SAN FRANCISCO HEALTH PLAN
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Joint Meeting of the San Francisco Health Authority and the San Francisco Community Health Authority

Governing Board Agenda
Wednesday January 5, 2022
12:00 pm – 2:00 pm

- TIME**: 12pm to 2pm**
- LINK: Click here to join the meeting on Microsoft Teams

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 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 link on MS Teams:

- TIME**: 12pm to 2pm**
- LINK: Click here to join the meeting

Or call in (audio only)

- +1 323-475-1528,,749397692#

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

Call to Order and Public Comment on any matters within SFHA/SFCHA purview

1. (V) Election of Officers for San Francisco Health Authority and San Francisco Community Health Authority (John F. Grgurina, Jr.)
2. (V) Approval of Consent Calendar
   a. Minutes from November 3, 2021, December 1, 2021, and December 8, 2021 Meetings
   b. Quality Improvement Committee Minutes
   c. Credentialing and Recredentialing Recommendations

d. Updates to 2022 SFHP Employee Handbook Effective on January 1, 2022

e. Findings and Resolution That Establish the State of Emergency Continues to Impact the Ability of Governing Board and Committee Members to Meet Safely in Person and/or State or Local Officials Continue to Impose or Recommend Measures to Promote Social Distancing

3. (V) Review and Approval of Year-To-Date Unaudited Financial Statements and Investment Reports (Skip Bishop and Rand Takeuchi)

4 (V) Review and Approval of Reinsurance Vendor Contract (Skip Bishop and John F. Grgurina, Jr.)

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

6. Chief Medical Officer's Report (Fiona Donald, MD)

(D) a. Medi-Cal Rx Implementation Updates

(V) b. Review and Approval of Evaluation of SFHP's 2021 Quality Improvement Program

(V) c. Review and Approval of SFHP's 2022 Quality Improvement Program Workplan

7. Member Advisory Committee (MAC) Report (Maria Luz Torre and Irene Conway)

(V) a. Review and Approval of 2022 MAC Goals

(D) b. Report on MAC Meeting from Co-Chairs

8. (D) Review Option to Purchase Employee Health Benefits from CalPERS (Brian Gentner and Skip Bishop)

9. (D) CEO Report (John F. Grgurina, Jr.)
Highlighted Items – Healthy San Francisco and City Option Updates, Operations Updates, Return to Office Status, COVID-19 Vaccine Outreach Efforts, and Security Updates

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

10. (D) Review Status of Medi-Cal Rate Changes for Provider Contracts (Skip Bishop and John F. Grgurina, Jr.)

Pursuant to Welfare and Institutions Code Section 14087.36(x)

11. (D) Search Committee Updates and Next Steps for CEO Recruitment (Steven Fugaro, MD, Kate Gormley and Nicole Lambrou, ThreeTenents)

Pursuant to Government Code section 54957 (b)(1)

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

12. (D) Report on Closed Session Action Items (Chair)

13. 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***

Please Note These Up Coming SFHA/SFCHA Meetings:

- Member Advisory Committee: January 14, 2022 (1:00 pm – 3:00 pm)
- Special Governing Board: February 2, 2022 (12:00 pm – 12:10 pm)
- Member Advisory Committee: February 11, 2022 (1:00 pm – 3:00 pm)
- Quality Improvement Committee: February 10, 2022 (7:30 am – 9:00 am)
- Finance Committee: March 2, 2022 (11:00 am – 12:00 pm)
- Governing Board: March 2, 2022 (12:00 pm – 2:00 pm)

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

Election of Officers

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	**December 22, 2021**
To	**SFHP Governing Board**
From	**John F. Grgurina, Jr., CEO**
Regarding	**Election of Board Officers**

Recommendation:
We recommend that the Governing Board of the San Francisco Health Authority and San Francisco Community Health Authority conduct its annual election of its Governing Board officers, with the nominations and elections to take place at the January Board meeting.

Please note that according to the San Francisco Community Health Authority By-laws, the officers of the San Francisco Health Authority also function as the officers of the San Francisco Community Health Authority. Nominations will be taken at the meeting.

Background:
According to the Bylaws of the San Francisco Community Health Authority, there are four officers of the Board: Chair, Vice-Chair, Secretary, and Treasurer (relevant sections are attached). The positions of Secretary and Treasurer may be combined into Secretary/Treasurer and held by the same individual. The Board also has the authority to create additional officers, if the Board finds that necessary. All officers serve for one year or until their successor has been elected.

The current officers are:
Chair – Steven Fugaro, MD
Vice Chair – Roland Pickens, MHA, FACHE
Secretary & Treasurer – Reece Fawley

The following are nominations that have been proposed to date:
Chair – Steven Fugaro, MD
Vice-Chair – Roland Pickens, MHA, FACHE
Secretary & Treasurer – Reece Fawley

EXCERPT FROM THE GOVERNING BOARD BY-LAWS
ARTICLE VI
OFFICERS

6.1 **Officers**. The officers of the Governing Body shall be a Chairperson, one or more Vice Chairpersons, a Secretary and a Treasurer. At the discretion of the Governing Body, the positions of Secretary and Treasurer may, from time to time, be combined into a single position of Secretary/Treasurer.

6.2 **Election of Officers**. Each year, the Governing Body shall elect the officers set forth in section 6.1 of these Bylaws and such other officers as the business of the Authority may require, each of whom shall have such authority and perform such duties as set forth in these Bylaws and/or which the Governing Body may from time to time determine. Subject to section 6.3 hereof, each officer shall be a Member and shall serve for a term of one (1) year or until his or her successor is selected.

6.3 **Removal of Officers**. Any officer may be removed, either with or without cause, by the Governing Body at any regular or special meeting of the Governing Body. An officer shall immediately cease to be an officer in the event such person ceases to be a Member of the Governing Body or in the event the Governing Body recommends to the Board that such individual be removed as a Member.

6.4 **Chairperson**. The Chairperson shall, subject to the control of the Governing Body, have general supervision, direction and control of the business and affairs of the Governing Body. The Chairperson, if present, shall preside at meetings of the Governing Body.

6.5 **Vice Chairperson**. In the absence or disability of the Chairperson, the Vice Chairperson shall perform all the duties of the Chairperson and when so acting shall have all the powers of, and be subject to all the restrictions upon, the Chairperson. The Vice Chairperson shall have such other powers and perform such other duties as from time to time may be prescribed by the Governing Body or the Chairperson.

6.6 **Secretary**. The Secretary shall keep or cause to be kept a book of minutes of all meetings and actions of Members and committees of Members. The Secretary shall give, or cause to be given, notice of all meetings of the Governing Body required by the Bylaws or by law to be given, and shall have such other powers and perform such other duties as may be prescribed by the Governing Body or by the Chairperson.

6.7 **Treasurer**. The Treasurer shall keep and maintain, or cause to be kept and maintained, adequate and correct books and records of accounts of the funds, properties and business transactions of the Authority including accounts of its assets, liabilities, receipts, disbursements, gains, losses, and capital.

Agenda Item 2

Action Item

Approval of Consent Calendar:

a. Minutes from November 3, 2021, December 1, 2021 and December 8 2021 Meetings
b. Quality Improvement Committee Minutes
c. Credentialing and Recredentialing Recommendations
d. 2022 Employee Handbook
e. Findings and Resolution That Establish the State of Emergency Continues to Impact the Ability of Governing Board and Committee Members to Meet Safely in Person and/or State or Local Officials Continue to Impose or Recommend Measures to Promote Social Distancing

SAN FRANCISCO HEALTH PLAN
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P.O. Box 194247
San Francisco, CA 94119

MEMO

Date: December 22, 2021

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 2a. Recommendation to Approve Board Minutes
It is recommended that the Governing Board approve the minutes from the Governing Board meetings held on November 3, 2021, December 1, 2021 and December 8, 2021. The minutes are attached for review.

Item 2b. Recommendation of the Quality Improvement Committee (QIC) Minutes
It is recommended that the Governing Board approve the attached minutes from the August 2021 QIC meeting, as approved and recommended by the QIC.

Item 2c. 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 2d. Updates to 2022 SFHP Employee Handbook Effective on January 1, 2022
It is recommended the Governing Board approve the proposed revisions to the SFHP Employee Handbook for calendar year 2022. Each year we update the Employee Handbook to provide additional clarity to existing policies, add new policies, or update policies as required by law. This year there are no new policies, so the attached memo summarizes the changes recommended this year, described in two sections. The first section lists slight updates or clarifications to existing practices. The last section contains updates that were recommended by our legal counsel. Stylistic or grammatical changes are not described. We have also enclosed the full Employee Handbook with the changes redlined.

Item 2e. Findings and Resolution That Establish the State of Emergency Continues to Impact the Ability of Governing Board and Committee Members to Meet Safely in Person and/or State or Local Officials Continue to Impose or Recommend Measures to Promote Social Distancing.

It is recommended the Governing Board approve the findings and proposed Resolution 2022-01 that establish the state of emergency continues to impact the ability of Governing Board and Committee members to meet safely in person and State and local officials continue to recommend measures to promote social distancing and masking for safety.

Agenda Item 2

Action Item

Approval of Consent Calendar:

a. Minutes from
   November 3, 2021
   December 1, 2021
   December 8, 2021
   Meetings

Joint San Francisco Health Authority/San Francisco Community Health Authority
Governing Board
November 3, 2021
Meeting Minutes

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

Members Present: Eddie Chan, PharmD, Lawrence Cheung, MD, Irene Conway, Reece Fawley, Steve Fields, Steven Fugaro, MD, Maria Luz Torre, Emily Webb, David Woods, PharmD, and Jian Zhang, DNP, MS, FNP-BC

Members Absent: Dale Butler, 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 Board members, staff members and public attended the meeting via video conference.

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, SFHP's counsel with DSR Health Law, Deena Lahn, with the San Francisco Community Clinic Consortium (SFCCC), and Nicole Lambrou, founder and President of Three Tenets. There were no other members of the public and no public comments.

1. Approval of Consent Calendar

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

a. Approval of minutes from September 1, 2021 Governing Board Meeting
b. Quality Improvement Committee (QIC) Minutes
c. Credentialing and Recredentialing Recommendations

The Board unanimously approved the consent calendar without any issues.

2. Review and Approval of the Annual Independent Auditor's Report for FY 2020-21

Recommendation: Review and Approval of the Annual Independent Audit Report for FY 2020-21.

Chris Pritchard, Partner, and Rianne Suico, Partner, Moss Adams Consultants, the independent audit firm hired by SFHP, presented the FY 2020-21 independent financial audit report. The auditors gave SFHP an "Unmodified Opinion," which is the highest opinion available (also known as a "clean opinion"). There were no significant, or material, comments in the Communication to the Governing Board. There were no required or recommended adjustments to the journal entries.

Ms. Suico reviewed the following key points of the audit report:

- Over the years, SFHP has been very consistent, which is a testament to management's ability to produce financial statements without material error.
- All reported receivables and assets were properly supported and appropriate.
- All payments and liabilities were appropriated accounted.
- Assumptions and information used by SFHP's actuary for the Incurred But Not Reported (IBNR) were tested and all liabilities were reasonably stated.
- All capitation payments to providers were properly supported.
- Recording of operational expenses were in accord with accounting policies and principles.
- Trends were consistent with expectations, without any unusual spikes.
- SFHP's tangible net equity (TNE), which is a measure of an organization's financial health, was very strong.
- There were no disagreements with SFHP's management.

The consultants discussed that the audit went well.

Dr. Fugaro thanked the auditors, and Mr. Fawley was pleased with the audit and stated there were no surprises. He stated the Finance Committee complimented the SFHP Finance team for their outstanding work. He stated the Committee recommended to maintain Moss Adams as the independent audit firm for the next couple of years to ensure continuity of financial oversight with the upcoming change in CEO. They felt this would be an important action to take to provide stability during a time of significant change. The Finance Committee has confidence in the Finance department leadership and recommended the Board approve the Moss Adams independent audit report.

With the Finance Committee recommendation, the Board unanimously approved the independent auditor's report for FY 2020-21 as presented.

3. Review and Approval of Unaudited Monthly Financial Statements and Investment Reports

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

Rand Takeuchi, Director, Accounting, reviewed the unaudited monthly financial statements for the period ending September 30, 2021.

1. September 2021 reported a loss of ($3,226,000) versus a budgeted loss of ($947,000). After removing Strategic Use of Reserves (SUR) activity, the actual loss from operations was ($3,133,000) versus a budgeted loss of ($842,000).

   On a year-to-date basis, we have a margin of $520,000 versus a budgeted margin of $3,022,000. After removing SUR activity, the actual margin from operations was $803,000 versus a budgeted margin of $3,337,000.

   In September, we received $22.7 million in Directed Payments funding related to the Bridge Period of July 2019 through December 2020. This funding covered only two of the four types of Directed Payments and covered only July through December 2019. The FY 21-22 budget projected Directed Payments funding of $132.0 million for September which was based on historical patterns. The next wave of funding should bring us much closer to our budget projections. It is important to note that Directed Payments funding is a pass-through to hospital providers and does not impact SFHP's bottom line. As has been the case in previous years, 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 decrease in revenue of $107.6 million due to:
      i. $109.3 million less in Directed Payments funding related to the Bridge Period of July 2019 through December 2020.
      ii. $1.5 million more in Medi-Cal and Healthy Workers premium revenue due to an additional 3,225 member months along with actual premium rates that were 0.8% higher than what was used for the budget projections.
      iii. $133,000 more in Hepatitis C revenue. There were 218 treatment weeks in September versus a budget of 171 treatment weeks.
      iv. $118,000 more in Maternity revenue. We reported 105 maternity events during September versus a budget of 91 maternity events.

   b. A net decrease in medical expense of $31.5 million primarily due to:
      i. $109.3 million less in Directed Payments funding related to the Bridge Period of July 2019 through December 2020.
      ii. $1.6 million more in fee-for-service (FFS) expense. We had five claims payment cycles in September. The budget anticipated

higher FFS cost due to the extra payment cycle, however actual paid claims were even greater than expected. When looking at the paid claims data, we saw several high dollar claims submitted by Zuckerberg San Francisco General for services rendered to members enrolled with the University of California San Francisco (UCSF) and Brown & Toland Medical Group. For example, one claim totaled $300,000 for a 35-day stay in the intensive care unit at ZSFG.

iii. $766,000 more in net capitation as the result of having 3,225 more member months as well as a more favorable membership mix than what the budget projected. This additional cost is offset by the revenue SFHP received for these additional members.

iv. $1.4 million more in Medi-Cal non-Hepatitis C pharmacy expense. The main driver of this additional expense can be found in the cost for generic drugs. Beginning July 1, 2021, SFHP moved to Magellan for Pharmacy Benefit Management (PBM) services. Results for July through September clearly show that Magellan's cost for generic drugs is higher than the pricing SFHP received through PerformRx. Generic medications represent 89% of all prescription filled. For the first three months of FY 21-22, generics represented 26.4% of total drug costs. This compares to 15.0% for the period of April through June 2021. The largest factor here appears to be network contracting. Magellan is paying Walgreens, our largest retail pharmacy chain, significantly more for generics. Our Pharmacy department is engaged in ongoing discussions with Magellan to better understand the reasons for the higher than expected drug costs. The MLR for September was 103%. SFHP will continue to have responsibility for the pharmacy benefit through December 2021. Beginning in January 2022, the pharmacy benefit will transition to the State.

v. $119,000 more in Hepatitis C drug expense. We had 218 treatment weeks versus a budget of 171 weeks, or an increase of 47 weeks. In addition, the budget assumed 39% of the treatment weeks would be under 340B pricing which is lower cost. For September, only 1% of the actual treatment weeks were under 340B pricing. Limiting the purchasing under 340B rules is a benefit to SFHP due to the fact that SFHP pays the same for the Hepatitis C drug but receives a lower reimbursement from the State. The entity with whom we have the 340B special pricing arrangement retains the spread.

vi. Healthy Workers pharmacy expense was slightly higher than budget expectations, i.e., $1,073,000 in drug costs versus a budget of $1,009,000. On a pmpm basis, the actual cost was $90.82 versus a budget of $86.42. Although actual expense exceeded the budget, SFHP had a margin of $33,000 as we receive $93.61 in the Healthy Workers rate for pharmacy.

vii. $84,000 more in Non-Specialty Mental Health (NSMH) expense as utilization continues to be higher than expected.

viii. $82,000 more is Community-Based Adult Services (CBAS) expense. This increase is due to higher utilization resulting from the implementation of Temporary Alternative Services (TAS) which allows the CBAS centers to submit claims for telephonic and telehealth services provided to Medi-Cal members during the Public Health Emergency (PHE). The PHE is expected to last until the end of the calendar year.

c. A net increase in administrative expenses of $169,000 primarily due to:
   i. $267,000 less in all non-compensation administrative expense categories. This difference is primarily due to timing as it was anticipated that more professional fees/consulting services and system maintenance/infrastructure costs would be incurred in the earlier part of the fiscal year. The expectation is that actual spending will align with the budget as we move further into FY 21-22.
   ii. $98,000 more in Compensation, Benefits and GASB 68 costs. The budget assumed a staff attrition factor of 10%. The actual attrition factor for September continues to run slightly less than 10%.

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

	SEP 2021				FYTD 21-22 THRU SEP			
CATEGORY	ACTUAL	BUDGET	FAV (UNFAV)	% FAV (UNFAV)	ACTUAL	BUDGET	FAV (UNFAV)	% FAV (UNFAV)
MEMBER MONTHS	163,415	160,190	3,225	2.0%	487,711	478,743	8,968	1.9%
REVENUE	$ 82,654,000	$ 190,174,000	$ (107,520,000)	-56.5%	$ 204,689,000	$ 308,879,000	$ (104,190,000)	-33.7%
MEDICAL EXPENSE	$ 81,032,000	$ 186,248,000	$ 105,216,000	56.5%	$ 190,618,000	$ 291,851,000	$ 101,233,000	34.7%
MLR	98.8%	98.3%			94.0%	95.1%		
ADMINISTRATIVE EXPENSE	$ 4,746,000	$ 4,915,000	$ 169,000	3.4%	$ 13,548,000	$ 14,131,000	$ 583,000	4.1%
ADMINISTRATIVE RATIO	5.0%	2.2%			5.7%	3.9%		
INVESTMENT INCOME	$ (102,000)	$ 42,000	$ (144,000)	-342.9%	$ (3,000)	$ 125,000	$ (128,000)	-102.4%
MARGIN (LOSS)	$ (3,226,000)	$ (947,000)	$ (2,279,000)	-240.7%	$ 520,000	$ 3,022,000	$ (2,502,000)	-82.8%
ADD BACK: SUR ACTIVITY	$ 93,000	$ 105,000			$ 283,000	$ 314,000		
MARGIN (LOSS) FROM OPERATIONS	$ (3,133,000)	$ (842,000)	$ (2,291,000)	-272.1%	$ 803,000	$ 3,336,000	$ (2,533,000)	-75.9%

On a year-to-date basis through September and after the removal of SUR activity, SFHP is reporting a margin of $803,000 which is $2.5 million less than budget expectations.

- After removing the Directed Payments funding, premium revenue is above budget by $5.1 million. This is due to:
  - An overall net increase of 8,968 member months. Member months for the Adult, Adult Expansion and Seniors and Persons with Disabilities (SPD) categories of aid are all above budget which has

a favorable impact on revenue due to the fact that the premium rates for these members are much higher than the premium rates for Child and Dual members.
    - A Medi-Cal rate increase effective January 1, 2021 that was 0.8% greater than budget expectations.

- After removing SUR activity and Directed Payments funding, medical expense is above budget by $8.1 million. This increase can be accounted for as follows:

    - Medi-Cal non-Hep C pharmacy expenses are up $2,788,000
    - Capitation expenses are up $2,548,000
    - FFS expenses are up $2,215,000
    - Hepatitis C expenses are up $ 555,000

- Overall administrative expense is below budget by $583,000. The majority of this decrease was due to lower costs in the areas of professional services and information technology services. The lower costs were due to timing differences as actual spending should align more closely with the budget as we move through the fiscal year. Overall administrative expense savings have been partially offset by increases in Compensation, Benefits and GASB 68 costs due to a slightly lower attrition rate than what was used for budgeting purposes.

PROJECTIONS

Mr. Bishop reviewed the following financial projections through March 2022.

1. Beginning in July 2021, hospital risk for 16,000 San Francisco Community Clinic Consortium (SFCCC) members became the responsibility of SFHP. SFHP no longer pays capitation to ZSFG for these members. SFHP will be responsible for all in-network and out-of-network hospital services under a fee-for-service arrangement – All Patient Refined Diagnosis Related Groups (APR-DRG) for inpatient services and 140% of the Medi-Cal Fee Schedule (MCFS) for outpatient facility services. Primary care and specialty care services remain under capitation. It is estimated that this new risk will cost SFHP approximately $16 million to $20 million per year, which is built into the FY 21-22 budget. Our draft CY 2022 Medi-Cal rates confirm that DHCS and Mercer included this added cost in the CY 2022 Medi-Cal rate development process, which means SFHP has to absorb the costs only for the period of July through December 2021.

   SFHP expects the fee-for-service claims cost to exceed the capitation savings by approximately $1.5 million per month. Due to the normal pattern of claims lag, SFHP has increased its Incurred But Not Reported (IBNR) claims reserve in an amount equal to its projected exposure in order to cover the anticipated claims incurred July through September, but not received as of September 30, 2021.

2. SFHP started the new fiscal year with 2,400 more Medi-Cal members versus what was anticipated in the budget. Due to the ongoing COVID-19 pandemic,

SFHP anticipates adding another 2,000 members through December 2021. With some upcoming changes in the Medi-Cal eligibility rules, SFHP expects to add another 3,000-4,000 members in early 2022. This will increase our Medi-Cal membership to approximately 160,000 members.

It is important to note that with the State's intention to lift the Public Health Emergency by December 31, 2021, SFHP anticipates that Medi-Cal membership will gradually decrease during CY 2022 as members will be placed on hold or terminated due to no longer qualifying for the program.

3. The Medi-Cal pharmacy benefit is scheduled to be carved out effective January 2022. This aligns with how SFHP prepared its FY 21-22 budget, i.e., we would have responsibility for this benefit through December 31, 2021. The State takes over this benefit on January 1, 2021 with Magellan as its Pharmacy Benefits Manager (PBM). This will be viewed as a positive development as drug costs have increased now that Magellan is our PBM.

4. Beginning on January 1, 2022, SFHP will take responsibility for Enhanced Care Management (ECM), Community Supports, formerly known as In Lieu Of Services (ILOS) and major organ transplants. Multiple teams within SFHP have been working for several months to prepare for these new programs. Draft rates for ECM and Community Supports were released in early October. We are still waiting on draft rates for major organ transplants from DHCS.

5. Proposition 56 – this program will continue for all of FY 21-22. Proposition 56 provides 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.

HIGHLIGHTED IMPACTS TO THE HEALTH PLAN AND/OR PROVIDERS

Medi-Cal Pharmacy Costs

Mr. Bishop reviewed a memo from Lisa Ghotbi, Director, Pharmacy Services, related to increasing generic pharmacy costs. Work is continuing to understand the cause of the cost increases with Magellan, the new PBM for Healthy Workers, HSF, and Medi-Cal (only through December 31, 2021 for Medi-Cal).

Investment Reports

Mr. Takeuchi briefly reviewed the investment reports that were provided to the Board in the packet.

With the Finance Committee recommendations, the Board unanimously approved the monthly financial statements and investment reports ending September 30, 2021.

4. Review and Approval of Additional Governing Bord Meetings to Comply with 361 Teleconference Brown Act Flexibilities

Recommendation: Approve the SFHP Governing Board to hold special meetings to comply with AB 361.

Nina Maruyama, Chief Officer, Compliance and Regulatory Affairs, reviewed the new relaxation of teleconference requirements allowed by the Brown Act. With the passage of AB 361, local public entities such as the San Francisco Health Authority and San Francisco Community Health Authority would be allowed to meet using teleconferencing during the public health emergency as long as they met requirements of the new law. Ms. Maruyama described the following requirement that the Governing must meet at least every 30 days to establish factual findings that find a State of emergency decree, or local orders regarding social distancing and other supporting materials such as Center for Disease Control (CDC) or local health department recommendations to support the recommendation to meet via teleconference.

Ms. Maruyama stated that SFHP would like the Governing Board to approve that it would take action on behalf of the Board and its Standing Committees – Finance, Quality Improvement, Member Advisory and Pharmacy and Therapeutics and approve two, ten-minute meetings in December to allow the January 5, 2022 Board meeting to be held via teleconference.

The Board unanimously approved the additional Governing Board meetings to comply with AB 361 Teleconference Brown Act Flexibilities.

5. Federal and State Updates

Sumi Sousa, Chief Officer of Policy Development and Coverage Programs, provided the Board with an overview of Governor's State budget. (Detailed PowerPoint slides were provided in the Board packet.)

Ms. Sousa stated Governor Newsom defeated the recall. She explained that this means Medi-Cal's major new programs and benefits (CalAIM, Student Behavioral Health Initiative, Medi-Cal expansion for undocumented aged 50+years and homelessness proposals) can continue to be planned for, rolled out.

Ms. Sousa shared the following Medi-Cal Managed Care Procurement Updates:

- DHCS will open the Medi-Cal managed care commercial plan contracts for an RFP. The effective date of the new commercial contracts will be January 2024. Public plans (County Organized Health Systems, such as Health Plan of San Mateo, and Local initiatives, such as San Francisco Health Plan) are not subject to the procurement
- In San Francisco, other commercial health plans and Anthem Blue Cross must apply to be the commercial plan option for Medi-Cal managed care members. It is possible there would be new commercial plan that competes with SFHP for membership that is not Anthem Blue Cross.

- The draft Request for Proposal (RFP) was released in June 2021 and DHCS received extensive comments. As a result, DHCS will delay the release of the RFP for Medi-Cal managed care commercial plans to February 2, 2022.
- The January 1, 2024 implementation date remains unchanged.

Ms. Sousa then provided the Board with Federal updates:

- Within the $1.85T Reconciliation Bill, there was increased funding for Medicaid Home and Community Based Services.
- $190B in increased funding for services to elderly and disabled in Medicaid that allow them to stay at home/in the community.
- Makes increased APTC/Covered CA affordability subsidies permanent.
- American Rescue Plan provided funding for two years for the following:
    - 12-month continuous eligibility for kids in Medicaid.
    - 12-month continuous Medicaid eligibility for pregnant and post-partum individuals.

6. Member Advisory Committee Report

Maria Luz Torre and Irene Conway provided the Board with a Member Advisory Committee (MAC) report.

Ms. Torre reported at the September meeting, SFHP staff attended to discuss ADHD, which is one of the Committee's goals. At the October meeting, the Committee, SFHP staff attended to discuss grievances and concerns about mental health under stress and grievances. A question was raised, if a grievance is filed will there be repercussion with the person that filed the grievance? Fiona Donald, MD, CMO, who attended the meeting, assured MAC members that there would not be any retaliation or negative repercussions for filing a grievance.

Dr. Fugaro thanked Ms. Torre and Ms. Conway for their report.

7. Chief Medical Officer's Report

Dr. Donald provided the Board with CalAIM, Medi-Cal, and COVID-19 Vaccine updates. (Detailed PowerPoint slides were provided in the Board packet.)

Dr. Donald reviewed the launch of the following new Medi-Cal benefits on January 1, 2022:

- Major Organ Transplants, in addition to the existing kidney only and cornea transplants, will be carved into managed care. Other organ transplants were covered under Medi-Cal fee-for-service, but would now be under Medi-Cal managed care.
- Enhanced Care Management & Community Supports (formerly "In Lieu of Services") Target Populations, which will cover specific eligible populations, particularly those that are high utilizers of services, members with a diagnosis of Serious Emotional Disturbance or Serious Mental Illness and individuals experiencing homelessness, among other eligibility criteria.

Dr. Donald also provided the following updates regarding Medi-Cal Rx, the pharmacy benefit, which will also be implemented on January 1, 2022:

- The administration of the formulary, pharmacy network, and claims payment are the responsibilities of DHCS/Magellan.
- SFHP will continue to monitor quality and provide care coordination.
- SFHP will support high-risk transition members.

Dr. Donald informed the Board that SFHP and San Francisco County continue to lead the state in Medi-Cal members that are vaccinated, but the Department of Health Care Services (DHCS) created an incentive program to continue efforts to close the vaccination gap between the general population and Medi-Cal members. DHCS is providing health plans with funds for member incentives of $50 gift cards when they complete the vaccination series. There are also outreach funds available, which SFHP will use to fund projects through a grant application process.

Dr. Donald closed with the following HEDIS and CAHPS highlights from Measurement Year 2021.

- SFHP is accredited with NCQA with a rating of four stars.
- Like other health plans, SFHP is experiencing an impact in primary care access and utilization due to COVID-19. This will likely have an impact on SFHP's "Use of Preventive Health Care" measures, but there is an NCQA allowance for telehealth visits for many measures.
- To help improve CAHPS scores related to member experience, SFHP created a video series to help inform members about how to use their benefits and work with their health care providers and health plan.

8. CEO Report – Highlighted Items – Updates on Healthy San Francisco, Operations, and Board Reappointments

Mr. Grgurina highlighted the status of staff vaccinations. As we continue to plan a safe return to the workplace, we began collecting COVID-19 vaccination status of all our employees. The data will provide critical data needed for planning purposes and prepare us for potential reporting obligations, e.g. to the City and the County of San Francisco. We collected this information via ADP using the ADP Mobile app. The deadline to respond was October 22, 2022 and here are the results:

- Total Number of Employees Vaccinated – 323 (90%)
- Declined to Answer – 4 (1%)
- Not Vaccinated – 9 (3%)
- No response – 22 (6%)

Human Resources will be reaching out to the 22 employees who did not respond to collect their response and provide assistance, if needed.

The Board Adjourned to Closed Session.

9. Search Committee Updates and Next Steps for CEO Recruitment

This item was discussed in closed session.

The Board resumed in Open Session.

10. Report on Closed Session items

Dr. Fugaro reported that there were no actions taken in closed session.

11. Adjourn

Dr. Fugaro adjourned the meeting.

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Reece Fawley, Secretary/Treasurer

Joint San Francisco Health Authority/San Francisco Community Health Authority
Minutes of the Governing Board
November 3, 2021
Closed Session

1. Search Committee Updates and Next Steps for CEO Recruitment

Kate Gormley, Chief Human Resources Officer, and Nicole Lambrou, founder and President of Three Tenets, provided the following updates regarding the Search Committee and process for the CEO recruitment:

- In late August a request for proposals was issued to recruiting firms. Of the seven firms that submitted proposals, four were selected for interviews.
- Through this process, Russell Reynolds was selected by unanimous vote of the Search Committee on October 4, 2021.

The search firm and Search Committee have the next following steps in the process:

- Develop CEO Profile, Candidate Scorecard & Interview Questions.
- Identify Candidates.
- Conduct Interviews & Data Collection.
- Candidate Evaluation & Decision Making.
- Select Final Candidate, Negotiate Offer, & Final Approval.

While a target only, the selection of a final candidate may be in late February or March. The full Governing Board will vote on the final candidate during the March meeting or a Special Meeting, if needed. If a candidate is not selected prior to John F. Grgurina, Jr.'s last day on April 2nd, the Chief Operations Officer, Kaliki Kantheti, will serve as the Interim CEO.

Reece Fawley stated the process has been thorough and he thanked Dr. Fugaro, Ms. Gormley and Ms. Lambrou. Ms. Gormley thanked the Search Committee members and Board and informed them that she will keep them updated.

Joint San Francisco Health Authority/San Francisco Community Health Authority
Governing Board Special Meeting
December 1, 2021
Meeting Minutes

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

Members Present: Eddie Chan, PharmD, Lawrence Cheung, MD, Irene Conway, Steve Fields, Steven Fugaro, MD, Maria Luz Torre, PharmD, Roland Pickens, MHA, FACHE, Greg Wagner, Emily Webb, and David Woods

Members Absent: Dale Butler, Reece Fawley, and Jian Zhang, DNP, MS, FNP-BC

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 Board members, staff members and public attended the meeting via video conference.

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, SFHP's counsel with DSR Health Law.

1. **Approval of Findings and Resolution 21-01 That the State of Emergency Continues to Impact the Ability of Governing Board and Committee Members to Meet Safely in Person and/or State or Local Officials Continue to Impose or Recommend Measures to Promote Social Distancing**

   Recommendation: SFHP recommended the Governing Board adopt Resolution No. 2021-01 to authorize the continued use of remote teleconferencing pursuant to Government Code section 54953(e) ("AB 361") for a period of thirty (30) days. SFHP recommended that the Governing Board continue to meet to make the findings required by AB 361 no later than every thirty (30) days thereafter.

   Betty Clark, SFHP's Regulatory Affairs Counsel, and Eunice Majam-Simpson, SFHP's counsel with DSR Health Law, attended the Special Meeting required by the law recently passed, AB 361, which relaxes the teleconference requirements

of the Brown Act during the COVID-19 public health emergency.

Ms. Clark reviewed the memo of findings to the Board, which presents the requirements for holding meetings via teleconference in compliance with the new law. She stated that the key requirements are for the Board to reconsider at least every 30 days the circumstances of the COVID-19 state of emergency, establish that state or local offices have imposed or recommended measures to promote social distancing, and find that meeting in person would present imminent risks to the health and safety of attendees.

Ms. Clark reviewed that the Governor's proclaimed state of emergency due to COVID-19 remains in effect and that holding Governing Board and Standing Committee meetings in person would present imminent risks to the health and safety of attendees.

Ms. Clark reviewed that both State of California officials and officials of the City and County of San Francisco continue to require or recommend measures to promote social distancing.

Ms. Clark reviewed Resolution 21-001, which is necessary to comply with AB 361. Resolution 21-001, which authorizes the continued use of remote teleconferencing pursuant to Government Code section 54953(e) for a period of thirty (30) days. SFHP recommends that the Governing Board continue to make the findings required by AB 361 every thirty (30) days.

The Board unanimously approved the findings and Resolution 21-01 that the state of emergency continues to impact the ability of Governing Board and Committee members to meet safely in person and State and local officials continue to impose or recommend measures to promote social distancing.

2. Adjourn

Dr. Fugaro adjourned the meeting.

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Reece Fawley, Secretary/Treasurer

Joint San Francisco Health Authority/San Francisco Community Health Authority
Governing Board Special Meeting
December 8, 2021
Meeting Minutes

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

Members Present:	Eddie Chan, PharmD, Lawrence Cheung, MD, Irene Conway, Reece Fawley, Steve Fields, Steven Fugaro, MD, Maria Luz Torre, PharmD, Roland Pickens, MHA, FACHE, Emily Webb, and David Woods
Members Absent:	Dale Butler, Greg Wagner, and Jian Zhang, DNP, MS, FNP-BC

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 Board members, staff members and public attended the meeting via video conference.

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, SFHP's counsel with DSR Health Law.

1. **Approval of Findings and Resolution 21-002 That the State of Emergency Continues to Impact the Ability of Governing Board and Committee Members to Meet Safely in Person and/or State or Local Officials Continue to Impose or Recommend Measures to Promote Social Distancing**

   Recommendation: SFHP recommended the Governing Board adopt Resolution No. 2021-02 to authorize the continued use of remote teleconferencing pursuant to Government Code section 54953(e) ("AB 361") for a period of thirty (30) days. SFHP recommended that the Governing Board continue to meet to make the findings required by AB 361 no later than every thirty (30) days thereafter.

   Nina Maruyama, Chief Officer, Compliance and Regulatory Affairs, reviewed with the Board that the need for the Special Meeting was to comply with AB 361, as reviewed at the December 1, 2021 Special Meeting. She stated that like the

findings presented to the Board at the December 1, 2021 Special Meeting, San Francisco Health Plan (SFHP) is presenting finding that the public health emergency continues to exist and State and local public health officials continue to recommend social distancing and masking for safety. She also stated that since the December 1st meeting, a new COVID-19 variant, Omicron, was found to be spreading aggressively throughout many countries and has been found in California, as well.

Ms. Maruyama reviewed Resolution 21-002, which is necessary to comply with AB 361 and authorizes the continued use of remote teleconferencing pursuant to Government Code section 54953(e) for a period of thirty (30) days. She stated SFHP recommends that the Governing Board approve Resolution 21-002 and continue to establish the findings required by AB 361 at least every thirty (30) days.

The Board unanimously approved the findings and Resolution 21-002 that the state of emergency continues to impact the ability of Governing Board and Committee members to meet safely in person and State and local officials continue to impose or recommend measures to promote social distancing.

2. Adjourn

Dr. Fugaro adjourned the meeting.

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Reece Fawley, Secretary/Treasurer

Agenda Item 2

Action Item

Approval of Consent Calendar:

b. Quality Improvement Committee (QIC) Minutes

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Quality Improvement Committee Minutes

Date: October 14, 2021

Meeting Place: Microsoft Teams Meeting
+1 323-475-1528 : Conference ID: 982 103 462#

Meeting Time: 7:30AM - 9:00 AM

Members Present: Fiona Donald, MD *Chief Medical Officer, SFHP*; Jackie Lam, MD *Medical Director and QI Director Northeast Medical Services;* Kenneth Tai, MD *Chief Medical Officer, North East Medical Services*; Jaime Ruiz, MD *Chief Medical Officer, Mission Neighborhood Health Center;* Irene Conway *SFHP Member Advisory Committee Member*; Idell Wilson *SFHP Member Advisory Committee Member;* Ana Valdes, MD *Chief Healthcare Officer, Healthright360;* Lukejohn Day, MD *Chief Medical Officer, Zuckerberg San Francisco General Hospital*; Claire Horton, MD *Chief Medical Officer, San Francisco Health Network*

Staff Present: Lisa Ghotbi, PharmD *Director, Pharmacy;* Se Chung *Health Services Administrative Specialist*; Suu Htaung *Policy Analyst;* José A. Méndez *Senior Program Manager, Health Services Product Management (HSPM);* Kaitie Hawkins, PharmD BCPS *Pharmacist Supervisor, Clinical Programs;* Elizabeth Sekera, RN *Manager, Population Health;* Nicole Ylagan *Interim Supervisor of Appeals & Grievances*; Etecia Burrell *Population Health Program Manager*; Yves Gibbons *Sr. Program Manager, Quality & Access*; Sue Chan *Program Manager, Pharmacy Compliance*; Jim Glauber, MD *Health Plan Physician Advisor*

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 7:34 AM with a quorum. • Roll Call.		

Consent Calendar	All in favor to approve consent calendar. IHA Reinstatement update: State has requested that all Health Plans restart program and create a plan to catch up post pandemic. IHA requirement: All new enrollees as required to have an Initial Health Assessment within 120 days.		Approved. • Review of August 2021 Minutes • UM Committee Minutes - August and September 2021 • Q2 2021 Grievance Report • Q2 2021 Appeals Report • Q3 2021 PQI Report • Q2 PHM/QI Scorecard • P&T Committee Assignments • HE P&P Updates Summary - August – September 2021 • IHA Reinstatement
Quality Improvement	• ***Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) 2021*** Presented by Yves Gibbons -SFHP achievements: Rating of All Healthcare-ranking maintained, highest performing ranking. Improvement projects: increased registration & utilization of Teladoc, increased visits to primary/specialty care through telehealth, and created multi-language member experience videos. -Approximately 50 questions in survey; key focus area examples: rating of health plan, rating of personal doctor, coordination of care, etc. SFHP steady increase as of 2015. Getting Care quickly was the only area where there a slight decrease in performance. But also had slight increase in Getting Needed care. -Top Key Drivers: 3 priority questions for SFHP to address to improve overall member experience. 1. Ease of access to care, tests		

	or treatment (currently SFHP's score 77%; room for improvement 17% to reach best practice). Rating of doctor (current score 67%; 8% room for improvement to reach best practice) 3. Customer service provided needed information or help (current score 74%; 17% room for improvement to reach best practice). -Next Steps – CAHPS workgroup planning FY21/22 off cycle survey. Purpose to see if interventions are effective. Also providing feedback/guidance on member experience projects. SFHP has set an organization goal to meet NCQA's Health Equity accreditation standard. Also, there are plans to develop and implement a process to use this data in two member facing programs. *Dr. Fiona Donald: Any comments/challenges regarding access to care?* *Dr. Jamie Ruiz: Difficult recruitment from primary care, specialty and staff has created challenges for access to care. Especially in Behavioral Health.* *Dr. Fiona Donald: Beacon Health Options is SFHP's behavioral health provider. SFHP working with Beacon for solutions, looking expand telehealth.* ***• Disparities Leadership Program (DLP)*** Presented by Etecia Burrell, Elizabeth Sekera, RN, and Jim Glauber, MD -Project purpose: To support leaders in health care organizations to develop quality improvement programs/initiatives that specifically focus on disparities in the populations that they serve. -Project title: *Centering the Voices of Black & Transgender SFHP Members.* Focusing on these two populations because of ongoing trend of rates in access. Examples: Black members high utilization		

	of ER vs primary care. Transgender & Non-binary data is difficult to capture because this is a self- reported identity. Data shows: 31% lack access to regular care, 25% report insurance programs related to gender, and 23% avoid healthcare. -Milestone: Identifying TG/NB members – to develop quantitative data to analyze; traditionally qualitative data was collected since 2015. SFHP has developed an internal data model that can be added to HEDIS disparities and population assessment dashboards. Agreement with Quality Director's group of sister plans to have LHPC advocate on their behalf to DHCS to start to process of submitting the wavier to CMS to start collecting SO/GI data upon Medi-Cal enrollment. State has begun this process. -Milestone: Provider Directory Enhancement – create a filter function to include race, ethnicity, language, and LGBT identity. In early internal development and planning stage. -Milestone: Community Collaborations – partnerships to better understand community access, equity issues in vulnerable populations. SFHP developing more robust TG/NB Medical Necessity criteria; participating in State Doula access workgroup; discussing POC midwives to join network; collaborated with SF Women's Cancer Network & Rafiki Coalition for Breast Cancer Screening PDSAs. -Milestone: Social Vulnerability index – census tracked data to be incorporated into core data at member level. Will be able to apply scoring methodology for SDOH factors. -Milestone: Programs Incorporating DEI – include DEI lens to current projects. PIP has added health equity improvement project. DEI evaluation tool being used to evaluate and plan for health services programs. Diversified languages in Health Education materials.		

	• ***Potential Quality Issue (PQI)*** Presented by Nicole Ylagan and Fiona Donald, MD -Identified adverse variation from expected clinical standard of care requiring further investigation. Can be a confirmed quality issue with a provider or system. -Monitoring and oversight by quarterly report back to QIC; Inter-Rater Reliability (IRR) process; specific Policy & Procedure QI-18; trained staff to identify PQIs and make referrals. -SFHP PQI team: Quality Review Registered Nurse, CMO, Facility Site Review Nurse, Medical Director & Supervisor of Appeals & Grievances, Clinical Operations & Care Management clinical staff. -Examples of sources of PQI: external referrals, utilization management, provider preventable conditions, etc. -4 Steps in PQI process: 1. Referral (Description of quality concern) 2. Investigation (Nurse review, recommend to MD) 3. Findings (MD reviews; assigns severity rank) 4. Follow up or Recommendations (Notification, Correction Action Plan (CAP) and notification to Physician Advisory Committee (PAC)). • Will be reporting any PQIs to PAC for discussion and comments. • Meeting adjourned at 8:40 AM.		

QI Committee Chair's Signature & Date __ Fiona Donald, MD _____12/9/21_____

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

Agenda Item 2

Action Item

Approval of Consent Calendar:

c. Credentialing and Recredentialing Recommendations

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

MEMO

Date: December 21, 2021

To	Governing Board
From	Fiona Donald, MD, CMO Chair, Physician Advisory/Peer Review/Credentialing Committee
CC	Sean Dongre, Manager, Provider Network Operations
Regarding	Summary of SFHP Credentialing Activities (Oct 2021 to Dec 2021)

Recommendation:

San Francisco Health Plan (SFHP) completed the credentialing and recredentialing of the following practitioners and ancillary providers. SFHP's CMO, Dr. Fiona Donald, recommends the Governing Board approve the following providers for participation in the SFHP provider network.

PRACTITIONERS

NAME	DEGREE	BOARD	INITIAL / RECRED	LICENSE
Tyler Anderson	LAc	N/A	Initial	19005
Alexandria Steppe	LAc	N/A	Initial	17834
Zhi Liu	LAc	N/A	Initial	19235
Pui Fung Alice Leung	AuD	N/A	Recred	1813
Mary Wheeler	PA	N/A	Recred	55762

ANCILLARY

ORGANIZATION NAME	# OF SITES	TYPE OF SERVICE	INITIAL / RECREDENTIALED
Westlake Sleep Center	1	Independent Diagnostic Testing Facility	Recred

Vitas Healthcare Corporation • Milpitas	1	Hospice	Recred
Vitas Healthcare Corporation • Sacramento • Walnut Creek	2	Hospice	Initial
Hanger Prosthetics and Obstetrics • Antioch • Folsom • Fremont • Mountain View • Oakland • San Francisco • San Jose • San Mateo • Santa Rosa • Walnut Creek	10	DME Provider	Recred
City Wheelchairs	1	DME Provider	Recred
Dimitras Skin Care and Electrolysis	1	Electrolysis Clinic	Recred
Carquinez Dialysis Center	1	Dialysis	Initial
Curry Senior Center	1	ECM/CS	Initial
HealthRight 360	1	ECM/CS	Initial
Marin City Health and Wellness	1	ECM/CS	Initial
MedZed Physician Services	1	ECM/CS	Initial
St. Anthony Foundation	1	ECM/CS	Initial
UCSF Citywide Case Management	1	ECM/CS	Initial
North East Medical Services • 1400 Noriega St • 1450 Noriega St • 2574 San Bruno Ave • 2633 San Bruno Ave • Clement St • Leland Ave • Polk St • Stockton St • Taraval St	9	ECM/CS	Initial

San Francisco Health Network • BHS Outpatient Case Management • Care Coordination and Transitions Management • Medical Respite and Sobering Center • Primary Care ECM • Street Medicine ECM	5	ECM/CS	Initial

Agenda Item 2

Action Item

Approval of Consent Calendar:

d. 2022 Employee Handbook

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	**December 22, 2021**
To	**Governing Board**
From	**Kate Gormley, Chief Human Resources Officer, and John F. Grgurina, Jr., CEO**
Regarding	**Approval of Revisions to the 2022 Employee Handbook**

Recommendation

San Francisco Health Plan (SFHP) recommends the Governing Board approve the proposed revisions to the SFHP Employee Handbook for calendar year 2022.

Background

Each year we update the Employee Handbook and present the changes to the Governing Board for review and approval. The following is a summary of the changes made to the Handbook.

Summary of Proposed Changes

Based on internal review, there are typically several changes recommended for the Employee Handbook to provide additional clarity to an existing policy, add a new policy or to update policies as required by law. The changes recommended this year are shown in red-lined format in the enclosed document. This year we do not have any new policies to introduce so we only have two sections this time. There are slight updates or clarifications to existing practices and updates that are recommended by our legal counsel. Stylistic or grammatical changes are not described in this memo.

Updates/Clarification to Current Practices

- **Page 16 –** Clarified definition of a Regular-Full Time Employee to 30 or more hours worked each week to align with the benefits definition. Added clarifying statement for Regular Part Time Employee to include at least 20 hours of work each week, but less than 30 hours worked per week.
- **Page 17 –** Updated purpose and statement of the Ergonomic Evaluation Policy.
- **Page 19 –** Clarified the language regarding the request of PTO during the notice period when employee voluntarily resigns.

- **Page 22 –** Updated the Bonus section to address how SFHP will handle rehires and bonus eligibility.
- **Page 24 –** Updated the statement regarding the approval of Overtime work and address supervisor accessibility in a remote/telecommute environment.
- **Page 26 –** Updated language to the Telecommuting Policy to clarify that SFHP reserves the right to require employees to return to the office.
- **Page 27 –** Inserted statement to Telecommuting Policy to clarify that not all medical plans may be available in locations outside of the Bay Area.
- **Page 33 & 34 –** Update to CalPERS employer paid pension contributions for current fiscal year.
- **Page 39 –** Updated PTO Donation policy to clarify request period as well as requiring 80 hours of unpaid time to qualify for the policy.
- **Page 41 –** Addition of Juneteenth observed holiday.
- **Page 42** – Update to the Bereavement policy so that employees can use it up to 90-days after passing of immediate family member. Included *siblings* and *stepsiblings* in the definition of immediate family members.
- **Page 57 –** Removed outdated language in "Problem Resolution" section.
- **Page 58 –** Added language to clarify conflict of interest for employees involved with vendor selection.
- **Page 66 –** Inserted SFHP policy title referring to internal policy related to Personal Use of Cell Phones.
- **Pages 66 & 67 –** Inserted SFHP policy title referring to Remote Work and HIPAA compliance guidelines.

Legal Updates/Requirements and Recommendations by Attorney

- **Page 51** – Clarification of State and Local Family and Medical Leave laws to clarify that employees outside of California are not eligible for California-specific medical leave laws.

We believe the changes are necessary and improve the information provided to our employees and recommend approval by the Governing Board. Please feel free to contact either Kate Gormley or John F. Grgurina, Jr., with any questions.

Welcome to the San Francisco Health Authority

Starting a new job is exciting. This employee handbook has been developed to help you get acquainted and to answer many of your initial questions.

As an employee of the San Francisco Health Authority, which operates and does business as the San Francisco Health Plan ("Plan"), the importance of your contribution cannot be overstated. Our goal is to provide the finest quality health care services to customers and to do this more efficiently and effectively than our competitors. We believe that satisfied customers will continue to do business with us and will recommend us to others.

You are an important part of this process because your work directly influences our organization's reputation and success.

This employee handbook explains our personnel policies and some of the opportunities and responsibilities that exist for you within the Plan. In an effort to be responsive to the needs of a growing organization, changes or additions to this handbook will be made when necessary, with the exception of our Employment At-Will policy. We will attempt to provide you with notification of such changes when they occur.

We are glad you have joined us, and we hope you will find your work to be both challenging and rewarding.

Contents

About This Handbook / Employment At-Will

Employment at the San Francisco Health Plan is on at "at-will" basis, is for no definite period, and may, regardless of the date or method of payment of wages or salary, be terminated at any time with or without cause and with or without notice. Other than the Governing Board and/or the CEO of the Plan, no supervisor, manager, or other person, irrespective of title or position, has the authority to alter the at-will status of your employment or to enter into any employment contract for a definite period of time with you.

Any agreement with you altering your at-will employment status must be in writing and signed by the CEO or the Chair of the Governing Board. This at will policy supersedes any prior agreement you may have had with the Plan regarding the term of your employment.

Except with respect to the at-will employment policy, the policies outlined in this handbook should be regarded as management guidelines only, which in a developing organization require change from time to time. The San Francisco Health Authority, which does business as the San Francisco Health Plan ("Plan"), retains the right to make management decisions as needed in order to conduct its work in a manner that is beneficial to the employees and the Plan.

This Handbook was last modified January [~~6~~5], ~~2021~~2022. This Handbook supersedes and replaces any and all prior handbooks, policies, procedures, practices, letters, memoranda and understandings of the San Francisco Health Authority or the Plan.

Full facts and details about policies, procedures and benefits referenced in this Handbook may be contained in formal written documents such as plan documents and summary plan descriptions. Please keep in mind that this Handbook is provided for general information only and is not intended to cover all possible situations that may arise during your employment with the Plan. The Plan has the right to modify or eliminate the policies, procedures and practices described in this Handbook at any time. The Plan will attempt to provide you with notification of such changes when they occur.

You may be receiving this Handbook during uncertain and unprecedented times due to the COVID-19 pandemic. The Plan takes the health and safety of its employees very seriously and is fully committed to following agency guidance and all federal, state and local laws seeking to minimize the negative effects of COVID-19. That being said, the agency guidance and laws concerning the COVID-19 pandemic are constantly changing. Therefore, please contact Human Resources for information about the Plan's current response, policies, procedures and benefits related and specific to the COVID-19 pandemic.

The contents of this Handbook will be reviewed periodically. Changes and modifications are the responsibility of Human Resources, with final approval by the Governing Board. Material modifications will be in the form of new, substitute pages which will be distributed to all employees.

Date of Issue: January [~~6~~5], ~~2021~~2022

Approved by: San Francisco Health Plan Governing Board

About the San Francisco Health Plan

Mission

The mission of San Francisco Health Plan is to improve health outcomes of the diverse San Francisco communities through successful partnerships.

The Plan was established to create, in San Francisco:

1. an efficient, integrated health care delivery system to provide access to comprehensive health care services for Medi-Cal beneficiaries and other persons;
2. to provide quality care that is compassionate, respectful and culturally and linguistically appropriate; and
3. to ensure preservation of the safety net.

Organizational Overview

The Plan is an NCQA-accredited Medicaid HMO plan and is a unique public-private partnership which was originally created in response to the State's strategic plan for Medi-Cal managed care. The Plan is an independent public agency created through State legislation and City ordinance.

The Plan is directed by a Governing Board which includes representatives of providers, members, health and government officials, labor, and other health professionals.

The Plan's lines of coverage include Medi-Cal and Healthy Workers

The Plan is also the third-party administrator for the Healthy San Francisco and SF City Option, which are non-insurance health access programs offered in partnership with the San Francisco Department of Public Health.

As new opportunities arise to serve the underserved/uninsured populations of San Francisco, the Plan may continue to develop new lines of coverage to meet those needs.

San Francisco Health Plan Policies

Equal Employment Opportunity

The Plan provides equal employment opportunity for all employees. Equal employment opportunity related questions can be directed to Human Resources or to any member of management.

Equal Employment Opportunity Policy

The Plan maintains a policy of non-discrimination with employees and applicants for employment. No aspect of employment within the Plan will be influenced in any manner by sex/gender (including gender identity, gender expression, pregnancy, childbirth and related medical conditions), sexual orientation, race (including traits historically associated with race such as hair texture and protective hairstyles involving braids, locks, and twists), color, national origin, ancestry, citizenship, religion, age (40 and over), physical or mental disability, medical condition (as defined under California law), genetic characteristics, military status, veteran status, marital status, registered domestic partnership status, political activity or affiliation, taking or requesting a statutory leave, height, weight or any other basis protected by law. Decisions also will not be influenced by a perception you fall within any of these categories or your association with a person falling within any of these categories.

Appropriate disciplinary action, up to and including termination of employment, may be taken against any employee violating this policy.

Disability, Pregnancy and Lactation Accommodation

The Plan's policy and practice is to comply with the Americans with Disabilities Act (ADA) (and related Federal, State and local laws) and ensure equal employment opportunity for all qualified persons with disabilities. The Plan is committed to ensuring non-discrimination in all terms, conditions and privileges of employment. The Plan will make reasonable accommodations for the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee unless undue hardship would result.

Reasonable accommodation is determined on a case-by-case basis. Any applicant or employee who requires an accommodation in order to perform the essential functions of their job should talk to their supervisor or Human Resources to request an accommodation. The Plan and the employee will engage in an interactive process to identify possible accommodations.

Employees who are disabled by pregnancy, childbirth, or related medical conditions may request reasonable accommodation (including, without limitation, a transfer to a less strenuous position or less strenuous duties where the transfer is medically advisable). Transfer requests will be granted to the extent the Plan can reasonably accommodate the request without eliminating the requirement for anyone to perform the essential functions of their specific position. Employees requesting an intermittent leave or reduced schedule leave may be transferred, at the Plan's discretion, to a position more suited to such a leave for which the employee is qualified. The position to which the employee is transferred will have the same pay and benefits as the employee's former position. The Plan may require a doctor's certification of the condition, any limitations associated with the condition, and need for accommodation. The Plan prohibits retaliation against employees who request accommodation.

Employees have a right to request Lactation Accommodation. An employee shall make a written request to their supervisor of the proposed schedule, with a copy to Human Resources. The supervisor will respond to the employee and Human Resources within 5 business days. If the request is denied, the supervisor will identify the basis for the denial in their response and will engage in an interactive process

with the employee to determine a suitable accommodation. Retaliation against an employee who exercises her rights under the San Francisco Lactation in the Workplace ordinance is prohibited.

The Plan will provide all employees who wish to express breast milk at work with a reasonable amount of break time. The break time will be required to run concurrently, if possible, with any paid break time already provided. In the event it is not possible for the break time for expressing milk to run concurrently with the paid break time already provided to the employee, the break time for expressing milk is unpaid. The Plan will provide all employees desiring to express breast milk at work with reasonable accommodations. Employees have a right to file a complaint with the Labor Commissioner for any violation of a right under SB 142.

A Lactation Room is available at Plan offices ~~50 Beale~~ and may be reserved on Outlook. The Lactation Room at Spring Street is scheduled with the Enrollment Center Supervisor. The employee's normal work area may be used if it allows the employee to express milk in private.

Policy Prohibiting Discrimination, Harassment, and Retaliation

The Plan is committed to providing a work environment that is free of discrimination and harassment. In keeping with this policy, the Plan strictly prohibits discrimination and harassment of any kind, including discrimination and harassment on the basis of sex/gender (including gender identity; gender expression; and pregnancy, childbirth, breastfeeding and related medical conditions), sexual orientation, race (including traits historically associated with race such as hair texture and protective hairstyles involving braids, locks, and twists), color, national origin, ancestry, citizenship, religious creed (including religious dress and grooming practices), age (40 and over), physical or mental disability including HIV and AIDS, medical condition (cancer and genetic characteristics), genetic information, military status, veteran status, marital status, registered domestic partnership status, political activity or affiliation, taking or requesting a statutory leave (including Family and Medical Care Leave), height, weight, or any other characteristics protected under Federal, State, or local laws.

Definitions

1. Harassment may take many forms, but the most common forms include:

    a. Verbal harassment – such as jokes, epithets, slurs, negative stereotyping, and unwelcome remarks about an individual's body, color, physical characteristics, or appearance, questions about a person's sexual practices, or gossiping about sexual relations;

    b. Physical harassment – such as physical interference with normal work, impeding or blocking movement, assault, unwelcome physical contact, leering at a person's body, and threatening, intimidating, or hostile acts that relate to a protected characteristic;

    c. Visual harassment – such as offensive or obscene photographs, calendars, posters, cards, cartoons, e-mails, drawings, and gestures, display of sexually suggestive or lewd objects, unwelcome notes or letters, and any other written or graphic material that denigrates or shows hostility or aversion toward an individual, because of a protected characteristic, that is placed on walls, bulletin boards, or elsewhere on the employer's premises or circulated in the workplace.

2. Sexual harassment – There are two distinct categories of sexual harassment:

    a. Quid Pro Quo – When an individual's submission to or rejection of unwelcome sexual conduct is used as a basis for employment decisions affecting that individual, including granting of employment benefits; and

b. Hostile Environment – When unwelcome sexual conduct unreasonably interferes with an individual's job performance or creates an intimidating, hostile, or offensive working environment, even if it does not lead to tangible or economic job consequences.

Sexual harassment includes harassment of women by men, of men by women, and same-sex harassment. The Fair Employment and Housing Act prohibit co-workers, supervisors, managers, and third parties doing business with or for the Plan from engaging in discriminatory, harassing or retaliatory conduct.

The Plan prohibits any and all conduct that may reasonably be interpreted as harassment as defined above whether or not such conduct is pervasive enough or severe enough to meet the technical legal requirements of harassment.

Reporting and Investigation

If you believe you have been subject to or witnessed harassment or discrimination of any kind or any conduct that violates this policy, you must immediately report the facts of the conduct to your supervisor or the Human Resources Department, or both. If, for any reason, you do not feel comfortable discussing the matter with your supervisor, you should bring the matter to the attention of the Human Resources Department, to your second-tier supervisor, or report the issue anonymously to the Compliance Hotline, at www.convercent.com, or 1(800) 461-9330. The important thing is that you bring the matter to the Plan's attention promptly so that any concern of harassment or discrimination can be investigated and addressed appropriately.

Supervisors must promptly report any complaints of misconduct to the Human Resources Department so that the Plan can try to resolve the claim internally.

When the Plan receives an allegation of misconduct, it will conduct an impartial, timely and thorough investigation by qualified personnel that provides all parties appropriate due process and reaches a reasonable conclusion based on the evidence collected. All information disclosed during the course of the investigation will remain confidential, except as necessary to conduct the investigation and take any remedial action, and in accordance with applicable law. All employees and supervisors have a duty to cooperate in the investigation of alleged harassment or discrimination. In addition, failing to cooperate or deliberately providing false information during an investigation shall be grounds for disciplinary action, including termination of employment. The investigation will be tracked and documented for reasonable progress. At the conclusion of its investigation, if the Plan determines a violation of policy has occurred, it will take timely and effective remedial action commensurate with the severity of the offense. This action may include disciplinary action against the accused party, up to and including termination of employment. Steps will be taken, as reasonable and necessary, to prevent any further violations of policy.

Retaliation

Retaliation for reporting any incidents of harassment or discrimination, or perceived harassment or discrimination, for making any complaints of harassment or discrimination, or participating in any investigation of incidents of harassment or discrimination, or perceived harassment or discrimination, is strictly prohibited.

Any report of retaliation by the one accused of harassment or discrimination, or by co-workers, supervisors, or managers, will also be promptly and thoroughly investigated in accordance with the Plan's investigation procedures outlined above. If a complaint of retaliation is substantiated, appropriate disciplinary action, up to and including termination of employment, will be taken.

Additional Information

In addition to the Plan's internal complaint procedure, employees should also be aware that the Federal Equal Employment Opportunity Commission (EEOC) and the California Department of Fair Employment

and Housing (DFEH) investigate and prosecute complaints of harassment, discrimination, and retaliation in employment.

Information about the EEOC complaint procedure can be found on their website (www.eeoc.gov).
You may also contact the EEOC at:

1-800-669-4000 (English)

1-800-669-6820 (TTY)

Information about the DFEH can be found on their website (www.dfeh.ca.gov).
You may also contact the DFEH at the following numbers if you are calling within California:

1-800-884-1684 (English)

1-800-700-2320 (TTY)

This policy can be modified unilaterally by the Plan at any time without notice. Modification may be necessary to maintain compliance with local, State, and Federal laws and/or accommodate organizational changes within the Plan.

Translated

Oportunidades de empleo igualitarias

El Plan ofrece oportunidades de empleo igualitarias para todos los empleados. Las preguntas relacionadas con las oportunidades de empleo igualitarias pueden remitirse e Recursos Humanos o a cualquier miembro de la gerencia.
Política de oportunidades de empleo igualitarias

El Plan mantiene una política de no discriminación con los empleados y solicitantes de empleo. Ningún aspecto del empleo contemplado por el Plan se verá afectado de ninguna manera por el sexo/género (ni siquiera la identidad de género, la expresión de género, el embarazo, el parto y afecciones médicas relacionadas), la orientación sexual, la raza, el color, la nacionalidad, la ascendencia, la ciudadanía, la religión, la edad (mayores de 40), la discapacidad física o mental, cualquier afección médica (tal como lo define la ley de California), las características genéticas, el estado militar, el estado de veterano, el estado civil, el estado de pareja de hecho registrada, la actividad o afiliación política, el hecho de tomar o solicitar una licencia reglamentaria, la altura, el peso o cualquier otra base protegida por la ley. Las decisiones tampoco se verán afectadas por una percepción que pueda tener en relación con alguna de estas categorías o su asociación con una persona que pertenezca a cualquiera de estas categorías.
Pueden tomarse acciones disciplinarias adecuadas, hasta e incluso la terminación del empleo, contra cualquier empleado que infrinja esta política.
Política sobre la prohibición de la discriminación, el acoso y las represalias

El Plan se compromete a proporcionar un ambiente de trabajo libre de discriminación y acoso. En consonancia con esta política, el Plan prohíbe estrictamente la discriminación y el acoso de cualquier tipo, incluso la discriminación y el acoso sobre la base del sexo/género (incluso la identidad de género, la expresión de género y el embarazo, el parto, la lactancia y enfermedades relacionadas), la orientación sexual, la raza, el color, la nacionalidad, la

ascendencia, la ciudadanía, el credo (incluso la vestimenta religiosa y las prácticas aseo), la edad (mayores de 40), la discapacidad física o mental incluso el VIH y SIDA , la afección médica (cáncer y características genéticas), la información genética, el estado militar, el estado de veterano, el estado civil, el estado de pareja de hecho registrada, la actividad o afiliación política, el hecho de tomar o solicitar una licencia reglamentaria (incluso una licencia familiar y médica), la altura, el peso o cualquier otra característica protegida por las leyes federales, estatales o locales.

Definiciones

1. El acoso puede tomar diferentes formas, pero las más comunes incluyen:

a. Acoso verbal: como chistes, epítetos, insultos, estereotipos negativos y comentarios desagradables sobre el cuerpo, el color, las características físicas o el aspecto de una persona, preguntas acerca de las prácticas sexuales de una persona, o chismes acerca de las relaciones sexuales;

b. Acoso físico: como interferencia física con el trabajo normal, impedir o bloquear el movimiento, ataques, contacto físico desagradable, mirar lascivamente en el cuerpo de una persona y amenazas, intimidación o actos hostiles que se relacionen con una característica protegida;

c. Acoso visual: como fotografías, calendarios, carteles, tarjetas, dibujos animados, correos electrónicos, dibujos y gestos ofensivos u obscenos, exhibición de objetos sexualmente sugerentes o lascivos, notas o cartas desagradables y cualquier otro material escrito o gráfico que denigre o muestre hostilidad o aversión hacia una persona, debido a una característica protegida, que se coloque en las paredes, carteleras o en otros lugares de las instalaciones del empleador o circulen por el lugar de trabajo.

2. Acoso sexual: existen dos categorías diferentes de acoso sexual:

a. Quid Pro Quo: cuando el sometimiento o rechazo por parte de una persona de una conducta sexual desagradable se utiliza como base para tomar decisiones laborales que afectan a esa persona, incluso el otorgamiento de las prestaciones laborales; y

b. Ambiente hostil: cuando una conducta sexual desagradable interfiere de forma irrazonable con el desempeño laboral de una persona o crea un ambiente de trabajo intimidante, hostil u ofensivo, aunque no genere consecuencias laborales tangibles o económicas.

El acoso sexual incluye el acoso de mujeres por parte de hombres, de hombres por parte de mujeres y entre personas del mismo sexo. La Ley de Empleo Justo y Vivienda prohíbe que compañeros de trabajo, supervisores, gerentes y terceros que realicen negocios con o para el Plan adopten conductas discriminatorias, de acoso o de represalia.

El Plan prohíbe cualquier y toda conducta que razonablemente pueda interpretarse como acoso, según la definición anterior, ya sea o no lo suficientemente invasiva o grave como para cumplir con los requisitos técnicos legales del acoso.

Informes e investigación

Si considera que ha sido objeto de acoso o discriminación de cualquier tipo o de cualquier conducta que viole esta política, debe informar inmediatamente los hechos de la conducta a su supervisor o al Departamento de Recursos Humanos, o a ambos. Si, por cualquier motivo, no se siente cómodo hablando sobre el asunto con su supervisor, debe informarle el asunto al

Departamento de Recursos Humanos, al supervisor de segundo nivel, o anónimamente a Compliance Hotline, www.convercent.com, or 1(800) 461-9330. Lo importante es informar el asunto al Plan de forma oportuna para que cualquier preocupación de acoso o discriminación pueda investigarse y abordarse apropiadamente.
Los supervisores deben informar de forma oportuna Cualquier queja de mala conducta al Departamento de Recursos Humanos para que el Plan pueda intentar resolver la queja de forma interna.
Cuando el Plan recibe una acusación de mala conducta, el personal cualificado llevará a cabo una investigación imparcial, oportuna y exhaustiva que les ofrezca todas las partes un debido proceso y llegue a una conclusión razonable basada en la evidencia recopilada. Toda la información revelada durante el curso de la investigación se mantendrá confidencial, excepto según sea necesario para llevar a cabo la investigación y tomar medidas correctivas, y de acuerdo con la ley aplicable. Todos los empleados y supervisores tienen el deber de cooperar en la investigación de los presuntos actos de acoso o discriminación. Además, el hecho de no cooperar o proporcionar deliberadamente información falsa durante una investigación será motivo de acción disciplinaria, incluso la terminación del empleo. Se realizará un seguimiento y se documentará el progreso razonable de la investigación. Una vez que finalice la investigación, si el Plan determina que se ha producido una violación de la política, tomará acciones correctivas oportunas y eficaces, acordes con la gravedad de la ofensa. Esta acción puede incluir una acción disciplinaria contra la parte acusada, hasta e incluso la terminación del empleo. Se tomarán medidas, según sea razonable y necesario, para prevenir cualquier otra violación de la política.

Represalias
Se prohíben estrictamente las represalias por informar de cualquier incidente de acoso o discriminación, o supuesto acoso o discriminación, por realizar cualquier tipo de queja de acoso o discriminación, o por participar en la investigación de incidentes de acoso o discriminación, o supuesto acoso o discriminación.
Cualquier informe de represalias por parte del acusado de acoso o discriminación, o por parte de compañeros de trabajo, supervisores o gerentes, también será investigado de forma oportuna y minuciosa, de acuerdo con los procedimientos de investigación del Plan detallados anteriormente. Si la queja por represalias está fundamentada, se tomarán acciones disciplinarias apropiadas, hasta e incluso la terminación del empleo.

Información adicional
Además del procedimiento de quejas interno del Plan, los empleados también deben saber que la Comisión para la Igualdad de Oportunidades en el Empleo (EEOC) federal y el Departamento de Empleo Justo y Vivienda (DFEH) de California investigan y procesan las quejas de acoso, discriminación y represalias en el empleo.
Puede encontrar información sobre el procedimiento de quejas de la EEOC en su Sitio web (www.eeoc.gov). También puede comunicarse con la EEOC llamando a:
1-800-669-4000 (inglés)
1-800-669-6820 (TTY)

Puede encontrar información sobre el DFEH en su sitio web (www.dfeh.ca.gov). También puede comunicarse con el DFEH llamando a los siguientes números, si se encuentra en California:
1-800-884-1684 (inglés)
1-800-700-2320 (TTY)
El Plan puede modificar unilateralmente esta política en cualquier momento y sin previo aviso. La modificación puede ser necesaria para seguir en cumplimiento de las leyes locales, estatales y federales o para incluir cambios organizativos en el Plan.

平等就业**机会**

本计划为所有从业人员提供平等就业机会。平等就业机会相关问题可直接找人力资源部或任何管理人员。
平等就业**机会政策**

本计划主张**采用**对从业人员和就业申请者的无差别待遇政策。本计划中任何就业方面均不受以下任何方式的影响：**性**别（包括性别认同、性别表达、怀孕、分娩等相关医疗条件）、性取向、种族、肤色、国籍、血统、公民身份、宗教、年龄（40岁及以上）、身体或心理障碍、医疗条件（按照加利福尼亚州法律定义）、遗传特征、兵役状况、退伍军人状况、婚姻状况、登记同居伴侣状况、政治活动或联盟、法定休假或申请法定休假、身高、体重或任何其他法律保护的基本信息。所做决定也不受对您属于**以上任何**类别或对您的组织有人属于**以上任何**类别的看法**影响**。
任何违反此政策的员工，都可能受到**相**应**的**纪律处分，严重者将被解雇。
禁止歧视**、**骚扰**和**报**复的政策**

本计划致力于**提供一个无歧**视**、无**骚扰的工作环境。为执行该政策，本计划严格禁止任何形式的歧视和骚扰，包括以下基本信息的歧视和骚扰：性别（含性别认同、性别表达、怀孕、分娩、哺乳等相关医疗条件）、性取向、种族、肤色、国籍、血统、公民身份、宗教信仰（含宗教穿着和仪容整洁）、年龄（40岁及以上）、身体或心理障碍（包括HIV**和艾滋病**）**、医**疗条件（癌症和遗传特征）、遗传信息、兵役状况、退伍军人状况、婚姻状况、登记同居伴侣状况、政治活动或联盟、法定休假或申请法定休假（含探亲假和医疗护理假）、身高、体重或任何联邦、州或当地法律保护的基本信**息**。
定义
1. 骚扰方式有多种，但最常见的方式包括：
a. **言**语骚扰**—如**对个人身体、肤色、身体特征或外貌的玩笑、绰号、侮辱,**消极刻板印象和不受**欢迎的言论、对个人性习惯的质疑、或对性关系散播谣言；
b. **身体**骚扰**—如正常工作中的身体干**扰、妨碍或阻碍**行**为**、攻**击、不受欢迎的身体接触、色眯眯地斜眼看别人身体，和对受相关法律保护的特征进行威胁、胁迫或敌对行为；
c. 视觉骚扰**—根据受保**护的特点，是指在墙壁、公告板,**或在雇主**经营**的其他地方**张贴或在工作场所传播的东西，如攻击性或淫秽照片、日历、海报、卡片**、漫画、**电子邮件、图纸和手势、展示性暗示或淫秽物体、不受欢迎的纸条或信件**以及任何其他**诋毁或对个人表示敌意或厌恶的书面或图片**材料**。
2. **性**骚扰**—有两种不同的性**骚扰：
a. **交**换补偿**—利用个人屈服或拒**绝不受欢迎的性行为作为影响个人就业决定的基础时，包括授予就业福利；

b. 敌对环境—**当不受**欢迎的性行为虽然未造成有形的或经济上的工作后果，但不合理地影响个人工作表现或造成胁迫、敌对或攻击性工作环境。

性骚扰包括男性骚扰女性、女性骚扰男性以及同性骚扰。《公平就业和住房法案》禁止与本计划业务相关的同事、主管、经理和第三方涉及歧视、骚扰或报复行为。

本计划禁止任何部分或全部根据上述定义可能解释为骚扰的行为，不论该行为是否具有足够说服力或足以严重到**符合**骚扰的技术法律要求。

报告和调查

如您认为您已受到任何形式的骚扰或歧视或任何违反该政策的行为，您必须立刻向您的主管或人力资源部或同时向他们报告该行为事实。如果因任何原因，您感觉与您的主管讨论此事不舒服的话，您**可以将此事反映**给人力资源部或引起人力资源部的注意，或向您的二级领导报告。重要的是您要立刻让此事引起注意，以便任何所涉及的骚扰或歧视可以进行适当地调查和处理。

主管必须立即向人力资源部报告任何**不当行**为的投诉，以便本计划能够内部解决该投诉。

当本计划收到任何**不当行**为的指控时，本计划将组织**有**资质的**人**员进行公平、及时和全面的调查，并给各方提供**合适的**调查**程序，且在所收集**证据**的基**础上**达成合理**结论。除**根据适用法律，在需**进行调查和采取补救措施等必要情况下，调查期间获得**的所有信息将**进行保密。在质控骚扰或歧视调查期间，所有员工和主**管有**责任给予配合。此外，在调查期间，不予配合或故意提供虚假信息**的行**为应当给予纪律处分，包括**解雇。**该调查将**在合理**进展**中被追**查和记录。在调查结论中，如本计划确定发生了违反政策行为，本计划将采取及时有效的**、与**该冒犯行为严重程度相应的补救措施。该行为可能包括对被指控方的纪律处分，最严重者将被**解雇。在合理且必要情况下，将采取措施**预防更多违反本政策的行为发生。

报复

严厉禁止对报告任何骚扰或歧视（或视为骚扰或歧视）事件、对投诉骚扰或歧视、或参与任何骚扰或歧视（或视为骚扰或歧视）调查的报复行为。

被指控骚扰或歧视者**、其同事、主管或**经理报告的报复行为也将立即根据上述所列的本计划调查程序进行全面调查。如果对报复行为的投诉得以证实，将采取**相**应**的**纪律处分，严重者将被**解雇**。

附加信息

除本计划的内部投诉程序，员工还应该了解联邦平等就业机会委员会（EEOC）**以及加利福尼**亚州公平就业和住房部（DFEH）**依法**查处对就业中骚扰、歧视和报复行为的投诉。

有关EEOC**投**诉程序的信息可在其网站上查找 (www.eeoc.gov)。**您可以通**过以下方式联系EEOC：

1-800-669-4000 (**英**语)

1-800-669-6820 (传真)

有关DFEH**投**诉程序的信息可在其网站上查找 (www.dfeh.ca.gov)。**如您在加利福尼**亚州内，也可以通过以下电话联系DFEH：

1-800-884-1684 (**英**语)

1-800-700-2320 (传真)

本计划无需通知即可随时单方面地修改本政策。对该政策的修改必须符合当地、州和联邦法律规定和**/或适**应本计划的组织改动。

Religious Accommodation Policy

The Plan provides equal employment opportunity to all employees and applicants without regard to their membership in any religious group. Discrimination against employees or applicants because of religion is prohibited.

The Plan will reasonably accommodate employees' religious beliefs, observances, and practices as long as they do not impose undue hardship on the conduct of the business or infringe upon the rights of any other individual. In order to request an accommodation, employees should put the request in writing to their supervisor, specifying the nature of the religious belief, observance, or practice that needs to be accommodated. Accommodations are determined on a case-by-case basis. The Plan prohibits retaliation against any employee who requests accommodation for a sincerely held religious belief.

Employment Practices

Categories of Employment

The Plan maintains standard categories of employment status for purposes of personnel administration and related payroll transactions. Categorization of employment is for administrative and payroll purposes only and does not impact the at-will status of employment. Categories of employment are as follows:

1. **Regular Full-time Employee**. Employees who are regularly scheduled to work ~~40~~ 30 or more hours per week.
2. **Regular Part-time Employee**. Employees who are regularly scheduled to work at least 20 hours but less than 30 hours per week.
3. **Limited Term Employee**. Employees who are hired for a ~~specific~~ defined period of time and work 40 or more hours per week and receive the same benefits as regular employees.

Note: Independent Contractors and individuals placed on short term assignments through a staffing agency *are NOT considered to be employees and are NOT eligible for Plan benefits, holiday pay, etc., except to the extent required by law.*

Employment of Relatives

The Plan desires to avoid situations in which actual or potential conflicts of interest may be caused by relatives working in the same environment. Relatives of present employees may be hired by the Plan only if they do not directly or indirectly supervise another family member or are not supervised by another family member. Additionally, relatives of current employees may not report to the same supervisor.

For the purposes of this policy, relatives include an employee's parent, child, spouse, registered domestic partner, brother, sister, in-laws, or immediate step relations. This policy is also extended to individuals sharing the same household.

If employees become related after employment and a conflict of interest or management problems of supervision, safety, security or morale result, reasonable time may be provided to resolve the matter. If resolution is not possible, the Plan may require one or both of those employees to transfer positions or resign, at the Plan's exclusive discretion.

The Plan reserves the right to determine that other relationships not specifically listed within this policy may represent actual or potential conflicts of interest as well.

Employment of Minors

As a general rule, employees of the Plan must be 18 years of age or older. However, minors may occasionally be hired during school breaks, at peak work periods, or on an internship basis. Minors must have a valid work permit, a certificate of high school proficiency, or be a high school graduate. There are also limitations as to the number of hours minors who have not graduated may work.

Re-Employment

Former employees who are eligible for rehire and who seek to return to employment with the Plan may apply for positions and be considered along with other applicants. It will be noted that the applicant is a former employee. Former employees who are rehired within one year (365 calendar days) after separation will have their service bridged. This means that the employee will retain the original date of hire and will continue to accrue benefits (PTO accruals) at the same rate as before separation. Employees rehired after a break of service of more than 365 consecutive calendar days will be treated as a new employee for the purpose of benefits and other employment related issues, except as may be otherwise required by law.

New Employee Orientation

New employees will be promptly scheduled for an orientation. Human Resources will ensure that all tax forms, insurance forms, and any other required forms are completed on the first day of employment. The new employee must furnish proof of eligibility to work in the U.S. and complete the I-9 form within three (3) business days from date of hire. If at any time an employee cannot verify their right to work in the United States, the Plan is obligated to terminate their employment.

After reading this employee handbook, all employees will be asked to sign the acknowledgment of receipt page and return it to the Human Resources Department. The new employee should also complete personnel, payroll and benefit forms at this time.

Employees are encouraged to learn as much as they can about the work of the Plan, and how each job contributes to the Plan's mission and objectives. Supervisors will be a good source of information about the Plan and your job.

Ergonomic Evaluation Policy

The Plan works to ~~ensure that~~support the comfort and well-being of our employees. The Ergonomic Evaluation Program helps to ~~are~~ mitigate~~d by~~ and identify~~ing and correcting~~ any ergonomic risk factors in the workplace. The Ergonomic Program is developed to improve the health of its employees by minimizing ergonomic stressors. Methods to effectively prevent work-related musculoskeletal disorders include proper work practices, administrative controls, engineering and equipment.

Transfers and Promotions / Internal Applicant Guidelines

Because the Plan believes that career advancement is rewarding for both the employee and the organization, available positions will be posted internally.

The Plan is committed to assisting employees to reach their professional goals through internal promotion and transfer opportunities. One of the tools the organization makes available to employees in

managing their career is our internal job posting system, which enables current employees to apply for any available position either before or at the same time the position is advertised outside of the Plan.

Internal job opportunities are regularly posted on SharePoint under Jobs@SFHP.

Eligibility and Participation

- Transfer/promotion eligibility requirements:
  - Must be a current, regular full- or part-time Plan employee.
  - Must be in current position for at least six (6) months. (Exceptions to this six-month requirement can be made, consistent with Plan business needs.)
  - Performance meets established work standards for current position.
  - No participation in employee counseling or been on a performance improvement plan ("PIP") or a formal written warning within the past six (6) months.
  - Must meet the qualifications for the position.
- It is highly recommended for Internal Applicants to consult with the Talent Acquisition Team before deciding to apply to an open position.
- Once the decision is made to formally apply, Internal Applicants must notify their manager via email and copy the Talent Acquisition team.
- ~~-~~Applicants must apply via the Jobs@SFHP link on the ~~Sharepoint~~SharePoint home page.
- Once reviewed by the Talent Acquisition Team, if an applicant meets the minimum qualifications for a position, there will be a meeting scheduled to discuss your background and qualifications.
- Although the Plan is committed to making opportunities available to existing employees, the Plan reserves the right to hire any candidate, internal or external, that best fits Plan business needs.

If selected for the position, the hiring and releasing managers must discuss and agree upon a transfer plan. Once agreement has been reached, employees will be notified by the hiring manager.

Outside Employment

Employment with the Plan is a full-time responsibility requiring full-time commitment. Part-time employees, may engage in outside employment. Whether employees work for the Plan on a full- or part-time basis, all employees must disclose outside employment to their supervisor to allow the Plan to assess whether outside employment presents a conflict of interest. Final determination as to conflict of interest will be made by the CEO. Except as otherwise protected by applicable law, outside employment or other outside activities must not conflict with an employee's work schedule, duties, responsibilities, and performance.

Termination of Employment

San Francisco Health Plan is an at-will employer. This means that employees may terminate employment at any time, with or without notice, for any reason, and similarly, the Plan may terminate employment at any time, with or without notice and with or without cause for any reason. No one other than the Governing Board and/or the CEO of the Plan has the authority to alter this arrangement, to enter into an agreement for employment for a specified period of time, or to make any agreement contrary to this policy. Furthermore, any such agreement must be in writing and must be signed by the Chair of the Governing Board and/or the CEO.

Your employment with the Plan may be terminated through one of the following actions:

- Voluntary resignation;
- Retirement;
- Reduction in force;
- Involuntary termination, with or without cause, with or without notice;
- Failure to return to work as scheduled after an absence (which will be considered abandonment of position);
- Failure to report for work without notice for three consecutive work days (which will also be considered abandonment of position);
- Prolonged disability resulting in an inability to safely and satisfactorily perform all of the essential functions of the job with or without reasonable accommodation; or
- Death.

Employees who wish to resign from the Plan, are requested to give at least two (2) weeks' written notice, if possible. Additionally, employees must be present on the last day of employment. ~~Taking PTO during the notice period is highly discouraged.~~ Taking PTO during the two (2) week notice period is highly discouraged, and requests for PTO during that period may be denied. Upon exit from the Plan, employees are responsible for ensuring the return of all Plan documents, equipment, keys, and other Plan property. Employees must also turn in all identification badges and all passwords used to access work computer or communications systems.

Employees will also be asked to participate in an exit interview with Human Resources. During this interview, employees may be asked about their views regarding work with the Plan, including duties, training, supervision, and benefits. Employees may be asked to sign an exit form that states that they have received their final paycheck and that they have returned all Plan property. If any money is owed to the Plan, employees will be asked to make arrangements for repayment at this time.

Human Resources will provide you with information regarding any conversion or continuation rights to insured benefits. When employees leave the Plan, all enrolled dependents may have the right to continue group medical benefits temporarily under COBRA.

Former employees should notify the Plan if their address changes during the calendar year in which termination occurs so that their tax information will be sent to the proper address.

On-Going Confidentiality Obligations

Information concerning the Plan's members and providers, including their personal and contact information, is confidential information and may be protected from disclosure by ~~HIPPA~~HIPAA. Separated employees continue to be subject to on-going confidentiality and proprietary information obligations, particularly in regards to HIPAA-related information. Separated employees are prohibited from using or disclosing confidential information obtained in connection with their employment with the Plan, including using the Plan's confidential information to contact its members and providers.

Employees References for Former Employees

The Plan will provide only dates of employment and job title to any inquiring prospective employer. Additionally, pay rate at time of separation may be provided if the separated employee provides written authorization directing the release of such information to Human Resources. Absent such written

authorization, the Plan will not provide an Employee's prior salary information to anyone, including prospective employers.

All inquiries regarding former employees should be referred to Human Resources.

Employee Referral Bonus Program

The purpose of the Employee Referral Bonus Program is to provide an incentive award to current regular full or regular part time employees bringing new talent to the Plan by referring applicants who are subsequently selected and successfully employed in an eligible position.

Eligibility and Participation

Applicant: Applicants must be persons who are not currently or were not formerly employed by the Plan in any capacity.

Referring Employee: All regular employees are eligible to receive a referral bonus with the exception of the following:

- Executives
- Hiring manager/supervisor or other persons associated with the sourcing, recruiting and/or selection of the candidate
- Human Resources Department employees (Facilities and Marketing Employees are eligible)
- Contractors/Consultants

Positions Eligible: Positions eligible for this program will be determined by Human Resources. Bonus amounts will be determined by position and are as follows, less applicable withholdings:

- Director level positions $3,000
- Manager level, IT technical or RN positions $2,000
- All Other Positions $1,000

Referral Bonus Payment

Payment will be made as follows:

- 50% once the referred candidate has been employed for 45 days.
- 50% once the referred candidate has been employed for 90 days.

Referral bonuses may be apportioned between multiple employees at management's discretion where it is determined there is more than one simultaneous candidate referral source.

In order for the Referral Bonus to be earned, the referred employee must be actively employed by the Plan at the time of payment and the name of the referring employee must be indicated on the candidate's application or resume at the time of the initial interview. Human Resources must be aware of the referral prior to the interview. The Plan reserves the right to amend the award amounts based on market conditions.

Compensation

Position Evaluation

Each position at the Plan is classified and evaluated in accordance with the knowledge, skills, required experience, complexity, responsibility, and authority associated with its assigned duties. The compensation range for each position is based on a number of factors, including the position's evaluation and competitive marketplace realities. Employees can direct any questions they may have about their position's evaluation, classification or compensation range to their supervisor or to Human Resources.

Employee Classifications

The Plan maintains standard employment classifications for payroll and related transactions:

- **Exempt:** An employee whose position meets specific exemption tests established by the California Industrial Welfare Commission ("IWC") and/or the federal Fair Labor Standards Act ("FLSA") is exempt from overtime pay requirements. An employee whose position meets specific exemption tests established by the California Industrial Welfare Commission ("IWC") and/or the federal Fair Labor Standards Act ("FLSA") is exempt from overtime pay requirements.
- **Non-Exempt:** An employee whose position does not meet the specific exemption tests of the FLSA or IWC is entitled to the applicable overtime pay rate. An employee whose position does not meet the specific exemption tests of the FLSA or IWC is entitled to the applicable overtime pay rate.

You will be informed of your initial exempt or non-exempt classification at the start of your employment. Your subsequent position or duties may result in a change of your employment classification and whether you are entitled to overtime pay. You will be informed of your initial exempt or non-exempt classification at the start of your employment. Your subsequent position or duties may result in a change of your employment classification and whether you are entitled to overtime pay.

Performance Reviews

Supervisors will formally review job performance with their employees approximately once a year, whenever the Plan is contemplating a pay raise, when an employee is transferring to another manager and/or department and any other time that the Plan determines that such a review is appropriate. The purposes of these evaluations are:

1. To evaluate the strengths and opportunities of employee work
2. To communicate both areas to the employee
3. To provide employees with the opportunity to discuss work and career goals
4. To set future performance goals

Supervisors may prepare a written assessment of employee job performance, which may be reviewed by the next-higher level of management. After that, employees will meet with their supervisor to discuss the evaluation. Employees and their supervisor are encouraged to ask clarifying questions and to talk candidly about expectations and achievements. Employees will be allowed to enter their own comments into the evaluation form and to digitally sign it to show that they have read and discussed it. Employees

may request a copy of the completed form for their own records. If an employee transfers to another department within the Plan, the supervisor or manager and employee will complete a performance review and give it to the receiving manager on or before the transfer date. During the annual review period, the reviews will be scored and weighted based on time spent in each role and one final score will be calculated. If the employee transfers before 90 days in their current review period, completing a transitional review is optional.

A good performance evaluation does not guarantee a pay raise, nor is it a promise of continued employment. Nothing in this policy alters anyone's at-will employment status.

Pay Changes

Several factors impact the granting of pay increases: the availability of funding, employee performance, increased responsibilities, position in one's salary range, competitive pressures, etc. Receipt of a pay increase should not be considered a promise of job security nor should employees expect that increases are automatic. Pay decreases may also occur in certain situations.

Bonus Program Eligibility

Regular full-time and regular part-time employees may be eligible to receive an annual bonus which is based on organizational and individual goals and objectives. Bonus program payout will vary from year to year depending on the financial health of SFHP and is subject to Financial Committee and Governing Board approval. Interns, Residents and Contract employees are ineligible for the bonus program.

All employees must complete the mandatory training requirements to be eligible for an employee bonus. The Plan is committed to the education of our employees and the guidance provided in the training, which is in the best interest of our organization and services to our members.

The training programs are either mandated by the Plan, State law or regulatory agencies. Mandatory training requirements may change annually and requirements will be announced at the beginning of each fiscal year. New hires are required to take the training within 30 days of their first day of work. Employees will be notified when each training program is available, and the respective completion date. Participation for each program will be tracked. Employees who do not complete the mandatory training requirements will not be bonus eligible and may be subject to disciplinary action, up to and including termination.

Employees who are on a leave of absence will not receive their bonus while on leave. Upon return from the leave of absence, employees have 30 days to complete their performance review and any mandatory training requirements to be eligible for their bonus.

Employees that are rehired within 90 days of their separation date may receive a prorated bonus.

Your Paycheck

Normal Pay Day

Pay periods are bi-weekly. Employees will be paid every other Friday. When a payday falls on a holiday, employees will normally be paid on the last working day before the holiday. If there appears to be an error in the paycheck, employees must report it immediately to Payroll/Finance.

Payroll Deductions

Federal and State laws require that the Plan withhold taxes from employees' wages. The mandatory deductions are:

- Federal income tax
- California income tax
- Employee contribution to CalPERS retirement
- Medicare
- California State Disability Insurance (SDI)
- California Paid Family Leave contribution
- State and Federal income tax liens
- Court-ordered garnishments

Payroll and tax withholding and exemption certificates (Form W-4) are required to be on file before payment of wages can be made. An employee who wants to change the number of exemptions or marital status for Federal and/or State income tax withholding tax purposes should contact Payroll/Finance.

Direct Deposit Option

Employees have the option of receiving a payroll check or receiving their pay through the direct deposit program. Employees opting for direct deposit will receive an earnings statement. All employees will receive a written statement of their gross pay, deductions, and resulting net pay, as well as year-to-date totals.

Employees may begin and stop automatic payroll deposit at any time. To begin automatic payroll deposit, employees must complete the Employee Direct Deposit Enrollment Form (available from ADP Workforce Now, Human Resources or Payroll) and return it within ten (10) days prior to the pay period that the service is to begin.

To stop automatic payroll, you should complete the Employee Direct Deposit Enrollment Form and return it to Payroll at least ten (10) days prior to the pay period that the service is to end. Employees will receive a regular paycheck on the first pay period after receipt of the form, provided it is received within the required ten (10) days prior to the end of the pay period.

Advances

The Plan does not permit advances against paychecks or against paid time off (PTO).

Your Work Week

The Work Week Defined

For payroll purposes, the Plan has defined the work week as running from Monday through Sunday.

Working Hours

Because of the nature of the Plan's business, employee work schedules may vary depending on the job they perform. The Plan's normal business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday. However, certain parts of the Plan's operations require 24/7 coverage and may require employees to work alternate shifts depending on the business needs. Supervisor will assign employee individual work schedules, which may deviate from the Plan's normal business hours. Employees should check with their supervisor if they have questions on hours of work.

Breaks and Meal Periods

Non-exempt employees who are scheduled to work more than 5 hours in a day are entitled to and required to take an unpaid, off-duty meal period of at least 30 minutes to begin no later than the start of the fifth hour of work. A second ~~30 minute~~30-minute meal period is required after an employee works ten hours or more. The failure to take off-duty meal periods is a violation of Plan policy unless the employee submits a written request to waive a meal period and receives prior written authorization from their supervisor. Employee~~s~~ are prohibited from performing any work during any meal period that is provided under this policy. You are expected to clock in and clock out for all meal periods, and to precisely account for all time spent on the meal period.

Non-exempt employees are also required ~~-~~to take a 10-minute rest period for every four hours of work or major portion thereof. These breaks are paid. Employees are entitled to these breaks as a matter of law and cannot be required to work through these breaks. If at any time you feel you are being coerced into working through your breaks, you should immediately bring a complaint to Human Resources.

Exempt employees, while not entitled under California law to take a meal period of at least 30 minutes per day, should take meal and rest breaks as their work and schedules permit. Everyone should make every effort to stay safe and effective while at ~~work, and~~work and taking necessary breaks and time for meals is a must for all employees regardless of their exempt status.

Overtime

There may be times when employees will be required to work overtime so that the Plan may successfully meet the needs of our Members and Providers. However, only non-exempt employees qualify for overtime pay. Non-exempt employees will be paid a rate of one and one-half their regular hourly rate for hours worked in excess of eight (8) hours per day or 40 hours per workweek, or for the first eight hours worked on the 7th consecutive day worked in a workweek. Double time is paid to non-exempt employees for hours worked in excess of 12 hours in a day or after 8 hours on the 7th consecutive workday in a workweek.

All overtime must have prior written authorization by a supervisor and a supervisor should be present during overtime work. In the case of overtime remote work or telecommuting, a supervisor should be available via remote means during overtime work. ~~All overtime must have prior written authorization by a supervisor and a supervisor should be present during overtime work.~~ However, regardless of whether the

overtime is preapproved or whether the supervisor is present, non-exempt employees should account for all time worked in order to get paid. An employee who continues to perform overtime without preapproval may be subject to discipline. The Plan strictly prohibits any non-exempt employee from working off the clock, or performing work without compensation. This includes work performed before or after any regular scheduled shift, or during any off-duty meal or rest periods. For purposes of determining which hours constitute overtime, only actual hours worked in a given workday or work week will be counted. Time off with pay for any reason will not be deemed hours worked for purposes of overtime calculation or credited for purposes of overtime calculation.

Attendance and Punctuality

Attendance and punctuality are important factors for our employees' success within the Plan. We work as a team, and this requires that each person be in the right place at the right time.

Employees are expected to report to work as scheduled, on time and prepared to start work. Employees are also expected to remain at work for the entire work schedule, except for rest breaks, meal periods and when required to leave for authorized Plan business. Any change in employees' work schedules must have a supervisor's prior approval.

Employees who are going to be late for work or absent, must notify their supervisor before the start of the workday. Employees must inform their supervisor of the expected duration of any absence. Absent extenuating circumstances, employees must call in on any day they are scheduled to work and will not report to work. Regular attendance is an essential function of every position with the Plan.

Excessive employee absence or lateness are undesirable performance factors and can result in disciplinary action up to and including termination. If an employee is absent for **three (3) days** without notifying the Plan, the employee is considered to have voluntarily abandoned their ~~position, and~~position and will be terminated. The employee ~~will~~ may be considered for reinstatement if exceptional circumstances explain why the employee could not have called in.

Makeup Time Request

The Plan will allow non-exempt employees to make up time for work missed or alter their work schedule due to their personal obligations in certain circumstances. Employees must fill out a "Makeup Time Policy and Request Form", and have it approved by their supervisor, department Director, Payroll and Human Resources for each occasion that they desire to make up time. Employees can request make-up time up to four (4) weeks in advance; requests for recurring obligations must be made at least every four (4) weeks.

Employees must make up the time within the same work week during which time was lost. However, an employee who makes up missed time in the same work week will not be paid overtime for the additional hours of work on a given day unless they exceed eleven (11) on that day or total more than forty (40) in that week. Nothing in this policy should be construed as encouraging or otherwise soliciting employees to take personal time off and make up the work hours within the same work week.

Electronic Time-Keeping

Electronic timesheets (e-timesheets) are used as a means of accurately recording hours worked and calculating pay. All **non-exempt** employees are required to complete their e-timesheets on-line, recording their start and end times, meal breaks and any times that the employee leaves the workplace for personal reasons (except during a rest break) down to the minute. Rest breaks need not be

designated on this e-timesheet as rest breaks are paid time. If an employee is unable to take a rest break due to work or because a manager or supervisor asked them to skip it, the employee must report this to Human Resources immediately.

Exempt employees are also required to submit weekly e-timesheets indicating days worked. Exempt employees may be required to record start and end times or breaks. All employees whether exempt or non-exempt must indicate on their e-timesheets any exceptions to the regular work period (e.g. holiday, PTO, etc.). The list of exceptions and codes appears on the e-timesheet.

E-timesheets are available through your computer ~~desktop, and~~desktop and are accessible any time. They can also be accessed from a home computer (with internet access). It is important for you to keep an accurate record of your work hours and submit your e-~~timecard~~ timesheet when they are due. These e-timesheets are legal documents. They must reflect actual time worked and must not be tampered with or falsified in anyway. Reporting inaccurate time worked (including not reporting all time worked) is a serious violation of Plan policy that will be subject to discipline, including up to termination. Corrections to e-~~Timesheets~~ timesheets must be submitted to, and approved by, your supervisor. Altering the e-timesheet of a fellow employee or falsifying your own e-timesheet (overstating or understating your actual time worked) is dishonest and may lead to immediate ~~discharge~~termination.

E-timesheets must be submitted electronically to payroll by the Friday prior to payday. Non-exempt employees who work the second weekend of the pay period should electronically resubmit a copy of their e-timesheet to payroll by ~~9~~10:00 a.m. of the Monday before payday. Any pay adjustments required, whether because an e-timesheet was turned in late or for any other reason will be made on the following paycheck.

Telecommuting

Purpose

The purpose of this policy is to outline the Plan's rules and expectations for employees who are mandated or have been authorized by the Plan to work from a Remote Work Location/Home, including as the result of the COVID-19 pandemic or Plan office closure. Please contact Human Resources for more information about the Plan's current policies and procedures related to the COVID-19 pandemic.

It is your responsibility to provide Human Resources with accurate and up to date information about your primary work~~ing~~ location during periods of telework. Part-time, temporary or full time telecommuting from a location outside of California is based on business needs, and requires the approval of the department executive, Human Resources and the CEO. Working outside of the United States is strictly prohibited.

Terms of Telecommuting Arrangement

Other than those additional duties and obligations expressly imposed on the employee under this policy, the duties, obligations, responsibilities and conditions of ~~employee's~~ employment with the Plan shall remain unchanged while teleworking from a Remote Work Location/Home. In addition, the employee's salary and benefits shall remain unchanged.

The Plan reserves the right to require employees to return to the Plan's offices.

The teleworker's conditions of employment, such as employee salary, benefits and employer-sponsored insurance coverage, will remain the same as for non-telework employees. Medical plan choices may be limited for employees who reside outside of the San Francisco Bay Area.

The Plan's policies, rules and practices apply at the teleworker's Remote Work Location / Home, including those governing internal and external communications, employee rights and responsibilities, mandated breaks and meal periods, facilities and equipment management, financial management, information resource management, purchasing of property and services, and safety. Failure to follow policy, rules and procedures may result in disciplinary action.

Work Schedule and Accessibility

The teleworker's schedule must be approved by their supervisor and the department executive.

The supervisor will take into consideration the overall impact of the teleworker's total time outside of the Plan's offices. Considerations include, but are not limited to, flex time, meetings, consultations, presentations and conferences. The Plan shall also give consideration to the overall effect of the teleworker's and co-workers' schedules in maintaining adequate communication. The number of hours worked by the teleworker will not change because of telework.

A non-exempt (hourly) teleworker must receive their supervisor's written approval in advance before working overtime, consistent with current Human Resources policy. Failure to do so will be grounds for disciplinary action and/or termination of the telework arrangement unless reasonable cause can be shown why it was not possible to obtain prior approval. In addition, non-exempt employees who are approved to telework must adhere to all other policies, including recording all hours worked, and taking the meal and rest periods that the Plan provides.

Telework must not adversely affect service delivery, employee productivity, or the progress of an individual or team assignment.

The teleworker will attend job-related meetings, training sessions, and conferences, as requested by the supervisor. In addition, management may request the teleworker to attend meetings or to come into the offices for other Plan business-related purposes. The teleworker's supervisor will use telephone conference calling whenever possible as an alternative to requesting attendance at short notice meetings.

During telework hours, the teleworker must be available via telephone, video chat and/or e-mail during agreed-upon work hours or specific core hours of accessibility. Non-exempt employees who telework are not required to respond to communications during any off-duty meal period, or rest break, and should instead, respond when their break finishes. The supervisor and teleworker will agree on how to handle telephone messages, including the feasibility of call forwarding and frequency of checking telephone messages.

If there is an emergency at the Remote Work Location / Home such as a power outage, the teleworker will notify their supervisor as soon as possible.

Dependent Care

A teleworker will not act as a primary caregiver for dependent(s) during the agreed upon telework hours. This does not mean dependents must be absent from the home during telework hours. A teleworker must

make dependent care arrangements to permit concentration on work assignments to the same extent as if they were performing work at the Plan's offices.

Liability

The teleworker is responsible for ensuring the safety of their Remote Work Location / Home or alternative work environment. The teleworker will agree to a safety inspection and photographic documentation of the teleworker site to comply with workers' compensation liabilities at the Plan's discretion.

All ergonomic issues must be reported to HR/Facilities. It is the responsibility of the teleworker to notify HR/Facilities early of any potential ergonomic issues in the home office workspace in the Remote Work Location-/-Home. Because liability may arise from hazards in the Remote Work Location-/-Home that might cause serious harm or injury, the Plan reserves the right to periodically inspect the teleworker's Remote Work Location-/-Home workspace. The Plan will precede any such inspection by advanced notice and will schedule an appointment.

The Plan is not liable for any incident or accident that occurs outside of normal ~~job-related~~job-related activities or hours. In the event of a job-related incident or accident during telework hours, the teleworker must immediately report the incident to their supervisor and Human Resources. The teleworker, supervisor, and the Plan must follow the policies regarding the reporting of injuries for employees injured while at work.

The Plan is not responsible for any injuries to family members, visitors, and others in the teleworker's Remote Work Location-/-Home workspace.

The Plan is not responsible for any loss or damage to:

1. The teleworker's property;
2. Personal property owned by the teleworker or any of the teleworker's family members; or
3. Property of others in custody of the teleworker.

The teleworker is responsible for contacting the teleworker's insurance agent and a tax consultant and consulting local ordinances for information regarding Remote Work Location / Home workplaces.

Compliance: Handling Protected Health Information (PHI) from a Remote Work Location / Home
The same precautions governing the use and disclosure of PHI at the Plan's offices (See *IS-29, Permitted and Appropriate Use of Electronic Assets* and *IS-36, HIPAA and Working Remotely*) shall apply to the Remote Work Location / Home.

- The teleworker shall protect all documents that contain Member PHI, both in electronic and hard copy form, from unauthorized use and disclosure.
- The teleworker shall not print at home, unless approved by the Security and Privacy Officers.
- The teleworker shall not leave systems or documents containing PHI- unlocked or unattended in areas accessible by persons unauthorized to use and disclose PHI.
- When the teleworker leaves the Remote Work Location / Home or workspace, all PHI shall be stowed in a locked drawer designated for such storage.

- PHI and equipment shall not be stored in automobiles.

- Upon their disposal, the teleworker shall shred any document -containing PHI.

- The teleworker shall immediately report any breaches of security or compromised PHI to the supervisor and the Plan's Compliance Officer, in accordance with SFHP policy, *C&RA-~~08~~06, PHI Breach Investigation and Reporting*, and contractual requirements, applicable Federal and State statutes and regulations, and Plan policies.

PC/Laptop from Remote Work Location / Home

The Plan may provide the teleworker with access to personal computers (PC) or company issued laptop and grant access to the Plan's network. The teleworker shall adhere to the following information security procedures:

- Maintain the confidentiality of their user sign-on identification code and password;

- Keep the PC/ laptop secure at all times, and locked when not in use;

- Log off the network when the PC/laptop will be left inactive or unattended; and

- Ensure that passwords or operating instructions are not stored with the computer.

The teleworker shall report any security breaches to the Plan Compliance Officer including or Security Officer including, but not limited to:

- Loss of a PC/laptop, mobile phone, or other mobile device;

- Software irregularities indicating possible virus infection; or

- Access by unauthorized persons.

Use of electronic mail with PHI

- Internal e-mail is defined as e-mail sent within the Plan's system that may contain PHI that is limited to the use and disclosure of the minimum necessary data to complete the required message.

- External e-mail is defined as e-mail that is sent external to the Plan via the open internet shall not contain PHI unless the e-mail is encrypted using the 'send secure' function.

Telework Site/Remote Work Location / Home

- The teleworker will maintain a designated workspace inside the teleworker's residence that is clean, safe, and free from distractions to the extent possible. Ideally, this workspace should be a separate room that is designated as a home office. However, it is acceptable for a teleworker to have a designated workspace that consists of a desk that has at least four (4) linear feet of work space, four (4) feet of clearance for a desk chair, internet access, adequate access to power outlets, and is reasonably free of distractions.

- The teleworker will not hold in-person business meetings with providers, members, or professional colleagues at the Remote Work Location / Home. (Teleconferences and video conferences are permitted.)

Teleworkers are advised to consult with an insurance agent and/or tax consultant for information regarding their home office site. Individual tax implications, auto and homeowner's insurance, and incidental residential utility costs are the responsibility of the teleworker.

Teleworker Performance Management

All Plan employees are subject to individual goals and metrics; additional metrics may be set for the teleworker. Depending on the job responsibilities and manager discretion, a work diary may be used to manage performance. A work diary is a document that the teleworker completes and tracks what is being accomplished during the course of the week. A work diary can be especially useful for positions where traditional work metrics are not relevant or practical.

Establishing a Remote Work Location / Home (Home Office)

- The Plan will provide a teleworker with PC/Laptop and necessary software applications. SFHP may issue a stipend for new hires to be used for the purchase of office equipment and supplies.

- The teleworker will provide the following:
  1. Home office location (as described in this policy)
  2. A work desk that provides adequate space for a laptop/PC, , and other work necessities
  3. Secured wired/wireless internet access with a transfer speed of at least 1.5 MB per second.

- Teleworkers that need additional office supplies, equipment or services to perform their work from a Remote Work Location / Home should speak with Plan management. The Plan's management must authorize any additional costs related to telework prior to an employee incurring the expense.

- The Plan may send employees and/or agents of the organization to help with the information technology or equipment set-up in the Remote Work Location / Home.

- The teleworker may be required, at the Plan's discretion, to provide visual documentation of the workspace, in the form of a photograph, and shall submit it to Human Resources.

- The Plan's ITS Department will maintain a central inventory of equipment and software located in Remote Work Location / Homes of teleworkers. The Plan shall document all equipment that is provided for use at the telework site .

Security of Plan Assets

- Teleworkers must take reasonable precautions to secure and prevent damage to the Plan's equipment.

- Teleworkers must immediately report any device used for SFHP-related work that is lost or stolen to the Compliance Officer or Security Officer

- The Plan's equipment must only be used by the teleworker and may not be used by other family members for personal use. If property of the Plan is stolen or damaged in the teleworker's home, the Plan will repair or replace the property at the Plan's expense, provided there is no contributory negligence on the part of the teleworker.

- Upon termination of employment or the telework arrangement, voluntary or otherwise, the employee shall return all property of the Plan.

- The Plan may pursue recovery, from the teleworker, for organization property that is not returned at the conclusion of employment or is deliberately, or through negligence, damaged, destroyed, or lost while in the teleworker's control.

Inspection

In case of injury, theft, loss, or liability related to telework, the teleworker must allow employees and/or agents of the organization to investigate and/or inspect the telework site. Reasonable notice of inspection and/or investigation will be given to the teleworker.

Working from the Plan's Offices

At a future date, work spaces at the Plan's offices may change based on the number of teleworkers and the amount of time they are teleworking. Changes may include the creation of community work stations or the sharing of cubicle spaces.

Travel Reimbursement

The Plan will not reimburse mileage for days the teleworker drives into the Plan's offices. For work-related off-site visits from the teleworker's home, the Plan shall base reimbursement for use of privately owned vehicles on actual mileage, to the nearest mile, less the number of miles required to drive from the teleworker's residence to the Plan's offices, and back again, on a single day. Reimbursement shall be made at the mileage rate currently in effect for the Plan.

Program Reporting and Evaluation:
The teleworker will agree to reporting and analyses relating to their performance in order to evaluate the effectiveness of the telework program at the Plan.

Timekeeping

- All- employees will be required to complete their e-~~Timesheet~~ timesheet on the ADP system.

- Meal periods and breaks for a teleworker will be consistent with those at the Plan's offices. It is the employee's responsibility to adhere to the Plan's policies with respect to meal and rest breaks and ensure that they take all meal and rest breaks the Plan requires.

Exceptions to Policy

In certain cases, other arrangements than those defined in this policy may be negotiated between the Plan's management and the teleworker. All policy deviations must be approved by Human Resources and the CEO and shall be reviewed with the teleworker's executive.

Benefits

Employee Benefits

The Plan offers a benefits program to its regular full-time and regular part-time employees. Regular full-time employees who regularly work 30 or more hours per week are eligible to participate in the Plan's benefits program. Regular part-time employees who work 20 or more hours, but less than 30 hours are eligible for employee-only coverage under Kaiser HMO.

Benefit choices include options for medical (choosing one medical plan is required), dental, vision and life/AD&D, and long-term disability options for the employee and their dependents (including coverage for certified domestic partners and spouses), as well as flexible spending plans and pre-tax transit plans. New employees are eligible for coverage effective the first day of the month following 30 days of employment.

Employees should make their choices very carefully, whether they are made during Open Enrollment or upon commencement of employment with the Plan. Subject to some limited exceptions, changes cannot be made until the next Open Enrollment period (usually in May to be effective July 1). Some changes may be made during the year if the employee has a qualifying event such as a change in family status, or a change in the employment situation of a family member. Please check with Human Resources if you have ~~any questions~~recently experienced a qualifying event.

The Plan complies with the City and County of San Francisco's Health Care Accountability Ordinance. Accordingly, the Plan will make a reasonable effort to provide medical coverage ~~only~~ for employees who work 20 or more hours per week, but fewer than 30 hours per week. If an employee is unable to provide proof of credible coverage or does not wish to sign the SF HCAO Waiver form, the Plan will auto-enroll the employee into the Kaiser Employee Only HMO Plan at no charge. If an employee is working less than 20 hours per week, the Plan will make the required minimum payments to the City on behalf of the employee.

The Plan reserves the right to change, amend or discontinue the benefits it offers to its employees at any time. This includes changing carriers. The Plan's right to make these changes is not limited by your length of service, or by your reliance on the availability of these benefits in deciding whether to accept, continue, or retire from employment with the Plan.

A full summary plan description of employee benefits is available from Human Resources.

Domestic Partner/Spousal Certification for Benefits

The value, or premium equivalent, of employer provided Domestic Partner (DP) healthcare coverage generally must be included in the earned income of the employee for Federal Income tax purposes. The Plan is required to report the value of employer provided coverage to the employee as "imputed income"

when a DP is not recognized as a dependent for tax purposes. This imputed income can be reported incrementally on employee paychecks or can be handled as a one-time entry on Form W-4.

Employer provided coverage includes both:

- Direct contributions made by the employer toward the cost of DP coverage; and
- Pre-tax contributions made by the employee for their DP.

The value of DP coverage may not be taxable for Federal Income tax purposes if the DP is recognized as a common-law spouse or is considered an IRS qualified dependent. To be an IRS qualified dependent, the DP must at a minimum meet the following criteria: 1) the domestic partner receives 50% of their support from the taxpayer, 2) the individual must reside with the employee for the tax year at issue and 3) the domestic partner is a member of the taxpayer's household, as defined by the IRS.

In California, if a domestic partnership has been properly registered with the Secretary of the State of California, the value of DP coverage is not taxable for California Personal Income Tax purposes. Although it is included in the employee's taxable wage base for purposes of Unemployment Insurance and California State Disability Insurance.

If a plan extends eligibility to the children of a Domestic Partner and those children are not otherwise dependents of the employee, the tax treatment will generally be the same as for coverage provided to the Domestic Partner.

Please see Finance for the forms needed to qualify for exemption from California Personal Income Taxes.

Retirement Benefits (CalPERS)

All regular Plan employees are automatically enrolled into the CalPERS pension system.

Employees hired on or before 12/31/12 are part of the CalPERS "2% at 55" Pension Plan and are considered "Classic" members. In this plan, employees contribute 7% of their gross income towards their retirement in lieu of paying into Social Security. The Plan also makes a contribution towards the employee pension accounts - the current amount is ~~10.484%~~10.34% and generally increases every fiscal year depending on the financial health of the investments. Employees become vested in the plan after 5 years of service credit is earned. The earliest age at which a member of the plan can retire and start receiving pension payments is 50. If an employee leaves the Plan before becoming vested, the employee has 3 options:

1. Leave their contributions in the Pension Plan. This option allows the employee to stay active in the CalPERS retirement system in case they become employed by another agency that also participates with the CalPERS retirement system. In most cases, any vesting service time earned with the Plan will be transferable.

2. Leave their contributions in the Pension Plan until reaching age of 59 ½. The contribution amounts will earn interest income and can be withdrawn without penalty.

3. Contact CalPERS and submit a "Refund Election Form". This will allow the employee to be refunded of all of their individual contributions plus accrued interest. However, this action will be subject to a tax penalty (if initiated before reaching age 59 ½) and will also permanently remove the CalPERS membership status of the employee and if they joins another CalPERS participating organization, that employee's vesting service will start over at 0 years of vesting service.

Employees hired on or after 01/01/13 are part of the CalPERS "2% at 62" Pension Plan and are considered "New" members. In this plan, employees contribute 6.75% of their gross income towards their retirement in lieu of paying into Social Security. The Plan also makes a contribution towards the employee pension accounts - the current amount is ~~7.732~~7.59%. Both Employee and Employer contribution amounts typically increase every fiscal year. Employees become vested in the plan after 5 years of service credit is earned. The earliest age at which a member of the plan can retire and start receiving pension payments is 52. If an employee leaves the Plan before becoming vested, the employee has 3 options:

1. Leave their contributions in the Pension Plan. This option allows the employee to stay active in the CalPERS retirement system in case they become employed by another agency that also participates with the CalPERS retirement system. In most cases, any vesting service time earned with the Plan will be transferable.

2. Leave their contributions in the Pension Plan until reaching age of 59 ½. The contribution amounts will earn interest income and can be withdrawn without penalty.

3. Contact CalPERS and submit a "Refund Election Form". This will allow the employee to be refunded of all of their individual contributions plus accrued interest. However, this action will be subject to a tax penalty (if initiated before reaching age 59 ½) and will also permanently remove the CalPERS membership status of the employee and if they joins another CalPERS participating organization, that employee's vesting service will start over at 0 years of vesting service.

CalPERS 457 Deferred Compensation Plan

The CalPERS 457 Deferred Compensation Plan is a voluntary plan which offers the opportunity to plan for a secure financial future. The Plan allows employees to automatically save a portion of their salary and invest it in a choice of 25 different investments. Employee's taxable income is reduced by the amount saved on a before-tax basis, lowering the taxable wage base. A Roth option is also available so that contributions can be made on an after-tax basis. Earnings are automatically reinvested before-taxes, which makes savings grow even faster.

401(a) Defined Contribution Plan

Plan employees are automatically enrolled into the 401(a) Defined Contribution Plan. The Plan will contribute 5% of your annual base salary into a 401(a) retirement savings account. However, this is a discretionary contribution on behalf of the Plan and is subject to change. Employees are responsible for selecting the funds in which they would like to invest the money. Vesting schedule is as follows:

- Less than one year of service: 0% vested.
- 1 year of service but less than 2 years: 33% vested.
- 2 years of service but less than 3 years: 66% vested.
- 3 years or more: 100% vested.

Vesting date is calculated from date of hire.

COBRA

Under terms of the Consolidated Omnibus Budget Reconciliation Act (**COBRA**), Plan employees participating in any of the health care plans (medical, dental or vision) may have a right to continue coverage of that plan(s) for a period of time when their coverage would otherwise end (e.g., upon termination of employment or after three (3) months on a leave of absence, applicable law permitting). The employee (and dependents if applicable) will be responsible for paying the monthly insurance premium plus an administrative surcharge.

Formal notice of COBRA rights will be given to eligible employees and their qualified dependents at the time insurance coverage begins and again when they become eligible for COBRA benefits.

Tuition Reimbursement

All regular full-time employees who are scheduled for at least 30 hours or more per week are eligible to participate in the Tuition Reimbursement Program. The maximum amount of reimbursement available under this program is $2,000 per Plan fiscal year (July 1 through June 30). An employee becomes eligible after 90 days of employment. ~~Additionally,~~Employees ~~they~~ need approval from their manager, department director and Human Resources. Employees must be employed by the Plan, and have their request approved 30 days prior to the start of the class for which they are seeking reimbursement. Employees must have received a "meets expectations" or better on their most recent performance appraisal to be considered. Additionally, employees must be currently employed by the Plan at time of payout to receive reimbursement. Employee must receive a passing grade ~~in order to~~to be reimbursed. Reimbursement will be received approximately one pay cycle from the date the completed form and copy of grade is received by Human Resources. The course(s) must be directly related to obtaining an Associate's, Bachelor's, Master's or higher-level degree from an accredited college or university. Certificate courses are not eligible. Please note: If an employee is intending to use the tuition reimbursement for a post graduate degree (Master's level or higher), it must be directly related to the furtherance of employee's knowledge or skills in respect to their own job, or to the work of the department or Plan in general. The Plan reserves the right to make the final decision regarding eligibility. For more specific details, please contact Learning and Development in the Human Resources Department.

Professional Licensure or Membership Dues

The Plan will reimburse for professional licensure and membership ~~dues, when~~dues when the membership or licensure is a requirement to perform the job function of the position. Professional licensures are nurse licenses, physician board licenses, and pharmacist licenses. Professional licensure or memberships that are beneficial to the position may be reimbursed by the Plan at the supervisor's sole discretion. The Plan reserves the right not to pay excessive dues if another option is available.

Licensed Health Professionals

If required for the employee's Plan position, the license of a health professional must be in active status to maintain employment at the Plan. A suspended license may result in termination. The Plan recognizes that there may be time when a license is in a renewal process and the process may be delayed. A health professional's license may be placed under "active renewal pending" disposition. "Active-Renewal Pending" does not mean that the license has lapsed, is inactive or invalid. Employee is required to notify their immediate manager when their licensure status changes.

Employee Recognition Programs

The Plan has established an employee recognition program. The purpose of the program is to recognize employees who support our Strategic Anchors: Universal Coverage, Quality Care & Access, Exemplary Service and Financial Viability. Eligible employees are Regular Full-Time or Regular Part-Time employees who demonstrate professional excellence and model our core values: Serve with Respect, Strive to Excel and Work as a Team. There are 3 components to the program: (1) $20 on-the-spot awards throughout the year where employees can immediately recognize each other's accomplishments, (2) up to 3 quarterly team awards for cross-functional team initiatives ($25 per person toward lunch), and (3) up to 3 quarterly $250 individual awards whereby managers recognize employee achievements. Employees nominated but not selected will also receive a $50 award. The awards program is evaluated on an ongoing basis, and the Plan reserves the right to amend or discontinue the plan at any time.

Employee Service Awards

The Plan also recognizes employees on their length of service on their employment anniversary dates. The rewards for eligible employees who have attained an anniversary date are as follows:

- 10 Years
  - $250 Service Award*
  - Plant
  - 10 Years of Service Plaque
- 15 Years
  - $500 Service Award*15 Years of Service Plaque
- 20 Years
  - $2,000 Service Award* payable on the earlier of the employee's anniversary date or All Staff Meeting
  - One-time award of 40 PTO hours, subject to PTO accrual maximum
  - 20 Years of Service Plaque

* Service award payments will be grossed up for taxes.

Time Off From Work

Paid Time Off

Paid time off (PTO) is a creative approach which gives our employees maximum flexibility to determine how they wish to use their time off. Rather than rigid vacation or sick leave, which can only be used for these purposes, PTO allows employees to best meet their own needs by electing how to use the time

accrued. The Plan's PTO benefits for its employees exceed the benefit requirements of the San Francisco Sick Leave Ordinance and the California Paid Sick Leave statute.

PTO days or hours may be used for vacation, short-term illness, medical, dental, and preventive health appointments, illness of or preventive~~preventative~~ health appointments for immediate family members (defined as spouse, child, parent, sibling, registered domestic partner, legal guardian/ward, grandparent, grandchild, or designated person), family emergencies, religious observances, holidays not otherwise observed by the Plan, funeral attendance outside of immediate family members, safe time purposes (as described in Sections 230(c) and 230.1(a) of the California Labor Code), purposes related to bone marrow or organ donation, participation in children's school activities, and other excused elective absences. Parental leave, bereavement leave, jury duty, and certain other types of leave (except FMLA, CFRA, Pregnancy Disability and Personal leave) listed in the Employee Handbook are paid in addition to PTO and the employee's PTO account may not be charged for this time off.

PTO is calculated for regular full-time employees as follows:

Length of Employment	***Approximate Hours of Annual PTO Accrual***	***Days of PTO Accrual (annualized)***	***Maximum Accrued Hours***	***Maximum Accrued Days (annualized)***
Less than 3 years of continuous service	**3.54 hours per week (184 hours per year)**	**23 days per year**	**322 hours**	**40.25 days**
More than 3 years but less than 5 years of continuous service	**3.85 hours per week (200 hours per year)**	**25 days per year**	**392 hours**	**49 days**
5 or more years of continuous service to less than 10 years of continuous service	**4.31 hours per week (224 hours per year)**	**28 days per year**	**392 hours**	**49 days**
10 or more years of continuous service but less than 15 years of continuous service	**4.61 hours per week (240 hours per year)**	**30 days per year**	**392 hours**	**49 days**
15 or more years of continuous service	**4.77 hours per week (248 hours per year)**	**31 Days per year**	**392 hours**	**49 days**

All regular part-time employees scheduled to work a minimum of 20 hours per week are eligible for PTO on a pro-rated basis, based upon their regularly scheduled hours.

Employees must obtain advance approval from their supervisor for any requested PTO use. In the case of emergencies or illnesses, PTO can be taken without prior notice. However, in such a case, please notify your immediate supervisor or department head as quickly as possible on the first business day of your absence. Your supervisor may ask that you provide updates of your condition so they can plan for your absence and return. In all other cases, PTO must be requested in advance, and agreed to in advance by your immediate supervisor or department head. Any PTO request for three (3) weeks or more must be

approved by the employee's manager, and if approved, must also be approved by the department executive. Requests for PTO will not be unreasonably denied.

Use of your PTO during your first 90 days is highly discouraged, unless it is needed for unforeseen or unavoidable illness. Your first 90 days should be reserved for learning and adapting to your new position.

Any available PTO time must be used before taking unpaid time off, whether for whole or partial days. If you wish to take PTO in the form of vacation, you must submit a request in writing at least 30 days in advance to your supervisor. Requests for lesser amounts of PTO should also be made with as much advance notice as possible. When possible, vacation periods will be assigned in accordance with employee requests, taking operating requirements into account.

PTO pay will not be granted in-lieu of taking the actual time off, except as described in the Cash Out Program policy set forth below. However, PTO time may be accrued up to the maximums designated above. Once you have reached the maximum accrual, PTO will not continue to accrue. Accrual will resume when your PTO drops below the maximum identified in the chart above. Eligible employees will be paid for any earned but unused PTO up to the maximum accrual in a lump sum upon termination.

PTO cannot be used in advance of its accrual and you will not be allowed to accrue a negative balance. You begin accruing PTO on your first day of employment.

California enacted a Paid Sick Leave law in 2015 providing that employees accrue paid sick leave at a rate of one hour for every 30 hours worked. The Plan's PTO policy complies with this law, as well as San Francisco's local ordinance as well as the California Paid Sick Leave statute. PTO may be used for any reason specified above, including for any reason covered by AB 1522, California Paid Sick Leave Law.

If you have exhausted all available PTO time and find that you have a need for additional time off, you should refer to the guidelines for "Personal Leave" as described below.

Call - Out Policy

When an employee has been out sick for more than three (3) consecutive workdays, they are required to submit documentation from a health care provider certifying the medical necessity for the absence and the expected date of return to work. If the employee already has provided a certification and application for FMLA leave covering the same period, this shall suffice.

PTO Donation Program

The Plan has a PTO Donation Program which allows employees to donate accrued but unused PTO to benefit another employee experiencing a catastrophic event which requires the employee to be absent from work for an extended period of time. A catastrophic event is defined as a medical emergency, serious illness or the need to care for a family member or domestic partner with a serious health condition. Donating and receiving employees must meet eligibility requirements.

This is a voluntary program and the decision to participate or decline to participate will in no way affect your employment with the Plan. Employees who are considering participating in this program should contact their own tax consultant to determine if there are any tax consequences to making or receiving a donation.

Eligibility and Participation

Recipient: Employees benefitting from PTO donation must:

- Be a regular employee of the Plan; no consultants or contractors may participate;
- Be scheduled to work a minimum of 32 hours per week;
- Be placed on a leave for their own serious medical condition or to care for a family member with a serious medical condition, as certified by a physician;
- Have exhausted all of their accrued but unused PTO before utilizing donated PTO;
- Have exhausted all options (State and voluntary programs) before requesting PTO Donation;
- Request for PTO donation must be within 30 days of exhausting all other options.
- Accept only the number of donated PTO hours necessary to cover the period of time until s/he returns to work;
- Accept only the number of donated PTO hours which will carry employee until they qualify for the Plan's long term disability program, if absence is due to their own serious medical condition; and
- Accept no more than 480 hours of donated PTO.
- Have exhausted 80 hours of unpaid time before using donated PTO.

Donor: Employees who wish to donate some of their accrued but unused PTO to an eligible fellow employee must:

- Be a regular employee of the Plan; no consultants or contractors may participate;
- Retain a minimum of 40 hours of PTO for their own use; employees with less than 40 hours of accrued but unused PTO may not donate until their balance exceeds 40 hours;
- Donate no more than 40 hours of PTO; and,
- Provide the Plan with a signed, written consent of the employee's spouse or registered domestic partner agreeing to the donation, if applicable.

Process

Recipient:

- The potential recipient should contact Human Resources for information on eligibility for the PTO donation program. Human Resources will work with the employee to properly document the request.
- Once approved as a recipient, Human Resources will solicit anonymous donations on their behalf. After the donation solicitation period has run, Human Resources will provide the recipient with detailed information on the PTO donation amount.

Donor:

- In response to the solicitation by Human Resources for donation of PTO, employees wishing to donate should notify Human Resources in writing of the number of hours they would like to donate.
- Donor employees can view their accrued but unused PTO balance by accessing ADP and clicking on the My Benefits tab, or employees can view their PTO balance on their most current pay stub.

Other

- No donor or recipient may solicit PTO donations.
- All donations will be anonymous.
- Holidays and floating holidays may not be donated.

- The hours of PTO from a donor will be re-calculated into hours for the recipient according to the actual cash value. For example, if Donor A contributes 8 hours of PTO priced at $40/hour and recipient's equivalent hourly rate is $20, recipient will receive 16 hours of PTO from Donor A.
- If more hours are donated than needed or allowed by recipient, hours will be returned to the donors in a pro-rated fashion, e.g., if Donor A contributed 8 hours of the total 80 hours donated (10%) and only 40 hours are needed, 4 hours (10%) will be returned to Donor A.

Paid Time-Off – Cash Out Program

All regular employees are eligible to participate in the Paid Time Off – Cash-Out Program. This program allows all employees to receive compensation (minus applicable taxes and withholdings) in lieu of taking time off from work. This program is designed to give employees flexibility in the use of their PTO benefit. The Plan encourages employees to take time off to maintain a healthy work/life balance.

However, in order to protect employees who choose not to elect to cash out all of their PTO that could be cashed out, from being taxed on the value of that PTO not cashed out by the application of the IRS doctrine of "constructive receipt," the cash received by an employee who elects to cash out will be equal to 94% of the value of the PTO that the employee elected to cash out during the annual cash out periods.

Employees are allowed to exchange PTO hours for cash twice per calendar year in November and May. Employees may choose to receive cash in exchange for PTO under the following conditions:

- The employee must keep a minimum of 40 hours of PTO;
- The employee may elect to exchange only as many hours as they have taken in PTO during the two eligibility periods. The November cash out eligibility period is 11/1 through 10/31 of the previous year. The May cash out eligibility period is 5/1 through 4/30 of the previous year;
- The employee may elect to exchange up to 100 hours of PTO in any of the cash out periods;
- The cash-out program is only available during a specified period in November and May;
- The PTO is paid out at the employee's existing rate of pay, minus any applicable taxes or other withholdings, including a six percent reduction in value;
- The employee must cash-out a minimum of 8 hours of PTO.

For more specific details, please contact Human Resources.

Holidays

The Plan observes ~~twelve~~ thirteen holidays during the year. A schedule of holidays will be approved and distributed annually.

If a holiday falls on Saturday, it normally will be observed on the preceding Friday. If a holiday falls on Sunday, it normally will be observed on the following Monday.

The holidays observed by the Plan are as follows:

Holiday	**Holiday Observed Date**
New Year's Day	January ~~1~~3, ~~2021~~2022
Dr. Martin Luther King Jr. Day	January ~~18~~17, ~~2021~~2022
Presidents' Day	February ~~15~~21, ~~2021~~2022
Memorial Day	May ~~31~~30, ~~2021~~2022
Juneteenth	June 20, 2022
Independence Day	July ~~5~~4, ~~2021~~2022
Labor Day	September ~~6~~5, ~~2021~~2022
Thanksgiving Day	November ~~25~~24, ~~2021~~2022
Day After Thanksgiving	November ~~26~~25, ~~2021~~2022
Christmas Eve	December ~~24~~23, ~~2021~~2022
Christmas Day ~~(observed)~~	December ~~27~~26, ~~2021~~2022
New Year's Eve Day	December ~~31~~30, ~~2021~~2022
Birthday Month Floating Holiday	

All regular ~~full~~ full-time and part-time employees are eligible for holiday pay on a pro-rated basis, based upon their regularly scheduled hours, immediately upon hire, with the exception of the Birthday Month Floating Holiday (see below). Temporary employees and Independent Contractors or temporary agency contractual workers are not eligible for holiday pay. Part-time regular employees are eligible for holiday pay in proportion to the number of hours they normally would be scheduled to work on the holiday. Employees will only be paid for holidays which fall (or are scheduled on) days they would normally be assigned to work. Employees who are on an unpaid leave of absence will not be eligible for Holiday pay.

Because the Plan must be accessible 365 days per year, employees designated by their supervisor may ~~have~~ be required to work on these recognized holidays.

- **Exempt** employees will receive their normal salary for that day plus an additional PTO day. Exempt employees are required to work a substantive day and have Executive preapproval before being eligible. Exempt employees that are working on an approved alternate work schedule (e.g., UM nurses and doctors) and are receiving holiday incentive pay will also be eligible for the additional PTO day.
- **Non-exempt** employees who are required to work a Plan observed holiday, will receive holiday pay and will be paid double time for the actual time worked on the observed holiday. Non-exempt employees who are required to be physically present at a Plan facility (300 Mission/50

Beale Street, 7 Spring Street, ITS data warehouse locations) on an observed holiday, will be paid a four (4) hour minimum regardless if they actually work four (4) hours. The four (4) hour minimum will not apply to those who are required to work on an observed holiday and are able to telecommute.

All employees must have supervisor and Executive approval before they can work on a holiday or notify supervisor and Executive as soon as feasible for an emergency event.

To receive the Holiday Pay, the employee must be active and paid status. The employee must work the day before and ~~after, or~~after or have PTO available to cover the day before and after. If one of the days before or after the observed holiday is unpaid, the employee will not qualify for the holiday pay.

Birthday Month Floating Holiday

During the calendar year, each employee working 30 hours or more per week will be allowed one (1) floating holiday to be used during the calendar month of their birthday. This has a "Use it or Lose it" policy and if unused, the floating holiday will expire and cannot be redeemed for cash compensation. This floating holiday must be requested in advance and agreed to in advance by your immediate supervisor or department head. New employees will be eligible for this benefit on the first day of the month following 30 days of employment. If the new employee's birthday occurs before they become eligible, they will have to wait until the following year. Employees who are on an unpaid leave of absence will not be eligible for this floating holiday pay. For more specific details, please contact Human Resources.

Other Time Off

Bereavement

Regular full-time and part-time employees who experience a death in their immediate family will be allowed to be absent with pay for three (3) days for each family member who dies. The days do not need to be consecutive, must be used within 90-days of the death.~~, but do need to be within 2 weeks of the death~~. Part-time employees are compensated only for those days they were scheduled to work within their regular work week.

The employee's immediate family include the following: parents, spouse; registered domestic partner; biological, adopted, step or foster child; adopted, step or foster parent; legal guardian; ~~brother, sister;~~sibling step-sibling; grandparent; grandchild; parents in law; siblings in law; or child in law. Paid bereavement days are not deducted from your paid time off (PTO). If additional time off is required, PTO may be used.

Employees who have less than 90 days of service may be allowed to take unpaid bereavement leave of up to three days with written approval by your supervisor.

Jury Duty

If you are a regular full-time employee and you receive a jury summons, you must provide your supervisor with a copy. If you are not excused from jury duty or your work schedule cannot be rearranged to avoid conflict you will receive your regular wages for four (4) weeks or 160 hours of jury duty served, whichever is greater. Thereafter, you will be granted an unpaid leave in order to serve, unless you have available

PTO. However, the salary of exempt employees will not be reduced for any week in which they perform any work, even if they miss part of the week due to jury duty.

You must report to work on days or parts of days when you are not required to serve on a jury. Employees must obtain from the Court Clerk, and submit to their supervisor, a statement verifying days and hours of jury service performed. If you do not return to work immediately after approved time off for jury duty, the Plan may assume you voluntarily quit your job.

All employee benefits the employee is enrolled in will continue while the employee is on jury duty leave. However, the employee will be required to continue payment of any required contributions for insured benefits and retirement benefits during the jury duty leave if they choose to keep them in effect.

Compensation received from the Court during the first four (4) weeks or 160 hours of jury duty must be returned to the Plan (travel and subsistence may be retained).

Time Off to Vote in Statewide Elections

The Plan encourages voter participation and will adjust your work hours to allow you to meet polling schedules. If adjustment of work hours is not sufficient, you may be granted up to two paid hours of excused time in order to vote, to be taken either before work or at the end of your ~~work day~~workday. This excused time will be made available if you provide notice of the need for voting time off at least two working days before the Election Day. Employees will not be given time off because personal commitments in their nonworking hours prevent them from voting.

Witness Leave; Leave for Victims of Domestic and Sexual Violence and Certain Crimes

Any employee required by law to appear in court as a witness or because they are a victim of a crime may take time off for such purpose, so long as the employee provides ~~provided they provide~~ the Plan with reasonable advance notice. Time off is unpaid, although employees may elect to use PTO, if available. Exempt employees' pay will not be reduced for partial workdays missed.

An employee who is a victim of a felony crime or is an immediate family member of a victim (defined as a spouse, registered domestic partner, child, stepchild, brother, stepbrother, sister, stepsister, mother, stepmother, father or stepfather), a registered domestic partner of a victim, or the child of a registered domestic partner of a victim may also take time off to attend judicial proceedings related to the crime. Time off is unpaid, although employees may elect to use PTO, if available. Exempt employees' pay will not be reduced for partial workdays missed.

Prior to any absence for witness or crime victim leave, the employee shall provide the Plan with a copy of the official notice of the scheduled judicial proceeding, unless advance notice is not feasible. When an employee cannot provide advance notice of such an absence, the employee shall, within a reasonable time after the absence, provide the Plan with documentation evidencing the judicial proceeding.

The Plan also complies with applicable law in giving victims of domestic violence, sexual violence, and/or stalking time off to obtain medical, psychological and legal relief provided the employee provides the Plan with reasonable advance notice (except if notice is not feasible such as in cases of emergency or unscheduled court appearances) and supporting verification of such relief (when required). The Plan will also afford employees time off to address personal safety issues, such as residence relocation. Time off is unpaid, although employees may elect to use PTO, if available. Exempt employees' pay will not be reduced for partial workdays missed. It is the Plan's policy to be flexible regarding leaves of absence due to domestic violence, sexual assault, or stalking. The Plan will treat the employee's request with the

utmost confidentiality. The Plan will not discriminate or retaliate against an employee due to their status as a victim of domestic violence, sexual assault, or stalking or who requests time off due to domestic violence, sexual assault, or stalking.

An employee called as a witness in a case arising out of and in the course of the employee's employment with the Plan is considered "on duty" and will not experience a loss of pay. In this case, any witness fee received by the employee shall be paid to the Plan together with any mileage allowed if the employee uses Plan-provided transportation.

New Parental ~~Two Week~~ Paid Leave Benefit

Under the Plan's New Parental ~~Two Week~~ Paid Leave Benefit, the Plan will provide two (2) weeks of paid leave to employees who have been with the Plan for at least one year. This Plan sponsored benefit is available to either parent upon the birth or adoption of a child, and should be used within 90 days of the event. The New Parental ~~Two Week~~ Paid Leave Benefit is a stand-alone benefit and is in addition to the California Paid Family Leave benefit. However, if the Plan deems a sufficient business need impairs the ability of the employee to use the benefit within the ~~90 day~~90-day period, special exceptions may be made at the Plan's discretion. This benefit addresses pay issues ~~only, and~~only and does not extend the time provisions of the Family Medical Leave Act, California Family Rights Act, or Pregnancy Disability Leave law as outlined later in this handbook.

California Paid Family Leave (PFL)

The State of California provides partial wage replacement benefits to eligible employees that have a wage loss due to a statutory or approved leave of absence. Paid Family Leave Insurance ("CA PFL") does not provide any independent right to a leave of absence. Thus, only employees that are entitled to another statutory leave or are approved for leave by the Plan and suffer a wage loss are eligible for PFL benefits. Eligible California employees may file a claim and apply for up to eight (8) weeks of PFL benefits with the Employment Development Department ("EDD") within any 12-month period for the following reasons:

- To care for a serious health condition of an employee's child, parent, spouse, registered domestic partner, grandparent, grandchild, sibling or parent-in-law, or
- To bond with a new child, or
- To bond with a new child in connection with adoption or foster care placement, or
- Qualifying exigencies related to a family member's military service.

This wage ~~supplement~~ replacement benefit is a State-sponsored insurance program within the California State Disability Insurance ("CA SDI") program, administered by the EDD, and is funded through mandatory employee contributions. Employees may not receive CA PFL benefits while receiving CA SDI, unemployment insurance, or workers' compensation insurance benefits.

Like CA SDI, CA PFL is a wage replacement program for current employees who take time off for any of the above-listed covered reasons. Any employee who is applying for PFL benefits must be entitled to leave under the Federal Family Medical Leave Act ("FMLA"), the California Family Rights Act, the California Pregnancy Disability Leave law and/or any other approved leave of absence.

Employees ~~are~~ may be required to use up to two weeks of earned but unused paid time off ("PTO") before they are eligible to receive PFL benefits. An employee is not eligible for CA PFL for any day that another family member is able and available for the same period of time to provide the required care. Additionally, an employee is also ineligible for CA PFL if the employee has received or is entitled to receive

unemployment compensation benefits, permanent disability insurance benefits, and/or disability insurance benefits.

Benefits received under the Plan's Parental Leave program are offset by any PFL benefits received by the employee (see above section entitled "Parental Leave").

A medical certification, in the form provided by the EDD, is required in order to be eligible for CA PFL benefits. The CA PFL certificate should be submitted directly to the EDD, not to the Plan. The certificate must include:

- A diagnosis and International Classification of Diseases code;
- The commencing date of the disability;
- The probable duration;
- The estimated time care is needed;
- A statement that the serious health condition warrants the participation of the employee to provide care; and
- An estimate of the amount of time necessary to provide care.

If ~~the Paid Family Leave~~CA PFL is taken for purposes of bonding, it must be taken within the first year after the birth, adoption, or foster care placement of the child. Documentation to support a claim for bonding with a minor child ~~will also~~may be required by the EDD. The certificate for CA PFL is distinct from those used by the Plan for FMLA, CFRA, or Pregnancy Disability Leave, which must be submitted to the Plan for purposes of those leaves regardless of certification submitted to the EDD.

Receipt of PFL benefits does not guarantee any greater right to reinstatement than if the employee had been continuously employed rather than on leave, except as provided by applicable law. If an employee is receiving PFL benefits and is not eligible for continued paid health benefit coverage under FMLA/CFRA, an employee will be offered the opportunity to elect COBRA benefits subject to the eligibility requirements of COBRA.

You are responsible for filing your claim for PFL with the EDD. All eligibility and benefit determinations are made by the EDD, not the Plan. Additional information is available on the EDD's website (www.edd.ca.gov). You may also contact the EDD at:

1-877-BE-THERE (English)
1-877-379-3819 (Espanol)
1-800-445-1312(TTY)
P.O. Box 997017, Sacramento, CA 95799-7107

Paid Parental Leave Ordinance

Under the San Francisco Paid Parental Leave Ordinance (PPLO), the Plan will provide supplemental wage replacement to eligible employees taking leave to bond with a new child under the California Paid Family Leave program (see above section entitled "Paid Family Leave"). This supplemental compensation is available only to employees who are eligible for and receive PFL benefits for new child bonding.

To qualify as a "Covered Employee" under the PPLO, an employee must have commenced employment with the Plan at least 180 days prior to the start of the leave period, perform at least eight (8) hours of work per week for the Plan within the geographic boundaries of San Francisco, perform at least 40% of their total weekly hours worked within the geographic boundaries of San Francisco, and be eligible to receive CA PFL benefits for the purpose of bonding with a new child.

In order to receive supplemental compensation under the PPLO, an employee must complete and submit to the Plan the San Francisco Paid Parental Leave Form (PPL Form). The PPL form is available on the Office of Labor Standards Enforcement (OLSE) website at www.sfgov.org/pplo. The employee also must either: (1) provide the Plan with a copy of the Notice of Computation form(s) the employee receives from the Employment Development Department (EDD) and notify the Plan when the employee receives the first PFL payment from the EDD, or (2) provide the EDD with permission to share the employee's PFL weekly benefit amount with the Plan and notify the Plan that they have granted such permission to the EDD. Note: the election of the second option may result in delayed receipt of any supplemental compensation.

The Plan may require an employee to submit a copy of the Notice of Computation form the employee receives from the EDD to confirm the employee's eligibility for and actual receipt of PFL benefits. Employees should retain a copy of their Notice of Payment form as proof of their eligibility and actual receipt of CA PFL benefits.

In its discretion, the Plan may apply up to two weeks of an employee's accrued but unused PTO that is available at the start of the leave period to meet the Plan's obligation to provide supplemental compensation during the leave period. If the employee does not agree to allow the Plan to use such PTO, the Plan will not be required to provide supplemental compensation to the employee under the PPLO.

An employee who receives CA PFL benefits may not receive supplemental compensation under the PPLO that would result in the employee receiving total compensation during their leave that is greater than the employee's normal gross weekly wages. An employee who voluntarily separates from employment with the Plan within 90 days of the end of the employee's leave period may be required to reimburse the full amount of supplemental compensation received from the Plan.

The Plan strictly prohibits any discrimination or retaliation against any employee who exercises their rights to supplemental compensation under the PPLO.

Leaves of Absence

Sometimes you may need to take a leave of absence from employment. To the extent that your need to take leave is sufficiently foreseeable, you must give the Plan 30-days advance notice; otherwise, inform us as early as possible.

Regardless of the nature of the leave of absence, you should submit a completed Request for Leave of Absence form to Human Resources, as soon as possible.

In some situations, employees may be required to use any accrued PTO during their leave. Please consult with Human Resources if you have questions in this regard.

If you take actions during your leave that are inconsistent with the intention to return to your employment with the Plan (e.g., accepting full-time employment with another employer), you will be considered to have voluntarily terminated your employment. If your leave of absence expires and you do not contact your supervisor concerning a date to return to work, you will be considered to have voluntarily terminated your employment.

Described below are the leaves of absence permitted by the Plan:

Medical Disability, Family Care, Qualifying Exigency and Service Member Care Leave

The Plan provides unpaid family and medical leaves of absence to eligible employees in accordance with the Family and Medical Leave Act ("FMLA") and California Family Rights Act ("CFRA") as set forth below.

Eligible Employees

Employees who have been employed for an aggregate of at least twelve months' service with the Plan at any time and who have worked 1250 hours in the last twelve months may be eligible for leave under this policy.

Approved Reasons for Leave

Eligible employees may be granted up to twelve weeks of unpaid leave per year for:

- **Newborn or newly-adopted children.** To care for the employee's child after birth, or placement for adoption or foster care (FMLA/CFRA);
- **Pregnancy disability.** Disabilities due to pregnancy or pregnancy-related condition (FMLA only);
- **Illness of a family member.** To care for an employee's spouse, child (under 18, or over 18 and incapable of self-car because of a mental or physical disability) or parent who has a serious health condition (FMLA/CFRA), or an employee's registered domestic partner, adult child, domestic partner's child, grandparent, grandchild, or sibling who has a serious health condition (CFRA only);
- **Illness of an employee.** For a serious health condition that makes the employee unable to perform their job (FMLA/CFRA);
- **Qualifying Exigency.** Qualifying exigency arising out of the fact that an employee's spouse, son, daughter or parent (or domestic partner for purposes of the CFRA only) is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (FMLA/CFRA).

The 12-month period is defined as the period measured forward from the date an employee's first family leave begins. Subsequent 12 month periods would begin the first time family leave is taken after completion of any previous 12-month period.

Notably, some extensions to the 12 week maximum may be granted when the leave is necessitated by an employee's pregnancy related disability, work related injury/illness or a "Disability" as defined under the Americans with Disabilities Act or California law.

Eligible employees may be granted up to 26 weeks of unpaid leave per year for:

- **Service member care.** Eligible employees may request a leave of absence to care for your husband, wife, child, parent or next of kin who is a member of the Armed Forces and who has incurred a serious injury or illness during active duty (referred to as "service member care leave") (FMLA only).

The Plan will also provide leave for any other reason required by law. Under most circumstances, leave under the FMLA and CFRA will run at the same time. Leave may not run concurrently for:

- Leave to care for a registered domestic partner (CFRA only).
- Disabilities due to pregnancy or pregnancy-related condition (FMLA only).
- Leave for a qualifying exigency related to a domestic partner's military service (CFRA only).
- Leave to care for an ill or injured service member (FMLA only). Note that if the service member is a CFRA-covered family member and if the service member has a qualifying serious health

condition that warrants the participation of the employee, the first 12 weeks of care would qualify as a CFRA leave and run concurrently with FMLA. The last 14 weeks would be FMLA only.

Medical Disability and Family Care Leave Definitions

- **Child:** Anyone who is the employee's biological, adopted, or foster child, stepchild, or legal ward. This may also include a child for whom the employee has day-to-day responsibility.
- **Parent:** Biological, foster or adoptive parents, stepparents, legal guardians, or someone who plays or has played the role of parent, but does not include parents-in-law.
- **Spouse:** A legal marital relationship or registered domestic partner (CFRA only).
- **Serious Health Condition:** An illness, injury, impairment, or physical or mental condition serious enough to involve hospitalization, in-patient care in a residential health care facility, continuing treatment or supervision by a health care provider. The Plan may require appropriate medical certification before a leave is granted. In some instances, a second or third medical opinion may also be required.

When it is medically necessary, you may take your leave on an intermittent basis for use on a reduced-time schedule i.e., work fewer hours per day or per week than your usual schedule requires.

If you request a leave of absence that is foreseeable because of a scheduled medical procedure, you must make a reasonable effort to schedule it so that it will not unduly disrupt Plan operations, subject to the approval of your health care provider.

If you are granted a leave of absence, you may be required to provide periodic reports, as requested, that describe your status and when you will return to work.

Applying for Medical Disability, Family Care or Service Member Care Leave

In addition to a Request for Leave ~~Of~~of Absence form, you must submit written certification from your health care provider containing the following information:

- The date on which the serious health condition began or will begin.
- The probable duration of the condition.
- *(If the purpose of the Leave is for your own serious illness):* A statement that, due to your serious health condition, you are (or will be) unable to perform the functions of your position.
- *(If the purpose of the Leave is for family care, including service member care):* The estimate of the amount of time that the physician believes you need to take in order to care for the family member and a statement that the serious health condition warrants your participation to provide care.

If you request intermittent leave or leave on a reduced-time schedule, you also must provide certification of the medical necessity for either kind of leave, its expected duration and, if applicable, the date on which your medical treatment is to be given and the duration of the treatment. Note: if you request an intermittent leave or reduced time leave, the Plan may require you to temporarily transfer to an available alternative position for which you are qualified, that has equivalent pay and benefits if, in the Plan's view, that position better accommodates the recurring periods of leave.

If you need additional leave after the time stated in your original certification, you must submit re-certification containing the information outlined above.

Applying for Qualifying Exigency Leave

In addition to a Request for Leave ~~Of~~of Absence form, you also are required to furnish a certification of qualifying exigency for Qualifying Exigency leave. Employees must make every practicable effort to provide the Plan with the certification within fifteen (15) days of the date of the request or an employee's leave may be delayed or denied.

Return to Work

When you are ready to return to work from medical disability leave, you must present certification from your physician that you are able to safely perform all of the essential functions of your position, or can do so with reasonable accommodation.

Employees on leave are asked to confirm their return date at least two weeks before they return to work.

If you take twelve (12) work weeks of leave or less in a 12-month period due to either your own serious health condition (not including pregnancy or work-related injury or illness), family care or a qualifying exigency, you are entitled, upon your return from leave, to be reinstated in the position you held before going on leave, or to be placed in an equivalent position with equivalent employment benefits, pay and other terms and conditions of employment. If you take 26 work weeks of leave or less in a 12-month period due to service member care, you are entitled, upon your return from leave, to be reinstated in the position you held before going on leave, or to be placed in an equivalent position with equivalent employment benefits, pay and other terms and conditions of employment.

If you have been on FMLA/CFRA-qualifying leave, you have no greater right to reinstatement than if you had remained continuously employed by the Plan. Thus, if you would have been laid off during your FMLA/CFRA-qualifying leave period you are not entitled to reinstatement.

Integration with Other Benefits

Leave is unpaid unless an employee has accrued benefits under the PTO policy.

To the extent permitted by applicable law, except in the case of pregnancy-related disability or industrial injury, the Plan requires you to utilize your accrued PTO during leave. However, if you are taking medical disability leave for any reason, family care leave or service member care leave, and you are receiving any wage supplements (as described below), you may choose, at your option, whether to utilize PTO.

If the reason for the leave is the employee's pregnancy-related disability or industrial injury, then you may choose, at your option, whether to utilize your accrued PTO benefits during leave.

Any PTO utilized will count toward the employee's maximum allowable leave.

Wage Supplements

Employees may also be eligible to supplement wages through workers' compensation insurance, California State Disability Insurance and/or California Paid Family Leave. If the Employee receives workers' compensation insurance, State Disability Insurance or Paid Family Leave, the Plan will reduce the payment amount of any accrued PTO paid during the leave so that the total amount received by you shall not exceed 100% of your regular pay. You must immediately notify the Plan of workers' compensation or California benefit eligibility in order for payments to be coordinated.

Limited Continuity of Benefits – Medical Disability, Family Care, Qualifying Exigency and Service Member Care Leave

You will not accrue PTO, seniority, or other benefits, nor will you be paid for holidays that occur during your leave of absence (except as required by law). The Plan will maintain your group health benefits during the first twelve (12) work weeks of any leaves of absence you take during the relevant 12-month period for the purposes of non-occupational disability, family care, or a qualifying exigency, under the same terms and conditions of coverage that would prevail had you not gone on leave. The Plan will maintain your group health benefits during the first 26 work weeks of any leaves of absence you take during the relevant 12-month period for the purposes of qualifying exigency or service member care, under the same terms and conditions of coverage that would prevail had you not gone on leave.

While on a FMLA leave, you can participate in other employee benefit plans which may be available, such as group life insurance, if you pay the premium yourself. The Plan will not make payments to any pension and/or retirement plans for employees during the leave period nor count the leave period for purposes of time accrued under the plan(s). Upon return from leave, benefits will be resumed without a waiting period.

California Pregnancy Leave: Disability Because of Pregnancy, Childbirth or Related Medical Conditions

Eligibility and Terms of the Leave

If you are female, you are entitled to a leave of absence due to disability during the time that you are actually disabled on account of pregnancy, childbirth, or related medical conditions, up to a maximum period of four months. You may take this leave, as needed, for all disabilities related to each pregnancy. The decision as to whether a woman is "disabled by pregnancy" is left entirely to the woman's health care provider. The leave does not have to be taken in one continuous ~~period of time~~period.

Applying for the Leave

You should give notice of your need for a pregnancy-related disability leave of absence as soon as you know, with reasonable certainty, the expected date on which your leave will begin. You should submit a Request for Leave of Absence form, and you must present written certification from your health care provider stating your anticipated delivery date and the estimated duration of your absence, including any period of time before and after delivery that you are expected to be disabled, assuming a normal delivery.

Any request for a leave of absence after your disability has ended will be treated as a request for family care leave.

Return to Work from Medical Leave – Disability Due to Pregnancy, Childbirth or Related Medical Conditions

To return to work, you must present a written release from your health care provider certifying that you are able to perform safely all of the essential functions of your position, or can do so with reasonable accommodation.

The Plan will reinstate you to the position you held before your leave began, unless one of the following conditions exists:

- Your job has ceased to exist for legitimate business reasons;
- Your job could not be kept open or filled by a temporary employee without substantially undermining the Plan's ability to operate safely and efficiently;
- You have indicated your intention not to return to your job;

- You are no longer able to perform the essential functions of your job with or without reasonable accommodation; or
- You are no longer qualified for the job.

If the Plan cannot reinstate your job, you will be offered a substantially similar position provided that:

- A substantially similar position exists and is available,
- Filling the available position would not substantially undermine the Plan's ability to operate safely and efficiently, and
- You are qualified for the position.

Integration with Other Benefits

If eligible, the Plan will pay for the first two weeks of leave due to the birth of a child, under the "New Parent Two Week Paid Leave Benefit" policy described earlier in this handbook. The Plan will not pay you during the remainder of your leave of absence for pregnancy, childbirth or related medical conditions, but, if you choose, you may use your PTO during your leave. When you become disabled you should apply for State Disability Insurance. Any PTO you use or New Parent Two Week Paid Leave benefits you receive will be integrated with State Disability Insurance benefits so that you do not receive over 100 percent of your regular pay.

You will not accrue PTO during your leave absence, nor will you be paid for holidays that occur during your leave.

During Pregnancy Disability Leave, the Plan will maintain your group health benefits under the same terms and conditions as if you were actively working for the Plan for the period of pregnancy-related disability, up to 17 1/3 weeks.

State and Local Family and Medical Leave Laws

Where State or local family and medical leave laws offer more protection or benefits to employees, the protection or benefits provided by such local laws will apply.

Employees outside of California are not eligible for California-specific medical leave laws (e.g., the CFRA).

Integration with FMLA and CFRA

As allowed by law, Pregnancy Disability Leaves or portions of Pregnancy Disability Leaves which also fall under the FMLA will be integrated with the ~~FMLA, and~~FMLA and will run concurrently. Pregnancy Disability Leaves do not run concurrently with CFRA. After the employee stops being eligible for Pregnancy Disability Leave (either because the employee has recovered from the pregnancy/childbirth or the leave exceeds 17 1/3 weeks) the employee can take CFRA leave for up to 12 weeks, if they are eligible for it. If the employee has any FMLA leave remaining after the Pregnancy Disability leave, the FMLA leave will run concurrently with the CFRA leave. During this portion of the leave, the Plan maintains the employee's group health benefits under the same terms and conditions as if she were actively working for the Plan for the period of up to 12 weeks.

It is the Plan's policy to be fair and impartial in all its relations with employees or applicants. The Plan will not discriminate against employees or applicants as a result of the approved use of family and medical leaves or disability leaves or a proper request for such leaves.

Parental Leave for School Visits

Under certain circumstances, eligible employees may be entitled to take time off to participate in activities of their child's school. In order to be eligible for time off under this policy, an employee must be the parent, guardian, or grandparent of a child who is in kindergarten, a grade between one and 12, or a licensed child day care facility. In addition, the employee must provide reasonable notice of the planned absence to their supervisor before taking the time off. The employee may not take more than 40 hours off for this purpose in any year or more than eight hours off in any calendar month of the year. This policy covers nonexempt employees for any time missed and exempt employees for full days missed.

If both parents of a child are employed by the employer at the same work site, only one parent may take time off at a time under this policy. The parent who first gives appropriate notice of the need for time off under this policy will have preference for the time off. In some cases, the Plan may agree to provide both parents the opportunity to take time off at the same time. However, that may occur only with the advance written approval of the Plan.

Any employee who takes time off under this policy must utilize any existing PTO for the absence. If the employee does not have any accrued PTO available at the time the time off is taken, or does not have enough accrued PTO to cover the time taken off, the time off will be taken without pay. However, exempt employees need only use PTO for entire days missed and if no accrued time is available will only lose pay for entire days missed.

Any employee who takes time off under this policy must provide documentation from the child's school to substantiate the fact that the employee participated in a school activity. The documentation must verify that the employee participated in the activity on a specific date and at a particular time.

The Plan also complies with all applicable laws regarding time off for required appearances at school after a child is disciplined or suspended, time off for finding, enrolling, or reenrolling a child in a school or with a licensed child care provider, and time off to address a child care provider or school emergency.

San Francisco Administrative Code Chapter 12z (SFFFWO)

The San Francisco Family Friendly Work Ordinance may be available to employees in very limited circumstances. A flexible working arrangement means a change in an employee's terms and conditions of employment that provides flexibility to assist an employee with caregiving responsibilities. A flexible or predictable working arrangement may be requested by any employee who has completed six months of employment, works at least eight hours per week on a regular basis, and is the primary contributor to the ongoing care of: (1) a child or children under eighteen years old for whom the employee has assumed parental responsibility; (2) a parent age 65 or older; or (3) a family member with a serious health condition. An employee generally may make two requests for a flexible or predictable working arrangement within a twelve month period, but may make an additional request if the Plan revokes an existing flexible or predictable working arrangement or if the employee experiences a major life event within this time frame.

For purposes of this policy, a major life event is defined as the birth of the employee's child, the placement with an employee of a child through adoption or foster care, or an increase in an employee's caregiving duties for a person with a serious health condition who is in a family relationship with the employee. A serious health condition is defined as an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment or continuing supervision by a health care provider. Family relationship is defined as a relationship in which a caregiver is related by blood, legal

custody, marriage, or domestic partnership, to another person as a spouse, domestic partner, child, parent, sibling, grandchild, or grandparent.

An employee requesting a flexible or predictable working arrangement must do so in writing, and must specify the arrangement applied for, the date on which the arrangement becomes effective, the duration of the arrangement, and how the request is related to caregiving. A request may include accommodations in terms of the employee's hours, schedule, work location, work assignments, or predictability in work scheduling.

The Plan will meet with an employee making the request within 21 days of receiving it, and will provide a written response within 21 days after such meeting. The Plan may require verification of caregiving responsibilities as part of this process. The Plan may deny a flexible or predictable scheduling request for a bona fide business reason. The Plan will set forth its reason for denial in writing, and notify the employee of the right to request reconsideration. An employee whose request for a flexible or predictable working arrangement has been denied may submit a request for reconsideration to the Plan in writing within 30 days of the decision. If the employee submits such a request, the Plan will arrange to meet with the employee to discuss the request within 21 days after receiving the notice of the request. The Plan will inform the employee of the Plan's final decision in writing within 21 days after the meeting to discuss the request for reconsideration. If the request for reconsideration is denied, the Plan will explain the bona fide business reasons for the denial.

Either the Plan or the employee may revoke an applicable flexible or predictable working arrangement with 14 days written notice to the other party. If either party revokes an applicable flexible or predictable working arrangement, the employee may submit a request for a different flexible or predictable working arrangement. The employee may make an additional request for a flexible or predictable working arrangement each time the Plan revokes a flexible or predictable working arrangement. If the Plan grants a predictable working arrangement, and if there is insufficient work for the employee during the period of the predictable working arrangement, the employee may not be compensated during such period of insufficient work.

The Plan will not discriminate or retaliate against an employee who exercises their right to request a flexible or predictable working arrangement.

Personal Leave

A Personal Leave of Absence may be taken for compelling reasons, must be approved by the employee's supervisor, and are granted at the sole discretion of the CEO and the Plan. Sufficient notice must be given. Requests should be made in writing to your supervisor and should include the reason for requesting the leave, along with the dates of the requested leave. Whether to grant such a leave, and the terms of the leave (e.g. duration), remain solely within the discretion of the CEO. Personal leave is unpaid. Employees must exhaust ~~all of~~all their available PTO before taking an unpaid leave of absence.

In determining the feasibility of granting requests for Personal Leave, factors such as purpose of requested leave, availability of coverage for job responsibility during the requested leave, previous absences, length of employment, prior work record and performance, and similar considerations will be reviewed.

An employee's benefits will not be paid or accrued during a Personal Leave.

The Plan will attempt to return an employee to their former position or a comparable position upon return from a personal leave, at the Plan's discretion. However, given changing business needs, no guarantee of reinstatement can be made, and reinstatement is at the discretion of management.

Employees on leave are asked to confirm their return date at least two weeks before they return to work. Any requests for additional leave must be made as soon as possible. The employee should notify their supervisor.

Organ and Bone Marrow Donation Leave

The Plan complies with all applicable leave requirements for employees donating organs or bone marrow. Employees who plan to donate an organ or bone marrow should provide at least 15 days' notice to the Plan. Employees should direct requests for leave to Human Resources. An employee who requests this leave will be required to provide written verification from a health care provider that they are an organ or bone marrow donor and that there is a medical necessity for the donation of the organ or bone marrow.

If an employee donates an organ, they may receive up to 30 ~~work days~~workdays of paid time off in one year plus an additional 30 unpaid days. For a donation of bone marrow, an employee may receive up to five (5) ~~work days~~workdays off in a one-year period. The one-year period is calculated beginning with the date an employee uses this type of leave and rolls forward for 12 months. If the employee taking the leave has any accrued PTO, they must use up to five (5) days of that accrual for bone marrow leave or up to two (2) weeks of accrued time for organ donation leave.

During a leave for organ or bone marrow donation, the Plan will continue the employee on its group health plan under the same terms and conditions as if the employee were actively working for the Plan for the duration of the approved leave.

Taking time off for bone marrow or organ donation is not considered a break in service and will not affect an employee's seniority. Employees continue to accrue PTO during this leave, but do not get paid for any holidays that take place during the leave. A leave of absence for bone marrow or organ donation does not run concurrently with FMLA or CFRA leave.

Military Service

All regular employees may take leaves of absence to accommodate service in the Armed Forces, Military Reserves, and National Guard. The specific terms of the leave and of your rights to reinstatement, seniority, benefits, and compensation after a military leave are governed by law. If you have questions about military leaves of absence, please contact Human Resources.

Family Military Leave

Under certain circumstances, the Plan will grant an eligible employee a family military leave of absence of up to ten (10) days, when the employee's military spouse or registered domestic partner is on leave from deployment during a time of military conflict. Time off is unpaid unless the employee has available paid time off. To the extent permitted by law, this leave shall run concurrently with Qualifying Exigency and/or Service Member Care Leave, if the employee is eligible for both Military Family Leave and Qualifying Exigency or Service Member Care Leave.

To be eligible for family military leave, the employee must work for the Plan for an average of 20 or more hours per week and be the spouse/registered domestic partner of a "qualified member" of the United States Armed Forces, National Guard, or Reserves. A "qualified member" is a member of the United States

Armed Forces who has been deployed during a period of military conflict to an area designated as a combat theater or combat zone by the President of the United States, or a member of the National Guard or Reserves who has been deployed during a period of military conflict. The employee may only take the leave of absence during the time that the spouse/registered domestic partner is ~~actually on~~on leave from deployment during a period of military conflict.

In order to be eligible for the leave, the employee must provide the Plan with: (1) notice of intention to take family military leave within two business days of receiving official notice that the employee's military spouse/registered domestic partner will be on leave from deployment, and (2) documentation certifying that the employee's military spouse/registered domestic partner will be on leave from deployment during the time that the employee requests leave.

The Plan will not discriminate or retaliate against any eligible employee who requests or takes a family military leave of the absence.

Workplace Environment and Conduct Policies

Compliance Hotline

Employees must report incidents of suspected fraud or HIPAA violations. The Plan's Compliance Hotline 1-800-461-9330), www.convercent.com/Report, is the vehicle to anonymously report such suspected violations. This service is available through a contracted vendor, 24-hours a day, seven (7) days a week. Employees may also report suspected fraud or HIPAA violations to their supervisor, or to the Plan's Compliance & Privacy Officer at (415) 615-4217, or the Security Officer, at (415) 615-4202.

Standards of Conduct

The Plan believes that a reputation for integrity and honesty is a highly valued asset -- one which must be constantly maintained and enhanced. Each of us has a personal responsibility to uphold the Plan's reputation above all other considerations. In every decision we make, that principle cannot be compromised.

The employees of the Plan are expected to demonstrate the highest standards of public trust by:

- Being honest and ethical;
- Adhering to all Federal, State and local laws and regulations;
- Protecting the Plan's reputation and assets;
- Maintaining complete confidentiality of health plan and health plan members' confidential information such as demographics, medical information, eligibility, etc.;
- Maintaining complete confidentiality of Plan and provider information, including rates, credentials, claims for services rendered, resolution of patient complaints, etc.

Each employee has an obligation to observe and follow the Plan's policies and to maintain proper standards of conduct at all times. It is not possible to provide employees with a complete list of every possible offense that will, like unsatisfactory job performance, result in discipline, including discharge. However, in order to give you some guidance, examples of unacceptable conduct are listed below. You should be aware that conduct that is not listed, but that is unprofessional or potentially embarrassing, adversely affects or is otherwise detrimental to the Plan's interests, or the interests of its employees,

customers, providers, or the public at large, may also result in disciplinary action, up to and including immediate termination.

- Malicious or willful destruction or damage to Plan property or supplies, or to the property of another employee, a customer, a provider, or a visitor;
- Theft or unauthorized removal from Plan premises of any Plan property, or the property of another employee, a customer, a provider, or a visitor;
- Obtaining employment or employee benefits by giving false or misleading information; falsifying or omitting any material information on employment documents or records, including your or a co-worker's time records;
- Dishonesty of any kind in relations with the Plan, its employees, customers, or providers;
- Bringing or possessing firearms, weapons, or other hazardous or dangerous devices or substances on Plan property without proper authorization;
- Possession, use, sale, manufacture of or distribution of controlled substances on Plan property or while conducting Plan business, or reporting for work or working under the influence of alcohol or illegal drugs;
- Insubordination, including improper conduct toward a supervisor or refusal to perform tasks assigned by a supervisor;
- Fighting on Plan property, or "horseplay" or any other action that is dangerous to others or to Plan property, or that disrupts work;
- Harassing, threatening, intimidating or coercing another employee, a customer, a provider, or members of the public who do business with the Plan, at any time, including off-duty periods;
- Pleading guilty to or being convicted of any crime other than a minor traffic violation (to the extent permitted by law);
- Unauthorized disclosure or use of any confidential information about the Plan, its customers, its providers, or its employees or any trade secrets that you have learned through your employment with the Plan;
- Failure to follow all safety rules, to cooperate in safety inspections, or to promptly report all unsafe conditions encountered during work to the appropriate person;
- Unsatisfactory attendance, chronic lateness, or unreported absence of three (3) consecutive scheduled workdays;
- Failure to observe the terms and conditions of all software agreements and licenses to which the Plan may be a party;
- Unauthorized use of Plan equipment; and
- Violation of any Plan policy, including any of the policies described in the handbook as revised from time to time.

Nothing in the above listing alters the at-will nature of employment with the Plan. Nothing in the above listing is intended to deter or punish lawful concerted protected activity protected under the National Labor Relations Act (NLRA) or any other law.

Discipline

Unsatisfactory performance may subject you to discipline. The nature of the discipline imposed will depend upon the seriousness of the problem and your record of prior performance, behavior problems or safety violations. The Plan has the right to determine what disciplinary action is appropriate based on the facts of each case. Not all available forms of discipline are appropriate to every disciplinary situation, and it is not required that the Plan treat each form of discipline as a step in a series to be followed with an employee before discharge. The Plan's practice of employee discipline does not imply that "progressive" discipline is required. Employees on a formal disciplinary process will not be eligible for a bonus. Regardless of what disciplinary action is taken, the at-will status for all employees shall remain.

Regarding Performance:

The following bonus eligibility guidelines have been established for employees who are on a formal disciplinary process:

- An employee who has been in a formal disciplinary process will not be eligible for an annual bonus. A "formal disciplinary process" means the employee has been given a formal written warning or a performance improvement plan document that includes a specified period of time in which the employee is expected to correct their performance. These documents require signatures from the employee's Manager, Executive, and Human Resources. The dates that will be used to determine which performance year will be impacted are September 15 to September 14 of the following year.
- Employees who score below a 3.0 on their combined Key Expectation Score for two consecutive years will not be eligible for a bonus for the second year.
- Employees who score below a 2.5 (1.0-2.4) on their combined Key Expectation Score will not be bonus eligible for that annual performance review period.

Problem Resolution Process

The Plan encourages open and direct communication between all employees, especially between managers and those they supervise. Just as your manager is expected to treat you with dignity and respect, and to deal openly and directly with all work-related issues, as are you expected to respond and/or approach your manager in the same manner.

If something about your job is bothering you or if you feel that you have not been treated fairly or in accordance with Plan policy, you should talk with your immediate supervisor about your concerns. If you still have questions after this discussion, or if you feel strongly that you cannot discuss the matter with your supervisor, discuss the matter with your supervisor's supervisor. Issues can be taken up all the way to the CEO, whose decision will be final.

If your concern is about the CEO, you may complain about the CEO's actions to the Chair of the Plan's Governing Board.

Human Resources is available to counsel you or to help you talk to your manager.

~~If your employment has been terminated, you may still use our problem resolution process if you feel that your termination was unfair or handled improperly.~~

It may not always be possible to achieve the result you want, but if it is not, we will do our best to explain why. You will not be disciplined or otherwise penalized for raising a good faith concern. Nothing in this Problem Resolution Process alters the at-will status of employment.

Conflicts of Interest

Plan employees are expected to avoid situations that create an actual or potential conflict in which an employee's actions or loyalties are divided between personal and Plan interests or between Plan interests and those of another. For example, you may never steer Plan business to a relative or to any company in which you or your family has invested. If participating in the selection of or contracting with a vendor, Plan employees are to disclose a potential conflict of interest with the potential or selected vendor and recuse themselves from the selection or contracting process. If you have any question about whether you have a conflict of interest, please bring it to the attention of your supervisor. Any doubt should be resolved in favor of disclosure and a request for specific guidance. Licensed professional staff or staff holding the position of Director, or above, will be required to complete an annual disclosure of potential conflicts (Form 700), as well as other documents that may be needed to disclose or waive the conflict of interest.

In addition, an employee may, as a condition of employment, be required to complete a Disclosure for the Conflict of Interest Code as required under the California Fair Political Practices Commission. A designated employee is anyone who is at the Director level or above. Disclosure statements are due within 30 days of taking the position and every April 1st thereafter.

The Governing Board has the right to adopt a conflict of interest code, and when or if it does so, this code will be binding on all employees.

Additionally, all employees are not permitted to purchase or lease services, equipment, supplies, or real property from an entity in which you or any of your immediate family members have a substantial financial interest. If you have any question about whether you are in violation of this requirement, please bring it to the attention of your supervisor. Any doubt should be resolved in favor of disclosure and a request for specific guidance. All supervisors shall immediately communicate any potential violations to the Plan's ~~Counsel, Compliance Officer,~~Chief Compliance Officer, CHRO and Human Resources Director.

Gifts and Gratuities

In the course of the contacts you make with vendors, providers, or beneficiaries, you may find them offering you gifts or gratuities to thank you for services rendered. In order to maintain a high level of integrity and avoid potential conflicts of interest, individual employees are not permitted to accept gifts or gratuities offered to them by vendors, providers, or beneficiaries, with the following exceptions:

- Gifts of nominal value (under $25.00), such as an inexpensive or moderately-priced meal, modest items with logos attached, etc.;
- Complimentary passes to professional or educational conferences or seminars;
- Other gifts permitted by Board policy.

If you have any question about whether or not a gift or gratuity is permissible under this policy, discuss it with your supervisor. If it is not permissible, politely decline the offer, explaining the Plan policy.

Fees and Honoraria

When staff members consult, lecture, counsel, or advise outside individuals or organizations on behalf of the Plan, all fees, donations, or cash honoraria must be paid to the Plan.

Disclosure of Confidential Information

Within the limits of State and Federal law it is both a legal and ethical responsibility that the business and internal affairs of the Plan be kept confidential. Employees with access to information concerning procedures or other data records utilized/maintained by the Plan are forbidden to divulge this information to unauthorized persons, or to publish or otherwise make public any information regarding persons either receiving the services of the Plan or providing services to the Plan or that would make them identifiable to anyone outside the Plan.

Employees who use cell phones, cordless phones or other mobile communications devices should not use these methods for communicating confidential or sensitive information or any trade secrets.

Employees must exercise a greater degree of caution in transmitting the Plan confidential information by e-mail, instant message, text message or any other means of electronic communication than they take with other means of communicating information, (e.g., written memoranda, letters or phone calls) because of the reduced human effort required to redistribute such information. Plan confidential information should never be transmitted or forwarded to outside individuals or companies not authorized to receive that information and should not even be sent or forwarded to other employees inside the Plan who do not need to know the information. Always use care in addressing e-mail messages, instant messages, text messages or any other means of electronic communication to make sure that messages are not inadvertently sent to outsiders or the wrong person inside the Plan. In particular, exercise care when using distribution lists to make sure that all addresses are appropriate recipients of the information. Lists are not always kept current and individuals using lists should take measures to ensure that the lists are current. Refrain from routinely forwarding messages containing Plan confidential information to multiple parties unless there is a clear business need to do so.

Unauthorized release of confidential information may make you subject to civil and criminal sanctions pursuant to California statutory law and may result in disciplinary action up to and including termination.

Personal Blogs / Social Networks

This policy describes the Plan's guidelines with respect to publicly accessible communications via the Internet relating to the Plan. This includes blogs, discussion forums, newsgroups, e-mail distribution lists, social networking sites (including but not limited to: Twitter, Facebook, Snapchat, Instagram, TikTok, YouTube and LinkedIn) and any communications that may be publicly accessible. The Plan respects the individual privacy rights of its employees and encourages open communication; however, activities in or outside of work that affect adversely your job performance, the performance of others, or the Plan's business interests are a proper focus of Plan policy.

Communication concerning the Plan must not violate any guidelines set forth in this handbook, whether or not you specifically identify yourself as an employee of the Plan. Employees are prohibited from disclosing sensitive, proprietary, confidential, member/participant related or financial information about the Plan, personnel actions and/or other work-related occurrences in a blog or other Internet forum that may be publicly accessible. This provision shall be construed in accordance with applicable law.

If you identify yourself as a Plan employee or regularly or substantively discuss the Plan publicly on matters of public concern, you must make it clear that the views expressed are yours alone and do not necessarily represent the views of the Plan.

Failure to follow these guidelines may result in disciplinary action, up to and including ~~discharge~~termination of employment. All employees are expected to exercise good judgment and restraint in their personal participation in all internet activity, blogging activity, discussion forums, newsgroups, e-mail distribution lists and social networking sites and any other communications that may be publicly accessible. Employees are directed to ask their manager or Human Resources if they have any specific questions about what material is appropriate. Placing the Plan or its employees in a false or negative light may lead to discipline up to and including termination of employment.

Nothing in this policy is intended to prohibit, deter or punish lawful protected concerted activities otherwise protected under the National Labor Relations Act or any other law.

Circumventing Computer Rights

Employees with access to the Plan's computer data resource banks must respect the system policies and thresholds. Any unauthorized attempts by an employee to circumvent their level of network security to access confidential data on the Plan's computer and/or telecommunications system or the unauthorized modification or reconfiguration of Plan-defined software programs and/or hardware configurations is strictly prohibited. This includes unauthorized installation or downloading of software programs, games, tools or other electronic devices or information, whether from the internet, privately purchased, or from any other non-authorized source. Such attempts may subject the employee to immediate termination.

Customer and Public Relations

The Plan's reputation is built on excellent service and quality work. Building and maintaining this reputation requires the active participation of every employee.

The opinions and attitudes that customers have toward our organization may be determined for a long period of time by the actions of one employee. It is sometimes easy to take a customer for granted, but when we do, we run the risk of losing not only that customer, but their associates, friends or family who may also be current or prospective customers.

Each employee must be sensitive to the importance of providing courteous treatment in all working relationships.

Prevention of Fraud, Waste and Abuse

The Plan takes health care fraud, waste and abuse seriously. It is our policy to provide information to all employees, contractors and agents about the Federal and State False Claims Acts, remedies available under these acts and how employees and others can use them, and about employee protections available to those who claim a violation of the Federal or State False Claims Acts. We also inform our employees, providers, contractors and agents of the policy and procedures we have in place to detect health care fraud and abuse. The complete fraud and abuse Compliance Program is available on the ~~Sharepoint~~SharePoint under Compliance & Regulatory Affairs, Fraud, Waste & Abuse and a hard copy can be provided to you by your supervisor or the Compliance Officer upon request.

Federal False Claims Act (Section 1902 of the Social Securities Act)

What it does:

Allows a civil action to be brought against a health care entity who:

- Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid; or
- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any Federal employee;
- Conspires to defraud the government by getting a false of fraudulent claim allowed or paid (31USC sec. 3729(a)).

Examples of a false claim**:**

- Falsifying information in the medical record;
- Plan intentionally paying providers who did not provide services to its members;
- Billing for procedures not performed;
- Violation of another law, for example a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (physician received kick-backs for referrals).

Penalties

Health care entities that violate the False Claims Act can be subject to civil monetary penalties ranging from $5,500 to $11,000 for each false claim submitted. In addition to civil penalties, they can be required to pay three times the amount of damages sustained by the U.S. government. The Office of Inspector General may also seek to exclude the entity from participation in Federal health care programs, which includes Medi-Cal.

Employee Rights and Protections

To encourage individuals to come forward and report misconduct involving false claims, the False Claims Act includes a provision to allow any person with actual knowledge of alleged false claims file a lawsuit on behalf of the U.S. government. Federal law prohibits an employer from discriminating against an employee in the terms or conditions of their employment because the employee initiated or otherwise assisted in a false claims action. The employee is entitled to relief necessary to make the employee whole (31 USC 3730(h)). The employee with actual knowledge of a false claim files their lawsuit on behalf of the government in a Federal district court. The lawsuit will be kept confidential while the government reviews and investigates the allegations and determines how it will proceed. If the government decides to proceed with lawsuit, the prosecution of the lawsuit will be directed by the U.S. Department of Justice. If the government decides not to intervene, the employee may continue to pursue the lawsuit on their own. If the lawsuit is successful, and provided that certain requirements are met, the employee may receive an award from the government ranging from 15 to 30 percent of the amount received by the U.S. government, as well as reasonable expenses.

No Retaliation

In addition to the financial reward, the False Claims Act entitles employees that file a lawsuit with the government additional protection, including employment reinstatement, back pay, and any other

compensation that may have arisen from retaliatory conduct against the employee for filing an action. San Francisco Health Plan strictly prohibits retaliation against employees for engaging in protected activity and strongly encourages employees to raise concerns about what they perceive to be false claims or false statements with their supervisor, another administrator or the San Francisco Health Plan Compliance Officer.

Statute of Limitations

A statute of limitations says how much time may pass before an action may no longer be brought for violation of the law. Under the False Claims Act, the statute of limitations is six years after the date of violation or three years after the date when material facts are known or should have been known by the government, but no later than ten years after the date on which the violation was committed.

California False Claims Act

The California False Claims Act was the first State statute passed after the Federal law. The California law prohibits the knowing presentation of a false claim for payment to a State government agency, including the Medi-Cal program. California's law is similar to the Federal law, except that the State law also requires a person who unknowingly submitted a false claim and then later discovers the claim was false, to report the false claim to the State, or face penalties. California also has other laws dealing with fraud, including Labor Code $1102.5, Health and Safety Code $1278.5, Insurance Code $1871.7, Penal Code $550 and Welfare and Institutions Code $14107. A copy of these laws along with any requested explanation can be provided to you by the Compliance Officer upon request.

What you should do if you think the Plan may have made a false claim:

An employee may report concerns about false claims or statements in the following ways:

- Report it to your supervisor or the Compliance Officer for further investigation.
- If you are not comfortable doing this or do not see action in response to your report, call the anonymous compliance hotline at 1(800) 461-9330 or report the incident online at http://www.convercent.com/Report.

You are not required to report a possible false claims act violation to the Plan first. You may report the incident directly to the Federal Department of Justice. The Plan will not retaliate against you if you inform the Plan or the Federal government of a possible false claims act violation.

Process for detecting fraud and abuse

Pursuant to applicable law and in accordance with the Plan's Fraud and Abuse Compliance Program, employees are encouraged to report suspected incidences to their supervisor or Compliance Officer. A copy of the Program Integrity and Compliance Program are available on the Plan's Intranet and Plan wide education is given annually. Feel free to ask your supervisor or the Compliance Officer any questions you may have.

Suspected incidents of fraud will be investigated in an objective and timely manner by the Compliance Officer or other third party, if appropriate. The Compliance Officer will report the incident to the Compliance Committee, the CEO and the Board. You may obtain a copy of the Program Integrity program from the Compliance Officer. If you have any questions whatsoever, you are strongly encouraged to

contact your supervisor or the Compliance Officer at your convenience. We are here to meet your needs and we must all work together to provide services to our members in an ethical manner.

Dress Code and Personal Hygiene

Professional appearance is essential to job performance and customer relations. Every employee must practice good grooming and personal ~~hygiene, and~~hygiene and must dress in a professional manner appropriate for performing their job duties. Business casual dress is allowed, but please avoid overly casual attire, ~~-~~clothing that is revealing, and clothing that contains offensive material and/or political messages. Jeans are permitted Monday through Thursday only when worn with a visible, approved Plan logo shirt. Jeans may be worn on Fridays without wearing an approved Plan logo shirt. Professional or business casual attire is required for meetings with any outside vendor or client. Managers have the discretion to determine whether attire is appropriate based on the employee's role in the organization. Even though ~~-~~most of our interaction is on video calls, it is still important to adhere to our dress code.

Employees who work in the office should be aware that many individuals, such as those with asthma or allergies, are extremely sensitive to fragrances such as cologne or perfume. Care should be taken to apply these fragrances lightly, if they are used at all.

Reasonable accommodations (including exceptions) for any of these rules will be considered when based upon any category listed in our Equal Employment Opportunity Policy. Requests for accommodations should be addressed to Human Resources.

Use of Equipment / Plan Property / Computers

You are expected to use proper care when using the Plan's property and equipment. No property may be removed from the premises without the proper authorization of management. If you lose, break or damage any property, report it to your supervisor at once.

You are expected to use the Plan's property, systems and supplies for Plan purposes only. Use of any equipment or supplies for personal use must be kept to an absolute minimum, must not interfere with the performance of your job, and may not be used to promote personal or outside interests. This means that personal phone calls, emails, instant messages, text messages, other electronic or digital communications and the use of the fax machine should be kept to a minimum, and you should discourage friends and relatives from calling, emailing, text messaging, instant messaging or otherwise communicating with you during business hours unless there is an emergency. Personal ~~long distance~~long-distance calls are prohibited. Any such calls which must be made during your ~~work day~~workday must be charged to your home or mobile phone, phone calling card, or made collect. The (800) number must be kept free for Plan business purposes at all ~~times, and~~times and is never to be used for incoming calls of a personal nature.

There are many tools that may aid you in your role here at the Plan. If the Plan does not have a specific tool you need (i.e. cell phone, laptop computer), you may request the item. The requirements are:

- The tool is a business need
- You must receive approval to purchase that item.
- The Systems Administrator will purchase the unit for you,
- The tool will need to be purchased using funds from your department's budget.
- You are required to return this item as you would any of the Plan's equipment/property.

Phone lines, e-mail, voicemail, internet access, computer network systems and any other Plan provided communications systems or devices are for conducting Plan business and are subject to monitoring by the Plan. Therefore, the use of such equipment must be limited to Plan business. You should not expect that any phone calls, emails, instant messages, text messages, voicemails, internet usage or other uses of Plan property or Plan systems are private. The Plan may monitor phone calls emails, instant messages, text messages, voicemails, or other uses of Plan property and systems at any time, including without any cause. The Plan has the capability to access, review, copy and delete any messages sent, received or stored on the systems. The Plan reserves the right to access, review, copy or delete all such messages for any purpose and to disclose them to any party (inside or outside the Plan) as it deems appropriate. Back-up copies of electronic mail messages, instant messages, text messages, voice mail messages, computer files and other electronic and digital communications are maintained and referenced for business and legal reasons.

Employees should not install personal software on Plan computer systems. Use of e-mail, instant messages, text messages, the Internet, or any other electronic device/medium to copy and/or transmit any documents, software or other information protected by copyright laws is prohibited.

When you leave the Plan's employ, or at any other time the Plan requests, you must return all keys, documents, equipment, manuals, and any other property belonging to the Plan. You must also relinquish ~~any and all~~all passwords used by you in performing your job.

Use of Plan Meeting Rooms or Offices for External Business

During your employment with the Plan, there may be times where another organization may request the use of our conference rooms for meetings or discussions. If you or a group you are in contact with requests to use the Plan's space (meeting room, etc.), you must receive explicit written approval from the CEO prior to the meeting taking place. Additionally, these meetings must not interfere with any Plan business and there~~. Additionally, there must be a Plan representative at all times~~ must always be a Plan representative present during such meetings.

Endpoint Protection Policy

The Plan has developed the following policy and procedures to ensure electronic Protected Health Information (ePHI) and sensitive Plan data are not disclosed or transported outside of the network without authorization and proper encryption. The policy affects all departments.

PROCEDURE

1. All Plan ePHI and sensitive Plan data are subject to data encryption when intended to be transported outside of the Plan's network.
2. To protect Plan data and systems, employees are prohibited from copying electronic folders and files onto mobile devices, external hard drives, flash drives, DVDs, CDs, or any form of removable or portable storage.
3. All CD/DVD writers, USB ports, and any output interfaces to removable storage will be disabled by Production Services staff to prevent the ability copy electronic folders and files.
4. Specified employees may be exempt from this policy to allow the ability to perform their routine activities. These activities are defined under the responsibilities of the given role.
   Employees who are exempt include:
   a. Executive Team (ET) members
   b. Staff designated by the ET; and
   c. Information Technology Services (ITS) staff, as authorized by the CIO.

5. ITS Production Services will maintain the list of exempted employees; requests to amend the list will be through ~~Remedy Force~~TeamDynamix.
6. For copying files or folders that contain ePHI, only ITS has the capability to copy the data with encryption.
    a. Staff is prohibited from copying ePHI onto a storage device.
    b. If ePHI must be copied onto a storage device, the requesting staff must submit the request to ITS.
    c. Staff is encouraged to use alternatives to providing ePHI, e.g., secure FTP site, rather than storing ePHI onto a portable device.
7. If an employee requires data, files or folders to be copied onto removable storage, they must follow the procedure below:
    a. Follow their department's procedures for requesting designated staff's assistance with copying files or folders.
    b. Use ONLY Plan ITS-issued removable storage devices. Copying onto other storage devices is not allowed.
    c. Any lost or stolen storage devices must be reported immediately to the employee's supervisor, Compliance Officer and/or Security Officer.
    d. If not using designated department staff, open a ~~Remedy Force~~TeamDynamix ~~-~~request.
    e. Include the following specific requirements of the request:
        i. Data needed to be copied
        ii. Location data is to be copied to
        iii. Number of copies are needed
8. Assign ~~Remedy Force~~TeamDynamix ticket to "Production Services."
9. The ~~Remedy Force~~ TeamDynamix ticket will be completed per details of the request.
10. Production Services will create the removable media per the request, encrypt the data if necessary, and provide the copy to the requestor.

DEFINITIONS

Encryption puts data into a coded form that is obfuscated from the original format

Decryption is a process that takes encrypted data and converts the data into a readable format

Removable Storage is a device or media where data can be stored

Cell Phone Policy

Acquiring a Plan Cell Phone

The Plan will provide company-paid cell phones to individuals having a justifiable need. Generally, to be eligible for a Plan cell phone, you must be:

- An executive of the Plan (e.g., CEO, CFO, CIO, COO, CHRO, CMO, ~~Compliance/Regulatory Affairs Officer~~Chief Compliance & Regulatory Affairs Officer, ~~Officer, Policy and Coverage Programs,~~Chief Policy Development & Coverage Programs Officer)

- An employee with 24/7 on-call responsibilities (certain ITS staff members, Facilities Manager, Human Resources Director); or

- A staff member working a significant amount of time outside the office with approval from your supervisor.

Employees must have a compelling written business justification for requesting a Plan cell phone and will be required to obtain Executive level approval or higher. All final decisions on Plan cell phone acquisitions for employees are subject to CEO approval.

Prior to requesting a Plan cell phone, employees should consider whether the use of a personal cell phone could meet the needs of work-related cell phone use. In addition to offering a Plan cell phone when appropriate, the Plan also offers employees reimbursement for any calls made for work use on a personal cell phone. To obtain a copy of the Plan reimbursement form for work-related personal cell phone use, visit ~~Sharepoint~~SharePoint. The Expense Reimbursement Form can be found on ~~Sharepoint~~SharePoint under Finance Forms.

Employees who are interested in acquiring a cell phone for business use must create a ~~Remedy Force~~TeamDynamix ticket.

Use of Personal Cell Phones

The Plan's system infrastructure ~~is able to~~can support a variety of cellular phones. An employee who volunteers the use of their personal cellular phone to access Plan services must adhere to ~~the following policy~~SFHP P&P, *IS-29: Permitted and Appropriate Use of Electronic Assets* which can be found on SharePoint under Square1.~~.~~ Services included are email, calendar, and contacts. A signed agreement will allow the employee native access to their email, contacts, and calendar information through their windows credentials. In return, the Plan reserves the right to perform a remote reset/wipe of their device at any time.
If a Plan phone is misplaced or lost, the user has a responsibility to immediately notify the ITS Production Services department at production_services@sfhp.org or call (415) 615-4411 If the loss of the phone also involves a HIPAA breach (breach of confidentiality or security of a member's PHI), the user must also immediately notify the Plan's Compliance Officer, Nina Maruyama, at nmaruyama@sfhp.org or call (415) 615-4217. The breach may also be reported to the Plan's Compliance Hotline at (415) 547-7835.

Prohibited Use of Plan Cell Phone While Driving

An employee who uses a Plan supplied cell phone is prohibited from using the device while driving unless a ~~legally-acceptable~~legally acceptable hands free device is used. Text messaging, reading or responding to email while driving is strictly prohibited. The Plan recommends that employees using a personal cell phone or device when driving follow these same guidelines.

The Plan recognizes that other distractions occur during driving; however, eliminating the use of cell phones while driving is one way to minimize the risk of accidents for our employees. Therefore, should you need to use your Plan cell phone while in your car; you are required to stop your vehicle in a safe location so that you can safely use your cell phone unless it is equipped with a legally acceptable hands free device.

Permitted and Appropriate Use of Electronic Assets

Plan employees who use either a company-paid cell phone, or a personal cell phone for Plan use or other electronics must adhere to SFHP P&P, *IS-29: Permitted and Appropriate Use of Electronic Assets, and IS-36:*

HIPAA and Working Remotely, which can be found on ~~Sharepoint~~SharePoint under Square1. All communications made from the Plan's electronic devices should be appropriate to a business environment. The Plan's Management team retains the right to access any communications made utilizing the Plan's Electronic Assets.

Appropriate Use and Disclosure of Protected Health Information (PHI)

- Employees are prohibited from storing any member protected health information (PHI) onto the hardware of either a company-paid or personal cell phone.
- All e-mails that are sent to external contracts from Plan information systems (including cell phones and any other electronic devices) that include PHI must be sent in an encrypted method.
- The Plan's cell phone or personal cell phone used must also be password-protected.
- Users are responsible for the physical security of all mobile devices in their possession. The Plan reserves the right to hold the user responsible for the loss of Plan owned mobile devices. Mobile devices include laptops, tablet computers and smart phones.

Non-Retaliation for Reporting Incidents or Potential Breaches

Retaliation for reporting any incidents or potential breaches is strictly prohibited.

Any report of retaliation will also be promptly and thoroughly investigated in accordance with the Plan's investigation procedures of allegations of retaliation. If a complaint of retaliation is substantiated, appropriate disciplinary action, up to and including termination of employment, will be taken.

Personal Property

The Plan is not responsible for replacement or repair of any personal articles, items or equipment that employees choose to bring on the premises if they are damaged, lost or stolen.

Solicitation and Distribution

The Plan's business objectives require that certain types of solicitation and distribution of literature be prohibited.

The following rules apply to non-employees: (i) no solicitation on Plan property at any time; and (ii) no distribution of literature on Plan property at any time.

The following rules apply to employees: (i) no distribution of literature within working areas; and (ii) no solicitation of or distribution of literature to any employees when either the employee who is soliciting/distributing or the employee being solicited is on working time. As used herein, the term "working time" does not include meal periods, rest periods or other specified periods during the workday when employees are properly non-engaged in performing their work tasks.

Political Activity, Speech and Signage

The Plan respects the rights of its employees as citizens to hold their private political and social views, and strongly encourages each employee to use their right to vote. (Please reference the Time Off to Vote policy in the *Other Time Off from Work* section.) As employees of a public agency, however, compliance with the following guidelines is required:

- Domestic or International political signs may not be displayed at employee workstations, on clothing or displayed in any other visible manner. Examples of prohibited political signs or slogans include, but are limited to, references to any political party or organizations such as Republican, Democratic, Independent, Libertarian, Green parties or candidates. Additionally, signs that promote a political cause are also prohibited.
- Employees may not engage in the promotion of or opposition to any political organization or cause or any candidate for public office while working during regular business hours at the Plan. Further, employees may not engage in any political activity that is disruptive to the workplace or the Plan's operations.
- Hate or other offensive speech ~~is prohibited at all times~~is always prohibited. All workplace speech, whether political or otherwise, should be respectful and tolerant of others' views.
- Small signs, attire and decorations that are non-controversial and promote inclusivity and support of our local community or a part of a cultural heritage are acceptable (i.e. "Pride Flags", country of heritage flags, etc.)

Exceptions to prohibition on political activity include communications and activities protected by the NLRA or applicable state laws.

The Plan is committed to a safe and comfortable workplace environment free of discrimination and harassment and that embraces the diversity, equity and inclusivity of our workforce. Employees are encouraged to review our policy prohibiting discrimination, harassment and retaliation, which includes procedures for reporting any such behaviors, found in the Employee Handbook, and Human Resources is always available to discuss any employee's concerns. Additionally, the Plan reserves the right to review all items displayed in the workplace and visible to co-workers and determine if they are appropriate.

Bulletin Boards and Cubicle/Office Etiquette

The Plan has bulletin boards for the purpose of communications with its employees. Posting on these boards are limited to Plan-related materials including statutory and legal notices, safety and disciplinary roles, Plan policies, and memos of general interest relating to the Plan. All postings require approval from Human Resources.

The following spaces must be free of all decoration, signs or postings:

- All glass (inside and outside)
- All outside cube walls
- All pedestals / filing cabinets
- Hallway walls and office doors

Those seeking to put up **company logoed** material on walls will need to seek approval from the Executive Team. The lone exception will be during the annual "Winter Wonderland" celebration for which Facilities will provide all decorations.

Safety: Each Employee's Responsibility

Workplace Safety and Health

The Plan has adopted an Injury and Illness Prevention Program (the "Safety Program"), which is administered by the Safety Program Administrator. Each employee receives training in this program, and employees receive appropriate training upon a change in job assignment, when the introduction of new substances, process, procedures or equipment presents a new hazard, or when the Plan receives notification of a new or previously unrecognized hazard.

The responsibility for safety extends to every individual working for the Plan. The Plan has established its program to maintain the safety and health of its employees, and strongly encourages every employee to report any unsafe condition, accident (no matter how minor) and near miss, so that the Plan can take corrective action as soon as possible.

The Plan ~~requires that all equipment and machinery be in proper working order and safe to work with at all times~~always requires that all equipment and machinery be in proper working order and safe to work with. If any equipment or machinery breaks down, do not use it until a qualified technician certifies that it is repaired and safe.

Business Continuity Plan

We value our employees' safety and the quality of services we provide to our members, participants and providers. We have developed a Business Continuity Plan to provide a framework so that we will be prepared for different levels and types of emergencies or other events that would disrupt operations at the Plan. This way we can ensure we are able to respond effectively to and recover from an emergency or other disruption as quickly as possible and continue with essential services during an emergency.

As part of this plan, we involve our employees in quarterly tests of the communication system that will be used in an emergency or other event. As an employee, you will:

- Be notified when we will conduct the quarterly test of the communication system.
- Participate in the quarterly communication test and will receive an automated call on your personal phones, with an option to receive texts, and an email on your personal email account.
- Be prompted to confirm receipt of the call and email.
- Be required to keep your contact information up-to-date, with accurate phone numbers and email addresses.

With everyone's cooperation with these tests throughout the year, we can ensure we are prepared to account for our employees, keep employees informed and continue to serve our members, participants and providers in the event of a true emergency or other event that would disrupt our normal operations. To update your personal contact information, please log onto the ADP website and follow the instructions. For questions regarding the ADP site, please contact Human Resources.

Threats of Violence

Employees who overhear a coworker, member or anyone on Plan property making a threat of violence, or otherwise learn of any threat of harm to themselves, to other employees, or to guests on our property, have an obligation to immediately report the matter to their supervisor or Human Resources. Employees should report all threats, even those that appear to have been in jest. All threats of harm should be reported so that the Plan will have the opportunity to investigate and respond to the truly volatile situations. All reports made to the Plan will be thoroughly and promptly investigated.

Reporting On-The-Job Injuries or Illnesses

If you or another employee are injured on the job, you should seek medical treatment immediately. If necessary, call an ambulance. If the injury is less serious, contact your supervisor and make arrangements to get medical help. The Plan's employees are covered by a Worker's Compensation insurance policy, and Human Resources will take appropriate steps towards initiating a claim if necessary.

Under the terms of our Worker's Compensation policy, if you are injured, you may be sent to one of the Plan's physicians for medical treatment, unless you have previously notified the Plan in writing that you wish to see your own physician. In emergency situations, a particular referral may not be possible or practical.

You are responsible for reporting any on-the-job accident, injury, or illness in which you are involved, no matter how minor. The report is to be made to your immediate supervisor or to Human Resources within 24 hours of the time of occurrence, using the appropriate forms provided by Human Resources.

Workers Compensation Coverage

The Plan is covered by Worker's Compensation insurance for the protection of employees who may be injured on the job. This insurance may provide coverage to an employee for hospital or doctor bills and lost earnings. If you are injured at work and you require more than incidental time off, you will be placed on a leave of absence until

- a medical professional certifies that you are able, with or without accommodation, to resume all of the essential duties of your former position;
- you are unable to come back to work in your position (i.e., your condition is permanent and stationary and cannot be accommodated); or
- you resign or otherwise indicate that you are not going to return to your former position.

Smoking in the Workplace

The Plan is committed to providing a safe and healthy environment for employees and visitors. Therefore, smoking is not permitted in any indoor office area. Smoking is permitted in designated outside areas only. Please be considerate of those entering the building and do not smoke directly in the path to the building entrance.

Alcohol Consumption While ~~On~~on Duty/On Property

The Plan strictly prohibits drinking alcohol while on property or during work hours. Exemptions from this policy would include:

- While on a business trip, but not during your work hours and is not a reimbursable expense.

Life Threatening Illnesses

The Plan is committed to keeping your work environment healthy and safe of all ~~employees, and~~employees and has established the following guidelines if you or one of your co-workers has or contracts a life-threatening illness.

The Plan will treat life-threatening illnesses the same as other illnesses in terms of all our employee policies and benefits. If you have or contract a life-threatening illness, you will be allowed to keep working, as long as:

- You can meet the Plan's performance standards,
- Your illness does not actually endanger the health or safety of employees, beneficiaries, providers or visitors, and
- You provide the Plan with any Fitness for Duty Certifications from your health care providers that the Plan requests, in accordance with applicable law.

You may not refuse to work because you are afraid of contracting a non-contagious life-threatening illness from a co-worker, as long as that illness is non-contagious within normal work activities. You may not harass or otherwise discriminate against a co-worker who has a life-threatening illness. Employees who refuse to work with or who harass or discriminate against any employee with a life-threatening illness will be disciplined, up to and including discharge. In this Handbook, "life-threatening illness" includes cancer, heart disease, Lou Gehrig's disease, AIDS, and other illnesses of a severely degenerative nature.

Drug Free Workplace/ Substance Abuse

No employee shall work, report to work, be present in Plan vehicles, or engage in Plan activities while under the influence of alcohol, marijuana, or any controlled substance, which significantly affects job safety or performance. The unlawful or unauthorized manufacture, distribution, dispensation, possession, sale or use of alcohol or controlled substances on Plan premises, in Plan vehicles or while engaged in Plan activities is also strictly prohibited. Any violation of this substance abuse policy may result in disciplinary action, up to and including discharge.

An employee's conviction on a charge of illegal sale or possession of any controlled substance while off Plan property will not be tolerated because such conduct, even though off duty, reflects adversely on the Plan.

The Plan further reserves the right to take any and all appropriate and lawful actions necessary to enforce this substance abuse policy including, but not limited to, the inspection of the employees' personal property in certain circumstances, as well as Plan issued lockers, desks or other suspected areas of concealment. Full compliance with this substance abuse policy is a condition of employment and continued employment.

In order to protect yourself and other employees, we require that you be able to perform your job safely and unimpaired. If a supervisor believes that you are not working safely and unimpaired, you will be reassigned or laid off for the remainder of the day pending an investigation. If there is any violation of this policy, the violator will be subject to discipline up to and including discharge. Any employee who is using prescription or over-the-counter drugs that may impair the employee's ability to safely perform the job, or affect the safety or well-being of others, must notify a supervisor of such use immediately before starting or resuming work.

Consistent with our fair employment policy, our organization maintains a policy of non-discrimination and reasonable accommodation with respect to recovering addicts or alcoholics, those who are perceived as having a dependency and those having a medical history reflecting treatment for this condition.

The Plan will encourage and reasonably accommodate employees with chemical dependencies to seek treatment and/or rehabilitation. To this end, employees desiring such assistance should request a treatment or rehabilitation leave. The Plan is not obligated, however, to continue to employ any person whose performance of essential job duties is impaired because of drug or alcohol use, nor is the Plan obligated to re-employ any person who has participated in treatment and/or rehabilitation if that person's job performance remains impaired as a result of dependency.

This policy on treatment and rehabilitation is not intended to affect the Plan's treatment of employees who violate the regulations described above. Rather, rehabilitation is an option for an employee who acknowledges a chemical dependency and voluntarily seeks treatment to end that dependency.

Plan Procedures

Employee File

The information in your employee file is confidential and can be reviewed only by authorized managers. Any request for information from personnel files must be directed to Human Resources.

You have the right to review your employee file at reasonable times and at reasonable intervals. If you wish to do so, provide a request in writing to Human Resources. A manager or Human Resources must be present while you review its contents. Please note, during this time of remote working for all employees, access to certain employee files may be difficult to obtain and HR will do their best to accommodate requests.

Only Human Resources is authorized to release information about current or former employees. Please consult with Human Resources if you receive any requests to provide references on current or former Plan employees. The Plan shall have no obligation to release information other than job title, dates of employment and hours worked. Disclosure of salary information will only be provided with prior written authorization.

Each employee is responsible for keeping Human Resources informed of any change of address, telephone number, person to be notified in case of emergency, beneficiary, and current professional licenses. Changes to family status (births, marriage, domestic partnership registration, death, divorce, legal separation, etc.) must also be reported immediately to Human Resources, as an employee's income tax status and group insurance may be affected by these changes.

Travel/ Expense Accounts

The Plan will reimburse employees for reasonable expenses incurred through business travel and for reasonable business expenses. Expense reports must be submitted *as soon as possible* after you incur the expense; reimbursement will be included in your next paycheck. Expenses should be submitted within 30 days of their occurrence. All reports must state the reason the expense was incurred and have receipts attached. If you are going to incur a large expense, talk to your supervisor and/or Finance to see if we can pay some of the costs directly.

Local Expenses:

1. **Travel**: The Plan reimburses for the cost of travel.
    a. **Taxis**: Luxor taxi vouchers may be used, when appropriate, for Plan business use only. Vouchers are obtained on an as-needed basis from the accounting department. Each taxi voucher must be fully complete and include a brief description of the business purpose.
    b. **Public Transit**: We will reimburse you for the cost of public transit. The City of San Francisco has a "transit first" policy, so please consider using public transit where feasible. Do be aware, however, that if public transit will take much longer than other forms of travel, you should probably take a faster method.
    c. **Driving**: The Plan reimburses for driving in your own automobile at the IRS's reimbursement rate (see Accounting for updated rate), plus parking and bridge tolls. We do not reimburse you for travel to/from your home to the Plan's offices.
2. **Meals**: For some positions, there are occasions when you will need to pay for a meal for someone with whom we are doing business to foster a good working relationship. But there is a potential downside to this if our providers or vendors get the erroneous perception that we have lots of money to spend on such items. Accordingly, you and your supervisor should discuss under what circumstances you should pay for meals for other people. As a general rule, unless prior approval from your supervisor is approved, meals should be limited to no more than $25 per person for lunch or $30 per person for dinner. The Plan never reimburses for alcoholic beverages. To be reimbursed, you must submit the receipt for the meal with an indication of every person at the meal and the purpose of the meal. As a general rule, the Plan does not pay for meals when the staff eats together, unless a supervisor is taking their supervisee(s) to a meal for a business reason.
3. **Other expenses**: We ask that you use good judgment in incurring other expenses. If you have questions, talk to your supervisor BEFORE you incur an expense.

Out of Town Travel:

All out of town travel on the Plan's business must be approved in advance by your supervisor.

1. **Airfare**: Please obtain the lowest price airfare that is consistent with your travel needs. You must weigh the lower costs of non-refundable tickets against the likelihood that the travel will be canceled. Talk to your supervisor BEFORE you make a decision if you have any question. To be reimbursed, we need the receipt for the airfare, plus the stubs from your boarding pass(es).
2. **Lodging**: The cost of overnight lodging (room rate and tax only) will be reimbursed to the traveler if the authorized travel is 80 miles or more from the traveler's home or primary worksite. Exceptions to this restriction may be approved in writing by the Chief Financial Officer. The Plan will reimburse lodging expenses at reasonable, single occupancy or standard business room rates. When the hotel or motel is the conference or convention site, reimbursement will be limited to the conference rate. Only single room rates are authorized for payment or reimbursement unless the second party is representing the agency in an authorized capacity. If you take a relative or friend with you, the Plan can only pay that portion of the lodging cost attributable to your stay. Talk to your supervisor BEFORE you make a decision if you have any question.
3. **Meals/incidentals**: As a general rule, the Plan will reimburse for meals and other expenses incurred during out of town travel up to a maximum of $60/day. You still need to submit receipts.

The Plan never reimburses for alcoholic beverages. If you are taking others out for a meal, please see the rules for meals under LOCAL TRAVEL.

Employees who use their own automobiles on Plan business are expected to comply with California laws regarding insurance, vehicular and operational safety.

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End

Acknowledgement of Receipt of San Francisco Health Plan Employee Handbook
version January [~~6~~5], ~~2021~~2022

All new employees of the San Francisco Health Plan (the "Plan") will receive a copy of this Handbook from their supervisor or Human Resources early in their employment with the Plan. All persons employed by the Plan when this version of the Handbook was issued received a copy of it. Every employee receiving a handbook must read and sign the form below acknowledging receipt. This form will be retained in the employee's personnel file.

This is to acknowledge that I have received and agree to read a copy of the Plan Employee Handbook, version January [~~6~~5], ~~2021~~2022. I understand that it sets forth the terms and conditions of my employment as well as the rights, duties, responsibilities, and obligations of employment with the San Francisco Health Plan. I understand and agree that it is my responsibility to familiarize myself with the provisions of this handbook. I further acknowledge that I have received, read, and understand the Plan's discrimination, harassment, and retaliation prevention and reporting policies.

I understand that my employment is "at-will," and that there is no guarantee of any minimum length of employment. I further understand that the at-will status of my employment can only be changed by written agreement signed by the CEO or the Chair of the Governing Board.

I also agree to protect the confidentiality of all member protected health information and provider information, as well as other confidential information received in the course of my employment at the Plan.

I also understand and agree that I do not possess a right to privacy with respect to my use of any Plan information systems and supplies (including, but not limited to phone, voicemail, email, text messages, instant messages, internet access and other electronic or digital communications) and that my usage of any such resources may be monitored at any time without prior notice and without cause.

Employee's Signature: _____

Employee's Name (*Please Print*): _____

Date: _____

This Acknowledgment of Receipt should be retained in employee's personnel file

Agenda Item 2

Action Item

Approval of Consent Calendar:

e. Findings and Resolution That Establish the State of Emergency Continues to Impact the Ability of Governing Board and Committee Members to Meet Safely in Person and/or State or Local Officials Continue to Impose or Recommend Measures to Promote Social Distancing

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:	**December 22, 2021**
To:	**Governing Board**
From:	**Betty Clark, Esq., Regulatory Affairs Counsel** **Nina Maruyama, Chief Compliance & Regulatory Affairs Officer**
Regarding:	**Findings of the COVID-19 State of Emergency**

RECOMMENDATION

San Francisco Health Plan (SFHP) recommends the Governing Board adopt Resolution No. 2021-003 authorizing the continued use of remote teleconferencing pursuant to Government Code section 54953(e) ("AB 361") for a period of thirty (30) days. SFHP recommends that the Governing Board continue to make the findings required by AB 361 no later than every thirty (30) days thereafter.

COVID-19 State of Emergency Findings Summary

To continue meeting by teleconference pursuant to AB 361, the Governing Board must reconsider the circumstances of the novel coronavirus (COVID-19) state of emergency; and establish state or local officials have imposed or recommended measures to promote social distancing, or meeting in person meeting would present imminent risks to the health and safety of attendees.

The Governor's proclaimed state of emergency due to COVID-19 remains in effect.

Holding Governing Board and Standing Committee meetings in person would present imminent risks to the health and safety of attendees, especially given the emergence of COVID-19 variants.

Both State of California officials and officials of the City and County of San Francisco continue to require or recommend measures to promote social distancing.

Current State of Emergency

The state of emergency due to COVID-19 remains in effect at both the state and local levels.

California Proclaimed State of Emergency

On March 4, 2020, Governor Newsom proclaimed a state of emergency to exist in California as a result of the threat of COVID-19.[1] The proclaimed state of emergency in California due to COVID-19 remains in effect.

Local Emergency Declarations

On February 25, 2020, Mayor London Breed declared a local emergency due to the spread of COVID-19 within the City and County of San Francisco.[2] On March 6, 2020, the Health Officer of the San Francisco Department of Public Health (SFDPH) declared a local health emergency under Health & Safety Code § 101080.[3] Both these declarations remain in effect.

State and Local Officials Continue to Impose or Recommend Measures that Promote Social Distancing

Both state and local officials continue to require or recommend measures to promote physical distancing and other social distance, such as masking.

State Requirements and Recommendations

State officials, including the California Department of Public Health (CDPH) and the California Occupational Safety and Health Administration (Cal/OSHA), continue to impose or recommend measures that promote social distancing.

The CDPH's continues to promote vaccination and social distancing measures, such as masking. The CDPH's current Guidance for Use of Face Coverings[4] requires unvaccinated persons wear masks in all indoor public settings. Mask wearing is recommended for fully vaccinated people in indoor public settings. Fully vaccinated people may wear a mask in indoor non-public settings, particularly if the person is immunocompromised or at increased risk for severe illness. The same information is provided as "current safety measures" on the State of California's COVID-19 website.[5]

Masks are similarly required for unvaccinated persons in the workplace setting. The California Occupational Safety and Health Administration (Cal/OSHA) issued the COVID-19 Emergency Temporary Standards (ETS),[6] which require most employers to train employees about measures that can decease the spread of COVID-19. The ETS

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[1] *Available at* **www.gov.ca.gov/wp-content/uploads/2020/03/3.4.20-Coronavirus-SOE-Proclamation.pdf**
[2] Mayoral declarations regarding COVID-19 are available at **sfmayor.org/mayoral-declarations-regarding-covid-19**
[3] *Available at* **www.sfdph.org/dph/alerts/files/HealthOfficerLocalEmergencyDeclaration-03062020.pdf**
[4] *Available at* **https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx**
[5] *See* **https://covid19.ca.gov/safely-reopening/#what-to-do-now**
[6] *Available at* **https://www.dir.ca.gov/dosh/coronavirus/ETS.html**

requires masks or at least a six feet distance from others unless the unmasked employee is fully vaccinated or tested at least weekly for COVID-19. Cal/OSHA also encourages employers and workers to follow the CDPH Guidance for Use of Face Coverings.[7] The ETS also requires employers to evaluate how to maximize ventilation with outdoor air to the highest level of filtration efficiency compatible with the existing ventilation system and whether HEPA filtration units would reduce the risk of COVID-19 transmission.

Thus, State of California officials continue to impose or recommend measures to promote social distancing, including mask wearing.

San Francisco Department of Public Health Orders

Local City and County of San Francisco officials continue to impose or recommend measures that promote social distancing.

The SFDPH's main health order governing the COVID-19, C19-07y – Safer Return Together,[8] remains in place. In the health order, which was last revised on October 13, 2021, the SFDPH continues to promote mask wearing. Consistent with Centers for Disease Control (CDC) recommendations regarding indoor masking, the order imposes a universal face covering requirement for indoor public settings, regardless of vaccination status (with some exemptions). The order requires businesses control access to ensure all people entering the office space are fully vaccinated or require that people who enter on an intermittent basis for short periods of time wear a well-fitted mask. The order recommends that those who are not yet fully vaccinated to stay at home or choose outdoor activities as much as possible with physical distancing from others whose vaccination status is unknown to prevent the risk of COVID-19 transmission.

The SFDPH has also issued a directive, Directive No. 2020-33i,[9] that recommends measures to promote physical distancing and other social distancing measures, such as masking. While Directive No. 2020-33i is specific to Kindergarten through 12th grade contexts, the directives and recommendations contained therein underline the importance of physical distancing and masking measures to reduce the spread of COVID-19 among the unvaccinated, as the FDA only recently approved COVID-19 vaccines for children 5-11 years old on October 29, 2021.[10]

On December 1, 2021, the SFDPH issued a press release regarding the confirmation of the Omicron variant in San Francisco, which was the first confirmed case of Omicron in the United States.[11] While more information about the Omicron variant is needed, the City continues to recommend vaccination and other safety protocols, such as universal

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[7] *See* **https://www.dir.ca.gov/DIRNews/2021/2021-86.html**

[8] *Available at* **www.sfdph.org/dph/alerts/coronavirus-healthorders.asp**.

[9] All SFDPH health directives are available at **www.sfdph.org/dph/alerts/coronavirus-health-directives.asp**

[10] *See* **www.fda.gov/news-events/press-announcements/fda-authorizes-pfizer-biontech-covid-19-vaccine-emergency-use-children-5-through-11-years-age**.

[11] ***Available at* www.sfdph.org/dph/alerts/files/12.1.21_SFDPH_CDPH_First_Omicron_Case.pdf**

masking in indoor public settings, proof of vaccination for certain businesses, and testing and surveillance.

Thus, local San Francisco officials continue to promote physical distancing and other social distancing measures, such as masking.

The COVID-19 State of Emergency Continues to Directly Impact the Ability of the Governing Board to Meet Safely in Person

The spread of COVID-19 poses a continued risk to the health and safety of members of the Governing Board, Standing Committee members, SFHP staff, and members of the general public, who attend such meetings.

Prior to the COVID-19 pandemic, the Governing Board meetings, as well as meetings by the Standing Committees of the Board, took place in Conference Rooms at the SFHP headquarters, 50 Beale St, 13th Floor, San Francisco, CA 94105. The Member Advisory Committee held meetings at the Lighthouse,1155 Market Street, 10th Floor, San Francisco, CA, which has been closed to in-person meetings. SFHP Conference Rooms and the Lighthouse cannot accommodate six feet of distance between Governing Board members, SFHP staff, and members of the public. Moreover, SFHP staff cannot ensure ventilation of the Conference Rooms and the Lighthouse meets Cal/OSHA ETS standards as ventilation is controlled by the building. SFHP Conference Rooms and the Lighthouse contain no windows that can be opened to maximize outdoor airflow.

Members of the public who attend Governing Board and Standing Committee meetings may be unvaccinated or partially vaccinated. Those who are unvaccinated or partially vaccinated persons are at higher risk of contracting COVID-19, including the COVID-19 Delta variant. The Delta variant is twice as contagious as previous variants and might cause more severe illness in unvaccinated people.[12] Even fully vaccinated persons can contract and potentially unknowingly spread COVID-19, including the Delta variant.[13]

The emergence of a new variant, Omicron, poses a continued risk to Governing Board and Standing Committee attendees. The United States designated Omicron as a "Variant of Concern" on November 30, 2021,[14] and it was first confirmed in San Francisco on December 1, 2021. While more data is still being collected about Omicron, the CDC states that the Omicron variant likely will spread more easily than the original COVID-19 virus and expects anyone with Omicron infection can spread the virus to others, even if they are vaccinated or don't have symptoms.[15]

For these reasons, the COVID-19 state of emergency continues to directly impact the Governing Board's ability to meet in person. The threat of COVID-19 transmission poses a continued risk to the health and safety of vaccinated and unvaccinated

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[12] *See* **www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html**

[13] *See* **www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html**

[14] The definition of "Variant of Concern" is available at **https://www.cdc.gov/coronavirus/2019-ncov/variants/variant-classifications.html**

[15] *See* **www.cdc.gov/coronavirus/2019-ncov/variants/omicron-variant.html**

members of the Governing Board, its Standing Committees, SFHP staff, and members of the general public who attend such meetings.

RECOMMENDATION

SFHP recommends that the Governing Board adopt Resolution No. 2021-003 authorizing the continued use of remote teleconferencing pursuant to Government Code section 54953(e) ("AB 361") for a period of thirty (30) days. SFHP recommends that the Governing Board continue to make the findings required by AB 361 every thirty (30) days thereafter.

ATTACHMENTS:

Resolution No. 21-003

APPENDIX: AB 361 (Rivas), Open Meetings: local agencies: teleconferences

AB 361 Legislative History

Governor Gavin Newsom signed Executive Order N-29-20 on March 17, 2020, in response to the COVID-19 pandemic.[16] Executive Order N-29-20 waived certain requirements of the Brown Act to allow public agencies' legislative bodies more flexibility to hold meetings by teleconference and was set to expire on September 30, 2021.

Governor Newsom signed AB 361 on September 16, 2021.[17] AB 361 amends Government Code Section 54953 of the Brown Act to allow public agencies to hold virtual meetings during a proclaimed state of emergency without having to comply with the traditional Brown Act teleconferencing requirements stated in Gov. Code § 54953(b)(3).

AB 361 was enacted as an urgency legislation and was effective immediately. However, on September 20, 2021, Governor Newsom issued Executive Order N-15-21, delaying the application of AB 361 until 11:59 p.m. on October 1, 2021.[18] Public agencies could continue to hold virtual meetings through September 30, 2021 consistent with Executive Order N-29-20. However, any meetings starting October 1, 2021 need to comply with traditional Brown Act requirements or the specific requirements for teleconference meetings in AB 361.

Applicability of AB 361

AB 361, Gov. Code § 54953(e)(1), states that public agencies may use teleconferencing in any of the following circumstances:

(A) The legislative body holds a meeting during a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing.
(B) The legislative body holds a meeting during a proclaimed state of emergency for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health and safety of attendees.
(C) The legislative body holds a meeting during a proclaimed state of emergency and has determined, by majority vote, pursuant to subparagraph (B) that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

Public agencies may use the AB 361 teleconferencing flexibilities only during a proclaimed state of emergency, which is defined in Government Code 8558. The definition of emergency is broader than the COVID-19 pandemic and could include fire,

[16] *Available at* **www.gov.ca.gov/wp-content/uploads/2020/03/3.17.20-N-29-20-EO.pdf**
[17] The full text of AB 361 is available at leginfo.legislature.ca.gov/faces/billPdf.xhtml?bill_id=202120220AB361&version=20210AB36192CHP
[18] *Available at* ***www.gov.ca.gov/wp-content/uploads/2021/09/9.20.21-executive-order.pdf***

flood, epidemic, sudden and severe energy shortage, plan or animal infestation or disease, or earthquake. If there is no proclaimed state of emergency, the traditional Brown Act requirements for teleconference meetings apply, as shown in the table below.

The AB 361 teleconference flexibilities are set to expire on January 1, 2024.

Differences Between Traditional Brown Act Teleconferencing Requirements and AB 361

	Traditional Brown Act Teleconferencing Requirements Gov. Code § 54953(b)(3)	**AB 361 Teleconferencing Requirements** Gov. Code § 54953(e)
Quorum	At least a quorum of members must participate from locations within the boundaries of the territory over which the public agency exercises jurisdiction.	Quorum of member not required to be located within the boundaries of the territory.
Agenda	Each teleconference location from which a member will be participating must be identified in the meeting notice and agenda. Agenda must be posted for the required period of time at each teleconference location from which a member will be participating.	The public agency must only give notice and post the agenda per Brown Act requirements for in-person meetings. Agenda must include an opportunity for anyone the public to attend via a call-in or internet-based option.
Teleconference Location	Each teleconference location must be physically accessible to the public. Member of the public must be able to physically address the legislative body from each teleconference location.	Public agency does not have to allow member of the public to attend at each teleconference location. Public agency is not required to provide a physical location for the public to attend or provide comments.
Public Comment	Public agency required to allow public comment at the in-person meeting and from every teleconference location.	The legislative body must allow the public to address the legislative body directly and provide the means by which the public may access the meeting and offer public comment. In the event of a technical disruption, the legislative body

	Traditional Brown Act Teleconferencing Requirements Gov. Code § 54953(b)(3)	**AB 361 Teleconferencing Requirements** Gov. Code § 54953(e)
		cannot take further action on the agenda until the technical disruption is resolved. The legislative body may request, but cannot require, public comments be submitted in advance of the meeting. The public must be able to address the legislative body and offer comment in real time. Individuals providing public comment through a website or online platform that is not controlled by the legislative body may be required to register to participate, if required by the third-party internet website or online platform. If the legislative body provides timed comment periods for each agenda item, it cannot close the public comment period until the timed public comment period has elapsed. If the legislative body does not provide time public comment period, but takes public comment separately on each agenda item, it must allow a reasonable amount of time per agenda item for public comment, including time for the public to register. If the legislative body provides a timed general public comment period that does not correspond to a specific agenda item, it cannot close the public comment period or the opportunity to register until the

	Traditional Brown Act Teleconferencing Requirements Gov. Code § 54953(b)(3)	**AB 361 Teleconferencing Requirements** Gov. Code § 54953(e)
		timed general public comment period has elapsed.

Required Action by the Legislative Body

In addition to the AB 361 requirements described above, the legislative body must make the following factual findings, by majority vote, within 30 days after teleconferencing for the first time after September 30, 2021, and every 30 days thereafter:

1. The legislative body has reconsidered the circumstances of the state of emergency; and
2. Either of the following circumstances exist:
    a. The state of emergency continues to directly impact the ability of the members to meet safely in person.
    b. State or local officials continue to impose or recommend measures to promote social distancing.

San Francisco Health Plan Governing Board
Joint Resolution for San Francisco Health Authority/San Francisco Community Health Authority

Resolution 2022-001

Resolution to Establish the Findings That the State of Emergency Continues to Impact the Ability of Governing Board and Standing Committee Members to Meet Safely in Person and/or State or Local Officials Continue to Impose or Recommend Measures to Promote Social Distancing

WHEREAS, the San Francisco Health Authority and San Francisco Community Health Authority's Governing Board and its Standing Committees hold meetings in its jurisdiction of the City and County of San Francisco subject to the Ralph M. Brown Act (Cal. Gov. Code §§ 54950-54936, hereinafter "Brown Act"); and

WHEREAS, on March 4, 2020, the Governor of the State of California proclaimed a state of emergency in California in connection with the novel coronavirus ("COVID-19") pandemic, and that state of emergency remains in effect; and

WHEREAS, in February 25, 2020, the Mayor of the City and County of San Francisco (the "City") declared a local emergency, and on March 6, 2020 the City's Health Officer declared a local health emergency, and both those declarations also remain in effect; and

WHEREAS, on September 16, 2021, the Governor signed AB 361, a bill that amends the Brown Act to allow legislative bodies of local public agencies to continue to meet by teleconferencing during a state of emergency, as defined in Government Code Section 8558, without complying with restrictions in State law that would otherwise apply, provided that the legislative bodies make certain findings at least once every 30 days; and

WHEREAS, the findings that must be established per AB 361 are 1) the legislative body has reconsidered the circumstances of the proclaimed state of emergency, and 2) either state or local offices have imposed or recommended measures to promote social distancing, or meeting in person would present imminent risks to the health and safety of attendees; and

WHEREAS, while federal, State, and local health officials emphasize the critical importance of vaccination and consistent mask-wearing to prevent the spread of COVID-19, the City's Health Officer has issued at least one order (Health Officer Order No. C19-07y, available online at www.sfdph.org/healthorders) and one directive (Health Officer Directive No. 2020-33i, available online at www.sfdph.org/directives) that continue to recommend measures to promote physical distancing and other social distancing measures, such as masking, in certain contexts; and

WHEREAS, the California Department of Industrial Relations Division of Occupational Safety and Health ("Cal/OSHA") has promulgated Section 3205 of Title 8 of the

California Code of Regulations ("COVID-19 Prevention Emergency Temporary Standards"), which requires most employers in California, including in the City, to train and instruct employees about measures that can decrease the spread of COVID-19, including physical distancing and other social distancing measures; and

WHEREAS, without limiting any requirements under applicable federal, state, or local pandemic-related rules, orders, or directives, the City's Department of Public Health, in coordination with the City's Health Officer, has advised that for group gatherings indoors, such as meetings of the San Francisco Health Authority Governing Board, people can increase safety and greatly reduce risks to the health and safety of attendees from COVID-19 by maximizing ventilation, wearing well-fitting masks (as required by Health Officer Order No. C19-07), using physical distancing where the vaccination status of attendees is not known, and considering holding the meeting remotely if feasible, especially for long meetings, with any attendees with unknown vaccination status and where ventilation may not be optimal; and

WHEREAS, San Francisco Health Authority's Governing Board and its Standing Committees meetings are held in Conference Rooms at 50 Beale St, 13th Floor, San Francisco, CA 94105; and

WHEREAS, the Member Advisory Committee meetings are held at the Lighthouse, 1155 Market Street, 10th Floor, San Francisco, CA, which has been closed to in-person meetings; and

WHEREAS, Conference Rooms, and the Lighthouse cannot accommodate at least six feet distance between Governing Board members, its Standing Committee members, members of the public, and SFHP staff; and

WHEREAS, San Francisco Health Authority staff cannot ensure Conference Rooms and the Lighthouse meet the ventilation standards of the Cal/OSHA COVID-19 Prevention Emergency Temporary Standards; and

WHEREAS, the threat of COVID-19 transmission poses a continued risk to the health and safety of vaccinated and unvaccinated members of the Governing Board, San Francisco Health Authority staff, and members of the general public who attend such meetings; and

WHEREAS, the United States classified the Omicron variant as a Variant of Concern and the first United States case of the Omicron variant was confirmed in San Francisco on December 1, 2021; and

WHEREAS, the Omicron variant likely spreads more easily than the original COVID-19 virus and more data are needed about the effect of Omicron variant on unvaccinated and vaccinated people; and

WHEREAS, the San Francisco Health Authority Governing Board has met remotely during the COVID-19 pandemic and can continue to do so in a manner that allows public participation and transparency while minimizing health risks to members, staff, and the public that would be present with in-person meetings while this emergency continues; and

WHEREAS, the San Francisco Health Authority Governing Board has approved Resolution 21-01 and Resolution 21-02, which establish the continued findings of the public health emergency, that State and local health departments continue to recommend physical distancing and that conducting meetings in person would present imminent risks to the safety of meeting attendees.

NOW, THEREFORE, BE IT RESOLVED, that the San Francisco Health Authority Governing Board finds as follows:

1. The State of California and the City remain in a state of emergency due to the COVID-19 pandemic.
2. At this meeting, the members of the Governing Board have reconsidered the circumstances of the state of emergency.
3. State and City officials continue to recommend measures to promote physical distancing and other social distancing measures, in some settings.
4. Due to the COVID-19 pandemic, conducting meetings of this Governing Board and its Standing Committees in person would present imminent risks to the safety of attendees, and the state of emergency continues to directly impact the ability of members to meet safely in person; and

BE IT FURTHER RESOLVED, that for at least the next 30 days meetings of the San Francisco Health Authority's Governing Board and its Standing Committees will continue to occur exclusively by teleconferencing technology and not by any in-person meetings or any other meetings with public access to the places where any Governing Board member is present for the meeting. Such meetings of the Governing Board and its Standing Committees that occur by teleconferencing technology will provide an opportunity for members of the public to address this Governing Board and its Standing Committees and will otherwise occur in a manner that protects the statutory and constitutional rights of parties and the members of the public attending the meeting via teleconferencing; and

BE IT FURTHER RESOLVED, that the San Francisco Health Authority staff is directed to place a resolution substantially similar to this resolution on the agenda of a future meeting of the San Francisco Health Authority Governing Board within the next 30 days.

Adopted by the Governing Board on January 5, 2022.

_____
Reece Fawley, Secretary
San Francisco Health Authority/San Francisco Community Health Authority

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 – NOVEMBER 2021

1. November 2021 reported a margin of $631,000 versus a budgeted loss of ($653,000). After removing Strategic Use of Reserves (SUR) activity, the actual margin from operations was $730,000 versus a budgeted loss of ($448,000).

   On a year-to-date basis, we have a margin of $2,484,000 versus a budgeted margin of $2,130,000. After removing SUR activity, the actual margin from operations was $2,961,000 versus a budgeted margin of $2,754,000.

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

   a. A net increase in revenue of $1.3 million due to:

      i. $1.2 million more in Medi-Cal and Healthy Workers premium revenue due to an additional 2,626 member months along with actual premium rates that were 0.8% higher than what was used for the budget projections. Membership mix was also favorable as 90% of the additional member months were in the Adult, Adult Expansion and Seniors and Persons with Disabilities (SPD) categories of aid where the per member, per month premium rates are much higher than the Child and Duals categories of aid.
      ii. $118,000 more in Maternity revenue. We reported 105 maternity events during November versus a budget of 91 maternity events.

   b. A net increase in medical expense of $99,000 due to:

      i. $694,000 more in net capitation as the result of having 2,626 more member months as well as a more favorable membership mix than what the budget projected. This additional cost is offset by the revenue SFHP received for these additional members.
      ii. $523,000 less in fee-for-service claims. Claims volume during the second half of November was less than anticipated, most likely due to the Thanksgiving holiday break. We accrued the first claims check run in December which is our normal practice, however we did not make up for the shortfall in the volume for November. The expectation is that claims expense for December will end up higher than budget.
      iii. $42,000 more in Pharmacy expense. Medi-Cal pharmacy costs were $204,000 above budget, however Healthy Workers pharmacy expense came in $162,000 below budget. Our Pharmacy department has been working with Magellan on reductions in drug costs. As a reminder, the Medi-Cal pharmacy benefit will transition to the State effective January 1, 2022.

iv. $114,000 less in Health Education and Utilization Management costs. This variance is primarily due to timing issues as it is expected that the actual costs will align with the budget as we get further into the fiscal year.

c. A net decrease in administrative expenses of $188,000 primarily due to lower than expected professional fees and consulting costs. This difference is primarily due to timing as it was anticipated that higher costs would be incurred during the first half of the fiscal year. The expectation is that actual spending will align with the budget as we move further into FY 21-22.

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

	NOV 2021				FYTD 21-22 THRU NOV			
CATEGORY	ACTUAL	BUDGET	FAV (UNFAV)	% FAV (UNFAV)	ACTUAL	BUDGET	FAV (UNFAV)	% FAV (UNFAV)
MEMBER MONTHS	163,954	161,328	2,626	1.6%	814,807	800,826	13,981	1.7%
REVENUE	$ 59,872,000	$ 58,588,000	$ 1,284,000	2.2%	$ 323,725,000	$ 425,849,000	$ (102,124,000)	-24.0%
MEDICAL EXPENSE	$ 54,282,000	$ 54,184,000	$ (98,000)	-0.2%	$ 298,190,000	$ 399,874,000	$ 101,684,000	25.4%
MLR	91.7%	93.6%			93.0%	94.7%		
ADMINISTRATIVE EXPENSE	$ 4,911,000	$ 5,099,000	$ 188,000	3.7%	$ 22,889,000	$ 24,053,000	$ 1,164,000	4.8%
ADMINISTRATIVE RATIO	7.2%	7.6%			6.1%	4.8%		
INVESTMENT INCOME	$ (48,000)	$ 42,000	$ (90,000)		$ (162,000)	$ 208,000	$ (370,000)	
MARGIN (LOSS)	$ 631,000	$ (653,000)	$ 1,284,000		$ 2,484,000	$ 2,130,000	$ 354,000	16.6%
ADD BACK: SUR ACTIVITY	$ 99,000	$ 205,000			$ 477,000	$ 624,000		
MARGIN (LOSS) FROM OPERATIONS	$ 730,000	$ (448,000)	$ 1,178,000		$ 2,961,000	$ 2,754,000	$ 207,000	7.5%

On a year-to-date basis through November and after the removal of SUR activity, SFHP is reporting a margin of $2,961,000 which is slightly above budget expectations.

- After removing the Directed Payments funding, premium revenue is above budget by $7.1 million. This is due to:
  - An overall net increase of 13,981 member months. Member months for the Adult, Adult Expansion and SPD categories of aid are all above budget which has a favorable impact on revenue due to the fact that the premium rates for these members are much higher than the premium rates for Child and Dual members.
  - A Medi-Cal rate increase effective January 1, 2021 that was 0.8% greater than budget expectations.

- After removing SUR activity and Directed Payments funding, medical expense is above budget by $7.8 million. This increase can be accounted for as follows:
  - Capitation expenses are up $3,370,000
  - FFS expenses are up $2,434,000
  - Medi-Cal non-Hep C pharmacy expenses are up $1,640,000
  - Hepatitis C expenses are up $ 684,000
  - Healthy Workers pharmacy expenses are down ($ 328,000)

- Overall administrative expense is below budget by $1,164,000. The majority of this decrease is due to lower costs in the areas of professional services and information technology services. The lower costs are due to timing differences as actual spending is expected to more closely align with the budget as we move through the fiscal year. Overall administrative expense savings has been partially offset by increases in Compensation, Benefits and GASB 68 costs due to a slightly lower attrition rate than what was used for budgeting purposes.

PROJECTIONS

Financial projections through May 2022:

1. Beginning in July 2021, hospital risk for 16,000 San Francisco Community Clinic Consortium (SFCCC) members became the responsibility of SFHP. SFHP no longer pays capitation to ZSFG for these members. SFHP is responsible for all in-network and out-of-network hospital services under a fee-for-service arrangement – All Patient Refined Diagnosis Related Groups (APR-DRG) for inpatient services and 140% of the Medi-Cal Fee Schedule (MCFS) for outpatient facility services. Primary care and specialty care services remain under capitation. It is estimated that this new risk will cost SFHP approximately $16 million to $20 million per year which is built into the FY 21-22 budget. Our draft CY 2022 Medi-Cal rates confirm that DHCS and Mercer have included this added cost in the CY 2022 Medi-Cal rate development process which means SFHP has to absorb the costs only for the period of July through December 2021.

   SFHP expects the fee-for-service claims cost to exceed the capitation savings by approximately $1.5 million per month. Due to the normal pattern of claims lag, SFHP increased its Incurred But Not Reported (IBNR) claims reserve in an amount equal to its projected exposure in order to cover the anticipated claims incurred from July 2021 through November 2021, but not received as of November 30, 2021.

2. SFHP started the new fiscal year with 2,400 more Medi-Cal members versus what was anticipated in the budget. Due to the ongoing COVID-19 pandemic, SFHP anticipates adding another 500 members for December. With some upcoming enrollment changes in certain aid code groups due to CalAIM's Mandatory Managed Care Enrollment, which will be effective on January 1, 2021, SFHP expects to add another 3,000 members. This will increase our Medi-Cal membership to approximately 158,000 members.

   It is important to note that with the Public Health Emergency expected to end in April 2022, SFHP anticipates that Medi-Cal membership will begin to gradually decrease during CY 2022 as members will be placed on hold or terminated due to no longer qualifying for the program.

3. The Medi-Cal pharmacy benefit is scheduled to be carved out effective January 1, 2022. This aligns with how SFHP prepared its FY 21-22 budget, i.e., we would have responsibility for this benefit through December 2021. The long-term plan has been for the State to take on this benefit and has selected Magellan as its Pharmacy Benefits Manager (PBM). This will be viewed as a positive development as drug costs have increased now that Magellan is our PBM.

4. Beginning on January 1, 2022, SFHP will take responsibility for Enhanced Care Management (ECM), Community Supports, formerly known as In Lieu Of Services (ILOS), and Major Organ Transplants (MOT). Multiple teams within SFHP have been working for several months to prepare

for these new programs. Draft rates for ECM and Community Supports were released in early October. Draft rates for MOT were released in November. It is important to note that the ECM and MOT benefits will be subject to a risk corridor which will limit SFHP's exposure to gains and losses.

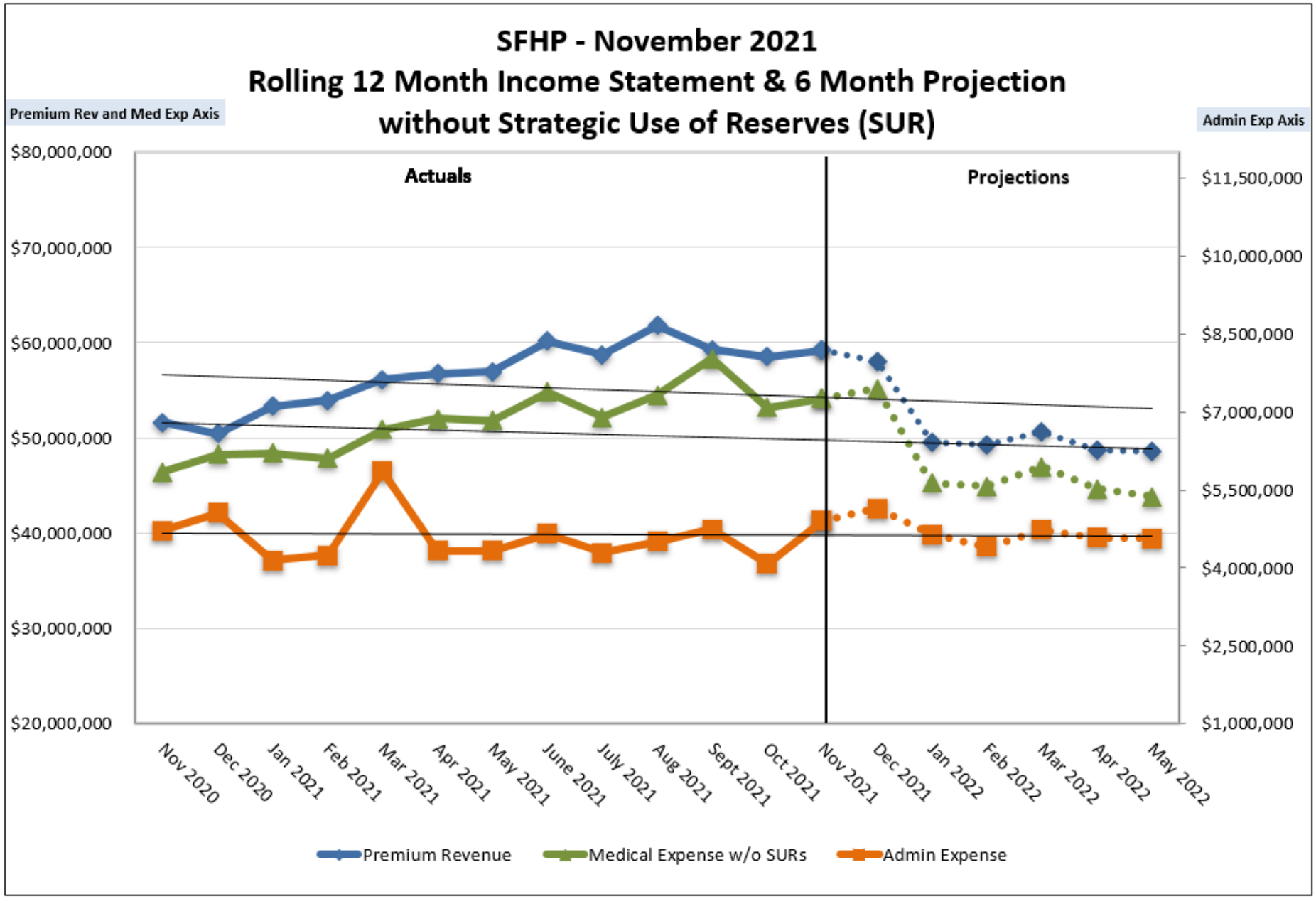
5. Proposition 56 – this program will continue for all of FY 21-22. Proposition 56 provides enhanced payments to medical groups for qualifying physician services, supplemental payments for developmental screenings, adverse childhood experiences screenings, trauma screenings, family planning services and value-based payments related to a variety of health care quality measures.

6. 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.

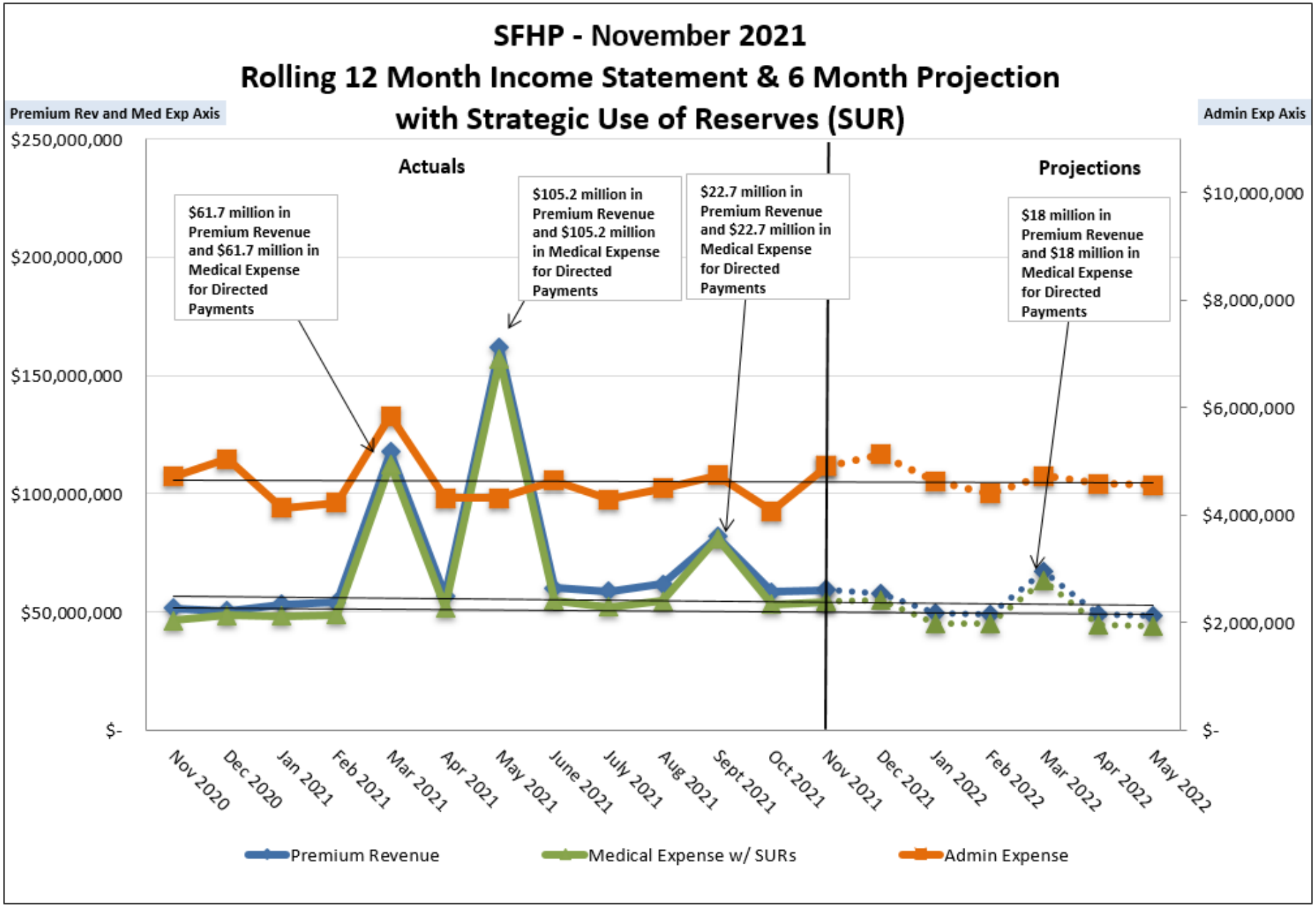
HIGHLIGHTED IMPACTS TO THE HEALTH PLAN AND/OR PROVIDERS

CY 2022 Medi-Cal Rates and Potential Impact to Provider Rates and SFHP Reserves

Please see separate memo – Finance Committee Agenda Item #5 and Governing Board Agenda Item #10.



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 - November 2021

	Nov-21			Nov-20	Fiscal Year to Date (21/22)			FY 20/21
	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 ($)	630,531	(652,559)	1,283,090	507,904	2,483,963	2,130,231	353,732	(1,323,633)
Total Medical Loss Ratio_All LOB	91.7%	93.6%	2.0%	92.7%	93.0%	94.7%	1.7%	96.1%
Admin Expense Ratio	7.2%	7.6%	0.4%	6.4%	6.1%	4.8%	-1.3%	4.3%
Number of FTE's	357			350				
Premium Revenue ($)	59,223,563	57,868,708	1,354,855	50,086,967	320,487,462	422,271,896	(101,784,435)	382,128,551
Medical Expenses ($)	54,282,557	54,183,872	(98,685)	46,428,480	298,190,395	399,873,271	101,682,876	367,352,678
Administration Expenses w/o HSF ($)	4,910,714	5,098,830	188,115	3,878,414	22,888,798	24,053,493	1,164,695	19,670,429
Member Months	163,954	161,328	2,626	149,315	814,807	800,826	13,981	738,790
Cash on Hand (Days)	14			7				

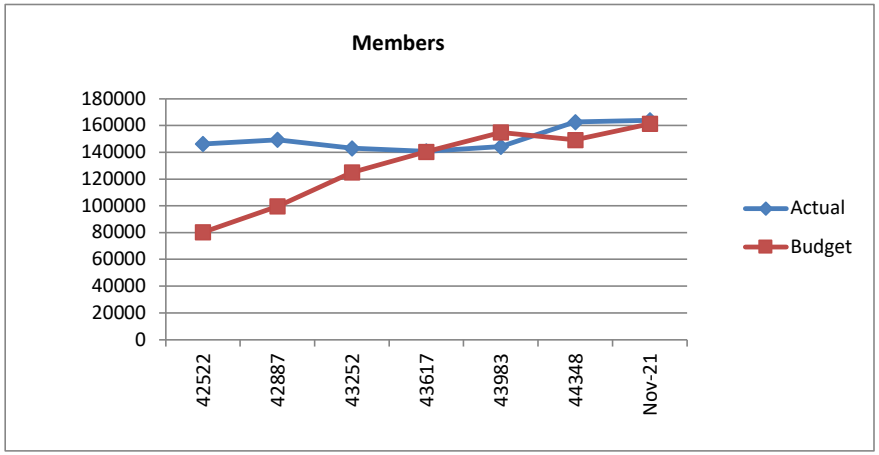
RESERVES:	November-2021	Budget @ 6/30/22	June-2021	June-2020	June-2019	June-2018	June-2017	June-2016
Reserves ($)	98,092,179	99,037,922	96,977,825	91,960,120	97,935,725	108,542,472	120,761,132	112,637,840
SUR carry-over balance from prior years	(2,411,584)	(2,500,000)	(2,511,173)	(4,145,463)	(6,046,189)	(15,567,350)		
FY18-19 SUR for Medical Groups and Targeted Interv.	(2,168,525)	-	(2,548,975)	(2,945,000)	(6,558,333)	0		
Adjusted Reserve Balance	93,512,071	96,537,922	91,917,677	84,869,657	85,331,203	92,975,122		
Reserve Policy 2x Premium Rev (Rolling 12 month avg)	118,447,125	96,586,486	118,618,434	86,669,751	93,747,256	93,684,010	94,325,464	100,027,410
Reserves Over (Under) 2 x Premium Revenue	(24,935,054)	(48,564)	(28,700,757)	(1,800,095)	(8,416,053)	(708,888)		
DMHC Required TNE	15,607,702	12,000,000	14,662,413	13,951,203	12,597,375	11,960,363	11,818,641	10,744,461
TNE Multiple	6.0	8.3	6.3	6.1	6.8	7.8	10.2	10.5

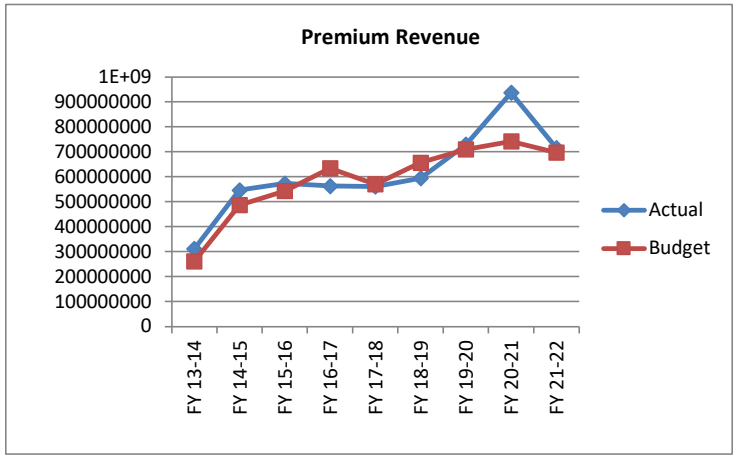
FINANCIAL TREND:	**FY 21/22 Original Budget**	**Change**
Premium Revenue ($)	422,271,896	(101,784,435)
Medical Expenses ($)	399,873,271	101,682,876
Administration Expenses w/o HSF ($)	24,053,493	1,164,695

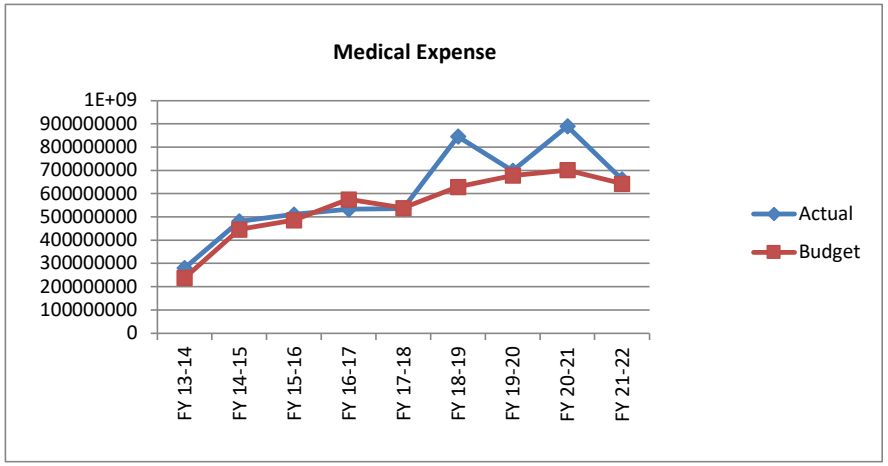
	November-2021	June-2021	June-2020	June-2019	June-2018	June-2017	June-2016	
Member Months	163,954	162,666	144,308	140,765	143,096	149,348	146,289	Membership for the Month
Average Monthly Enrollment	158,770	152,436	138,890	142,038	146,847	148,354	144,347	Rolling 12 Month Average

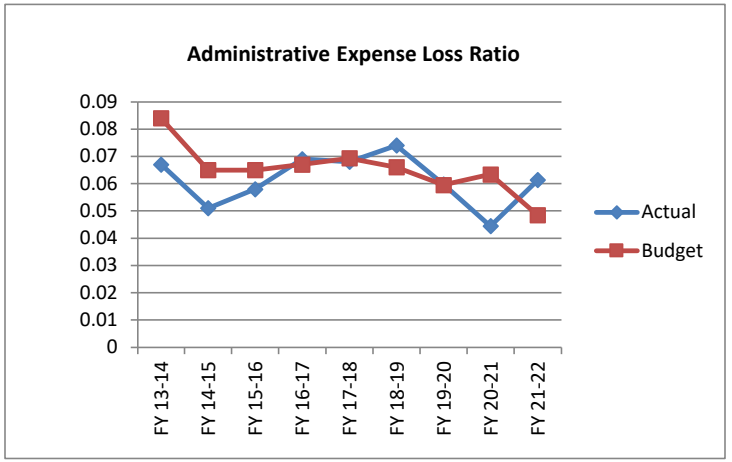
San Francisco Health Plan
Finance Big Picture Dashboard - November 2021

FINANCIAL TREND:
(Rolling 12 months)









San Francisco Health Plan

Finance Dashboard Metrics - November 2021

	Nov-21			Nov-20	Fiscal Year to Date (21/22)			FY 20/21
	Actual	Budget	Fav (Unfav)	Actual	Actual	Budget	Fav (Unfav)	Actual
Member Months	163,954	161,328	2,626 1.6%	149,315	814,807	800,826	13,981 1.7%	738,790
Premium Revenue ($)	59,223,563	57,868,708	1,354,855 2.3%	50,086,967	320,487,462	422,271,896	(101,784,435) -24.1%	382,128,551
Administration Expenses w/o HSF ($)	4,910,714	5,098,830	188,115	3,878,414	22,888,798	24,053,493	1,164,695	19,670,429
Admin Expense Ratio	7.2%	7.6%		6.4%	6.1%	4.8%		4.3%
Medical Expenses ($)	54,282,557	54,183,872	(98,685)	46,428,480	298,190,395	399,873,271	101,682,876	367,352,678
Total Medical Loss Ratio	91.7%	93.6%		92.7%	93.0%	94.7%		96.1%
MC Medical Loss Ratio	97.6%	86.9%		95.5%	94.2%	89.8%		91.3%
MC SPD Medical Loss Ratio	92.9%	94.2%		83.3%	95.1%	93.7%		96.9%
MC Expansion	94.0%	96.1%		94.4%	95.2%	97.3%		97.3%
HW Medical Loss Ratio	93.9%	97.0%		100.0%	94.7%	96.2%		101.4%
HSF + SFCMRA - TPA Fee ($)	1,027,674	1,150,445	(122,771) -10.7%	836,727	4,817,848	5,666,741	(848,893) -15.0%	4,397,129
Cash on Hand (Days)	14			7				
Maternity Reimb. Performance ($)	882,167	764,545	117,622	871,125	4,310,016	3,822,725	487,291	4,162,022
(per case pymt, actual vs. budget)			15.4%				12.7%	
Number of Births	105	91	14	99	513	455	58	473
Hep-C Revenue ($)	375,423	342,578	32,845	506,132	2,339,358	1,712,890	626,468	1,982,582
Hep-C Expense w/rebates (FFS + Cap) ($)	410,347	342,578	67,769	516,217	2,400,507	1,712,890	687,617	1,997,597
Net Margin ($)	(34,924)	0	(34,924)	(10,085)	(61,149)	0	(61,149)	(15,015)
Total Hep-C Treatments	174	171	3	204	1,077	855	222	795
Net Profit/Loss w/o HSF ($)	630,531	(652,559)	1,283,090	507,904	2,483,963	2,130,231	353,732	(1,323,633)

San Francisco Health Plan
Consolidated Balance Sheet for SFHA and SFCHA
As of November 30, 2021

		SFHA	HSF	11/30/2021 Total	11/30/2020 Total	Variance
	ASSETS					
	CURRENT ASSETS					
(1)	SFHP Cash and Cash Equivalents	8,051,188		8,051,188	3,531,781	4,519,407
	Short Term Investments	63,508,436		63,508,436	38,958,490	24,549,946
	HSF Cash and Cash Equivalents		726,107,287	726,107,287	629,533,210	96,574,077
	Petty Cash	1,000		1,000	1,000	-
(2)	Other Receivables	166,135		166,135	7,558,889	(7,392,755)
	Interest Receivable	137,075		137,075	175,649	(38,575)
	Grant Funds Receivable	106,834		106,834	-	106,834
(3)	Capitation Receivable	117,352,241		117,352,241	105,331,521	12,020,720
	HSF Operation Receivable	3,820,955		3,820,955	4,430,578	(609,623)
	HSF Provider Payment & Advance		1,488,462	1,488,462	1,082,122	406,341
(4)	HSF Receivables		15,329,201	15,329,201	15,563,477	(234,276)
	Prepaid Insurance	132,656		132,656	73,053	59,603
	HSF Prepaid Insurance	12,962		12,962	11,784	1,178
	Prepaid Rent	360,647		360,647	338,636	22,012
	Prepaid Expenses	4,734,496		4,734,496	3,251,218	1,483,278
	HSF Prepaid Expenses	26,111		26,111	13,688	12,424
	CalPERS Unfunded Pension			-	208,691	(208,691)
	CalPERS Deferred Outflow Fund	5,943,426		5,943,426	7,887,320	(1,943,894)
	Deposits	79,874		79,874	79,874	-
	Total Current Assets	204,434,035	742,924,950	947,358,985	818,030,980	129,328,004
	OTHER ASSETS					
	Long Term Investments	24,872,749		24,872,749	23,716,847	1,155,902
	Restricted Funds Required by DMHC	300,000		300,000	300,000	-
	Total Other Assets	25,172,749	-	25,172,749	24,016,847	1,155,902
	FIXED ASSETS					
	Furniture & Equipment	15,448,397		15,448,397	15,071,270	377,127
	Accumulated Depreciation	(13,177,067)		(13,177,067)	(11,520,390)	(1,656,677)
	Net Fixed Assets	2,271,331	-	2,271,331	3,550,880	(1,279,550)
	TOTAL ASSETS	**231,878,114**	**742,924,950**	**974,803,064**	**845,598,707**	**129,204,357**

San Francisco Health Plan
Consolidated Balance Sheet for SFHA and SFCHA
As of November 30, 2021

		SFHA	HSF	11/30/2021 Total	11/30/2020 Total	Variance
	LIABILITIES & FUND BALANCE					
	CURRENT LIABILITIES					
	Accounts Payable	17,383,688		17,383,688	15,499,215	1,884,473
	HSF Accounts Payable		871,292	871,292	717,469	153,823
	Deferred Rent	1,730,708		1,730,708	1,909,990	(179,282)
	Salaries/Benefits/PERS Payable	6,021,667		6,021,667	8,217,595	(2,195,928)
	CalPERS Unfunded Pension	(395,440)		(395,440)		(395,440)
	CalPERS Pension Deferred Inflow	227,878		227,878	180,387	47,491
	Notes Payable - Lease Equipment	738		738	69,899	(69,161)
	Unearned Premium Revenue	-		-	-	-
(5)	DHCS, MCO, IGT, AB-85, SB-335, SB-208 and ACA Payable	34,946,552		34,946,552	25,325,026	9,621,526
	HSF Earned Premium - Due to DPH		67,387,392	67,387,392	59,283,387	8,104,005
	Waiver, Discount, and Account Write-off		(43,696)	(43,696)	(325,801)	282,105
	HSF Unearned Participant Fees		148,151	148,151	1,322,113	(1,173,962)
	ESR due to DPH		499,212,660	499,212,660	423,187,616	76,025,045
	HSF MRA Fund Payable (Claim & Fee)		175,349,150	175,349,150	161,994,025	13,355,126
	Capitation Payable	60,123,767		60,123,767	53,864,409	6,259,358
	Claims Payable	1,897,799		1,897,799	1,292,928	604,870
	Claims IBNR	12,845,471		12,845,471	2,837,667	10,007,804
	TOTAL LIABILITIES	134,782,828	742,924,950	877,707,778	755,375,926	122,331,851
	FUND BALANCE					
	Contributed Capital	1,516,840		1,516,840	1,516,840	-
	Accumulated Surplus Revenue	94,091,376		94,091,376	90,029,573	4,061,803
	Current Year Surplus / Deficit	1,487,070		1,487,070	(1,323,633)	2,810,703
	Fund Balance	97,095,287	-	97,095,287	90,222,781	6,872,506
	TOTAL LIABILITIES & FUND BALANCE	**231,878,114**	**742,924,950**	**974,803,064**	**845,598,707**	**129,204,357**

San Francisco Health Plan
Consolidated Balance Sheet for SFHA and SFCHA
As of November 30, 2021

Notes:

(1) SFHP Cash, Cash Equivalents and Short Term Investments had a combined balance of $71.6 million at 11/30/21 as compared to $42.5 million at 11/30/20. The balances are much lower than normal as October Medi-Cal premium payments were not received until December 2021.

The days cash on hand as of 11/30/21 was 14 days compared to 33 days at 9/30/21. This decrease was due to a delay in receiving the October Medi-Cal premium payment. The payment arrived in December. SFHP has a $40 million line of credit with City National Bank to cover unexpected delays in payments from DHCS. Fortunately the payment for October arrived in early December, therefore it was not necessary to use the line of credit.

(2) The $7.4 million reduction in Other Receivables is due to the collection of $4.5 million in provider advances made during FY 19-20 to assist providers with cash flow as they worked through the pandemic. The remainder represents an amount collected from Kaiser. This amount was related to timing differences on capitation payments (SFHP pays Kaiser 98% of the final premium rates from DHCS).

(3) Capitation Receivable is a combination of Medi-Cal premiums totaling $117.2 million along with $191,000 of receivables for the Healthy Workers program.

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

(5) The balance at 11/30/21 included $23.5 million in Proposition 56 funding that will have to be returned to DHCS as we will not reach the required MLR of 95%. The balance also included $10.3 million in Managed Care Organization (MCO) tax payable 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 November 30, 2021

	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				
	18,979	17,249	1,730	10.0%	Medi-Cal - Adult 19	93,820	85,977	7,843	9.1%
	41,734	42,267	(533)	(1.3%)	Medi-Cal - Child 18	208,456	210,680	(2,224)	(1.1%)
	14,767	14,029	738	5.3%	Medi-Cal - Dual Members	73,338	69,928	3,410	4.9%
	13,493	13,206	287	2.2%	Medi-Cal SPD	67,370	65,962	1,408	2.1%
	63,255	62,902	353	0.6%	Medi-Cal Expansion	312,838	309,904	2,934	0.9%
	11,726	11,675	51	0.4%	Healthy Workers	58,985	58,375	610	1.0%
(1)	163,954	161,328	2,626	1.6%	TOTAL MEMBER MONTH	814,807	800,826	13,981	1.7%
					REVENUE				
	6,556,604	5,918,477	638,127	10.8%	Medi-Cal - Adult 19	36,027,221	41,223,766	(5,196,545)	(12.6%)
	5,314,348	5,343,193	(28,845)	(0.5%)	Medi-Cal - Child 18	28,415,330	37,763,878	(9,348,549)	(24.8%)
	2,317,800	2,200,808	116,992	5.3%	Medi-Cal - Dual Members	11,511,244	11,124,675	386,569	3.5%
	12,631,440	12,337,486	293,954	2.4%	Medi-Cal SPD	74,640,274	105,970,016	(31,329,742)	(29.6%)
	25,417,372	25,127,409	289,963	1.2%	Medi-Cal Expansion	134,728,514	191,482,884	(56,754,370)	(29.6%)
	90,000	71,415	18,585	26.0%	MC Health Homes	474,860	357,075	117,785	33.0%
	6,895,999	6,869,920	26,079	0.4%	Healthy Workers	34,690,019	34,349,601	340,418	1.0%
(2)	59,223,563	57,868,708	1,354,855	2.3%	Total Capitation Revenue	320,487,462	422,271,896	(101,784,435)	(24.1%)
	648,115	719,769	(71,654)	(10.0%)	Other Income - Admin Svc & TPL	3,216,325	3,576,765	(360,440)	(10.1%)
	-	-			Other Income - Navigator Grant	21,334	-	21,334	
	-	-	-		Other Income - BHI	-	-	-	
	648,115	719,769	(71,654)	(10.0%)	Total Other Income	3,237,660	3,576,765	(339,106)	(9.5%)
	59,871,678	**58,588,477**	**1,283,201**	**2.2%**	**TOTAL REVENUE**	**323,725,121**	**425,848,662**	**(102,123,540)**	**(24.0%)**

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
For the Month Ending November 30, 2021

	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				
	17,961,945	18,062,193	100,248	0.6%	Professional	89,664,664	89,278,295	(386,369)	(0.4%)
	24,787,005	24,583,067	(203,938)	(0.8%)	Hospital	127,082,842	122,520,307	(4,562,535)	(3.7%)
	9,136,989	9,094,748	(42,241)	(0.5%)	Pharmacy	47,059,628	45,063,877	(1,995,750)	(4.4%)
	50,803	33,475	(17,328)	(51.8%)	Immunizations	198,758	166,009	(32,750)	(19.7%)
	892,966	843,614	(49,352)	(5.9%)	Vision and Mental Health	4,935,980	4,195,157	(740,822)	(17.7%)
	1,452,849	1,566,775	113,926	7.3%	Health Ed & Stop Loss & Other	29,248,524	138,649,626	109,401,102	78.9%
(3)	**54,282,557**	**54,183,872**	**(98,685)**	**(0.2%)**	**Total Medical Expenses**	**298,190,395**	**399,873,271**	**101,682,876**	**25.4%**
	91.7%	93.6%			Medical Cost Ratio %	93.0%	94.7%		
					Operating Expenses				
	2,528,107	2,488,698	(39,409)	(1.6%)	Compensation & Benefits	12,287,181	11,920,403	(366,778)	(3.1%)
	47,803	78,162	30,359	38.8%	GASB-68 CalPERS Contribution	158,315	414,819	256,504	61.8%
	451,828	513,081	61,253	11.9%	Lease, Insurance, D & A	2,302,755	2,545,209	242,454	9.5%
	149,732	108,004	(41,728)	(38.6%)	Marketing & Outreach	407,245	477,131	69,886	14.6%
	400,029	355,161	(44,868)	(12.6%)	PBM and Mental Health TPA Fees	1,854,050	1,762,835	(91,215)	(5.2%)
	293,889	483,241	189,352	39.2%	Professional Fees & Consulting	1,560,094	2,353,704	793,611	33.7%
	1,039,325	1,072,484	33,158	3.1%	Other Expenses	4,319,158	4,579,391	260,233	5.7%
(4)	4,910,714	5,098,830	188,115	3.7%	Total Operating Expenses	22,888,798	24,053,493	1,164,695	4.8%
	7.2%	7.6%			Administrative Cost Ratio %	6.1%	4.8%		
					(Op Exp-Other Inc/Premium)				
	59,193,272	**59,282,702**	**89,430**	**0.2%**	**TOTAL EXPENSES**	**321,079,193**	**423,926,764**	**102,847,571**	**24.3%**
	678,406	**(694,225)**	**1,372,631**	**(197.7%)**	**Operating Surplus / Deficit**	**2,645,928**	**1,921,897**	**724,031**	**37.7%**
	3,693	41,667	(37,974)	(91.1%)	Interest Income & Realized G/L on Investment	275,525	208,333	67,192	32.3%
	(51,568)	-	(51,568)		Unrealized Gain / Loss on Investment	(437,490)	-	(437,490)	
	(47,875)	41,667	(89,542)	(214.9%)	Total Interest Income & Realized G/L on Investment	(161,965)	208,333	(370,298)	(177.7%)
	630,531	**(652,559)**	**1,283,090**	**(196.6%)**	**SURPLUS / DEFICIT**	**2,483,963**	**2,130,231**	**353,732**	**16.6%**

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
For the Month Ending November 30, 2021

Notes:

Following are key points that impacted our financial performance during November 2021. For a more detailed discussion of each of these points, please refer to the attached FINANCIAL RESULTS-NOVEMBER 2021 memo.

(1) November member months were 1.6% ahead of budget which is not surprising given the fact that we started the fiscal year with 2,400 more Medi-Cal members and 194 more Healthy Workers members than expected. Membership is expected to increase over the next two months as the Public Health Emergency (PHE) will remain in place until at least mid-January 2022. Due to some upcoming changes to the Medi-Cal eligibility rules, we expect to add approximately 3,000 members in January 2022. It is important to note that once the PHE ends, we expect a gradual decline in membership as the redetermination process will resume which means members will be placed on hold or terminated.

(2) Premium revenue was up $1.3 million due to an additional 2,626 member months along with actual premium rates that were 0.8% higher than what was used for the budget projections. Membership mix was also favorable as 90% of the additional member months were in the Adult, Adult Expansion and Seniors and Persons with Disabilities (SPD) categories of aid where the per member, per month premium rates are much higher than the Child and Duals categories of aid.

(3) Overall medical expense was up $99,000. We had $694,00 more in capitation expense as the result of having 2,626 more member months as well as a more favorable membership mix than what the budget projected. This additional cost is offset by the revenue SFHP received for these additional members. We saw $523,000 less in fee-for-service claims. Claims volume during the second half of November was less than anticipated, most likely due to the Thanksgiving holiday break. We accrued the first claims check run in December which is our normal practice, however we did not make up for the shortfall in the volume for November. The expectation is that claims expense for December will end up higher than budget. Pharmacy expense was $42,000 higher than budget while Health Education and Utilization Management expenses were $114,000 less than budget due to timing.

(4) Overall administrative expenses came in $188,000 less than budget. This is primarily due to lower than expected professional fees and consulting costs. This difference is due to timing as some professional services were budgeted slightly heavier in the first few months of FY 21-22. It is expected that actual expenses will align more closely with the budget in the coming months.

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
For the Month Ending November 30, 2021
($ 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				
345.47	343.12	2.34	0.7%	Medi-Cal - Adult 19	384.00	479.48	(95.47)	(19.9%)
127.34	126.41	0.92	0.7%	Medi-Cal - Child 18	136.31	179.25	(42.93)	(24.0%)
156.96	156.88	0.08	0.1%	Medi-Cal - Dual Members	156.96	159.09	(2.13)	(1.3%)
942.82	939.64	3.18	0.3%	Medi-Cal SPD	1,114.96	1,611.94	(496.98)	(30.8%)
401.82	399.47	2.35	0.6%	Medi-Cal Expansion	430.67	617.88	(187.21)	(30.3%)
588.13	588.43	(0.30)	(0.1%)	Healthy Workers	588.12	588.43	(0.31)	(0.1%)
361.22	**358.70**	**2.52**	**0.7%**	**Total Capitation Revenue**	**393.33**	**527.30**	**(133.97)**	**(25.4%)**
3.95	4.46	(0.51)	(11.4%)	Other Income - Admin Svc & TPL	3.95	4.47	(0.52)	(11.7%)
-	-			Other Income - Navigator Grant	0.03	-	0.03	
3.95	**4.46**	**(0.51)**	**(11.4%)**	**Total Other Income**	**3.97**	**4.47**	**(0.50)**	**(11.1%)**
365.17	**363.16**	**2.01**	**0.6%**	**TOTAL REVENUE**	**397.30**	**531.77**	**(134.46)**	**(25.3%)**

San Francisco Health Plan
Income Statement w/o HSF
Consolidated Statement for SFHA and SFCHA
For the Month Ending November 30, 2021
($ 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				
109.55	111.96	2.40	2.1%	Professional	110.04	111.48	1.44	1.3%
151.18	152.38	1.20	0.8%	Hospital	155.97	152.99	(2.97)	(1.9%)
55.73	56.37	0.65	1.1%	Pharmacy	57.76	56.27	(1.48)	(2.6%)
0.31	0.21	(0.10)	(49.3%)	Immunizations	0.24	0.21	(0.04)	(17.7%)
5.45	5.23	(0.22)	(4.2%)	Vision and Mental Health	6.06	5.24	(0.82)	(15.6%)
8.86	9.71	0.85	8.8%	Health Ed & Stop Loss & Other	35.90	173.13	137.24	79.3%
331.08	**335.86**	**4.78**	**1.4%**	**Total Medical Expenses**	**365.96**	**499.33**	**133.36**	**26.7%**
91.7%	93.6%			Medical Cost Ratio %	93.0%	94.7%		
				Operating Expenses				
15.42	15.43	0.01	0.0%	Compensation & Benefits	14.76	14.24	(0.52)	(3.7%)
0.29	0.48	0.19	39.8%	GASB-68 CalPERS Contribution	0.15	0.57	0.42	73.3%
2.76	3.18	0.42	13.3%	Lease, Depreciation & Amortization	3.39	3.23	(0.16)	(5.0%)
0.91	0.67	(0.24)	(36.4%)	Marketing & Outreach	0.26	0.76	0.50	66.2%
2.44	2.20	(0.24)	(10.8%)	PBM and Mental Health TPA Fees	1.96	2.20	0.24	11.0%
1.79	3.00	1.20	40.2%	Professional Fees & Consulting	1.32	2.65	1.33	50.2%
6.34	6.65	0.31	4.6%	Other Expenses	4.70	5.54	0.84	15.2%
29.95	**31.61**	**1.65**	**5.2%**	**Total Operating Expenses**	**26.55**	**29.19**	**2.65**	**9.1%**
7.2%	7.6%			Administrative Cost Ratio %	5.7%	4.7%		
361.04	**367.47**	**6.43**	**1.8%**	**TOTAL EXPENSES**	**392.51**	**528.52**	**136.01**	**25.7%**
4.14	**(4.30)**	**8.44**	**-196.2%**	**Operating Surplus / Deficit**	**4.79**	**3.25**	**1.54**	**47.5%**
0.02	0.26	(0.24)	(91.3%)	Interest Income & Realized G/(L) on Investment	0.20	0.26	(0.07)	(25.3%)
(0.31)	-	(0.31)	-	Unrealized Gain / (Loss) on Investment	0.46	-	0.46	-
-	-	-	-	Realized Gain / (Loss) on Lease Equipments	-	-	-	-
(0.29)	0.26	(0.55)			0.65	0.26	0.39	149.7%
3.85	**(4.04)**	**7.89**	**-195.1%**	**SURPLUS / DEFICIT**	**5.45**	**3.51**	**1.93**	**55.1%**

San Francisco Health Plan
Income Statement
Healthy San Francisco & SF Covered MRA
For the Month Ending November 30, 2021

Current Month Actual	Current Month Budget	Fav (Unfav) Amount ($)	Fav (Unfav) %		Year to Date Actual	Year to Date Budget	Fav (Unfav) ($)	Fav (Unfav) %
				REVENUE				
1,027,674	**1,150,445**	**(122,771)**	**-10.7%**	**TPA Fee - HSF + SFCMRA**	**4,817,848**	**5,666,741**	**(848,893)**	**(15.0%)**
				EXPENSES				
802,088	849,511	47,424	5.6%	Compensation & Benefits	3,954,070	4,162,071	208,002	5.0%
94,316	94,316	-	0.0%	Lease, Insurance, D & A	466,015	471,582	5,567	1.2%
64,697	41,831	(22,866)	(54.7%)	Marketing & Outreach	78,608	209,156	130,548	62.4%
316	67,167	66,850	99.5%	Professional Fees & Consulting	1,342	335,833	334,491	99.6%
66,256	97,620	31,364	32.1%	Other Expenses	317,813	488,098	170,285	34.9%
1,027,674	**1,150,445**	**122,771**	**10.7%**	**TOTAL EXPENSES**	**4,817,848**	**5,666,741**	**848,893**	**15.0%**
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)

November 30, 2021

Fixed Income Securities	Purchase Date	Quantity	Purchase Price	11/30/21 Price	Market Value 11/30/21	Amortized Prem / Disc	Remaining Cost	Unrealized Gain (Loss)	Estimated Annual Income
Local Agency Investment Fund (LAIF) - rate @ .262%			$ 1,220,852		**$ 1,220,852**	$ -	$ 1,220,852	$ -	$ 3,199
Principal Cash									
Principal Cash		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -
City National Rochdal Gov - 0.01%		62,065	$ 62,065	$ 1.000	$ 62,065	$ 1	$ 62,066	$ (1)	$ 6
Total Cash and Cash Equivalents		**$ 62,065**	**$ 62,065**		**$ 62,065**	**$ 1**	**$ 62,066**	**$ (1)**	**$ 6**
U.S. Govt Bonds, Notes, & U.S. Agencies									
US Treasury Note - 2.625% - Mat 02/28/2023	10/6/21	485,000	$ 501,653	$ 102.848	$ 498,813	$ (797)	$ 500,856	$ (2,043)	$ 12,731
US Treasury Note - 1.500% - Mat 03/31/2023	10/6/21	805,000	$ 820,691	$ 101.531	$ 817,325	$ (709)	$ 819,982	$ (2,658)	$ 12,075
US Treasury Note - 2.750% - Mat 04/30/2023	10/30/19	840,000	$ 871,997	$ 103.313	$ 867,829	$ (25,755)	$ 846,242	$ 21,587	$ 23,100
US Treasury Note - 1.375% - Mat 09/30/2023	10/6/21	990,000	$ 1,011,579	$ 101.598	$ 1,005,820	$ (730)	$ 1,010,849	$ (5,029)	$ 13,613
US Treasury Note - 2.750% - Mat 11/15/2023	5/7/20	680,000	$ 738,517	$ 104.277	$ 709,084	$ (24,289)	$ 714,229	$ (5,145)	$ 18,700
US Treasury Note - 0.250% - Mat 11/15/2023	10/6/21	1,010,000	$ 1,008,738	$ 99.414	$ 1,004,081	$ 39	$ 1,008,777	$ (4,696)	$ 2,525
US Treasury Note - 2.875% - Mat 11/30/2023	10/6/21	950,000	$ 1,001,990	$ 104.598	$ 993,681	$ (1,623)	$ 1,000,367	$ (6,686)	$ 27,313
US Treasury Note - 2.375% - Mat 02/29/2024	12/23/20	125,000	$ 133,691	$ 103.844	$ 129,805	$ (2,325)	$ 131,366	$ (1,561)	$ 2,969
US Treasury Note - 2.125% - Mat 03/31/2024	6/8/20	585,000	$ 624,945	$ 103.379	$ 604,767	$ (14,833)	$ 610,111	$ (5,344)	$ 12,431
US Treasury Note - 2.000% - Mat 06/30/2024	10/6/21	785,000	$ 817,811	$ 103.250	$ 810,513	$ (806)	$ 817,005	$ (6,492)	$ 15,700
US Treasury Note - 2.375% - Mat 08/15/2024	5/7/20	570,000	$ 619,229	$ 104.293	$ 594,470	$ (16,886)	$ 602,343	$ (7,873)	$ 13,538
US Treasury Note - 1.250% - Mat 08/31/2024	3/15/21	985,000	$ 1,009,122	$ 101.285	$ 997,657	$ (5,535)	$ 1,003,587	$ (5,930)	$ 12,313
US Treasury Note - 2.250% - Mat 12/31/2024	6/2/20	685,000	$ 745,553	$ 104.203	$ 713,791	$ (18,722)	$ 726,831	$ (13,041)	$ 15,413
US Treasury Note - 0.375% - Mat 04/30/2025	6/2/20	625,000	$ 626,904	$ 98.066	$ 612,913	$ (549)	$ 626,355	$ (13,443)	$ 2,344
US Treasury Note - 2.875% - Mat 05/31/2025	6/2/20	670,000	$ 754,430	$ 106.578	$ 714,073	$ (23,929)	$ 730,502	$ (16,429)	$ 19,263
US Treasury Note - 2..750% - Mat 06/30/2025	7/17/20	700,000	$ 763,218	$ 106.227	$ 743,589	$ (21,393)	$ 741,825	$ 1,764	$ 19,250
US Treasure Note - 0.250% Mat 07/31/2025	11/3/20	520,000	$ 516,913	$ 97.301	$ 505,965	$ 644	$ 517,557	$ (11,591)	$ 1,300
US Treasury Note - 2.00% - Mat 08/15/2025	9/10/20	150,000	$ 162,604	$ 103.613	$ 155,420	$ (2,892)	$ 159,712	$ (4,292)	$ 3,000
US Treasury Note - 0.250% - Mat 09/30/2025	10/6/21	645,000	$ 631,369	$ 97.113	$ 626,379	$ 230	$ 631,599	$ (5,220)	$ 1,613
US Treasury Note - 0.375% - Mat 11/30/2025	12/23/20	250,000	$ 250,127	$ 97.293	$ 243,233	$ (22)	$ 250,105	$ (6,873)	$ 938
US Treasury Note - 0.375% - Mat 12/31/2025	5/7/21	510,000	$ 501,732	$ 97.207	$ 495,756	$ 860	$ 502,592	$ (6,837)	$ 1,913
US Treasury Note - 0.375% - Mat 01/31/2026	2/16/21	505,000	$ 502,574	$ 97.086	$ 490,284	$ 345	$ 502,919	$ (12,635)	$ 1,894
US Treasury Note - 2.250% - Mat 03/31/26	10/6/21	355,000	$ 376,120	$ 104.856	$ 372,239	$ (316)	$ 375,803	$ (3,564)	$ 7,988
US Treasury Note - 0.750% - Mat 04/30/2026	5/7/21	575,000	$ 573,720	$ 98.430	$ 565,973	$ (1,009)	$ 572,710	$ (6,738)	$ 4,313
US Treasury Note - 0.625% - Mat 07/31/2026	8/9/21	965,000	$ 956,305	$ 97.668	$ 942,496	$ (1,847)	$ 954,458	$ (11,962)	$ 6,031
Federal National Mortgage Assn-2.625% Mat 09/06/2024	10/30/19	790,000	$ 824,357	$ 105.079	$ 830,124	$ (14,523)	$ 809,834	$ 20,290	$ 20,738
Total U.S. Govt Bonds, Notes, & U.S. Agencies		**$ 16,755,000**	**$ 17,345,887**		**$ 17,046,077**	**$ (177,370)**	**$ 17,168,518**	**$ (122,441)**	**$ 273,000**
Corporate Bonds									
Wells Fargo & Company - 3.750% Mat - 01/24/2024	4/22/19	685,000	$ 701,050	$ 105.390	$ 721,922	$ (8,487)	$ 692,563	$ 29,359	$ 25,688
Morgan Stanley - Variable rate 3.737% Mat 04/24/2024	7/25/19	575,000	$ 599,121	$ 103.755	$ 596,591	$ (11,476)	$ 587,646	$ 8,946	$ 21,488
United Health Group Inc - 2.375% Mat 08/15/2024	2/17/21	320,000	$ 341,024	$ 103.605	$ 331,536	$ (4,176)	$ 336,848	$ (5,312)	$ 7,600
JP Morgan Chase - 3.875% Mat 09/10/2024	5/10/21	680,000	$ 745,151	$ 106.703	$ 725,580	$ (9,135)	$ 736,016	$ (10,436)	$ 26,350
Paccar Financial Corp - 1.80% Mat - 02/06/2025	5/18/20	375,000	$ 380,438	$ 101.648	$ 381,180	$ (1,649)	$ 378,789	$ 2,391	$ 6,750
Bank of America Corp - Variable rate 3.458% Mat 03/15/2025	5/12/20	695,000	$ 742,031	$ 104.742	$ 727,957	$ (14,123)	$ 727,908	$ 49	$ 24,033
3M Company -2.650% Mat 04/15/2025	5/19/20	360,000	$ 382,644	$ 104.557	$ 376,405	$ (6,626)	$ 376,018	$ 387	$ 9,540
Citigroup Inc - Variable Rate 3.352% Mat 04/24/2025	5/19/20	480,000	$ 505,618	$ 104.701	$ 502,565	$ (7,496)	$ 498,122	$ 4,443	$ 16,090
Chevron USA INC - .687% Mat 08/12/2025	2/17/21	505,000	$ 504,753	$ 97.901	$ 494,400	$ 38	$ 504,791	$ (10,391)	$ 3,469
Comcast Corp- 3.95% Mat 10/15/2025	2/17/21	440,000	$ 501,675	$ 109.029	$ 479,728	$ (9,212)	$ 492,463	$ (12,736)	$ 17,380
Apple Inc - .700% Mat 02/08/2026	2/17/21	630,000	$ 629,049	$ 97.656	$ 615,233	$ 133	$ 629,181	$ (13,949)	$ 4,410
Total Corporate Bonds		**5,745,000**	**6,032,551**		**5,953,097**	**(72,207)**	**5,960,345**	**(7,248)**	**162,797**
Foreign Bonds									
BK Montreal Mtn. 3.3% Mat - 02/05/2024	3/29/19	700,000	$ 709,618	$ 104.772	$ 733,404	$ (5,062)	$ 704,556	$ 28,848	$ 23,100
Santander UK PLC. 4% Mat - 03/13/2024	10/31/19	565,000	$ 603,606	$ 106.380	$ 601,047	$ (17,495)	$ 586,112	$ 14,935	$ 22,600
Total Foreign Bonds		**1,265,000**	**1,313,224**		**1,334,451**	**(22,556)**	**1,290,668**	**43,783**	**45,700**
Municipal Bonds									
Wisconsin State - 0.361% Mat-05/01/2024	3/17/2021	545,000	$ 545,000	$ 98.922	$ 539,125	$ -	$ 545,000	$ (5,875)	$ 1,967
Total Municipal Bonds		**545,000**	**545,000**		**539,125**	**-**	**545,000**	**(5,875)**	**1,967**
Municipal Zero Coupon Bonds									
Total Zero Coupon Bonds		**-**	**$ -**		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Total of City National Investments		**24,310,000**	**25,236,663**		**24,872,749**	**(272,133)**	**24,964,530**	**(91,781)**	**483,465**
Total City National Holdings		**24,372,065**	**$ 25,298,728**		**$ 24,934,814**	**$ (272,132)**	**$ 25,026,596**	**$ (91,782)**	**$ 483,471**
Estimated Accrued Income					$ 100,295.75				
Total of City National Investments					**$ 25,035,109.71**				
					$ (31,378.85)				
				Unrealized G/L of Market Value				**$ (363,914)**	$ -
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			**$ 26,819,579**		**$ 26,455,666**			**$ (91,782)**	**$ 488,470**

City National Rochdale®
INVESTMENT MANAGEMENT

SFHA – Short Intermediate Portfolio Review Snapshot as of 11/30/2021

Estimated MV + Accrued as of:	10/31/2021	11/30/2021	Change
	$25,066,489	$25,035,110	-$31,379

Fiscal Year Accounting Estimates 6/30/2021 through 11/30/2021:

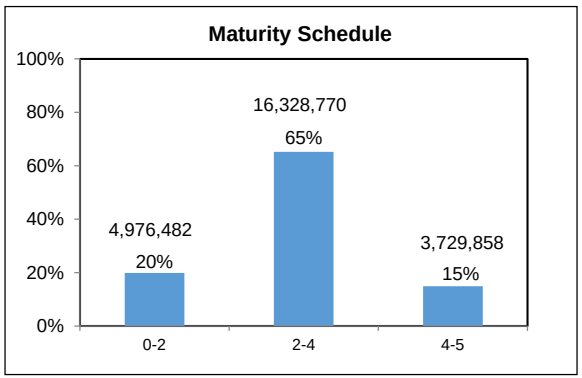
Beginning Balance (6/30/2021)	**$25,211,795**
Contributions	$0
Withdrawals	$0
Interest & Dividends Received	$231,585
Accrued Interest Sold	$26,098
Accrued Interest Purchased	-$23,887
Accrued Interest	$100,296
Fees	-$33,871
Value Before Market Changes	**$25,512,016**
Change in Market Value	-$476,906
Ending Balance (11/30/2021)	**$25,035,110**

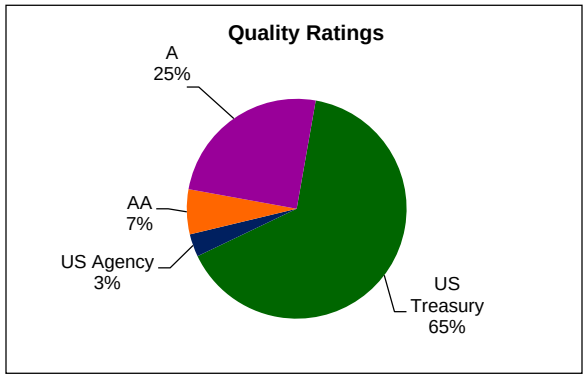
Portfolio Structure

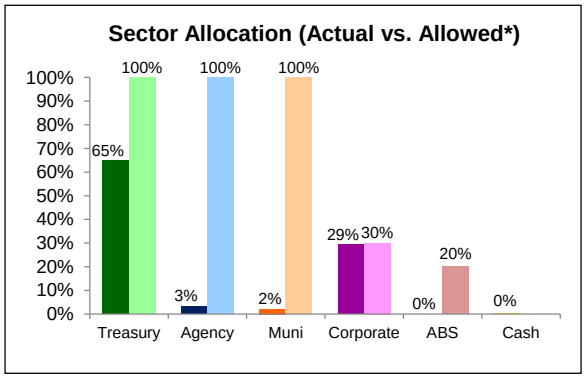
Yield to Maturity	0.88%
Yield to Cost	0.88%
Average Maturity	2.86 Years
Average Credit Quality	AAA-

Historical Total Return Performance as of 11/30/2021:

Time Period	Portfolio	Barclays 1-5 Year Gov't/Credit
Fiscal YTD (6/30/21 – 11/30/2021)	-0.57%	-0.52%
November 2021	-0.10%	-0.06%
Inception to Date (5/31/12 – 11/30/2021)	2.16%	1.77%







*At time of purchase

Credit Issues

There were no credit issues for the month of November.

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 11/30/2021

Estimated MV + Accrued as of:	10/31/2021	11/30/2021	Change
	$107,329,611	$62,320,802	-$45,008,809

Portfolio Structure

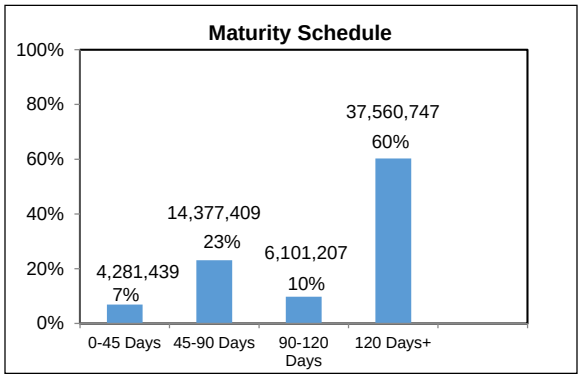
Yield to Maturity	0.25%
Yield to Cost	0.20%
Average Maturity	138 Days
Average Credit Quality	AA

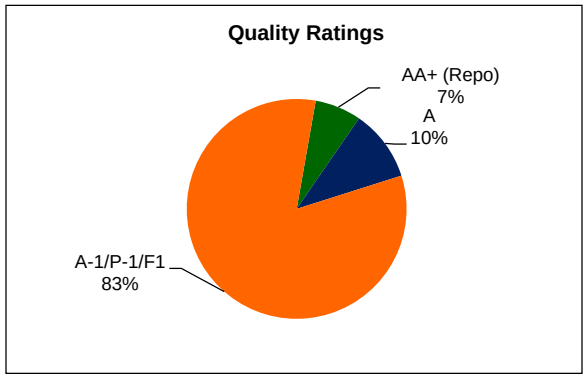
Fiscal Year Accounting Estimates 6/30/2021 through 11/30/2021:

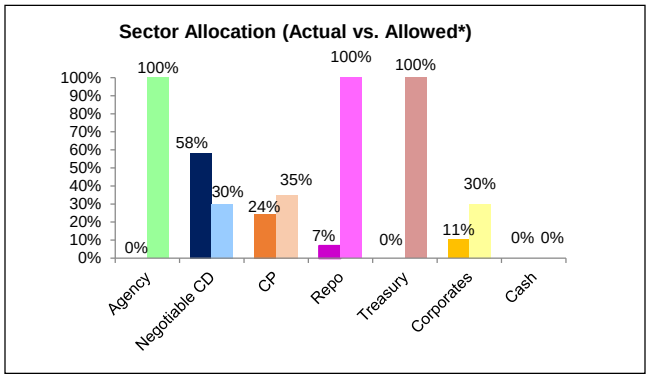
Beginning Balance (6/30/2021)	**$96,332,230**
Contributions	$238,000,000
Withdrawals	-$272,000,000
Interest & Dividends Received	$91,959
Accrued Interest Sold	$4,766
Accrued Interest Purchased	-$12,858
Accrued Interest	$95,554
Fees	-$38,376
Value Before Market Changes	**$62,473,275**
Change in Market Value	-$152,473
Ending Balance (11/30/2021)	**$62,320,802**

Historical Total Return Performance as of 11/30/2021:

Time Period	Portfolio	Barclays US T-Bill 1-3 Month
Fiscal YTD (6/30/21 – 11/30/2021)	0.03%	0.02%
November 2021	0.00%	0.01%
Inception to Date (7/3/17 – 11/30/2021)	1.29%	1.16%







*At time of purchase

Credit Issues

There were no credit issues for the month of November. 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
Action Item

- Review and Approval of Reinsurance Vendor Contract

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: December 22, 2021

To	**SFHP Finance Committee and Governing Board**
From	**Skip Bishop, CFO**
Regarding	**Review and Approval of Contract with Reinsurance Vendor**

Recommendation:
San Francisco Health Plan (SFHP) will bring a recommendation to the Finance Committee and Governing Board meetings to contract with a reinsurance vendor for calendar year (CY) 2022.

SFHP will bring the proposed rate or rate range to the Finance Committee and Governing Board meetings for approval as we are collecting more information and our broker is continuing to negotiate a final price.

Background:
SFHP purchases reinsurance to protect from losses due to high-cost professional and hospital claims and encounters.

Our current broker has requested quotes from several carriers offering reinsurance coverage. We have been with our current broker and reinsurance carrier since CY 2015.

RGA, our current reinsurance carrier, has presented four options for the CY 2022 renewal:

Option #1 – Renew under existing policy terms with no changes. Annual reinsurance premiums would decrease by 2.0% or $91,000.

Option #2 – Renew under existing policy terms and include coverage for major organ transplants. Annual reinsurance premiums would increase by 0.7% over current rates, or $33,000.

Option #3 – Renew under existing policy terms and include coverage for gene and cell therapy drugs. Annual reinsurance premiums would increase by 14.8% or $667,000.

Option #4 – Renew under existing policy terms and include coverage for major organ transplants and gene and cell therapy drugs. Annual reinsurance premiums would increase by 17.5% or $792,000.

Reinsurance premiums for CY 2021 will be approximately $4.5 million. Under the options outlined above, premiums for CY 2022 would range from $4.4 million to $5.3 million.

The final recovery percentages for CY 2019 and CY 2020 will be in the range of 80% to 85%. For CY 2021, the final recovery percentage is expected to be in the range of 75% to 80%. Reinsurance companies target their premiums to achieve a 70% to 75% loss ratio.

SFHP is working with our Pharmacy department, other Local Health Plans, and the reinsurance broker to evaluate adding coverage for gene and cell therapy drugs. These drugs are very expensive and not part of the Medi-Cal pharmacy carve-out to DHCS. Should we choose to add this coverage, the additional premium would affect the hospital portion of the reinsurance policy.

We will provide additional information and a recommendation to the Finance Committee and Governing Board on January 5, 2022.

Agenda Item 5
Discussion Item

- Federal and State Updates

State & Federal Updates

Sumi Sousa

FY 22-23: Another Record State Surplus

- The state's Legislative Analyst Office estimates a ***$31B state surplus*** for the upcoming fiscal year. Why?
  - Last four months of 2021 have seen rapid economic growth in CA
    - September 2021 collections from state's three main taxes are 40% higher than September 2020 and 60% higher than September 2019 collections
    - Overall state tax collections for the 12-month period ending September 2021 grew at an annual rate of 30%, the highest growth rate in 40 years
  - FY 21-22 state budget assumed lower revenues; current spending is also lower than estimated, further contributing to the size of the estimated surplus
- CA's state surplus in FY 21-22 was ***$47B***

Expect Similar Approach in FY 22-23

- Governor Newsom's proposed FY 22-23 state budget to be released January 10
- Expect bulk of spending for FY 22-23 on one-time or temporary programs and then shoring up of state reserves, similar to FY 21-22
  - In FY 21-22:
    - $39B on one-time spending such as state stimulus payments, transportation projects, drought relief
    - $3.4B in new, ongoing programs such as CalAIM, Medi-Cal expansion
    - $4.6B went to reserve, debts, liabilities

Implications for Medi-Cal, SFHP

- Surplus of this size is great news for Medi-Cal
  - FY 21-22 state budget added $8.1B in one-time and ongoing spending to Medi-Cal including:
    - Major commitments to child and young adult behavioral health, CalAIM, Medi-Cal expansion for 50+ undocumented adults, new benefits
  - Potential for more investments in FY 22-23
- In FY 22-23, anticipate reduction in SFHP membership once the public health emergency ends and Medi-Cal renewal work resumes
  - More CalAIM rollout: getting ready for long-term care benefit and duals

Build Back Better (BBB) Stalls in Senate

- House passed $2T BBB in November
- Senator Manchin has indicated that he won't support the bill; means BBB in its current form is stalled
- Medicaid-related provision in Senate version of BBB:
  - 12-month continuous eligibility for kids in Medicaid
  - 12-month continuous Medicaid eligibility for pregnant and post-partum individuals
  - Federal Medicaid benefit for low-income people in non-Medicaid expansion states
  - $146B in increased Medicaid funding for Home and Community Based Services

BBB Stalls in Senate; Next Steps?

- Other Important BBB Health Provisions for CA
  - Extends bigger Covered CA affordability subsidies through 2025, improving affordability, providing major state General Fund relief and increasing enrollment in Covered CA and Medi-Cal
- Manchin opposition is latest impasse for President Biden in his aim to pass historic legislation investing in the social safety net that will gain 50 votes in Senate
- But this impasse is more serious and may be irreversible – more negotiations in January to potentially salvage BBB

Agenda Item 6

Chief Medical Officer's (CMO) Report

Discussion and Action Items:

a. Medi-Cal Rx Implementation Updates

b. Review and Approval of Evaluation of 2021 Quality Improvement Program

c. Review and Approval of 2022 Quality Improvement Program Workplan

December 2021 - Governing Board - CMO Report

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NCQA Accredited Medicaid HMO Health Plan

Medi-Cal Rx Transition – January 2022

Review and Approval of Evaluation of SFHP's 2021 Quality Improvement Program

Review and Approval of SFHP's 2022 Quality Improvement Workplan

Medi-Cal Rx - Pharmacy Transition

- **Medi-Cal Rx will occur effective January 1, 2022**
  - Administration of Formulary, Network, Claims payment with DHCS/Magellan
  - SFHP continues quality monitoring and care coordination pharmacy activities
  - SFHP supporting High Risk Transition members
  - Provider training/Member support will continue to be critical

Governing Board's Role in QI Program

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- Oversight for SFHP's ongoing QI Program
- Updates on SFHP's annual work plan through quarterly monitoring (QIC minutes)
- Review and approve the annual QI Evaluation and subsequent year's Work Plan

QI Workplan Domains

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- Keeping Members Healthy
- Patient Safety or Outcomes Across Settings
- Managing Members with Emerging Risk
- Managing Multiple Chronic Illnesses
- Quality of Service and Access to Care
- Utilization of Services

2021 QI Program Successes

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Quality of Service & Access to Care	• Specialty Appointment Access • Goal: 60.8% Achieved: 80.9%
Patient Safety	• Opioid Safety/Buprenorphine Use • Goal: 15% Achieved: 22%
Managing Multiple Chronic Illnesses	• Care Management Perception of Health Status--*improvement* • Goal: 55% Achieved: 61.5%
Utilization of Services	• Telehealth Visits • Goal: 25% Achieved: 50%
Utilization of Services	• Continued Engagement in Behavioral Health Services • Goal: 42.8% Achieved: 44%
Utilization of Services	• Primary Care Utilization • Goal: 302/1000MM • Achieved: 315/1000MM

2021 Ongoing Improvement Opportunities

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NCQA Accredited Medicaid HMO Health Plan

Managing Emerging Risk Illness
- Hepatitis C Rx
- Goal: 40%
- Achieved: 37%

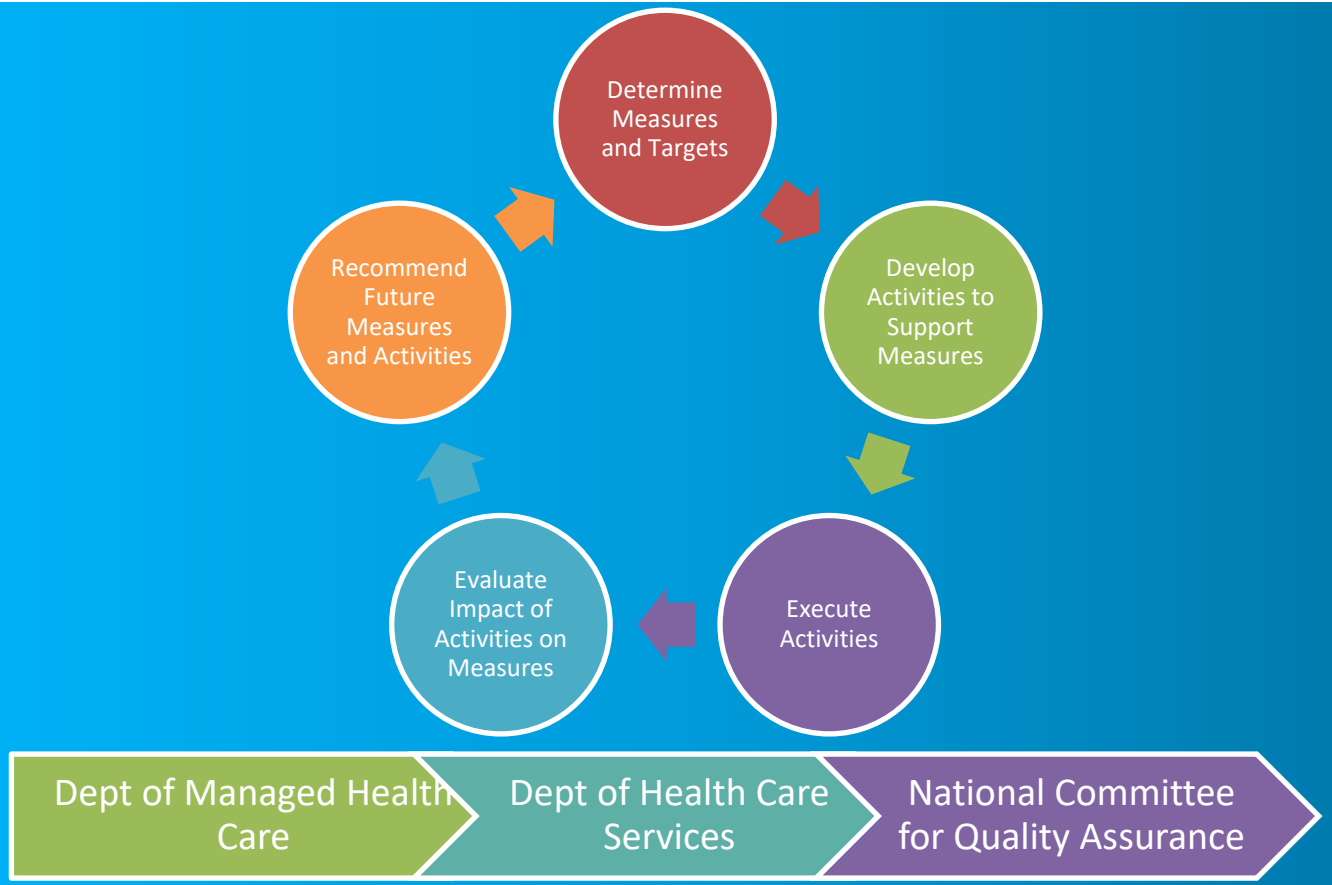
Patient Safety
- Opioid and Benzo Co-prescribing
- Goal: 8.0% (lower is better)
- Achieved: 8.5%

Keeping Members Healthy
- Breast Cancer Screening
- Goal: 68.9%
- Achieved: 54.4%

Quality of Service and Access to Care
- Provider Race/Ethnicity/Language Information in Provider Directory
- Assessment of how to collect data

Measure Development & Evaluation Process

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



QI Planning for 2022

SAN FRANCISCO HEALTH PLAN
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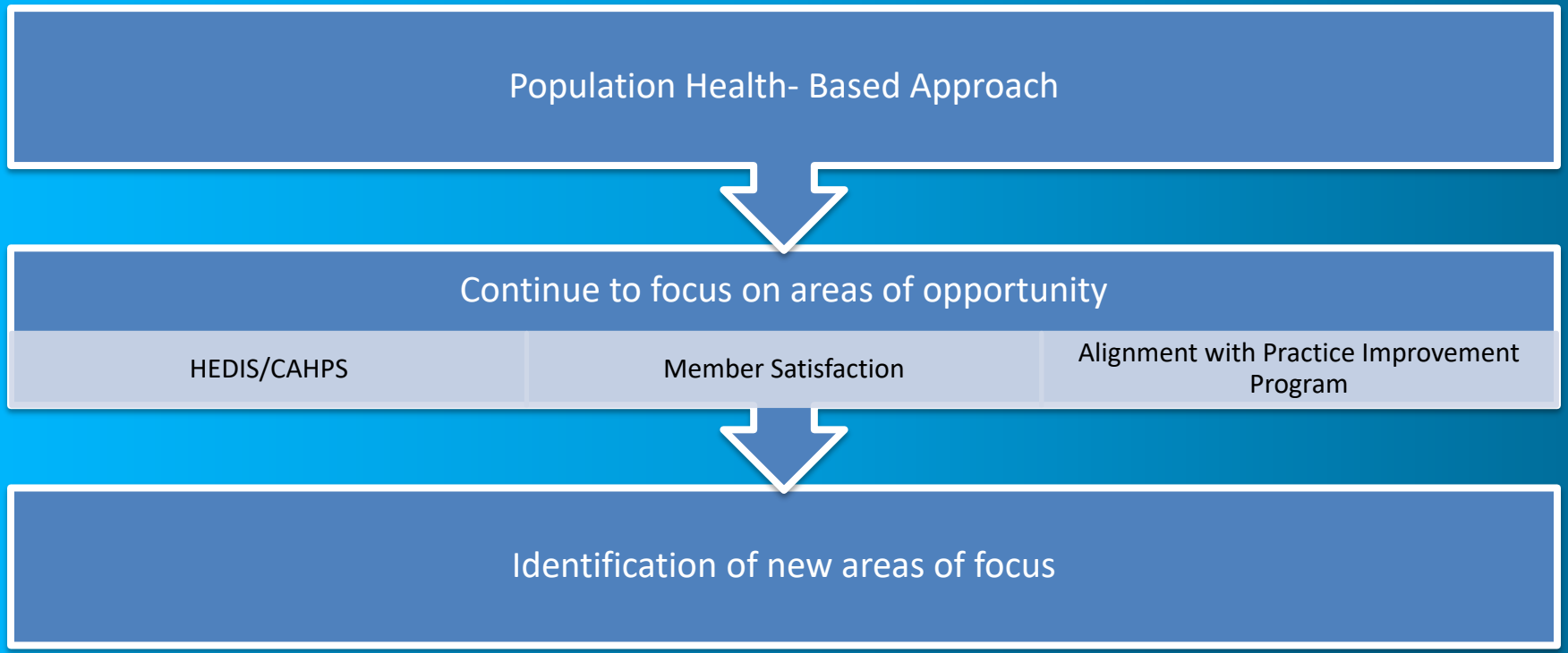

2022 QI Workplan Highlights

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QI Domain	Highlight 2022
Keeping Members Healthy	**COVID Vaccination** Goal: Stay within 10% of rate of County of SF
Utilization of Services	**Acute inpatient utilization** Goal: Standard benchmark for managed care plan comparable to other Medi-Cal plans
Patient Safety	**Medi-Cal Rx High and medium Risk for Transition** Goal: contact 80% of eligible population **High Dose Opioid Prescriptions:** Goal: 7.0%
Managing Emerging Risk	**Diabetes control-% members with Diabetes with poor control** Goal: 34.05% (lower is better)
Quality of Service and Access to Care	**Cultural and Linguistic Service (CLS) provider data** Goal: 10%

Next Steps - QI Program 2021/2022

SAN FRANCISCO HEALTH PLAN
Here for you
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- Comments/Questions
- Request for Review and Approval
  - 2021 QI Program Evaluation
  - 2022 QI Program Workplan

Agenda Item 6

Chief Medical Officer's (CMO) Report

Action Item:

b. Review and Approval of Evaluation of 2021 Quality Improvement Program

50 Beale St. 12th Floor
San Francisco, CA 94105
www.sfhp.org

San Francisco Health Plan

2021 Quality Improvement Program Evaluation

Table of Contents

1. Introduction

The goal of the San Francisco Health Plan (SFHP) Quality Improvement (QI) Program is to ensure high quality care and services for its members by proactively seeking opportunities to improve the performance of its internal operations and health care delivery system.

SFHP's QI Program is detailed in the SFHP QI Program Description. The QI Program Description contains an annual Work Plan, outlined in Appendix I, representing the current year improvement activities and measure targets. The QI Work Plan is evaluated on a quarterly basis and consolidated annually. The QI Evaluation provides a detailed review of progress towards the measures and goals set forth in the QI Work Plan. In this evaluation, the results are presented for seven activity domains:

- Quality of Service & Access to Care
- Keeping Members Healthy
- Patient Safety or Outcomes Across Settings
- Managing Members with Emerging Risk
- Managing Multiple Chronic Illnesses
- Utilization of Services
- Quality Oversight

1.1 Executive Summary

Oversight
Under the leadership of SFHP's Governing Board, the Quality Improvement Committee (QIC) oversees the development and implementation of the QI Program and annual QI Work Plan. The QIC and the QI Program is supported by multiple committees including Utilization Management, Physician Advisory/Peer Review/Credentialing, Pharmacy and Therapeutics. The QI Program is also supported by multiple other committees including Access Compliance, Grievance Program Leadership, Grievance Review, Policy and Compliance, Practice Improvement Program and Provider Network Oversight. SFHP's Quality Committees, under the leadership of the Chief Medical Officer, ensure ongoing and systematic involvement of SFHP's staff, members, medical groups, practitioners, and other key stakeholders where appropriate.

Participation in the QI Program: Leadership, Practitioners, and Staff
Senior leadership, including the Chief Executive Officer (CEO) and Chief Medical Officer (CMO), provided key leadership for the QI program. The CEO champions SFHP's NCQA accreditation journey as well as an organization-wide effort to improve member care and quality of service, namely by establishing organizational strategic priorities and ensuring resources to support key initiatives. In addition, the CEO ensures that Governing Board members received regular reports and involvement on components of the QI program.

The CMO provides ongoing support for all quality improvement studies and activities and was responsible for leading the Quality Improvement Committee; Physician Advisory/Peer Review/Credentialing Committee; Pharmacy and Therapeutics Committee; and Grievance Review

Committee. The CMO leads key clinical improvement efforts, particularly prioritizing and designing interventions for clinical quality performance measures as represented in the QI Work Plan.

Beyond SFHP senior leadership, SFHP achieved stakeholder participation in the QI program through provider and member involvement in several key committees. Stakeholders participate in the Quality Improvement Committee, the Practice Improvement Program (PIP) Advisory Committee that advises on the pay-for-performance program (PIP), and the annual Healthcare Effectiveness Data and Information Set (HEDIS) performance meetings during which health plan leadership meets with senior leadership in the network to review outcomes and solicit input on measures in the Keeping Members Healthy and Managing Members with Emerging Risk domains of the QI Program. Overall, leadership and practitioner participation in the QI program in 2021 was sufficient to support the execution of the QI Plan.

The staff accountable for implementing the annual QI Work Plan work cross-functionally to oversee and carry out quality improvement activities at SFHP. Staff monitor quality indicators and programs and implement and evaluate SFHP's QI work plan. For a detailed summary of all staff supporting the QI Program, please refer to the Quality Improvement Program Description.

1.2 Highlights from the 2020 QI Program Measures

SFHP had positive outcomes during the 2021 QI Program period. Of the 22 measures included in the 2021 QI Evaluation, 11 met the target. SFHP will utilize lessons learned from 2021 to inform the 2022 QI Program and to drive continuous improvement in operations and outcomes.

In summary, SFHP identified the following areas from the QI Work Plan as either demonstrating effectiveness or as opportunities for improvement.

Quality of Service and Access to Care:

SFHP met two of the measure targets in this domain.

Some notable activities include:

- Implemented a cross functional-work group to create a work plan to improve member engagement with the health plan. The work group created seven videos in five languages for members to learn how to access various types of care including primary and specialty care.
- Interviewed three health plans high performing in Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) to collect best practices for member experience improvement. Best practices identified by the health plans that SFHP is not doing include conducting member experience surveys outside of HP-CAHPS survey fielding and implementing member interventions for specific populations or provider groups that have statistically significant scores.

Recommendations for continued improvement include:

- Conduct CAHPS surveying off-cycle from annual HP-CAHPS.
- Provide practitioner race/ethnicity on request and/or explore publishing practitioner race/ethnicity in the provider directory.

Keeping Members Healthy:

SFHP did not meet any of the three measure targets in this domain. One additional measure was not completed.

Some notable activities include:

- Included chlamydia screening information in both member and provider communications. Sexual health mailers, in the form of pamphlets, were mailed out to members in the fall. In spring, Chlamydia screening information were included in provider newsletters and "Your Health Matters."
- Partnered with community-based organization to offer patient navigation services for Black/African American members due for a breast cancer screening.

A recommendation for continued improvement includes:

- Provide patient navigation services through Rafiki Coalition for Black/African American members due for a breast cancer screening.

Patient Safety or Outcomes Across Settings:

SFHP met two of the three measure targets in this domain.

A notable improvement includes:

- Exceeded target of 15.0% for increasing the percent of members with Opioid Use Disorder with at least one buprenorphine prescription with a final result of 22.0 percent.

A recommendation for continued improvement includes:

- Work with mental health and substance use specialist providers to create and distribute provider information how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia.

Managing Members with Emerging Risk:

SFHP did not meet the measure target in this domain. Three additional measure were not completed.

A notable activity includes:

- SFHP's Care Transitions and Care Management programs provided treatment support for members with Hep C.

A recommendation for continued improvement includes:

- Outreach to SFHP primary care providers and gather any information on treatment hesitancy or failure that they can provide for their patients.

Managing Multiple Chronic Illnesses:

SFHP met four of the five measure targets in this domain.

Some notable improvements include:

- Attained high member satisfaction with care management services provided by SFHP.
- Met target of 89.0% for member clinical depression follow-up with a final result of 89.0 percent.

A recommendation for continued improvement includes:

- Provide more thorough life skills, health education and training to members as it pertains to their health maintenance.

Utilization of Services:

SFHP met all three of the three measure targets in this domain.

Some notable improvements include:

- Exceeded target of 25.0% for increasing the percent of visits delivered via tele-health modalities with a final result of 50.0 percent.
- Increased the percentage of members engaged in non-specialty mental health (NSMH) services receiving more than two NSMH visits from 39.8% to 44.6%, exceeding the target of 42.8 percent.

Recommendations for continued improvement include:

- Prioritize inpatient measures for monitoring over and under-utilization.

2. Quality of Service and Access to Care

Quality of Service and Access to Care are measures that improve service to members. They may include service metrics (wait times), accessibility (ease of access), or member perception of care (Consumer Assessment of Healthcare Providers and Systems).

2.1 Provider Appointment Availability Survey – Routine Appointment Availability in Specialty Care

Measure: Provider Appointment Availability Survey – Routine Appointment Availability in Specialty Care					
Numerator	753	**Baseline**	58.8%	**Final Performance**	80.9%
Denominator	931	**Target**	60.8%	**Evaluation Year**	2021

The Routine Appointment Availability in Specialty Care measure is in the Quality of Service and Access to Care domain. Increasing timely appointment availability improves access to care for members. This measure demonstrates SFHP's continued emphasis on connecting members to preventive care and chronic disease management in order to better manage their health. Increasing appointment availability may also support other QI program measures such as HEDIS and CAHPS, as members with timely specialty care visits are more likely to receive recommended care. Members with a physician visit tend to score SFHP higher in CAHPS.

Routine Appointment Availability in Specialty Care is the total number of providers with appointments offered within 15 business days out of the total number providers surveyed in the Provider Appointment Availability Survey, set by the Department of Managed Health Care. SFHP set a target of 60.8% based on 2.0% absolute improvement from baseline.

Provider Appointment Availability Survey Denominator & Results by Provider Type

	2020 Numerator	2020 Denominator	2020 Routine Appointment Availability
Cardiology	104	120	86.7%
Dermatology	30	50	60.0%
Endocrinology	35	45	77.8%
Gastroenterology	49	53	92.4%
General Surgery	39	51	76.4%
Gynecology	116	162	71.6%
Hematology	24	25	96.0%
HIV/Infectious Diseases	19	21	90.4%
Nephrology	42	56	75.0%
Neurology	52	70	74.2%
Oncology	68	77	88.3%
Ophthalmology	59	72	81.9%
Orthopedics	64	72	88.9%
Otolaryngology	29	31	93.5%
Physical Medicine & Rehabilitation	8	8	100.0%
Pulmonology	15	18	83.3%
Total	**753**	**931**	**80.9%**

Data is based on returned surveys of the Provider Appointment Availability Survey created by DMHC. Performance increased by 20.1% from the previous measurement year, exceeding the target.

To improve performance, SFHP completed the activities listed below.

- Included additional specialties in the 2020 survey.
- Communicated timeline, elements, and requirements of survey to network providers and provider network leadership.
- Issued requests for Corrective Action Plans of provider groups performing under 80% compliance with appointment access.
- Groups who received a request for a Corrective Action Plan from SFHP's access monitoring surveys implemented activities to improve access to care. SFHP provided technical assistance to providers for their access Corrective Action Plans.
- Provided incentives to support providers' telehealth visit delivery through Strategic Use of Reserves program.
- Published materials in the provider newsletter to promote telehealth.

For the next evaluation period SFHP recommends retaining this measure. The target for this revised measure will be set at 82.9% or 2.0% absolute improvement over 2020 performance. Activities will include:

- Request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate.
- Provide technical assistance with Corrective Action Plans.
- Train network providers on providing successful telehealth visits.

2.2 Cultural & Linguistic Services (CLS)

Measure: Cultural & Linguistic Services (CLS)			
Final Performance	Not Available	**Evaluation Year**	2021

The Cultural & Linguistic Services (CLS) measure is in the Quality of Service and Access to Care domain. The goal of this measure is to ensure the organization's use provider data to determine the race/ethnic and languages spoken by 10.0% of individual practitioners in network. SFHP chose the target of 10.0% to help establish a baseline as this initiative has not been done before.

One out of the five planned activities to support this measure were completed, including:

- Explored ways to collect information about practitioner race/ethnicity and languages in which a practitioner is fluent when communicating about medical care. Possible sources identified through the exploration process: Practitioner survey, credentialing application, provider relations script, CVO, medical association, or medical specialty directories.

The following planned activities to support this measure were not completed:

- Collect information about language services available through the practice.
- Publish individual practitioner languages in the provider directory .
- Publish language services available through the practice in the provider directory.
- Provide practitioner race/ethnicity on request and/or explore publishing practitioner race/ethnicity in the provider directory.

One barrier to reaching the target and completing all the planned activities to support this measure was the lack of organizational priority.

SFHP recommends continuing this measure to help establish a baseline and to address the racial, ethnic, and linguistic needs and preferences of our members. In order to establish a baseline for this measure SFHP will need to establish a cross-collaborative work group to support completing the planned activities and follow up on the next steps outlined during the exploration process mentioned above. The target for this measure will remain at 10.0%. Activities will include:

- Explore ways to collect information about languages in which a practitioner is fluent when communicating about medical care.
- Collect information about language services available through the practice.
- Explore ways to collect practitioner race/ethnicity data Sources of practitioner language and race/ethnicity information.
- Publish individual practitioner languages in the provider directory.
- Publish language services available through the practice in the provider directory.
- Provide practitioner race/ethnicity on request and/or explore publishing practitioner race/ethnicity in the provider directory.

2.3 Health Plan Consumer Assessment of Healthcare Providers and Systems Rating of Specialist

Measure: Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) Rating of Specialist					
Numerator	50	**Baseline**	57.5%	**Final Performance**	64.1%
Denominator	78	**Target**	59.5%	**Evaluation Year**	2021

Rating of Specialist is a question within the Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) survey, which assesses member experience of care and is in the Quality of Service and Access to Care domain. HP-CAHPS performance is important to SFHP because HP-CAHPS is the primary means by which members provide feedback about their satisfaction with SFHP and their overall health care. SFHP strives for high member satisfaction, in addition to high quality and affordability.

Five out of the six planned activities to support this measure were completed, including:

- Increased monitoring of network access and issued requests for Corrective Action Plans of provider groups performing under 80% compliance with appointment access.
- Identified access-related issues via the Access Compliance Committee and develop plans to address found issues.
- Promoted SFHP's telehealth services to increase access to care.
- Implemented a cross functional-work group to create a work plan to improve member engagement with the health plan. The work group created seven videos in five languages for members to learn how to access various types of care including primary and specialty care.
- Interviewed three health plans high performing in HP-CAHPS to collect best practices for member experience improvement. Best practices identified by the health plans that SFHP is not doing include conducting member experience surveys outside of HP-CAHPS survey fielding and implementing member interventions for specific populations or provider groups that have statistically significant scores.

The following planned activity to support this measure was not completed:

- Conduct member focus groups.

The COVID-19 pandemic created barriers in 2021 that impacted the ability to conduct member focus groups. SFHP chose to not conduct member focus groups due to the difficulty in recruiting members to focus groups that would be conducted via tele-conference. SFHP staff prioritized member outreach around COVID-19 vaccination over member focus groups for this measurement period.

For 2022, SFHP recommends modifying this measure to focus on improvement in HP-CAHPS overall as measured by performance in Rating of Health Plan.. Activities to improve in Rating of Health Plan will include:

- Implement and communicate member experience YouTube videos.
- Identify access-related issues via the Access Compliance Committee and develop plans to address found issues.
- Conduct CAHPS surveying off-cycle from annual HP-CAHPS.
- Promote SFHP's telehealth services to increase access to care.

3. Keeping Members Healthy

These are measures that improve clinical outcomes involving preventative care.

3.1 Well-Child Visits in the First 15 Months of Life (W15)

Measure: Well Child Visits in the First 15 months of Life (W15)					
Numerator	305	**Baseline**	46.9%	**Final Performance**	45.2%
Denominator	673	**Target**	49.9%	**Evaluation Year**	2021

The Well-Child Visits in the First 15 Months of Life (W15) is in the Keeping Members Healthy Domain. The goal of the W15 measure is to improve the Well-Child Visits in the "First 15 months of Life" rate for SFHP members is in the Clinical Quality. W15 is a HEDIS measure specification which describes the percentage of members who turned 15 months old during the measurement year and who had a number of Well-Child visits with a PCP during their first 15 months of life. The Well-Child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. Preventive services may be rendered on visits other than Well-Child visits. Well-Child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure. Also not included in the measure are services rendered during an inpatient or ED visit.

The 2021 W15 rate is calculated based on the total number of members who turned 15 months old during the measurement year and who had the six or more well-child visits with a PCP during their first 15 months of life out of the total number of members who turned 15 months old during the measurement year. The W15 target is set based on results from the 2020 administrative rate of 46.9 percent.

The following activities to support this measure were completed, including:

- Restructured incentives report to filter for members who have not had a visit in past nine months to send incentive form three months before next birthday. Previous reporting mechanisms timing didn't incentivize visits; the new mechanism incentivizes visits that have not yet occurred and allow three months for members to receive incentive within the reporting year.
- Determined age groupings for target populations for Health Ed materials to be categorized by appropriate age milestones and will be sent on an annual basis.
- Health education materials added to incentive form to help inform parents/guardians of importance of visit.
- Explored ways to support provider network to promote telehealth visit options—provider newsletter, webpage updates, our Health Matters newsletter.

The final 2020 W15 rate is 45.2% of members in the eligible population during completed six Well-Child visits with their PCP during the measurement year. This result is 4.7% below the target of 49.9%. A barrier to meeting the 49.9% target is the COVID-19 pandemic effecting member's engagement with primary care and scheduling office visits. SFHP recommends retiring this measure to focus on other HEDIS measures identified for MY 2021 as priority.

3.2 Child and Adolescent Well-Care Visits

Measure: Child and Adolescent Well-Care Visits			
Final Performance	Not Available	**Evaluation Year**	2021

The Adolescent Well Care (AWC) measure is in the Keeping Members Healthy Domain. The goal of the AWC measure is to improve the Adolescent Well-Care Visits rate for SFHP members. AWC is a HEDIS measure specification which describes the percentage of enrolled members 12–21 years of age who had at least one comprehensive Well-Care visit with a PCP or an Obstetrician or Gynecology practitioner during the measurement year. Well-Care visits to Obstetrician and Gynecology providers are counted as PCPs since SFHP members can have an Obstetrician or Gynecology provider as their PCP. Visits to school-based clinics with practitioners with whom the organization would consider PCPs may be counted if documentation that a Well-Care exam occurred is available in the medical record or administrative system in the time frame specified by the measure.

This measure and its associated activities were not completed. The barrier to reaching the target and completing all the planned activities to support this measure was the lack of organizational priority. SFHP recommends retiring this measure to focus on other HEDIS measures identified for MY 2021 as priority.

3.3 Chlamydia Screening

Measure: Chlamydia Screening					
Numerator	1,247	**Baseline**	58.1%	**Final Performance**	60.2%
Denominator	2,073	**Target**	61.1%	**Evaluation Year**	2020

The Chlamydia Screening (CHL) measure is in the Keeping Members Healthy domain. This rate is calculated based on the total number of SFHP members, with a female gender marker 16–24 years of age, who are identified as sexually active and have had at least one test for chlamydia during the measurement year. Chlamydia Screening is important because chlamydia infections in patients can cause cervicitis and Pelvic Inflammatory Disease, which can result in Fallopian tube damage, scarring, and blockage. It can also result in long-term adverse outcomes of infertility, ectopic pregnancy, and chronic pelvic pain. Improvement in the chlamydia screening rate benefits members by enabling early detection and treatment of chlamydia infections and preventing complications from the infection. The target of 61.1% was set to achieve a 3% absolute improvement over baseline.

The following activities were completed:

- Continued to include Chlamydia Screening as a pay-for-performance measure in SFHP's Practice Improvement Program (PIP).
- Included STI topic in the Adult Wellness member incentives, which is sent out to members ages 18-24 who have not had a Chlamydia screening.
- Included chlamydia screening information in both member and provider communications. Sexual health mailers, in the form of pamphlets, were mailed out to members in the fall. In spring, Chlamydia screening information were included in provider newsletters and "Your Health Matters."

The following planned activities were not fully implemented and were barriers to achieving the target:

- Complete lab data analysis for other data sources to identify data and/or clinical quality issues potentially contributing to the screening rate and make recommendations for improvement. Due to time and resource constraints, lab data analysis was not able to be completed during the program year.

- Budget for and develop educational materials about Sexually Transmitted Infections (STIs) for teens. Instead of creating a separate budget for educational materials about STIs for teens, STI screening health education will be included in the annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) member letters for the 18-20 year-old age group.
- Explore expanding the Well Child member incentive population to the age of 21. The Health Outcome Improvement Leadership determined that it was not necessary to expand the age range of the Well Child member incentive population. Instead, STI is mentioned in the Adult Wellness incentive mailing.

The final result of 60.15% was a 2.05% percentage points increase from the baseline, but it was just 0.95% percentage points shy of the 61.1% target. SFHP recommends retiring this measure as there is no expressed prioritization for this measure. STI screening health education material will be included in the EPSDT member letters that are sent out annually. SFHP will retire this measure to focus on other HEDIS priorities. Data improvements made in the previous program year regarding the chlamydia lab data will continue to be applied and the HEDIS workgroup will continue to monitor this measure.

3.4 Breast Cancer Screening

Measure: Breast Cancer Screening					
Numerator	4,549	**Baseline**	65.1%	**Final Performance**	54.4%
Denominator	8,357	**Target**	68.9%	**Evaluation Year**	2020

Breast Cancer Screening (BCS) is in the Keeping Members Healthy Domain. The goal of the BCS measure is to improve the breast cancer screening rate for SFHP members is in the Clinical Quality domain. BCS is the percentage of members with a female gender marker who are ages 50-74 during the measurement year who had a mammogram to screen for breast cancer. The mammogram breast cancer screening visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the member. Not included are services rendered during an inpatient or ED visit.

The 2021 BCS rate is calculated based on the total number of members with a female gender marker who were 50-74 years old months old during the measurement year and who had a mammogram to screen for breast cancer (numerator) divided by the total number of members with a female gender marker who were 50-74 years old months old during the measurement year (denominator). The BCS target is set based on the baseline administrative rate of 65.9 percent.

The following activities to support this measure were completed, including:

- Partnered with community-based organization to offer patient navigation services for Black/African American members due for a breast cancer screening.

The final 2021 BCS rate is 54.4% of members in the eligible population completed a mammogram to screen for breast cancer during the measurement year. This result is 14.5% below the target of 68.9%. SFHP recommends keeping this measure the same for the 2022 QI workplan, narrowing the population to members engaged with providers participating in SFHP's PIP program who are administering the BCS navigation project. Although the target was not reached SFHP made great progress in achieving the successful implementation of this measure and executing the planned activities. SFHP contracted with a community based organization, SF Women's Cancer Network for a placement of a patient navigator at the Rafiki Coalition whose mission is to eliminate health inequities in San Francisco's Black and

marginalized communities through education, advocacy, and by providing holistic health and wellness services in a culturally affirming environment. This navigator has been hired and training will be completed by the end of 2021. Moreover, navigation services will begin to be provided by January 2022. A barrier to completing the planned activity of developing health education materials for members was the organizations prioritizing the development of COVID-19 related health education materials. However, content creation of health education materials for Black members is currently being developed by Health Educator and other subject matter experts on BCS engagement for Black patients. In addition, SFHP is developing a structure for member feedback for health education materials. The Population Health team will continue their work with members to prioritize their health needs and the importance of mammograms to screen for breast cancer will be communicated to members who are a focus for this target population.

Recommended activities:

- Provide Health Education materials to Black/African American SFHP members.
- Provide patient navigation services through Rafiki Coalition for Black/African American members due for a breast cancer screening.

4. Patient Safety or Outcomes Across Settings

These are measures that improve clinical outcomes related to safety. Patient safety prevents adverse health outcomes, such as death or poor quality of life.

4.1 Opioid Safety – Buprenorphine Prescription

Measure: Opioid Safety – Buprenorphine Prescription					
Numerator	650	**Baseline**	12.3%	**Final Performance**	22.0%
Denominator	2,590	**Target**	15.0%	**Evaluation Year**	2021

The Opioid Safety – Buprenorphine Prescription measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of SFHP members with Opioid Use Disorder (OUD) with at least one buprenorphine prescription in the last year, out of the total number of SFHP members with OUD. SFHP works to reduce the risk of overdose and address the psychological and physical impact of Opioid Use Disorder. Promoting the use of Buprenorphine in this population helps reduce the risk of overdose and death.

OUD is a pattern of opioid use which includes behaviors such as: craving, withdrawal, tolerance, continued use despite medical or social consequences, using opioids in hazardous situations, and taking opioids at higher doses or for a longer period than intended. Members are considered for the denominator of this measure if they have ever had a diagnosis of OUD or an encounter for an opioid overdose. This broad definition has been implemented to ensure that all members who might be candidates for buprenorphine therapy are considered. The target of 15.0% was chosen based on results from last year's measure evaluation.

Medication-Assisted Treatment (MAT) is the treatment of substance use disorder with medications in combination with counseling. MAT options to treat OUD include buprenorphine, methadone, and naltrexone. These medications can be taken for a short time or continued indefinitely. The goal of

treatment is to reduce the risk of overdose, eliminate the use of illicit opioids, and to provide the member with strategies to address their mental and physical health needs.

The following activity was completed:

- A review of frequency of buprenorphine fills, focusing on members with only one fill during 2020 was created in Q2.

There were two major barriers to reaching the target: the lack of access to methadone data and the ongoing impacts of the COVID-19 pandemic. Methadone taken to treat OUD is not provided to SFHP and the plan has no access to this data. As a result, SFHP has no insight into how many members with OUD are currently being treated with methadone. To address this barrier the internal SFHP Pain and Opioid Workgroup plan to reach out the providers at the methadone clinics in order to discuss any concerns they have for the population and how SFHP can assist in increasing access to MAT. Another barrier was the impact of the COVID-19 pandemic. COVID-19 also halted further outreach activities during this evaluation period.

The final result is 22.0%, exceeding the target of 15.0%. SFHP will keep this measure in 2022 to continue monitoring and improving the percentage of members with OUD with at least one buprenorphine prescription in the last year. We will also consider tracking buprenorphine adherence for the following year. Next year's target will be 30.0% and activities to support this measure include:

- Outreach to methadone clinic providers in order to better support the use of MAT.
- Monitor buprenorphine adherence using the repository.
- Disseminate educational material to members on MAT options.
- Consider targeted outreach to members with buprenorphine single fills or their providers.

4.2 Opioid Safety – Benzodiazepine Co-prescribing

Measure: Opioid Safety – Benzodiazepine Co-prescribing					
Numerator	246	**Baseline**	10.7%	**Final Performance**	8.5%
Denominator	2,898	**Target**	8.0%	**Evaluation Year**	2021

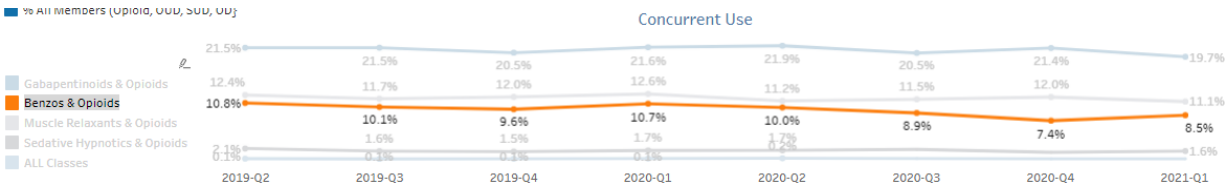
The Opioid Safety – Benzodiazepine Co-prescribing measure is in the Patient Safety or Outcomes Across Settings Domain. This measure calculates the percentage of SFHP members prescribed both opioids and benzodiazepine, out of the total number of SFHP members prescribed opioids. This measure allows SFHP to evaluate members at high risk for negative outcomes related to central nervous system depression such as overdose, coma, and death. SFHP chose a target of 8.0% or lower in order to reduce the percentage of members who have been prescribed both opioids and benzodiazepines to. This target was chosen as a 2.3% absolute improvement from SFHP's baseline rate.

The following activities were completed:

- SFHP staff began the process of creating provider information on how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia. This information will be completed and distributed to providers in 2022.
- Discussed expansion of the acupuncture benefit to include anxiety in the behavioral health committee meeting. If it is appropriate, this will be added to the activities for the first quarter of the next reporting period.

The main barrier to reaching the target was COVID-19, which caused a reorganization of priorities that impeded completion of planned activities. Additional barriers to reaching the target included self-paid prescriptions in the data not being available in the analysis. To address this barrier, providers are mandated to check the CURES database prior to all controlled drug prescriptions to ensure that providers are aware of members' current prescriptions and opioid safety risk. All controlled prescriptions, including self-paid, are recorded through the CURES database.

The current performance of 8.5% from the baseline of 10.7% indicates a slow reduction in benzodiazepine and opioid co-prescribing. As has been seen in previous quarters, the decline in opioid use has driven the decline in co-prescribing. From 2Q2019 to 1Q2021, the total number of members with opioid prescriptions fell from 3,469 to 2,898.



SFHP will retain this measure for 2022 and the target will be reduced to 7.0%. Activities will include:

- Work with mental health and substance use specialist providers to create and distribute provider information how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia.

4.3 Medication Therapy Management (MTM)

Measure: Medication Therapy Management (MTM)					
Numerator	108	**Baseline**	85.0%	**Final Performance**	89.3%
Denominator	121	**Target**	87.0%	**Evaluation Year**	2020

The Medication Therapy Management (MTM) measure is in the Patient Safety or Outcomes Across Settings domain. MTM is a process of medication reconciliation, that consists of a clinical assessment by a pharmacist of all the medications a member is taking, identification of potential harmful medication issues, recommendations to optimize the medication regimen, and providing medication-related education and advice to the member and provider. This intervention improves medication safety among members with chronic diseases.

The 2021 MTM rate is calculated by the number of initial medication reconciliation completed by a pharmacist (numerator) divided by number of members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation (denominator). The MTM target of 87.0% is based on results using the 2020 MTM measure's final performance of 85.0%. This target represents a significant increase from the 2020 target of 80%.

All activities conducted to support this measure were completed, including:

- Continued reviewing members in the initial assessment process which recommends an MTM assessment and establishes the denominator population for this measure.
- Designated pharmacist resources to support the population of members engaged in Care Management and Care Transitions team.

- Updated member management software workflow for both Pharmacist and Pharmacy Technician to improve efficiencies.
- Added question in Care Transitions Assessments to trigger a task for pharmacist to review medication history claims and if medication reconciliation is recommended.
- Developed member management software Pharmacist workflow for Care Transitions integration.
- Completed medication reconciliations for clients engaged in Care Transitions.

Added new member management software tasks to document pharmacist involvement: Pharmacist to review reconciled med list with Care Management Team and Pharmacist to contact provider.

- Developed new monthly pharmacy dashboard for MTM on number of interventions created and completed.
- Created new medical reconciliation tool in member management software for continued integration with Care Management and Care Transitions team.
- Presented new medical reconciliation tool to pharmacy, Care Management and Care Transitions team.
- Identified bug issues in the new med rec tool and resolved it with internal and external teams.

The final result of 89.3% exceeded the target of 87.0% and was an increase of 4.3 percentage points from baseline. SFHP recommends retaining this measure due to the benefits MTM adds to medication safety for members. The target will increase to 90% using this year's final performance as a baseline to ensure sustainability for this measure. Activities to support this measure will include:

- Monitor the pharmacist resource requirements needed to support the population of members engaged in Care Management and Care Transitions team.
- Assess for additional efficiencies in workflow and member assessment configurations.
- Continue reviewing members in the initial assessment process which recommends an MTM assessment and establishes the denominator population for this measure.

5. Managing Members with Emerging Risk

These are measures that that improve clinical outcomes related to members with chronic conditions or emerging conditions.

5.1 Hepatitis C Treatment

Measure: Hepatitis C Treatment					
Numerator	1,463	**Baseline**	37.3%	**Final Performance**	37.0%
Denominator	3,956	**Target**	40.0%	**Evaluation Year**	2021

The Hepatitis C Treatment measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of SFHP members with any past history of Hepatitis C diagnosis who have completed the Hepatitis C treatment regimen. The measure benefits members because treatment can prevent the spread of Hepatitis C disease and lowers the risk of liver disease. The target of 40.0% was selected based on year's final performance.

The following activities were completed:

- Care Transitions and Care Management programs provided treatment support for members with Hep C.
- SFHP Care Coordinators and Pharmacy staff have continued to recommend members with active Hep C be treated.
- SFHP staff met with San Francisco's End Hep C to discuss educational campaigns.
- SFHP Pharmacy staff collaborated with Business Analytics to create a new Hep C monitoring report that is more comprehensive.

Barriers for this measure include:

- COVID-19 proved to be the greatest barrier to carrying out activities and reaching the target. Educational activities were put on hold due to the COVID-19 public health emergency.
- SFHP's data is limited by ICD-10 codes that exist for diagnosis data, as there is no procedure code for Hepatitis C treatment and cure therefore, SFHP may be missing data for members who were previously treated and cured or who spontaneously cleared the virus and are cured.
- There is a stigma related to Hepatitis C that prevents members from wanting to seek screening and treatment.
- Members report not wanting a positive Hepatitis C screening to be in their medical record.
- Effective Hepatitis C Treatment requires eight – 12 weeks of medication adherence which can be a barrier for members without access to safe medication storage or are experiencing other barriers to completing treatment.
- The clinics and provider offices serving populations with a high prevalence of Hepatitis C infection have been aggressive to screen and treat infected members leaving the untreated members in clinics with a lower prevalence with less provider awareness and comfort.

The final result of 37.0% decreased 0.3 percentage points from baseline and did not reach the target of 40.0%. SFHP recommends retaining this measure to continue monitoring and improving the percentage of members who complete Hepatitis C treatment. For the next fiscal year, the target will remain 40.0% considering ongoing barriers to access from COVID-19. Activities to support this measure will include:

- Use reporting to develop a profile (age, ethnicity, gender, location) for members not yet treated for Hepatitis C.
- Outreach to SFHP primary care providers and gather any information on treatment hesitancy or failure that they can provide for their patients.
- Continue to provide treatment support through SFHP's Care Transitions and Care Management programs.

5.2 Diabetes Prevention Program

Measures: • Diabetes Prevention Program – Do 150 Mins of Physical Activity Per Week • Diabetes Prevention Program – Satisfaction • Diabetes Prevention Program - Weight Loss			
Final Performance	Not Available	**Evaluation Year**	2021

The Diabetes Prevention Program (DPP) measures are in the Managing Members with Emerging Risk Domain. The goal of the measures are to improve the efficacy of the DPP, including member satisfaction with the program, members losing weight as a result of the program, and members achieving at least 150

minutes of physical activity per week. This program was delayed in 2021 and outcome data will not be available until 2022. These measures will be included in the 2022 QI Evaluation.

6. Managing Multiple Chronic Illnesses

These are measures that improve care and facilitate coordination of care across multiple providers and facilities. They may also be defined as serving a specific population with complex medical needs.

6.1 Care Management Client Perception of Health

Measure: Care Management Client Perception of Health					
Numerator	48	**Baseline**	50.5%	**Final Performance**	61.5%
Denominator	78	**Target**	55.0%	**Evaluation Year**	2021

The Care Management Client Perception of Health measure is in the Managing Members with Multiple Chronic Illnesses domain. This measure reflects activities to improve adult Care Management (CM) clients' perception of their health. A member's stronger relationship with their PCP and a greater understanding of their conditions can positively impact the member's perception of their health since they have more resources to manage their conditions. This outcome is based on changes in their self-reported health status between initial and closing assessments. Clients self-report via a question on the SF-12; a health questionnaire used to capture self-reported health status for clients with chronic conditions. The target for this measure was 55.0%. The target was selected based on evaluation data from the prior years of the Complex Care Management program. This target represents SFHP's commitment to ensuring that Care Management programs are member-centered, support self-management of health conditions, and promote members feeling in control of their health.

The following activities were completed:

- Clinical Supervisors and Medical Director provided coaching to the CM Nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP.
- CM Nurses and Community Coordinators completed bi-monthly self-audits; this enabled them to identify and remedy any gaps in the member's care plan.
- Clinical Supervisors and Medical Director conducted quarterly audits to ensure best practices and regulatory requirements were met including members having chronic condition self-management goals as part of their care plans as indicated.
- Utilization of Milliman Care Guidelines (MCG) condition specific assessments and MCG health education materials by CM Nurses.
- Medical Director met weekly with the RNs and joined the RNs and Clinical Supervisors 1:1s to provide individual feedback on health coaching/education efforts as needed.
- Pharmacy team provided the CM team with educational trainings on effects of COVID-19 on Congestive Heart Failure and Chronic Obstructive Pulmonary Disease, Diabetes, Opioid Use Disorder, Use of Steroid Treatment in Autoimmune Conditions and a review of the Pharmacy Tool.

The final result for this measure was 61.5%. Forty-eight out of 78 CM clients completed the SF-12 health questionnaire during their initial and closing assessments and indicated an improvement in their self-reported health status. The target was met.

SFHP will keep this measure for 2022 and continue to focus on improving the health status of those who indicate "Poor" or "Fair" health and maintaining the health status of those who indicate "Good," "Very Good," or "Excellent" during their initial assessment. The target will be 63.0% as the baseline is 61.5%. Activities to support this measure will include:

- Clinical Supervisors and Medical Director coaching the CM Nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP.
- CM Management have developed a 2-year training syllabus for the team, to include trainings on subjects the team have identified gaps in and areas management feel would benefit the team in their ongoing work with members.
- Review of self-management goal report with CM Nurses to ensure that members have chronic condition self-management goals as part of their care plans as indicated.
- Utilization of Milliman Care Guidelines (MCG) condition specific assessments and MCG health education materials by CM Nurses.

6.2 Screening for Clinical Depression

Measure: Screening for Clinical Depression					
Numerator	54	**Baseline**	83.1%	**Final Performance**	85.7%
Denominator	63	**Target**	85.0%	**Evaluation Year**	2021

The Screening for Clinical Depression measure is in the Managing Members with Multiple Chronic Illnesses domain. This measure reflects activities to increase the percentage of adult clients in SFHP's Care Management (CM) programs successfully screened for depression symptoms using the Patient Health Questionaire-9 (PHQ-9) when indicated by their responses to the Patient Health Questionaire-2 (PHQ-2). The PHQ-2 is a brief series of questions used to screen for possible depression and the PHQ-9 is an instrument used to screen, monitor, and measure the severity of depression. All adult clients enrolled in CM programs receive the PHQ-2 screening. The PHQ-9 is triggered based on the PHQ-2 score. The target for this measure was 85.0%. The target was selected based on results from past clinical measures.

The following activities were completed:

- Coaching Community Coordinators, including role-playing activities to reduce the rate of members declining PHQ-9 screening.
- Trained staff in mental health, particularly on severe mental illness (SMI), in order to ensure that staff was equipped to identify signs and symptoms of clinical depression and address client safety. Coordinators and RNs completed the following quarterly trainings: Psychosis 101/Depressive Disorder 101/The Sudden Shift from Face to Face Interviews to Telephone Interviews/Grief Literacy/Bipolar Disorders 101/Forecasting and Understanding the Behavioral Health Impacts of COVID-19/How to Reduce Risk for Patients with Substance Use Disorders during the Pandemic/ Health Equity Culturally Responsive Care in the context of COVID-19/Maximizing Resilience/Leveraging Strengths in a Challenging World/Co-Occurring Disorders/ Living with Chronic Pain/ ADLs/ Provider Tool Review/ CBAS overview.
- Clinical Supervisors reviewed monthly reports with staff and coached staff to ensure members were screened and received appropriate follow up.
- Monitored the rate of members declining the PHQ-9 screening via additional report tracking.
- Completed bi-monthly staff self-audits; this enabled Coordinators to identify and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated.

- Clinical Supervisors conducted quarterly audits to ensure best practices and regulatory requirements were met.

The final result for this measure was 85.7%. Sixty-three Care Management clients screened positive using the PHQ-2, indicating additional follow-up was needed. Fifty-four of those clients had the longer, more in-depth PHQ-9 completed to identify the severity of their symptoms and inform follow up. The 85.0% screening target was met.

SFHP will retire this measure for 2021 because the Care Management Coordinators have continued to meet this goal with higher targets over the past few years. CM Management feel at this time it would be more beneficial to focus on following up on members who have screened positive for Clinical Depression.

6.3 Follow Up on Clinical Depression

Measure: Follow Up on Clinical Depression					
Numerator	39	**Baseline**	85.7%	**Final Performance**	88.6%
Denominator	44	**Target**	89.0%	**Evaluation Year**	2020

The Follow Up on Clinical Depression measure is in the Managing Members with Multiple Chronic Illnesses domain. This measure reflects activities to increase the percentage of adult clients in SFHP's Care Management (CM) programs who screen positive for depression symptoms and are connected to services for care. The target for this measure was 89.0%. The target was selected based on results from past clinical measures. This target represents SFHP's commitment to ensuring that Care Management programs are member-centered, and address follow up care for members with behavioral health needs.

The following activities were completed:

- Trained staff in mental health, particularly on severe mental illness (SMI), to ensure that staff was equipped to identify signs and symptoms of clinical depression and address client safety. Coordinators and RNs completed the following quarterly trainings: Psychosis 101/Depressive Disorder 101/The Sudden Shift from Face to Face Interviews to Telephone Interviews/Grief Literacy/Bipolar Disorders 101/Forecasting and Understanding the Behavioral Health Impacts of COVID-19/How to Reduce Risk for Patients with Substance Use Disorders during the Pandemic/ Health Equity Culturally Responsive Care in the context of COVID-19/Maximizing Resilience/Leveraging Strengths in a Challenging World/Co-Occurring Disorders/ Living with Chronic Pain/ ADLs/ Provider Tool Review/ CBAS overview.
- Reviewed monthly reports with staff and Clinical Supervisors coached staff to ensure members were screened and received appropriate follow up.
- Completed bi-monthly staff self-audits; this enabled Coordinators to identify and remedy any gaps in the member's care plan.
- Clinical Supervisors conducted quarterly audits to ensure best practices and regulatory requirements were met.

The final result for this measure was 88.6%, falling 0.4% of the 89.0% target. Forty-four Care Management clients had a positive score in the PHQ-9 completed to determine the severity of their depression. Thirty-nine of those CM Clients had a care plan goal completed, in progress, or had declined to connect to appropriate behavioral health services. Clients may decline services because they are

already connected to behavioral health services or they are not ready to discuss or prioritize their mental health; 15 clients declined the goal for these reasons. Staff is trained to re-assess every six months, at a minimum. Ultimately, 46.7% of clients who initially declined the "Connect to Behavioral Health" goal were re-engaged and connected to appropriate behavioral health services.

SFHP will keep this measure for 2022 to ensure sustained high rates of depression screening and follow up which continue to be a priority for Care Management programs. As of 2021, 6.7% of the overall SFHP Medi-Cal population had a depression diagnosis based on claims and encounters in the past 24 months, though there is reason to believe that depression is underdiagnosed due to stigma or failure to document diagnosis on claims or encounters, among other factors. Depression screening will continue to be a priority for the CM programs to connect clients to behavioral health services as clinically indicated and with the client's consent. The target will be increased to 90.0% to support continued improvement. Activities to support this measure will include:

- Train staff in mental health, particularly on severe mental illness (SMI) and community resources, in order to ensure that staff is equipped to identify signs and symptoms of clinical depression, address client safety including connection to behavioral health services.
- Clinical Supervisors to review monthly reports with staff and to coach staff to ensure members are screened and receive appropriate follow up.
- Coach and conduct role-playing activities to reduce the rate of members declining PHQ-9 screening.
- Complete bi-monthly staff self-audits which will enable Coordinators to identify and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated.
- Clinical Supervisors to conduct quarterly audits to ensure best practices and regulatory requirements are met.

6.4 Care Management Client Satisfaction with Care Management Services to achieve their health goals

Measure: Care Management Client Satisfaction with Staff					
Numerator	32	**Baseline**	100%	**Final Performance**	97.0%
Denominator	33	**Target**	90.0%	**Evaluation Year**	2021

The Care Management Client Satisfaction with Staff measure is in the Managing Members with Multiple Chronic Illnesses domain. This measure reflects activities to increase the percentage of clients enrolled in SFHP's Care Management (CM) programs who respond "Yes" to Question 2: 'Has the Care Management program helped you reach your health goals?' and who respond "Always" or "Often" to Question 6: 'After receiving information from the Care Management staff, I feel confident I can take the actions needed to maintain or improve my health.' The client satisfaction survey is conducted twice a year and is used to assess client experience with CM services and staff. The target for this measure was 90% and was chosen based on results from previous versions of the survey. This target represents SFHP's commitment to ensuring that Care Management programs are member centered.

The following activities were completed:

- Maintained a process to triage members into longer-term case management programs when requested by member or indicated by member's self-efficacy skills.

- Provided more thorough life skills education and training to members as it pertained to their health maintenance.
- Improved communication of care plan goal progress between Care Management staff and members.

The final result for this measure was 97.0%. The target was met, however, the population measured was lower than usual. Typically, this survey is conducted in person twice a year during April and October. Due to the COVID-19 pandemic and San Francisco's shelter in place directive, surveys were only able to be mailed resulting in a low response rate. Staff continue to only provide telephonic case management at this time. This measure will be retired as the Care Management staff have continued to meet this goal over the past few years. CM Management feel at this time it would be more beneficial to focus on measures focused on future CalAIM initiatives.

- Maintain a process to triage members into longer-term case management programs when requested by member or indicated by member's self-efficacy skills.
- Provide more thorough life skills, health education and training to members as it pertains to their health maintenance.
- Improve communication of care plan goal progress between Care Management staff and members.
- CM staff completes a 6-month reassessment and review of care plan including goals with member

6.5 Health Homes CB-CME Case Conference Rate

Measure: Health Homes CB-CME Case Conference Rate					
Numerator	318	**Baseline**	44.0%	**Final Performance**	47.4%
Denominator	671	**Target**	51.0%	**Evaluation Year**	2021

The Health Homes CB-CME Case Conference Rate measure is in the Managing Members with Multiple Chronic Illnesses domain. This measure reflects the percent of unique Health Homes Program (HHP) enrolled members that had at least one case conference during their time in the program. The target for this measure was 51.0%. The target was selected based on baseline results to ensure continued improvement. Achieving the target would mean that more than half of the HHP members had at least one session where their care team collaborated in real time to discuss the best course of action for their care. This results in a more cohesive care team, who is more likely to collaborate in the future on behalf of the member, and ultimately produces better outcomes for patients in the program.

The following activities were completed:

- Provided CB-CMEs with education on importance of case conferences, the definition of case conference, and a reminder that this measure was being tracked.
- Trained new CM staff on HHP workflow.
- Review of quarterly metrics with team by Clinical Supervisors highlighting both strengths as well as areas for improvement.
- Completion of bi-monthly self-audits by staff to identify and remedy any gaps in the member's care plan including completing case conferences.
- Completion of quarterly audits by Clinical Supervisors to ensure best practices and regulatory requirements are met.

The final result for this measure was 47.4%. Three hundred and eighteen out of 671 HHP clients had at least one case conference completed. The target was not met. Barriers to meeting the target included some impacts from the COVID-19 pandemic on the program. There was some loss of staff due to reallocation of resources for SF COVID response. Clinics had to adjust and develop new workflows for COVID-19 response that deprioritized HHP activities.

SFHP will retire this measure as the Health Homes Program is being phased out in 2022. SFHP will transition into meeting the program requirements of the Department of Healthcare Services' CalAIM initiative beginning in January 2022. SFHP will consider adding ECM Case Conference Rates as a measure in the future once we have a full year of data available to establish a baseline and targets.

7. Utilization of Services

These are measures that address appropriate utilization, i.e., decrease over-utilization or increase under-utilization.

7.1 Percentage of Members Utilizing the Non-Specialty Mental Health Benefit with More Than Two NSMH Visits

Measure: Percentage of Members Utilizing the Non-Specialty Mental Health Benefit with More Than Two NSMH Visits					
Numerator	925	**Baseline**	39.8%	**Final Performance**	44.6%
Denominator	2,075	**Target**	42.8%	**Evaluation Year**	2021

The Percentage of Members Utilizing the Non-Specialty Mental Health (NSMH) Benefit with More Than Two NSMH Visits is in the Utilization of Services domain. Increasing NSMH visits reflects improved access for members with behavioral health conditions who do not consistently seek or continue treatment once initiated. This measure reflects continued focus on enhancing member and provider awareness of the availability of the NSMH benefit and in sustaining engagement in care. The measure is the percentage of non-dually enrolled Medi-Cal members utilizing the NSMH benefit who had at least two or more visits with a behavioral health provider from April 1, 2020 to March 31, 2021.

Data is based on NSMH claims paid by Beacon Health Options. The baseline rate of 39.8% was based on a broad set of mental health therapy claim codes and SFHP set the target of 42.8% based on 3.0% absolute improvement from this initial baseline.

To improve performance, SFHP completed the following activities:

- Promoted in person and tele-behavioral health benefit to members through member communications including weekend and after-hours appointment access to members.
- Communicated to providers on how to refer to behavioral health services.

SFHP exceeded the target of 42.8% by 1.8% for a final performance of 44.6%. SFHP will retire this measure to focus on other behavioral health priorities.

7.2 Primary Care Utilization

Measure: Primary Care Utilization			
Baseline	Q3 2020 rate	**Final Performance**	315.1
Target	≥ Q2 2019 rate: 302.1	**Evaluation Year**	2021

The Primary Care Utilization measure is in the Utilization of Services domain. This measure demonstrates SFHP's continued emphasis on connecting members to preventive care in order to better manage their health. Increasing the rate of members with a primary care visit may also support other QI program measures such as HEDIS and HP-CAHPS, as members with primary care visits are more likely to receive preventive care. Members with a primary care visit have higher satisfaction with their health care as reflected in HP-CAHPS. Primary Care Utilization is the number of outpatient visits from July 1, 2020 to June 30, 2021 out of 1000 member months.

Data is based on outpatient visit claims and encounters submitted by SFHP's provider groups. SFHP set a target of meeting or exceeding Q2 2019 rate of the same measure, reflecting pre-COVID-19 levels of utilization.

To improve performance, SFHP completed the following activities:

- Informed members of the importance of primary care visits through marketing to members.
- Included PCP visit rate improvement in SFHP's pay-for-performance program.
- Participated in a Disparities Leadership Program with the aim to increase primary care engagement among SFHP's Black members. As a result, SFHP provided health education materials to Black members.
- Conducted outreach to members high risk for COVID-19 to facilitate connection to care.
- Provided member financial incentive for adult wellness visit and expand age of target population for well child visit incentive.
- Implemented a cross functional-work group to create a work plan to improve member engagement with the health plan. The work group created seven videos in five languages for members to learn how to access various types of care including primary and specialty care.
- Provided grants to SF Community Clinic Consortium for the purchase of Personal Protective Equipment for front line providers. This will make it safer for targeted providers to provide in-person care when indicated.

The following planned activities were not completed:

- Conduct Early and Periodic Screening, Diagnostic and Treatment calls mandated by DHCS
- Utilize Prop 56 Value Based Purchasing for several types of preventive and chronic care visits.

SFHP met the target. SFHP will retire this measure to focus on other priorities involving over and under-utilization.

7.3 Telehealth Utilization

Measure: Telehealth Utilization					
Numerator	264, 419	**Baseline**	Not Available	**Final Performance**	50.0%
Denominator	528,838	**Target**	25.0%	**Evaluation Year**	2021

The Telehealth Utilization measure is in the Utilization of Services domain. This measure demonstrates SFHP's focus on connecting members telehealth to aid members in managing their health during the COVID-19 pandemic. Telehealth Utilization is the outpatient visits by telehealth modalities from July 1, 2020 to June 30, 2021 out of all outpatient visits.

Data is based on outpatient visit claims and encounters submitted by SFHP's provider groups. SFHP set a target of meeting of 25.0%.

To improve performance, SFHP completed the following activities:

- Promoted tele-health services to members.
- Provided grants to provider network to invest in telehealth infrastructure.
- Implemented a cross functional-work group to create a work plan to improve member engagement with the health plan. The work group created seven videos in five languages for members to learn how to access various types of care including primary and specialty care.
- Provided training to SFHP providers on how to conduct telehealth visits during the COVID-19 pandemic.

The following planned activities were not completed:

- Provide incentives for registration of tele-health services and for younger members to receive preventative health visits.

SFHP met the target. SFHP will retire this measure to focus on other priorities involving over and under-utilization.

8. Quality Oversight Activities

These are quality oversight activities monitored and completed this year.

	Oversight	Summary	Responsible Staff	Activities	Due Date
A	Quality Improvement Committee	Ensure Quality Improvement Committee (QIC) oversight of QI activities outlined in the QI Plan	CMO	• Five meetings held in 2021	12/30/2021
B	Pharmacy and Therapeutics Committee	Ensure oversight and management of the SFHP formulary and DUR initiatives	CMO	• Quarterly and ad hoc P&T Committee meetings	12/30/2021
C	Physician Advisory/Peer Review/Credentialing Committee	Ensure oversight of credentialing and peer review by the Provider Advisory Committee	CMO	• Five meetings held in 2021	12/30/2021
D	Utilization Management Committee	Ensure oversight of SFHP Utilization Management program	Director, Clinical Operations	• Ten meetings held in 2020	12/30/2021
E	Annual Evaluation of the QI Program	Review Quality Improvement plan and determine efficacy of implemented plan based on outcomes	CMO	• Evaluated each measure in the QI work plan • QIC reviewed QI evaluation • Governing Board reviewed QI Evaluation	3/1/2021
F	QI Plan Approval for Calendar Year	Review and approve proposed Quality Improvement work plan	CMO	• QIC reviewed QI work plan • Governing Board reviewed QI Work Plan	3/1/2021
G	Delegation Oversight for QI	Ensure oversight of QI for all delegated entities	CMO	• Followed delegation oversight procedures • QIC review of Delegated Oversight Audits for QI • All groups delegated for QI passed audit	12/30/2021
H	DHCS Performance Improvement Projects	Ensure oversight and follow through on required DHCS Performance Improvement Projects (PIPs)	CMO	• Attended DHCS-led PIP calls • Adhered to process delineated by DHCS	12/30/2021

Reviewed & Approved by:

Chief Medical Officer: Date: 12/09/21

Fiona Donald, MD

Fiona Donald, MD

Quality Improvement Committee Review Date: 12/09/21

Board of Directors Review Date:

Agenda Item 6

Chief Medical Officer's (CMO) Report

Action Item:

c. Review and Approval of 2022 Quality Improvement Program Workplan

50 Beale St. 12th floor
San Francisco, CA 94105
www.sfhp.org

San Francisco Health Plan

2022 Quality Improvement Program Description & Work Plan

Contents

1. Introduction

San Francisco Health Plan (SFHP) is a community health plan that provides affordable health care coverage. As of August 2021, membership included 162,516 low and moderate-income individuals and families. Members have access to a range of medical benefits including preventive care, specialty care, hospitalization, prescription medications, behavioral health and family planning services. SFHP was designed by and for the residents it serves and takes great pride in its ability to serve a diverse population that includes children, young adults, and seniors and persons with disabilities (SPDs).

SFHP is a unique public-private partnership established by the San Francisco Health Authority as a public agency distinct from the county and city governments. A nineteen-member Governing Board directs SFHP. The Governing Board includes physicians and other health care providers, members, health and government officials, and labor representatives. The Board is responsible for the overall direction of SFHP, including its Quality Improvement (QI) Program. The Governing Board meetings are open for public participation.

To ensure high quality care and service, SFHP embarked on a journey to be accredited with the National Center for Quality Assurance (NCQA) in 2015. SFHP received interim accreditation status in 2016 and first survey accreditation in 2017, earning 48.3 of 50 possible points. SFHP renewed its accreditation in 2020.

SFHP's products include Medi-Cal and Healthy Workers:

- **Medi-Cal**
  Medi-Cal is California's Medicaid program, which is a federal and state-funded public health insurance program for low-income individuals. As a managed care plan, SFHP manages the funding and delivery of health services for Medi-Cal members. As of August 2021, SFHP retained 88% (150,707 members) of the managed care market share in San Francisco County. [1]

- **Healthy Workers**
  Healthy Workers is a health insurance program offered to providers of In-Home Supportive Services or temporary exempt employees of the City and County of San Francisco. As of August 2021, 11,840 members are enrolled in this program.

2. QI Program Purpose, Scope and Goals

SFHP is committed to continuous quality improvement for both the health plan and its health care delivery system. The purpose of the SFHP QI Program is to establish comprehensive methods for systematically monitoring, evaluating, and improving the quality of the care and services provided to San Francisco Health Plan members. The QI Program is designed to ensure that members have access to quality medical and behavioral health care services that are safe, effective, accessible, equitable, and meet their unique needs and expectations. Delivery of these services must be in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

[1] Medi-Cal Managed Care Enrollment Report – September 2021, https://data.chhs.ca.gov/dataset/c6ccef54-e7a9-4ebd-b79a-850b72c4dd8c/resource/95358a7a-2c9d-41c6-a0e0-405a7e5c5f18/download/mcod-mc-mc-enrollment-report-september-2021.csv

SFHP contracts with medical and behavioral health care providers, including medical groups, clinics, independent physicians and their associated hospitals, ancillary providers, behavioral health clinicians, and pharmacies to provide care. SFHP maintains responsibility for communicating regulatory and contractual requirements as well as policies and procedures to participating network providers. SFHP retains full responsibility for its QI Program and does not delegate quality improvement oversight. In certain instances, SFHP may delegate some or all QI functions to accredited provider organizations.

Under the leadership of SFHP's Governing Board, the QI Program is developed and implemented through the Quality Improvement Committee (QIC). The QIC structure, under the leadership of the SFHP Chief Medical Officer, ensures ongoing and systematic collaboration between SFHP and its key stakeholders: members, provider groups, and practitioners. The QI Program is also part of a broader SFHP improvement strategy that includes a Population Health Management Program. The Population Health Management Program develops SFHP's strategic targets for addressing the needs of its members across the continuum and manages the effective execution of that strategy. Strategic targets from Population Health Management are incorporated into the QI program. A shared leadership team ensures accountability and collaboration between both programs.

The QI Program's objectives and outcomes are detailed in the QI Work Plan (see Appendix A). Each program objective is monitored at least quarterly, evaluated at least once per year and is shared with QIC quarterly in the form of a QI scorecard. Measures and targets are selected based on volume, opportunities for improvement, risk, organizational priorities, and evidence of disparities.

The scope and goals of the QI Program are comprehensive and encompass major aspects of care and services in the SFHP delivery system, as well as the clinical and non-clinical issues that affect its membership. These include:

- Improving members' health status, including reducing health disparities and addressing, where possible, the social determinants of health that adversely impact our members
- Ensuring continuity and coordination of care
- Ensuring access and availability of care and services, including parity between medical and behavioral health care services
- Ensuring member knowledge of rights and responsibilities
- Providing culturally and linguistically appropriate services
- Ensuring that health care practitioners are appropriately credentialed and re-credentialed
- Ensuring timely communication of Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) standards and requirements to participating medical groups and organizational providers
- Ensuring effective and appropriate utilization management of health care services, including medical, pharmaceutical, and behavioral health care services
- Providing health education resources
- Ensuring clinical quality and safety in all health care settings
- Ensuring excellent member care experience
- Ensuring that responsibilities delegated to medical groups meet plan standards
- Evaluating the overall effectiveness of the QI Program through an annual comprehensive program evaluation
- Using the annual evaluation to update the QI Program and develop an annual QI Work Plan

3. QI Program Structure

The following section describes the quality committees and staff of SFHP. Appendix B - Quality Improvement Committee Structure, includes details on committee reporting structure.

A. Quality Committees

The Quality Committees listed below report either to the Quality Improvement Committee (QIC), the Governing Board, or the Chief Medical Officer (CMO).

i. The Quality Improvement Committee

The SFHP QIC is comprised of network clinicians (physicians, behavioral health, and pharmacists) and three members of the Member Advisory Committee, one of whom is an SPD member. The QIC is chaired by SFHP's CMO. The QIC is a standing committee of the San Francisco Health Authority Governing Board that meets six times a year. It is the main forum for member and provider oversight, ensuring the quality of the healthcare delivery system. The committee is responsible for reviewing and approving the annual QI Program and QI Evaluation, and for providing oversight of the Plan's quality improvement activities. SFHP brings new quality improvement programs to the QIC to ensure the committee members provide input into program planning, design, and implementation. SFHP maintains an annual calendar to ensure that key SFHP QI activities are brought to the QIC for ongoing review. This includes review and approval of policies and procedures related to quality improvement, utilization management, and delegation oversight. SFHP maintains minutes of each QIC meeting, submits them to the Governing Board for review and approval, and submits these to DHCS on a quarterly basis. The QIC meetings are open to the public and agendas and minutes are published on SFHP's website.

ii. The Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee convenes at least quarterly to review, evaluate, and approve the SFHP Formulary revisions based on safety, comparable efficacy and cost and to adopt pharmaceutical management procedures including prior authorization criteria, quantity limits, and step therapy protocol for covered outpatient prescription medications. The P&T Committee is responsible for pharmaceutical and therapeutic treatment guidelines and an annual approval of the pharmacy clinical policies and procedures for formulary, prior authorization, monitoring of utilization rates, timeliness of reviews, and drug utilization review (DUR) processes. The SFHP P&T Committee governs formulary, utilization management, and related policies/procedures for the Healthy Workers HMO line of business and Healthy San Francisco program. Formulary, utilization management, and related policies/procedures for Medi-Cal will be governed by the Department of Health Care Services (DHCS) upon implementation of Medi-Cal Rx (January 1, 2022). The retrospective DUR processes and related policies governed by the P&T Committee may include Medi-Cal for the purpose of oversight of adherence and disease and medication management. The P&T Committee is comprised of network physicians, including a psychiatrist, and pharmacists along with the SFHP Pharmacy Director and is chaired by SFHP's CMO or designee. The committee meets quarterly and on an ad hoc basis, and meetings are open to the public. The P&T Committee reports to the QIC.

iii. The Physician Advisory/Peer Review/Credentialing Committee

The Physician Advisory/Peer Review/Credentialing Committee (PAC) provides comments and recommendations to SFHP on standards of care and peer review. The PAC Committee is chaired by SFHP's CMO and consists of providers in SFHP's network. The PAC Committee serves to review and provide recommendations regarding substantive quality of care concerns, in particular those related to credentialed provider performance. The Sanctions Monitoring Report is reviewed by SFHP monthly to

ensure that any identified providers with investigations or actions are brought to the PAC Committee for review, including confirmed Potential Quality Issues of requisite severity and Facility Site Review finding. The PAC Committee also reviews credentials and approves practitioners for participation in the SFHP network as appropriate. The PAC Committee meets every two months and is a subcommittee of QIC.

iv. The Member Advisory Committee

The Member Advisory Committee (MAC) serves as the Public Policy Committee of SFHP as defined and required by the Knox-Keene Act. The MAC advises the Plan on issues of concern to SFHP's service beneficiaries. The committee is made up of SFHP members and health care advocates. In this forum, members can voice concerns and give advice about what health services are offered and how services are delivered to members. It consists of at least 10 to no more than 30 members and is led by an SFHP member. The Committee meets monthly and reports to the Governing Board.

v. The Practice Improvement Program Advisory Committee

The Practice Improvement Program (PIP) Advisory Committee provides guidance to SFHP on pay-for-performance program development, implementation, and evaluation. Committee members review prior and current year PIP network performance, identify and predict barriers to success for participants, and problem-solve solutions. Membership is made up of representatives from all PIP-participating organizations. Meetings are held at least twice a year. The PIP Advisory Committee reports to the CMO.

B. Committees with Internal Membership Only

The Committees with Internal Membership Only listed below report either to the CMO, or the Compliance and Regulatory Affairs Officer, which in turn provide updates to the QIC or the Governing Board through minutes or representation as appropriate.

i. The Policy & Compliance Committee

The Policy and Compliance Committee (PCC) is comprised of SFHP staff and led by SFHP's Compliance and Regulatory Affairs Officer. The PCC reviews and approves all new policies and procedures and changes to existing policies and procedures. Policies and procedures with clinical implications must be approved by the QIC before review by the PCC. The PCC also communicates regulatory updates and compliance issues to SFHP management. The PCC meets at least 11 times per year and is chaired by the Compliance Programs Supervisor. Members include representatives from Health Services, Operations, Finance, Information Technology Services, Human Resources, and Marketing departments. PCC members include:

- Chief Officer of Compliance and Regulatory Affairs Regulatory Affairs Counsel, Chairperson
- Regulatory Affairs Counsel, Chairperson
- Manager, Compliance and Oversight
- Director of Policy Development and Coverage, or delegate
- Director of Finance, or delegate
- Director of Pharmacy, or delegate
- Director of Clinical Operations, or delegate
- Director of Human Resources, or delegate
- Director of Systems Development Infrastructure, or a delegate
- Director of Claims, or delegate
- Senior Manager, Member Services

- Director of Marketing & Communications, or delegate
- Director of Provider Network Operations, or delegate
- Director of Care Management, or delegate
- Director of Health Services Program, or a delegate

ii. The Provider Network Oversight Committee

The Provider Network Oversight Committee (PNOC) is comprised of SFHP staff and led by SFHP's Compliance and Regulatory Affairs Officer. The PNOC provides a forum for evaluating providers' compliance with DHCS, DMHC, and NCQA requirements and standards. This committee identifies issues and addresses concerns related to provider performance of their administrative responsibilities. The committee is responsible for making penalty recommendations when providers do not meet performance standards according to federal and state requirements. The PNOC is chaired by the Manager, Compliance and Oversight and is comprised of members from the following departments: Compliance and Regulatory Affairs, Operations, and Health Services. PNOC voting members include:

- Manager, Compliance and Oversight (Chair)
- Officer, Compliance and Regulatory Affairs
- Director, Provider NetworkDirector, Clinical Operations
- Manager, Access and Care Experience
- Director, Health Services
- Behavorial Health Manager
- Director of Pharmacy

iii. The Grievance Review Committee

The Grievance Review Committee (GRC) is an internal SFHP committee that reviews all grievances and serves as an escalation point for trends identified from member grievances. If a grievance trend is identified or there is a particularly concerning grievance, the committee will recommend a Corrective Action Plan (CAP) or a notification to the Medical Group. Member grievances are not delegated to Medical Groups, except Kaiser, Beacon, and Vision Service Plan (VSP). The GRC also reviews individual member grievances through a collaborative process to ensure that all the components of the grievances have been resolved. The committee is led by the CMO with cross functional representation from Member Services, Provider Relations, Health Outcomes Improvement, and Compliance and Regulatory Affairs departments. The committee meets twice weekly. GRC members include:

- Chief Medical Officer or designee (Chair)
- Health Plan Physician Advisor
- Chief Officer, Compliance and Regulatory Affairs
- Senior Manager, Member Services
- Account Manager, Provider Network Operations
- Quality Review Nurse
- Supervisor, Appeals and Grievances
- Counsel, Regulatory Affairs
- Senior Analyst, Regulatory Affairs
- Program Manager, Appeals and Grievances
- Grievance Staff
- Lead, Customer Service
- Pharmacy, Utilization Management, Care Management, Health Education, and Cultural & Linguistics staff participate as needed.

iv. The Grievance Program Leadership Team

The Grievance PLT is an internal SFHP committee that provides oversight and monitoring of all grievance program functions such as process improvement opportunities, audits, reporting, regulatory requirements, operations, and grievance trends. Grievance PLT also ensures follow through of Grievance Review Committee recommendations for grievance trends and reviews for system issues. The Grievance PLT is led by the Manager of Access and Care Experience with cross functional representation from Health Services, Member Services, Health Outcomes Improvement, and Compliance and Regulatory Affairs departments. Grievance PLT meets quarterly. PLT members include:

- Chief Medical Officer or designee (Chair)
- Chief Officer, Compliance and Regulatory Affairs
- Chief Officer, Operations
- Senior Manager, Member Services
- Supervisor, Appeals and Grievances
- Quality Review Nurse
- Program Manager, Appeals and Grievances
- Manager, Provider Relations and/ or Account Manager, Provider Network Operations as needed.

v. The Access Compliance Committee

The Access Compliance Committee (ACC) coordinates the monitoring and improvement activities for the accessibility and availability of medical and behavioral health care services. The committee meets at least quarterly to review access data, monitor progress of access-related corrective action plans, and recommend and review actions based on non-compliance with timely access standards. The committee is cross-functional and comprised of representatives from Operations, Health Services, and Compliance and Regulatory Affairs departments. The committee reports to the QIC. ACC members include:

- Regulatory Affairs Counsel (Chair)
- Manager, Provider Relations
- Network Manager, Provider Relations
- Senior Analyst, Regulatory Affairs and Compliance
- Senior Program Manager, Quality and Access
- Specialist, Provider Relations

vi. The Utilization Management Committee

The Utilization Management Committee (UMC) provides oversight to ensure effective and compliant implementation of SFHP's Utilization Management Program and to support compliance with SFHP's policy requirements, the Medi-Cal contract, NCQA accreditation requirements, and DHCS/DMHC statutory and regulatory requirements. Discussion outcomes may result in changes to medical policy and criteria, prior authorization requirements, and/or UM Process enhancements. The UMC is a subcommittee of the QIC. The UMC meets 10 times annually and provides monthly minutes, quarterly trend reports, and annual reports to the QIC. The UMC membership, with voting rights on all motions, consists of:

- Chief Medical Officer, MD
- Associate Medical Director, MD
- Director, Clinical Operations, RN
- Senior Manager, Prior Authorization, RN

- UM Nurse Manager, Prior Authorizations, RN
- Manager, Concurrent Review and Care Transitions, RN
- Program Manager, Utilization Management, PhD
- Director of Pharmacy, Pharm.D
- Manager, Pharmacy, RPh

The UMC membership, with voting rights limited to behavioral health and mental health motions, consists of:

- Director of Clinical Services – Beacon Health Options (ad hoc)
- Valid State Clinical License required (RN, LCSW, LMFT, PhD, or PsyD)
- Medical Director (MD/Psychiatry) – College Health IPA (Beacon Health Options) (ad hoc)

C. Quality Improvement Communications

i. Communication to members

SFHP updates members regularly regarding key QI activities. A summary of the QI work plan and evaluation is published and distributed to members annually by mail in the member newsletter "Your Health Matters," and on SFHP's website.

ii. Communication to providers

SFHP updates providers regularly regarding key QI activities, including:

- Disseminating the QI work plan and evaluation to providers via the SFHP Provider Newsletter and by posting on SFHP's website.
- Informing providers of new and revised policies and procedures, and legislative and regulatory requirements as they occur through the SFHP Provider Newsletter and the Network Operations Manual (NOM).
- Sharing preventive care and other clinical practice guidelines.
- Distributing results of quality monitoring activities, audits and studies, including grievances that identify potential system issues and member experience and provider satisfaction survey results
- Providing training for new providers on SFHP's NOM.

D. Quality Improvement Staff

The Health Outcomes Improvement (HOI) department within Health Services has primary accountability for implementing the QI Program, corresponding QI Work Plan, and conducting an annual population health assessment and strategy. The department is organized to provide interdisciplinary involvement in ensuring the quality of health care and services provided to SFHP's membership. HOI staff monitors quality indicators and implements and evaluates the Plan's quality improvement activities. HOI staff develop and comply with policies and procedures describing SFHP standards, legislative and regulatory mandates, contractual obligations and, as applicable, NCQA standards. HOI staff support management of QI studies and reports, including statistical analysis and interpretation of data. Based on the QI Work Plan activities, HOI staff provides summary data, analysis, and recommendations to the QIC.

i. Health Services Staffing Structure

The Health Services Leadership that supports the QI program are:

Chief Medical Officer – responsible for leading the Quality Improvement Committee, Physician Advisory/Peer Review/Credentialing Committee, and the Pharmacy and Therapeutics Committee, and for all quality improvement studies and activities. The CMO provides guidance and oversight for development of policies, programs, and projects that support all activities identified in the QI Program. The CMO carries out these responsibilities with support from direct reports, including Medical Director, Associate Medical Director, and Directors of Health Outcomes Improvement, Pharmacy, Clinical Operations, and Care Management. In addition, the CMO partners with the Officer of Compliance and Regulatory Affairs. The CMO is a board-certified physician who holds a current license to practice medicine in California. The Senior Medical Director holds a Medical Doctorate and has 30 years of healthcare experience including 12 years of clinical practice experience and 18 years of clinical quality and managed care experience.

ii. Population Health & Special Programs Staffing Structure

Interim Director, Population Health & Quality – The Interim Director, Population Health & Quality reports to the Chief Medical Officer, ensures the completion of the QI Program (including work plan and evaluation), and directs the execution of QI activities identified in the QI Work Plan. The Interim Director, Population Health & Quality, oversees teams focused on fostering quality for SFHP's members. The Interim Director, Population Health & Qiality has a Master of Health Administration and has 19 years of experience in program development, process improvement, and quality implementation experience.

- **Senior Program Manager, Quality & Access –** reports to the Director, Population Health & Special Programs, and is responsible for operating quality improvement oversight and project manages SFHP's access monitoring requirements, measures CAHPS performance, develops and implements interventions to improve the care experience of SFHP members. The Quality & Access Senior Program Manager has 12 years of experience in a clinical setting and six years of experience in quality improvement.

- **Manager, Population Health –** reports to the Director, Population Health & Special Programs, and oversees activities related to the improvement and auditing of clinical HEDIS measures, health education & promotion programs, and pay-for-performance. The Population Health Manager is a Registered Nurse with an Associate Degree in Nursing Science. The Population Health Manager has 14 years of clinical experience and 11 years of quality improvement experience. Reporting to the Manager, Population Health, the following positions support SFHP's QI efforts:

    - **Program Manager, Population Health –** project manages interventions to improve HEDIS measures, including member incentives, medical record review, health disparities, and cultural linguistic services. The Population Health Program Manager has a Bachelor of Arts in Sociology and is a Certified Full Spectrum Doula and a Certified Family Planning Health Educator, with 11 years of experience in qualitative research, four years of experience in a clinical setting, and three years of experience in quality improvement.

    - **Program Manager, Population Health –** project manages interventions to improve HEDIS and member experience measures through SFHP's pay-for-performance program.

The Population Health Program Manager has a Master of Public Health, with four years of experience in quality improvement.

- **Program Manager, Population Health (Qualified Health Educator) –** designs and implements interventions to improve HEDIS rates, ensures that members have access to low-literacy health education materials/classes, and ensures that members have access to services in their preferred language. The Qualified Health Educator and Program Manager of Population Health has a Master of Public Health, with 16 years of experience in public health including 11 years of experience in health education.

- **Specialist –** provides support to the above staff to execute their responsibilities, developing marketing materials, pay-for-performance data management, and coordinating with providers to report pay-for-performance data. The Specialist in Population Health has a Bachelor of Science in Public Health, with one year of experience in clinical research, one year experience in health promotion, and two years experience in care coordination.

- **Supervisor, Special Programs** – reports to the Director, Population Health & Special Programs, and is responsible for the overall planning, execution, and implementation of projects and work products related to Special Projects within Health Services. The Program Manager Supervisor has10 years of experience in program management in a health care and administrative program setting. The Supervisor Program Manager has a Bachelor's of Science in Health Services.

  - **Program Manager, Social Determinants of Health –** reports to Supervisor of Special Programs and is responsible for navigating county and community SDoH agencies and interventions, analyzing SDoH policy trends as relevant to SFHP members and consults with internal staff on pathways connecting to communityagencies that address SDoH while tracking barriers to access. The SDoH Program Manager has a Bachelors of Science or Social Work , with four years of experience in program management, and two years of direct service.
  - **Program Manager, Children and Families –** reports to Supervisor of Special Programs and is responsible for implementing activities and measurement of programs involving children and family services. Children & Family program manager monitors DHCS & DHMC requirements, coordinates with county andcommunity services and develops and implements interventions to improve the care experience of SFHP members. The Children & Family Program Manager has a Bachelors of Science or Social Work , with four years of experience in program management, and two yearsof direct service with children and family.

iii. Health Services Departments that contribute to the QI Program

Clinical Operations Department
SFHP's Clinical Operations Department conducts Utilization Management (UM) for both inpatient and outpatient requests. In addition, they oversee delegated UM activities within the provider network to comply with all regulatory UM requirements. Activities are comprised of the following functional areas: Care Transitions, Concurrent Review, Prior Authorization, UM Delegation Oversight, UM Claims Edits, and Provider Dispute Resolutions.

Pharmacy Department
SFHP's Pharmacy Department leads initiatives to improve quality of care, including medication reconciliation and drug utilization reviews. The Pharmacy Department also includes the Health Services Product Management team, which oversees SFHP's HEDIS process and internal applications supporting SFHP processes that impact member care

Care Management Department
SFHP's Care Management department administers case management programs aimed at improving care for members who may be high risk, high-utilizing, and/or experiencing challenges when trying to effectively engage the health care system. Care Management provides a wide range of services from basic telephonic care coordination to intensive, in-person case management. The goals of Care Management's programs are to improve member health, support members' self-management of chronic conditions, improve connection with and utilization of primary care, and reduce inpatient admissions and avoidable ED visits. As part of these goals, the program works to address psychosocial stability (e.g. housing, access to healthy food, clothing, and in-home supportive services) when needed. All programs include comprehensive assessments and member-driven care plans. Through a collaborative process with primary care providers, behavioral health providers, community agencies, and the member, Care Management staff work to improve coordination of services.

iv. External Agency that contributes to the QI program

Beacon Health Options
Beacon Health Options is delegated to provide non-specialty mental health care to SFHP's Medi-Cal members. Beacon's Quality Director presents annually on their QI plan and participates in QIC meetings as needed. SFHP's CMO provides oversight and strategic guidance of the NSMH benefit to Beacon Health Options. Beacon's on-site clinical staff participates in Care Management rounds to ensure a smooth connection of our member to Beacon services. SFHP collaborates with Beacon's Clinical Management Director on QI initiatives as needed.

4. Quality Improvement Method and Data Sources

A. Identification of Important Aspects of Care

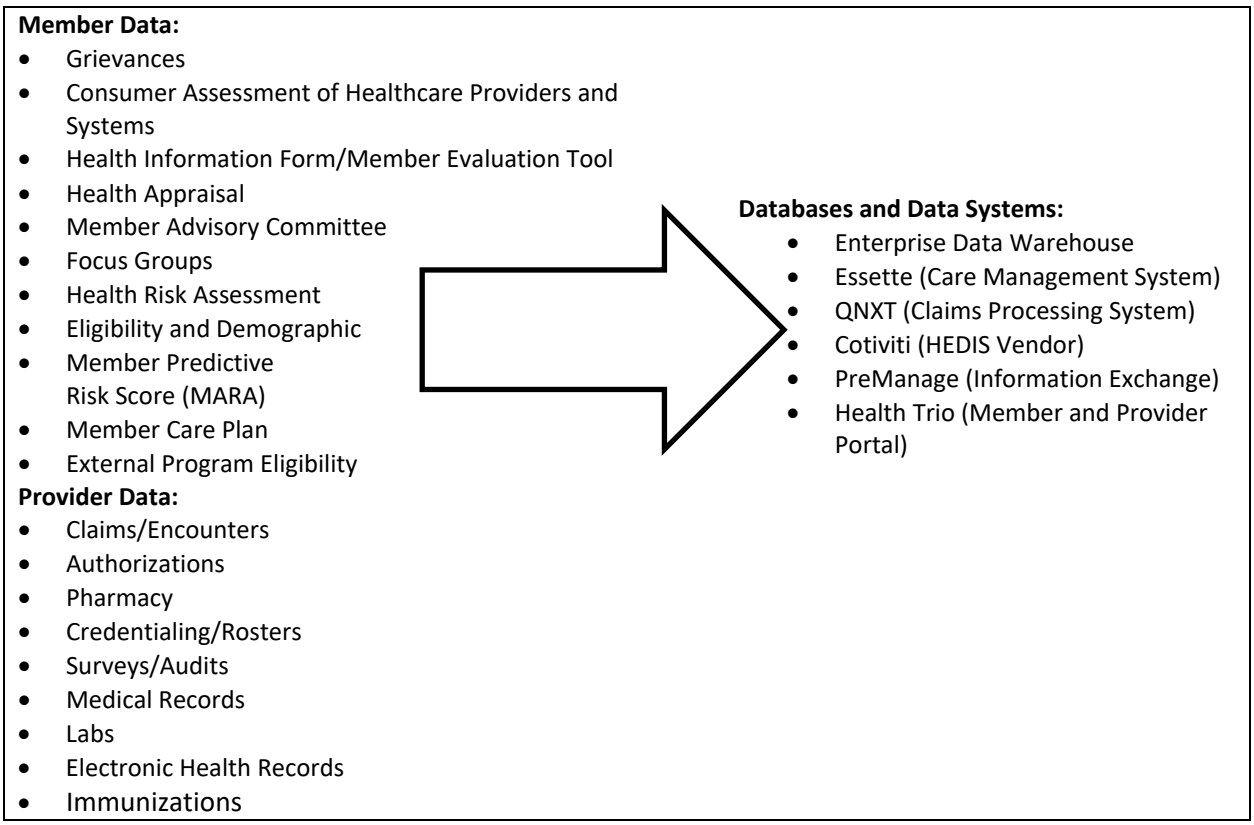
SFHP identifies priorities for improvement based on regulatory requirements, NCQA standards, data review, and provider- and member- identified opportunities in the key domains of Clinical Quality & Safety, Quality of Service & Access to Care, Utilization Management, and Care Coordination & Services. Particular attention is paid to those areas that are high risk, high volume, high cost, or problem prone.

The QI Program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. The QI Program uses the following methods to improve performance:

- Establish targets and/or benchmarks for key indicators within each domain
- Systematically collect data
- Analyze and interpret data at least annually
- Identify opportunities for improvement
- Identify barriers to improvement
- Prioritize opportunities

- Establish improvement objectives in support of priorities
- Design interventions based on best practices or previous interventions
- Implement and track progress of interventions
- Measure effectiveness of interventions based on progress toward standards or benchmarks

B. Data Systems and Sources



Data Monitoring and Reporting

SFHP monitors and improves data quality via the following mechanisms:

- **Encounter Data Monitoring** – SFHP measures the quality of encounter data monthly for completeness, accuracy, reasonability, and timeliness using methodology published in the DHCS Quality Measures for Encounter Data (QMED) document. SFHP works with its Trading Partners to ensure timely encounter submissions by reviewing error reports, reconciling and resubmitting rejected encounters.
- **Health Services Product Management (HSPM) HEDIS Workgroup** – The HSPM HEDIS Workgroup is an internal SFHP workgroup that sets the overall direction for HEDIS data quality improvement and monitoring efforts. The workgroup's goals include improvement of data quality (lab, encounter/claim, pharmacy, and member data), regular and recurring monitoring of data quality, and vetting of new data sources (carve out, lab, EHR feeds, Medicare, etc.). The workgroup supports improvement of data that impacts NCQA Accreditation and the California Managed Care Accountability Set quality indicators.

C. Policies and Procedures

SFHP reviews and updates all of its quality and clinical policies and procedures (Utilization Management, Care Coordination, Pharmacy, Quality Improvement, Health Education, Cultural and Linguistic Services) biennially at a minimum. Clinical policies and procedures are also updated on an as-needed basis to reflect changes in federal and state statutory and regulatory requirements and/or NCQA standards. QIC and SFHP's internal Policy and Compliance Committee approve new and updated policies and procedures.

5. QI Program

San Francisco Health Plan evaluates the overall effectiveness of the Quality Improvement Program through an annual evaluation process that results in a written report which is approved by the CMO, QIC, and Governing Board and then submitted to DHCS.

A. QI Work Plan

Results of the annual evaluation described above, in combination with information and priorities determined by the Health Services leadership and staff, are reviewed and analyzed in order to develop an annual QI Work Plan (see Appendix A). This comprehensive set of measures and indicators is divided into six domains:

1. Managing Members with Emerging Risk
2. Patient Safety or Outcomes Across Settings
3. Keeping Members Healthy
4. Quality of Service and Access to Care
5. Utilization of Services
6. Managing Multiple Chronic Illnesses

The QI Work Plan also includes a summary of Quality Improvement Committee Activities and updates are communicated to QIC via a scorecard each quarter.

B. QI Program Evaluation

Measures completed within the evaluation timeline are included in the evaluation for that calendar year. Measure completion is determined by the staff responsible for the measure and is indicated by either completion of planned activities, achievement of the stated target, or receipt of the required data for evaluation. Measure timelines are determined by the activities and the data frequency and can be longer than a single calendar year. Each measure's timeline is indicated in the Work Plan found in Appendix A. The evaluation includes an executive summary and a summary of quality indicators, identifying significant trends and areas for improvement. Each measure included in the evaluation includes the following elements:

- Brief description of the QI activity/intervention and how it aims to improve the domain in which it is included
- Measure target of the QI activity/intervention

- Measure definition
- Measure results, trended over at least three years when available
- Barriers that affected the effectiveness of the activity/intervention
- Recommended interventions/actions to overcome barriers in the following year

6. QI Activities

A. Managing Members with Emerging Risk

The domain of Managing Members with Emerging Risk involves QI activities related to clinical outcomes related to chronic condition care management.

i. Chronic Condition Management

SFHP monitors and reports on a variety of HEDIS measures focused on recommended interventions for members with chronic conditions. These include:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Antidepressant Medication Management
- Asthma Medication Ratio
- Comprehensive Diabetes Care
- Concurrent Use of Opioids and Benzodiazepines
- Controlling High Blood Pressure
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications
- Medical Assistance with Smoking and Tobacco Use Cessation
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Pharmacotherapy Management of COPD Exacerbation
- Plan All Cause Readmissions
- Risk of Continued Opioid Use
- Statin Therapy for Patients with Cardiovascular Disease
- Statin Therapy for Patients with Diabetes
- Use of First-Line Psychosocial Care For Care for Children and Adolescents on Antipsychotics
- Use of Imaging Studies for Low Back Pain
- Use of Opioids at High Dosage
- Use of Opioids at High Dosage in Persons Without Cancer
- Use of Opioids from Multiple Providers

SFHP promotes chronic condition management guidelines to providers through the quarterly provider newsletter and by publishing guidelines on SFHP's public website. These guidelines include but are not limited to:

- American Diabetes Association: Clinical Practice Guidelines
- Institute for Clinical Systems Improvement Guidelines
- SFDPH Asthma Home Visiting Program and Resources
- JNC8 Guidelines for Hypertension

B. Patient Safety or Outcomes Across Settings

The domain of Patient Safety or Outcomes Across Settings involves QI activities related to clinical outcomes related to preventing adverse health outcomes.

i. Patient Safety

SFHP is committed to the safety of its members. Current patient safety initiatives include the following:

Medication Therapy Management (MTM) Program – SFHP Clinical Pharmacists review medication needs for members identified by the Care Management and Care Transitions program. The goal is to optimize medication regimens by promoting safe and effective use of medications. Achieving this goal and completing interventions is a multidisciplinary effort between Pharmacy services, the Care Management and Care Transitions team, Senior Medical Director, and primary care providers. Educational medication resources for targeted members will also increase adherence and knowledge of their drug regimen.

SFHP Pain Management Program – SFHP conducts trainings for providers and clinic staff on multiple aspects of pain management, including safe opioid prescribing. SFHP works with external and internal experts to provide clinical and non-clinical pain management resources to the community. SFHP's pay-for-performance program (PIP) also supports best practices in opioid prescribing and pain management. SFHP has an internal Pain and Opioid Workgroup and pain management is discussed at SFHP's Pharmacy & Therapeutics Committee.

Potential Quality Issues (PQIs) – SFHP Clinical Operations, Care Management, and Pharmacy staff are trained to identify PQIs and refer them to the Quality Review Nurse. SFHP defines a Potential Quality Issue (PQI) as an identified adverse variation from expected clinical standard of care that may present potential or real harm to SFHP members and requires further investigation. SFHP ensures that PQIs are initially evaluated by the Quality Review Nurse for clinical review of elements meeting an acceptable standard of care and presents to the SFHP Associate Medical Director to review investigation results and determine if a clinical quality issue is evident, which may result in corrective action plans and referral to Provider Advisory Committee (PAC) for peer review and next step recommendations.

C. Keeping Members Healthy

The domain of Keeping Members Healthy involves QI activities related to clinical outcomes related to disease prevention.

i. Preventive Care

SFHP monitors and reports on a subset of U.S. Preventive Services Task Force (USPSTF) clinical recommendations and preventive service guidelines as well as other preventive service HEDIS and CMS measures. These include:

- Adolescent Immunization Status
- Ambulatory Care
- Appropriate Testing for Pharyngitis
- Appropriate Treatment Upper Respiratory Infection
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- Breast Cancer Screening
- Cervical Cancer Screening

- Childhood Immunization Status
- Chlamydia Screening in Women
- Contraceptive Care: All Women Ages 15-44
- Contraceptive Care: Postpartum Women Ages 15-44
- Screening for Depression and Follow-Up Plan
- Developmental Screening in The First Three Years of Life
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Well-Child Visits in the First 30 Months of Life
- Child and Adolescent Well-Care Visits

SFHP promotes pediatric and adult preventative health care guidelines to providers through the monthly provider newsletter and by publishing links to established guidelines on SFHP's public website. These guidelines include:

- Recommended immunization schedules (e.g. HPV, Influenza)
- Recommended screenings (e.g. Initial Health Assessment, Colon Cancer)
- Pediatric laboratory/diagnostic studies (e.g. Newborn Blood Screening)
- Recommended counseling (e.g. violence, tobacco use/cessation)

To encourage members to receive high priority services, SFHP offers a $50 incentive to eligible members for completing adult wellness visits.

ii. DHCS Performance Improvement Projects (PIP)

SFHP implements DHCS PIPs at any given time. PIP measures aim to understand key drivers of poor performance and conduct improvement activities based on the key drivers. One of SFHP's PIPs for 2019-2021 targets the large disparities in breast cancer screening rates seen among the SFHP member population by race/ethnicity. SFHP aims to improve the rate of African American members who receive a breast cancer screening within the HEDIS timeframe. The second PIP aims to improve the rate of well-child visits for infants up to the age of fifteen months. This is a new measure for SFHP so there is significant improvement opportunity for the entire SFHP member population. Due to COVID related delays, the two DHCS PIPs will continue through 2022.

iii. Health Education

SFHP ensures that members have access to low-literacy health education and self-management resources in all threshold languages mandated by DMHC and DHCS. These resources are available on the SFHP website, and through SFHP providers. Select materials are also mailed to members as part of SFHP's population health campaigns.

Health topics covered by these tools and fact sheets include smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, asthma and diabetes control, parenting, and perinatal care, among others. SFHP's member newsletter, "Your Health Matters," features emerging health education topics prioritized by SFHP's clinical leadership. In addition, the SFHP website includes a sortable listing of free group wellness classes offered by SFHP's provider network on a variety of topics.

SFHP's member portal prompts members to complete the Health Trio Health Appraisal tool to identify risk factors and health concerns. Based on the Health Appraisal results, members are provided with a risk

and wellness profile, along with prevention strategies. In addition, the Health Trio online platform provides members with access to dynamic and evidence-based self-management tools based on their individual areas of risk or interest. These include topics such as healthy weight, healthy eating, promotion of physical activity, managing stress, tobacco use cessation, avoiding at-risk drinking, and identifying symptoms of depression.

D. Quality of Service and Access to Care

The domain of Quality of Service and Access to Care incorporates all aspects of the services provided to members including customer service, language access, appointment access, and wait times.

i. Monitoring Member Access

SFHP monitors members' access to care, following regulations delineated by DMHC and DHCS as well as accreditation standards set by NCQA. DMHC monitoring requirements are met by the annual Timely Access Regulations submission in March. DHCS monitoring requirements are met via the annual contract oversight audit performed by DHCS. These access monitoring measures, among others, are reviewed quarterly by SFHP's Access Compliance Committee. Based on monitoring and survey results, the committee identifies issues and requests a response when performance thresholds are not met. Data are comprehensive, addressing core areas such as member and provider experience with access, appointment availability, after hours care, wait times, as well as indicators of network adequacy to meet members' needs.

ii. Financial Incentives to Support Improvement

The Practice Improvement Program (PIP) is SFHP's pay-for-performance program. PIP incentive funds are sourced from approximately an 18.5% withholding of provider payments. Providers are eligible to earn 100% of these funds back if they meet program requirements. Supporting the goals of the triple aim, PIP has four domains: Clinical Quality, Patient Experience, Systems Improvement, and Data Quality. Participants have opportunities to gain incentive funds both from meeting benchmarks and from relative improvement. Unearned funds are reserved to support improvement of performance measures via technical assistance and provider-level grants**.**

In addition to the pay-for-performance program, SFHP's governing board caps financial reserves equal to two months of member capitation. Reserves in excess of these amounts are allocated to the Strategic Use of Reserves (SUR). SFHP then reviews quality indicators (HEDIS, CAHPS, utilization, etc.) and recommends projects to improve quality for SFHP members, using funds from SUR.

iii. Provider Satisfaction

On an annual basis, SFHP conducts a Provider Satisfaction Survey to gather information about network-wide provider issues and concerns with SFHP's services. The survey targets primary care and specialty care providers, ancillary providers, and office staff. It measures their satisfaction with the following SFHP functions:

- Telehealth Services
- Utilization Management]
- Care Management
- Network/Coordination of Care
- Timely Access to Health Care Services
- Pharmacy
- Health Plan Customer Service Staff

- Provider Relations
- Ancillary Provider Network
- Member Incentives

Results are distributed to the impacted SFHP departments and the QIC to identify and implement improvement activities. Applicable improvements are integrated into QI Program activities.

iv. Provider Credentialing

SFHP ensures that health care practitioners and organizational providers are qualified to perform the services for which they are contracted by credentialing, re-credentialing, screening and enrolling all network providers. This process includes:

- Bi-annual review of credentialing policies and procedures for compliance with legislative and regulatory mandates, contractual obligations, and NCQA standards
- Peer review of credentialing and re-credentialing recommendations, potential quality of care issues, and disciplinary actions through the Physician Advisory Committee (PAC)
- Providing a mechanism for due process for practitioners who are subject to adverse actions
- Reviewing licensing and accreditation documentation of organizational providers, or reviewing for compliance with industry standards
- Conducting ongoing provider monitoring through the Medical Board of California and other licensing organizations, List of Excluded Individuals/Entities (LEIE), DHCS' Suspend & Ineligible List (S&I), the System for Award Management (SAM), National Plan and Provider Enumeration System (NPPES), the Social Security Death Master File (SSADMF), and the Restricted Provider Database (RPD).

v. Member Grievances and Appeals

SFHP ensures that member grievances and appeals are managed in accordance with Managed Care, Medi-Cal, and NCQA standards. SFHP manages and tracks complaints and grievances and provides a quarterly analysis, identifying trends and addressing patterns when evident, to the QIC. To identify patterns and trends in grievances, grievance reports are generated to report rates by line of business, medical group, and grievance category. When a grievance pattern has been identified, SFHP works with clinics or medical groups to develop strategies for improvement or request corrective action as appropriate. SFHP's Utilization Management Committee (UMC) reviews all member appeals for issues and trends.

vi. Member Rights and Responsibilities

SFHP works to ensure that members are aware of their rights and responsibilities. This includes the annual review, revision, and distribution of SFHP's statement of member rights and responsibilities to all members and providers for compliance with SFHP standards and legislative mandates. SFHP's member rights and responsibilities are available in the Medi-Cal Member Handbook, Medi-Cal Member Guidebook, Healthy Workers HMO Evidence of Coverage and Disclosure Form, and Healthy Workers HMO Member Guidebook. Members can also view their rights and responsibilities on SFHP's public-facing website. Providers are able to view the member rights and responsibilities in SFHP's Provider Manual. SFHP also implements specific policies that address the member rights to confidentiality and minor's rights. SFHP conducts a review of grievance and appeal policies and procedures to ensure compliance with SFHP standards, legislative mandates, DHCS contractual obligations, and NCQA standards, at least once every other year. In addition, SFHP analyzes member grievances and appeals that specifically concern member rights and responsibilities.

vii. Cultural and Linguistically-Appropriate Services and Anti-Discrimination Procedures

SFHP's Cultural and Linguistic Services program is informed by regular assessment of the cultural and linguistic needs of its members via the DHCS Population Needs Assessment (PNA) and NCQA Population Assessnent: Cultural, Ethnic, Racial and Linguistic Needs of SFHP Members and Practitioner Availability (NET 1 A). All SFHP member materials are available in Medi-Cal threshold languages. All SFHP health education materials are written at a sixth-grade reading level. Alternative formats for member materials, such as large text and braille, are available to members upon request.

All non-English monolingual and Limited English Proficient (LEP) SFHP members have access to confidential, no-cost linguistic services at all SFHP and medical points of contact. SFHP informs members about the availability of linguistic services through its Member Handbook, Evidence of Coverage, member newsletters and through other member contacts. The SFHP identification card also indicates the right to interpreter services. Linguistic services may be provided by bilingual providers and staff, or via interpreter services. Interpreter services are provided by a face-to-face interpreter, telephone language line, or Video Monitoring Interpretation (VMI). Interpreter services include sign language interpreters and/or TTY/TDD.

Most SFHP members have the option to select a primary care provider that speaks their preferred language. The SFHP Provider Directory indicates languages spoken at clinic sites.

SFHP contracts the responsibility for providing interpreter services at all medical points of contact to its medical groups. All medical groups must have language access policies and procedures that are consistent with SFHP's policy and meet all legal and regulatory requirements. The SFHP Program Manager, Population Health, conducts an audit of linguistic services, provider participation in cultural awareness training, and anti-discrimination policies as part of the annual Medical Group Compliance Audit. The Program Manager, Population Health, also assists in addressing grievances related to cultural and linguistic issues and discrimination at both medical and non-medical points of contact, systemically investigating and intervening as needed. In addition, SFHP publishes anti-discrimination notices on member and provider-facing materials, including Evidence of Coverage and Provider Network Operations Manual.

E. Utilization of Services

The domain of Utilization of Services addresses quality of care through the lens of appropriate utilization (i.e. monitoring and improving both overused and underused services).

i. Over and Under Utilization of Services

SFHP monitors and evaluates outpatient, inpatient, emergency department, and ancillary services, through monthly reviews of service utilization data. The intent of the reviews is to identify patterns of under and overutilization of services and address any outlier patterns by creating actionable steps to promote evidence-based, medically appropriate service utilization. Service utilization monitoring is reviewed through a UM trending report providing national and state benchmarks for:

- Ambulatory Care – Emergency Dept Visits
- Inpatient Utilization – Acute Care – Total Inpatient Average Length of Stay (ALOS)
- Inpatient Utilization – Acute Care – Total Inpatient Days/1000 MM
- Plan all Cause Readmission Rates

Service utilization patterns are shared with internal leadership, as well as, with external leadership in SFHP's provider network. Adverse patterns are discussed with SFHP's internal and external leadership for root-cause identification, and if needed, corrective action plans are developed.

ii. Pharmacy Services Drug Utilization Review (DUR)

The DUR program consists of a Retrospective DUR Program and an Educational Program promoting optimal medication use to prescribers, pharmacists, and members. The SFHP DUR Program coordinates with the Medi-Cal DUR Board and the Medi-Cal Pharmacy Benefit Manager on retrospective DUR and educational activities for the Med-Cal line of business. The Pharmacy DUR Program activities may focus on identifying medication use patterns to reduce fraud, abuse, and waste, inappropriate, unsafe or unnecessary care and develop education programs to optimize medication use.

- **Retrospective DUR Program** consists of reporting and analysis for prescription claims data and other records to identify patterns of fraud, abuse, gross overuse, inappropriate or medically unnecessary care and other aspects of optimizing medication use. Drug utilization reports evaluate prescribing trends and potential over and under use and potential outlier cases. Utilization reports may include member adherence reports, controlled substance utilization reports, pharmacy outlier reports, etc.

- **Educational Program** consists of verbal and written communication outreach activities developed by the Medi-Cal DUR team and by SFHP to educate prescribers, pharmacists and members on common drug therapy problems with the aim of improving prescribing and dispensing practices.

iii. Care Transitions

SFHP manages members assigned to the San Francisco Health Network, Community Clinic Network and UCSF Medical Group who are discharged from an out of medical group inpatient setting and assists in creating a discharge plan to ensure a medically safe and effective transition to an alternate level of care. The SFHP Concurrent Review and Care Transitions Nurses and Coordinators collaborate internally and with the acute care and SNF facilities to ensure that safe transitions are completed. These include medically necessary services and supportive services in the community for the member upon discharge. SFHP also conducts pre- and post- discharge calls or in-person visits with members and works to coordinate timely post-discharge follow-up appointments as part of the discharge planning process. These activities help to coordinate care with the goal of reducing avoidable readmissions or emergency department visits by ensuring the member's discharge needs are met and there is appropriate follow-up through the continuum of care.

F. Managing Multiple Chronic Illnesses

The Managing Multiple Chronic Illnesses domain encompasses QI activities that improve coordination across multiple providers and facilities and focuses on members with more complex medical and psychosocial needs.

i. Care Management Programs

SFHP's Care Management department administers case management programs aimed at improving care for members who may be high risk, high-utilizing, and/or experiencing challenges when trying to effectively engage the health care system. Care Management provides a wide range of services from basic telephonic care coordination to intensive, in-person case management. Effective March 2020, in

efforts to adhere to the Shelter in Place guidelines during the COVID-19 pandemic, all Care Management programs were adapted to providing telephonic case management only. The goals of Care Management's programs are to improve member health, support members' self-management of chronic conditions, improve connection with and utilization of primary care, and reduce inpatient admissions and ED visits. As part of these goals, the program works to address social determinants of health and psychosocial stability (e.g. housing, access to healthy food, clothing, and in-home supportive services) when needed. All programs include comprehensive assessments and member-driven care plans. Through a collaborative process with primary care providers, behavioral health providers, community agencies, and the member, Care Management staff work to improve coordination of services. Staff identify and address barriers to care and enhance and support members' self-care knowledge and skills. The Health Homes Program (HHP) will be ending on December 31st 2021 and effective January 1st 2022 we will be launching the Enhanced Care Management (ECM) program, an initiative under CalAIM. ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services nand comprehensive care management that is community-based, interdisciplinary, high-touch, and person centered.

ii. Care Coordination with External Agencies

SFHP's Care Management and Utilization Management teams ensure coordination of care for members per Medi-Cal contractual requirements. These coordination activities include executed MOUs with key agencies such as California Children Services (CCS), Golden Gate Regional Services (GGRC), Early Start (ES) and Community Behavioral Health Services (BHS) that outline coordination activities. These coordination activities are designed to ensure members are aware of non-plan benefits and programs available to them and confirm coordination of care across agencies and services. As part of the Health Homes Program, SFHP addresses the needs of members living in supportive housing and those experiencing homelessness. Through collaboration with the Department of Homelessness and Supportive Housing, supportive housing providers, and various community partners, SFHP enhances the scope of care coordination to create a more unified and effective service system.

iii. Children and Transitional Aged Youth

The Children and Transitional Aged Youth (CATY) care coordination program is designed to serve SFHP members aged 0-21 and their families and/or caregivers. Evidence-based assessment tools, consent documents, and care plan goals and interventions have been developed to meet the needs of this population. This program has specific workflows outlining program eligibility, policies, procedures, and outcome metrics. Dedicated Care Management staff have been hired and trained on workflows and California consent laws and policies pertaining to case management with children and transitional aged youth.

iv. Health Risk Assessment (HRA)

All new Seniors and Persons with Disabilities (SPDs) members complete Health Risk Assessments. Members are then reassessed annually. Members are stratified as either high or low risk based on their responses to the HRA questionnaire or the reassessment report data. Members who are high risk receive outreach both by phone and mail, while low risk members receive outreach by mail. HRA telephonic care management is provided for 30 days to members who receive services within the non-delegated medical groups (San Francisco Health Network, Community Clinic Network and UCSF Medical Group). Members receiving care within delegated medical groups in the network receive follow-up from their assigned medical group.

G. Delegation Oversight

i. Standards and Process for Delegated Medical Groups

SFHP oversees functions and responsibilities delegated to subcontracted medical groups, health plans and behavioral health organizations (Delegated Entities). These Delegated Entities must comply with laws and regulations stated in 42 CFR 438.230 and Title 22 CCR § 53867, the DHCS contract, and NCQA Health Plan Standards. SFHP ensures that delegated functions are in compliance with these laws, regulations, and standards through an annual audit process and monthly and quarterly monitoring activities.

As a prerequisite to enter into a delegation agreement, SFHP conducts a pre-delegation audit of the prospect's delegated functions. Subject to approval from the Provider Network Oversight Committee, SFHP may waive the pre-delegation audit in lieu of current and in good standing documented evidence of NCQA Accreditation or Certification.

Once the pre-delegation audit is complete, a Delegation Agreement and Responsibilities and Reporting Requirements (R3) Grid is executed. The R3 Grid describes the specific responsibilities that are being delegated, and provides the basis for oversight. The R3 Grid indicates which activities are to be evaluated through annual audits, and which activities are to be evaluated through more frequent monitoring.

Six to twelve months post execution of the Delegation Agreement, SFHP conducts an audit of all delegated functions. The audit scope and review period are determined by the Provider Network Oversight Committee.

Delegated Entities are required to demonstrate compliance with applicable requirements and standards by achieving a passing score of 95%. A Corrective Action Plan (CAP) is required if:

- A critical element is missed.
- The overall audit score is below 95%.
- There are inappropriate UM denials.
- There are incorrectly paid or denied claims.

Audit results are communicated to the Delegated Entity within 60 days from the completion of the audit. When a CAP is submitted by the Delegated Entity, the SFHP Delegate Oversight team will evaluate the response and issue either an approval or a request for additional information.

Annually, the Provider Network Oversight Committee, the UM Committee, and the Quality Improvement Committee review a summary of delegated groups audit results, provide feedback or request additional information or corrections from the delegate as needed.

ii. Delegated Functions

Credentialing – The following groups are delegated to conduct credentialing activities on behalf of the plan:

- American Specialty Health
- Beacon Health Options
- Brown and Toland
- Chinese Community Health Care Association
- Hill Physicians Medical Group

- Jade HealthCare Medical Group
- Kaiser Foundation Health Plan
- North East Medical Services
- San Francisco Health Network
- University of California, San Francisco Medical Center (UCSF)
- Teladoc

Utilization Management – The following groups are delegated to conduct UM activities on behalf of the Plan:

- American Specialty Health
- Beacon Health Options
- Brown and Toland
- Chinese Community Health Care Association
- Hill Physicians Medical Group
- Jade HealthCare Medical Group
- Kaiser Foundation Health Plan
- North East Medical Services
- San Francisco Behavioral Health Services

Pharmacy Services – Kaiser Health Plan Foundation and Magellan are delegated to manage pharmaceutical services on SFHP's behalf.

Complex Case Management –The following groups are delegated to conduct Complex Case Management on behalf of the plan:

- Brown and Toland
- Chinese Community Health Care Association
- Hill Physicians Medical Group
- Jade HealthCare Medical Group
- North East Medical Services
- Kaiser Foundation Health Plan

Non-Specialty Mental Health – Kaiser Foundation Health Plan is delegated to provide behavioral health services to all of its SFHP Medi-Cal members. Beacon Health Options provides non-specialty mental health services to all other SFHP Medi-Cal members. Community Behavioral Health Services (BHS) provides all non-specialty and specialty behavioral services to SFHP Healthy Workers members.

Quality Management – Kaiser Foundation Health Plan and Beacon Health Options are delegated for QI.

Member Appeals and Grievances – Kaiser Foundation Health Plan and Beacon Health Options are delegated for Appeals and Grievances.

Reviewed & Approved by:

Chief Medical Officer: **Date:** 12/09/21

Fiona Donald, MD

Quality Improvement Committee Review Date: 12/09/21

Board of Directors Review Date:

Appendix A: Work Plan

Managing Multiple Chronic Illnesses

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Care Management Follow Up On Clinical Depression	Total clients 18 years or older screened positive for clinical depression with Patient Health Questionnaire-9 with a "Connect to Behavioral Health" care plan goal	Total Care Management clients 18 years or older screened positive for clinical depression with Patient Health Questionnaire-9	90.0%	Senior Manager, Care Management	• Train staff in mental health, particularly on severe mental illness (SMI) and community resources, in order to ensure that staff is equipped to identify signs and symptoms of clinical depression, address client safety including connection to behavioral health services. • Clinical Supervisors to review monthly reports with staff and to coach staff to ensure members are screened and receive appropriate follow up. • Coach and conduct role-playing activities to reduce the rate of members declining PHQ-9 screening. • Clinical Supervisors to conduct quarterly audits to ensure best practices and regulatory requirements are met. • Complete bi-monthly staff self-audits which will enable Coordinators to identify and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated.	6/30/2022
Care Management Client Perception Of Health	Total clients who responded to self-reported health question of SF-12 on both the intake and closing assessments and: - Increased at least one box in rating their health if "Poor" or "Fair" indicated - Maintained or increased at least one box in rating their health if "Good", "Very Good", or "Excellent" indicated	Total Care Management clients who responded to self-reported health question of SF-12 on both the intake and closing assessments	63.0%	Senior Manager, Care Management	• Clinical Supervisors and Medical Director coaching the CM Nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP. • CM Management have developed a 2-year training syllabus for the team, to include trainings on subjects the team have identified gaps in and areas management feel would benefit the team in their ongoing work with members. • Utilization of Milliman Care Guidelines (MCG) condition specific assessments and MCG health education materials by CM Nurses. • Review of self-management goal report with CM Nurses to ensure that members have chronic condition self-management goals as part of their care plans as indicated.	6/30/2022

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Care Management Client Satisfaction	Number of satisfaction survey respondents who respond “Yes” to Question 2: Has the Care Management program helped you reach your health goals? and who respond “Always” or “Often" to Question 6: After receiving information from the Care Management staff, I feel confident I can take the actions needed to maintain or improve my health.	Total Care Management clients who responded to the Care Management satisfaction survey	90.0%	Senior Manager, Care Management	• Maintain a process to triage members into longer-term case management programs when requested by member or indicated by member’s self-efficacy skills. • CM staff completes a 6 month reassessment and review of care plan including goals with member • Provide more thorough life skills, health education and training to members as it pertained to their health maintenance. • Improve communication of care plan goal progress between Care Management staff and members.	6/30/2022

Managing Members with Emerging Risk

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Percentage of Members completing Hepatitis C Treatment	Total number of members with any past history of Hepatitis C infection who have completed the Hepatitis C treatment regimen	Total number of members with any past history of Hepatitis C diagnosis	40.0%	Care Coordination Pharmacist	• Use reporting to develop a profile (age, ethnicity, gender, location) for members not yet treated for Hepatitis C. • Continue to provide treatment support through SFHP’s Care Transitions and Care Management programs. • Outreach to SFHP primary care providers and gather any information on treatment hesitancy or failure that they can provide for their patients.	6/30/2022

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
HbA1c in Poor Control	Total members 18–75 years of age with diabetes who have their most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year	Total members 18–75 years of age with diabetes	34.05%	Care Coordination Pharmacist	• Promote screening for members diabetes through member incentives. • Conduct Drug Utilization Review with members with diabetes prescribed multiple diabetes medications. • Enroll members with diabetes into the Medically Tailored Meals program administered by Project Open Hand.	6/30/2022
Project Open Hand Member Satisfaction	Members with diabetes and pre-diabetes enrolled in the program who found the Project Open Hand program helpful	Members with diabetes and pre-diabetes enrolled in the program who complete the Project Open Hand client survey	85.0%	Social Determinants of Health Program Manager	• Partner with Project Open Hand, a community organization which will deliver medically tailored meals and/or groceries to SFHP members with chronic conditions and evaluate members' food needs through appointments with dieticians.	9/30/2022

Patient Safety or Outcomes Across Settings

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Medication Therapy Management (MTM)	Total number of SFHP members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation to be completed with initial medication reconciliation completed	Total number of SFHP members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation to be completed	90.0%	Care Coordination Pharmacist	• Monitor the pharmacist resource requirements needed to support the population of members engaged in Care Management and Care Transitions team. • Assess for additional efficiencies in workflow and member assessment configurations. • Continue reviewing members in the initial assessment process which recommends an MTM assessment and establishes the denominator population for this measure.	6/30/2022

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Opioid Safety - Buprenorphine Prescription	Total number of SFHP members with Opioid Use Disorder with at least one buprenorphine prescription in the last year	Total number of SFHP members with Opioid Use Disorder	30.0%	Care Coordination Pharmacist	• Outreach to methadone clinic providers in order to better support the use of MAT. • Disseminate educational material to members on MAT options. • Monitor buprenorphine adherence using the repository. • Consider targeted outreach to members with buprenorphine single fills or their providers.	6/30/2022
Opioid Safety - Opioid and Benzodiazepine Co-prescribing	Total number of SFHP members with both an opioid and benzodiazepine prescription	Total number of SFHP members with an opioid prescription	7.0%	Care Coordination Pharmacist	• Work with mental health and substance use specialist providers to create and distribute provider information how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia.	6/30/2022
High Dose Opioid Prescriptions	Total number of SFHP members with an opioid prescription prescribed between 120-500 morphine milligram equivalents for at least one quarter in the last year who do not have a buprenorphine prescription in that quarter	Total number of SFHP members with an opioid prescription	6.0%	Care Coordination Pharmacist	• Work with mental health and substance use specialist providers to create and distribute provider information on buprenorphine prescribing	6/30/2022
Pharmacy Transition	Total number of targeted members outreached	Total medium and high-risk members as identified by the high-risk member dataset	80.0%	Pharmacy Clinical Programs Supervisor	• Send pre-transition outreach letter to all medium- and high-risk members offering plan support. • Provide high-risk member profiles to delegated medical groups to facilitate provider-member communication. • Coordinate direct member outreach for high-risk members engaged in Care Management, Care Transitions, and Beacon services. • Provide education and resources to internal member-facing staff to support continuity of care related to pharmacy transition.	6/30/2022

Keeping Members Healthy

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Breast Cancer Screening	Total number of African American members who have had a mammogram	Total number of African American members 52-74 years of age	50.0%	Program Manager, Population Health	• Provide patient navigation services through Rafiki Coalition for Black/African American members due for a breast cancer screening. • Provide Health Education materials to Black/African American SFHP members.	6/30/2022
COVID-19 Vaccination	Members who have received first dose	Members eligible to receive first dose	No greater than 10% less than percentage of SF residents who have received first dose	Program Manager, Population Health	• Incentivize members 12 years and up to receive vaccination through the COVID Vaccine Incentive. • Conduct letter outreach and live phone outreach to unvaccinated members 12 years and up to provide vaccine information and coordination of vaccination appointments and transportation to vaccination appointments. • Provide grants to provider groups and community-based organizations for outreach to underserved populations. • Coordinate with the SF Department of Public Health and community organizations via weekly meetings. • Letter outreach to members 5 – 11 to communicate need for members to be vaccinated. • Provider outreach via provider newsletters and SFHP website update.	6/30/2022

Quality of Service and Access to Care

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) Rating of Health Plan	Total respondents to SFHP's HP-CAHPS Rating of Health Plan question who rate the health plan 9 or 10	Total respondents to SFHP's HP-CAHPS Rating of Health Plan question	61.3%	Senior Program Manager, Access & Care Experience	• Implement and communicate member experience YouTube videos. • Identify access-related issues via the Access Compliance Committee and develop plans to address found issues. • Conduct CAHPS surveying off-cycle from annual HP-CAHPS • Promote SFHP's telehealth services to increase access to care.	9/30/2022

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Provider Appointment Availability Survey (PAAS) - Routine Appointment Availability In Specialty Care	Total non-behavioral health specialists surveyed in PAAS with eligible survey responses that indicate routine appointment availability compliant with Department of Managed Health Care standards	Total non-behavioral health specialists surveyed in PAAS with eligible survey responses	82.9%	Senior Program Manager, Access & Care Experience	• Request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate. • Provide technical assistance with Corrective Action Plans. • Train network providers on proving successful telehealth visits	3/31/2022
Cultural and Linguistic Services (CLS) Provider Data	Total number of practitioners who have voluntarily provided SFHP with their race/ethnicity and language proficiency data	Total number of active credentialed practitioners in network	10.0%	Program Manager, Population Health	• Explore ways to collect information about languages in which individual practitioners are fluent when communicating about medical care. Possible sources may include: practitioner survey, credentialing application, provider relations script, Credentials Verification Organization. • Collect information about language services available through the practice. • Explore ways to collect practitioner race/ethnicity and practitioner language data. • Publish practitioner languages in the provider directory. • Publish language services available through the practice in the provider directory. • Provide practitioner race/ethnicity on request and/or explore publishing practitioner race/ethnicity in the provider directory.	6/30/2020

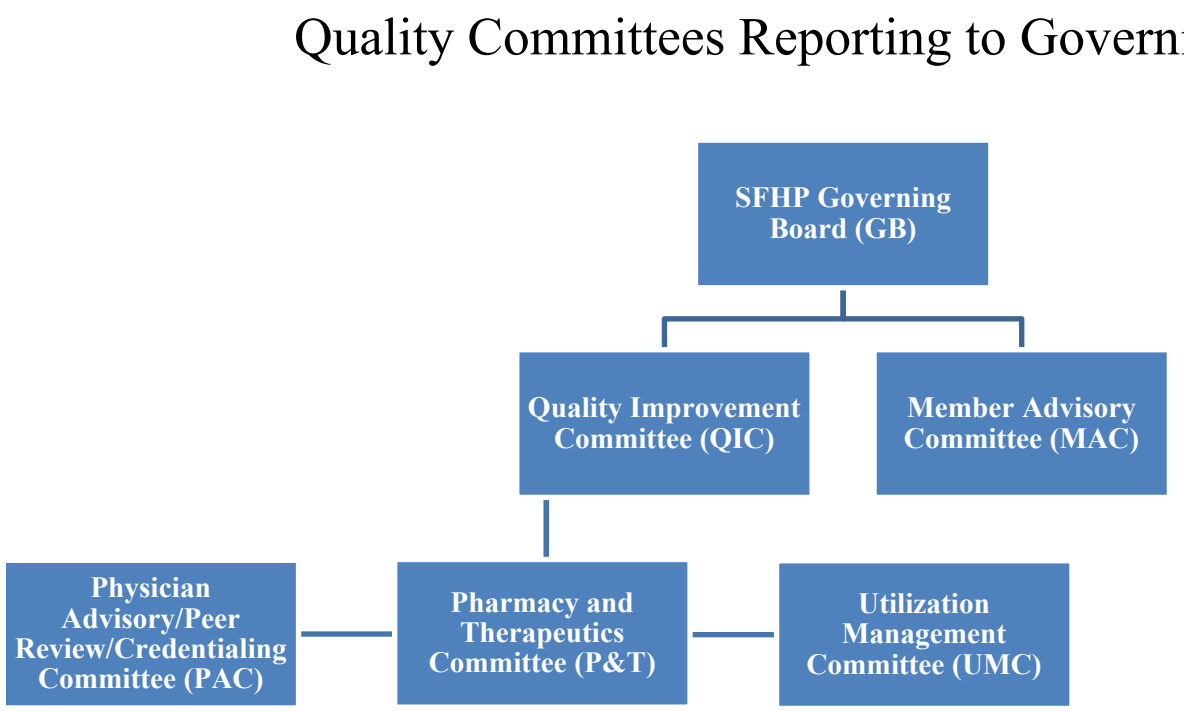
Utilization of Services

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Antidepressant Medication Management (AMM) — Effective Continuation Phase Treatment	Members 18 years of age and older with a diagnosis of major depression treatment who were treated with antidepressant medication and who remained on an antidepressant medication treatment for at least 180 days	Members 18 years of age and older with a diagnosis of major depression treatment who were treated with antidepressant medication	52.49%	Interim Director, Population Health/Quality	• Members enrolled in a Care Management program will be engaged to assist members adhering to medication. Care Management staff will be given access to AMM dashboards to identify members falling in this denominator. • Conduct annual training on HEDIS related measures to Provider Advisory Council. Disseminate HEDIS Toolkit which includes billing recommendation, best practices, and resources available to providers for their members that meet the HEDIS definitions. • Share PCP Toolkit with Health Plans to post on their website and promote to their providers. Educate physical health providers on assessment and treatment of depression.	6/30/2022
Inpatient Admissions	Sum of acute inpatient admissions	Sum of member months (rate will be annualized)	82.8%	Director, Clinical Operations	• Review diagnostic related groups that are driving utilization in Utilization Management Committee • Recommend care management programs to look address driver population	6/30/2022

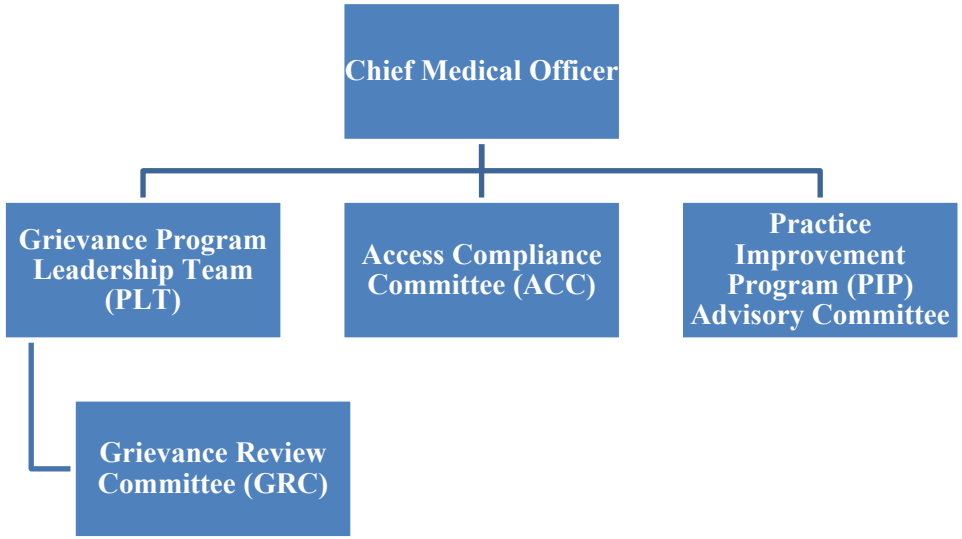
Quality Oversight Activities

Oversight	Summary	Resp. Staff	Activities	Due Date
Quality Improvement Committee	Ensure Quality Improvement Committee (QIC) oversight of QI activities outlined in the QI Plan	CMO	• Six meetings to be held in 2022	12/30/2022
Pharmacy and Therapeutics Committee	Ensure oversight and management of the SFHP formulary and DUR initiatives	CMO	• Quarterly and ad hoc P&T Committee meetings	12/30/2022
Provider Advisory, Peer Review, and Credentialing Committee	Ensure oversight of credentialing and peer review by the Provider Advisory Committee	CMO	• Six meetings to be held in 2022	12/30/2022
Annual Evaluation of the QI Program	Review Quality Improvement plan and determine efficacy of implemented plan based on outcomes	Interim Director, Population Health & Quality	• Evaluate each measure in the QI work plan • QIC review of QI evaluation • Governing Board review of QI Evaluation	3/1/2022
QI Plan Approval for Calendar Year	Review and approve proposed Quality Improvement work plan	Interim Director, Population Health & Quality	• QIC review of QI work plan • Governing Board review of QI Work Plan	3/1/2022
Delegation Oversight for QI	Ensure oversight of QI for all delegated entities	Interim Director, Population Health & Quality	• Follow delegation oversight procedures • QIC review of Delegated Oversight Audits for QI	12/30/2022
DHCS Performance Improvement Projects	Ensure oversight and follow through on required DHCS Performance Improvement Projects (PIPs)	Interim Director, Population Health & Quality	• Attend DHCS-led PIP calls. • Adhere to process delineated by DHCS.	12/30/2022

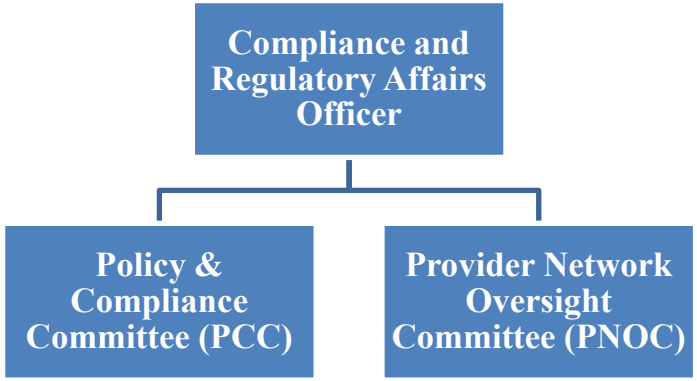
Appendix B: Quality Improvement Committee Structure



Operational Quality Committees Reporting to Chief Medical Officer



Quality Committees Reporting to Officer, Compliance and Regulatory Affairs



Agenda Item 7
Discussion and Action Items

Member Advisory Committee Report

a. Review and Approval of 2022 MAC Goals

b. Report on MAC Meeting from Co-Chairs

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Here for you

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

Date: December 22, 2021

To	**Governing Board**
From	Valerie Huggins, Executive Assistant
Regarding	Member Advisory Committee Goals for Calendar Year 2022

Recommendation:
The Member Advisory Committee (MAC) recommends the San Francisco Health Plan Governing Board approve the goals for the MAC for calendar year 2022.

Attached are the Member Advisory Committee (MAC) goals for review and approval by the San Francisco Health Plan Governing Board for calendar year 2022.

We are pleased the Member Advisory Committee continues to set goals for themselves and for the Plan; this year's goals are both reasonable and appropriate in our opinion.

Maria Luz Torre and Irene Conway will present more detail at the meeting and respond to any questions.

	San Francisco Health Plan Member Advisory Committee 2022 Goals	
Month	**Goal**	**Who is Responsible?**
Feb	1. Basic Zoom Training for the MAC / Discussion on Meeting Etiquette and Rules	SFHP IT, Members (Maria will check)
March	2. Updates on Covid Vaccine/ Resources/ Pharmacy Change Updates	SFHP
April	3. Health Care Legislation Updates	SUMI/ SFHP
May	4. Dealing with Grief, Loss and Mental Wellness	James, Jon
June	5. Advanced Health Care Directive, and Do Not Resuscitate,	MAC
August	6. Public Health and Safety	DPH
Sept	7. Prevention and Cure of Dementia and Alzheimer's	SFHP
Oct	8. Review SFHP Grievance and Appeals Log	SFHP
	Note: As time permits, Val Huggins will arrange for SFHP staff to speak on available incentives e.g. Blood pressure check, Well-Child visits, Diabetes incentives AND Access to acupuncture, chiropractor, wholistic services, etc. Note: November agenda: draft 2023 goals, plan Christmas party	

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MEMO

Date: December 21, 2021

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 November 2021 Member Advisory Committee meeting. There was no meeting in December 2021, as the Committee celebrated their year-end annual holiday party.

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

MEMBER ADVISORY COMMITTEE
SAN FRANCISCO HEALTH AUTHORITY
www.sfhp.org
Valerie Huggins
Phone: (415) 615-4235 /Email: vhuggins@sfhp.org
Maria Luz Torre (415) 722-6229 & Irene Conway, Co-Chairs

Meeting Agenda & Zoom Information
November 12, 2021
1:00PM- 3:00PM
Via Zoom Meeting

Please note the Zoom information is different
Meeting ID: 937 4103 2985
Passcode: 253070

By Mobile Phone
Number: 1-669-900-6833 - Meeting ID: 93741032985#

To use the **LANGUAGE INTERPRETATION SERVICES,** you will need to **DOWNLOAD** and install the Zoom app either on a Windows or Mac computer **OR** download and install the Zoom app onto an Android or IOS device (**iPhone/iPad**). You will need to set up a free Zoom account to use this service. **PLEASE** do this the day **BEFORE** the meeting.

LANGUAGE INTERPRETATION will not work if you connect via a web browser or on a Chromebook.

In addition, we ask if you could follow these simple ground rules during the meeting:

1. Attend on time. Be engaged. Do not drift in and out of the meeting. And do not leave before meeting is adjourned.

2. Be patient while we are working out the technical issues.

3. Be courteous. Mute yourself and listen while others are talking.

4. Raise your hand to speak. (We will give instructions on how to do this on zoom).

5. Mute yourself unless you are recognized to speak and make sure you are in a quiet location.

6. Turn off TV, radio and other background noise.

****

AGENDA

1. Welcome, Introductions & Roll Call

2. Adopt Agenda/Approve Minutes

3. Reports-
    - Chairs & Governing Board: Maria Luz Torre & Irene Conway
    - Quality Improvement Committee: Irene Conway, Edward Evans, and Idell Wilson
    - Staff Report: John F. Grgurina, Jr., CEO

4. Discussion: Committee Meeting Etiquette

5. Discussion: Wellness Check

6. Discussion: Draft 2022 Committee Goals

7. Discussion: Year-End Holiday Party

8. Public Comment:

9. Calendar Items for Next Meeting:

10. Announcements:

11. Other:

12. Adjournment:

Please Note These Upcoming SFHA Meetings:

Quality Improvement Committee:	December 9, 2021 (7:30am- 9:30am)
Member Advisory Committee:	December 10, 2021 (1pm-3pm) Party
Finance Committee:	January 5, 2022 (11am-12pm)
Governing Board:	January 5, 2022 (12pm-2pm)

****

SAN FRANCISCO HEALTH PLAN
Here for you

November 12, 2021
Member Advisory Committee
Meeting Minutes

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

Members Absent: Lourdes Alarcon

Excused: None

Guests: Weikuen Tang (Interpreter)

Staff: Valerie Huggins

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 Zoom. The meeting was closed to in-person public attendance, but the Zoom information was provided on the publicly posted agenda. This precaution was taken to protect all members, staff, and the public. All the Committee members, staff and public attended the meeting virtually.

1. **Welcome, Introductions and Roll Call:**
   The meeting was called to order at 1:00pm.

2. **Approval of Agenda & Minutes:**
   The agenda was approved, and the minutes from the October 2021 Committee meeting were approved as written.

3. **Committee Reports: Chair & Governing Board Report-Maria Luz Torre and Irene Conway**
   Ms. Torre and Ms. Conway both reported that the Board met on November 3, 2021. The next scheduled meeting is January 5, 2022.

   Ms. Conway reported that the Health Plan conducted its yearly audit by Moss Adams, and it went well.

   Ms. Torre reported that the Health Plan is using Search Firm, Russell Reynolds to conduct the hiring process for the new SFHP CEO. The Search Committee trusts the process.

Quality Improvement Committee (QIC) Report-Ed Evans, Irene Conway, and Idell Wilson

Irene Conway and Idell Wilson reported that the QIC met on October 14th, 2021.

Ms. Wilson says she continues to get adjusted to the QIC and reading the materials provided.

Ms. Conway reported Dr. Donald provided updates from the Department of Health Care Services' CalAIM and Medi-Cal Rx implementation, which are on target for a January 1, 2022 start date. She also provided updates on the City's and Health Plan's COVID-19 vaccination rates and SFHP's HEDIS and CAHPS scores.

The next scheduled meeting is December 9, 2021.

Staff Report: John F. Grgurina, Jr., CEO

There was no staff report as Mr. Grgurina was unable to attend the Committee meeting.

4. **Discussion: Committee Etiquette**

   The Co-chairs reminded the members to participate in the meetings, be on time, and be courteous to one another as well as the Health Plan staff.

5. **Discussion: Wellness Check**

   The Committee continues to practice keeping themselves healthy, safe, and sharing different activities to do during these difficult times.

6. **Discussion: Draft 2022 Committee Goals**

   The Committee discussed and finalized their 2022 Committee goals for approval at the January 2022 Board meeting.

7. **Discussion: Year-End Holiday Party**

   The Committee discussed their year-end holiday celebration on December 10th.

8. **Public Comment:**

   There were no public comments.

9. **Calendar Items for Next Meeting:**

   There were no items calendared for the next meeting.

10. **Announcements:**

    There were no announcements.

11. **Other:**

    No other topics were discussed.

12. **Adjournment**

    The meeting adjourned at 3pm.

Date Approved _____

_____
Maria Luz Torre and Irene Conway, Co-Chairs

Agenda Item 8

Discussion Item

Review Option to Purchase Employee Health Benefits from CalPERS

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MEMO

Date: December 22, 2021

To	**Finance Committee and Governing Board**
From	**Brian Gentner, Director, Human Resources** **Skip Bishop, Chief Financial Officer**
Regarding	**Decision not to pursue CalPERS Health Benefits – Information Only**

The following information is presented to the Finance Committee and Governing Board for information only. No action is needed at this time.

SFHP has decided to suspend the pursuit of CalPERS Health Benefits because of high costs of the insurance premiums provided through CalPERS, as well as costs associated with Public Employees' Hospital and Medical Care Act (PEMHCA) requirements.

Background

As mentioned previously, our ability to maintain a non-Kaiser option remains in serious jeopardy as the majority of our employee population continues to select Kaiser as their health plan of choice despite the employee cost ($0) being equal for both the Kaiser and the Aetna HMO products. Currently, we have a 60/40 split between Kaiser/Aetna, and most medical insurance providers are not interested in providing a quote for us because they would like to either have our entire population or a large majority (60%+) of it. Given all these factors, we felt an obligation to investigate moving to CalPERS as a non-Kaiser option.

On Tuesday, November 2, 2021, we met with a representative from CalPERS to get an overview of the CalPERS medical insurance offerings and below is a summary of our findings:

Pro:

- CalPERS health insurance pool would have no minimum participation requirements.
- Employees would have a wider choice of plans at different price points based on geographical locations.

Con:

- Premium Costs/Fees
    - Premiums increased significantly for 2022 and their lowest cost HMO is now roughly $300 per member per month above our lowest HMO offering though Kaiser. This would translate to a $700,000 increase in annual costs.
    - Additional administration fee would be added to total costs of premiums.

- Public Employees' Hospital and Medical Care Act (PEMHCA) Requirements
    - Requires us to offer the same medical benefits to our retirees along with mandatory subsidies that increase over time. This would make it very difficult to project costs.
    - Requirement to offer medical plans up to a month earlier than our current practice, as well as maintain them for up to two months after an employee separates from SFHP, which would also increase our costs.

Next Steps

We will continue to research alternative medical insurance plan options/policies to allow us to maintain a non-Kaiser option. We anticipate being able to keep our current providers (Kaiser and Aetna) for the next year or two if premiums remain reasonable.

Please feel free to contact Brian Gentner, Director, Human Resources, with any questions.

Agenda Item 9
Discussion Item

CEO Report

- Healthy San Francisco Updates
- Operations Updates
- Security Updates
- Return to Office and Field Updates

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MEMO

Date:	**December 22, 2021**
To:	**Governing Board**
From:	**John F. Grgurina, Jr., Chief Executive Officer**
Regarding:	**CEO Report for January 5, 2022 Meeting**

SAN FRANCISCO HEALTH PLAN STRATEGIC ANCHORS

Strategic Anchor: Universal Coverage

Healthy San Francisco Program Enrollment as of November 30, 2021

Total Enrollment: 16,573

A total of 16,573 participants were enrolled in Healthy San Francisco as of November 30, 2021. Enrollment continues to be at a higher level due to the temporary policy of extending HSF eligibility with no need for renewal due to COVID-19. The DPH will continue to extend HSF enrollment through January 2022, similar to Medi-Cal and in alignment with the continuation of the federal public health emergency.

One-e-App Replacement Project: Vendor Chosen, Contracting Commencing. SFHP's Product Management group issued its Request for Proposal (RFP) to replace the HSF eligibility and enrollment system by January 2023 to six potential vendors. This effort is one of SFHP's FY 21-22 organizational goals and is on schedule. The RFP selection committee unanimously chose a replacement vendor, Redmane. The scope of work is currently being negotiated and we will notify you once the contracting is completed.

HSF Program Metrics/Contract Requirements

HSF monitors multiple operational metrics that are tied to contract requirements with the DPH. These include multiple operational reporting requirements (monthly, quarterly, and annual), ranging from customer service call abandonment and service levels, no-show rates at the SFHP Service Center and participant and provider complaint resolution timelines. The Healthy San Francisco Program administration is currently meeting all program metrics and contract requirements in FY 21-22.

SF City Option Program Enrollment as of November 2021

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 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 particular program and continue to be assigned to the program while the employee is enrolled.

Increasing employee utilization within the City Option program through multiple efforts, including streamlining and simplifying the program is a multi-year priority for SFHP and the DPH. The project work to transition into a single MRA program is in progress and will be complete January 1, 2022. Other approved projects to increase SF City Option utilization that will be implemented in FY 2021-22 include an overhaul of outreach and education materials, the program website, and piloting a targeted employer outreach strategy. These two projects related to outreach are SFHP organizational goals for FY 21-22.

San Francisco City Option Program Data – November 2021

	Program-to-Date (PTD)	November 2021
Employers		
Employers Participating in SF City Option	4,335	n/a
Employers with Contributions Within the Past 12 Months	n/a	1,813
Total SF City Option Program Contributions	$1.40B	$27.2M
Contributions Assigned to the Contribution Pool	$498.0M	$16.6M
Contributions Assigned to San Francisco Medical Reimbursement Account (SF MRA)	$748.4M	$10.6M
Contributions Assigned to San Francisco Covered Medical Reimbursement Account (SF Covered MRA)	$6.8M	$61,524
Employees		
Unique Participants receiving SF City Option Employer Contributions	386,715	n/a

	Program-to-Date (PTD)	November 2021
Employees Receiving SF City Option Employer Contributions	515,600	n/a
SF MRA		
Number of SF MRAs with Deposits	229,449	10,026
SF MRA Claims Paid	$460.8M	$5.3M
SF MRA Dollars Available	$171.4M	
SF Covered MRA		
SF Covered MRA Participants	940	n/a
SF Covered MRA Subsidy Deposits	$5.5M	$0
SF Covered MRA Claims Paid	$4.6M	$0.04M
SF Covered MRA Dollars Available	$.4M	

Notes: As a result of increasing the Policy Development and Coverage Programs department's capacity for monitoring and evaluation, we identified an opportunity to improve the accuracy of our Employee claims reporting, by using a different source. This led to an increase in the reported SF Covered MRA Claims Paid to date from $3.6m to $4.6m, and a decrease in SF MRA claims paid to date from $510M to $460.8M.

'Employee' is the measure we have used historically to report on the number of employees. It is defined as one participant receiving funds into one Contribution Account, from one employer. Thus, one unique participant may count as two or more employees depending on the number of employers that contributed to SFCO, or where different contributions have been assigned.

SF City Option Program Metrics/Contract Requirements

Similar to HSF, the SFCO program monitors multiple operational metrics and contract requirements from the DPH. SFCO is currently meeting all operational metrics and contract requirements.

SFHP Enrollment Services

SFHP Enrollment Services continues to provide enrollment assistance to the public via the phone while the SFHP Service Center remains closed due to the COVID-19 pandemic. Appointment volume and successful enrollment has been maintained throughout the pandemic, as no show rates remain lower than pre-pandemic due to the convenience of phone.

SFHP Enrollment Services is actively preparing for January 2022 reopening of the SFHP Service Center to resume in-person enrollment and renewal to the San Francisco public. SFHP will continue to provide phone enrollment and renewal and is pleased to be able to add in-person enrollment services after a nearly two-year interruption due to the COVID-19 pandemic. The SFHP Service Center will initially be open two days a week in January and February, expand to three days per week in March, and will test in person, phone and after-business hour demand to best meet the needs of our diverse clientele.

SFHP MEMBERSHIP UPDATE

The total SFHP membership as of December 1, 2021 is 165,268 members. **Attachment 1** includes the membership reports for December. On page 2 of the report, Medi-Cal membership is 153,480 members, which is an increase of 10.4% increase compared to December 2020. The number of members on hold (page 4) is 2,319 and the number disenrolled is 1,077 members.

Healthy Workers enrollment as of December 1, 2021 is 11,789 members, which is an 1.3% increase compared to December 2020. The County Human Services Agency has resumed determining eligibility for IHSS workers, which has resulted in some IHSS providers to lose their Healthy Workers health plan coverage. When Healthy Workers members lose coverage, their information is sent to Covered California, per a recent state law for employer coverage, so that coverage options can be offered to them that are in addition to COBRA that is also offered to them. 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.

Please see the table below for the SFHP Medi-Cal expansion default assignments of non-choosers to the public hospital system. SFHP was compliant with the requirements of AB 85 to default the 50% of non-choosers to the public hospital system.

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)
2021			
January	1,326 M1 members, 1,314 did not choose	0 7U members	657 of 1,314 members (50%) were defaulted to DPH
February	1,400 M1 members, 1,385 did not choose	0 7U members	692 of 1,385 members (50%) were defaulted to DPH
March	1,418 M1 members, 1,410 did not choose	0 7U members	705 of 1,410 members (50%) were defaulted to DPH
April	1,550 M1 members, 1,530 did not choose	0 7U members	765 of 1,530 members (50%) were defaulted to DPH
May	1,719 M1 members, 1,690 did not choose	0 7U members	846 of 1,690 members (50%) were defaulted to DPH
June	1,228 M1 members, 1,218 did not choose	0 7U members	615 of 1,218 members (50%) were defaulted to DPH
July	1,106 M1 members, 1,088 did not choose	0 7U members	544 of 1,088 members (50%) were defaulted to DPH

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)
August	997 M1 members, 986 did not choose	0 7U members	494 of 986 members (50%) were defaulted to DPH
September	949 M1 members, 928 did not choose	0 7U members	466 of 928 members (50%) were defaulted to DPH
October	901 M1 members, 879 did not choose	0 7U members	441 of 879 members (50%) were defaulted to DPH
November	1,050 M1 members, 1,026 did not choose	0 7U members	513 of 1,026 members (50%) were defaulted to DPH
December	920 M1 members, 868 did not choose	0 7U members	434 of 868 members (50%) were defaulted to DPH

STRATEGIC ANCHOR 2: QUALITY CARE & ACCESS

Department of Health Care Services (DHCS) Routine Medical Audit

The annual DHCS routine medical audit of SFPH will be conducted from March 7, 2022 through March 18, 2022 and will cover the audit review period of March 1, 2021 through February 28, 2022. The Entrance Conference will be held on March 7, 2022 via video teleconference call. The audit will consist of an evaluation of SFHP's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity. Interviews will be conducted with the Medical Director, Director of Quality Management, Director of Utilization Management, Member Services Manager, Provider Relations Manager, Grievance Coordinator, and other staff as necessary. In addition, DHCS chooses a delegated entity as a focus each year. For the March 2022 audit, DHCS chose Beacon as the delegated entity that will be reviewed. DHCS' focus in the delegate review is primarily to audit SFHP's oversight of the delegate. The audit will also involve medical record reviews, which involves all delegated entities. Our audit team will be contacting delegates for required authorizations, denials and claims reports in the coming weeks. From these reports, DHCS selects a sample of records for review in March.

STRATEGIC ANCHOR 3: EXEMPLARY SERVICE

OPERATIONS

Operations is comprised of the following departments: Customer Service, Claims, Member Eligibility Management (MEM), Business Solutions (includes Configuration, Business Systems Analysis, and Continuous Improvement), Provider Network Operations (includes Provider Relations, Contracting, Credentialing, and Facility Site Review), and Enterprise Project Management Office (EPMO). We continually strive to streamline processes to strengthen our core operations. All departments are operating smoothly in the current remote environment. We adapted our processes and work tools

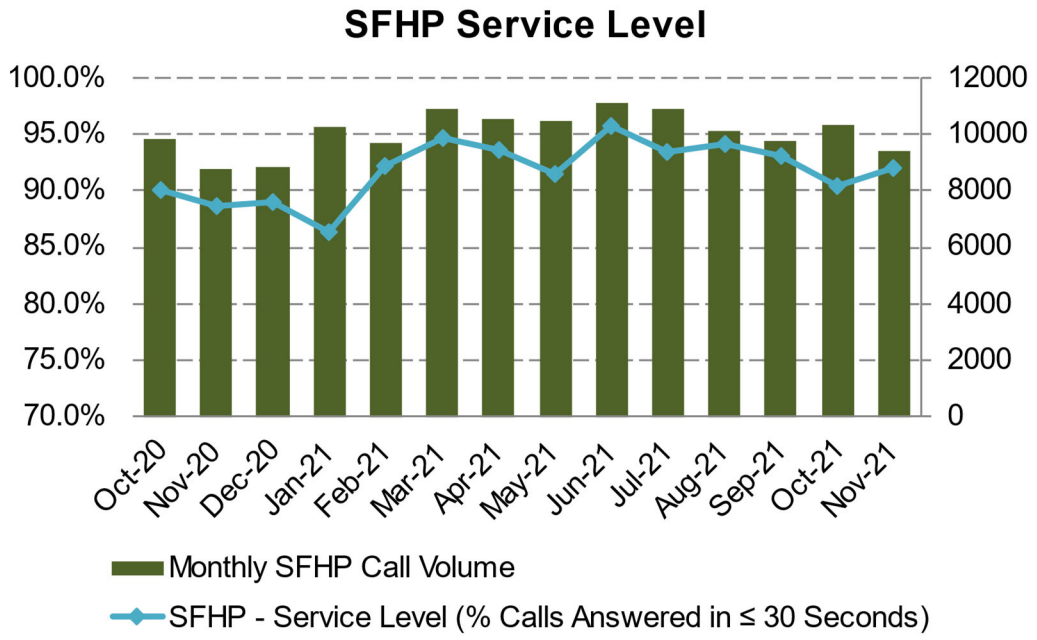
as needed to support virtual operations. All units continue to meet or exceed targets on department metrics and are performing well.

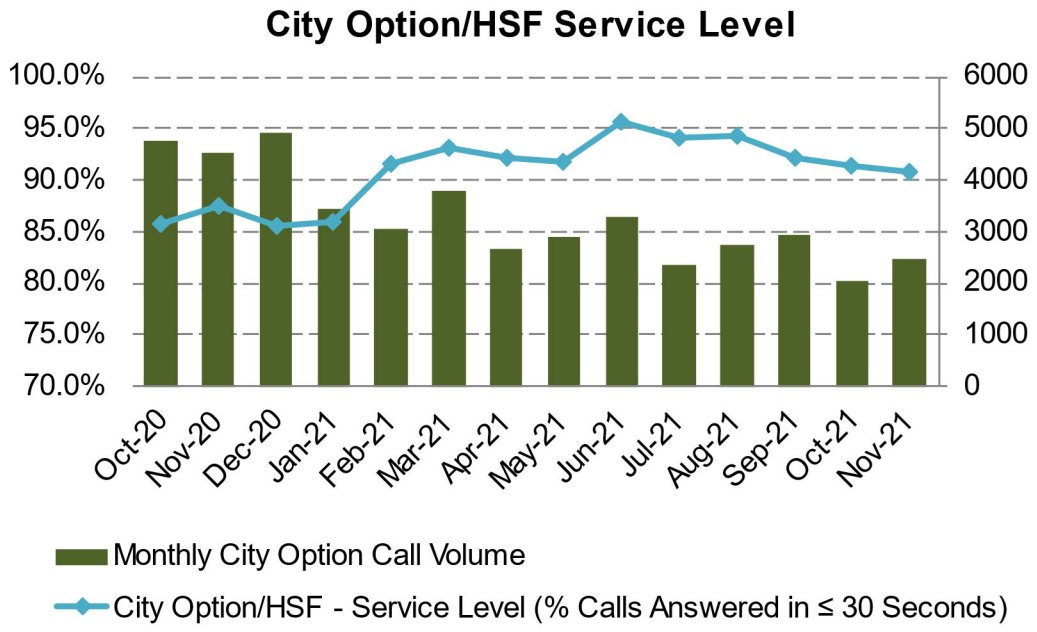
Customer Service (CS)

The Customer Service department has been focused on staff trainings to ensure the highest level of service is delivered to our members and providers.

- Delivered a robust training to prepare our Customer Service staff for the upcoming Medi-Cal Rx Transition. This involved staff participation in reviewing member facing documents, recording of messages in various languages, and working with project teams to ensure FAQs are developed to meet the needs of the callers.
- Completed a Primary Care Physician (PCP) change refresher training.
- Worked with our Member Eligibility Manager to facilitate training of the staff on Enhanced Care Management, a new Medi-Cal benefit effective January 1, 2022. This offers a broad range of care options to the high-risk population of our membership.

Charts below and on the following page show our service level performance on both queues alongside our incoming call volume since October 2020.



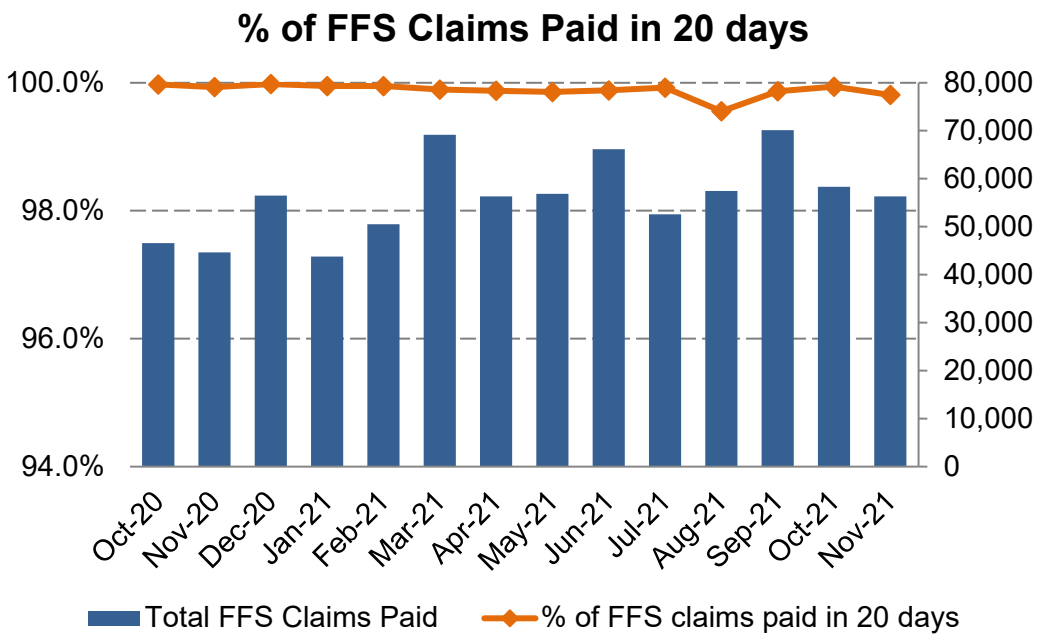


Claims

Claims continues to operate efficiently and is focused on opportunities to further enhance our operations. Key accomplishments include:

- Initiated the project for Optum's Claims Editing Software (CES) implementation. This software applies Medi-Cal and National Correct Coding Initiative (NCCI) guidelines to identify claims coding discrepancies.
- Collaborated with Varis, a chart review vendor who reviews medical records to identify overpayments, to create a process to recoup claim payments associated with inaccurate diagnosis codes.
- 99.8% of all received claims were processed within 20 business days in November 2021, well within the regulatory requirement of 45 business days, or 60 calendar days.

The chart on the next page shows our percentage of claims paid within 20 business days since October 2020.



Member Eligibility Management (MEM)

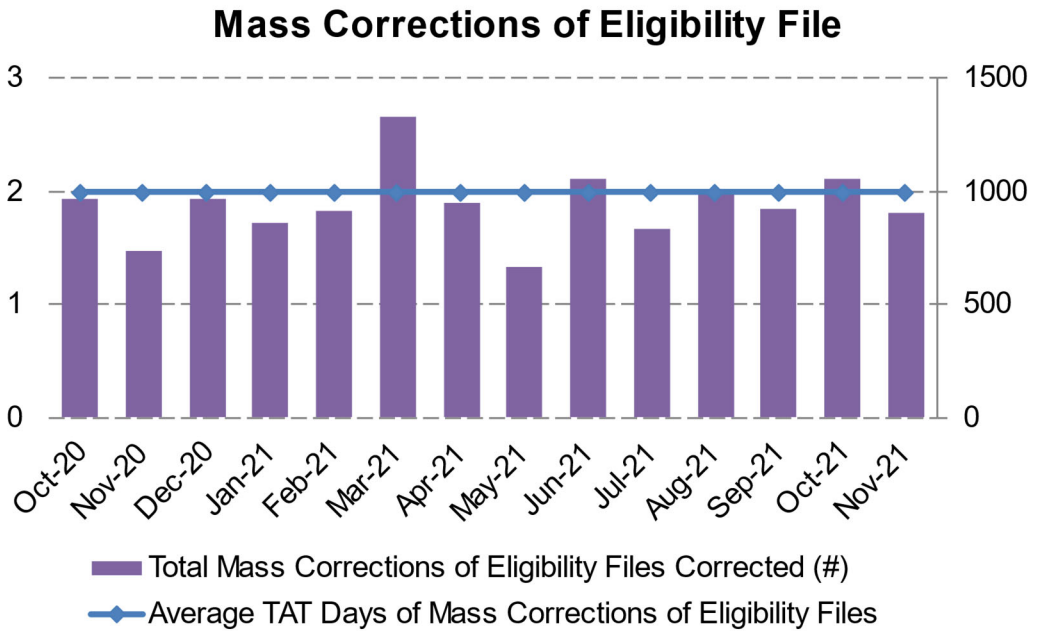
The MEM team consistently performed well to ensure all eligibility files were processed and necessary corrections made in a timely manner, within two business days.

- Timely eligibility file processing ensures accurate member eligibility information and capitation payments to our providers and vendors.

Other key updates include:

- Collaborated with two other internal departments to assist the Public Authority for In-Home Support Services (IHSS) in successfully transitioning their eligibility file process from an external vendor to an in-house operation. This allows better data quality control by the Public Authority, which results in more accurate eligibility data in our system than with the previous system. More accurate eligibility data helps to minimize interruptions to members' access to health care services.
- Collaborated with the Public Authority for IHSS and our internal Marketing department to issue 2,453 enrollment applications to eligible IHSS providers who are qualified, but not yet enrolled into benefits. SFHP helped to update and improve the enrollment application for the program.

The chart on the following page shows our eligibility file processing timeline alongside volume of manual corrections made by staff.



Business Solutions

All units in the Business Solutions are performing well and met established goals and metrics. Key accomplishments include:

- CalAIM Enhanced Care Management (ECM) and Community Supports software and processes are on track for the January 1, 2022 go-live.
- Eliminated inefficiencies in processing of roughly 10,000 claims per year received from CMS without matching claim ID's, saving approximately 300 hours annually in manual review.

Provider Network Operations

All units in Provider Network Operations are performing well and met established goals and metrics. Key accomplishments include:

- The annual provider holiday baskets were distributed to provider offices beginning the week of December 7th. This marks the 15th year of wishing our valued provider network a happy holiday through the distribution of a basket full of Harry and David sweets and treats.
- The Provider Relations Team will be sending a provider appreciation package to network providers in early 2022. Last year's package included masks, hand sanitizer and sanitizing wipes, all displaying the SFHP logo. This year's package will include SFHP branded chocolates and coffee and a note of thanks and appreciation from the plan. The appreciation package was developed as an alternative to the annual Provider Awards Dinner that was cancelled due to pandemic related restrictions and concerns.

- The Facility Site Review (FSR) Team developed, produced, and presented a virtual training program detailing SFHP's efforts and accomplishments toward updating and modernizing FSR processes including SFHP's innovative development of a virtual FSR. Training session attendees included statewide sister plans as well as representatives from DHCS.

Enterprise Project Management Office (EPMO)

The EPMO team is wrapping up several large projects with January 1, 2022 go-live dates and is closing out continuous improvement work associated with its two-year project management maturity roadmap.

Key updates include:

- CalAIM – work on the CalAIM program is on track for January 1 implementation of DHCS mandated services for Transplants, Enhanced Care Management (ECM), and Community Supports.
- Medi-Cal Rx Transition – project is on track for January 1 transition of Pharmacy Benefit Management (PBM) services to statewide arrangement with Magellan for Medi-Cal beneficiaries.
- Project Management Maturity – the team has worked cross-functionally to implement standards and guidelines for ongoing growth and maturity with project, program, and portfolio management. Key accomplishments include development of a program management guide, documenting the SFHP program management life cycle and methodology, and publishing an Enterprise Project Governance guide, detailing the portfolio management framework for project selection, prioritization, governance, and benefit (project outcomes) management.

STRATEGIC ANCHOR 4: FINANCIAL VIABILITY

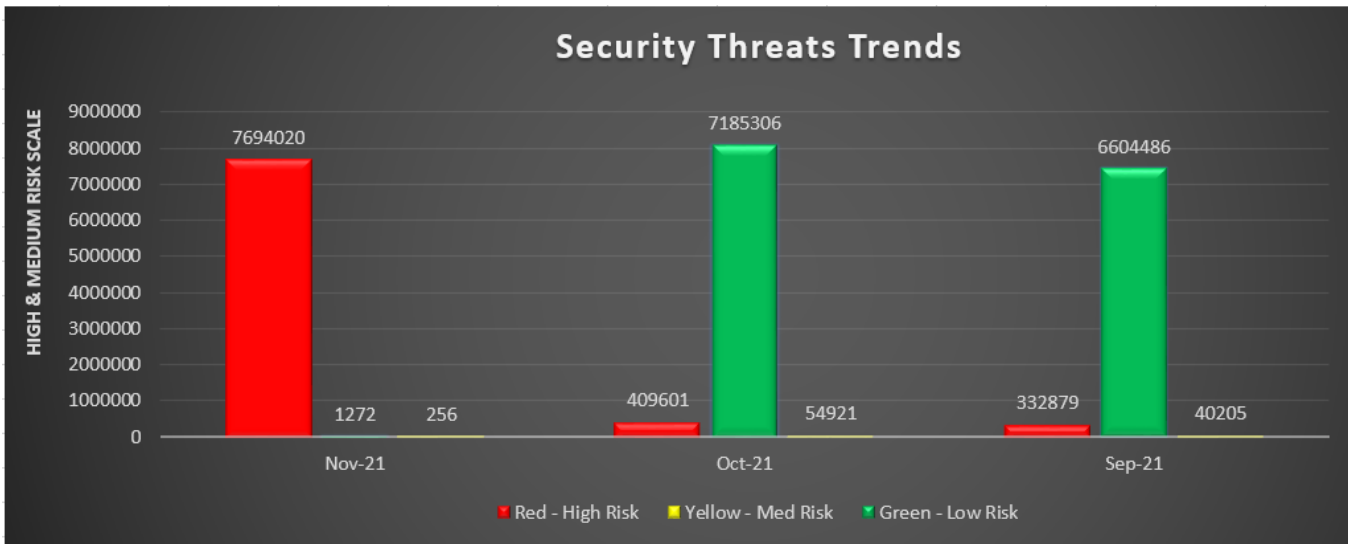
Information Technology Services (ITS)

ITS Security Metrics Report

Threats

- Number of Attacks Detected and Thwarted at the Network Perimeter – September 2021 through November 2021

Risk Category	November	October	September
High/Critical – Attempts to exploit various vulnerabilities, including repeated brute force attempts	513,435	409,601	332,879
Medium - Malware, ransomware, and virus attempts	28,595	54,921	40,205
Low/Informational –Authentication failures, login failures, HTTP Errors	7,153,518	7,185,306	6,604,486



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Malware

We experienced zero malware infections at our endpoints during the months of September 1, 2021 through November 30, 2021.

Email

The volume of legitimate emails into SFHP has remained about the same over time. On average approximately half of the emails sent to SFHP are blocked as either spam or viruses.

Rejected emails included blocked senders, viruses, spam, and other unwanted communications. 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
Dec - 2020	173,610	83,088	90,522	47.86 %	333,733	576,841
Jan - 2021	165,264	79,834	85,430	48.31 %	367,377	618,233
Feb - 2021	168,085	85,230	82,855	50.71 %	222,402	541,250
Mar - 2021	191,270	94,399	96,871	49.35 %	353,111	657,371
Apr - 2021	196,915	104,859	92,056	53.25 %	156,093	657,450
May - 2021	197,725	108,838	88,887	55.05 %	137,555	2,031,261
June - 2021	191,144	93,346	97,798	48.84 %	81,447	503,378
July - 2021	180,728	90,238	90,490	49.93 %	33,040	466,196
Aug - 2021	178,732	94,305	84,427	52.76 %	43,160	511,578
Sep - 2021	174,515	88,739	85,776	50.85 %	167,470	489,008
Oct - 2021	184,058	94,881	89,177	51.55 %	35,904	520,439
Nov - 2021	177,784	83,241	94,543	46.82 %	54,101	518,621
Total	**2,179,830**	**1,100,998**	**1,078,832**	**N/A**	**1,985,393**	**8,091,626**
Mean	**181,652.5**	**91,749.84**	**89,902.66**	**50.44 %**	**165,449.42**	**674,302.19**

Penetration Testing

SFHP's 2021 penetration test was completed in the month of June. Remediation of the latest findings is still underway. A retest conducted in August showed significant improvements over the results from the June test. The retest also validated the remediations from the June test. The findings and status are as follows:

Risk Category	Number of Findings	Remediated	Remaining
Critical	1	1	0
High	2	1	1
Medium	4	4	0
Low	13	11	2

Penetration Testing is the process of identifying security gaps in our infrastructure by mimicking an attacker.

DEPARTMENT OF MANAGED HEALTH CARE (DMHC) FINANCIAL AND ADMINISTRATIVE SURVEY

In additional to medical surveys, the DMHC also conducts Financial and Administrative surveys approximately every three to four years. SFHP's last DMHC Financial and Administrative survey was in October 2018. Due to several audits in 2021, DMHC agreed to wait until January 2022 to begin the Financial and Administrative survey. The survey will begin on January 10 and will be virtual. These surveys are an extensive review of financial and claims policies and procedures, review of controls, claims samples, provider dispute resolution cases, and payment timeliness. The surveys also include interviews with Finance and Claims staff.

SFHP RETURN-TO-OFFICE AND COVID-19 VACCINATION RATE UPDATE

We want to provide the Board with the following updates on our staff vaccine status, remote work situation and our current plans to reopen the SFHP Service Center and 50 Beale (now 300 Mission), as well as plans for getting field staff back out into the field.

Of our 355 active staff members, 340 are vaccinated and one is in progress. A 95.7% vaccination rate is great news.

Phased Return to the Office and Field Work

The following target dates for a phased return to the office and field work:

- January 4, 2022 is the target date for opening the Service Center in a phased manner.
    - In January and February, staff will be in-person on Tuesdays and Wednesdays.
    - Starting in March, staff will be in-person Tuesday through Thursday.
- Staff will return to field work as follows:
    - Facility Site Review targeted for January 2022.
    - First Phase of Care Management return to field work targeted for first week of March 2022.
    - Provider Relations targeted for first week of July 2022.
- We are continuing to target a voluntary return to Beale/Mission Street for the first week of March 2022 (two days in March and three days in April). We will limit the number of staff coming in, with priority going to those who indicated they want to work in the office full-time and four days per week.
- Positions that can work full-time remote will be allowed to do so through September 30, 2022 to provide additional time for the incoming CEO to work with the Executive Team and Governing Board on the remote work options for the future.

Vaccination Requirements and Exemptions

Effective now, proof of full vaccination is required for:

- All member-facing, provider-facing and public-facing employees returning to work in our offices or in the field:
  - Service Center employees
  - Facility Site Review employees
  - Care Management field staff
  - Provider Relations field staff
- Any employee or contractor going into Beale/Mission office, even if for a brief visit.
- Full vaccination will be a condition of employment for all new hires.

Employees without proof of full vaccination have 60 days to provide proof of full vaccination, find another SFHP position, or be separated from SFHP. Employees may request accommodation based on a medical or religious exemption.

- Exemption process will be outsourced to employment counsel.
- If employee's exemption is deemed valid, SFHP and outside counsel will review whether a reasonable accommodation can be made given the employee's position requirements.
- If employee's exemption is deemed invalid OR SFHP cannot provide employee with a reasonable accommodation, employee will be accorded 60 days to find another SFHP position.
- At end of 60 days, if employee has not found another position or provided proof of full vaccination, employee will be separated from SFHP.
- The 60 calendar days begins the later of (1) the date the employee is asked to return to the office or the field; or (2) the date the employee is notified of the exemption request outcome if they requested on exemption.
- SFHP cannot guarantee the employee a move into another position.

Face Masks

- Masks must be worn at all times for employees working at the Service Center and in the field.
- The Beale/Mission building requires a mask to be worn upon entry and in "common space" areas (lobby, elevators, etc.).
- Per current San Francisco Department of Public Health ("SFDPH") masking guidelines, wearing a mask indoors is optional within SFHP's office space (12th and 13th floors in 50 Beale).
- Modifications may occur if there are any changes to the SFDPH guidelines.

Additional Measures

SFHP employee safety is our top priority and we will be taking the following measures to protect staff:

- Provide safety supplies (hand sanitizer, cleaning supplies, masks, etc.).
- Deep cleaning of Service Center for January opening.

- Daily evening janitorial service for all days worked at Service Center.
- Extra daytime janitorial service for high traffic areas at Service Center.
- COVID wellness questionnaire/signage for Service Center (will follow CalOSHA updated guidance).
- COVID wellness notification for anyone going into Beale/Mission office.
- COVID testing if and when needed; COVID quarantine guidance will mirror SFDPH guidelines.
- ITS will ensure all systems and equipment is provided for Service Center.

Long-Term Remote Work Policy

SFHP has demonstrated it can be highly successful in a remote work environment, as evidenced by our 2020-2021 Organizational Goals and Mandates scores of 100%, a first in the organization's history. Our staff are interested in a hybrid work model, as evidenced by the April All Staff Work Preference Survey; staff want flexibility to go into the office and field as necessary. The long-term remote work policy will be the responsibility of the new CEO, will be vetted by the Governing Board and thus will most likely not be defined before July 2022.

The Executive Team will start work on a Remote Work Briefing for the incoming CEO and Governing Board in February. We will provide data on how we have performed in a remote work environment. We have a high regard for how well our staff have made the adjustment to a remote work environment amidst the significant challenges we have all faced in this new way of life. We are extremely grateful for the support of our Governing Board and we are proud of our continued success with serving our members, providers, and each other.

MEDIA ROUNDUP

Please see **Attachment 2** for the Media Roundup with articles related to Medi-Cal, COVID-19, and Affordable Care Act.

Closed Session

Agenda Item 10

Discussion Item

- Review of Future Medi-Cal Rate Changes for Provider Contracts

SAN FRANCISCO HEALTH PLAN
Here for you

Finance Committee & Governing Board

MEMO

Date:	**December 22, 2021**
To:	**Finance Committee and Governing Board**
From:	**Skip Bishop, Chief Financial Officer** **John F. Grgurina Jr., Chief Executive Officer**
Regarding:	**Discussion of CY 2022 Medi-Cal Rates**

Discussion:

San Francisco Health Plan (SFHP) is not making any recommendation at this time regarding changes to current Medi-Cal capitation and fee-for-services rates. Information regarding the draft calendar year (CY) 2022 Medi-Cal rates is being provided for discussion purposes only.

DHCS released draft CY 2022 Medi-Cal rates at the beginning of October. Although the preliminary rates shared with SFHP appear to be very favorable, DHCS still needs to apply adjustments for program changes as well as for county-wide averaging which have the potential to increase or decrease these draft rates. It is expected that DHCS will release final CY 2022 rates at the end of January 2022.

When compared to our CY 2021 rates for existing benefits, the overall weighted average rate increase for CY 2022 is approximately **6.7%.** This increase is projected to be worth $33 million in additional revenue for January through December 2022. This is an extremely positive development for SFHP as the CY 2018 Rate Development Template (RDT) on which the CY 2022 rates are based indicated that we should receive an increase in the range of 3.0%. This can be viewed as a reflection of the strength of the financial position of the state of California.

In addition to the 6.7% increase noted above, DHCS and its actuary, Mercer, built in 5.2% to cover the net additional medical expense SFHP expects to incur as a result of taking on the hospital risk for the San Francisco Community Clinic Consortium (SFCCC) members effective July 1, 2021. This increase is projected to be worth $26 million in additional revenue for January through December 2022 and will be retained by SFHP to cover hospital claims for SFCCC members. As mentioned during our meeting in November, SFHP would like to thank DHCS and Mercer for agreeing to include this additional cost in the CY 2022 rate development process. DHCS and Mercer could have waited to consider these costs as part of the normal Medi-Cal RDT submission process which would have pushed these costs into the CY 2023 and CY 2024 rate development cycles. Including a rate adjustment in the CY 2022 rates means SFHP will have to absorb these costs only for the period of July through December 2021.

Highlights of significant changes affecting CY 2022 rates include:

- Elimination of the pharmacy benefit which transfers to the State effective January 1, 2022.
- A new rate increment for Ground Emergency Medical Transportation (GEMT) for public providers.
- A new rate increment for the Community Supports/Whole Person Care (CS/WPC) transition to Medi-Cal managed care.
- A new rate increment for the Enhanced Care Management (ECM) benefit (not included in draft rates).
- A new rate increment for the Major Organ Transplants (MOT) benefit (not included in draft rates).
- Increases in unit cost and utilization trend factors for the various categories of service.
- Increase in administrative load to cover expanded administrative requirements placed on the health plan.
- Restoration of the 0.5% underwriting gain (margin) for the health plan. The underwriting gain was reduced by 0.5% for the Bridge Period (July 2019 through December 2020) as well as for CY 2021.

As we look at the additional revenue SFHP will receive beginning January 2022, we are considering several options including:

- Passing more dollars to the delegated medical groups through increases to the Practice Improvement Program (PIP).
- Passing more dollars to the delegated hospitals through increases in capitation rates.
- Increasing rates for the Community-Based Adult Services (CBAS) providers. The last increase was effective July 1, 2018.
- Increasing the SFHP reserve balance to the Board-approved maximum level of two times premium revenue.
- A new Strategic Use of Reserves (SUR) program for reserves in excess of two times premium revenue.

SFHP will come back to the Finance Committee and Governing Board in March to provide more details about the Medi-Cal rates for CY 2022.

Closed Session
Agenda Item 11
Discussion Item

- Search Committee Updates and Next Steps for CEO Recruitment

Agenda Item 12

- Report on Closed Session Action Items

  (Verbal report only)