's Discussion and Analysis have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information.

42. We acknowledge our responsibility for presenting the supplemental pension benefit information, as required by accounting principles generally accepted in the United States of America, and we believe the supplemental pension information are measured and presented in accordance with the prescribed guidelines. The methods of measurement and presentation of the supplemental pension information have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information

43. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the combined financial statements of the Plan are properly disclosed.

44. We believe that the actuarial assumptions and methods used to measure net pension asset/liability for financial accounting purposes are appropriate in the circumstances.

45. We have not completed the process of evaluation the impact that will result from adopting GASB 87, Leases, GASB 84, Fiduciary Activities, and GASB 97, Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans, as discussed in Note 2. The Plan is therefore unable to disclose the impact that adopting GASB 87, GASB 84, and GASB 97 will have on its combined financial position and the combined results of operations when such statements are adopted.

46. With regard to the fair value measurements and disclosures of investments in equity and debt securities, we believe that:

    a. The measurement methods, including the related assumptions, used in determining fair value were appropriate and were consistently applied.

    b. The completeness and adequacy of the disclosures related to the fair values are in conformity with Governmental Accounting Standards Board Statement No. 61, The Financial Reporting Entity: Omnibus and amendment of GASB Statements No. 14 and No. 24, Governmental Accounting Standards Board Statement No. 72, Fair Value Measurement and Application, and Governmental Accounting Standards Board Statement No. 62, Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements.

    c. No events have occurred subsequent to June 30, 2020 that requires adjustment to the fair value measurements and disclosures included in the combined financial statements.

47. We have performed an analysis of expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under our contracts. We have determined that expected costs do not exceed anticipated revenues. Based on our analysis, we believe no premium deficiency reserves are necessary at June 30, 2020 and 2019, respectively.

48. San Francisco City Option accounts payable is properly classified as current liabilities on the combined statements of net position as these amounts are due on demand to participating employers and employees of the San Francisco City Option program.

49. We confirm we are subject to the audit requirements of the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and in compliance with the State Controller's Office prescribed reporting guidelines.

50. We were in compliance with our tangible net equity regulatory requirement at June 30, 2020 and 2019.

51. The Plan is not subject to the requirements of Office of Management and Budget (OMB) Title 2 U.S. Code of Federal Regulations ("CFR") Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards ("Uniform Guidance").

52. We confirm that the eligibility of Medi-Cal beneficiaries is determined by the San Francisco County Department of Health Services and validated by the State of California. The State of California provides the Plan the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month.

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53. To the best of our knowledge and belief, no events have occurred subsequent to the combined statements of net position date and through the date of this letter that would require adjustment to or disclosure in the aforementioned combined financial statements.

54. In March 2020, the World Health Organization declared the novel coronavirus outbreak a public health emergency. The Plan's results of operations could be adversely affected to the extent that the coronavirus or any other epidemic harms the global economy. Although the Plan does not expect the impact on its operations and financial results to be significant, the duration and intensity of the impact of the coronavirus and resulting disruption to the Plan's operations is uncertain.

DocuSigned by:
John Grgurina
5BD8B5B0FBA7424...
John Grgurina, CEO

DocuSigned by:
Skip Bishop
9FCE1D8325964C4...
Skip Bishop, CFO

DocuSigned by:
Rand Takeuchi
F7D58ECB9A12494...
Rand Takeuchi, Director of Accounting


MOSSADAMS

Communication of Internal Control Related Matter

San Francisco Health Authority and San Francisco Community Health Authority

June 30, 2020

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Communication of Internal Control Related Matter

To the Governing Board
San Francisco Health Authority and San Francisco Community Health Authority

In planning and performing our audit of the combined financial statements of San Francisco Health Authority and San Francisco Community Health Authority (collectively the "Plan"), as of and for the year ended June 30, 2020, in accordance with auditing standards generally accepted in the United States of America, we considered the Plan's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the combined financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, we do not express an opinion on the effectiveness of the Plan's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's combined financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

We believe the following operational or administrative recommendation may be of potential benefit to the Plan:

Third-Party Vendor Review

> ***Observation and Recommendation:*** During our audit, we noted the Plan does not have a formal process in place in regards to oversight of significant vendors used to process transactions for the Plan, such as San Francisco City Option MRA accounts. We recommend management review their current policies and procedures to ensure policies and procedures are in place to evaluate and monitor significant vendors to ensure Plan transactions are processed accurately and in accordance with Plan protocols as outlined in their vendor agreements.

Management's Response: The Plan has various policies and procedures in place as well as specific contract language in vendor agreements to address third-party vendor oversight. The Plan will review its policy and procedures to ensure vendors are properly monitored and to confirm that transactions are processed accurately in accordance with the terms outlined in vendor contract agreements.

The Plan's written response to the operational recommendation identified in our audit was not subjected to the auditing procedures applied in the audit of the combined financial statements and, accordingly, we express no opinion on it.

This communication is intended solely for the information and use of management, the Governing Board, and others within the Plan, and is not intended to be, and should not be, used by anyone other than these specified parties.

Moss Adams LLP

San Francisco, California
October 26, 2020

Report of Independent Auditors and
Combined Financial Statements

San Francisco Health Authority and San Francisco Community Health Authority

June 30, 2020 and 2019

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Table of Contents

Management's Discussion and Analysis

The management's discussion and analysis of San Francisco Health Authority and San Francisco Community Health Authority (collectively, the "Plan"), is intended to provide readers and interested parties with an overview of the Plan's financial activities for the fiscal years ended June 30, 2018, 2019, and 2020. It should be reviewed in conjunction with the Plan's combined financial statements and accompanying notes to enhance the reader's understanding of the Plan's financial performance.

Overview of the Plan's Combined Financial Statements

The Plan's annual financial report includes the combined results for San Francisco Health Authority and San Francisco Community Health Authority. The latter entity was formed on July 1, 2005, to segregate for reporting purposes, the Healthy Families, Healthy Workers, and Healthy Kids programs. The former retains the Medi-Cal program only. The combined reports contain the annual combined financial statements and related notes, which reflect the Plan's combined financial condition and changes in combined financial position for the fiscal years ended June 30, 2018, 2019, and 2020. The combined financial statements include the statements of net position, statements of revenues, expenses, and changes in net position, and statements of cash flows as well, as the notes to the combined financial statements. These statements report the following financial information:

- The combined statements of net position summarize the Plan's assets and deferred outflows of resources, liabilities, deferred inflows of resources, and net position as of June 30, 2018, 2019, and 2020.

- The combined statements of revenues, expenses, and changes in net position present the results of operations during the fiscal years ended June 30, 2018, 2019, and 2020.

- The key operating indicators report significant operating statistics and changes as of June 30, 2018, 2019, and 2020.

Financial Position Highlights

The financial position of the Plan remained strong as of June 30, 2018, 2019, and 2020. Significant changes included the following:

- Total assets and deferred outflows of resources increased by $134,432,969 to $952,254,685 as of June 30, 2020, from $817,821,716 as of June 30, 2019, primarily from increases in Plan cash deposits and Plan receivables. The increase is reflecting the timing of receipts of certain premium revenues due from the State of California and Directed Payments, which will be passed through to Private and Designated Public hospitals. Also driving the increase is the timing of receipts for managed care organization taxes related to the fiscal year ended June 30, 2020, paid after June 30, 2020. Total assets and deferred outflows of resources increased by $250,700,394 to $817,821,716 as of June 30, 2019, from $567,121,322 as of June 30, 2018, primarily from increases in Plan cash deposits and Plan receivables. The increase is reflecting the timing of receipts of certain premium revenues due from the State of California and Directed Payments, which will be passed through to Private and Designated Public hospitals.

- Capital assets, net of accumulated depreciation and amortization, decreased by $1,069,690 to $4,206,407 as of June 30, 2020, from $5,276,097 as of June 30, 2019, mainly as a result of recording $1,539,748 in depreciation expense, partially offset by net capital additions of $470,058. Capital assets, net of accumulated depreciation and amortization, decreased by $1,574,540 to $5,276,097 as of June 30, 2019, from $6,850,637 as of June 30, 2018, mainly as a result of recording $1,347,813 in depreciation expense and the loss from write off of certain software costs amounting to $1,692,458, partially offset by net capital additions of $1,465,731.

- Net position decreased by $8,956,776 to $91,546,413 as of June 30, 2020, from $100,503,189 as of June 30, 2019, due to $5.4 million in Strategic Use of Reserves ("SUR") either paid to or accrued for San Francisco Health Plan ("SFHP") providers during 2020. In 2020, net position further decreased by $6.0 million due to the impact of a 1.5% Medi-Cal rate reduction retroactive to July 1, 2019, and partially offset by the positive impact of a $2,600,000 reduction in reserves for incurred but not reported claims, margin on the Medi-Cal line of business and earnings on investments. Net position decreased by $8,039,287 to $100,503,189 as of June 30, 2019, from $108,542,476 as of June 30, 2018, due to $15.9 million in Strategic Use of Reserves ("SUR") either paid to or accrued for SFHP providers during 2019 partially offset by positive margin on the Medi-Cal line of business and earnings on investments.

- The current ratio (current assets divided by current liabilities) of 1.06 as of June 30, 2020, decreased from 1.10 as of June 30, 2019. This decrease is driven by increases in Plan accounts payable and accrued expenses due to the timing of payment of managed care organization taxes related to the fiscal year ended June 30, 2020, paid after June 30, 2020, and increases in due to providers for Directed Payments, which will be passed through to Private and Designated Public hospitals. The current ratio (current assets divided by current liabilities) of 1.10 as of June 30, 2019, decreased from 1.17 as of June 30, 2018. This decrease is driven by decreases in Plan cash and short-term investments and increases in Plan accounts payable and accrued expenses due to the timing of payment of managed care organization provider taxes related to the fiscal year ended June 30, 2019, paid after June 30, 2019.

Key Operating Indicators

Changes in member months, revenue yield, and efficiency ratios are highlighted below:

	Fiscal Years Ended June 30			Net Change 2020 - 2019		Net Change 2019 - 2018	
Key Operating Indicators	2020	2019	2018	$	%	$	%
Member months							
Medi-Cal	1,517,555	1,539,541	1,602,718	(21,986)	-1.43%	(63,177)	-3.94%
Healthy Kids	7,069	26,176	20,605	(19,107)	-72.99%	5,571	27.04%
Healthy Workers	142,051	138,336	136,338	3,715	2.69%	1,998	1.47%
Total member months	1,666,675	1,704,053	1,759,661	(37,378)	-2.19%	(55,608)	-3.16%
Capitation revenue, net of premium tax	$ 592,379,699	$ 597,940,490	$ 601,285,178	$ (5,560,791)	-0.93%	$ (3,344,688)	-0.56%
SF City Option ("SFCO") TPA fees	9,984,699	8,446,231	7,581,951	1,538,468	18.21%	864,280	11.40%
Interest income	2,569,841	3,178,133	2,680,517	(608,292)	-19.14%	497,616	18.56%
Other income and grants	8,485,486	9,132,676	9,117,252	(647,190)	-7.09%	15,424	0.17%
	613,419,725	618,697,530	620,664,898	(5,277,805)	-0.85%	(1,967,368)	-0.32%
Operating expenses							
Medical expenses	560,986,435	568,897,089	575,739,485	(7,910,654)	-1.39%	(6,842,396)	-1.19%
Administrative expenses	61,390,066	57,839,728	57,144,071	3,550,338	6.14%	695,657	1.22%
Total operating expenses	622,376,501	626,736,817	632,883,556	(4,360,316)	-0.70%	(6,146,739)	-0.97%
Change in net position	$ (8,956,776)	$ (8,039,287)	$ (12,218,658)	$ (917,489)	11.41%	$ 4,179,371	-34.20%
Per member per month ("pmpm")							
Capitation revenue	355.43	350.89	341.71	4.54	0.00%	9.18	2.69%
Interest income	1.54	1.87	1.52	(0.33)	0.00%	0.35	23.03%
Other income and grants	5.09	5.36	5.18	(0.27)	0.00%	0.18	3.47%
Operating expense							
Medical expense	336.59	333.85	327.19	2.74	0.00%	6.66	2.04%
Administrative expense	36.83	33.94	32.47	2.89	0.00%	1.47	4.53%
Change in net position	(5.37)	(4.72)	(6.94)	(0.65)	0.00%	2.22	-31.99%
Medical cost ratio	94.70%	95.14%	95.75%	-0.44%	0.00%	-0.61%	-0.64%
Administrative cost ratio	7.25%	6.73%	6.73%	0.52%	0.00%	0.00%	0.00%

Enrollment and membership

The overall change in net member months from June 30, 2019 to June 30, 2020, was a decrease of 2.19%. The total number of member months was 0.45% below our budget. In 2020, the Plan experienced a 1.43% decrease in Medi-Cal membership and a 2.69% increase in Healthy Workers membership. In 2020, the Healthy Kids membership transitioned into Medi-Cal. The Medi-Cal member months decrease is due to a higher number of members placed on hold awaiting completion of the annual redetermination process along with an increase in net terminations. Health care reform known as the ACA contained a provision allowing states to expand their Medicaid program effective January 1, 2014. California elected to expand the Medi-Cal program and as a result the Plan had 49,070 Medi-Cal Expansion ("MCE") members during the year ended June 30, 2020. This MCE membership generated 588,841 member months for fiscal year 2020 compared to a budget of 603,420 member months.

The overall change in net member months from June 30, 2018 to June 30, 2019, was a decrease of 3.16%. The total number of member months was 1.90% below our budget. In 2019, the Plan experienced a 3.94% decrease in Medi-Cal membership, a 1.47% increase in Healthy Workers membership, and a 27.04% increase in Healthy Kids membership. The Medi-Cal member months decrease is due to a higher number of members placed on hold awaiting completion of the annual redetermination process along with an increase in net terminations. Health care reform known as the ACA contained a provision allowing states to expand their Medicaid program effective January 1, 2014. California elected to expand the Medi-Cal program and as a result the Plan had 51,514 MCE members during the year ended June 30, 2019. This MCE membership generated 630,506 member months for fiscal year 2019 compared to a budget of 654,624 member months.

Healthy Kids – The Healthy Kids program fully transitioned to Medi-Cal in October 2019. Net membership is zero at June 30, 2020.

Net membership from June 30, 2018, to June 30, 2019 increased by 27.04% largely due to the transition of the County Children's Health Initiative Program ("CCHIP") application process to the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) which now screens for eligibility. In addition, more children were transitioning to Healthy Kids from Medi-Cal due to increases in income levels.

Healthy Workers – Net membership from June 30, 2019 to June 30, 2020, increased by 2.69%. This was slightly higher than the projected target for fiscal year 2020. As was the case during fiscal year 2019, we projected the membership to remain flat due to changes in eligibility requirements for In-Home Supportive Services ("IHSS"). This slight increase is likely due to an increase in the base of potential eligible Healthy Workers members (more people becoming IHSS workers).

Net membership from June 30, 2018 to June 30, 2019, increased by 1.47%. This was slightly higher than the projected target for fiscal year 2019. As was the case during fiscal year 2018, we projected the membership to remain flat due to changes in eligibility requirements for In-Home Supportive Services ("IHSS"). This slight increase is likely due to an increase in the base of potential eligible Healthy Workers members (more people becoming IHSS workers).

Operating revenues

The decrease in capitation revenues, net of premium tax reported for the fiscal year ended June 30, 2020, of $5.6 million (0.93%), was due to a decrease in overall member months of 37,378 and a Medi-Cal premium revenue rate reduction of approximately (1.5%) retroactive to July 2019.

The decrease in capitation revenues, net of premium tax reported for the fiscal year ended June 30, 2019, of $3.34 million (0.56%), was due a net decrease in overall members months of 55,608. Medi-Cal member months decreased by 63,177 as the result of a higher number of members placed on hold awaiting the completion of the annual determination process along with an increase in net terminations.

The decrease in capitation revenues, net of premium tax reported for the fiscal year ended June 30, 2018, of $12.07 million (1.97%), was due a decrease in Medi-Cal pass-through funding as well as a net decrease in overall members months of 20,588. Medi-Cal member months decreased by 28,513 as the result of a higher number of members placed on hold awaiting the completion of the annual determination process along with an increase in net terminations.

San Francisco City Option Third-Party Administration

The Plan provides Third-Party Administration ("TPA") for the City of San Francisco Department of Public Health's program for uninsured residents ("SFCO TPA"). Services provided include participant billing, enrollment, customer service call center, processing employer payments, and managing the Medical Reimbursement Accounts ("MRA"). The total amount of the reimbursement under the TPA business was $9.98 million for 2020 compared to $8.45 million for 2019. The total amount of the reimbursement was $8.45 million for 2019 compared to $7.58 million for 2018.

Medical expense

In 2020, total medical expenses decreased by $7.91 million, or 1.39%, over 2019 primarily from the following categories:

- In 2020, total hospital and professional expense including SUR activity decreased by $5.77 million, or 1.33%. The majority of this decrease is due to less provider capitation due to decreases in membership, reduction in reserves for incurred but not reported claims, offset by an increase in nonspecialty mental health utilization. In 2020, SFHP continued fee-for-service hospital rates at the All Patients Refined-Diagnosis Related Groups ("APR-DRG") method. APR-DRG is the generally accepted method for paying claims for Medi-Cal beneficiaries and is the state's payment method for inpatient services to nonmanaged care, fee-for-service Medi-Cal members. Increases in fee-for-service compensation and nonspecialty mental health utilization were partially offset by a decrease of $10.50 million in SUR activity.

- In 2020, total pharmacy expense increased by $0.48 million, or 0.53%. This increase is largely due to changes in utilization patterns as well as an increase in per member per month costs for the Healthy Workers line of business. Effective January 1, 2021, SFHP will no longer have the pharmacy benefit as it is being transitioned to Department of Health Care Services ("DHCS") as the administrator of the Medi-Cal pharmacy benefit.

In 2019, total medical expenses decreased by $6.8 million, or 1.19%, over 2018 primarily from the following categories:

- In 2019, total hospital and professional expense including SUR activity increased by $7.66 million, or 1.79%. The majority of this increase is due to provider capitation and fee-for-service rate increases along with an increase in nonspecialty mental health utilization. In 2019, SFHP continued fee-for-service hospital rates at the All Patients Refined-Diagnosis Related Groups ("APR-DRG") method. APR-DRG is the generally accepted method for paying claims for Medi-Cal beneficiaries and is the state's payment method for inpatient services to nonmanaged care, fee-for-service Medi-Cal members. Increases in provider capitation and fee-for-service compensation and nonspecialty mental health utilization were partially offset by a decrease of $10.98 million in SUR activity.

- In 2019, total pharmacy expense decreased by $3.69 million, or 3.90%. This decrease is largely due to changes in utilization patterns as well as a decrease in Hepatitis C treatment activity.

In 2018, total medical expenses increased by $4.72 million, or 0.83%, over 2017 primarily from the following categories:

- In 2018, total hospital and professional expense including SUR activity increased by $3.97 million, or 0.84%. The majority of this increase is due to provider capitation and fee-for-service rate increases along with an increase in nonspecialty mental health utilization. During 2018, SFHP converted fee-for-service hospital providers from per diem rates to the All Patients Refined-Diagnosis Related Groups ("APR-DRG"). APR-DRG is the generally accepted method for paying claims for Medi-Cal beneficiaries and is the state's payment method for inpatient services to nonmanaged care, fee-for-service Medi-Cal members. Increases in provider capitation and fee-for-service compensation and nonspecialty mental health utilization were partially offset by a decrease of $3.53 million in SUR activity.

- In 2018, total pharmacy expense decreased by $1.02 million, or 1.07%. This decrease is largely due to changes in utilization patterns as well as a decrease in Hepatitis C treatment activity.

Administrative expenses

Administrative expenses increased in 2020 by $3.55 million, or 6.14%, from 2019 driven by increases in salaries and benefits, and information technology support costs. Administrative expenses increased in 2019 by $0.70 million, or 1.22%, from 2018 driven by increases in salaries and benefits, and information technology support costs.

Results of operations

The Plan incurred a loss of $8.96 million in 2020 compared with a loss of $8.04 million in 2019. Excluding the SFCO TPA business, the Plan incurred a loss of $8.96 million in 2020. SFCO TPA was break even for 2020. In the last five fiscal years, the Governing Board approved six SUR programs. All programs are underway. Each provider must submit a plan as to how the SUR funding will be used to improve the provider network, member experience, and member outcomes. Once SFHP approves the plan, a portion of the SUR funds will be disbursed. Progress against the plan will be monitored with additional SUR funding released upon the attainment of agreed-upon milestones. $5.4 million of SUR funding was either paid or accrued during 2020. Payments and accruals related to the SUR programs were recorded as medical expense and represent the main driver for the operating loss in 2020. Administrative fees for claims processing and Electronic Data Interchange ("EDI") services were consistent in 2020 compared to 2019. Grant income for the Healthy Kids program decreased $322,000 in 2020 due to the transition of the program to Medi-Cal.

The Plan incurred a loss of $8.04 million in 2019 compared with a loss of $12.22 million in 2018. Excluding the SFCO TPA business, the Plan incurred a loss of $8.04 million in 2019. SFCO TPA was break even for 2019. In the last four fiscal years, the Governing Board approved five SUR programs. All programs are underway. Each provider must submit a plan as to how the SUR funding will be used to improve the provider network, member experience, and member outcomes. Once SFHP approves the plan, a portion of the SUR funds will be disbursed. Progress against the plan will be monitored with additional SUR funding released upon the attainment of agreed-upon milestones. $15.95 million of SUR funding was either paid or accrued during 2019. Payments and accruals related to the SUR programs were recorded as medical expense and represent the main driver for the operating loss in 2019. Grant income for the Healthy Kids program and administrative fees for claims processing and Electronic Data Interchange (EDI) services were consistent in 2019 compared to 2018.

The Plan incurred a loss of $12.22 million in 2018 compared with an income of $8.12 million in 2017. Excluding the SFCO TPA business, the Plan incurred a loss of $12.22 million in 2018. SFCO TPA was break even for 2018. SFHP received $39.17 million in retroactive adjustments related to MCE AB85 to cost for service periods in FY16-17. SFHP disbursed $33.86 million of this amount to the public hospital Zuckerberg San Francisco General Hospital. The remainder of $5.31 million was recorded as surplus in 2018. In the last three fiscal years, the Governing Board approved three SUR programs. All programs are underway. Each provider must submit a plan as to how the SUR funding will be used to improve the provider network, member experience, and member outcomes. Once SFHP approves the plan, a portion of the SUR funds will be disbursed. Progress against the plan will be monitored with additional SUR funding released upon the attainment of agreed-upon milestones. $15.75 million of SUR funding was either paid or accrued during 2018. Payments and accruals related to the SUR programs were recorded as medical expense and represent the main driver for the operating loss in 2018. Grant income for the Healthy Kids program and administrative fees for claims processing and Electronic Data Interchange (EDI) services increased by $481,926, or 5.58%.

Nonoperating income

Interest income is derived from investments in Local Agency Investment Fund ("LAIF") and in other U.S. government agency securities. Yields on the LAIF increased during the reporting period from an average of 2.27% in 2019 to 1.93% in 2020. The Plan also accounts for the market value fluctuations on other investments due to overall changes in the general level of interest rates. Changes in market value increased interest income by $570,292 during 2020. Nonoperating revenues (interest income) generated $1,999,549 in surplus in 2020.

Interest income is derived from investments in Local Agency Investment Fund ("LAIF") and in other U.S. government agency securities. Yields on the LAIF decreased during the reporting period from an average of 1.38% in 2018 to 2.27% in 2019. The Plan also accounts for the market value fluctuations on other investments due to overall changes in the general level of interest rates. Changes in market value increased interest income by $505,335 during 2019. Nonoperating revenues (interest income) generated $2,610,035 in surplus in 2019.

Interest income is derived from investments in LAIF and in other U.S. government agency securities. Yields on the LAIF increased during the reporting period from an average of .75% in 2017 to 1.38% in 2018. The Plan also accounts for the market value fluctuations on other investments due to overall changes in the general level of interest rates. Changes in market value decreased interest income by $210,000 during 2018. Nonoperating revenues (interest income) generated $2,917,266 in surplus in 2018.

Changes in financial position

	As of June 30			Net Change 2020 - 2019		Net Change 2019 - 2018	
Net position	2020	2019	2018	$	%	$	%
Assets							
Cash and cash equivalents	$ 60,769,229	$ 45,415,122	$ 60,202,473	$ 15,354,107	33.81%	$ (14,787,351)	-24.56%
SFCO TPA restricted cash and cash equivalents	602,379,943	464,727,793	340,421,270	137,652,150	29.62%	124,306,523	36.52%
Investments	42,617,014	39,769,079	75,973,987	2,847,935	7.16%	(36,204,908)	-47.65%
Receivables and prepaid expenses	234,451,452	255,094,091	74,506,108	(20,642,639)	-8.09%	180,587,983	242.38%
Capital assets, net of accumulated depreciation and amortization	4,206,407	5,276,097	6,850,637	(1,069,690)	-20.27%	(1,574,540)	-22.98%
Asset restricted as to use	300,000	300,000	300,000	-	0.00%	-	0.00%
Net pension asset	208,691	1,279,513	-	(1,070,822)	-83.69%	1,279,513	100.00%
Total assets	944,932,736	811,861,695	558,254,475	133,071,041	16.39%	253,607,220	45.43%
Deferred outflows of resources	7,321,949	5,960,021	8,866,847	1,361,928	22.85%	(2,906,826)	-32.78%
Total assets and deferred outflows of resources	$ 952,254,685	$ 817,821,716	$ 567,121,322	$ 134,432,969	16.44%	$ 250,700,394	44.21%
Total liabilities, deferred inflows of resources, and capital lease obligations	$ 860,708,272	$ 717,318,527	$ 458,578,846	$ 143,389,745	19.99%	$ 258,739,681	56.42%
Net position							
Invested in capital assets	4,099,010	5,082,429	6,759,459	(983,419)	-19.35%	(1,677,030)	-24.81%
Restricted - Knox-Keene	300,000	300,000	300,000	-	0.00%	-	0.00%
Unrestricted	87,147,403	95,120,760	101,483,017	(7,973,357)	-8.38%	(6,362,257)	-6.27%
Total net position	91,546,413	100,503,189	108,542,476	(8,956,776)	-8.91%	(8,039,287)	-7.41%
Total liabilities, deferred inflows of resources, and net position	$ 952,254,685	$ 817,821,716	$ 567,121,322	$ 134,432,969	16.44%	$ 250,700,394	44.21%

Assets

Cash balances for the Plan as well as from SFCO TPA participants and employer deposits totaled $663.14 million at June 30, 2020. Cash has increased due to employer deposits for SFCO TPA and cash provided by operating activities.

Cash balances for the Plan as well as from SFCO TPA participants and employer deposits totaled $510.14 million at June 30, 2019. Cash has increased due to employer deposits for SFCO TPA and cash provided by operating activities.

Cash balances for the Plan as well as from SFCO TPA participants and employer deposits totaled $400.62 million at June 30, 2018. Cash has increased due to employer deposits for SFCO TPA and cash used in operating activities.

Liabilities

As of June 30, 2020, SFCO TPA liabilities to the Department of Public Health include $527,672 of earned premiums and $1.84 million in unearned (pre-paid) participant fees. Employer contributions available in participant MRA's totaled $542.81 million. Capitation payable decreased in 2020 by $8.3 million due primarily to decreases in membership. Medical claims payable decreased by $476,911 in 2020, due to timing of payment for known claims at June 30, 2020, compared to June 30, 2019. The Plan holds an additional $1.58 million for a reserve margin and loss adjustment expense. The Plan also holds $11.59 million for a special Medical Loss Ratio ("MLR") reserve related to Proposition 56 program funding, which is included in payable to other governmental agencies. Amounts payable to governmental agencies increased by $11.9 million in 2020. This is mainly driven by a $6.97 million increase to the special MLR reserve related to Proposition 56 program funding and a $6.17 million reserve for Medi-Cal rate reduction. Total liabilities increased by $143.11 million in 2020. The increase is reflecting the timing of payments due to providers for the new Directed Payments, which will be passed through to Private and Designated Public hospitals. The increase is also driven by the increase of $137.8 million in SFCO TPA liabilities.

As of June 30, 2019, SFCO TPA liabilities to the Department of Public Health include $593,250 of earned premiums and $2.09 million in unearned (pre-paid) participant fees. Employer contributions held in participant MRA's totaled $403.49 million. Capitation payable decreased in 2019 by $10.04 million due primarily to decreases in membership. Medical claims payable decreased by $985,587 in 2019, due to timing of payment for known claims at June 30 2019, compared to June 30, 2018. The Plan holds an additional $1.58 million for a reserve margin and loss adjustment expense. The Plan also holds $4.62 million for a special MLR reserve related to Proposition 56 program funding, which is included in payable to other governmental agencies. Amounts payable to governmental agencies decreased by $3.26 million in 2019. This decrease is primarily due to the elimination of a special MLR reserve related to the MCE line of business. Total liabilities increased by $258.84 million in 2019. The increase is reflecting the timing of payments due to providers for the new Directed Payments, which will be passed through to Private and Designated Public hospitals. The increase is also driven by the increase of $124.35 million in SFCO TPA liabilities.

As of June 30, 2018, SFCO TPA liabilities to the Department of Public Health include $524,716 of earned premiums and $1.96 million in unearned (pre-paid) participant fees. Employer contributions held in participant MRA's totaled $304.31 million. Capitation payable decreased in 2018 by $5.93 million due primarily to decreases in membership. Medical claims payable increased by $2.79 million in 2018 due to increases in provider rates. The Plan holds an additional $728,000 for a reserve margin and loss adjustment expense. The Plan also holds $11.0 million for a special MLR reserve related to the MCE line of business, which is included in payable to other governmental agencies**.** Amounts payable to governmental agencies decreased by $222.6 million in 2018. This decrease is due to:

- The elimination of a liability owed to DHCS for premium overpayments received by SFHP for the MCE population. DHCS recovered all premium overpayments by June 30, 2018.

- Payments in 2018 for 2017 funding for IGT's and MCE AB85 to cost pass-through programs to SFHP providers.

Request for information

Please direct questions concerning this report to:

Chief Financial Officer
San Francisco Health Plan
50 Beale Street, 12th Floor
San Francisco, CA 94105

MOSSADAMS

Report of Independent Auditors

To the Governing Board
San Francisco Health Authority and San Francisco Community Health Authority

Report on the Financial Statements

We have audited the accompanying combined statements of net position of San Francisco Health Authority and San Francisco Community Health Authority (collectively the "Plan"), as of June 30, 2020 and 2019, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the combined financial statements are free from material misstatements.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined net position of San Francisco Health Authority and the San Francisco Community Health Authority, as of June 30, 2020 and 2019, and the results in its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 10, supplementary schedule of proportionate share of the net pension asset/liability and supplementary schedule of contributions on pages 39 through 40 are not a required part of the combined financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the combined financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of the Plan's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the combined financial statements, and other knowledge we obtained during our audit of the combined financial statements. We do not express an opinion or provide an assurance on the supplementary information because limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Moss Adams LLP

San Francisco, California
October 26, 2020

Combined Financial Statements

San Francisco Health Authority and
San Francisco Community Health Authority
Combined Statements of Net Position
June 30, 2020 and 2019

	2020	2019
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
CURRENT ASSETS		
Cash and cash equivalents	$ 60,769,229	$ 45,415,122
SFCO Third Party Administrator ("TPA") cash and cash equivalents	602,379,943	464,727,793
Short-term investments	18,538,149	20,218,897
Capitation receivables	209,209,083	232,194,062
SFCO TPA receivables	13,750,451	14,675,516
Other receivables	7,700,899	4,868,734
Prepaid expenses	3,791,019	3,355,779
Total current assets	916,138,773	785,455,903
Investments	24,078,865	19,550,182
Capital assets, net of accumulated depreciation and amortization	4,206,407	5,276,097
Asset restricted as to use	300,000	300,000
Net pension asset	208,691	1,279,513
Total assets	944,932,736	811,861,695
Deferred outflows of resources	7,321,949	5,960,021
Total assets and deferred outflows of resources	$ 952,254,685	$ 817,821,716
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
CURRENT LIABILITIES		
Accrued salaries and benefits	$ 7,990,587	$ 6,675,077
SFCO TPA liabilities	606,082,445	468,249,331
Accounts payable and accrued expenses	33,844,963	46,798,973
Payable to other governmental agencies	38,623,716	26,728,394
Due to providers	134,041,202	119,868,432
Capitation payable	30,908,734	39,171,688
Medical claims payable	7,157,322	7,634,233
Current portion of capital lease obligations	95,544	95,544
Healthy Kids advanced premiums	1,771,518	1,771,518
Total current liabilities	860,516,031	716,993,190
Capital lease obligations, net of current portion	11,853	98,124
Total liabilities	860,527,884	717,091,314
Deferred inflows of resources	180,388	227,213
NET POSITION		
Invested in capital assets, net of related debt	4,099,010	5,082,429
Restricted:		
Required by legislative authority	300,000	300,000
Unrestricted	87,147,403	95,120,760
Total net position	91,546,413	100,503,189
Total liabilities, deferred inflows of resources, and net position	$ 952,254,685	$ 817,821,716

See accompanying notes.

San Francisco Health Authority and
San Francisco Community Health Authority
Combined Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2020 and 2019

	2020	2019
OPERATING REVENUES		
Capitation	$ 611,515,025	$ 667,150,194
Other income	7,601,394	7,928,366
SFCO TPA fees	9,984,699	8,446,231
Grants	884,092	1,204,310
Premium tax	(19,135,326)	(69,209,704)
Total revenues	610,849,884	615,519,397
OPERATING EXPENSES		
Medical	560,986,435	568,897,089
Salaries and benefits	28,853,475	24,486,126
SFCO TPA expenses	9,984,699	8,446,231
Other administrative	7,778,219	7,529,136
Legal and professional	7,116,260	9,531,450
Occupancy	3,400,053	3,633,571
Office expenses	1,643,115	1,659,464
Depreciation and amortization	1,539,748	1,347,813
Marketing and promotion	841,724	936,605
Insurance	232,773	269,332
Total expenses	622,376,501	626,736,817
Operating loss	(11,526,617)	(11,217,420)
NONOPERATING REVENUES		
Interest income	2,569,841	3,178,133
Change in net position	(8,956,776)	(8,039,287)
TOTAL NET POSITION, beginning	100,503,189	108,542,476
TOTAL NET POSITION, ending	$ 91,546,413	$ 100,503,189

See accompanying notes.

San Francisco Health Authority and
San Francisco Community Health Authority
Combined Statements of Cash Flows
Years Ended June 30, 2020 and 2019

	2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES		
Premiums received	$ 796,611,792	$ 552,008,523
SFCO TPA premiums received and held	127,821,731	115,896,277
Medical expenses paid	(699,692,268)	(571,559,536)
Administrative expenses paid	(70,900,575)	(24,585,229)
Net cash provided by operating activities	153,840,680	71,760,035
CASH FLOWS FROM CAPITAL FINANCING AND RELATED ACTIVITIES		
Payments for purchase of capital assets	(470,058)	(1,465,731)
Principal payments on capital lease obligations	(86,271)	(158,173)
Net cash used in capital financing and related activities	(556,329)	(1,623,904)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of investment securities	(1,345,580,773)	(878,958,861)
Proceeds from sale and maturities of investments	1,342,732,838	914,863,769
Interest income on investments	2,569,841	3,178,133
Net cash (used in) provided by investing activities	(278,094)	39,383,041
Net change in cash and cash equivalents	153,006,257	109,519,172
CASH AND CASH EQUIVALENTS (including SFCO TPA restricted cash and cash equivalents), beginning of year	510,142,915	400,623,743
CASH AND CASH EQUIVALENTS (including SFCO TPA restricted cash and cash equivalents), end of year	$ 663,149,172	$ 510,142,915
RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating loss	$ (11,526,617)	$ (11,217,420)
Adjustments to reconcile operating loss to net cash provided by operating activities		
Depreciation and amortization	1,539,748	1,347,813
Loss on disposal of fixed assets	-	1,692,458
(Increase) decrease in assets		
Capitation receivables	22,984,979	(177,160,140)
SFCO TPA receivables	925,065	(2,260,174)
Other receivables	(2,832,165)	(608,725)
Prepaid expenses	(435,240)	(558,944)
Increase (decrease) in liabilities		
Accrued salaries and benefits	1,315,510	150,209
SFCO TPA liabilities	137,833,114	124,434,223
Accounts payable and accrued expenses	(12,954,010)	13,905,427
Payable to other governmental agencies	11,895,322	13,486,141
Capitation payable	(8,262,954)	(10,041,325)
Due to providers	14,172,770	119,868,432
Medical claims payable	(476,911)	(985,587)
Healthy Kids advanced premium	-	(3,370)
Net change in pension	(337,931)	(288,983)
Net cash provided by operating activities	$ 153,840,680	$ 71,760,035
SUPPLEMENTAL CASH FLOW DISCLOSURE		
Cash paid during the year for:		
Interest	$ 241,540	$ 264,617
Premium tax	$ 17,769,440	$ 69,209,704

See accompanying notes.

NOTE 1 – DESCRIPTION OF ORGANIZATION

San Francisco Health Authority and San Francisco Community Health Authority (collectively the "Plan"), is a public Health Maintenance Organization ("HMO") licensed by the State of California ("State") and located in the County of San Francisco (the "County"), California. San Francisco Health Plan's legal name is San Francisco Health Authority. However, it has operated since its inception as San Francisco Health Plan. The mission and purpose of San Francisco Health Plan are to develop, govern, and administer a comprehensive, integrated, competitive, and cost-efficient health care delivery system that will deliver quality health care to the Medi-Cal population in the County and to other populations in the County.

San Francisco Health Authority was established by the County Board of Supervisors on December 15, 1994, in accordance with the State's Welfare and Institutions Code Section 14087.54 (the "Code") and is considered to be a public entity as defined under the Code. This legislation provides that San Francisco Health Authority is a legal entity, separate and apart from the County, and is not considered to be an agency, division, department, or instrumentality of the County. Further, San Francisco Health Authority is not governed by, nor is subject to, the Charter of the County and is not subject to the County's policies or operational rules. The Plan became fully operational on January 1, 1997.

Effective July 1, 2005, San Francisco Health Authority and the City and County of San Francisco entered into a Joint Powers Agreement to create San Francisco Community Health Authority ("SFCHA") pursuant to Chapter 5, Division 7, Title 1 of the California Government Code. SFCHA serves as a Knox-Keene licensed health care service plan and enrolls members in the Healthy Workers and Healthy Kids programs, and any members in new programs that may be developed. All programs operate under the auspices of the Plan and the governing body and officers of San Francisco Health Authority are the governing body and officers, respectively, of SFCHA.

Effective July 1, 2007, the San Francisco Department of Public Health began enrolling participants in San Francisco City Option ("SFCO"), a program for uninsured residents of San Francisco who are under 300% of the Federal Poverty Level ("FPL"). The SFCO program is not health insurance. San Francisco Health Plan provides third-party administrative services, including fee billing, to participants over 100% of the FPL. In addition, effective January 2, 2008, employers have the option of providing health care coverage to their employees or be subject to a spending requirement and the option to participate in SFCO. San Francisco Health Plan receives employer payments and establishes Medical Reimbursement Accounts ("MRA") for qualifying employees.

Effective July 1, 2013 through June 30, 2016, a sales tax was in effect, administered by the California Board of Equalization. The amount was determined by multiplying the Plan's capitation revenue by 3.9375%. The premium tax was recognized in the period the related capitation revenue was recognized. On March 1, 2016, Senate Bill ("SB") X2-2 established a new managed care organization provider tax, to be administered by the Department of Health Care Services ("DHCS"), effective July 1, 2016 through June 30, 2019. The tax is assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill established applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. Effective January 1, 2020, Assembly Bill 115 (Chapter 348, Statutes 2019) authorizes the DHCS to implement a Managed Care Organization ("MCO") tax on specified health plans subject to approval by the federal Centers for Medicare and Medicaid Services ("CMS"). The tax effective date range under CMS approval is January 1, 2020 through December 31, 2022.

On September 8, 2010, the California State Legislature ratified Assembly Bill ("AB") No. 1653, which established a Hospital Quality Assurance Fee ("HQAF") program allowing additional draw down federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. Pursuant to the State's W&I Code Section 14167.6(a), California DHCS ("CDHCS") shall increase capitation payments to Medi-Cal managed health care plans retroactive for the months of April 2009 through December 2010. Additionally, Medi-Cal managed care plans are required to adhere to the following regarding the distribution of the increased capitation rates with HQAF funding: Section 14167.6(h)(1), "Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section on hospital services;" and, Section 14167.10(a), "Each managed health care plan receiving increased capitation payments under Section 14167.6 shall expend increased capitation payments on hospital services within 30 days of receiving the increased capitation payments." These payments were received and distributed in the manner as prescribed as a pass through to revenue. In April 2011, Senate Bill No. 90 ("SB 90") was signed into law, which extended the HQAF program through June 30, 2011. SB 335, signed into law in September 2011, extended the HQAF portion of SB 90 for an additional 30 months through December 31, 2013. SB 239, signed into law in October 2013, extended the program for an additional 36 months from January 1, 2014 through December 31, 2016. In November of 2016, California approved Proposition 52, which made SB 239 permanent and also created HQAF V. The program period for HQAF V is from January 1, 2017 through June 30, 2019. An extension of the program known as HQAF VI, covering July 1, 2019 through December 31, 2021 was approved by the Centers for Medicare & Medicaid Services in February 2020.

NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Accounting standards – Pursuant to Governmental Accounting Standards Board ("GASB") Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Plan's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines.

Proprietary fund accounting – The Plan uses the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and combined financial statements are prepared using the economic resources measurement focus.

Basis of combination – The accompanying combined financial statements as of June 30, 2020 and 2019, and the years then ended include San Francisco Health Authority and San Francisco Community Health Authority. All intercompany balances have been eliminated in the combination.

Use of estimates – The preparation of the combined financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period. Capitation receivable, liability for incurred but not reported claims expense, net pension asset/liability, fair value of investments, and useful lives of capital assets represent significant estimates. Actual results could differ from those estimates.

Cash and cash equivalents – Cash and cash equivalents consist of demand deposits and other short-term, highly liquid securities with original maturities of three months or less.

SFCO TPA restricted cash and cash equivalents – The Plan is required to maintain cash balances for the SFCO program on behalf of the San Francisco Department of Public Health. The Plan receives employer payments and establishes MRAs for qualifying employees. These amounts cannot be used by the Plan for its operations and result in a related liability. The SFCO TPA restricted cash and cash equivalents consist of demand deposits.

Asset restricted as to use – The Plan is required by the California Department of Managed Health Care ("DMHC") to restrict cash having a fair value of at least $300,000 for the payment of member claims in the event of its insolvency. The amount recorded was $300,000 at June 30, 2020 and 2019. Asset restricted as to use is composed of certificates of deposit and is stated at fair value.

Concentration of credit risk – Financial instruments potentially subjecting the Plan to concentrations of risk consist primarily of bank demand deposits in excess of Federal Deposit Insurance Corporation ("FDIC") insurance thresholds. The Plan maintains its cash in bank deposit accounts, which, at times, may exceed FDIC insurance thresholds. The Plan believes no significant concentration of credit risk exists with these cash accounts.

The Plan is highly dependent upon the State of California for its revenues. A significant portion of accounts receivable and revenue are from the State of California. Loss of the contracts with the State of California due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the combined financial position of the Plan.

As of June 30, 2020 and 2019, the Plan had capitation receivables of $209,209,083 and $232,194,062, respectively, due from the State of California. For the years ended June 30, 2020 and 2019, the Plan recognized capitation revenues of $611,515,025 and $667,150,194, respectively, from the State of California.

Investments – All short-term and long-term investments consist of certificates of deposit, domestic corporate bonds, U.S. fixed income securities, municipal bonds, and foreign bonds. Investments are stated at fair market value as determined by quoted market prices, with any changes in the fair value reported on the combined statements of revenues, expenses, and changes in net position.

The Plan has an investment in the State of California Local Agency Investment Fund ("LAIF"). The amounts invested in the investment pool are considered investments in an external investment pool and earn interest based on the blended rate of return earned by the entire portfolio in the pool. Fair value is the amount at which a financial instrument could be exchanged in a current transaction between willing parties, other than in forced liquidation. The fair value of the investment pool is generally based on published market prices and quotations from major investment firms. Because the Plan does not own identifiable investment securities of the pool but participates as a shareholder of the pool, these cash and cash equivalents are not individually identifiable and are not required to be categorized under GASB Codification Section C20, *Cash Deposits with Financial Institutions.* The fair value of the Plan's share in the pool approximated the fair value of the position in the pool at June 30, 2020 and 2019.

Capital assets – Capital assets include furniture, equipment, computer hardware, computer software, leasehold improvements, and capital leases. Capital assets are recorded at cost. Depreciation and amortization of equipment, furniture, fixtures, computer hardware, computer software, and leasehold improvements is based on the straight-line method over the estimated useful lives of the assets, estimated to be three to ten years. Equipment under capital leases is amortized over the shorter of the estimated useful life or anticipated lease term. The Plan capitalizes capital expenditures over $5,000 that will have a useful life of more than one year.

The Plan evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Pensions – For purposes of measuring the net pension asset/liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the Plan's California Public Employees' Retirement System ("CalPERS") plans ("pension plan") and additions to/deductions from the pension plans' fiduciary net position have been determined on the same basis as they are reported by CalPERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Payables to other governmental agencies – The Plan had the following as of June 30:

	2020	2019
Overpayments from DHCS for MCE population	$ -	$ 2,897,852
Medi-Cal rate reduction reserve	6,178,038	-
Proposition ("Prop") 56 related liabilities	11,590,331	4,622,226
Managed care tax	20,776,426	18,481,263
Assembly Bill ("AB") 85 related liabilities	-	868,444
Senate Bill ("SB") 208 related liabilities	-	(212,209)
Intergovernmental Transfer ("IGT") payable	78,921	70,818
Total payables to other governmental agencies	$ 38,623,716	$ 26,728,394

In addition to regular monthly Medi-Cal premium payments, DHCS also makes periodic supplemental payments to the Plan for pass-through programs designed to provide additional funding to designated public hospitals ("DPH"):

- IGT available to governmental funding entities and tied to providers of health care services rendered to Medi-Cal beneficiaries.
- IGT as outlined by Senate Bill 208 ("SB208") to preserve and strengthen the availability and quality of services provided by DPH's and their affiliated public providers. This IGT is specific to the Seniors and Persons with Disabilities ("SPD") population.
- AB85 to cost funding as required by the Affordable Care Act ("ACA"). DPH are to be reimbursed in amounts no less than cost for applicable services provided to newly eligible Medi-Cal Expansion members.

Due to providers – Beginning with the July 1, 2017, rating period, the CDHCS has implement managed care Directed Payments: 1) Private Hospital Directed Payment ("PHDP"), 2) Designated Public Hospital Enhanced Payment Program ("EPP-FFS" and "EPP-CAP"), 3) Designated Public Hospital Quality Incentive Pool ("QIP"). (1) For PHDP, the CDHCS will direct Managed Care Plans ("MCP") to reimburse private hospitals as defined in WIC 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care. The total funding available for the enhanced contracted payments are limited to a predetermined amount (pool). (2) For EPP-FFS and EPP–Capitated Pools, the CDHCS has directed MCPs to reimburse California's 21 DPH for network contracted services delivered by DPH systems, enhanced by either a uniform percentage or dollar increment based on actual utilization of network contracted services. (3) For QIP, the CDHCS has directed the MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to the delivery of services under the MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments the DPH and UC systems must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments will be limited to a predetermined amount (pool). As of June 30, 2020 and 2019, amounts due to providers consist of directed payments as detailed above, totaling $134,041,202 and $119,868,432, respectively.

Net position – Net position is classified as invested in capital assets, net of related debt, restricted, or unrestricted net position. Invested in capital assets, net of related debt, represents investments in equipment, furniture, fixtures, computer hardware, computer software, leasehold improvements, and capital leases, net of depreciation and amortization and related debt. Restricted net position is noncapital net position that must be used for a particular purpose, as specified by state regulatory agency, grantors, or contributors external to the Plan. Unrestricted net position consists of net position that does not meet the definition of invested in capital assets, net of depreciation and amortization, or restricted net position.

Operating revenues and expenses – The Plan's primary operating revenue is derived from capitation. As defined by GASB Codification Section P80, *Proprietary Fund Accounting and Financial Reporting,* all operating revenues are considered program revenues because they are charges for services provided and program-specific operating grants. The primary operating expense is medical expenses. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from nonexchange transactions or net investment income and changes in the fair value of investments.

Capitation revenue – The Plan has agreements with the Medi-Cal Program in the State to provide certain health care products and services to enrolled Medi-Cal beneficiaries. Eligibility of beneficiaries is determined by City and County of San Francisco Human Services Agency and validated by the State of California. The State of California provides the Plan the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month. A portion of revenues received from DHCS is subject to possible retroactive adjustments. Provisions have been made for estimated retroactive adjustments for a maximum of 12 months of retroactivity. Adjustments to revenue due to changes in member eligibility are recognized on a current basis.

Effective with the enrollment of the Adult Expansion Population per the Affordable Care Act on January 1, 2014, the Plan is subject to CDHCS requirements to meet a minimum of 85% medical loss ratio for this population. Specifically, the Plan will be required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by CDHCS. In the event the Plan expends less than the 85% requirement, the Plan will be required to return to CDHCS the difference between the minimum threshold and the actual allowed medical expenses. The 85% MLR requirement is for January 2014 through June 2016, a 30-month period. As of June 30, 2019, the Plan included, an estimated return of funds of $10,998,155 as a reduction to the total amount expected from CDHCS in the California Department of Health Care Services payable. In 2019, the Plan paid off the remainder liability to the CDHCS related to the original MLR reporting period of January 2014 through June 2016. As of June 30, 2020, there are no estimated liabilities for CDHCS between the minimum threshold and the actual allowed medical expenses for the reporting period July 2016 through June 2020.

Effective July 1, 2017, Proposition 56 provides supplemental reimbursement for eligible physician services provided to Medi-Cal beneficiaries. The supplemental reimbursements are for qualified physician services rendered between July 1, 2017 and June 30, 2018 and will continue through June 30, 2021. Providers who are eligible to provide and bill for certain Current Procedural Terminology (“CPT”) codes will receive the associated supplemental payment. For the period July 1, 2017 to June 30, 2018, the Plan is not subject to any CDHCS requirements to meet a minimum medical loss ratio for this program. For the period July 1, 2018 to June 30, 2020, the Plan is subject to CDHCS requirements to meet a minimum 95% medical loss ratio for this program. If the minimum requirement is not met, the Plan will be required to return to CDHCS the difference between the minimum threshold and the actual allowed medical expenses. In 2020 and 2019, the Plan accrued $11,590,331 and $4,622,226, respectively, for the estimated return of funds to CDHCS, which is included in payables to other governmental agencies.

The Plan has an agreement with the County to provide health care services to enrolled Healthy Kids beneficiaries. The Plan issues monthly invoices to the funding organization for its respective portion of premium costs for all Healthy Kids enrollees. Premiums are due monthly and are recognized as revenue in the period the Plan is obligated to provide medical services. Monthly premiums are billed one month in arrears. Premiums collected in advance are recorded as deferred revenue. Unearned income of $1,771,518 and $1,771,518 as of June 30, 2020 and 2019, respectively, is included in Healthy Kids advanced premiums on the combined statements of net position.

Premium deficiencies – The Plan performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is recorded. Management determined that no premium deficiency reserves were needed at June 30, 2020 and 2019.

Grants – The Plan receives grant revenues, which are restricted as to their purpose by the grantor organizations. Revenues from such grants are recognized as operating revenue when all requirements have been met, as they are restricted for specific operating purposes of the Plan.

SFCO TPA fee – The Plan is reimbursed for operating expenses required to support the SFCO program. The Plan bills the San Francisco Department of Health for the direct cost of personnel, space, supplies, and other expenses according to the administrative service agreement. Amounts due from the San Francisco Department of Health for administration fees are $10,022,947 and $11,130,007 at June 30, 2020 and 2019, respectively, and are included in SFCO TPA receivables.

Medical expenses – Hospital, physician, and other service costs are recognized in the period the services are provided and are based on actual paid claims plus an estimate for incurred, but not reported, claims. The estimate for reserves for claims is based on actuarial projections of hospital and other costs using historical analysis of claims paid and authorization and admission data. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Many physicians belonging to medical groups and certain hospitals are compensated primarily on a capitation basis with provisions for additional incentive payments in certain circumstances.

Insurance coverage – The Plan maintains its general liability insurance coverage through outside insurers in the form of "claims-made" policies. Should the claims-made policies not be renewed or replaced with equivalent insurance, claims related to the occurrences during the term of the claims-made policies but reported subsequent to the termination of the insurance contract may be uninsured. These policies were renewed subsequent to year end. Physicians and hospitals, with whom the Plan contracts, are required to maintain their own malpractice coverage.

Income taxes – The Plan operates under the purview of the Internal Revenue Code, Section 501(a) and corresponding California Revenue and Taxation Code provisions. As such, the Plan is not subject to federal or state income taxes.

New accounting pronouncements – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities* ("GASB No. 84"), which is effective for financial statements for periods beginning after December 15, 2018. GASB 84 establishes criteria for identifying fiduciary activities of all state and local governments and clarifies whether and how business-type activities should report their fiduciary activities. Further, the Statement provides that governments should report activities meeting certain criteria in a fiduciary fund in the basic financial statements and present a statement of fiduciary net position and a statement of changes in fiduciary net position. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance* ("GASB No. 95"), which extended the effective date for GASB No. 84 to reporting periods beginning July 1, 2020. The Plan is reviewing the impact of the adoption of GASB No. 84 for the fiscal year ending 2021.

In June 2017, the GASB issued Statement No. 87, *Leases* ("GASB No. 87"), which is effective for financial statements for periods beginning after December 15, 2019. GASB No. 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB No. 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. GASB No. 95 extended the effective date for GASB No. 87 to reporting periods beginning July 1, 2021. The Plan is reviewing the impact of the adoption of GASB No. 87 for the fiscal year ending 2022.

In June 2020, the GASB issued Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans - an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32* ("GASB No. 97"). This Statement amends the criteria for reporting governmental fiduciary component units – separate legal entities included in a government's financial statements. The guidance will result in consent and comparable information about fiduciary component units and Internal Revenue Service ("IRS") Section 457 plans. The Plan is reviewing the impact of the adoption of GASB No. 97 for the fiscal year ending 2022.

NOTE 3 – CASH, RESTRICTED CASH, AND INVESTMENTS

Cash, restricted cash, and investments as of June 30 consist of the following:

	2020	2019
Cash on hand	$ 1,000	$ 1,000
Cash deposits	663,148,172	510,141,915
Investments	42,917,014	40,069,079
Total cash, restricted cash, and investments	$ 706,066,186	$ 550,211,994
Reconciliation to combined statements of net position:		
Cash and cash equivalents	$ 60,769,229	$ 45,415,122
SFCO restricted cash and cash equivalents	602,379,943	464,727,793
Short-term investments	18,538,149	20,218,897
Investments	24,078,865	19,550,182
Asset restricted as to use	300,000	300,000
Total cash, restricted cash, and investments	$ 706,066,186	$ 550,211,994

Included in the investments balance as of June 30, 2020 and 2019, is $300,000 related to the Plan's Knox-Keene reserve requirement. This amount is included in asset restricted as to use in the combined statements of net position.

The Plan's Annual Investment Policy ("Policy") sets forth the guidelines for the investment of all operating funds. The Policy conforms to the California Investment Code §53646 ("Code") as well as customary standards of prudent investment management. The objectives of the Plan's investment policy, in order of priority, are safety of principal, maintenance of liquidity, and attainment of a market rate return that considers risk constraints and cash flow requirements. The policy also identifies certain provisions that address interest rate risk, credit risk, and concentration of risk.

Authorized Investment Type	Maximum Maturity	Maximum Specified Percentage Portfolio	Maximum Investment in One Issuer
Money Market	60 months	100%	None
Mutual Funds	60 months	20%	None
Bankers' Acceptances	270 days	40%	30%
Commercial Paper	180 days	30%	10%
Negotiable Certificates of Deposits	2 years	30%	None
Repurchase Agreements	10 days	30%	None
U.S. Treasury Obligations	Each investment will not exceed a weighted-average maturity of 60 months, with no individual investment to exceed a maturity period of 84 months (seven years).	100%	None
U.S. Agencies	Each investment will not exceed a weighted-average maturity of 60 months, with no individual investment to exceed a maturity period of 84 months (seven years).	100%	None
State Operating Funds and Reserves	Each investment will not exceed a weighted-average maturity of 60 months, with no individual investment to exceed a maturity period of 84 months (seven years).	None	None

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, the Plan will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The California Government Code requires financial institutions to secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the State law. As of June 30, 2020 and 2019, deposits exposed to custodial credit risk because they were uninsured, and the collateral held by the pledging bank not in the Plan's name, were $607,486,763 and $473,872,735, respectively.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. In accordance with its Policy, the Plan manages the risk of market value fluctuations due to overall changes in the general level of interest rates by limiting the weighted-average maturity of its portfolio to no more than 60 months.

The weighted average maturity in years for the Plan's portfolio are as follows as of June 30:

2020

Investment Type	Fair Value	Weighted-Average Maturity (Years)
Certificates of Deposit	$ 16,704,512	0.25
U.S. Agencies	23,016,443	2.87
Foreign Agencies	2,013,295	2.88
LAIF	1,182,764	-
Total fair value	$ 42,917,014	
Portfolio weighted average maturity		1.8

2019

Investment Type	Fair Value	Weighted-Average Maturity (Years)
Certificates of Deposit	$ 15,856,826	0.09
U.S. Agencies	22,303,421	2.40
Foreign Agencies	726,068	4.58
LAIF	1,182,764	-
Total fair value	$ 40,069,079	
Portfolio weighted average maturity		1.5

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a nationally recognized statistical rating organization. Per GASB Codification Section C20, *Cash Deposits with Financial Institutions,* Section I50, *Investments*, and Section I55, *Investments—Reverse Repurchase Agreements*, unless there is information to the contrary, obligations of the U.S. Government or obligations explicitly guaranteed by the U.S. Government are not considered to have credit risk and do not require disclosure of credit quality.

Presented below is the minimum rating required by (where applicable) the California Government Code or the Plan's policy and the actual rating as of year-end for each investment type.

Ratings as of June 30, 2020:

Investment Type	Fair Value	AAA	AA2	AA3	AA1	A-1	A-2	A-3	BAA3	None
Certificates of Deposit	$ 16,704,512	$ -	$ -	$ -	$ -	$ -	$ 16,704,512	$ -	$ -	$ -
U.S. Agencies	23,016,443	17,063,661	-	-	1,050,063	779,660	1,502,290	2,620,769	-	-
Foreign Agencies	2,013,295	-	-	-	-	1,253,011	760,284	-	-	-
LAIF	1,182,764	-	-	-	-	-	-	-	-	1,182,764
Total fair value	$ 42,917,014	$ 17,063,661	$ -	$ -	$ 1,050,063	$ 2,032,671	$ 18,967,086	$ 2,620,769	$ -	$ 1,182,764

Ratings as of June 30, 2019:

Investment Type	Fair Value	AAA	AA2	AA3	AA1	A-1	A-2	A-3	BAA3	None
Certificates of Deposit	$ 15,856,826	$ -	$ 5,900,531	$ -	$ -	$ 9,956,295	$ -	$ -	$ -	$ -
U.S. Agencies	22,303,421	15,850,217	-	-	444,677	-	2,086,642	3,236,193	685,692	-
Foreign Agencies	726,068	-	-	-	-	-	726,068	-	-	-
LAIF	1,182,764	-	-	-	-	-	-	-	-	1,182,764
Total fair value	$ 40,069,079	$ 15,850,217	$ 5,900,531	$ -	$ 444,677	$ 9,956,295	$ 2,812,710	$ 3,236,193	$ 685,692	$ 1,182,764

Concentration of credit risk – The investment policy of the Plan contains certain limitations on the amount that can be invested in any one issuer as listed in the table on page 25. There were no investments in any one issuer (other than U.S. Treasury securities, mutual funds, and external investment pools) that represent 5% or more of the Plan's total investments as of June 30, 2020 and 2019.

NOTE 4 – FAIR VALUE

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The following is a description of the valuation methodologies used for instruments measured at fair value on a recurring basis and recognized in the statements of net position at June 30, 2020 and 2019, as well as the general classification of such instruments pursuant to the valuation hierarchy:

Fixed income: Fixed income funds are valued at the net asset value of shares held by the Plan and are valued at the closing price reported on the active market on which the individual securities are traded.

The following tables present fair value measurements of assets recognized in the accompanying financial statements measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at June 30:

Description	Level 1	Level 2	Level 3	2020
Fixed income				
U.S. government bonds & notes	$ -	$ 10,173,150	$ -	$ 10,173,150
U.S. agencies	-	6,890,511	-	6,890,511
Corporate bonds	5,505,953	-	-	5,505,953
Municipal bonds	-	446,829	-	446,829
Other	-	2,013,295	-	2,013,295
Total investments and restricted cash by fair value level	$ 5,505,953	$ 19,523,785	$ -	25,029,738
Certificates of deposit				16,704,512
LAIF				1,182,764
Total investments and restricted cash				$ 42,917,014

Description	Level 1	Level 2	Level 3	2019
Fixed income				
U.S. government bonds & notes	$ -	$ 7,337,854	$ -	$ 7,337,854
U.S. agencies	-	7,729,958	-	7,729,958
Corporate bonds	6,008,526	-	-	6,008,526
Municipal bonds	-	444,677	-	444,677
Other	-	1,508,474	-	1,508,474
Total investments and restricted cash by fair value level	$ 6,008,526	$ 17,020,963	$ -	23,029,489
Certificates of deposit				15,856,826
LAIF				1,182,764
Total investments and restricted cash				$ 40,069,079

Investments and asset restricted as to use consist of the following at June 30:

	2020	2019
Short-term investments	$ 18,538,149	$ 20,218,897
Investments	24,078,865	19,550,182
Asset restricted as to use	300,000	300,000
Total	$ 42,917,014	$ 40,069,079

NOTE 5 – CAPITAL ASSETS

Capital assets balances as of June 30 consist of the following:

	2020				
	Balance at July 1, 2019	Increases	Decreases	Transfers	Balance at June 30, 2020
Furniture and equipment	$ 2,097,260	$ -	$ -	$ -	$ 2,097,260
Computer hardware	2,808,946	359,639	-	-	3,168,585
Computer software	7,337,252	-	-	-	7,337,252
Leasehold improvements	2,077,247	110,419	-	-	2,187,666
Equipment under capital lease	260,662	-	-	-	260,662
	14,581,367	470,058	-	-	15,051,425
Less accumulated depreciation for:					
Capital assets	(8,871,784)	(1,465,519)	-	-	(10,337,303)
Equipment under capital leases	(433,486)	(74,229)	-	-	(507,715)
	(9,305,270)	(1,539,748)	-	-	(10,845,018)
Net capital assets	$ 5,276,097	$ (1,069,690)	$ -	$ -	$ 4,206,407

	2019				
	Balance at July 1, 2018	Increases	Decreases	Transfers	Balance at June 30, 2019
Furniture and equipment	$ 2,097,260	$ -	$ -	$ -	$ 2,097,260
Computer hardware	2,065,870	743,076	-	-	2,808,946
Computer software	8,585,093	444,617	(1,692,458)	-	7,337,252
Leasehold improvements	2,059,872	17,375	-	-	2,077,247
Equipment under capital lease	362,416	260,663	(362,417)	-	260,662
	15,170,511	1,465,731	(2,054,875)	-	14,581,367
Less accumulated depreciation for					
Capital assets	(7,958,795)	(1,273,584)	360,595	-	(8,871,784)
Equipment under capital leases	(361,079)	(74,229)	1,822	-	(433,486)
	(8,319,874)	(1,347,813)	362,417	-	(9,305,270)
Net capital assets	$ 6,850,637	$ 117,918	$ (1,692,458)	$ -	$ 5,276,097

NOTE 6 – CAPITATION PAYABLE

Capitation payable represents capitation payments due to providers under the Medi-Cal, Healthy Workers, and Healthy Kids programs of the Plan to be paid to medical providers for services rendered to eligible members, for the months of June 2020 and 2019, respectively. Capitation payable as of June 30, 2020 and 2019, was $30,908,734 and $39,171,688, respectively.

NOTE 7 – MEDICAL CLAIMS PAYABLE

The Plan contracts with various providers, including physicians and hospitals, to provide certain health care products and services to enrolled Medi-Cal, Healthy Workers, and Healthy Kids beneficiaries. The cost of the health care products and services provided or contracted for is accrued in the period in which it is provided to a member and includes an estimate of the cost of services that have been incurred but not yet reported. The estimate for reserves for claims is based on projections of hospital and other costs using historical studies of claims paid. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

For the years ended June 30, 2020 and 2019, the following is a reconciliation of the medical claims payable liability and the reserve for future claims losses:

	2020	2019
Balance, July 1	$ 7,634,233	$ 8,619,820
Add: claims expenses incurred	45,017,828	45,310,396
Less: claims expenses paid	(45,494,739)	(46,295,983)
Balance, June 30	$ 7,157,322	$ 7,634,233

NOTE 8 – MEDICAL REINSURANCE (STOP-LOSS INSURANCE)

The Plan has entered into certain reinsurance (“stop-loss”) agreements with third parties to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse the Plan certain proportions of the cost of each member’s annual hospital services, in excess of specified deductibles, no more than $1,000,000 in aggregate over all contract years per member. Stop-loss insurance premiums of $2,580,866 and $2,966,223 are included in medical expense in 2020 and 2019, respectively. Stop-loss insurance recoveries were $8,072,376 and $0 in 2020 and 2019, respectively, and included certain amounts passed through to providers. Stop-loss insurance recoveries are recorded as an offset to stop-loss insurance expense and are included in other income in 2020 and 2019.

NOTE 9 – RETIREMENT, DEFERRED COMPENSATION, AND DEFINED CONTRIBUTION PLANS

Plan description – Effective May 3, 1999, the Plan joined CalPERS, a cost-sharing multiple-employer defined benefit pension plan (“pension plan”). CalPERS provides retirement and disability benefits, annual cost-of-living adjustments, and death benefits to CalPERS members and beneficiaries. CalPERS acts as a common investment and administrative agent for participating public entities within the State of California. Benefit provisions and all other requirements are established by State statute. Copies of the CalPERS annual financial report may be obtained from their Executive Office: 400 P Street, Sacramento, California 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost-of-living adjustments, and death benefits to plan members, who must be public employees, and beneficiaries. Benefits are based on years of credited service, equal to one year of full time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for nonduty disability benefits after 10 years of service. The death benefit is one of the following: the Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for each plan are applied as specified by the Public Employees' Retirement Law.

The pension plan's provisions and benefits in effect at June 30, 2020, are summarized as follows:

	Hire date prior to January 1, 2013	Hire date on or after January 1, 2013
Benefit formula	2% @ 55	2% @ 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	monthly for life	monthly for life
Retirement age	50-55	52
Monthly benefits, as a % of eligible compensation	monthly for life	monthly for life
Required employee contributions rates	7.00%	6.75%
Required employer contributions rates	9.68%	9.96%

Contributions – Section 20814(c) of the California Public Employees' Retirement Law requires that the employer contribution rates for all public employers be determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. Funding contributions for the pension plans are determined annually on an actuarial basis as of June 30 by CalPERS. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The Plan is required to contribute the difference between the actuarially determined rate and the contribution rate of employees.

For the year ended June 30, 2020, the employer contributions recognized as part of pension expense was $4,116,715 and employee contributions were $2,320,739.

For the year ended June 30, 2019, the employer contributions recognized as part of pension expense was $2,417,969 and employee contributions were $2,111,514.

As of June 30, 2020 and 2019, the Plan reported $208,691 and $1,279,513 of net pension asset, respectively, for its proportionate shares of the net pension asset (liability) of the pension plan.

The Plan's net pension asset/liability for the pension plan is measured as the proportionate share of the net pension asset/liability. For the fiscal years ended June 30, 2020 and 2019, the net pension asset/liability of the pension plan is measured as of June 30, 2019 and 2018, respectively, and the total pension liability for the pension plan used to calculate the net pension asset/liability was determined by an actuarial valuation as of June 30, 2018 and 2017, rolled forward to June 30, 2018 and 2017, using standard update procedures. The Plan's proportion of the net pension asset/liability was based on a projection of the Plan's long-term share of contributions to the pension plans relative to the projected contributions of all participating employers, actuarially determined. The Plan's proportionate share of the net pension asset/liability for the pension plan as of June 30, 2020 and 2019, was -0.00204% and -0.01328%, respectively.

For the year ended June 30, 2020 and 2019, the Plan recognized pension expense of $3,778,783 and $2,128,984, respectively, as included in salaries and benefits in the combined statements of revenue, expenses, and changes in net position.

At June 30, 2020, the Plan reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 1,123	$ 14,494
Changes of assumptions	3,528	9,951
Differences between projected and actual investment earnings	3,649	-
Differences between employer's contributions and proportionate share of contributions	2,155,510	-
Change in employer's proportion	1,041,424	155,943
Pension contributions made subsequent to measurement date	4,116,715	-
Total	$ 7,321,949	$ 180,388

At June 30, 2019, the Plan reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ (49,093)	$ (16,706)
Changes of assumptions	(145,868)	(35,748)
Differences between projected and actual investment earnings	-	6,326
Differences between employer's contributions and proportionate share of contributions	3,021,660	-
Change in employer's proportion	715,353	273,341
Pension contributions made subsequent to measurement date	2,417,969	-
Total	$ 5,960,021	$ 227,213

The Plan also reported $4,116,715 and $2,417,969 as deferred outflows of resources related to contributions subsequent to the measurement date that will be recognized as a reduction of the net pension asset/liability in the measurement years ended June 30, 2020 and 2019, respectively. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Fiscal Year Ending	
2021	$ 1,675,362
2022	1,027,286
2023	322,934
2024	(736)
	$ 3,024,846

Actuarial assumptions – The total pension liabilities in the June 30, 2019, actuarial valuations were determined using the following actuarial assumptions:

Valuation date	June 30, 2018
Measurement date	June 30, 2019
Actuarial cost method	Entry age normal cost method
Actuarial assumptions	
Discount rate	7.15%
Inflation	2.50%
Salary increases	Varies by entry age and service
Investment rate of return	7.15%
Mortality rate table	Derived using CalPERS' membership data for all funds

The underlying mortality assumptions and all other actuarial assumptions used in the June 30, 2019, valuation were based on the results of an actuarial experience study for the period 1997 to 2011. Further details of the experience study can found on the CalPERS website.

The total pension liabilities in the June 30, 2018, actuarial valuations were determined using the following actuarial assumptions:

Valuation date	June 30, 2017
Measurement date	June 30, 2018
Actuarial cost method	Entry age normal cost method
Actuarial assumptions	
Discount rate	7.15%
Inflation	2.50%
Salary increases	Varies by entry age and service
Investment rate of return	7.15%
Mortality rate table	Derived using CalPERS' membership data for all funds

Change of assumptions – The inflation rate remained 2.50% for the June 30, 2019, measurement date. The discount rate remained at 7.15% for the June 30, 2019, measurement date.

Discount rate – The discount rate used to measure the total pension liability at June 30, 2020 and 2019, was 7.15%. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans run out of assets. Therefore, the current 7.15% discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long-term expected discount rate of 7.15% will be applied to all plans in the Public Employees Retirement Fund. The cash flows used in the testing were developed assuming that both members and employers will make their required contributions on time and as scheduled in all future years. The stress test results are presented in a detailed report called “GASB Crossover Testing Report” that can be obtained from the CalPERS website.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make the required contributions as scheduled in all future years. Using historical returns of all the funds' asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11 - 60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one quarter of one percent.

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These rates of return are net of administrative expenses.

Asset Class	New Strategic Allocation	Real Return Years 1-10 (a)	Real Return Years 11+ (b)
Global equity	50.0%	4.80%	5.98%
Fixed income	28.0%	1.00%	2.62%
Inflation assets	0.0%	0.77%	1.81%
Private equity	8.0%	6.60%	7.23%
Real estate	13.0%	3.75%	4.93%
Liquidity	1.0%	0.00%	-0.92%

(a) An expected inflation rate of 2.00% was used for this period
(b) An expected inflation rate of 2.92% was used for this period

Sensitivity of the proportionate share of the net pension asset/liability to changes in the discount rate – The following presents the Plan's proportionate share of the net pension asset/liability for the pension plan, calculated using the discount rate for the pension plan, as well as what the Plan's proportionate share of the net pension asset/liability would be if it were calculated using a discount rate that is 1-percentage point lower or 1-percentage point higher than the current rate as of June 30:

2020	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Net pension liability (asset)	$ 5,793,396	$ (208,691)	$ (5,162,989)

2019	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Net pension liability (asset)	$ 3,800,246	$ (1,279,513)	$ (5,472,771)

Pension plan fiduciary net position – Detailed information about the pension plan's fiduciary net position is available in the separately issued CalPERS financial reports.

Payable to the pension plan – At June 30, 2020, the Plan reported an asset of $208,691 for the overfunding of contributions to the pension plan required for the year ended June 30, 2020. At June 30, 2019, the Plan reported an asset of $1,279,513 for the overfunding of contributions to the pension plan required for the year ended June 30, 2019.

Deferred compensation plan – The Plan offers its employees a deferred compensation plan with CalPERS created in accordance with Internal Revenue Code Section 457. The deferred compensation plan is available to all employees and permits them to defer a portion of their salary. No employer contribution to the plan is required. Deferred compensation is not available to employees until termination, retirement, death, or an unforeseeable emergency.

Defined contribution retirement plan – A defined contribution retirement plan (IRS 401a), was implemented effective October 1, 2013. In 2020 and 2019, the Plan contributed approximately $1,709,566 and $1,661,235, respectively, to the defined contribution retirement plan.

Employees of the Plan are eligible to participate in the defined contribution retirement plan upon date of hire. The Plan will make contributions in an amount equal to each participant's compensation times an applicable contribution rate as set by the Plan. Participants are fully vested upon completing three years of service. Members of the executive team are required to make pretax contributions into the defined contribution retirement plan.

NOTE 10 – OPERATING LEASE

The Plan entered a 10-year and 4-month lease on office space, executed on June 20, 2014. The lease commenced on July 1, 2015. The terms of the lease agreement require a standby Letter of Credit for the purposes of collateralizing the agreement. The lease runs through October 31, 2025.

Total rental expense for the years ended June 30, 2020 and 2019, was $4,418,982 and $4,274,661, respectively. Rent expense related to the Plan for the years ended June 30, 2019 and 2018, was $3,376,208 and $3,601,330, respectively, and is included in occupancy. Rent expense related to SFCO TPA for the years ended June 30, 2020 and 2019, was $1,042,773 and $673,331, respectively, and is included in SFCO TPA expenses.

Future minimum lease obligations consist of the following:

Fiscal Year Ending	
2021	$ 4,066,949
2022	4,195,214
2023	4,321,945
2024	4,449,857
2025	4,582,934
Thereafter	1,572,396
	$ 23,189,295

The Plan records minimum base rent on a straight-line basis over the life of the lease term and, accordingly, has recorded a deferred rent liability, included in accounts payable and accrued expenses of $1,971,866 and $2,038,335, as of June 30, 2020 and 2019, respectively.

NOTE 11 – CAPITAL LEASES

The Plan leases copier machines under capital lease obligations. These lease agreements require monthly payments of $7,962 and expire in 2021. A summary of capital lease obligations at June 30 is as follows:

	2020	2019
Capital lease obligations, at implicit rate ranging from 7% to 10%, collateralized by leased equipment	$ 107,397	$ 193,668
Less: current portion	(95,544)	(95,544)
Capital lease obligations, net of current portion	$ 11,853	$ 98,124

Scheduled payments on capital lease obligations at June 30 are as follows:

2021	$ 95,544
2022	15,924
2023	-
Total minimum lease payments	111,468
Less: amounts representing interest	(4,071)
	$ 107,397

A schedule of changes in the Plan's capital lease obligations for the year ended June 30, 2020, is as follows:

	June 30, 2019	Additions	Reductions	June 30, 2020
Capital leases - equipment	$ 193,668	$ -	(86,271)	$ 107,397
Total	$ 193,668	$ -	$ (86,271)	$ 107,397

A schedule of changes in the Plan's capital lease obligations for the year ended June 30, 2019, is as follows:

	June 30, 2018	Additions	Reductions	June 30, 2019
Capital leases - equipment	$ 91,178	$ 260,663	$ (158,173)	$ 193,668
Total	$ 91,178	$ 260,663	$ (158,173)	$ 193,668

Equipment held under capital lease obligations included in capital assets is as follows:

	2020	2019
Equipment	$ 260,663	$ 260,663
Less: accumulated amortization	(159,294)	(74,229)
Equipment held under capital lease obligations, net	$ 101,369	$ 186,434

NOTE 12 – TANGIBLE NET EQUITY

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975 (the "Act"), the Plan is required to maintain a minimum level of tangible net equity. The required tangible net equity level was approximately $13,967,751 and $12,597,375 at June 30, 2020 and 2019, respectively. The Plan's tangible net equity was $91,546,413 and $100,503,189 at June 30, 2020 and 2019, respectively.

NOTE 13 – RISK MANAGEMENT

The Plan is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Plan carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Plan's commercial coverage.

NOTE 14 – COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, the Plan is a party to claims and legal actions by enrollees, providers, and others. The Plan's policy is to accrue for amounts related to these claims and legal actions if it is probable that a liability has been incurred and the amount of the liability can be reasonably estimated. After consulting with legal counsel, the Plan's management is of the opinion that any liability that may ultimately result in claims or legal actions will not have a material effect on the combined financial position or results of operations of the Plan.

In August 2020, the Plan increased its revolving line of credit to from $40,000,000 as of June 30, 2020, to $80,000,000. The line of credit carries an interest rate of the greater of 2.25%, or LIBOR plus 2%. The expected maturity was extended to December 31, 2021, and will be extended month to month going forward. As of June 30, 2020 and 2019, the Plan had no balance outstanding under its revolving line of credit.

NOTE 15 – HEALTH CARE REFORM

The Patient Protection and Affordable Care Act ("PPACA") allowed for the expansion of Medi-Cal members in the State of California. Any further changes in federal or state funding could have an impact on the Plan. The future of the PPACA and the impact of future changes in medicaid to the Plan is uncertain at this time.

Supplementary Information

San Francisco Health Authority and
San Francisco Community Health Authority
Schedule of Proportionate Share of the Net Pension Asset/Liability

	2020	2019	2018	2017
Proportion of the net pension liability	-0.00204%	-0.01328%	0.04607%	0.04550%
Proportionate share of the net pension (asset) liability	$ (208,691)	$ (1,279,513)	$ 1,816,234	$ 1,580,736
Covered-employee payroll	$ 32,845,070	$ 29,450,405	$ 27,864,601	$ 26,420,916
Proportionate share of the net pension (asset) liability as a percentage of covered-employee payroll	-0.64%	-4.34%	6.52%	5.98%
Plan's fiduciary net position	$ 44,832,857	$ 38,831,925	$ 29,753,982	$ 22,916,361
Plan fiduciary net position as a percentage of the total pension liability	75.26%	75.26%	94.25%	93.55%

San Francisco Health Authority and
San Francisco Community Health Authority
Schedule of Contributions

	2020	2019	2018	2017
Measurement period	2018-2019	2017-2018	2016-2017	2015-2016
Actuarially determined contribution	$ 2,657,497	$ 2,417,969	$ 2,139,636	$ 2,038,856
Contributions in relation to the actuarially determined contribution	(4,116,715)	(2,417,969)	(2,139,636)	(2,038,856)
Contribution deficiency (excess)	(1,459,218)	$ -	$ -	$ -
Covered-employee payroll	$ 34,966,554	$ 32,845,070	$ 29,450,405	$ 27,864,601
Contributions as a percentage of covered-employee payroll	11.77%	7.36%	7.27%	7.32%


MOSSADAMS

Agenda Item 3
Action Item

- Review and Approval of Year-To-Date Unaudited Financial Statements and Investment Reports

SAN FRANCISCO HEALTH PLAN
Here for you

FINANCIAL RESULTS – SEPTEMBER 2020

1. September 2020 reported a loss of ($1,662,000) versus a budgeted loss of ($1,636,000). After removing Strategic Use of Reserves (SUR) activity, the actual loss from operations would remain ($1,662,000) versus a budgeted loss of ($1,220,000).

   On a year-to-date basis, we have a loss of ($2,127,000) versus a budgeted loss of ($3,784,000). After removing SUR activity, the actual loss from operations remains ($2,127,000) versus a budgeted loss ($2,388,000).

   In September, we received $133.9 million in Directed Payments funding related to FY 18-19. The FY 20-21 budget projected Directed Payments funding of $120.6 million for September. For FY 20-21, we projected a total of $137.0 million in Directed Payments – 88% in September 2020 and 12% in March 2021. It is likely we will exceed this total when the next payment is received in March 2021. The Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) allow Directed Payments funding to be treated as revenue and medical expense.

2. Variances between September actual results and the budget include:

   a. A net increase in revenue of $14.7 million due to:
      i. $13.3 million more in Directed Payments funding related to FY 18-19.
      ii. $1.6 million more in premium revenue due to 4,050 more member months when compared to the budget. Membership has been on an upward trend with new members coming in along with members not placed on hold. Due to the COVID-19 pandemic, DHCS has allowed Medi-Cal beneficiaries additional time to requalify for continued eligibility in the Medi-Cal program. Adult Expansion member months were 5,332 more than budget which brought in $2.0 million in additional revenue.
      iii. $124,000 less in Hepatitis C revenue as the result of 48 fewer treatment weeks.
      iv. $70,000 less in Maternity revenue as the result of 8 fewer maternity events.

   b. A net increase in medical expense of $15.2 million due to:
      i. $13.3 million more in Directed Payments funding related to FY 18-19.
      ii. $1.1 million more in capitation expense due primarily to increasing membership. The additional revenue generated by increasing membership offset this cost.
      iii. $489,000 more in fee-for-service claims. September was expected to be a heavy month for claims due to five payment cycles. The budget anticipated this additional activity and resulting professional and hospital pmpm costs were in line. The two areas where costs exceeded the budget were Community-Based Adult Services claims and supplemental payments for qualifying Proposition 56 services.

iv. $267,000 more in Healthy Workers pharmacy expense. The actual cost was $83 pmpm while the budgeted cost was $65 pmpm. It is important to note that SFHP receives only $58 pmpm in the Healthy Workers rate.
v. $260,000 more in Medi-Cal non-Hepatitis pharmacy expense. This increase is due to more members as the actual pmpm cost was in line with the budget.
vi. $216,000 less in Health Education expenses. This is a timing difference. Actual costs will align with the budget in the upcoming months.

c. A net decrease in administrative expenses of $458,000 due to:
   i. Anticipated external costs related to major projects such as CalAIM and CMS Interoperability have yet to be incurred.

Below is a chart highlighting the key income statement categories for September with adjustments for SUR activity in order to show margin or loss from ongoing operations.

	SEP 2020				FYTD 20-21 THRU SEP			
CATEGORY	ACTUAL	BUDGET	FAV (UNFAV)	% FAV (UNFAV)	ACTUAL	BUDGET	FAV (UNFAV)	% FAV (UNFAV)
MEMBER MONTHS	148,150	144,100	4,050	2.8%	438,682	428,936	9,746	2.3%
REVENUE	$ 184,402,000	$ 169,647,000	$ 14,755,000	8.7%	$ 283,400,000	$ 267,028,000	$ 16,372,000	6.1%
MEDICAL EXPENSE	$ 181,819,000	$ 166,604,000	$ (15,215,000)	-9.1%	$ 273,120,000	$ 257,141,000	$ (15,979,000)	-6.2%
MLR	99.0%	98.6%			97.1%	97.0%		
ADMINISTRATIVE EXPENSE	$ 4,262,000	$ 4,720,000	$ 458,000	9.7%	$ 12,537,000	$ 13,796,000	$ 1,259,000	9.1%
ADMINISTRATIVE RATIO	2.0%	2.4%			3.7%	4.4%		
INVESTMENT INCOME	$ 17,000	$ 41,000	$ (24,000)	-58.5%	$ 130,000	$ 125,000	$ 5,000	4.0%
MARGIN (LOSS)	$ (1,662,000)	$ (1,636,000)	$ (26,000)		$ (2,127,000)	$ (3,784,000)	$ 1,657,000	
ADD BACK: SUR ACTIVITY	$ -	$ 416,000			$ -	$ 1,396,000		
MARGIN (LOSS) FROM OPERATIONS	$ (1,662,000)	$ (1,220,000)	$ (442,000)		$ (2,127,000)	$ (2,388,000)	$ 261,000	

On a year-to-date basis through September and after the removal of SUR activity, SFHP is $261,000 ahead versus the budget. SFHP is concerned however due to the fact that we are above budget on member months but have yet to produce a positive margin.

- After removing the Directed Payments funding, premium revenue is above budget by $3.1 million. This is due to a net increase of 9,746 member months. Adult Expansion member months are 13,714 above budget which is a positive development due to the fact that the premium rate for this category of aid is $381 pmpm compared to $257 pmpm for the Adult 19 category and $113 pmpm for the Child 18 category.
- After removing SUR activity and Directed Payments funding, medical expense is above budget by $4.2 million. This increase can be accounted for as follows:
  - Capitation expenses are up $2,500,000
  - Prop 56 supplemental payments are up $ 909,000
  - Healthy Workers pharmacy costs are up $ 571,000
  - CBAS expenses are up $ 444,000
  - Health Education costs are down ($ 215,000)

- Overall administrative expense is below budget by $1.3 million. The majority of this decrease is due to lower costs in the areas of professional services and information technology services. In addition, the budget included dollars for major projects which have not been incurred yet, i.e., CalAIM and CMS Interoperability.

PROJECTIONS

Financial projections through March 2021:

1. Due to the impact of the COVID-19 pandemic, SFHP anticipates continued increases in Medi-Cal membership over the next six months. After working with our actuary, sister plans and the county of San Francisco to gather information to help us develop estimates for the upcoming months, SFHP expects to add approximately 22,000 new members during FY 20-21. These new members would be spread across the Adult, Child and Adult Expansion categories of aid.

2. In response to the COVID-19 pandemic and the effect it is having on state of California finances, the State Legislature approved the implementation of a 1.5% rate reduction retroactive to July 2019. This rate reduction is effective for the entire Bridge Period which runs through December 2020. The rate reduction applies to all categories of aid except dual eligible members. SFHP estimates the impact of this rate reduction to be $3.3 million for the period of July through December 2020. This revenue loss was built into the FY 20-21 budget.

3. Beginning January 2021, the pharmacy benefit will be carved out of Medi-Cal managed care. The State will take on this benefit and has selected Magellan as its Pharmacy Benefits Manager (PBM). For the period of January through June 2021, SFHP will see a revenue reduction of $44 million and an expense reduction of $43 million. This carve-out of the pharmacy benefit was built into the FY 20-21 budget.

4. In September, SFHP received preliminary rates for CY 2021. Although these rates look promising, the rates do not include adjustments for Low Acuity Non-Emergent (LANE) ER visits, risk adjustment and the population acuity adjustment. All three of these adjustments will reduce the preliminary rates. Our actuary believes that after these adjustments are incorporated into the rate-setting process, we may see an overall 3.2% increase, however this is only an estimate. SFHP does not expect to see final rates until late December.

5. Proposition 56 – this program will continue for FY 20-21 and will provide enhanced payments to medical groups for qualifying physician services, supplemental payments for developmental screenings, adverse childhood experiences screenings, trauma screenings, family planning services and value-based payments related to a variety of health care quality measures.

6. Directed Payments – SFHP received $133.9 million in Directed Payments funding during September. These funds were disbursed to Zuckerberg San Francisco General, UCSF and private hospitals.

7. See income statement charts on subsequent pages. Due to the impact that pass-through funding and the disbursement of Strategic Use of Reserves have on projections, we have included graphs

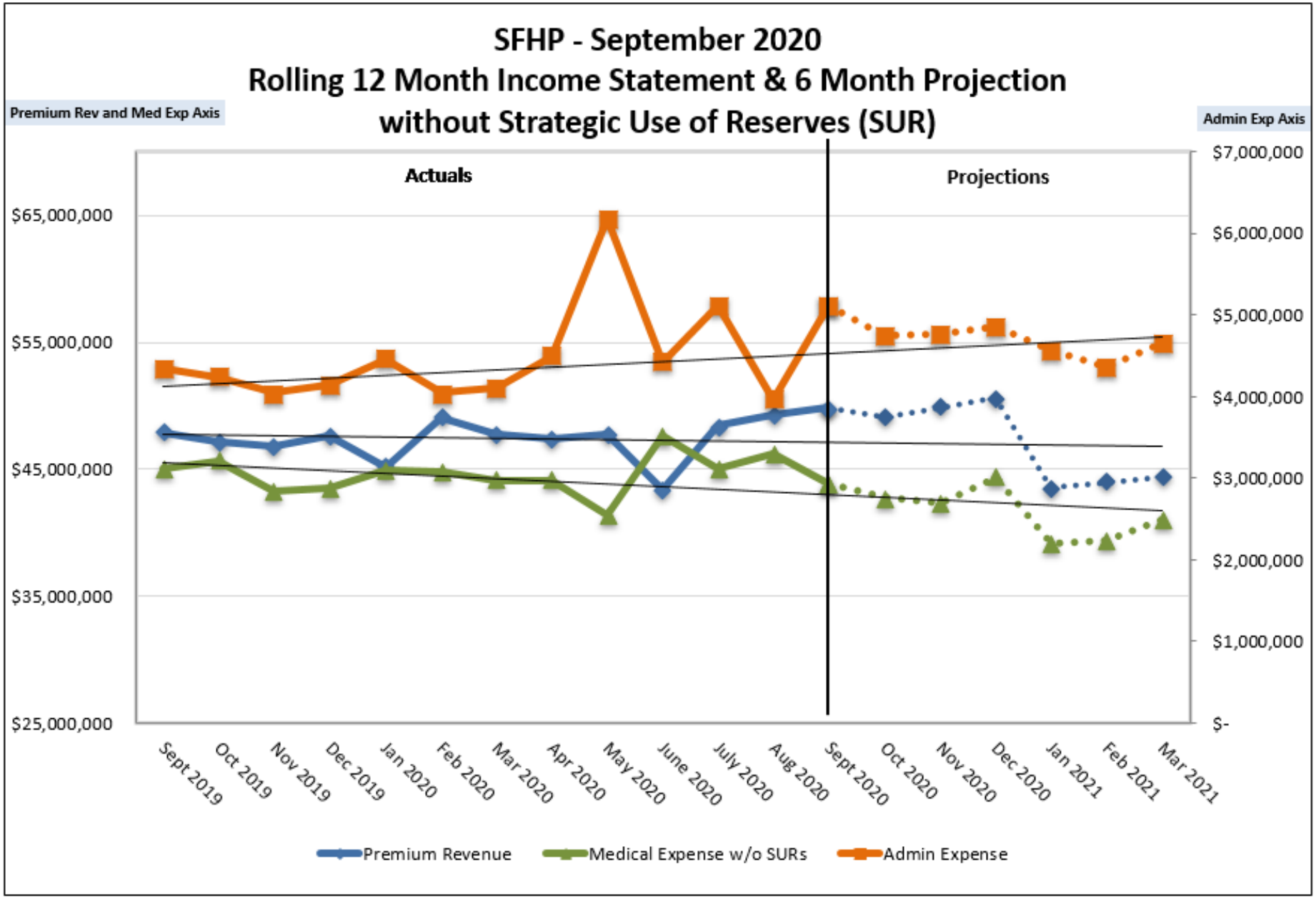
with and without this activity. It is important to note the anticipated decline in revenue and medical expense effective January 2021. This reflects the impact of carving out the pharmacy benefit.

HIGHLIGHTED IMPACTS TO THE HEALTH PLAN AND/OR PROVIDERS

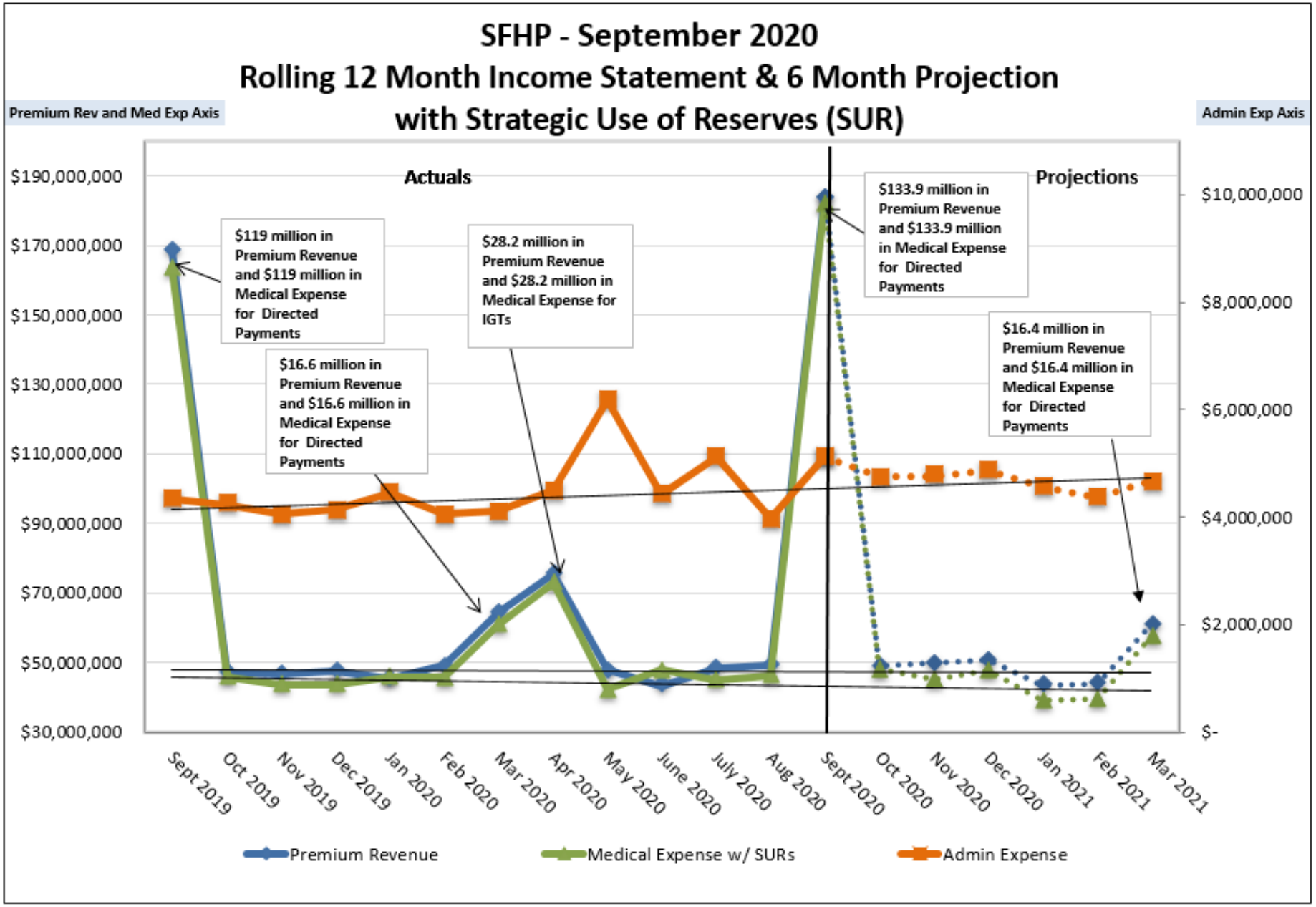
As a result of the COVID-19 pandemic, Medi-Cal membership has been increasing for all SFHP providers and this trend is expected to continue throughout FY 20-21. The table below shows how membership and capitation have changed between March 2020 and September 2020. Please note that the capitation amounts for September 2020 reflect the impact of the reduction in the Duals capitation rate effective July 2020. The impact of this rate change across all capitated providers was a reduction of 0.9%.

Overall Medi-Cal membership has increased by 8.7%. The percentage change in membership and the percentage change in capitation will not be equal due to membership mix. For example, providers receive more capitation for Adult Expansion and SPD members and less capitation for Adult 19 and Child 18 members.

SFHP MEDI-CAL MEMBERSHIP								
	----------SEP 2020---------		----------MAR 2020---------		-------MEMBERS-----		----CAPITATION----	
PROVIDER	MEMBERS	CAPITATION	MEMBERS	CAPITATION	INCREASE	%	INCREASE	%
HOSPITALS								
ZUCKERBERG SAN FRANCISCO GENERAL	62,065	$ 8,577,937	56,423	$ 7,958,485	5,642	10.0%	$ 619,452	7.8%
CALIFORNIA PACIFIC MEDICAL CENTER	37,403	$ 2,758,689	35,338	$ 2,663,795	2,065	5.8%	$ 94,894	3.6%
UCSF (FEE-FOR-SERVICE)	12,423	$ -	11,655	$ -	768	6.6%	$ -	
KAISER	10,893	$ 1,387,280	9,208	$ 1,176,742	1,685	18.3%	$ 210,538	17.9%
CHINESE HOSPITAL	9,177	$ 943,673	8,601	$ 896,444	576	6.7%	$ 47,229	5.3%
CALIFORNIA PACIFIC MEDICAL CENTER/ST. LUKE'S (FFS)	3,114	$ -	2,989	$ -	125	4.2%	$ -	
	135,075	$ 13,667,579	124,214	$ 12,695,466	10,861	8.7%	$ 972,113	7.7%
MEDICAL GROUPS								
CLINICAL PRACTICE GROUP	55,606	$ 3,775,534	50,829	$ 3,521,437	4,777	9.4%	$ 254,097	7.2%
UCSF (FEE-FOR-SERVICE)	12,423	$ -	11,655	$ -	768	6.6%	$ -	
KAISER	10,893	$ 1,387,280	9,208	$ 1,176,742	1,685	18.3%	$ 210,538	17.9%
CHINESE COMMUNITY HEALTH CARE ASSOCIATION	5,273	$ 420,020	5,043	$ 405,922	230	4.6%	$ 14,098	3.5%
JADE MEDICAL GROUP	3,904	$ 321,759	3,558	$ 300,079	346	9.7%	$ 21,680	7.2%
HILL PHYSICIANS	1,631	$ 119,076	1,543	$ 111,938	88	5.7%	$ 7,138	6.4%
BROWN & TOLAND MEDICAL GROUP	1,483	$ 127,002	1,446	$ 120,622	37	2.6%	$ 6,380	5.3%
	91,213	$ 6,150,671	83,282	$ 5,636,740	7,931	9.5%	$ 513,931	9.1%
SAN FRANCISCO COMMUNITY CLINIC CONSORTIUM								
NORTH EAST MEDICAL SERVICES	43,862	$ 4,522,088	40,932	$ 4,301,331	2,930	7.2%	$ 220,757	5.1%
MISSION NEIGHBORHOOD HEALTH CENTER	6,986	$ 217,845	6,365	$ 200,331	621	9.8%	$ 17,514	8.7%
HEALTHRIGHT 360	3,087	$ 157,845	3,055	$ 158,527	32	1.0%	$ (682)	-0.4%
SOUTH OF MARKET HEALTH CENTER	2,008	$ 106,925	1,824	$ 99,259	184	10.1%	$ 7,666	7.7%
SAN FRANCISCO COMMUNITY HEALTH CENTER	747	$ 32,611	608	$ 26,953	139	22.9%	$ 5,658	21.0%
ST. ANTHONY'S MEDICAL CLINIC	700	$ 28,544	663	$ 28,464	37	5.6%	$ 80	0.3%
NATIVE AMERICAN HEALTH CENTER	587	$ 23,473	501	$ 21,004	86	17.2%	$ 2,469	11.8%
BAART	249	$ 12,709	219	$ 12,046	30	13.7%	$ 663	5.5%
	58,226	$ 5,102,040	54,167	$ 4,847,915	4,059	7.5%	$ 254,125	5.2%
UNAFFILIATED								
MARIN CITY HEALTH & WELLNESS CENTER	473	$ 14,644	406	$ 12,493	67	16.5%	$ 2,151	17.2%
DR. THANH QUOC TRAN	336	$ 14,077	310	$ 13,228	26	8.4%	$ 849	6.4%
	809	$ 28,721	716	$ 25,721	93	13.0%	$ 3,000	11.7%
TOTAL SFHP	135,075		124,214		10,861	8.7%		



1) Medical Expense **without** Strategic Use of Reserves (SUR)
2) Dual axis chart
3) Trend line **without** impact of Strategic Use of Reserves (SUR) or pass-throughs



1) Medical Expense **with** Strategic Use of Reserves (SUR) and pass-throughs
2) Dual axis chart
3) Trend line **without** impact of Strategic Use of Reserves (SUR) or pass-throughs

San Francisco Health Plan
Finance Big Picture Dashboard - September 2020

	Sep-20			Sep-19	Fiscal Year to Date (20/21)			FY 19/20
	MTD	MTD	MTD	MTD	FYTD	FYTD	FYTD	FYTD
	Actual	Budget	Fav (Unfav)	Actual	Actual	Budget	Fav (Unfav)	Actual
FINANCIAL POSITION:								
Net Profit/Loss w/o HSF ($)	(1,662,065)	(1,626,263)	(35,802)	1,519,190	(2,127,190)	(3,784,592)	1,657,402	3,118,151
Total Medical Loss Ratio_All LOB	99.0%	98.6%	-0.4%	97.1%	97.1%	97.0%	0.0%	95.2%
Admin Expense Ratio	2.0%	2.4%	0.4%	2.1%	3.7%	4.4%	0.7%	3.9%
Number of FTE's	347			346				
Premium Revenue ($)	183,729,789	168,969,706	14,760,084	168,767,027	281,399,411	265,005,069	16,394,342	263,422,062
Medical Expenses ($)	181,818,741	166,604,554	(15,214,187)	163,879,524	273,120,453	257,141,498	(15,978,954)	250,672,128
Administration Expenses w/o HSF ($)	4,262,509	4,720,254	457,745	4,339,920	12,537,076	13,795,718	1,258,642	12,694,132
Member Months	148,150	144,100	4,050	138,840	438,682	428,936	9,746	419,834
Cash on Hand (Days)	31			37				

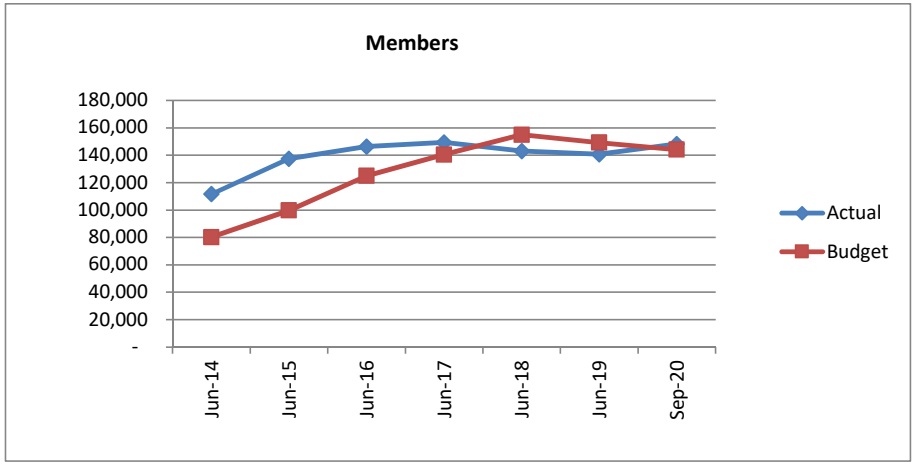
RESERVES:	September-2020	Budget @ 6/30/21	June-2020	June-2019	June-2018	June-2017	June-2016	June-2015
Reserves ($)	89,419,223	86,253,212	91,960,120	97,935,725	108,542,472	120,761,132	112,637,840	82,714,329
SUR carry-over balance from prior years	(3,992,060)	(1,800,000)	(4,145,463)	(6,046,189)	(15,567,350)			
FY18-19 SUR for Medical Groups and Targeted Interv.	(2,945,000)	-	(2,945,000)	(6,558,333)	0			
Adjusted Reserve Balance	82,482,163	84,453,212	84,869,657	85,331,203	92,975,122			
Reserve Policy 2x Premium Rev (Rolling 12 month avg)	99,650,058	90,000,000	86,669,751	93,747,256	93,684,010	94,325,464	100,027,410	51,400,000
Reserves Over (Under) 2 x Premium Revenue	(17,167,895)	(5,546,788)	(1,800,095)	(8,416,053)	(708,888)			
DMHC Required TNE	12,838,809	13,500,000	13,951,203	12,597,375	11,960,363	11,818,641	10,744,461	8,673,851
TNE Multiple	6.4	6.4	6.1	6.8	7.8	10.2	10.5	10.1

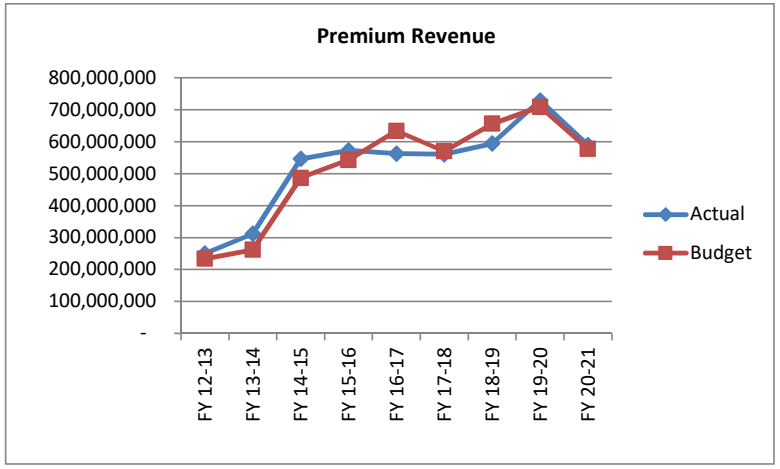
FINANCIAL TREND:	**FY 19/20 Original Budget**	**Change**
Premium Revenue ($)	265,005,069	16,394,342
Medical Expenses ($)	257,141,498	(15,978,954)
Administration Expenses w/o HSF ($)	13,795,718	1,258,642

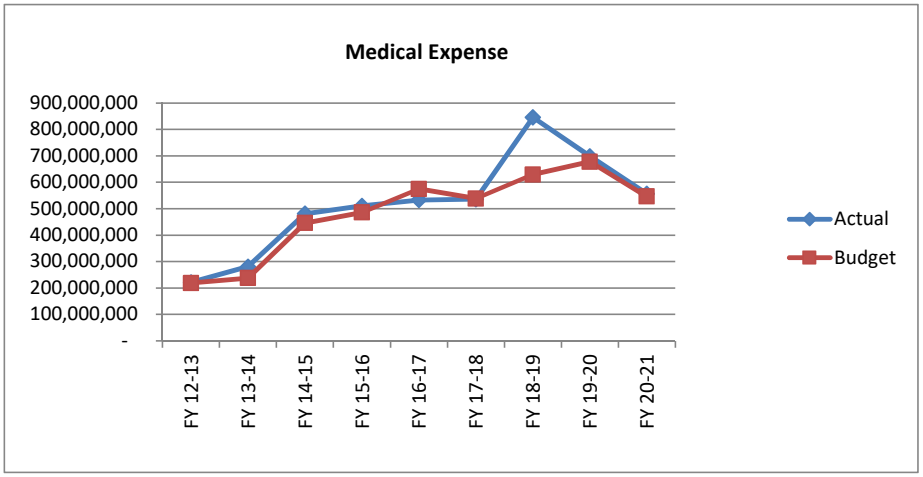
	September-2020	June-2019	June-2018	June-2017	June-2016	June-2015	June-2014	
Member Months	148,150	140,765	143,096	149,348	146,289	137,427	111,590	Membership for the Month
Average Monthly Enrollment	140,460	142,038	146,847	148,354	144,347	130,240	91,587	Rolling 12 Month Average

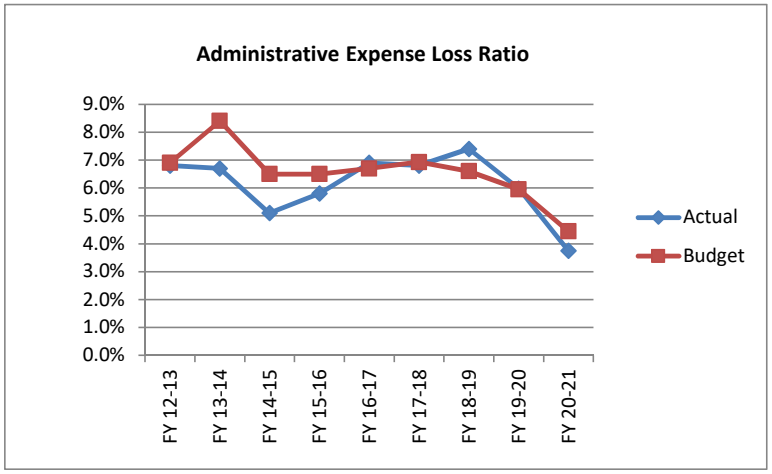
San Francisco Health Plan
Finance Big Picture Dashboard - September 2020

FINANCIAL TREND:
(Rolling 12 months)









San Francisco Health Plan

Finance Dashboard Metrics - September 2020

	Sep-20			Sep-19	Fiscal Year to Date (20/21)			FY 19/20
	Actual	Budget	Fav (Unfav)	Actual	Actual	Budget	Fav (Unfav)	Actual
Member Months	148,150	144,100	4,050 2.8%	138,840	438,682	428,936	9,746 2.3%	419,834
Premium Revenue ($)	183,729,789	168,969,706	14,760,084 8.7%	168,767,027	281,399,411	265,005,069	16,394,342 6.2%	263,422,062
Administration Expenses w/o HSF ($)	4,262,509	4,720,254	457,745	4,339,920	12,537,076	13,795,718	1,258,642	12,694,132
Admin Expense Ratio	2.0%	2.4%		2.1%	3.7%	4.4%		3.9%
Medical Expenses ($)	181,818,741	166,604,554	(15,214,187)	163,879,524	273,120,453	257,141,498	(15,978,954)	250,672,128
Total Medical Loss Ratio	99.0%	98.6%		97.1%	97.1%	97.0%		95.2%
MC Medical Loss Ratio	96.4%	95.6%		95.5%	92.0%	91.8%		92.3%
MC SPD Medical Loss Ratio	100.2%	100.2%		97.6%	99.0%	99.9%		94.7%
MC Expansion	99.2%	99.2%		97.8%	97.9%	97.9%		96.4%
HW Medical Loss Ratio	101.4%	98.2%		96.8%	101.5%	99.4%		98.4%
HSF + SFCMRA - TPA Fee ($)	858,991	1,098,785	(239,794) -21.8%	542,726	2,465,795	2,945,540	(479,745) -16.3%	2,096,398
Cash on Hand (Days)	31			37				
Maternity Reimb. Performance ($)	712,738	783,132	(70,394)	703,881	2,243,787	2,349,397	(105,610)	2,478,660
(per case pymt, actual vs. budget)			-9.0%				-4.5%	
Number of Births	81	89	(8)	80	255	267	(12)	287
Hep-C Revenue ($)	431,813	555,907	(124,094)	586,391	1,070,790	1,667,721	(596,931)	2,013,853
Hep-C Expense w/rebates (FFS + Cap) ($)	454,195	555,907	(101,712)	541,204	1,087,269	1,667,721	(580,452)	2,008,026
Net Margin ($)	(22,382)	0	(22,382)		(16,479)	0	(16,479)	5,827
Total Hep-C Treatments	172	220	(48)	213	429	660	(231)	777
Total reimbursable Hep-C weeks (exclude Daklinza)	172	220	(48)	213	429	660	(231)	777
Net Profit/Loss w/o HSF ($)	(1,662,065)	(1,626,263)	(35,802)	1,519,190	(2,127,190)	(3,784,592)	1,657,402	3,118,151

San Francisco Health Plan
Consolidated Balance Sheet for SFHA and SFCHA
As of September 30, 2020

		SFHA	HSF	9/30/2020 Total	9/30/2019 Total	Variance
	ASSETS					
	CURRENT ASSETS					
(1)	SFHP Cash and Cash Equivalents	2,601,996	-	2,601,996	4,880,297	(2,278,300)
(1)	Short Term Investments	232,479,074	-	232,479,074	219,162,759	13,316,315
	HSF Cash and Cash Equivalents		610,631,756	610,631,756	496,514,520	114,117,237
	Petty Cash	1,000	-	1,000	1,000	-
	Other Receivables	7,694,780	-	7,694,780	3,352,922	4,341,858
	Interest Receivable	192,522	-	192,522	248,532	(56,010)
	Grant Funds Receivable	-	-	-	1,724,076	(1,724,076)
(2)	Capitation Receivable	55,807,592	-	55,807,592	50,841,848	4,965,744
	HSF Operation Receivable	2,499,244	-	2,499,244	5,606,981	(3,107,737)
	HSF Provider Payment & Advance		551,055	551,055	3,371,946	(2,820,891)
(3)	HSF Receivables		13,309,644	13,309,644	652,868	12,656,776
	Prepaid Insurance	108,022	-	108,022	100,743	7,279
	HSF Prepaid Insurance	15,151	-	15,151	13,711	1,440
	Prepaid Rent	338,636	-	338,636	328,996	9,640
	Prepaid Expenses	3,066,130	-	3,066,130	2,559,900	506,230
	HSF Prepaid Expenses	16,425	-	16,425	16,425	-
	CalPERS Deferred Outflow Fund	7,353,081	-	7,353,081	6,003,521	1,349,561
	CalPERS Pension Asset	-	-	-	1,279,513	(1,279,513)
	Deposits	79,874	-	79,874	79,874	-
	Total Current Assets	312,253,527	624,492,456	936,745,983	796,740,430	140,005,553
	OTHER ASSETS					
	Long Term Investments	24,119,489	-	24,119,489	20,465,351	3,654,138
	Restricted Funds Required by DMHC	300,000	-	300,000	300,000	-
	Total Other Assets	24,419,489	-	24,419,489	20,765,351	3,654,138
	FIXED ASSETS					
	Furniture & Equipment	15,057,430	-	15,057,430	14,611,187	446,243
	Accumulated Depreciation	(11,251,764)	-	(11,251,764)	(9,676,956)	(1,574,808)
	Net Fixed Assets	3,805,666	-	3,805,666	4,934,231	(1,128,565)
	TOTAL ASSETS	**340,478,682**	**624,492,456**	**964,971,138**	**822,440,012**	**142,531,127**

San Francisco Health Plan
Consolidated Balance Sheet for SFHA and SFCHA
As of September 30, 2020

		SFHA	HSF	9/30/2020 Total	9/30/2019 Total	Variance
	LIABILITIES & FUND BALANCE					
	CURRENT LIABILITIES					
	Accounts Payable	13,777,727	-	13,777,727	18,661,486	(4,883,759)
	HSF Accounts Payable		2,390,875	2,390,875	678,602	1,712,272
	Deferred Rent	1,938,251	-	1,938,251	2,024,830	(86,579)
	Salaries/Benefits/PERS Payable	8,969,942	-	8,969,942	5,670,877	3,299,065
	CalPERS Unfunded Pension	(208,691)	-	(208,691)	-	(208,691)
	CalPERS Pension Deferred Inflow	180,387	-	180,387	227,213	(46,826)
	Notes Payable - Lease Equipment	85,010	-	85,010	172,582	(87,571)
	Unearned Premium Revenue	-	-	-	1,771,518	(1,771,518)
(4)	DHCS, MCO, IGT, AB-85, SB-335, SB-208 and ACA Payable	169,541,768	-	169,541,768	128,946,243	40,595,526
	HSF Earned Premium - Due to DPH		59,120,647	59,120,647	60,885,766	(1,765,120)
	Waiver, Discount, and Account Write-off		(217,165)	(217,165)	(249,300)	32,135
	HSF Unearned Participant Fees		1,643,994	1,643,994	2,113,801	(469,808)
	ESR due to DPH		406,880,264	406,880,264	304,757,768	102,122,497
	HSF MRA Fund Payable (Claim & Fee)		154,673,842	154,673,842	132,352,696	22,321,145
	Capitation Payable	50,083,667	-	50,083,667	55,562,144	(5,478,478)
	Claims Payable	3,853,730	-	3,853,730	99,883	3,753,847
	Claims IBNR	2,837,667	-	2,837,667	5,805,829	(2,968,162)
	TOTAL LIABILITIES	251,059,459	624,492,456	875,551,915	719,481,939	156,069,976
	FUND BALANCE					
	Contributed Capital	1,516,840	-	1,516,840	1,516,840	-
	Accumulated Surplus Revenue	90,029,573	-	90,029,573	98,986,350	(8,956,777)
	Current Year Surplus / Deficit	(2,127,190)	-	(2,127,190)	2,454,883	(4,582,073)
	Fund Balance	89,419,223	-	89,419,223	102,958,073	(13,538,850)
	TOTAL LIABILITIES & FUND BALANCE	**340,478,682**	**624,492,456**	**964,971,138**	**822,440,012**	**142,531,127**

San Francisco Health Plan
Consolidated Balance Sheet for SFHA and SFCHA
As of September 30, 2020

Notes:

(1) SFHP Cash and Cash Equivalents and Short Term Investments had a combined balance of $235.1 million at 9/30/20 as compared to $224.0 million at 9/30/19. The reason for the large cash balance is due to Directed Payments funding received during September of each year and not disbursed until October.

The days cash on hand as of 9/30/20 was 31 days compared to 31 days at 7/31/20. There is no change from July. Directed Payments funding is excluded as these funds are a direct pass-through to providers and therefore not available to fund ongoing operations.

(2) Capitation Receivable is a combination of Medi-Cal premiums totaling $52.9 million along with $2.9 million of receivables for the Healthy Workers program. SFHP and the SF Department of Human Resources are engaged in a weekly dialogue on the payment of the HW receivable. We have a verbal confirmation that this amount will be paid to SFHP as soon as the new contract is executed. This is expected to occur in the next 60-90 days.

(3) The majority of this increase is related to the $500 grants disbursed to SF City Option MRA holders. These funds will come back into the HSF SF City Option program at a later date.

(4) The additional $40.6 million is made up of $18.4 million in Managed Care Organization (MCO) tax payable, $14.2 million in Directed Payments funding due to providers and $7.7 million in Prop 56 money that may have to be returned to DHCS.

All other asset and liability account balances appear to be reasonable.

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
For the Month Ending September 30, 2020

	Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) ($)	Fav (Unfav) %
					Member Month				
(1)	68,605	70,155	(1,550)	(2.2%)	Medi-Cal	203,099	208,010	(4,911)	(2.4%)
	13,234	13,924	(690)	(5.0%)	Medi-Cal SPD	40,068	41,688	(1,620)	(3.9%)
	53,584	48,252	5,332	11.1%	Medi-Cal Expansion	157,678	143,964	13,714	9.5%
	12,727	11,769	958	8.1%	Healthy Workers	37,837	35,274	2,563	7.3%
	148,150	144,100	4,050	2.8%	TOTAL MEMBER MONTH	438,682	428,936	9,746	2.3%
					REVENUE				
(2)	35,313,833	37,948,304	(2,634,471)	(6.9%)	Medi-Cal	58,879,111	62,291,484	(3,412,373)	(5.5%)
	53,136,089	46,066,222	7,069,867	15.3%	Medi-Cal SPD	75,584,295	69,546,307	6,037,989	8.7%
	89,247,619	79,460,068	9,787,551	12.3%	Medi-Cal Expansion	128,996,390	116,697,026	12,299,363	10.5%
	219,135	116,090	103,045	88.8%	MC Health Homes	657,404	348,270	309,134	88.8%
	5,813,113	5,379,021	434,092	8.1%	Healthy Workers	17,282,211	16,121,982	1,160,229	7.2%
	183,729,789	168,969,706	14,760,084	8.7%	Total Capitation Revenue	281,399,411	265,005,069	16,394,342	6.2%
	672,668	677,173	(4,504)	(0.7%)	Other Income - Admin Svc & TPL	2,000,441	2,022,556	(22,114)	(1.1%)
	672,668	677,173	(4,504)	(0.7%)	Total Other Income	2,000,441	2,022,556	(22,114)	(1.1%)
	184,402,458	**169,646,878**	**14,755,579**	**8.7%**	**TOTAL REVENUE**	**283,399,852**	**267,027,624**	**16,372,228**	**6.1%**

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
For the Month Ending September 30, 2020

	Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) ($)	Fav (Unfav) %
					EXPENSES				
					Medical Expenses				
(3)	16,094,068	14,772,763	(1,321,305)	(8.9%)	Professional	47,521,443	44,292,071	(3,229,373)	(7.3%)
	21,381,833	20,988,762	(393,072)	(1.9%)	Hospital	61,050,137	61,831,095	780,957	1.3%
	8,272,760	7,847,927	(424,833)	(5.4%)	Pharmacy	23,916,493	23,532,400	(384,093)	(1.6%)
	28,944	43,362	14,418	33.2%	Immunizations	63,936	130,086	66,150	50.9%
	737,903	777,402	39,499	5.1%	Vision and Mental Health	2,174,262	2,216,111	41,849	1.9%
	135,303,232	122,174,338	(13,128,894)	(10.7%)	Health Ed & Stop Loss & Other	138,394,180	125,139,735	(13,254,445)	(10.6%)
	181,818,741	**166,604,554**	**(15,214,187)**	**(9.1%)**	**Total Medical Expenses**	**273,120,453**	**257,141,498**	**(15,978,954)**	**(6.2%)**
	99.0%	98.6%			Medical Cost Ratio %	97.1%	97.0%		
					Operating Expenses				
	2,461,761	2,449,700	(12,061)	(0.5%)	Compensation & Benefits	7,361,953	6,908,468	(453,485)	(6.6%)
	(15,142)	72,963	88,105	120.8%	GASB-68 CalPERS Contribution	(23,857)	199,423	223,280	112.0%
	439,207	461,019	21,811	4.7%	Lease, Insurance, D & A	1,335,141	1,363,000	27,859	2.0%
	96,392	63,738	(32,654)	(51.2%)	Marketing & Outreach	233,854	224,810	(9,044)	(4.0%)
	321,617	285,225	(36,392)	(12.8%)	PBM and Mental Health TPA Fees	933,624	859,255	(74,369)	(8.7%)
(4)	199,097	414,626	215,529	52.0%	Professional Fees & Consulting	588,664	1,266,379	677,714	53.5%
	759,577	972,983	213,406	21.9%	Other Expenses	2,107,697	2,974,383	866,686	29.1%
	4,262,509	4,720,254	457,745	9.7%	Total Operating Expenses	12,537,076	13,795,718	1,258,642	9.1%
	2.0%	2.4%			Administrative Cost Ratio %	3.7%	4.4%		
					(Op Exp-Other Inc/Premium)				
	186,081,250	**171,324,808**	**(14,756,442)**	**(8.6%)**	**TOTAL EXPENSES**	**285,657,529**	**270,937,216**	**(14,720,312)**	**(5.4%)**
	(1,678,793)	**(1,677,930)**	**(863)**	**0.1%**	**Operating Surplus / Deficit**	**(2,257,677)**	**(3,909,592)**	**1,651,915**	**(42.3%)**
	61,777	41,667	20,111	48.3%	Interest Income & Realized G/L on Investment	176,151	125,000	51,151	40.9%
	(45,049)	0	(45,049)		Unrealized Gain / Loss on Investment	(45,665)	0	(45,665)	
	0	0	0		Realized Gain / Loss on Lease Equipments	0	0	0	
	16,728	41,667	(24,939)	(59.9%)	Total Interest Income & Realized G/L on Investmen	130,486	125,000	5,486	4.4%
	(1,662,065)	**(1,636,263)**	**(25,801)**	**1.6%**	**SURPLUS / DEFICIT**	**(2,127,190)**	**(3,784,592)**	**1,657,402**	**(43.8%)**

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
For the Month Ending September 30, 2020

Notes:

Following are key points that impacted our financial performance during September 2020. For a more detailed discussion of each of these points, please refer to the

(1) September member months were slightly ahead of budget. Although Adult and Child member months were short of budget projections, Adult Expansion member months came in 5,332 ahead of budget which helped drive additional revenue for SFHP and additional capitation for providers. SFHP expects continued growth in membership due to the impacts of the COVID-19 pandemic.

(2) September revenue included $133.9 million in Directed Payments funding related to FY18-19. The FY20-21 projected $120.6 million. This funding is a direct pass-through to hospital providers. DHCS and DMHC allow health plans to treat this funding as revenue and medical expense.

(3) Additional professional and hospital expense is driven by increased capitation due to more membership. SFHP has also seen increases in CBAS and Prop 56 claims expense. Pharmacy expense is higher than the budget as the actual cost for Healthy Workers pharmacy was $83 pmpm versus a budget of $65 pmpm.

(4) Professional Fees and Consulting expense is lower than the budget as anticipated spending for major projects such as CalAIM and CMS Interoperability has not occurred yet. Other Expenses such as telecommunications, systems maintenance and systems support costs have come in lower than expected. This is related to timing issues as it is expected that actual spending and budget projections will align more closely in future months.

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
For the Month Ending September 30, 2020
($ PMPM)

Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %
				REVENUE				
514.74	540.92	(26.18)	(4.8%)	Medi-Cal	289.90	299.46	(9.56)	(3.2%)
4,015.12	3,308.40	706.71	21.4%	Medi-Cal SPD	1,886.40	1,668.26	218.14	13.1%
1,665.56	1,646.77	18.79	1.1%	Medi-Cal Expansion	818.10	810.60	7.50	0.9%
456.75	457.05	(0.30)	(0.1%)	Healthy Workers	456.75	457.05	(0.30)	(0.1%)
1,238.68	**1,172.59**	**66.09**	**5.6%**	**Total Capitation Revenue**	**639.97**	**617.82**	**22.15**	**3.6%**
4.54	4.70	(0.16)	(3.4%)	Other Income - Admin Svc & TPL	4.56	4.72	(0.16)	(3.3%)
4.54	**4.70**	**(0.16)**	**(3.4%)**	**Total Other Income**	**4.56**	**4.72**	**(0.16)**	**(3.3%)**
1,243.22	**1,177.29**	**65.94**	**5.6%**	**TOTAL REVENUE**	**644.53**	**622.53**	**21.99**	**3.5%**

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
For the Month Ending September 30, 2020
($ PMPM)

Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %
				EXPENSES				
				Medical Expenses				
108.63	102.52	(6.12)	(6.0%)	Professional	108.33	103.26	(5.07)	(4.9%)
144.33	145.65	1.33	0.9%	Hospital	139.17	144.15	4.98	3.5%
55.84	54.46	(1.38)	(2.5%)	Pharmacy	54.52	54.86	0.34	0.6%
0.20	0.30	0.11	35.1%	Immunizations	0.15	0.30	0.16	51.9%
4.98	5.39	0.41	7.7%	Vision and Mental Health	4.96	5.17	0.21	4.1%
913.29	847.84	(65.44)	(7.7%)	Health Ed & Stop Loss & Other	315.48	291.74	(23.73)	(8.1%)
1,227.26	**1,156.17**	**(71.09)**	**(6.1%)**	**Total Medical Expenses**	**622.59**	**599.49**	**(23.11)**	**(3.9%)**
99.1%	98.6%			Medical Cost Ratio %	97.3%	97.0%		
				Operating Expenses				
16.62	17.00	0.38	2.3%	Compensation & Benefits	16.78	16.11	(0.68)	(4.2%)
(0.10)	0.51	0.61	120.2%	GASB-68 CalPERS Contribution	(0.05)	0.46	0.52	111.7%
2.96	3.20	0.23	7.3%	Lease, Depreciation & Amortization	3.04	3.18	0.13	4.2%
0.65	0.44	(0.21)	(47.1%)	Marketing & Outreach	0.53	0.52	(0.01)	(1.7%)
2.17	1.98	(0.19)	(9.7%)	PBM and Mental Health TPA Fees	2.13	2.00	(0.13)	(6.2%)
1.34	2.88	1.53	53.3%	Professional Fees & Consulting	1.34	2.95	1.61	54.5%
5.13	6.75	1.63	24.1%	Other Expenses	4.80	6.93	2.13	30.7%
28.77	**32.76**	**3.99**	**12.2%**	**Total Operating Expenses**	**28.58**	**32.16**	**3.58**	**11.1%**
2.0%	2.4%			Administrative Cost Ratio %	3.8%	4.4%		
1,256.03	**1,188.93**	**(67.10)**	**(5.6%)**	**TOTAL EXPENSES**	**651.17**	**631.65**	**(19.52)**	**(3.1%)**
(12.81)	**(11.64)**	**(1.17)**	**10.0%**	**Operating Surplus / Deficit**	**(6.65)**	**(9.11)**	**2.47**	**-27.1%**
0.42	0.29	0.13	44.2%	Interest Income & Realized G/(L) on Investmer	0.40	0.29	0.11	37.8%
(0.30)	0.00	(0.30)	-	Unrealized Gain / (Loss) on Investment	(0.10)	0.00	(0.10)	-
0.00	0.00	0.00	-	Realized Gain / (Loss) on Lease Equipments	0.00	0.00	0.00	-
0.11	0.29				0.30	0.29		
(12.70)	**(11.36)**	**(1.34)**	**11.8%**	**SURPLUS / DEFICIT**	**(6.35)**	**(8.82)**	**2.48**	**-28.1%**

San Francisco Health Plan
Income Statement
Healthy San Francisco & SF Covered MRA
For the Month Ending September 30, 2020

Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) ($)	Fav (Unfav) %
				REVENUE				
858,991	**1,098,785**	**(239,794)**	**-21.8%**	**TPA Fee - HSF + SFCMRA**	**2,465,795**	**2,945,540**	**(479,745)**	**(16.3%)**
				EXPENSES				
706,258	819,220	112,961	13.8%	Compensation & Benefits	2,032,153	2,106,843	74,691	3.5%
88,581	78,737	(9,844)	(12.5%)	Lease, Insurance, D & A	265,743	236,212	(29,532)	(12.5%)
21,084	36,921	15,837	42.9%	Marketing & Outreach	45,232	110,764	65,532	59.2%
-	69,250	69,250	100.0%	Professional Fees & Consulting	-	207,750	207,750	100.0%
43,067	94,657	51,590	54.5%	Other Expenses	122,667	283,971	161,304	56.8%
858,991	**1,098,785**	**239,794**	**21.8%**	**TOTAL EXPENSES**	**2,465,795**	**2,945,540**	**479,745**	**16.3%**
100.0%	100.0%			Administrative Cost Ratio %	100.0%	100.0%		
-	**-**	**-**	**0.0%**	**SURPLUS / DEFICIT**	**-**	**-**	**-**	**0.0%**

San Francisco Health Plan
Investment Performance
(excludes balances in SFHA operating accounts)
September 30, 2020

Fixed Income Securities	Purchase Date	Quantity	Purchase Price	9/30/20 Price	Market Value 9/30/20	Amortized Prem / Disc	Remaining Cost	Unrealized Gain (Loss)	Estimated Annual Income
Local Agency Investment Fund (LAIF) - rate @ 0.685%			$ 1,210,597		**$ 1,210,597**	$ -	$ 1,210,597	$ -	$ 14,733
Principle Cash									
Principal Cash		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CNB Deposit Sweep (TBSCNBM) - Variable Rate 0.03%		68,020	$ 68,020	$ 1.000	$ 68,020	$ -	$ 68,020	$ -	$ 20
Total Cash and Cash Equivalents		**$ 68,020**	**$ 68,020**		**$ 68,020**	**$ -**	**$ 68,020**	**$ -**	**$ 20**
U.S. Govt Bonds, Notes, & U.S. Agencies									
US Treasury Note - 8.000% - 11/15/2021	6/17/19	245,000	$ 279,848	$ 108.813	$ 266,592	$ (18,428)	$ 261,420	$ 5,172	$ 19,600
US Treasury Note - 2.625% - 12/15/2021	6/1/20	660,000	$ 684,698	$ 102.992	$ 679,747	$ (5,184)	$ 679,515	$ 232	$ 17,325
US Treasury Note - 1.875% - Mat 02/28/2022	10/30/19	595,000	$ 598,114	$ 102.465	$ 609,667	$ (955)	$ 597,159	$ 12,508	$ 11,156
US Treasury Note - 2.375% - Mat 03/15/2022	6/8/20	690,000	$ 716,441	$ 103.262	$ 712,508	$ (4,853)	$ 711,589	$ 919	$ 16,388
US Treasury Note - 1.75% - Mat 04/30/2022	10/5/18	825,000	$ 790,453	$ 102.559	$ 846,112	$ (2,106)	$ 788,347	$ 57,765	$ 14,438
US Treasury Note - 1.875% - Mat 05/31/2022	6/23/17	915,000	$ 919,646	$ 102.906	$ 941,590	$ (3,508)	$ 916,138	$ 25,452	$ 17,156
US Treasury Note - 2.000% - Mat 11/30/2022	6/17/19	715,000	$ 720,019	$ 104.035	$ 743,850	$ (1,397)	$ 718,621	$ 25,229	$ 14,300
US Treasury Note - 1.500% - Mat 01/15/2023	5/7/20	600,000	$ 620,273	$ 103.102	$ 618,612	$ (436)	$ 619,837	$ (1,225)	$ 9,000
US Treasury Note - 2.750% - Mat 04/30/2023	10/30/19	575,000	$ 596,428	$ 106.703	$ 613,542	$ (1,022)	$ 595,406	$ 18,136	$ 15,813
US Treasury Note - 2.750% - Mat 11/15/2023	5/7/20	680,000	$ 738,517	$ 108.039	$ 734,665	$ (446)	$ 738,072	$ (3,406)	$ 18,700
US Treasury Note - 2.125% - Mat 03/31/2024	6/8/20	585,000	$ 624,945	$ 106.773	$ 624,622	$ (3,490)	$ 621,454	$ 3,168	$ 12,431
US Treasury Note - 2.375% - Mat 08/15/2024	5/7/20	570,000	$ 619,229	$ 108.379	$ 617,760	$ (455)	$ 618,774	$ (1,014)	$ 13,538
US Treasury Note - 2.250% - Mat 12/31/2024	6/2/20	685,000	$ 745,553	$ 108.543	$ 743,520	$ (4,405)	$ 741,148	$ 2,372	$ 15,413
US Treasury Note - 0.375% - Mat 04/30/2025	6/2/20	625,000	$ 626,904	$ 100.590	$ 628,688	$ (129)	$ 626,775	$ 1,912	$ 2,344
US Treasury Note - 2.875% - Mat 05/31/2025	6/2/20	670,000	$ 754,430	$ 112.156	$ 751,445	$ (5,630)	$ 748,800	$ 2,645	$ 19,263
US Treasury Note - 2..750% - Mat 06/30/2025	7/17/20	225,000	$ 252,211	$ 111.734	$ 251,402	$ (1,833)	$ 250,378	$ 1,024	$ 6,188
US Treasury Note - 2.00% - Mat 08/15/2025	9/10/20	150,000	$ 162,604	$ 108.371	$ 162,557	$ (148)	$ 162,456	$ 101	$ 3,000
Federal National Mortgage Assn- 2.5% Mat 04/13/2021	7/11/18	495,000	$ 491,911	$ 101.247	$ 501,173	$ 1,381	$ 493,292	$ 7,881	$ 12,375
Federal Home Loan Bank- 3% Mat 10/12/2021	11/9/18	695,000	$ 692,798	$ 102.948	$ 715,489	$ 1,401	$ 694,198	$ 21,290	$ 20,850
Federal National Mortgage Assn- 2% Mat 01/05/2022	7/23/18	945,000	$ 920,940	$ 102.384	$ 967,529	$ 14,943	$ 935,883	$ 31,646	$ 18,900
Federal National Mortgage Assn-1.875% Mat 04/05/2022	7/25/19	835,000	$ 835,921	$ 102.633	$ 856,986	$ (394)	$ 835,527	$ 21,458	$ 15,656
Federal National Mortgage Assn - 2.375% Mat - 01/19/2023	4/5/18	815,000	$ 803,016	$ 104.905	$ 854,976	$ 6,238	$ 809,254	$ 45,722	$ 19,356
Federal National Mortgage Assn - 2.75% Mat - 06/19/2023	7/11/18	575,000	$ 572,033	$ 106.760	$ 613,870	$ 1,326	$ 573,359	$ 40,511	$ 15,813
Federal National Mortgage Assn - 2.875% Mat - 09/12/2023	1/18/19	685,000	$ 695,533	$ 107.779	$ 738,286	$ (4,020)	$ 691,513	$ 46,773	$ 19,694
Federal National Mortgage Assn- 2.5% Mat 02/05/2024	3/5/19	695,000	$ 695,078	$ 107.504	$ 747,153	$ 111	$ 695,189	$ 51,964	$ 17,375
Federal National Mortgage Assn-2.625% Mat 09/06/2024	10/30/19	790,000	$ 824,357	$ 109.257	$ 863,130	$ (6,961)	$ 817,396	$ 45,734	$ 20,738
Total U.S. Govt Bonds, Notes, & U.S. Agencies		**$ 16,540,000**	**$ 16,981,902**		**$ 17,405,468**	**$ (40,402)**	**$ 16,941,500**	**$ 463,968**	**$ 386,806**
Corporate Bonds									
Goldman Sachs Group - 3.625% Mat 01/22/2023	7/25/19	705,000	$ 733,188	$ 106.895	$ 753,610	$ (10,462)	$ 722,726	$ 30,884	$ 25,556
Amex - 3.4% - Mat 02/27/2023	2/27/18	465,000	$ 464,577	$ 106.537	$ 495,397	$ 216	$ 464,793	$ 30,604	$ 15,810
Wells Fargo & Company - 3.750% Mat - 01/24/2024	4/22/19	685,000	$ 701,050	$ 108.652	$ 744,266	$ (4,846)	$ 696,204	$ 48,062	$ 25,688
Morgan Stanley - Variable rate 3.737% Mat 04/24/2024	7/25/19	575,000	$ 599,121	$ 107.642	$ 618,942	$ (5,996)	$ 593,125	$ 25,816	$ 21,488
Paccar Financial Corp - 1.80% Mat - 02/06/2025	5/18/20	375,000	$ 380,438	$ 104.602	$ 392,258	$ (418)	$ 380,019	$ 12,238	$ 6,750
Bank of America Corp - Variable rate 3.458% Mat 03/15/2025	5/12/20	695,000	$ 742,031	$ 108.410	$ 753,450	$ (3,699)	$ 738,332	$ 15,118	$ 24,033
3M Company -2.650% Mat 04/15/2025	5/19/20	360,000	$ 382,644	$ 108.508	$ 390,629	$ (1,672)	$ 380,972	$ 9,657	$ 9,540
Citigroup Inc - Variable Rate 3.352% Mat 04/24/2025	5/19/20	480,000	$ 505,618	$ 108.192	$ 519,322	$ (1,891)	$ 503,726	$ 15,595	$ 16,090
Total Corporate Bonds		**4,340,000**	**4,508,665**		**4,667,872**	**(28,768)**	**4,479,897**	**187,975**	**144,954**
Foreign Bonds									
Credit Suisse 3.00% Mat - 10/29/2021	6/2/2020	610,000	$ 629,544	$ 102.815	$ 627,172	$ (4,476)	$ 625,068	$ 2,103	$ 18,300
BK Montreal Mtn. 3.3% Mat - 02/05/2024	3/29/19	700,000	$ 709,618	$ 108.335	$ 758,345	$ (2,946)	$ 706,672	$ 51,673	$ 23,100
Santander UK PLC. 4% Mat - 03/13/2024	10/31/19	565,000	$ 603,606	$ 110.384	$ 623,670	$ (8,031)	$ 595,575	$ 28,094	$ 22,600
Total Foreign Bonds		**1,875,000**	**$ 1,942,769**		**$ 2,009,186**	**$ (15,453)**	**$ 1,927,316**	**$ 81,870**	**$ 64,000**
Municipal Bonds									
New York State - 2.790% Mat-03/15/2021	3/22/16	440,000	$ 455,972	$ 100.949	$ 444,176	$ (14,485)	$ 441,487	$ 2,689	$ 12,276
Florida State Brd Admin - 1.258% Mat-07/01/2025	9/16/20	530,000	$ 530,000	$ 101.535	$ 538,136	$ -	$ 530,000	$ 8,136	$ 6,667
Total Municipal Bonds		**440,000**	**455,972**		**982,311**	**(14,485)**	**971,487**	**10,825**	**18,943**
Total of City National Investments		**23,195,000**	**23,889,308**		**25,064,837**	**(99,109)**	**24,320,199**	**744,638**	**614,704**
Total City National Holdings		**23,263,020**	**$ 23,957,328**		**$ 25,132,857**	**$ (99,109)**	**$ 24,388,219**	**$ 744,638**	**$ 614,724**
Estimated Accrued Income					$ 150,613.40				
Total of City National Investments					**$ 25,283,470.58**				
	$ 1,013,368								
				Unrealized G/L of Market Value				**$ 1,175,529**	$ 530,000
Mandatory 3 CDs - Assigned to DMHC									
Banc of California - # 3030018015 - Mat 08/3/2020 - 1.40%	8/3/19	1	$ 100,000	$ 100,000	$ 100,000	$ -	$ -	$ -	$ 1,400
City National Bank - # 432928519 - Mat - 10/16/2020- 0.10%	10/16/19	1	$ 100,000	$ 100,000	$ 100,000	$ -	$ -	$ -	$ 100
Beacon Business Bank # 1507765 - Mat 09/21/20 - 0.30%	9/22/19	1	$ 100,000	$ 100,000	$ 100,000	$ -	$ -	$ -	$ 300
Total of Time Deposits			**$ 300,000**		**$ 300,000**			**$ -**	**$ 1,800**
Total of Investments			**$ 25,467,925**		**$ 26,643,454**			**$ 744,638**	**$ 631,257**

City National Rochdale®
INVESTMENT MANAGEMENT

SFHA – Short Intermediate Portfolio Review Snapshot as of 9/30/2020

Estimated MV + Accrued as of:	8/31/2020	9/30/2020	Change
	$25,295,699	$25,283,471	-$12,228

Portfolio Structure

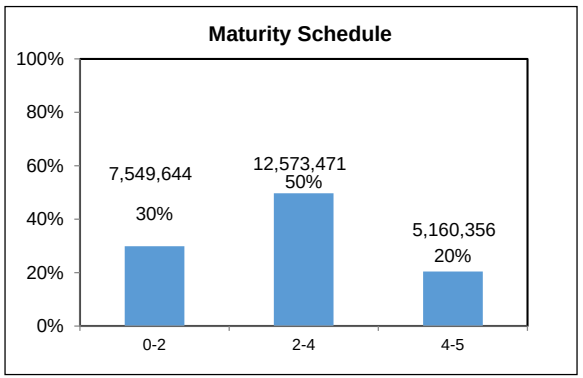
Yield to Maturity	0.37%
Average Maturity	2.65 Years
Average Credit Quality	AA+

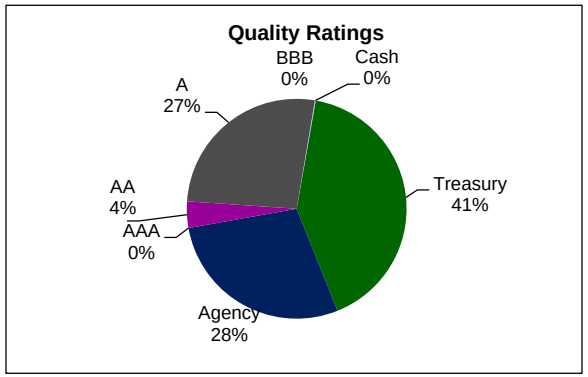
Fiscal Year Accounting Estimates 6/30/2020 through 9/30/2020:

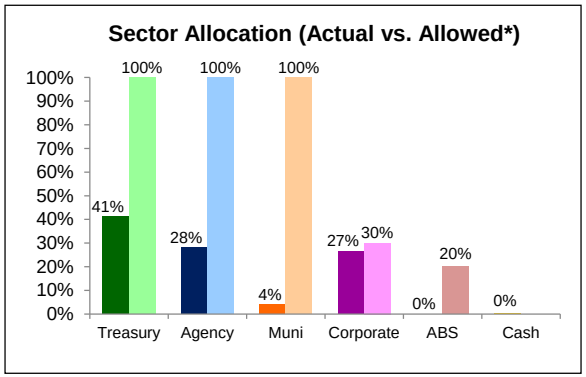
Beginning Balance (6/30/2020)	**$25,063,094**
Contributions	$0
Withdrawals	-$0
Interest & Dividends Received	$162,762
Accrued Interest Sold	$3,523
Accrued Interest Purchased	-$498
Accrued Interest	$150,613
Fees	-$20,298
Value Before Market Changes	**$25,,359,196**
Change in Market Value	-$75,725
Ending Balance (9/30/2020)	**$25,283,471**

Historical Total Return Performance as of 9/30/2020:

Time Period	Portfolio	Barclays 1-5 Year Gov't/Credit
Fiscal YTD (6/30/20 – 9/30/2020)	0.31%	0.37%
September 2020	-0.02%	-0.02%
Inception to Date (5/31/12 – 9/30/2020)	2.55%	2.08%







*At time of purchase

Credit Issues

There were no credit issues for the month of September.

Definition of Terminology

Portfolio Structure Terms

a) **Yield to Maturity**: The annual return that an investor earns on a bond, if the investor purchases the bond today and holds it until maturity. It takes into account the cash flow the investor receives as well as the adjustment of a bond's premium or discount.

Definitions are cited from the CFA Institute's Program Curriculum.

City National Rochdale®
INVESTMENT MANAGEMENT

SFHA – Liquidity Portfolio Review Snapshot as of 9/30/2020

Estimated MV + Accrued as of:	8/31/2020	9/30/2020	Change
	$82,282,392	$233,303,436	$151,021,044

Portfolio Structure

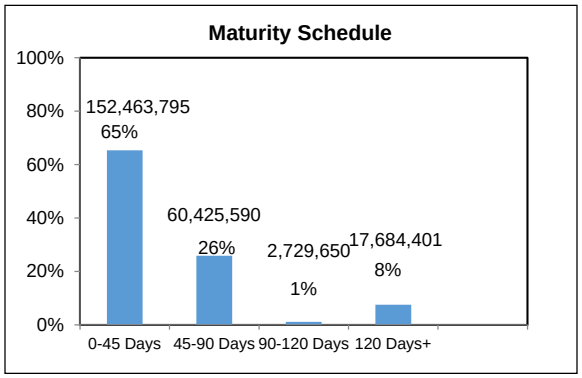
Yield to Maturity	0.10%
Average Maturity	40 Days
Average Credit Quality	AA+

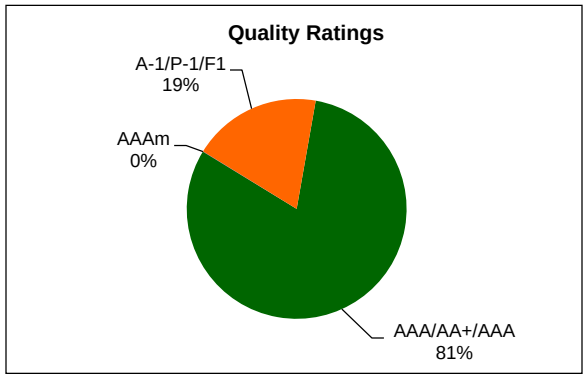
Fiscal Year Accounting Estimates 6/30/2020 through 9/30/2020:

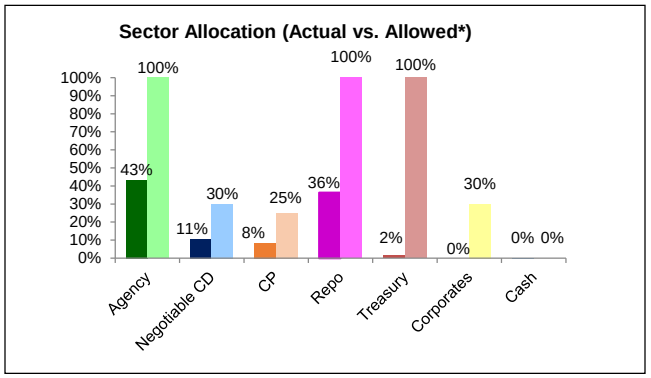
Beginning Balance (6/30/2020)	**$73,249,685**
Contributions	$254,000,000
Withdrawals	-$94,000,000
Interest & Dividends Received	$31,221
Accrued Interest Sold	$0
Accrued Interest Purchased	-$319
Accrued Interest	$20,727
Fees	-$16,634
Value Before Market Changes	**$233,284,680**
Change in Market Value	$18,756
Ending Balance (9/30/2020)	**$233,303,436**

Historical Total Return Performance as of 9/30/2020:

Time Period	Portfolio	Citigroup 3m T-Bill
Fiscal YTD (6/30/20 – 9/30/2020)	0.06%	0.03%
September 2020	0.02%	0.01%
Inception to Date (7/3/17 – 9/30/2020)	1.71%	1.60%







*At time of purchase

Credit Issues

There were no credit issues for the month of September. Strategy remains focused on improving yield while meeting cash flow estimates.

Definition of Terminology

Portfolio Structure Terms

a) **Yield to Maturity**: The annual return that an investor earns on a bond, if the investor purchases the bond today and holds it until maturity. It takes into account the cash flow the investor receives as well as the adjustment of a bond's premium or discount.

Definitions are cited from the CFA Institute's Program Curriculum.

Agenda Item 4
Discussion Item

- Federal and State Updates

Federal and State Updates

Sumi Sousa

Federal COVID-19 Stimulus Update

- House Democrats and Trump Administration continue to negotiate on a broad economic stimulus package ($1.8 trillion to $2.2 trillion).
  - Includes:
    - Direct state and local assistance (~$450 billion)
    - Direct economic aid to individuals and families ($1,200)
    - $600 enhanced unemployment benefit through 2021
    - Increase in Supplemental Nutrition Assistance Program (SNAP) benefit
    - Paycheck Protection Program for small businesses
- If current negotiations fail, potential passage in lame duck session.
- Additional possibility of larger package with a new Congress.

With No Stimulus, California Budget Reductions Stay Intact

- $11 billion in reductions/deferrals
  - $6.55 billion in grades K-14 deferrals
  - $1.9 billion in state employee pay reductions
  - $970 million in higher education reductions
- Medi-Cal is spared from these federal “trigger” cuts.
  - But CA will automatically suspend Proposition 56 enhanced provider payments and Medi-Cal optional benefits in FY 21-22, if revenues remain below expenditures.

Public Charge Rule Being Applied

- Final public charge rule that includes Medicaid enrollment as a factor in granting green card status was to be implemented February 24, 2020.
- Federal district court delayed implementation due to COVID-19 pandemic.
- Federal appellate courts lifted the stay on September 11.
- Department of Homeland Security enforcing the public charge rule retroactive to February 24.

CA v. Texas Update, SCOTUS Nomination

- Judge Amy Coney Barrett nominated on September 26 to the Supreme Court of the United States (SCOTUS)
  - Likely to be approved by the full Senate on November 2nd.
  - In *NFIB v. Sebelius*, Justice Ginsburg and Chief Justice Roberts were in the 5-4 majority upholding the constitutionality of individual mandate and most of the provisions of the Affordable Care Act (ACA).
- Oral arguments for *CA v. Texas* are November 10, decision released by June 10.
- Multiple potential scenarios, ranging from rulings with no impact to the ACA to full repeal.
- Likely Democratic Congress arrives in January and could pass legislation to support parts of ACA .

Election Implications

- Likely change in power at national level holds profound implications for California.
  - Increased direct economic support to states, individuals and businesses due to COVID-19.
    - Focus on addressing recession.
      - Federal Reserve Chair Powell calls for another increased, broad-based national stimulus necessary for economic recovery.
  - Greater federal ownership and coordination for COVID-19 response
    - Currently, states are responsible for COVID-19 response with federal government as back-up and funder, resulting in wide, national variances, lack of coordination, competition for resources and equipment.
    - Direct involvement and coordination from the President.
  - Gaining legislative approval will likely require elimination of Senate filibuster (majority vs. 60 votes).

Election Implications

- Buttressing of ACA
  - Legislative and executive actions to permanently cement basic protections now expected by most Americans and are embedded in health care delivery system.
    - Pre-existing condition protections
    - Individual market reforms (annual or lifetime limits on coverage, etc.)
    - Financial assistance for low to moderate income families for health insurance
    - Essential benefit protections (likely end to short term, limited duration plans)
  - California is among the biggest beneficiaries of ACA.
    - Uninsured rate has dropped from 17% to 7%.
    - $20 billion in federal support this year just for Medi-Cal expansion costs.
    - Over $7 billion in federal subsidies for CA's enrolled in Covered CA plans.
- Potential Expansion of ACA
  - Public option within the federal exchange; also available at no cost to Medicaid eligible in non-expansion states.

Election Implications

- More stability in safety net, particularly Medicaid, funding and beneficiary protections.
  - Fewer executive actions to reduce federal Medicaid funding to states.
    - Per capita caps
    - Medicaid Fiscal Accountability Regulation (MFAR)
  - End to attempts to impose work requirements.
  - Reproductive health funding stability and repeal of rules that bar any federal funds to clinics that provide or refer for abortion services.

Election Implications

- Withdrawal of Executive Orders on Immigration
  - Deferred Action for Childhood Arrivals (DACA)
  - Public Charge
  - Child Separation
  - Border Wall
- Likely impact on health and human services program enrollment and utilization, particularly in California.

State Updates

- No major changes in state leadership due to the November election, other than appointment to fill likely vacancy of Senator Harris' seat.
  - Governor Newsom will fill vacancy; Harris' term is through 2022.
- State Proposition 15 (split roll initiative), if approved, has significant future budgetary impacts that are positive for state and local governments.
  - Increases taxes on commercial properties worth more than $3 million based on sale price, not original purchase price; phase in from 2022-2025.
  - Significant new funding to local government (60%) and schools (40%).
    - LAO estimates $6.5 billion to $11.5 billion at full implementation.

Agenda Item 5
Discussion Item

- Member Advisory Committee Report

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
www.sfhp.org

MEMO

Date: October 27, 2020

To	**Governing Board**
From	Valerie Huggins (415) 615-4235 Fax: (415) 615-6435 Email: vhuggins@sfhp.org
Regarding	Member Advisory Committee Materials

Enclosed are the minutes and agenda for the September 2020 Member Advisory Committee meeting.

Please direct any questions to Maria Luz Torre and Irene Conway, Co-Chairs of the Members Advisory Committee.

September 11, 2020
Member Advisory Committee
Meeting Minutes

Members Present: Lourdes Alarcon, Liu Zhong Chen, Irene Conway, Charles Conway, Ed Evans, Ching Suk Lam, June Kealoha –Hall, Chin Hong Lou, Shaowei Luo, Diane Maluia, Lee Rogers, Linda Ross, Maria Luz Torre, Libah Sheppard, Kwai Fong Tsui, and Idell Wilson

Members Absent: Elia Fernandez, A Jon Martinelli, and James Walker,

Excused: None

Guests: None

Staff: Stephanie Boyce**,** Valerie Huggins, and John F. Grgurina, Jr.

Due to the COVID-19 public health emergency and in accordance with Governor Newsom's Executive Order N-29-20, the Member Advisory Committee members attended this meeting via teleconference. The meeting was closed to in-person public attendance, but the conference line information was provided on the publicly-posted agenda. This precaution was taken to protect all members, staff and the public. All Committee members, staff and public attended the meeting telephonically.

1. **Welcome, Introductions and Roll Call:**
   The Committee discussed a few ground rules as this was the first meeting via Skype since the Pandemic. Roll call followed with a brief check-in from each member to see how everyone has been doing during the pandemic. Since this was our first virtual meeting, we asked members to be patient as we worked out technical and noise issues, as well as working with a translator. The meeting was called to order shortly after 1:00pm.

2. **Approval of Agenda & Minutes:**
   The agenda was approved. There were no minutes to approve at this time.

3. **Committee Reports:**
   Chair & Governing Board Report-Maria Luz Torre & Irene Conway
   Ms. Torre and Ms. Conway both reported the Board met on September 2, 2020. John F. Grgurina, Jr. CEO, provided the Board report to the Committee.

   Quality Improvement Committee (QIC) Report-Ed Evans and Irene Conway
   There was no Quality Improvement report.

The next Quality Improvement Committee is October 8, 2020.

Staff Report: John F. Grgurina, Jr., CEO, presented a few highlights from the Board meeting. Mr. Grgurina mentioned SFHP staff has been working remotely during the pandemic with 100% productivity. For staff safety, majority of whom take public transportation, they will be working remotely until July 1, 2021.

Lastly, Mr. Grgurina spoke about two programs,

1) San Francisco Health Plan participated in an initiative which provided $200 grocery cards to undocumented persons who are members of Healthy San Francisco

2) San Francisco Health Plan distributed $500 cash grant to Healthy San Francisco members who had at least $100 in their MRA account.

4. Discussion: 2020 MAC Goals

The Committee discussed the MAC 2020 goals and voted on the following:

1) We will not be implementing any of our 2020 goals at the October MAC meeting. Instead, we will have another "practice" run whether it be through Skype, Zoom or other, in order to work out any technical problems. We will also be discussing our December Christmas MAC celebration. Ms. Torre offered her ZOOM account as a possible meeting tool to use – participants will also have an option to join via their phones. She can then make Val the host if needed.

2) At the November MAC meeting, if all goes well, SFHP staff will do a presentation for Goal #6 "PTSD and Trauma Recovery - How to Overcome, including Anger Management", and include a discussion of stress within the framework of COVID-19.

3) All other uncompleted 2020 goals will be deferred to 2021.

5. Public Comment:

There were no public comments.

6. Calendar Items for Next Meeting:

The October meeting will be canceled as the Health Plan would like to explore other options for host the Committee meetings.

7. Announcements:

There were no announcements.

8. Other:

No other topics were discussed.

9. Adjournment

The meeting adjourned at 2.30pm.

Date Approved _____

_____

Maria Luz Torre and Irene Conway, Co-Chairs

Agenda Item 6
Discussion Item

Chief Medical Officer's Report

- MY 2019 HEDIS Results
- 2020 CAHPS Results

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Here for you

HEDIS Measurement Year 2019

James Glauber, MD, MPH

MY2019 Achievements

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Here for you

- NCQA
  - Organizational goal of ½ rating increase in Prevention and Treatment composites of Health Plan Rating met
- DHCS
  - Minimum Performance Level (NCQA 50th percentile) met for all applicable Managed Care Accountability Set (MCAS) measures except Chlamydia Screening (CHL)
    - CHL improved due to Community Health Network (CHN) lab data improvement project - 19.81% absolute improvement

HEDIS Improvement Measures (included in QI and PHM Programs)

SAN FRANCISCO HEALTH PLAN
Here for you

- CHL (Chlamydia Screening)
  - Final rate of 58.06% (improved from 38.25%)
  - Just missed MPL of 58.34%
  - Activities:
    - Included in SFHP Practice Improvement Program (PIP)
    - CHN lab data improvement
- AWC (Adolescent Well-Care Visits)
  - New MCAS measure
  - Final rate of 60.4% (met 50th Percentile)
  - Activities:
    - Heath education via mail for members with no well-care visits

HEDIS Improvement Measures (included in QI and PHM Programs)

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- W15 (Well-Child Visits in the First 15 Months of Life)
  - New MCAS measure
  - Final Rate of 69.34% (met 50th Percentile)
- W34 (Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life)
  - Final Rate of 80.80% (met 50th Percentile)
- Activities for both measures included:
    - Included in SFHP PIP
    - Member incentive
    - Participation in the 0-5 year developmental screening and referral workgroup with network providers (UCSF led)
    - Provider funding via DHCS value-based payment disbursement program
    - Heath education via mail for members with no well-child visits

HEDIS Chronic Measures

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Here for you

- MY2019 Rates comparable to MY2018 – met 50th (yellow) or 90th percentile (green).
- **CDC BP** - Targeted medical record review helped improve rate but some challenges with record retrieval from providers due to impact of COVID-19.
- **SPC** - Change in denominator to only capture members with **primary** dx of Myocardial Infarction (MI) at discharge helped improve rate.

ASTHMA MEASURES	MY19 Final Rate	MY18 Final Rate	Absolute Change in Rates
AMR (Asthma Medication Ratio)	72.79%	74.77%	-1.98%
MMA (Medication Management for People with Asthma - Medication Compliance 75% Total)	41.90%	42.81%	-0.91%

DIABETES MEASURES	MY19 Final Rate	MY18 Final Rate	Absolute Change in Rates
CDC (Comprehensive Diabetes Care - Blood Pressure Control (<140/90))	82.11%	73.16%	8.95%
CDC (Comprehensive Diabetes Care - Eye Exams)	72.37%	73.16%	-0.79%
CDC (Comprehensive Diabetes Care - HbA1c Control (<8%))	60.26%	64.74%	-4.48%
CDC (Comprehensive Diabetes Care - Poor Control)	27.11%	27.11%	0.00%
CDC (Comprehensive Diabetes Care - A1C testing)	91.58%	90.00%	1.58%
SPD (Statin Therapy for Patients with Diabetes - Received Statin Therapy - Total)	68.67%	68.69%	-0.02%
SPD (Statin Therapy for Patients with Diabetes - Statin Adherence 80%)	76.03%	74.77%	1.26%

HEART DISEASE MEASURES	MY19 Final Rate	MY18 Final Rate	Absolute Change in Rates
CBP (Controlling High Blood Pressure)	72.81%	71.29%	1.52%
SPC (Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy - Total)	82.66%	82.33%	0.33%
SPC (Statin Therapy for Patients with Cardiovascular Disease-Statin Adherence 80%)	79.53%	72.93%	6.60%

HEDIS Measures Performance

SAN FRANCISCO HEALTH PLAN
Here for you

- Measures below had more than a 5 point *increase* in performance:
  - **AAB** - Age range expanded for MY2019 from 18-64 to 3 months and older. Better avoidance of antibiotic treatment for new age group of 3 months to 17 years old (72.54% vs. 56.29% for 18-64 years old) helped improve rate.
  - **PCE** – Change in denominator to only capture members with **primary** dx of COPD at discharge and targeted Care Management outreach to COPD members with poor medication adherence helped improve rate.

Measure	MY19 Final Rate	MY18 Final Rate	Absolute Change in Rates
(AAB) Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis/Bronchiolitis	65.40%	51.32%	14.08%
(PCE) Pharmacotherapy Management of COPD Exacerbation-Systemic Corticosteroid	61.26%	51.60%	9.66%

HEDIS Measures Performance

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Here for you

- Measures below had more than a 5-point *decrease* in performance:
  - **CIS** - Barriers to medical record retrieval due to COVID-19 impact on provider offices. Still met 90th percentile.
  - **SAA** - Low denominator (37) due to carve out of specialty mental health benefit.
  - **CWP** - Age range expanded for MY2019 from 3-18 to 3 years and older. Lower rate of appropriate testing for new age group of 18-64 years old (49.32% vs. 82.38% for 3-17 years old) impacted rate.

Measure	MY19 Final Rate	MY18 Final Rate	Absolute Change in Rates
CIS (Childhood Immunization Status Combo 10)	61.11%	68.86%	-7.75%
SAA (Adherence to Antipsychotic Medications for Individuals with Schizophrenia)	51.35%	67.57%	-16.22%
CWP (Appropriate Testing for Pharyngitis)	63.87%	84.51%	-20.64%

Upcoming MY2020

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- COVID-19 Impact for MY2020
  - Decrease in preventive care visits
  - Decrease in maintenance of chronic disease care
  - Increase in behavioral healthcare needs
- Upcoming Activities
  - Health Services Advisory Group (HSAG) and Healthcare Data Company (HDC) Audits in early February
  - Medical Record Review from February to May
  - Final rate submissions for NCQA and MCAS in June

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NCQA Accredited Medicaid HMO Health Plan

Health Plan CAHPS 2020

SFHP Governing Board

Amy Petersen, MPH
Senior Manager, Access & Care Experience

Why is CAHPS Important?

Members relate more easily to CAHPS data than to clinical data

Members have access to the data. Could use CAHPS data to choose a health plan

Performance in HEDIS and CAHPS contributes to SFHP's NCQA rating

Survey Information

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NCQA Accredited Medicaid HMO Health Plan

Mailed survey

February - May

Adult Medi-Cal Members enrolled for 6 months in 2019

CAHPS Measures

Composite	Answer Options & Scoring
Rating of Health Plan	Answer options: 1 through 10 Percent answering 9, and 10 represented in final score
Rating of Personal Doctor	
Rating of Specialist Seen Most Often	
Rating of All Health Care	
Getting Needed Care	Answer options: “Always”, “Usually”, “Sometimes”, “Never” Percent answering “Always” and “Usually” represented in final score
Getting Care Quickly	
Coordination of Care	
Customer Service*	

*does not contribute to NCQA scoring

Survey Response

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Year	2017	2018	2019	2020
SFHP Response Rate	27%	25%	32%	26%
Medicaid Average Response Rate	22%	21%	19%	16%

Respondent Age Groups

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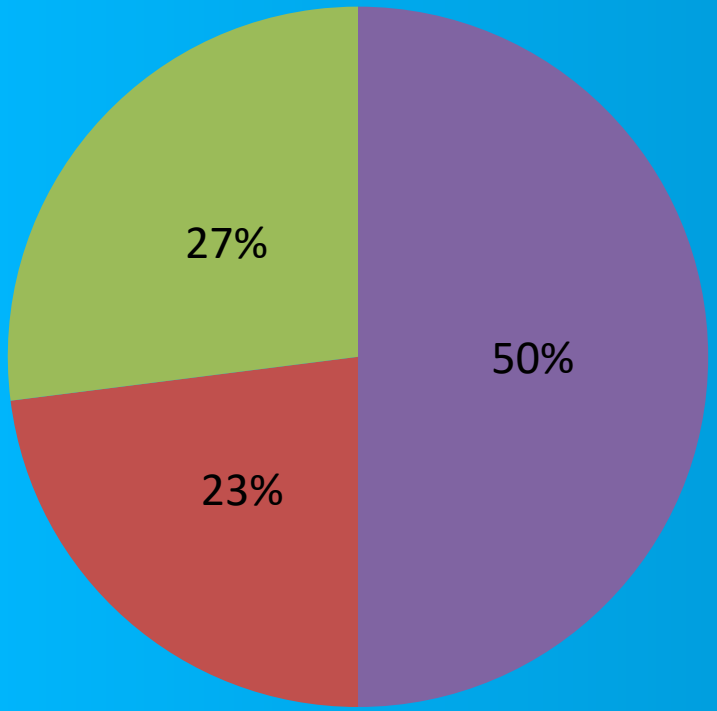

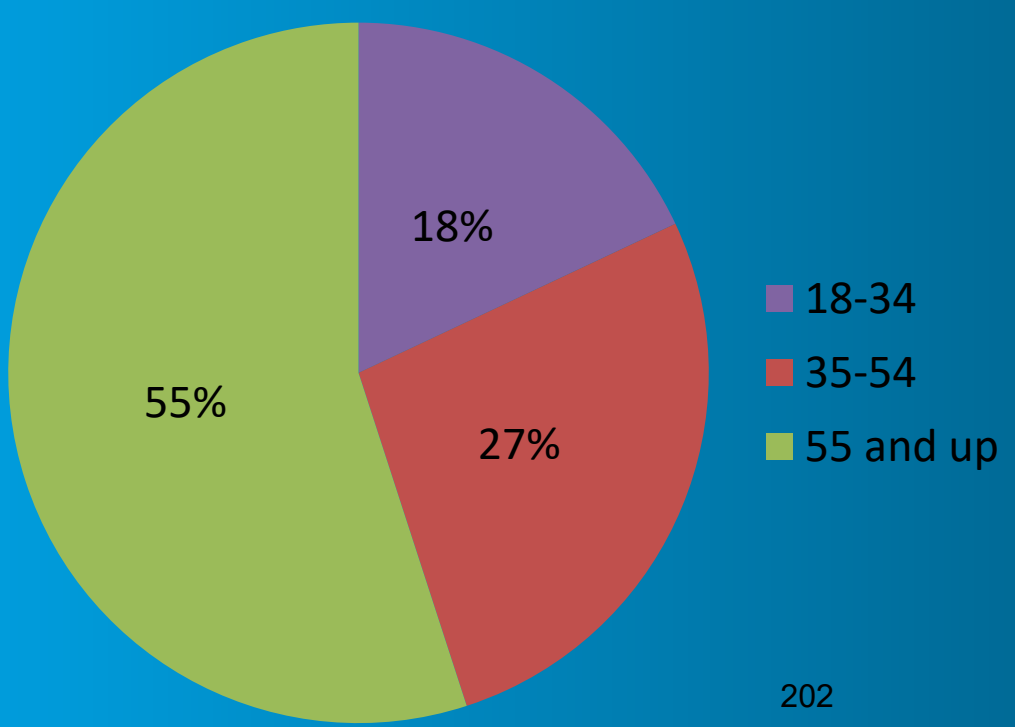

Respondent Race/Ethnicity Groups

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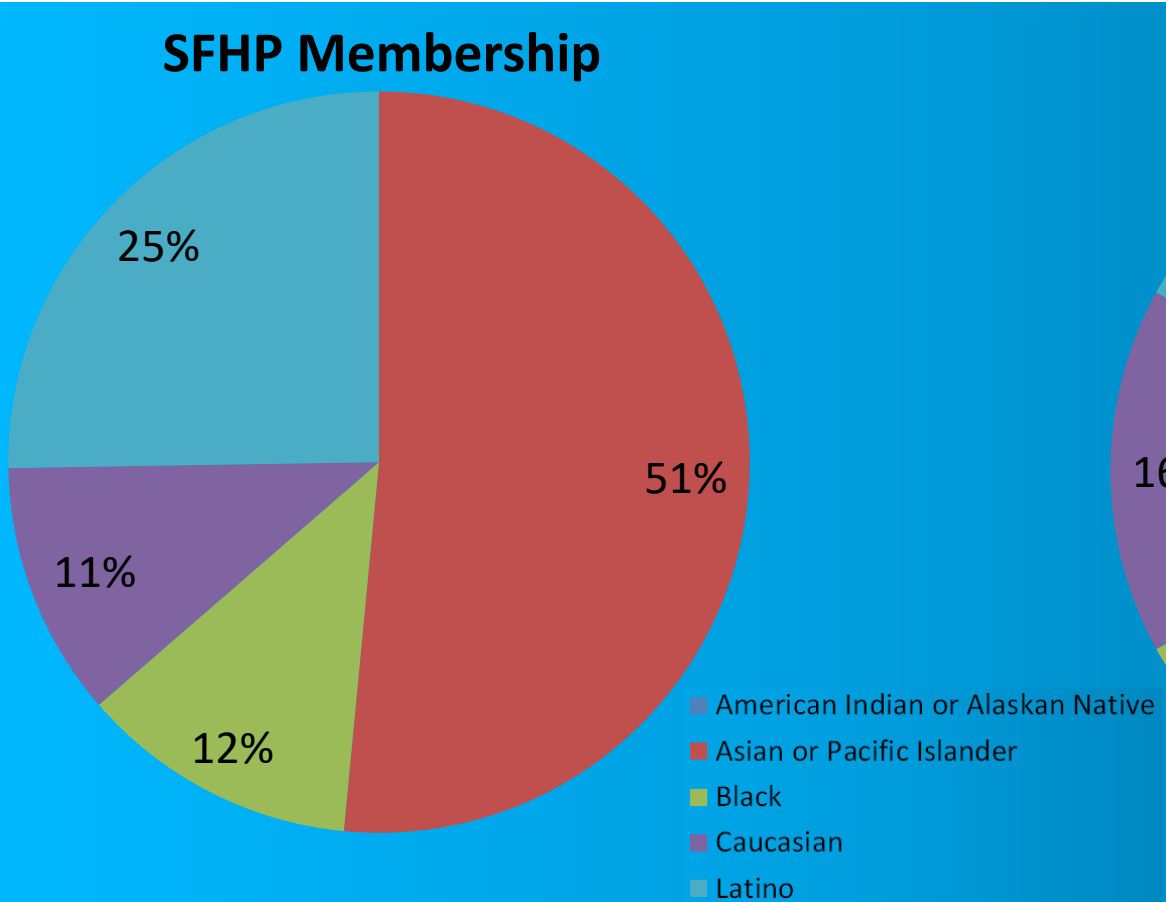

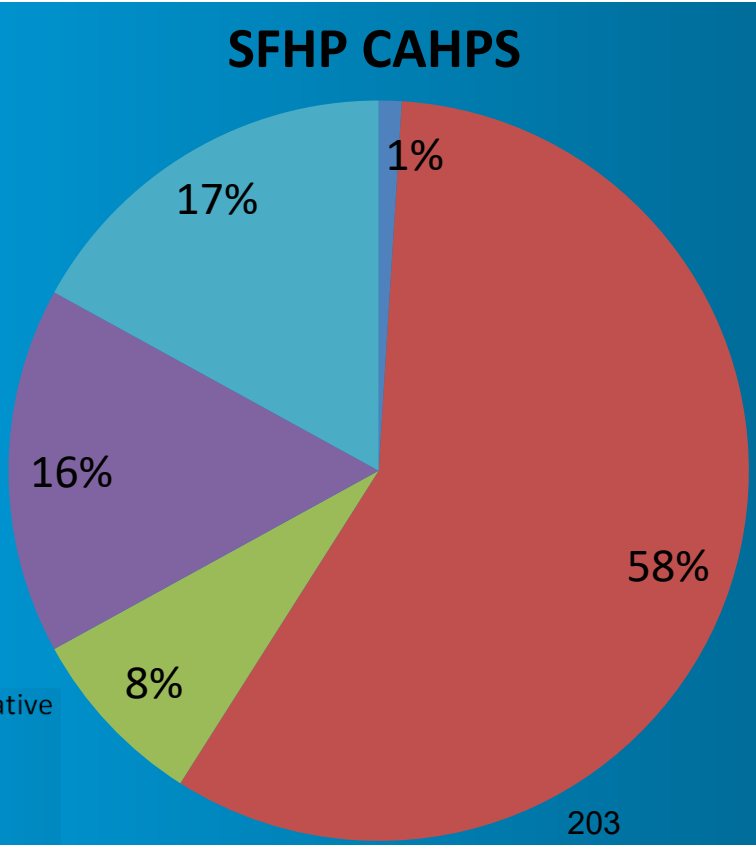

Comparison to prior 5 years

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NCQA Accredited Medicaid HMO Health Plan

Rating	2015	2016	2017	2018	2019	2020	% Difference Since 2015
Rating of Health Plan	40.2%	47.7%	51.6%	52.3%	55.9%	**57.5%**	**+17.3%**
Rating of Personal Doctor	51.7%	56.0%	62.6%	57.9%	66.6%	**63.4%**	**+11.7%**
Rating of Specialist Seen Most Often	53.9%	58.3%	61.5%	57.9%	64.0%	**62.8%**	**+8.9%**
Rating of All Health Care	39.3%	44.6%	54.3%	51.1%	48.7%	**53.5%**	**+14.2%**

Comparison to prior 5 years

SAN FRANCISCO HEALTH PLAN
Here for you
NCQA Accredited Medicaid HMO Health Plan

Composite	2015	2016	2017	2018	2019	2020	% Difference Since 2015
Getting Needed Care	62.0%	66.1%	68.5%	75.4%	83.7%	**72.3%**	**+10.3%**
Getting Care Quickly	66.0%	65.4%	68.1%	77.1%	77.4%	**72.2%**	**+6.2%**
Coordination of Care	77.5%	83.3%	77.8%	82.3%	90.0%	**79.8%**	**+2.3%**
Customer Service*	74.4%	80.7%	81.9%	87.2%	90.8%	**80.4%**	**+6.0%**

*does not contribute to NCQA scoring

NCQA Scores and Comparison

SAN FRANCISCO HEALTH PLAN
Here for you
NCQA Accredited Medicaid HMO Health Plan

Composite	2015-2020 Trend	2020	Percentile	NCQA Stars Out of Five
Rating of Health Plan		57.5%	10th	★★
Rating of Personal Doctor		63.4%	10th	★★
Rating of Specialist Seen Most Often		62.8%	10th	★★
Rating of All Health Care		53.5%	33rd	★★★
Getting Needed Care		72.3%	Below 10th	★
Getting Care Quickly		72.2%	Below 10th	★
Coordination of Care		79.8%	10th	★★
Customer Service		80.4%	Below 10th	NA

NCQA Rating

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NCQA Accredited Medicaid HMO Health Plan

Consumer Satisfaction

1.5

Barriers to CAHPS Improvement

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- COVID-19
  - Planned phone surveys cancelled
  - 2019: phone respondents scored SFHP higher
- SFHN
  - EPIC transition
  - Marked decrease in PCP utilization
  - SFHN call center service metrics impact
- Other SFHP
  - Transition of members from Hill & BTP to NEMS

Member Experience Improvement Efforts

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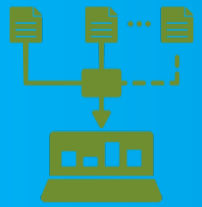
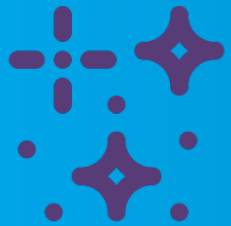
Website Update

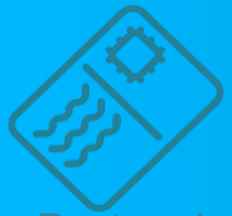

Provider Data Improvement


MAGIC Training

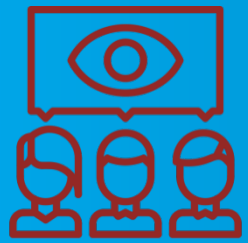

SUR


Formulary Revision


PIP


Postcard Reminders


Teladoc


Focus Groups


New Benefits


Access Monitoring


Health Homes

Icons sourced from Noun Project

Top Priorities for Improvement

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NCQA Accredited Medicaid HMO Health Plan

Current Key Driver Performance		Room for Improvement on Key Driver	Overall Improvement Opportunity
2020 Plan Rates		Percentage Point Difference Between Current Key Driver Score and the Best Practice Score	Expected Percentage Point Improvement in Rating of Health Plan score if Key Driver Performs at Best Practice Level
Rating of Specialist Seen Most Often:	62.75%	+22.25% → 85.00%	+5.05%
Ease of getting needed care, tests, or treatment:	77.25%	+14.49% → 91.74%	+4.77%
Customer service provided needed information or help:	75.56%	+15.62% → 91.18%	+4.64%

Rating of Specialist Seen Most Often

"Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?"

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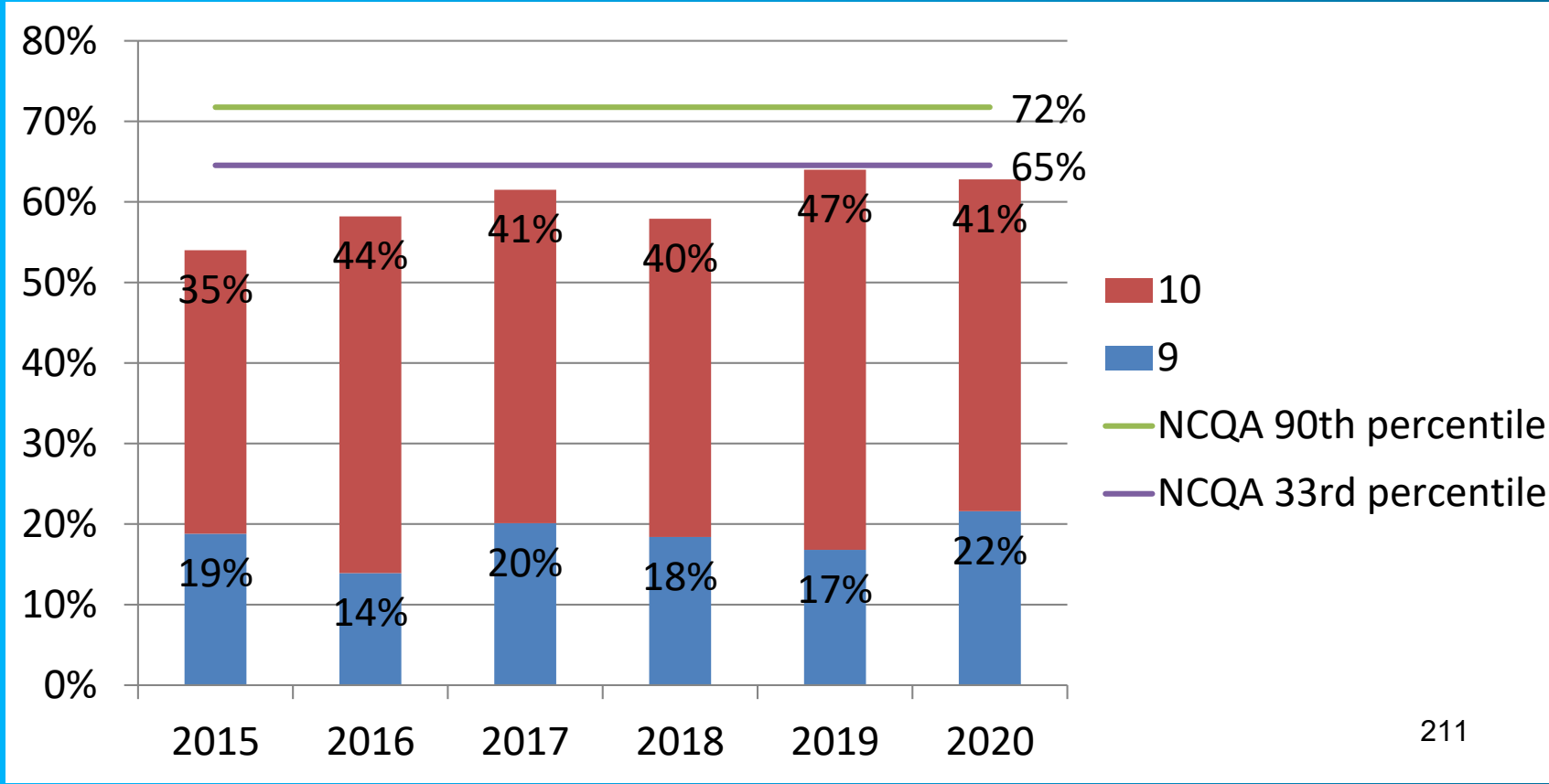

211

Getting Needed: Care, Tests, Treatment

"In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?"

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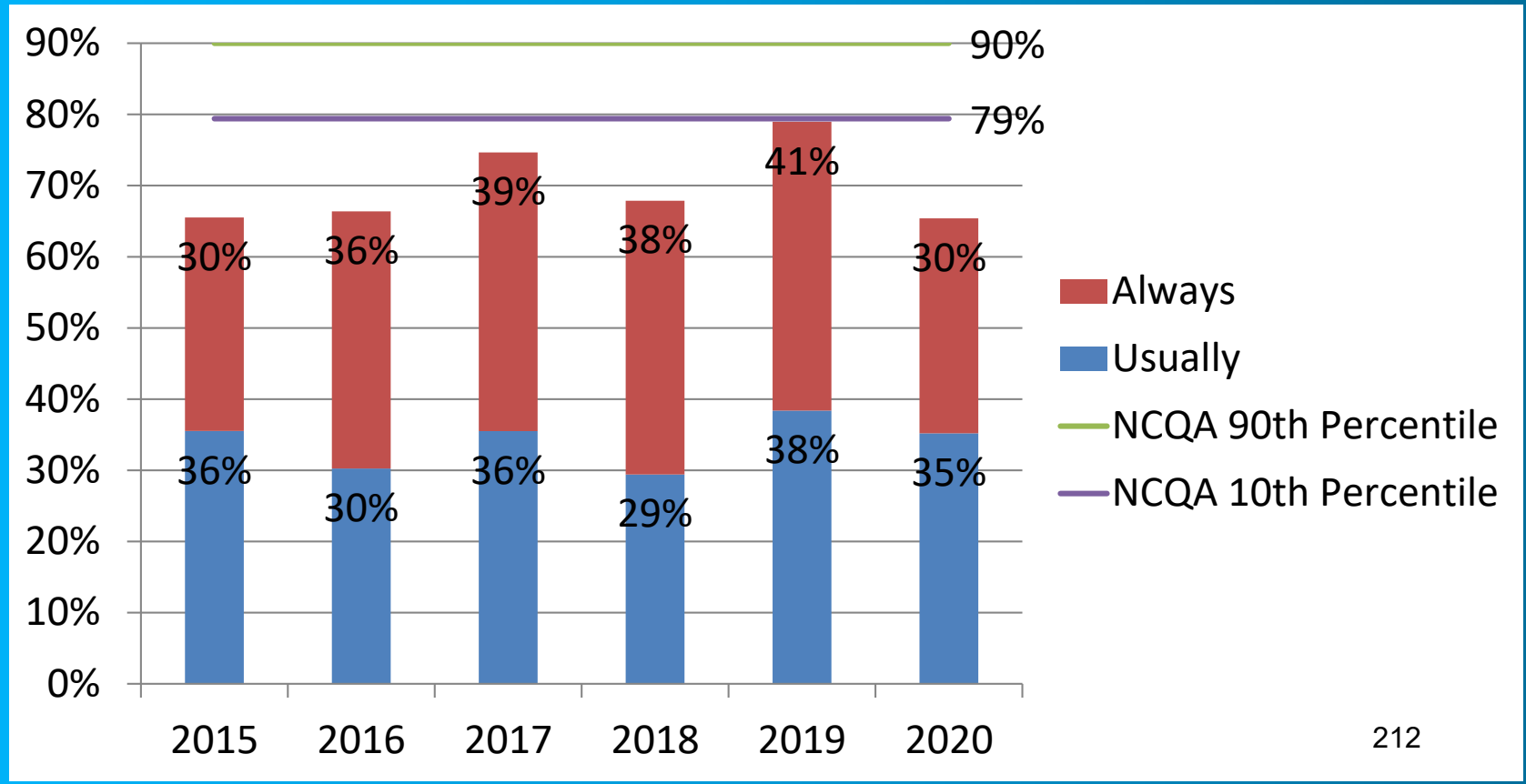

212

Rating of Health Plan by Race/Ethnicity

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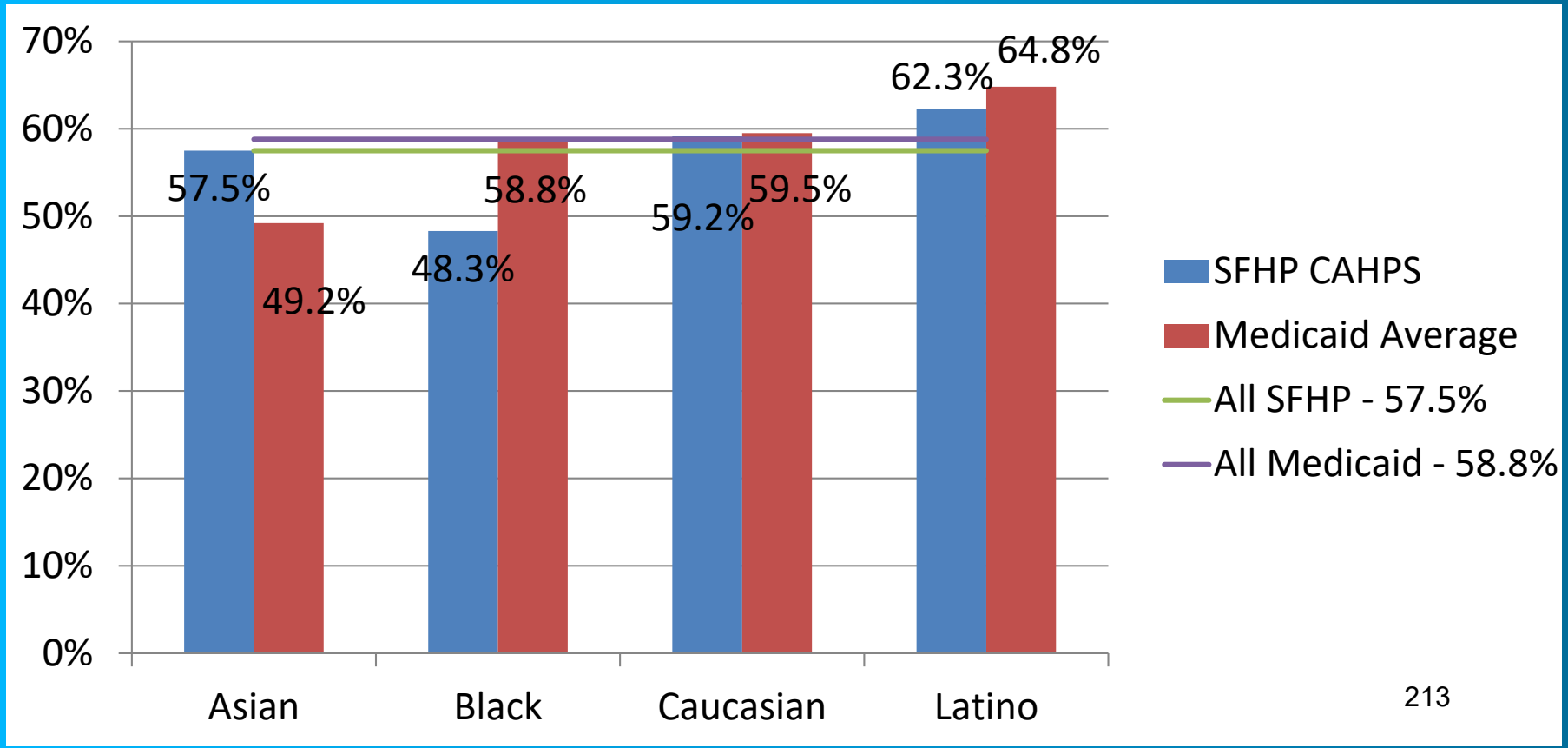

Network	Year	Rating of Health Plan	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of All Health Care	Getting Needed Care	Getting Care Quickly	Coordination of Care	Customer Service	How Well Doctors Communicate
SAN FRANCISCO HEALTH PLAN	2018	52.3%	57.9%	57.9%	51.1%	68.4%	73.0%	73.6%	84.2%	87.0%
	2020	57.5%	63.4%	62.8%	53.5%	72.3%	72.2%	79.8%	80.4%	91.4%
BROWN & TOLAND PHYSICIANS	2018	55.6%	64.0%	71.4%	61.9%	86.5%	86.4%	88.6%	83.8%	92.7%
	2020	61.5%	67.3%	76.7%	57.7%	83.6%	75.1%	87.5%	88.7%	93.3%
cchca 華美醫師協會	2018	43.4%	51.9%	50.0%	42.3%	57.5%	53.2%	71.1%	74.3%	85.1%
	2020	55.9%	62.7%	59.0%	55.2%	60.4%	65.1%	72.3%	72.0%	81.7%
Hill Physicians	2018	68.0%	71.6%	72.5%	62.5%	82.0%	74.7%	92.2%	89.1%	96.6%
	2020	62.1%	65.3%	75.0%	48.1%	79.2%	66.6%	80.8%	92.2%	91.9%
Jade HEALTH CARE MEDICAL GROUP	2020	51.4%	60.4%	56.9%	55.9%	52.8%	60.1%	66.0%	65.4%	84.3%
KAISER PERMANENTE	2018	64.8%	68.1%	65.0%	62.8%	82.0%	80.9%	80.0%	89.5%	88.4%
	2020	57.7%	65.6%	59.2%	52.9%	79.5%	89.9%	84.0%	81.7%	92.5%
NEMS NORTH EAST MEDICAL SERVICES 東北醫療中心	2018	51.7%	52.5%	50.0%	43.4%	58.7%	64.6%	63.0%	72.7%	84.1%
	2020	57.8%	62.8%	68.4%	53.2%	69.6%	69.9%	79.6%	79.3%	88.7%
SFCCC Community Clinic Consortium	2018	51.1%	60.9%	68.2%	45.9%	80.2%	82.5%	75.0%	85.7%	88.8%
	2020	51.9%	61.4%	69.6%	50.0%	76.4%	80.2%	92.9%	89.3%	93.8%
San Francisco Health Network	2018	48.6%	64.2%	59.5%	52.9%	72.1%	76.0%	87.2%	87.5%	93.9%
	2020	50.5%	63.4%	58.8%	44.3%	71.6%	70.1%	75.0%	80.7%	89.3%
UCSF	2018	62.2%	65.2%	68.4%	59.7%	82.7%	83.4%	82.9%	90.1%	93.9%
	2020	60.6%	67.4%	69.2%	62.2%	75.2%	81.6%	87.5%	87.1%	95.4%

SFHP Org Goals Impact CAHPS

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- SFHP Organizational Goals
  - Improve Member Engagement: implementing a cross functional-work group to create a work plan to improve member engagement with the health plan.
  - High-Risk COVID Outreach: Member outreach and targeted interventions (food access, rental and unemployment assistance).
  - Restore primary care utilization and support telehealth efforts.
  - Pharmacy Transition: integrate pharmacy data to ensure ease of data sharing with SFHP providers via web portals, 837 files, and Tableau. Support high risk members through transition.

Thank you!

Questions or reflections

Reference: 2020 Scoring Changes

- Languages
  - Pre-2020: English & Spanish
  - 2020 and beyond: Chinese, English, & Spanish
- Rating questions
  - Pre-2020: scored on 8, 9, & 10
  - 2020 and beyond: scored on 9 & 10 responses only
- Percentiles drive scoring
  - Pre-2020: below 25th, 25th, 50th, 75th, 90th
  - 2020 and beyond: below 10th, 10th, 33rd, 67th, 90th

Reference: NCQA Health Plan Ratings

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NCQA Health Insurance Plan Ratings 2019 - 2020

NCQA
Measuring quality. Improving health care.

NCQA Health Insurance Plan Ratings 2019-2020 - Summary Report (Medicaid)

Search for a health insurance plan by state, plan name or plan type (private, Medicaid, Medicare). Click a plan name for a detailed analysis.

In 2019, NCQA rated more than 1,000 health insurance plans based on clinical quality, member satisfaction and NCQA Accreditation Survey results. Ratings emphasize care outcomes (the results of care) and what patients say about their care.

The overall rating is the weighted average of all measures, not the average of the three composites (Consumer Satisfaction, Prevention, Treatment). For more information about the ratings, including how they are calculated, visit our 2019 ratings page.

Note: There were no Health Plan Ratings in 2020. See our Health Plan Ratings Marketing and Advertising Guidelines for more information regarding the continued usage of 2019-2020 Health Plan Ratings for advertising and marketing purposes.

Medicaid | California | Enter Plan Name | Search

Lower Performance — Higher Performance

≤1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0

Rating	Plan Name	States	Type	NCQA Accreditation	Consumer Satisfaction	Prevention	Treatment
4.0	Alameda Alliance for Health	CA	HMO	Yes	3.0	4.5	3.0
4.0	Community Health Group	CA	HMO	Yes	3.0	4.0	3.5
4.0	Local Initiative Health Authority, dba L.A. Care Health Plan	CA	HMO	Yes	2.0	3.5	3.5
4.0	Orange County Health Authority - dba CalOptima	CA	HMO	Yes	2.5	4.0	3.5
4.0	San Francisco Community Health Authority	CA	HMO	Yes	3.0	4.0	3.5
3.5	Contra Costa Health Plan	CA	HMO	Yes	2.0	3.5	3.0
3.5	Inland Empire Health Plan	CA	HMO	Yes	3.0	3.5	3.0
3.5	Molina Healthcare of California Partner Plan Inc.	CA	HMO	Yes	1.5	3.5	3.0
3.0	Blue Cross of California Partnership Plan	CA	HMO	Yes	1.5	3.0	2.5
3.0	Blue Shield of California Promise Health Plan	CA	HMO	Yes	2.0	3.5	2.0

Agenda Item 7
Discussion Item

CEO Report

- Department Updates
- Alternative to Annual Provider Recognition Dinner
- SFCCC Personal Protective Equipment Grants and Distribution
- Semi-Annual Compliance Report

SAN FRANCISCO HEALTH PLAN
Here for you

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MEMO

Date:	**October 27, 2020**
To:	**Governing Board**
From:	**John F. Grgurina, Jr., Chief Executive Officer**
Regarding:	**CEO Report for November 2020 Meeting**

SAN FRANCISCO HEALTH PLAN (SFHP) STRATEGIC ANCHORS

Strategic Anchor: Universal Coverage

Healthy San Francisco Program Enrollment as of September 30, 2020

Total Enrollment: 14,099

A total of 14,099 participants were enrolled in Healthy San Francisco as of September 30, 2020. Enrollment is higher due to the temporary policy of auto-renewing HSF eligibility for an additional six months due to COVID-19 and reduction of in-person enrollment capacity. SFHP and San Francisco Department of Public Health (DPH) continue to work on multiple strategies and process efficiencies to address the reduced enrollment capacity.

SF City Option Program Enrollment as of September 2020

Employers in San Francisco can choose to meet the employer spending requirement of the San Francisco Health Care Security Ordinance (HCSO) by participating in the SF City Option Program. Employees of participating employers may enroll in one of three programs depending on which eligibility requirements they meet: the Healthy San Francisco (HSF) Program, which provides health care coverage to uninsured San Francisco residents; SF Covered MRA, which provides premium subsidies and cost sharing reductions for certain San Francisco residents purchasing health insurance through Covered CA; or SF MRA, which provides a medical reimbursement account (MRA) to pay for eligible health care expenses.

Employer contributions are held in a contribution pool until the employee enrolls in an SF City Option health care program, at which point the eligible contributions are transferred to the appropriate program and continue to be assigned to the program while the employee is enrolled.

San Francisco City Option Program Data – September 2020

	Program-to-Date (PTD)	September 2020
Employers		
Employers Participating in SF City Option	4,072	
Employers with Contributions Within the Past 12 Months	n/a	2,049
Total SF City Option Program Contributions	$1.208B	$2.7M
Contributions Assigned to the Contribution Pool	$405.5M	$1.9M
Contributions Assigned to Healthy San Francisco	$144.6M	$20K
Contributions Assigned to San Francisco Medical Reimbursement Account	$651.5M	$.7M
Contributions Assigned to San Francisco Covered Medical Reimbursement Account	$6.1M	$5K
Employees		
Employees Receiving SF City Option Employer Contributions	478,891	
SF MRA		
Number of SF MRAs with Deposits	218,080	965
SF MRA Claims Paid	$440M	$8.6M
SF MRA Dollars Available	$152M	
SF Covered MRA		
SF Covered MRA Participants	897	
SF Covered MRA Subsidy Deposits	$4.8M	$33K
SF Covered MRA Claims Paid	$3M	$0.1M
SF Covered MRA Dollars Available	$.6M	
HSF		
HSF Participants with Employer Contributions	21,407	18

SF MRA COVID-19 Cash Grant Update

The SF DPH's SF MRA COVID-19 Cash Grant Program began in August to provide the eligible SF MRA participants with economic support due to the COVID-19 pandemic. Over 46,000 MRA accountholders are eligible for the program. Eligible MRA account holders were contacted in phases to inform them of their ability to claim their

$500 payment once their identity is identified by SF City Option. Currently, eligible MRA account holders for whom we do not have an email address are being mailed their notification of eligibility for the program. Here are the results of the program as of October 8:

- Outreach
    - 23,373 Cash Grant Forms received.
    - 92.9% approval rate (21,710 forms approved/23,373 forms received).
    - 46.6% response rate from eligible participants (21,710 approvals/46,543 eligible participants).
- Payments
    - 21,710 participants paid $500 Cash Payment.
    - $10.86 million in grants distributed.
- Next steps
    - Follow-up letters with paper Cash Grant Form and postage paid return envelope.
        - Letters will be sent on a staggered schedule between October 19 through October 30, 2020.
    - WageWorks will send an email reminder to eligible individuals in mid-November.

The deadline to claim the Cash Grant payment is December 31, 2020. We will continue to keep you updated on claims and payments for this important program.

Fraud Incident in SF MRA Cash Grant Program

Unfortunately, SFHP has verified an incident of fraud in the SF MRA Cash Grant Program committed by an SFHP employee. In September, SFHP was notified by a participant of unauthorized claims of their MRA account. SFHP investigated this complaint and verified that an SFHP employee obtained the full social security number of a family member and used their employee access to the Employer Spending Requirement (ESR) portal to make unauthorized updates to the information of their family member.

The SFHP employee fraudulently submitted a Program Finder Form to initiate account registration and subsequently accessed the participants' MRA accounts through the WageWorks Spending Account portal, submitted claims for reimbursement, and received payment for those claims, rather than the family member.

While identity theft is a risk in many industries and has previously occurred in the program, this is the first case in which internal fraud was committed by an SFHP employee. After a thorough investigation, SFHP took disciplinary action and the SFHP employee was terminated in September.

SF City Option has an Account Monitoring Committee whose role is to oversees SF City Option's approach to minimize fraud, abuse, and security and privacy breaches.

The SF City Option Account Monitoring Committee is responsible to ensure that:

- SF City Option implements industry standard best practices for fraud and abuse prevention, complies with HIPAA, and operates to address the best interests and needs of the San Francisco Department of Public Health (DPH).
- SF City Option policies and procedures are in alignment with SFHP and DPH compliance, privacy and security standards and protocols.
- SF City Option policies and procedures are in alignment with and adhere to HIPAA requirements and risk management.
- SF City Option Account Monitoring Program policies and procedures are followed. SF City Option complies with SFHP policies and procedures related to fraud and abuse prevention and security.
- There are appropriate escalation and communications within SFHP and to DPH and external stakeholders/partners.
- There is adequate investigation, tracking, and reporting of incidents, and if applicable, recommendations or corrective actions are developed after each incident
- Corrective actions are implemented and monitored until resolution.

SFHP notified the DPH of the fraud case and DPH is represented on the Account Monitoring Committee. The SF City Option program is currently finalizing internal recommendations with the SF City Option Account Monitoring Committee to prevent and address fraud, both internal and external, in the program. We will inform you of these final recommendations once they have been adopted

SFHP MEMBERSHIP UPDATE

SFHP membership as of October 1, 2020 is 149,611 members. **Attachment 1** includes the membership reports for October. On page 2 of the report, Medi-Cal membership is 136,821 members, which is an increase of 7.4% increase compared to October 2019. The number of members on hold (page 4) is 1,641 and the number disenrolled is 673 members. These significantly lower numbers are due to the Department of Health Care Services implementation of Governor Newsom's Executive Order to discontinue negative actions on Medi-Cal eligibility as of March 19, 2020. The Governor's order has been extended until the COVID-19 public health emergency is considered over. Medi-Cal beneficiaries will not be put on hold or disenrolled during this time, unless their cases were under review prior to mid-March 2020. These earlier cases will be processed according to the regular Medi-Cal eligibility requirements. Beneficiaries in the SSI/SSP aid categories may be placed on hold or disenrolled because the federal Social Security Administration office is processing eligibility reviews, which results in disenrollments or holds.

Healthy Workers enrollment as of October 1, 2020 is 12,790 members, which is a 9.74% increase compared to October 2019. Please see **Attachment 1** for the complete SFHP Membership reports.

MEDI-CAL EXPANSION UPDATES

Please see the table below for the SFHP Medi-Cal expansion default assignments of non-choosers to the public hospital system. SFHP remains compliant with the requirements of AB 85 to default the 50% of non-choosers to the public hospital system. The remaining non-choosers are defaulted to other providers based on family linkage, previous history, address, language and other factors.

Month of Enrollment	M1 Aid Code (Optional Expansion members)	7U Aid Code (CalFresh-related Optional Expansion members)	AB 85 Default Requirement to Public Hospital System (M1 and 7U only)
2020			
January	1,106 M1 members, 1,030 did not choose	0 7U members	537 of 1,030 members (52%) were defaulted to DPH
February	1,404 M1 members, 1,375 did not choose	0 7U members	688 of 1,136 members (50%) were defaulted to DPH
March	1,488 M1 members, 1,437 did not choose	0 7U members	718 of 1,437 members (50%) were defaulted to DPH
April	1,359 M1 members, 1,305 did not choose	0 7U members	653 of 1,305 members (50%) were defaulted to DPH
May	1,229 M1 members, 1,220 did not choose	0 7U members	610 of 1,220 members (50%) were defaulted to DPH
June	1,593 M1 members, 1,578 did not choose	0 7U members	789 of 1,578 members (50%) were defaulted to DPH
July	1,581 M1 members, 1,578 did not choose	0 7U members	785 of 1,570 members (51%) were defaulted to DPH
August	1,687 M1 members, 1,680 did not choose	0 7U members	840 of 1,680 members (50%) were defaulted to DPH
September	1,344 M1 members, 1,314 did not choose	0 7U members	649 of 1,314 members (50%) were defaulted to DPH
October	1,294 M1 members, 1,271 did not choose	0 7U members	638 of 1,271 members (50%) were defaulted to DPH

STRATEGIC ANCHOR 2: QUALITY CARE & ACCESS

Health Services

The Health Services department provides the following key updates from Health Outcomes Improvement, Clinical Operations, Pharmacy Services and Care Management departments.

Disparities Leadership Program

SFHP is among 19 health care institutions nationally selected to participate in this year's Disparities Leadership Program offered by the Massachusetts General Hospital Disparities Solutions Center. Our year-long project will focus on untangling the

contributors to the low utilization of primary care by Black SFHP members compared to other racial groups. A second aim will be to develop an administrative algorithm to identify trans/gender non-binary SFHP members, with the goal of better understanding the prevalence of this key population, and their use of services and quality of care.

Along these lines Business Solutions recently launched a HEDIS Disparities Dashboard. This allows users to assess differences in all HEDIS measures by both race/ethnicity and spoken language. Having this data readily available is a critical first step towards identify and prioritizing disparities for organizational intervention.

Pharmacy

SFHP staff throughout the organization continue with the work needed to prepare for the Medi-Cal Rx transition, slated to go live on January 1, 2021. Our Pharmacy team is preparing to support high-risk members whose medication regimens may be most impacted by the change in their pharmacy benefit from SFHP to Medi-Cal Rx.

A by-product of this pharmacy benefit transition is that SFHP will end its Postgraduate Year 2 Pharmacy Residency program. Our last PharmD resident left SFHP this July. The Pharmacy Residency program ran for six years. We trained the following seven pharmacists, including Jessica Shost, who transitioned into our drug utilization review (DUR) pharmacist after completing her residency.

- Kendrix Nguyen was hired by CalOptima.
- Dai Tan was hired by at Kaiser.
- Keira Truong was hired by Scan Health Plan.
- Jessica was hired by SFHP.
- Ryan Cotton was hired by Walgreens.
- Kent Truong was hired by Blue Shield.
- Jenny Nguyen was hired by Sharp Health Plan.

Not only did we help these seven pharmacists advance their careers, but we also provided development opportunities for our staff. Kaitie Hawkins has been the Residency Director for the past two years and our entire staff served as teachers for the residents. Contributions by our residents include: 1) instituting coverage and promoting vaccines through the pharmacy benefit and building monitoring reporting still used today; 2) instituting coverage and promoting Home Blood Pressure Monitors in the pharmacy benefit and studying the impact to members self-care of their hypertension; 3) building our DUR program in compliance with DHCS; 4) studying the importance of specialty pharmacy to our providers and members and recommending a local option; 5) evaluating the social determinants of health as a factor in our poorly controlled diabetes population; and 6) promoting our benefit for a 12-month supply of contraception with an impressive campaign developed with Marketing.

Primary Care Utilization

Utilization of services remains below pre-COVID baseline but has partially rebounded from the nadir in the months after shelter-in-place restrictions. This is especially the case for primary care, due in part to the broad adoption of telehealth modalities by SFHP providers. Emergency room and hospital utilization remain significantly reduced. Accordingly, we have relaunched our member incentives campaigns, which had been paused with shelter-in-place orders. These incentive programs encourage targeted member subgroups to see their physicians for recommended care or overdue care (i.e., adult members with an ER visit in the last year but no primary care visit).

Care Management

Advanced Primary Care

Our Advanced Primary Care pilot program, which was approved by the Governing Board, launched last month. This pilot will provide home-based primary care to selected high-risk SFHP members who have significant challenges accessing office-based primary care. MedZed (www.mymedzed.com) is the clinical vendor selected to provide home-based primary care, which will predominantly target members in San Francisco Health Network and San Francisco Consortium of Community Clinics. This pilot was funded by SFHP's Strategic Use of Reserves.

Health Homes Program

The Health Homes Program (HHP) pilot, involving 16 managed care plans (MCPs) in 12 counties, was extended by DHCS through the end of 2021. The UCLA Center for Health Policy Research recently published its first Interim Evaluation of California's HHP (see **Attachment 2** for the Executive Summary). The interim evaluation report is the first of a series of three planned evaluation reports. San Francisco County is referenced in the interim evaluation as Group 1 State Plan Amendment 1 (SPA 1). The largely favorable outcomes analysis of HHP heavily relied upon SFHP data since we were the first county to implement the HHP in July 2018, with SFHP having the majority of enrollments in the county. The following are highlights from the evaluation's Executive Summary:

- HHP outcomes were only measured for Group 1 SPA 1 enrollees because this was the only group with complete claims data for the first year of HHP implementation. Changes in selected metrics for Group 1 SPA 1 enrollees in San Francisco were examined before and after each individual's enrollment in HHP.
- For Group 1 SPA 1 enrollees, Assessment and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment increased significantly from a rate of 45% in Pre-HHP Year 1 (or 12 months prior to HHP enrollment) to 55% after HHP Year 1 (or 12 months of enrollment in HHP).
- For Group 1 SPA 1 enrollees, the rate of Emergency Department (ED) visits showed a steady increase 24 months prior to HHP enrollment. Pre-HHP Year 2

(or 24 months prior to HHP enrollment) the rate of ED visits was 315 per 1,000 enrollee months and increased to a rate of 404 in pre-HHP Year 1 (or 12 months prior to HHP enrollment). The ED visits rate decreased significantly after one year of HHP enrollment, or HHP Year 1, to a rate of 285.

- For Group 1 SPA 1 enrollees, inpatient utilization or the rate of hospitalizations, showed a steady increase 24 months prior to HHP enrollment. In pre-HHP Year 2, the rate was 92 inpatient visits per 1,000 enrollee months and increased to a rate of 134 in Pre-HHP Year 1. The rate of hospitalizations decreased significantly after one year of HHP enrollment, or HHP Year 1, to a rate of 91.

The interim report states that the findings provide evidence that MCPs developed comprehensive plans to build the needed infrastructure and to deliver HHP services; successfully enrolled eligible members; targeted appropriate members for the program; and delivered substantial HHP services to their members.

Telephonic Care Coordination

Our Care Management team continues its COVID-19 pivot from community-based to telephonic services to help members coordinate and navigate their care. This has rendered certain subset of the care management target population more challenging to engage. Health Services continues its outreach efforts to assess the needs of members at highest risk for severe COVID infection (members over 60 years of age and those with serious chronic health conditions).

National Committee on Quality Assurance (NCQA) Renewal Survey

SFHP continues to prepare for our NCQA renewal survey, which began on October 6th and continues through December 2020. Compliance and Regulatory Affairs leads the cross-functional, organization-wide effort. We have completed the following initial portions of the survey:

- Preparation of all documentation continued without impact by working remotely.
- All evidence (except case files) was submitted electronically to NCQA through the NCQA portal on October 6th. This includes policies, reports, materials, and screenshots to demonstrate compliance with NCQA standards. The organization worked cross-functionally to pull together over 100 documents.
- SFHP also worked with and appreciates all delegates, who submitted their documents as needed, including data files for case file selection by the NCQA surveyors. The case file audit will occur on December 7th and 8th.

Once SFHP receives notice from NCQA on November 16th of which files have been selected for review by NCQA, SFHP NCQA and Delegate Oversight will work with delegated medical groups to obtain and prepare files for the final portion of survey on December 7th and 8th.

NCQA has adjusted the health plan rating process due to the pandemic:

- As previously reported, HEDIS and CAHPS will not be included this year, so health plans will retain their previous year's health plan rating, which was 4.0 for SFHP. However, SFHP must pass the evidence portion of the renewal survey to maintain the rating.
- The file review portion of the survey on December 7th and 8th is traditionally conducted onsite, but with the pandemic this has been transitioned to a virtual format.

STRATEGIC ANCHOR 3: EXEMPLARY SERVICE

OPERATIONS

Operations is comprised of the following departments: Claims, Customer Service, Member Eligibility Management (MEM), Enterprise Project Management Office (EPMO), Business Solutions (composed of Configuration, Quality Assurance, Business Systems Analysis, and Continuous Improvement), and Provider Network Operations (PNO) (composed of Provider Relations, Contracting, Credentialing, and Facility Site Review). We continually strive to streamline processes to strengthen our core operations.

Customer Service (CS)

As noted earlier in this CEO Report, Mayor London Breed announced the MRA cash disbursement program to offer $500 to qualified individuals, to assist them and their families with COVID-19 related expenses. SFHP sent 12,600 letters to eligible participants in August. As a result, the CS call volume in August for City Option-related calls increased by 186% to 539 calls/day due to the cash disbursement. The average call volume for HSF/City Option (CO) was 188 calls/day pre-COVID. Our City Option call volume surpassed that of SFHP Medi-Cal for the first time in the history of the program and our overall call volume was averaging 1,061 calls/day in August. CS was not staffed to handle this extraordinary call volume. We leveraged our Member Eligibility Management (MEM) team to answer calls as well. When the MEM team could not fully address inquiries, a call-back request was created for CS staff. In August and September, CS completed a total of 2,280 call-backs. CS experienced 138 hours of overtime hours and helped the callers complete their cash grant certification forms.

Claims

The Claims department continues to operate efficiently. We processed 99.76% of claims within 19 business days in this quarter and ensured timely payments to our providers. In the first quarter of FY 20-21, SFHP received a total of 251,074 claims, an average of 83,691 claims per month. The claims volume increased by 34% over the previous quarter (April – June), which had a steep decline due to the pandemic. We are

experiencing a return to our normal claims volume as our total claims for the first quarter of FY 20-21 is only 1% less than the claims volume for the same period in FY 19-20.

The Claims department processed 430 provider disputes this quarter and the average turn-around time to resolve these PDRs and issue the determination letters was 23 business days within the regulatory requirement of 45 business days.

Member Eligibility Management (MEM)

DHCS informed us of a termination issue related to SSI/SSP members in the first week of September. A preliminary report showed that 106 members had been terminated. Having reviewed the list, MEM team identified the duplicated and on-hold members and concluded that only 42 members were terminated. The timely analysis and action by MEM helped us resolve this issue with DHCS in a timely manner. MEM continued to operate efficiently and achieved the stretch level of departmental metrics.

Business Solutions

The Business Solutions team automated sales tax computation on claims for taxable items effective November 2020. This automation will reduce manual calculations and interest payments due to delayed processing on claims. This successful automation was a collaboration with the Claims Department and ITS over several months. Incrementally, we improved process and data quality in eligibility, care management, and authorizations. In eligibility, member's program attributes can now be updated daily with effective date and multiple months of history as needed. For the care management systems, the member's health risk assessment and pharmacy data quality and reliability were enhanced. Lastly, capabilities were developed and deployed to audit and better match authorizations from delegated medical groups to claims received.

Provider Network Operations

<u>Provider Recognition Dinner Update</u>

As an alternative to this year's Provider Recognition Dinner, Provider Network Operations will be sending personal protective equipment (PPE) care packages to network providers. The packages will include various PPE items with the SFHP logo including: masks, hand sanitizers, disinfecting wipes, and packets of flower seeds to encourage planting of a calming, Zen garden. The packages will also include a stylized note card to thank the providers for their continued excellent service to SFHP members and the community.

<u>SFCCC PPE Grants</u>

SFHP's Governing Board approved grants for the San Francisco Community Clinic Consortium (SFCCC) earmarked to purchase of PPE for SFCCC and other network providers. This update provides the status of the purchase of distribution of PPE as the result of the grants.

Round One funding in the amount of $300,000 was distributed to SFCCC on April 15, 2020 and included $50,000 for SFCCC administrative expenses. PPE items were purchased by SFCCC and distributed to member clinics on July 16, 2020. The purchase included masks, face shields, gloves, shoe covers, and hair nets. Distribution also included various cleaning and testing supplies including hand sanitizer, disinfecting wipes, alcohol prep pads, nasal swabs, and sterile collection tubes.

Round Two funding in the amounts of $300,000 and $137,000 were distributed to SFCCC on July 15 and August 26, 2020 respectively. A requirement of Round Two funding was that PPE would be distributed to both SFCCC and select SFHP network providers. PPE included over 300,000 gloves of various sizes and 50,000 N95 masks and were allocated between SFCCC and other network providers including: CCHCA, Jade Med Group, Brown and Toland, Hill Physicians and Chinese Hospital. Distribution to providers commenced on 9/28/20 and were allocated in the following amounts:

SFCCC	**QUANTITY**
N95 Protective Mask (Purchased by SFCCC)	20,000
Gloves – Nitrile Examination Gloves – Small (0), Medium, Large and X-Large	144,000
CCHCA	**QUANTITY**
N95 Protective Mask (Purchased by SFCCC)	6,000
Gloves – Nitrile Examination Gloves – Small (0), Medium, Large and X-Large	32,000
Jade Medical Group	**QUANTITY**
N95 Protective Mask (Purchased by SFCCC)	6,000
Gloves – Nitrile Examination Gloves – Small (0), Medium, Large and X-Large	32,000
Brown and Toland	**QUANTITY**
N95 Protective Mask (Purchased by SFCCC)	6,000
Gloves – Nitrile Examination Gloves – Small (0), Medium, Large and X-Large	32,000
Hill Physicians	**QUANTITY**
N95 Protective Mask (Purchased by SFCCC)	6,000
Gloves – Nitrile Examination Gloves – Small (0), Medium, Large and X-Large	32,000
Chinese Hospital	**QUANTITY**
N95 Protective Mask (Purchased by SFCCC)	6,000
Gloves – Nitrile Examination Gloves – Small (0), Medium, Large and X-Large	32,000

Clinics	**QUANTITY**			
	N95 Masks	**Face Shields**	**Surgical Masks**	**Gloves**
BAART	50	68	3,700	3,818
Curry Senior Center	-	560	6,800	7,360

Clinics	QUANTITY			
HealthRight 360	50	50	600	700
Mission Neighborhood Health Center	200	1,100	20,250	21,550
Native American Health Center	50	150	1,700	1,900
NEMS	100	550	20,000	20,650
Planned Parenthood	50	-	1,500	1,550
SF Community Health Center	150	727	7,600	8,477
SF Free Clinic	50	50	2,000	2,100
South of Market Health Center	100	800	10,700	11,600
St Anthony Medical Clinic	50	85	1,050	1,185
Street Outreach Services	100	30	250	380
Total Distributed (as of 7/16)	950	4,170	76,150	81,270
Inventory Balance	15,000	5,680	26,400	29,000

Enterprise Project Management Office (EPMO)

The project work remains on track for the January 1, 2021 transition date of the Medi-Cal Rx benefit to Magellan, the new, statewide PBM. Several projects to address other regulatory mandates are underway and targeted for completion by the end of the calendar year.

- DMHC APL 19-016 Amendment to Risk-Based Organizations Regulations – adjustments to quarterly and annual financial survey reporting requirements for risk-based organizations.
- Proposition 56 APL Program – addresses several All Plan Letters related to provider payments from tobacco tax revenues and associated DHCS quarterly reporting.
- SB 260 Covered CA Automatic Enrollment – DMHC requirement to provide contact information of newly disenrolled Healthy Workers members to Covered California so disenrolled members may obtain other coverage.
- DHCS APL 19-010 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Implements requirements for delivering EPSDT services to Medi-Cal members.

In accordance with our project management maturity roadmap, the EPMO team has been working on internal process improvements for more effective management and delivery of enterprise projects, to include:

- Development of Enterprise Project Governance Guide – overview of SFHP project governance process and guidelines for oversight of the enterprise project portfolio.
- Project Business Lead, Project Sponsor and Project Management training – refresh of content for internal training of staff and leadership team on project management best practices.

STRATEGIC ANCHOR 4: FINANCIAL VIABILITY

Compliance and Regulatory Affairs

Members' Rights to State Fair Hearings, Consumer Complaints and Independent Medical Reviews

Compliance and Regulatory Affairs staff ensures members receive exemplary service with timely handling of State Fair Hearings (SFH), Consumer Complaints (CC) and Independent Medical Reviews (IMR), but also helps to ensure financial viability by protecting SFHP from non-compliance in these areas. Each case is handled with respected and thoroughly investigated. SFHs are processed as administrative hearings by the Department of Social Services and CCs and IMRs are processed through the Department of Managed Health Care (DMHC). The pandemic appeared to have an initial impact on the volume of members' requests as there were only two cases in the last quarter of FY 19-20. However, the volume has recently increased to numbers prior to the pandemic. There were ten cases during the first quarter of FY 20-21, which is slightly higher than pre-pandemic volumes during the previous year. Of the ten cases received July through September 2020, the response for one SFH was considered untimely because the member did not receive a physical copy of SFHP's response 48 hours prior to the hearing. SFHP has updated its processes to arrange for printing and timely mailing of SFH responses by staff with access to SFHP's offices. The table below (continues on next page) provides a summary of FY 20-21 Quarter 1 cases.

Complaint Type	Case Result	Q1	Q2	Q3	Q4	FY Total
SFH	Withdrawn, Dismissed, Denied / SFHP Acted in Compliance	0				**0**
SFH	Granted, Granted in Part / Dismissed in Part	0				**0**
SFH	SFHP Overturned Denial upon Review	0				**0**
SFH	Case Still Open	3				**3**

Complaint Type	Case Result	Q1	Q2	Q3	Q4	FY Total
IMR	SFHP Acted in Compliance	2				**2**
IMR	Unable to Process Case due to Missing Information	1				**1**
CC	SFHP Acted in Compliance	3				**3**
CC	SFHP Overturned Denial upon Review	0				**0**
CC	DMHC Overturned Plan Decision	0				**0**
CC	Case Still Open	1				**1**
TOTALS		**10**	**0**	**0**	**0**	**10**

Organization Policies and Procedures

Compliance and Regulatory Affairs (CRA) works with departments across the organization to maintain the organizational repository of policies and procedures, many which are required by NCQA, DMHC, DHCS and HIPAA. Absence of the policies and procedures or a lack of systematic process for review can lead to audit deficiencies and corrective actions, including fines. Departments are responsible for reviewing and revising their policies at least every two years, except Pharmacy, which must review and revise their policies on an annual basis. CRA facilitates the process by working with each business lead to prepare revisions for review by the Policy and Compliance Committee, which meets on a monthly basis. The pandemic and working remotely did not impact the process. A total of 142 policies and procedures were reviewed and updated in FY 19-20, compared to 139 the previous year. During the first quarter of FY 20-21, SFHP reviewed and updated 44 policies and procedures and retired 11. Departments across the organization work with the Regulatory Affairs team to update the policies and procedures in preparation for the Medi-Cal Rx transition that will be effective January 1, 2020.

Delegation Oversight

Delegation Oversight team, along with internal subject matter experts (SMEs) across the organization, completed thirteen delegate audits in 2020, including two pre-delegation audits that were not originally included in the 2020 Delegation Oversight Workplan. These audits not only ensure SFHP and its delegates are compliant with health plan and Medi-Cal requirements, they also help us prepare for external audits. Three audits are in process and are on track to be completed by the end of the calendar year. Three additional audits are scheduled to begin before the end of December. There has been a slight impact to the department due to the pandemic. Audits are taking approximately two weeks longer than pre-pandemic and some audit areas, such

as Credentialing, contain sensitive information that cannot be scanned and sent to us. We are working with IT and the delegates to find a safe solution for review of sensitive information.

Internal Audits

The Compliance Oversight team and internal SMEs have completed eight of the scheduled Internal Audits from the FY 20-21 Internal Audit Workplan, which also helps to ensure SFHP is prepared for external audits. We are working closely with the departments to monitor their quality assurance activities and in correcting deficiencies identified in this process. Our goal is to be as unobtrusive to regular operations as possible, while providing oversight to internal functions. We have added an additional six audits to the FY 20-21 Internal Audit Workplan as a result of deficiencies identified and new requirements from the DHCS. The pandemic has not impacted our ability to conduct internal monitoring and audits, with the exception of our inability to conduct privacy rounding to ensure that all employees are protecting PHI.

External Audits

We are in the process of completing our Corrective Action Plan from our March 2020 DHCS Annual Medical Survey. We are working closely with the DHCS Managed Care Quality Monitoring Division (MCQMD) to develop solutions to our open findings and expect to have all open items closed by February 2021. The next DHCS Audit is scheduled for March 2021 and will be our first full-scope audit in four years. Audit preparations will begin in November. We also worked with the DMHC over the past several months to close their follow-up audit (to the 2018 medical audit), which they conducted remotely. DMHC stated that two items will remain open, however, until DMHC returns for our next Full-Service Survey, scheduled for August 2021.

Program Integrity

The Compliance and Oversight team has been working closely with Pondera, our Fraud Detection as a Service (FDaaS) provider to identify additional ways to optimize our return on investment, as the pandemic has interrupted claims and claims processing behavior in such a way that identifying outlier or aberrant behavior is much more difficult. Pondera has agreed to implement four additional alerts and is conducting a full-scale analysis of telehealth behavior to help us understand telehealth billing practices better. In addition, Pondera provided a four-part training to the Program Integrity Workgroup and Compliance and Oversight Department.

For the first quarter of FY 20-21, there have been the following nine leads opened for investigation:

- We have requested records for three cases related to coding by clinics.

- Four cases are under review (potential member fraud, a DME case, one case of a provider billing after the date of death; and a coding issue related to an age and code conflict).
- Two cases were closed with no further issues.

Please see **Attachment 3** for the full Semi-Annual Compliance Report for the period from January 2020 through October 2020.

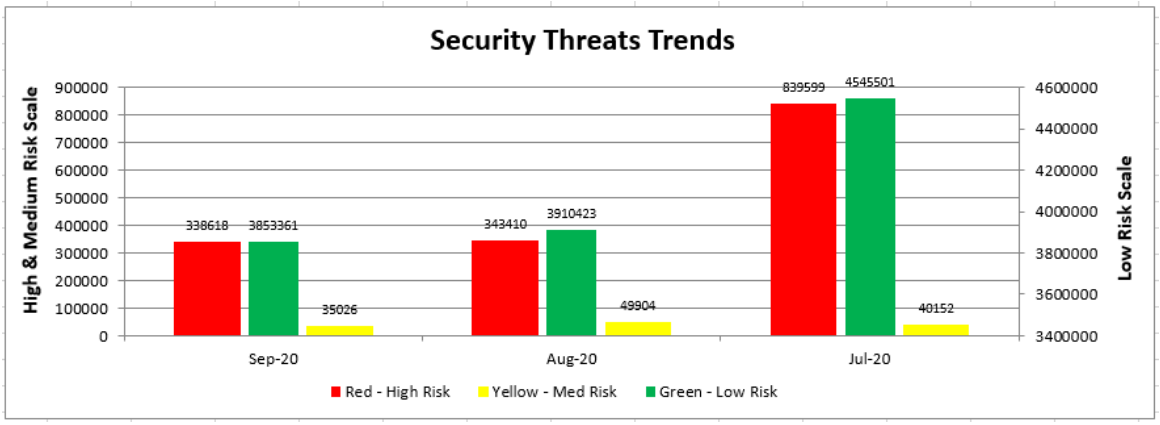
Information Technology Services (ITS)

ITS Security Metrics Report

Threats

- Number of Attacks Detected and Thwarted at the Network Perimeter
  April 2020 through July 2020

Risk Category	September	August	July
High/Critical – Attempts to exploit various vulnerabilities, including repeated brute force attempts	338,618	343,410	839,599
Medium - Malware, ransomware and virus attempts	35,026	49,904	40,152
Low/Informational –Authentication failures, login failures, HTTP Errors	3,853,361	3,910,423	4,545,501



Security Trends

The number of overall volume attacks on SFHP's network infrastructure are at the same levels as we have seen in the recent past, although there was a spike in July. Most inbound international traffic to SFHP, with some exceptions, is now being blocked. Most of the attacks we are seeing are coming from computers in the United States that appear to have been compromised.

Malware

There were no significant malware events over the last three months.

Email

Since January the quantity and volume of inbound emails to SFHP has dropped significantly. The trend that we observed in January is continuing. Emails into SFHP are down by approximately 30%. There are also less emails rejected than in the past. The theory is that as we block more incoming emails, spammers become less likely to send emails. Rejected emails include blocked senders, viruses, spam and other unwanted emails. Rejecting suspicious emails before they enter SFHP's internal systems reduces the threat attack surface.

Month-Year	Total Inbound Email	Rejections (includes viruses & spam)	Legit Inbound Email	% Rejections	Total Outbound Email	Total Internal Email
Oct - 2019	459,754	369,197	90,557	80.3 %	33,768	849,673
Nov - 2019	447,477	370,138	77,339	82.72 %	27,440	906,838
Dec - 2019	357,580	278,066	79,514	77.76 %	26,622	789,872
Jan - 2020	147,970	60,746	87,224	41.05 %	32,538	632,007
Feb - 2020	148,916	72,395	76,521	48.61 %	30,103	632,516
Mar - 2020	192,832	88,454	104,378	45.87 %	34,811	783,711
Apr - 2020	230,763	138,667	92,096	60.09 %	33,195	713,459
May - 2020	186,026	100,474	85,552	54.01 %	31,337	683,066
June - 2020	187,156	98,109	89,047	52.42 %	31,376	652,250
July - 2020	173,417	86,343	87,074	49.79 %	57,572	683,283
Aug - 2020	162,068	82,314	79,754	50.79 %	259,461	492,483
Sep - 2020	156,542	78,381	78,161	50.07 %	372,335	465,614
Total	**2,850,501**	**1,823,284**	**1,027,217**		**970,558**	**8,284,772**
Mean	**237,541.75**	**151,940.33**	**85,601.41**	**57.79 %**	**80,879.84**	**690,397.69**

Annual Risk Assessment

SFHP's is in the process of conducting our annual risk assessment with Clearwater Compliance. A risk assessment helps reveal areas where an organization's protected health information (PHI) could be at risk and is required as part of the HIPAA Security rule.

This annual effort consists of organizational reviews of all SFHP systems that contain and use ePHI. Clearwater Compliance consultants review documentation and conduct interviews with business units and application owners. The results of this risk

assessment will be available by early November. Based on the assessment, ITS and Compliance will work together to address any gaps with a corrective action plan.

Penetration Testing

SFHP's ITS department conducted an internal and external penetration test in June 2020. We are in the process of remediating the findings of this most recent test.

Risk Category	Number of Findings
Critical	1
High	4
Medium	13
Low	19
Informational	6

Penetration Testing is the process of identifying security gaps in our infrastructure by mimicking an attacker.

CMS Interoperability Solution

In early 2019 the Centers for Medicare and Medicaid Services (CMS) introduced the CMS Interoperability and Patient Access Proposed Rule. The intent of the CMS Interoperability Rule is to expand access to health information and improve the seamless exchange of data in health care.

The CMS Interoperability Rule introduces new technologies and standards that SFHP will have to acquire in order to be compliant. The deadline for implementation of the capabilities outlined in the CMS Interoperability Rule was recently extended to July 1, 2021.

Through a competitive RFP process SFHP selected the EDIFECS solution. The contract with EDIFECS was ratified in July.

Finally, SFHP is leading an effort to create a buying group in order to purchase the EDIFECS solution at a lower cost. Several local health plans have now selected EDIFECS, which has resulted in receiving the promised advantageous sliding scale pricing. The project is moving forward with requirement documentation, data mapping and development of consent management flows.

The formal project kickoff was October 19th. The kickoff included all health plans that have joined the buying group.

Encounter Management Solution

SFHP has had a home-grown encounter processing engine that enabled SFHP to perform our daily encounter processing business. However, there is inherent maintenance and support cost due to changes in state requirements. SFHP needed to

be able to improve the quality of our encounter data submission and have a faster turnaround on error correction. The state of California's DHCS is utilizing Managed Care Plan's (MCP) encounters to set MCP rates and to determine quality through the Managed Care Accountability Set (MCAS).

In October 2019, SFHP initiated the implementation of Edifecs' Encounter Management Solution that ensures the accuracy, completeness, and timeliness of encounter data submissions to DHCS. This solution provides the following:

- Pre-built state-specific business rules to reduce errors and improve data quality.
- Dashboards and reporting capabilities that provide visibility of state submissions.
- Mass correction capabilities to fix errors quickly and resubmit data.

Project Updates	- The Business Requirements Document was approved on 11/25/2019. - SFHP application development completed. - Test cases completed and in TFS. - All EMS environments ready. - Historical encounter data from 01/01/2018 -01/31/2020 loading completed. - DHCS Re-certification completed. - Production deployment planning completed. - The solution was successfully implemented into Production on 4/27/2020. - The project was closed as of 6/30/2020.
Project Results and Impact	- Encounter acceptance rate improved from 95 percent to 98 percent. - The solution has resulted in over 2,300 work hours saved due automation, reporting and the ability for mass corrections and resubmissions. - The above savings are in addition to the $1.2 million positive return on investment defined in the original project scope.

MEDIA ROUNDUP

Please see **Attachment 4** for the Media Roundup with articles related to Medi-Cal, COVID-19 and the Affordable Care Act.

Agenda Item 8

Closed Session

Discussion Item

- Discussion of the Chinese Community Health Care Association (CCHCA) Managed Services Organization Change from North East Medical Services to In-House within CCHCA

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MEMO

Date: October 27, 2020

To	**Governing Board**
From	**Kaliki Kantheti, Operations Officer** **Nina Maruyama, Officer, Compliance and Regulatory Affairs**
Regarding	**Chinese Community Health Care Association (CCHCA) Management Services Organization**

San Francisco Health Plan (SFHP) provides the Governing Board with an update regarding the management services organization (MSO) for Chinese Community Health Care Association (CCHCA). No action is required.

Chinese Community Health Care Association MSO Update

Chinese Community Health Care Association (CCHCA) and North East Medical Services (NEMS) entered into an agreement in August 2019 for NEMS to function as the CCHCA MSO. Both parties have agreed to terminate the agreement effective on December 31, 2020 and CCHCA will run the MSO functions in-house, as it currently does for its Medicare Advantage contracts.

To facilitate this transition, SFHP initiated a project to transition CCHCA's MSO functions from NEMS to CCHCA effective January 1, 2021. This project is on track and work is in progress to support this transition. SFHP's ITS team will be working with CCHCA to ensure they pass the testing phase to be able to exchange eligibility and encounter data files prior to the go-live date.

Pre-Delegation Oversight

One of the key components for the transition of the MSO functions to CCHCA is an audit of CCHCA to ensure they are prepared to perform all delegated functions. This type of audit is known as a pre-delegation audit and is conducted with a team of subject matter experts within SFHP. The MSO functions that were audited in the pre-delegation audit were claims, utilization management and case management. Since NEMS has been performing these functions on behalf of CCHCA, CCHCA does not have its own case files for review as part of the audit. This pre-delegation began in September and is ongoing. A draft report was provided to CCHCA on October 22, 2020. CCHCA has 30

days to provide evidence of corrections or provide a corrective action plan. The draft audit report details 22 findings in the three audited areas. Many of the following findings were deficiencies related to Medi-Cal requirements since the CCHCA MSO had only been functioning in Medicare Advantage. SFHP's Delegate Oversight team believes that CCHCA leadership will be able to close these gaps and correct the deficiencies prior to the end of the NEMS MSO agreement.

Utilization Management (UM) (13 findings):

1. No evidence provided to demonstrate the involvement of appropriate practitioners.
2. No evidence provided to show that UM criteria and procedures are reviewed against current clinical and medical evidence and are updated, when appropriate.
3. Written job descriptions for practitioners, who review denials of care, do not state practitioners are required to have "A current license to practice without restriction."
4. UM policies and procedures did not include the following:
    - For all authorization types, provide the initial written notification to requesting practitioners within 24 hours (one calendar day) of decision.
    - For urgent preservice written decisions, provide decision within 72 hours (three calendar days) of receipt of the request.
    - For urgent preservice written decisions, provide decision within 72 hours (three calendar days) of receipt of the request and provide member written notification within two working days from date of decision.
5. Policies and procedures did not include the following:
    - For all authorization types, provide the initial written notification to requesting practitioners within 24 hours (one calendar day) of decision.
    - For urgent preservice written decisions, provide decision within 72 hours (three calendar days) of receipt of the request.
    - For urgent preservice written decisions, provide decision within 72 hours (three calendar days) of receipt of the request and provide member written notification within two working days from date of decision.
6. Policies and procedures did not describe the process for "pending files" when additional clinical information is needed.
    - Final decision or decision to extend is made within 14 calendar days of receipt.
    - For deferred requests in extension, final decision is made within 28 calendar days of receipt.
7. The Discharge Planning check list or protocol did not include:
    - Member identifying information (Name, DOB, SFHP ID)
    - Member's PCP information (name and phone number)
    - Date PCP was notified of member discharge.
8. Policies and procedures did not describe the process for disenrolling members in Long Term Care (LTC) and members in need of Major Organ Transplant.
9. Policies and procedures did not specify that medically necessary services at an LTC are covered by the delegate from time of admission and up to one month after the month of admission.

10. Policies and procedures did not specify notifying Partner Plans that a member needs to be disenrolled due to major organ transplant surgery.
11. Policies and procedures did not state that the delegate has a list of providers to whom high-risk OB members can be referred for evaluation and care if beyond the scope of practice of the initial prenatal practitioner and the list is distributed to providers and educates accordingly.
12. Policies and procedures did not include written criteria used for determining medical necessity of transgender services to make authorization decisions. Clinical guidelines based on the most current Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People published by the World Professional Association for Transgender Health (WPATH).
13. List of services that outlines what requires a prior authorization and what does not require a prior authorization was not provided.

Claims and Provider Dispute Resolution (five findings):

14. Policies and procedures did not specify that the organization pays claims for both in and out-of-network emergency services and ancillary services.
15. Policies and procedures did not specify that the organization pays claims from in and out-of-network providers for family planning, STI testing, HIV testing and counseling, pregnancy testing, and abortion services.
16. Policies and procedures did not specify allowing for minor consent without parental notification.
17. Policies and procedures did not specify that the organization requires the State consent form, PM330, to be completed and signed in accordance with CCR, Title 22 regulations and attached to each claim before such services are be reimbursed.
18. Provider Dispute Resolution process did not state it included Medi-Cal claims.

Case Management and Coordination of Care (four findings):

19. Policies and procedures describe where Complex Case Management Services (CCM) cases can come from; however, does not describe how cases are found through those channels.
20. Policies and procedures state that California Children Services (CCS) eligible members are identified but does not describe how they are identified and the process for ensuring that members aging out of CCS at age 21 continue to receive necessary medical services through the delegate without a gap or delay in care.
21. Policies and procedures state members will be referred to the Local Education Agency (LEA); however, policies and procedures do not describe the process for identifying eligible members.
22. Policies and procedures state how Early Start (ES) referrals are made; however, policy and procedures do not describe the process for identifying ES eligible members, what services are provided by ES program, or who makes referrals/coordinates with ES program.

As relayed to the Board last year, non-compliance with regulatory and contractual requirements may require SFHP to take one or more of the following steps allowed by SFHP's provider service agreement with CCHCA:

1. De-delegation;
2. Freeze on new member auto-assignments;
3. Freeze all member assignments, e.g., close CCHCA to new enrollments;
4. Transfer of existing member assignments to other contracted provider groups;
5. Exclude CCHCA from SFHP's pay-for-performance program;
6. Withhold capitation in part or in full; or
7. Termination of the provider agreement.

As stated earlier, we believe CCHCA will be able to make the necessary corrections prior to taking over the MSO functions and such measures should not be needed.

Agenda Item 9

- Report on Closed Session Action Items

  (Verbal report only)