Provider Newsletter

ULTIMATE HEALTH PLANS

In this Issue:

Ultimate Health Plans wants to ensure that we prepare all the necessary information for our Providers. We hope you find this issue of the Provider Newsletter helpful in your practice.

Mission Statement

Ultimate Health Plans' mission is to provide all members with the highest quality healthcare with access to highly qualified physicians. We hold ourselves accountable for treating our members with dignity and respect, providing world-class customer service, and recognizing our commitment to the community as a local corporation.

A Message from our Medical Director

Dear Provider,

I hope the New Year has been great so far. I wanted to take this opportunity to discuss the authorization process at Ultimate Health Plans (UHP). Below is the outline of our authorization process:

- The process starts with the Prior Authorization List: Codes/Procedures that do not require prior authorization found at https://chooseultimate.com/Provider/Reference
  - Submission Methods for Prior Authorization Requests
    - Electronic: Calypso Provider Management (Portal Entry) – Preferred method of submission
      - Accessible at https://ultimate.mirrahealthcare.com
      - Paper: Outpatient Part B requests
      - Fax: 352-515-5975
      - Email: partbumrequests@ulthp.com
    - Paper: Inpatient Part A requests
      - Fax: 352-616-0943
      - Email: partaumrequests@ulthp.com
  - Prior Authorization Request Completion Timeframes
    - Expedited: 72 hours (Part B Medication Expedited: 24 hours)
    - Must meet the CMS Definition to qualify as an Expedited request: Submitting as Standard will result in the member's life, health, or ability to regain maximum function being jeopardized.
    - Standard: 14 days
    - Retrospective: 30 days
    - Retrospective requests cannot be submitted as Expedited
  - Requests must be submitted by the PCP or have an attached PCP referral if submitted by the Specialist. Failure to do so may result in the rejection of the prior authorization request.
  - (Exception: requests for prior authorizations for HHC, DME, SNF, IRF, LTAC required as part of discharge planning of an inpatient stay can be submitted directly to UHP without going through the PCP)
  - Clinical documentation must be submitted at the time of the prior authorization request to support the request made.
  - Prior authorization requests are clinically reviewed by an RN using NCD/LCD/InterQual and Medicare Manual Guidelines.
  - Requests that do not meet criteria under NCD/LCD/InterQual and Medicare Manual Guidelines are referred to a physician for review.
  - Peer-to-Peer (P2P) is offered for denied requests to allow for further dialogue and discussion regarding a case that may not be apparent from the medical records.
    - Intent to Deny is a process applied to Outpatient and Pre-Service reviews – UHP will notify the provider of intent to deny. The provider is given 24 hours to complete P2P so the final decision can be rendered timely.
  - P2P Inpatient is given up to 3 days to complete. Member must be inpatient at the time of the P2P discussion.
    - UHP will attempt verbal notification to the member and provider for all Expedited prior authorization requests to advise of prior authorization decisions.
    - If the prior authorization is approved, a notification is faxed to the provider with the authorization details, and an approval letter is sent to the member and provider.
    - If the prior authorization is denied, the PCP and member are notified by phone, and a letter is sent to the member and provider with instructions on how to file an appeal.

Note: All UM activity is available for viewing in the Calypso Provider Management portal for those providers with access. This allows the provider to track the prior authorization status from submission to completion.

I hope the above information was useful. Our goal is to make the authorization process as smooth as possible for our providers. If you have any suggestions, we certainly welcome them. I want to point out that we do receive a lot of "expedited requests." Some of them are even for services that have already been rendered (retrospective requests). I urge you to adhere to CMS' expedited request criteria prior to submitting any requests as expedited.

As always, thank you for taking great care of our members!

Yours in good health,

-Dr. Pragnesh Shah, MD, MBA, CPE

Case Management and How to Get Your Patient the Care They Need

At UHP, our members are important to us, so we have an extensive Complex Case Management Program within our Population Health Program to fit your patients' needs.

There are four ways your patients can be referred to the program:

1. Medical Management Referrals:
   - Occur within the health plan by Case Managers identifying high-risk patients
   - Referral from the Utilization Management Department when a patient has been diagnosed with COVID
   - Referral from Disease Management to Case Management to further management of chronic conditions
   - Referral from the Health Risk Assessment (HRA)
2. Discharge Planner Referrals:
   - UM staff and Case Managers coordinate with discharge planners to facilitate care for your patients

3. Member Referrals
   - Patients, our members, are continuously educated on ways to self-refer to Case Management; through our website at www.ChooseUltimate.com/Member/CaseManagement and the UHP Member Newsletters.
4. Physician Referrals:
   - Providers are encouraged and educated on ways to refer their patients to Case Management in the Provider Manual.
   - The Referral Form is in the Provider Manual on our website at www.ChooseUltimate.com/Provider/Reference

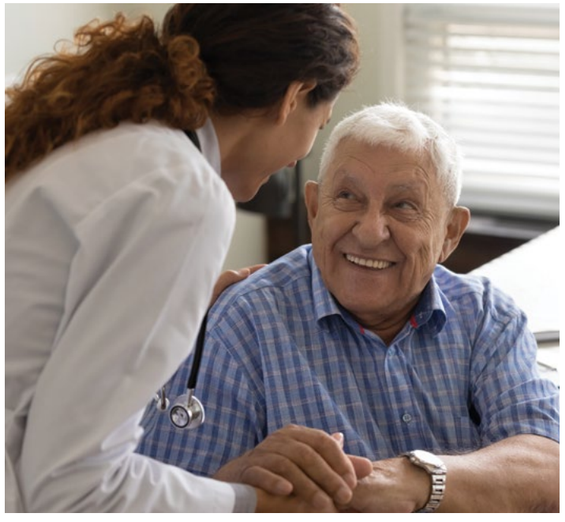
In our Quick Reference Guide, you can find the telephone number, fax number, and email to our Case Management department.

Case Management
Phone: (866) 967- 3430
Fax: (352) 691-5063
Email: caremanagement@ulthp.com

Thank you for partnering with us to meet your patients' needs!

Members and Obtaining Care

Our member's health is valuable, so it's important for your patient to know how to find in-network providers and obtain the care they need. Patients can refer to the following sections of your Evidence of Coverage (EOC) on these topics.



- The Provider and Pharmacy Directory: Your Guide to all Providers in the Plan's Network (EOC Chapter 1, Section 3.2)
- Obtaining Primary Care Provider (PCP) Services to Oversee Your Medical Care (EOC Chapter 3, Section 2.1)
- How to Get Care from Specialists and Other Network Providers (EOC Chapter 3, Section 2.3)
- How to Get Care from Out-of-Network Providers (EOC Chapter 3, Section 2.4)
- Getting Care When You Have an Urgent Need for Services – After Hours and Outside the Plan's Service Area (EOC Chapter 3, Section 3.2)
- Getting Care if you have a Medical Emergency (EOC Chapter 3, Section 3.1)

A copy of the Evidence of Coverage is available online at www.ChooseUltimate.com/Member/DocumentsandForms or members can call 1-888-657-4170 to request we mail them a copy.

Member Rights and Responsibilities

We honor our member's rights. They have the following rights to help protect themselves:

- We must treat you with fairness, respect, and dignity at all times
- We must ensure that you get timely access to your covered services and drugs
- We must protect the privacy of your personal health information
- For a complete list of Member Rights and Responsibilities, members can visit our website at www.ChooseUltimate.com/Member/RightsAndResponsibilities, or call 1-888-657-4170 to request we mail them a copy.

Assessment of New Medical Technology

Ultimate has a formal process to evaluate and address new developments in technology and new applications of existing technology. We consider including new technology in our benefit plans to keep pace with changes and to ensure our members have equitable access to safe and effective care. If a patient wants to learn more about this formal process, they can visit www.ChooseUltimate.com/Member/DocumentsandForms or call 1-888-657-4170 to request that we mail them a copy of the process.

Health Equity & Race and Ethnicity Data

As we grow, we must begin discussing the critical topic of Health Equity & Race and Ethnicity Data collection and analysis. It has been widely documented that there is a prevalence of racial and ethnic health disparities in the United States. We want to ensure we do everything we can to break any barriers for our members to receive the care they deserve.

NCQA has implemented, for the measurement year 2022, race and ethnicity stratification for five HEDIS (Healthcare Effectiveness Data and Information Set) measures, three of which are specific to Medicare:

- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients with Diabetes

The stratification will be implemented by:

- Stratifying race and ethnicity separately
- Include options for the member to decline answering and not provide their race or ethnicity
- Allow self-reported member data and indirect imputed data
- Use existing HEDIS audit and hybrid sampling guidelines

Gathering this type of data allows us to see any disparities in specific populations that we can address. It also allows us to see where our population is thriving and the best practices we have put in place that we can build upon.

By identifying the disparities, we can also attempt to fix the health inequities. They affect lives and finances, creating an economic burden on the members we serve.

Thank you for partnering with us to help give your patients, our members, the best possible care.

News from our Quality Management Department on Delivery Systems Supports

At UHP, our goal is to give our members, your patients, the best and most comprehensive care available. Our Quality Management Department is comprised of Case Management Nurses, Disease Management Nurses, and Social Workers who work behind the scenes to obtain resources to better help your patients. In addition, our Quality Management Department maintains its clinical licensures, CEUs, and education to give your patients the most up-to-date care available to meet the population's health goals.

We use various methods to obtain and share data with you to serve your patients better and identify which populations need resources that we can offer. Our goal is to break down any barriers that can impact a member's ability to receive the care they need. We share the data with you, the provider, by faxing Care Plans to your office to ensure communication on your patient is occurring.

Our Case Management Department also provides oversight in the costs and quality of care associated with your patient to better assist their needs and yours.

Our Quality Management Department annually works on CAHPS measures with simulation surveys throughout the year. The results of these surveys can show UHP and you, as the provider, how we can continue to provide quality care as a team.

Later in the year, we will be implementing cultural competency training incorporated in the annual Provider SNP training. The training will help introduce you to the NCQA initiative on Health Equity.

If you feel that a patient is unable to receive the care they need due to various barriers, please reach out to our Care Management Team at 1-866-967-3430.

Coverage Decisions, Appeals, and Complaints

Patients can learn about the processes for Coverage Decisions, Appeals, and Complaints by reading the following sections of your Evidence of Coverage (EOC) or by reaching out to us.

- Ask us to Pay Our Share of the Cost of Your Covered Services or Drugs (EOC Chapter 7, Section 1.1)
- How to Make a Complaint (EOC Chapter 9, Section 10)
- A Guide to the Basics of Coverage Decisions and Appeals (EOC Chapter 9, Section 4-9)
- Independent Review Entity: How a Level 2 Appeal is Done (EOC Chapter 9, Section 5.4)

A copy of the Evidence of Coverage is available online at www.ChooseUltimate.com/Member/DocumentsandForms or have members call 1-888-657-4170 to request we mail them a copy.

Importance of Members Understanding Their Benefits

It's important for patients to know the benefits they receive as an Ultimate member. They can refer to the following sections of their Evidence of Coverage (EOC) to learn about them in detail.

- Services that are Covered for You and How Much you Will Pay (EOC Chapter 4, Section 2.1)
- Services that are Not Covered by the Plan (EOC Chapter 4, Section 3.1)
- Restrictions on Coverage for Some Drugs (EOC Chapter 5, Section 4)

A copy of the Evidence of Coverage is available online at
www.ChooseUltimate.com/Member/DocumentsandForms
or members can call
1-888-657-4170 to request we mail them a copy.

Special Needs Plans (SNP)

At UHP, we are proud to offer several Special Needs Plans to our members, your patients. Special Needs Plans are a type of Medicare Advantage Plan that provides coordinated care to members with specific needs or chronic conditions. We offer five SNP plans in our service counties on the East Coast, West Coast, and Central Florida.

Advantage Care (C-SNP)	NEW Advantage Plus SNP (D-SNP)
• **Cardiovascular Disorder** • **Chronic Heart Failure** • **Chronic Lung Disorder** • **Diabetes Mellitus**	• **Full and Partial** Dual-Eligible • Member qualifies if eligible for both Medicare and Medicaid

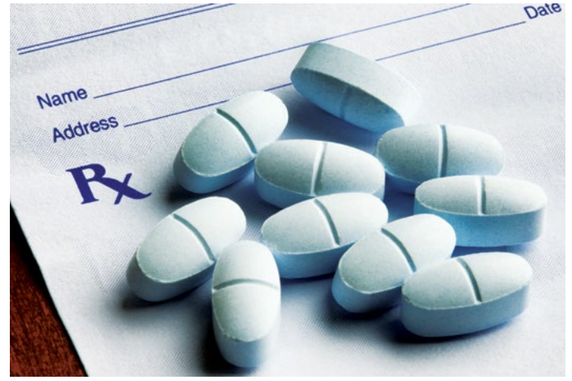
The following SNP benefits for your patients include:

- ✓ Case and Disease Management
- ✓ Social Services
- ✓ Transition of care
- ✓ Benefits for over-the-counter products
- ✓ Telemedicine services
- ✓ Transportation services
- ✓ Routine dental, vision, and hearing benefits
- ✓ SilverSneakers Program (gym membership)
- ✓ Meal Benefit

If you feel a patient meets the criteria and isn't enrolled in a Special Needs Plan, please reach out to your Provider Network Representative or our Provider Service Department at 1-888-657-4171. They are available to better assist you in getting your patient, our member, the care they need.

ULTIMATE HEALTH PLANS

Opioid Point-of-Sale (POS) Safety Edits What You Need To Know To Assist Members!



We understand the magnitude of our nation's opioid epidemic and its negative impact on our communities. When used appropriately, opioid medications effectively treat many types of pain, but the benefits come with the risk of tolerance, addiction, overdose, and even death.

Through the Center for Medicare & Medicaid Services (CMS) support, we have received approval to implement Real-Time Safety Alerts and Edits to aid in the safe and appropriate review and use of opioid medications.

These edits are designed to give prescribers more information and, if warranted, to encourage prescribers to emphasize opioid overdose risk and prevention with their patients, especially if the patient is receiving prescription opioids from multiple prescribers or pharmacies.

Below are details of the most common opioid edits experienced by members.

PLAN RULES FOR CY2022

Members are exempt from these edits if they are in Long-Term Care (LTC) or Hospice, receiving palliative care, are treating cancer-related pain, or are diagnosed with sickle cell anemia.

7-days supply limit for opioid naïve patients *hard edit:*

- Edit will affect a member who has not filled an opioid prescription under the current benefit within the past 120 days.
- This is a hard edit that stops the pharmacy from processing a prescription until an override is entered.
- Edit will affect a member that is NEW to Ultimate Health Plans who does not have a history of opioid use in their prescription history under the new plan.
- As the provider, if you believe that an opioid naïve patient will need more than a 7-day supply initially or the limited history may trigger a reject, **PLEASE CONSIDER** proactively requesting a coverage determination on behalf of the patient attesting to the medical need for a supply greater than 7 days. A member can also request a cover determination to be initiated.
- Pharmacies should also reach out to you to determine if it is appropriate to enter an override on demand.

Opioid care coordination 90 MME *soft edit*:

- This real-time safety edit is a soft reject that will affect members who present an opioid prescription at the pharmacy, and their cumulative morphine milligram equivalent (MME) per day across all their opioid prescriptions reaches or exceeds 90 MME.
- This alert is also designed to identify potentially high-risk patients who may benefit from closer monitoring and care coordination.
- The prescriber who writes the prescription that triggers the cumulative dose of over 90 MME per day will be contacted.
- The CDC Guideline cites the 90 MME as the level above, which prescribers should generally avoid. **However, this is not a prescribing limit**.
- The pharmacist is expected to consult with you to confirm the medical need for the higher MME. The pharmacist should then make appropriate indications in the pharmacy system so the prescription claim can pay.

Cumulative 200 MME opioid *hard edit*:

- This real-time safety hard edit will affect members when they present an opioid prescription at the pharmacy, and their cumulative morphine milligram equivalent (MME) per day across all their opioid prescriptions reaches or exceeds 200 MME.
- The pharmacist may alert you to this rejection.
- A coverage determination may be necessary to resolve the rejected claim. This would require you to provide OptumRx (PBM) information for a clinical review to be completed.

What can you do to best support our members?

✓ Regularly assess your patients' short and long-term needs and use of opioid prescriptions. https://www.cdc.gov/opioids/providers/prescribing/guideline.html

✓ If a member is switching health plans, anticipate that a 7-day opioid edit will be triggered. **Be proactive and initiate a coverage determination at 1-800-711-4555 for the member.**

✓ If you receive a call from the member, pharmacy, or coverage determinations team from OptumRx (PBM), please be as responsive as possible so the appropriate information can be gathered and assessed to make a determination.

✓ Educate the member on what they may experience. Assist members in knowing their rights.

- Members can initiate a coverage determination.
- Members should receive a copy of the "Medicare Prescription Drug Coverage and Your Rights" if the edit can not be resolved with ease at the point of sale.
- Please encourage the member to call OptumRx at 1-800-311-7517, so we may assist them.

Diabetic Supplies Information for 2022

Preferred brand glucose monitors and supplies

Our preferred glucose monitors and test strips for benefit year 2022 are from the manufacturers (Abbott) Freestyle and (Johnson & Johnson) OneTouch. These preferred manufacturer products are available and will process through the pharmacy benefit.

Non-preferred brand glucose monitors and supplies

Other brands of glucose monitors and test strips (including generic products) are available through our in-network Durable Medical Equipment (DME) providers, which you can find in the Provider & Pharmacy Directory at www.ChooseUltimate.com/Home/FindDoctor

Continuous Glucose Monitors (CGMs)

Continuous glucose monitors and supplies are only available through the plan's in-network DME providers and **require** the prior authorization of the member's benefit through the medical side.

Please fax your request to 352-515-5975 or call Provider Services at 888-657-4171 if you have questions. Once approved, the in-network DME provider will source the product. You can find our DME providers in the Provider & Pharmacy Directory at www.ChooseUltimate.com/Home/FindDoctor

Reminder The cost share of the blood glucose monitors, blood glucose test strips, lancets, lancet devices, and glucose-control solutions are covered through Part B for a $0 cost-share.

Prescription Mail Order Process

Members can utilize OptumRx's mail-order service as a convenient way to save time and money. In addition, the Auto-Refill service automatically reorders prescription medications before the member runs out of their medication!

- Prescriptions processed through mail-order require a 90-day supply. Mail-order pharmacy orders will arrive within 14 days.
- Medications used for chronic or long-term medical conditions are the best candidates for mail-order dispensing. Opioids are not available for mail order delivery.
- If there is a delay in a member's order, they are encouraged to call us as soon as possible so that we can arrange for them to pick up their prescription from a local pharmacy.

Get your patients started today with mail-order delivery.

ePrescribe to:

OptumRx

2858 Loker Ave East, Suite 100

Carlsbad, CA 92010

NCPDP ID = 0556540

PID =P0000000002017

Or call our dedicated clinician line at 1-800-791-7658, TTY 711.

Notable Medication Recalls

Eli Lilly voluntarily recalled Lot D239382D of Glucagon Emergency Kit to the patient/consumer level due to a product complaint reporting that the vial of Glucagon was in liquid form instead of the powder form. The use of liquid in the product may fail to treat severe low blood sugar due to the loss of potency. Patients with questions concerning the recall should contact Lilly Answers Center at 1-800-LILLYRX (1-800-545-5979) Monday-Friday 9 AM-7 PM EST. Patients are also encouraged to reach out to their Healthcare Providers for further guidance or if they have experienced any problems from using the product.

Any adverse reactions can be reported to the FDA's MedWatch Adverse Event Reporting program via phone at 1-800-332-1088 to request a form.

2022 Formulary Changes

With each new plan year, in collaboration with OptumRx's Clinical team, we review the formulary and find ways to enhance it for our members. There are a few notable updates to the formulary for 2022. We will outline some of them below based on non-formulary or Utilization Management (UM) status. This is not an all-inclusive list. Please review the complete formulary at www.ChooseUltimate.com/Home/PrescriptionDrugs

Notable Formulary Updates

	Drug Name	UM Criteria
Formulary Addition	Farixga	QL 30/30
	Tadalafil 10mg; 20mg	QL 10/30
	Drug Name	**Formulary Alternative**
Non-Formulary	Basaglar	Lantus
	Proair HFA	Albuterol HFA
	Advair HFA	Wixela
	Pradaxa	Xarelto; Eliquis
	Invokana	Farxiga
	Drug Name	**Quantity Limit Decreased**
UM Changes	Sildenafil 25mg; 50mg; 100mg	12/30 days
	Albuterol HFA	2 inhalers/30 days
	Omeprazole	60/30 days
	Pantoprazole	60/30 days
	Drug Name	**Quantity Limit Increased**
UM Changes	Omeprazole	60/30 days
	Pantoprazole	60/30 days
	Drug Name	**PA Removal**
UM Changes	Prolia	No PA required

Nondiscrimination, Accessibility, and Language Assistance

Ultimate Health Plans complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities. Ultimate Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages

If members need these services, they can contact Ultimate Health Plans Member Services. If a member believes that Ultimate Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities, they can file a grievance with the Ultimate Health Plans Grievance Department. Address: P.O. Box 6560, Spring Hill, FL 34611. Phone: 1-888-657-4170 (TTY users dial 711). Fax: 1-800-313-2798. Email: GrievanceAndAppeals@ulthp.com

Members can file a grievance in person or by mail, fax, or email. If members need help filing a grievance, an Ultimate Health Plans Grievance Coordinator is available to help them. Members can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-657-4170 (TTY: 711).
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-657-4170 (TTY: 711).
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-657-4170 (TTY: 711).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-657-4170 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-657-4170 (TTY: 711）。
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-657-4170 (ATS: 711).
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-657-4170 (TTY: 711).
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-657-4170 (телетайп: 711).
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-657-4170 (رقم هاتف الصم والبكم: 117).
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-657-4170 (TTY: 711).
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-657-4170 (TTY: 711).
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-657-4170 (TTY: 711)번으로 전화해 주십시오.
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-657-4170 (TTY: 711).
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-657-4170 (TTY: 711).
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-657-4170 (TTY: 711)

ULTIMATE HEALTH PLANS

CONTACT US

BY PHONE:
Monday thru Sunday: 8 a.m. to 6 p.m.
1-888-657-4171
(TTY: 711)

ONLINE:
You may find answers to many of your questions online at
www.ChooseUltimate.com

BY MAIL:
Ultimate Health Plans, Inc.
PO Box 3459
Spring Hill, FL 34611

CORPORATE OFFICE
1244 Mariner Blvd.,
Spring Hill, FL 34609
Currently, Monday thru Friday
9 a.m. to 5 p.m.

COMMUNITY OUTREACH OFFICES (In-Person)

17820 SE 109th Ave., Ste 103
Summerfield, FL 34491

2713 Forest Road
Spring Hill, FL 34606

4058 Tampa Road, Ste 7
Oldsmar, FL 34677