Blue Shield Medicare Advantage PPO Transition Update

Health Service Board Meeting • April 10, 2025

Presenters:

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Agenda

SFHSS Update	Blue Shield Update
SFHSS Call Metrics	BSC Call Metrics
Review of BSC Medical Benefit Design	Transition-Related Issues
Post Implementation Audits	Normal Health Plan Administrative Activities
	Update on American Specialty Health
	Commitment to Member Engagement
	Rules of Medicare Advantage Plans Administration
	Understanding Prior Authorizations
Closing Remarks	

HSS Call Metrics – January - March 2025

BSC Transition Calls Handled

75 - March
137 - February
139 - January

BSC Transition In-Person Interactions

5 - March
10 - February
22 - January

Members Connecting with BSC through the HSS Phone System

102 - March
154 – February
389 - January

Average Speed to Answer*
Goal: <3 mins

5.2 mins - March
8.8 mins - February
14.9 mins - January

Average Handle Time*
Goal: <10 mins

7.1 mins - March
7.1 mins - February
16.0 mins - January

First Contact Resolution
Goal: >75%

96% - March
90% - February
85% - January

*Data reflects all retiree queue calls

70 Medical Benefit Design Elements – MAPD RFP

Description	PPO Plan	Blue Shield
Annual Medical Deductible	$0	**Match**
Annual Medical Out-of-Pocket Maximum	$3,750	**Match**
Physician Services		
Primary Care Physician Office Visit	$5 co-pay per office visit	**Match**
Specialist Office Visit	$15 co-pay per office visit	**Match**
Diagnostic Procedures		
Outpatient Diagnostic Laboratory	$0 co-pay	**Match**
Outpatient Diagnostic X-Ray	$0 co-pay	**Match**
Outpatient Diagnostic Testing	$0 co-pay	**Match**
Outpatient Diagnostic Complex Imaging	$25 co-pay	**Match**
Outpatient Diagnostic Colonoscopy	$100 co-pay	**Match**
Emergency Medical Care		
Urgently Needed Care (Includes Worldwide Coverage)	$20 co-pay	**Match**
Emergency Care (Includes Worldwide Coverage)	$65 co-pay	**Match**
Ambulance Services	$50 co-pay	**Match**
Hospital Care		
Inpatient Hospital Care (Per Stay)	$150 co-pay, benefit periods do not apply	**Match**
Outpatient Surgery	$100 co-pay	**Match**
Outpatient Observation	$100 co-pay	**Match**
Hospital Diagnostic Laboratory	Covered in Inpatient Copay	**Match**
Hospital Diagnostic X-Ray	Covered in Inpatient Copay	**Match**
Hospital Diagnostic Testing	Covered in Inpatient Copay	**Match**
Hospital Diagnostic Complex Imaging	Covered in Inpatient Copay	**Match**

70 Medical Benefit Design Elements – MAPD RFP, *cont.*

Description	PPO Plan	Blue Shield
Mental Health Services		
Inpatient Mental Health Care (Per Stay)	$150 co-pay per inpatient admission	**Match**
Outpatient Mental Health Care	$5 co-pay for Group Therapy Visits; $15 co-pay for Individual Therapy and Virtual Visits	**Match**
Alcohol/Drug Abuse Services		
Inpatient Substance Abuse	$150 co-pay per inpatient admission	**Match**
Outpatient Substance Abuse	$5 co-pay for Group Therapy Visits; $15 co-pay for Individual Therapy Visits	**Match**
Outpatient Acute Short-Term Rehabilitation Services		
Physical Therapy	$20 co-pay per office visit	**Match**
Speech/Language Therapy	$20 co-pay per office visit	**Match**
Occupational Therapy	$20 co-pay per office visit	**Match**
Cardiac Therapy	$25 co-pay per office visit	**Lower Copay ($20)**
Pulmonary Therapy	$20 co-pay per office visit	**Match**

70 Medical Benefit Design Elements – MAPD RFP, *cont.*

Description	PPO Plan	Match or Deviation
Preventative Care		
Annual Wellness Exams	$0 co-pay	**Match**
Routine Physical Exams	$0 co-pay	**Match**
Medicare Covered Immunizations	$0 co-pay	**Match**
Routine Mammograms	$0 co-pay	**Match**
Routine Cervical and Vaginal Cancer Screening	$0 co-pay	**Match**
Routine Prostate Cancer Screening	$0 co-pay	**Match**
Routine Colorectal Cancer Screening	$0 co-pay	**Match**
Routine Bone Mass Measurement	$0 co-pay	**Match**
Medicare Diabetes Prevention Program	$0 co-pay	**Match**
Ultrasound screening for abdominal aortic aneurysm	$0 co-pay	**Match**
Cardiovascular disease screening	$0 co-pay	**Match**
Diabetes screening tests and diabetes self-management training	$0 co-pay	**Match**
Medical nutrition therapy	$0 co-pay	**Match**
Glaucoma screening	$0 co-pay	**Match**
Screening and behavioral counseling to quit smoking and tobacco use	$0 co-pay	**Match**
Screening and behavioral counseling for alcohol misuse	$0 co-pay	**Match**
Adult depression screening	$0 co-pay	**Match**
Behavioral counseling for and screening to prevent sexually transmitted infections	$0 co-pay	**Match**
Behavioral therapy for obesity	$0 co-pay	**Match**
Behavioral therapy for cardiovascular disease	$0 co-pay	**Match**
Kidney Disease education	$0 co-pay	**Match**
Dialysis training	$0 co-pay	**Match**

70 Medical Benefit Design Elements – MAPD RFP, *cont.*

Description	PPO Plan	Blue Shield
Other Services		
Skilled Nursing Facility (SNF) Care (100 days per Medicare Benefit Period)	$0 co-pay per day for up to 100 days	**Match**
Home Health Agency Care	$0 co-pay per visit	**Match**
Hospice Care	100% coverage; must receive care from a Medicare covered hospice facility	**Match**
Durable Medical Equipment (DME)	$15 co-pay	**Match**
Acupuncture	$15 copayment for each Medicare-covered visit; up to 24 visits per plan year are covered for Medicare beneficiaries	**Match**
Private Duty Nursing	Not Covered	**Match**
Telehealth	$0 co-pay	**Match**
Medicare Part B Prescription Drugs	$15 co-pay for each Medicare-covered Part B drug and chemotherapy drugs to treat cancer	**Match**
Dental	$15 co-pay per office visit for Medicare covered dental services. Non-Medicare dental not covered.	**Match**
Diabetes screening supplies pref. provider	$0 monitors and supplies	**Match**
Enhanced Chiropractic Services	Medicare covered: $15 co-pay per office visit. Routine Non-Medicare covered: $15 co-pay per office visit, limit of 24 visits per year.	**Match**
Eye exams and/or eyeglasses	$15 co-pay per office visit, limited to one eye exam every 12 months. $0 co-pay for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.	**Match**
Foot Care (Podiatry)	Medicare covered: $15 co-pay per office visit. Routine Non-Medicare covered: $15 co-pay per office visit, limit of 6 visits per year.	Routine Non-Medicare Covered at $100 per visit; x6/yr.
HouseCalls	Yearly in-home visit from a licensed health care practitioner at no additional cost.	**Match**
24/7 Nurse Support	Speak to a registered nurse 24/7 over the phone about medical concerns at no additional cost.	**Match**
Chronic Conditions Program	Special programs to help members who are living with a chronic disease like diabetes, heart disease or complex health needs.	**Match**
Nutritional Therapy Services	Nutritional therapy services $15 copay (Up to 4 visits per plan year)	**Match**
Transgender services	The plan covers surgery for gender dysphoria when the eligibility rules are met the plan will cover certain transgender surgical services including but not limited to genital surgery, surgery to change other features, and other related services. $150 for inpatient hospital or $100 for outpatient surgery, whichever is applicable.	**Match**

10 Pharmacy Design Elements – MAPD RFP

Description	Copay	Blue Shield
Retail Copay/Coinsurance (Non-Specialty)		
Select Generic Drugs	N/A	
Generic Drugs (Tier 1)	$5	**Match**
Formulary Brand (Tier 2)	$20	**Match**
Non-Formulary Brand (Tier 3)	$45	**Match**
Mail Order Copay/Coinsurance up to 90-day Supply(Non-Specialty)		
Select Generic Drugs	N/A	
Generic Drugs (Tier 1)	$10	**Match**
Formulary Brand (Tier 2)	$40	**Match**
Non-Formulary Brand (Tier 3)	$90	**Match**
Specialty Copay/Coinsurance		
Retail	$20	**Match**
Mail Order	$40	Preferred Pharmacy Network (expanded member options with lower share of costs); Tier 4 (clinical monitoring, 30-day supply)

Additional Benefits (Supp./Non-Medicare) – MAPD RFP

Description	PPO Plan	Blue Shield
RFP Criteria		
Fitness	Renew Active is available at no additional cost	**Included**
Hearing exams and/or hearing aids	Medicare covered: $15 co-pay per office visit. Routine Non-Medicare covered: $0 co-pay per office visit, limit of one exam per plan year. $5,000 hearing aid allowance, combined for both ears, every 36 months.	**Included**
Post Discharge: In-home support services	$0 co-pay; receive 6 hours of non-medical in-home personal care like companionship, meal prep, medication reminders and more available for all discharges. Health at Home bundle.	**Not Included**
Post Discharge: Meal benefit	$0 co-pay; receive 28 home-delivered meals for all discharges. Healthy at Home bundle.	**Included**
Post Discharge: Transportation	$0 co-pay; receive 12 one-way rides to and from medically related appointments and to the pharmacy for all discharges. Healthy at Home bundle.	**Not Included**
Routine Transportation	$0 copay for 24 one-way trips to approved medically related appointments and the pharmacy. No discharge criteria. Healthy at Home bundle.	**Included**
Personal Emergency Response System	$0 copay for a personal emergency response system. Partner with Lifeline for appropriate devices. All members are eligible.	**Included**
Virtual Coaching	Weight Management, Diabetes Prevention, Wellness Coaching and a tobacco cessation program, at no additional cost.	**Included**

Benefit Analysis by HSS Staff – Post-RFP (Q3.2024)

Description	Evaluation	Analysis
Routine Acupuncture and Chiropractic Services	Blue Shield has enlisted the ASH Network in California to Administer Routine Acupuncture and Chiropractic Services obtained within California. Outside of California, Blue Shield Members must find a provider (in-network or out-of-network) within the state which they reside and obtain these services	No cost difference or visit limitation
Cardiac Rehabilitation Services (including intensive) [M]	the member co-pay for Cardiac Rehabilitation Services through Blue Shield is $5 lower than the copay for these same services through united (UHC= $25 per visit, Blue Shield = $20 per visit)	**Lower Copay**
Blood Glucose Monitors [M]	BSC: Accu-Check (All Types) and One-Touch (All Types) for $0 copay; All other Manufacturers available at $15 copay. UHC: Specific Accu-Chek Types: Guide-me, Guide for $0 copay. Specific One-Touch Types: Verio Flex, Verio Reflect, Verio, and Ultra 2 for $0 copay. All other Manufacturers not covered.	**Expanded types of covered devices and supplies**
Continuous [Blood] Glucose Monitors and Supplies [M]	UHC covered CGMS and CGM Supplies at $0, for Blue Shield GCM (device) is a $15 copay, GCM Supplies is a $15 copay, and CGM Sensors are a $15 Copay	**Copay $15**
Home Delivered Meals	United offered 28 home-delivery meals, post in-patient or SNF stay ($0). Blue Shield offers 30 home delivered meals and 16 snacks, post in-patient or SNF stay ($0).	**Expanded benefit** (negotiated post-RFP)
Personal Care	United offered up to 6 hours of Personal Care, post in-patient or SNF stay ($0). Personal Care is not offered through Blue Shield.	**Not offered**
Routine Transportation	Blue Shield has enlisted Call-The-Car in California to Administer Routine Transportation obtained within the State of California. Outside of California, Blue Shield Members would need to call Blue Shield to arrange transportation and reimbursement. United had one vendor for nationwide services.	**Included for both in-state and out-of-state**
Routine Transportation “Post Discharge”	United provides an additional pool of transportation, which afforded an additional 12 one-way rides to medical appointments, post in-patient or SNF ($0). Blue Shield does not offer this additional benefit	**Not offered;** Routine Transportation offered
Hearing Aids	United was limited in the manner which they could administer the Hearing Aid Benefit, so this was available at $5,000 for both ears. Blue Shield was instructed by SFHSS to revert this benefit to the standard offering through all our plans at $2,500 per aid/per year.	**Expanded benefit**

Benefit Analysis by HSS Staff – Post-RFP (Q3.2024), *cont.*

Description	Evaluation	Analysis
Outpatient Rehab (CORF) [M]	United provided OutPt Rehab through CORF at $25 per visit, and with Blue Shield it is lower by $5, at $20 per visit.	**Lower cost-per-visit**
Mental Health and Substance Abuse Services [M]	Blue Shield has enlisted Magellan in California to administer Mental Health Administration Services (inclusive of network) obtained within the California. Outside of California, Blue Shield Members would need to find a provider (network or otherwise) within the state which they reside and obtain services.	**Included**
Routine Podiatry	United covered these services at 6 visits per year with a $15 copay. Blue Shield covers these services at 6 visits per year, for up to $100 per visit (No additional copay).	No share of cost, if under $100
Skilled Nursing	Blue Shield waives 3-day hospital stay requirement, only if network provider coordinates care. UHC did not have this limitation, and waives 3-day hospital stay, regardless of provider status.	Standard Medicare Care Coordination Requirement
Outpatient Prescription Drugs- Mail Service Day Supply (D and Non-D Drugs) [Part D]	United offered a maximum of a 90-day supply for Mail-order, and Blue Shield offers a 100-day supply.	**10% increase in supply**
Preferred Pharmacy Network [Part D]	United did not offer a preferred pharmacy network, and Blue Shield offers a Preferred Pharmacy Network. This Preferred Pharmacy Network allows members to receive up to a 100-day supply of medication at the mail-order share of cost, for specific retail pharmacy locations.	**Expanded Member options with lower share of costs**

RFP and Post-RFP Analysis – Summary

RFP	Blue Shield RFP Proposal
P	HSS post-RFP analysis and/or negotiation with Blue Shield
+	positive change/lower cost
=	No change/modified service
-	Change/modification in service or Member share of cost

- **70 Medicare Benefit Design Elements:**
  - \+ Cardiac Therapy (lower co-pay) RFP
  - \+ Outpatient Rehab (lower co-pay) P
  - = Blood Glucose Monitors (BGMs) not limited to Accu-Chek and One-Touch RFP; Continuous BGMs ($15 co-pay) P
- **10 Pharmacy Design Elements:**
  - \+ Outpatient Prescription Drugs/Mail Service (enhancement, additional 10-day supply) P
  - \+ Preferred Pharmacy Network (expanded member options with lower share of costs) RFP, P
- **Supplemental (Non-Medicare) Services:**
  - \+ Hearing Aids (expanded benefit) RFP
  - \+ Home Delivered Meals (more meals + snacks) P
  - \+ No change to fitness, routine transportation, personal ER response system (Lifeline) or virtual coaching RFP, P
  - \+ Routine Acupuncture/Chiro (no cost difference or visit limitation; network variations) P
  - = Skilled Nursing (three-day hosp. stay requirement waived if network provider coordinates care) P
  - = Routine Podiatry (no change to covered visits/yr.; modified share of cost +/- depending on provider) P
  - \- No post-discharge in-home support services (6 hr. limit) RFP, P
  - \- No additional 12 post-discharge transportation trips (routine transportation still covers up to 24 trips/yr.) RFP, P

San Francisco Health Service System
Health Service Board

Health Service Board – April 10, 2025

Review Blue Shield of California Medicare Advantage and Prescription Drug PPO Audit Findings

Presented by Anne Thompson, Account Executive

Post-Implementation Audit—Purpose

Programming and Claims Analysis

- The primary purpose is to test BSC's claim system, through the processing of 'test claim' scenarios, to determine whether the medical benefit features and provisions have been set up and programmed accurately. The expectation is that 100% of claims are processed correctly.

Operational Readiness Assessment

- The assessment is a comprehensive review of BSC's operating systems and service capabilities that will be in place to manage and deliver medical plan administrative services to SFHSS members.

Post-Implementation Audit—Approach

Audit Methodology

- The audit methodology combined document reviews, system test scenarios, and data analysis to ensure comprehensive insights were gathered.

Establishment of Criteria

- Criteria for the audit were established based on CMS regulations, industry standards, and best practices to ensure relevance and compliance.

Insights Gathering

- The combination of methodologies allowed for effective insights gathering, ensuring a robust audit outcome

Post-Implementation Audit—Programming and Claims Analysis

The Aon team conducted a review of the SFHSS Medicare Advantage medical plan benefits. Aon reviewed nearly 75 network and non-network claim scenarios.

Medicare Advantage Implementation Medical Claim Testing

The primary objectives of our medical claim testing accomplished the following:

- Confirm that the major features of the SFHSS plan has been correctly programmed.
- Clarify the intent of any potentially ambiguous plan provisions.
- Observe the degree of manual intervention necessary to adjudicate claims for the SFHSS plan. During the testing, edits issued by the system and claim adjudication protocols were also documented.
- We have also included a list of the medical claim scenarios Aon reviewed for your reference which you can find in the appendix.

Findings

Our review of the information provided show there are two programming errors that BSC is working to correct. This process has proven to be valuable in confirming that plan benefits were programmed as SFHSS intended.

- Incorrect copay applied for Medicare-covered telehealth services.
- Incorrectly applied nutritional counseling copay to the out-of-pocket maximum.

Post-Implementation Audit

Operational Readiness Assessment

Overview	Improvement Opportunities
Organization and Staffing • SFHSS claim processing is handled in the BSC designated service model, which includes 147 individuals, with 92% having 2 or more years of experience. • Member phone calls are also handled in a designated environment. The customer service team consists of 22 customer service representatives, of which approximately 54% have less than 2 years of experience. • Overall personnel turnover in 2025 as of March 2025 has been 5%. This is lower than the 8% to 10% reported by other carriers.	• Aon considers customer service representatives to be considered tenured when they have been in their role for at least 2 years.
Claims Administration • As of 2025, the BSC auto-adjudication rate for Medicare claims was 73%. Auto-adjudication is an excellent way to reduce “careless” errors when processing claims. • BSC is the fiduciary for the claim and independent review entity appeals. All Medicare Advantage plans will follow Centers for Medicare and Medicare Services appeal rules. The Centers for Medicare and Medicare Services allows BSC a 14-calendar day extension if the request is for a medical item. The extension, however, does not apply to prescription drugs. • Based on the SFHSS appeal reporting for 2025, the plan received 197 appeals, 22 independent review entity appeals and 74 complaints	• BSC reported the average turnaround for claim adjustments in 2025 was 30 calendar days. Aon typically sees in the industry meet 95% of adjustments are completed in 7 to 10 business days.

Post-Implementation Audit

Operational Readiness Assessment

Overview	Improvement Opportunities
Customer Service • BSC has an internal goal to respond to 100% of emails within 24 hours, which exceeds industry averages. • BSC records 100% of all inbound and outbound calls received in the standard member service lines. In addition, screen navigation information is collected to show how customer service representatives navigate the system. • BSC measures first call resolution based on the member surveys immediately following the telephonic interaction. Based on the self-reported statistics, the customer service representatives averaged 97% of calls closed within 2 days, exceeding BSC's internal goal of 90%.	• Based on the BSC secure messaging statistics, the team was responding to 90% of all emails within 2 business days which is below BSC's internal objective. • Though data was limited to 2 months, it appears the team's first call resolution results declined from January to February. • There is an opportunity for improvement in average speed to answer, call abandonment rate and telephone service factor in January 2025 however scores improved in February 2025.

Post-Implementation Audit

Operational Readiness Assessment

Overview	Improvement Opportunities
Audit Program • BSC uses several audit programs to assess internal controls, administrative procedures and the accuracy of claims processed by the system and claim processors. • BSC has internal objectives for Financial Accuracy of 99%, Payment Accuracy of 99% and Overall Accuracy of 98%. In the 2 months reported, both the Financial and Overall Accuracy objectives were met. • BSC has a claim payment timeliness objective of 98% in 30 calendar days. Based on the self-reported statistics, the team exceeded the goal for both months reported in 2025. • BSC also measures individual customer service performance through a call audit program.	• BSC slightly missed the Payment Accuracy objective during the 2 months report. On a positive note, while missing the goal in January, the team achieved a 100% in February. • The BSC claim payment timeliness objective of 95% in 30 calendar days is not as aggressive as the 99% in 30 calendar seen with other administrators. • The 5 calls reviewed for the customer service representatives audit program is less than best practice of 12 to 14 calls . However, in addition to the five calls, BSC also has other informal programs that are used to coach customer service representatives.

Post-Implementation Audit

Implementation Review

Category	Findings
Project Implementation Plan	• Based on our review, all major tasks connected with the implementation appear to have been accomplished on time
Customer Service Training	• BSC advised benefit training was conducted with the customer service team prior to the open enrollment period which consisted of an extensive one-day training with the designated team. In addition, online training and post-onboarding training was provided on an as needed basis
System Set-Up	• BSC advised the benefit booklets were compared to the Facets system prior to the review, along with post-production quality testing. • An additional review will be performed once the plan benefit review with Aon is completed, and any potential open items are resolved

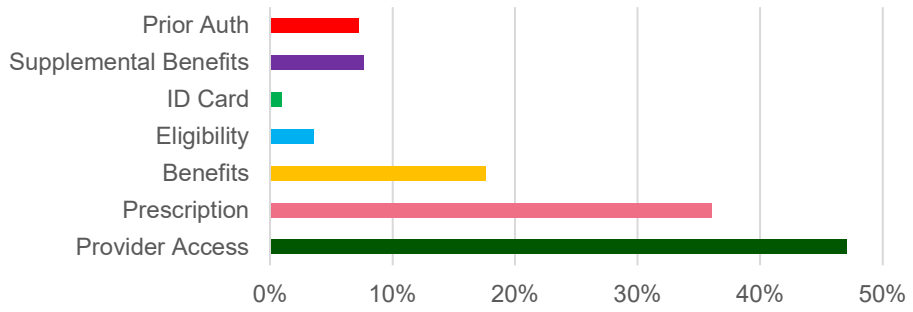
Blue Shield Update

BSC Call Metrics – Jan - March 2025

Call Volume

5,515 - March
5,575 - February
9,333 - January

Support Drivers Metrics



Abandonment Rate

Goal: <3%

1% - March
1% - February
7.5% - January

BSC to HSS Calls

196- March
285 - February
295 - February

Average Speed to Answer

Goal: <3 mins

35 secs - March
35 secs - February
227 sec - January

Average Handle Time

Goal: As Long as Required

16 mins - March
17 mins - February
18 mins - January

First Contact Resolution

Goal: >75%

96% - March
88% - February
98% - January

Transition Related Issues

Issue Description	Resolution	Records Corrected
Address issue for members on the Blue Shield plan previously.	Replaced the old mailing address with the current address from the eligibility file. ID cards and Welcome Kits were triggered early January.	658
Electronic enrollment issues for members on the Blue Shield plan previously and other errors that caused manual enrollments.	Audits were completed and any discrepancies were sent to our processing team to resolve. Weekly audits have been conducted to be sure there are no other issues. Resolved in December and early January.	243
Primary Care Physicians from prior enrollment showing up for the MAPD population causing confusion for providers.	Systematically strip the PCP information from the MAPD population.	~4,100
Call the Car program did not have MAPD eligibility in the first week of January.	Eligibility was corrected in the first week at Call the Car and direct reimbursement was handled through Concierge Member Services.	~10

Transition Related Issues

Issue Description	Resolution	Records Corrected
$100 Outpatient Facility Copay Applying for an Office Visit.	Updated claims processing coding so that claims are now processing as expected without the copay. Claims that were affected are being reprocessed. A communication will be sent to these members to understand how to be reimbursed.	~815
Pharmacy error where the Part D out-of-pocket maximum was assumed met and members paid $0 for a prescription; per CMS rules, recoupments letters will be sent.	The team put a fix in the system. Claims are now processing as expected and those claims that were affected will be reversed and reprocessed to accumulate the correct dollars. A test claim was done to confirm that the next fill for drugs will adjudicate at the right copay.	~390
Low Income Subsidy (LIS) not initially setup in time for January 2025.	Have resolved and established monthly process. Will have catch-up checks sent out first week in March 2025.	~200

Normal Health Plan Administrative Activities

- No new systemic issues were identified in February or March.
- All new issues since February were related to normal course of health plan activities such as provider coding errors and regular prior authorizations to verify medical necessity.
- The HSS Concierge Member Services team has been empowered to escalate and resolve such standard plan administrative activities.

Update on American Specialty Health

- American Specialty Health (ASH) for Chiropractic & Acupuncture Benefits
  - Blue Shield has partnered with ASH to remove the Medical Necessity Review after the 5th visit so there will be no unforeseen interruption with your ongoing chiropractic or acupuncture care.
  - For Out-of-network services, providers will need to submit their claims directly to ASH and receive payment.
  - ASH will reprocess prior Out-of-network claims and members will not be liable for more than their $15 copay for routine Chiropractic or Acupuncture visits.

Commitment to Member Engagement

Ongoing Communications:

- Plan for monthly educational webinar sessions on a variety of benefit utilization topics and address member questions.

Education:

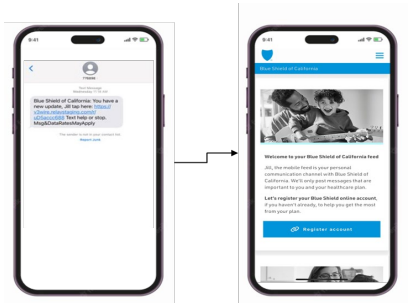
- Upcoming plan navigation mailer to address topics of interest such as:
  - 100-Day Rx Supply Benefit
  - Methods to submit an Appeal or Grievance
  - Hearing aids reimbursement process
  - Promote dedicated SFHSS Concierge Member Services

Additional Member Engagement

- In order to promote proactive engagement with members and identifying opportunities for preventative care, we are launching various programs:
  - Member Healthcare Journey communications throughout the year

Welcome | Health Tips & Reminders | Plan Education | Member Appreciation & Support | Plan Materials

  - Relay Network Communications



  - In Home Visits Program

Rules of Medicare Advantage Plan Administration

All health plans offering **Group Medicare Advantage MAPD PPO** coverage must follow the same rules set by **CMS (Centers for Medicare & Medicaid Services)**. Think of it like driving laws—no matter what car you drive, the traffic rules stay the same.

- **Same Rules for Everyone**: CMS sets the guidelines on what these plans must cover, how they operate, and how they protect members.
- **Different Processes, Same Standards**: While each insurance company (carrier) may handle things like customer service or claims processing a little differently, they all **must** follow CMS regulations.
- **Consistent Member Protections**: Whether you have a plan with Carrier A or Carrier B, your rights, benefits, and protections are guided by the same Medicare rules.

So, while the experience may vary slightly, the **core benefits and rules of the product remain the same** no matter which insurance company provides the plan.

Understanding Prior Authorizations

Prior authorization in a Managed Care MAPD PPO plan is implemented to ensure members receive the **right level of care** while promoting **quality, safety, and cost-effectiveness**. The key reasons include:

- **Ensuring Appropriate Care:** Prior authorization helps confirm that treatments, medications, or procedures align with clinical best practices, ensuring members receive the most effective and medically necessary care.
- **Closing Gaps in Care:** It enables proactive engagement by identifying opportunities for preventive services, disease management, and early interventions to improve health outcomes.
- **Minimizing Overuse and Misuse:** By reviewing requests based on medical necessity, prior authorization helps prevent unnecessary services while still allowing flexibility for providers to deliver clinically appropriate care.
- **Cost and Resource Optimization:** It supports affordability by directing care to the most appropriate setting, such as outpatient vs. inpatient, without restricting necessary services.

This approach **balances clinical oversight without excessive control over member services**, ensuring access to essential care while maintaining plan sustainability and compliance with CMS guidelines.

Closing Remarks

- At this point, staff feels the confident we have reached the normal plan administration phase of this transition due to:
  - No new transition-related systemic issues since the end of January.
  - A review by SFHSS Contracts staff verified that Blue Shield's response to the RFP closely aligned with the plan design of the former UnitedHealthcare plan.
  - The two post-implementation audits conducted by AON showed that while there are some improvement opportunities, overall, all major tasks connected with the implementation appear to have been accomplished on time.
- Therefore, SFHSS recommends discontinuing ongoing monthly reports as they would not provide additional value.
- We will continue to share the HSS and Blue Shield Call Metrics Dashboard in the monthly Director's Report.
- Staff will transition its focus to the PY 2026 contract renewal for the Medicare Advantage PPO plan.

Questions?

Appendix

Medical Claim Scenarios

Legal Disclaimer

Medical Claim Scenarios (1 of 4)

Plan Provisions	Benefit Level Audited	
	In-Network	Out-of-Network
General Plan Provisions		
Annual out-of-pocket maximum—individual	X	X
Professional Office Services		
Primary care physician office visit benefit	X	X
Specialist office visit benefit	X	X
Office surgery benefit	X	
Telehealth & Teladoc	X	X
Adult male routine examination benefit	X	
Adult female routine examination benefit	X	
Immunization coverage	X	X
Routine hearing care benefit	X	X
Routine hearing care maximum		X
Independent laboratory benefit	X	X

Medical Claim Scenarios (2 of 4)

Plan Provisions	Benefit Level Audited	
	In-Network	Out-of-Network
Emergency Care Services		
Ambulance		X
Emergency room benefit—professional fees		X
Emergency room benefit—ancillary services		X
Emergency room benefit—facility		X
Urgent care benefit		X
Outpatient Hospital Services		
Outpatient hospital benefit—professional fees	X	X
Outpatient hospital benefit—ancillary services	X	X
Outpatient hospital benefit—facility	X	X
Inpatient Hospital Services		
Inpatient hospital care—professional fees	X	X
Inpatient hospital care—ancillary services	X	X
Inpatient hospital care—facility	X	X
Observation room		

Medical Claim Scenarios (3 of 4)

Plan Provisions	Benefit Level Audited	
	In-Network	Out-of-Network
Mental Health Care Treatment		
Outpatient mental health—professional fees	X	
Outpatient mental health—facility	X	X
Inpatient mental health—professional fees		
Substance Abuse Treatment		
Outpatient substance abuse—professional fees	X	
Outpatient substance abuse—facility	X	X
Inpatient substance abuse—professional fees	X	
Chiropractic Care and Therapy Services		
Acupuncture	X	X
Chiropractic care benefit	X	X
Physical therapy benefit	X	
Speech therapy benefit	X	X

Medical Claim Scenarios (4 of 4)

Plan Provisions	Benefit Level Audited	
	In-Network	Out-of-Network
Other Services		
Ambulatory Surgical Facility	X	
Chemotherapy	X	
Dialysis	X	
Diabetic supplies coverage	X	X
Durable medical equipment benefit	X	X
Orthotic coverage		X
Home health care benefit	X	
Hospice care benefit	X	X
Hospice care maximum		
Skilled nursing facility care benefit	X	X
Skilled nursing facility care maximum	X	X

Legal Disclaimer

About Aon

Aon plc (NYSE: AON) exists to shape decisions for the better —to protect and enrich the lives of people around the world. Through actionable analytic insight, globally integrated Risk Capital and Human Capital expertise, and locally relevant solutions, our colleagues in over 120 countries and sovereignties provide our clients with the clarity and confidence to make better risk and people decisions that help protect and grow their businesses.