WINTER 2024

ULTIMATE HEALTH PLANS

ProviderNews

The Value of ADHERENCE

Addressing HEALTH CARE Disparities

PROTECTING OUR MEMBERS KIDNEYS

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2025 UPDATES

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Medicare Prescription Payment Plan

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.

Understanding Health Inequities

Ultimate Health Plans understands the importance of recognizing health inequities when considering meaningful interventions for our members. Health inequities are avoidable differences between distinct groups of people in society that impact fair access, experiences, and outcomes to health care.

Health Equity Plan Committee

This year, the Care Management team is tackling health inequities with the formation of a Health Equity Plan committee. This committee is comprised of a diverse group of dedicated, compassionate team members eager to make a difference in the healthcare experience of those members experiencing health disparities. The committee is comprised of resource coordinators, case managers, clinical care coordinators, and executive leadership.

Recognizing a Subpopulation in Need

The team has recognized a rise in members reporting the need for food assistance. Of those members, we have determined that this can place members with diabetes at a great disadvantage in managing their disease. The committee is dedicated to improving the outcomes of this population of members who rely on consistent, nutritious meals to safely manage their diabetes diagnosis.

Making a Difference

The Care Management team has created an action plan to serve those members with diabetes who also report food insecurities.

Community Resources
- Update and maintain our Online Community Resources with a variety of food pantry options

Education
- Create specific education designed to support diabetes dietary goals

Choices
- Create education that offers comparisons of food choices and prices

Outreach
- Provide 1-on-1 Case Management outreach to discuss barriers and self-management goals with members

Ultimate Health Plans aims to serve the unique needs of each individual member. Our members' well-being is important to us and addressing health inequities is one of the many ways we will continue to provide excellence in care.

For more information about our impact on promoting health equity, please feel free to reach out to Case Management at 1-866-967-3430.

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CCIP – ACE/ARB and Nephrology Visits

Protecting Our Member's Kidneys

We encourage our members to talk to their doctors about the importance of ACE/ARB therapies and the benefits of a Nephrology Visit.

According to the National Kidney Foundation, thirty-seven million adults in the United States have CKD and approximately 90% of them are not aware they have the disease.

Our members who manage elevated blood pressure or diabetes, have a family history of CKD or the history of smoking are at increased risk.

Important Medication to Protect the Kidneys

Medication can positively affect kidney health and treatment goals. The most important medicines to help slow or even stop the progression of kidney disease are **ACE inhibitors** or **ARB medications**.

It is important to consider ACE/ARB therapy for your patients!

Chronic Care Improvement Program

The Chronic Care Improvement Program (CCIP) is a Quality Improvement program driven by CMS to promote effective chronic disease management. Our Care Management department is meeting the CCIP goals with a concentrated focus on CKD management to improve our members' health outcomes. In this effort we are focusing on the following initiatives for those with a CKD diagnosis:

- improving utilization of ACE/ARB therapy
- including Nephrologists in the member's care
- decreasing the rate of hospital readmissions
- improving the rate of kidney evaluations as evidenced by the completion of a urine albumin-creatinine ration and estimated glomerular filtration rate

It is important to consider a Nephrology referral for our members with CKD!

Please help us support our members' chronic disease management through these focused interventions.

[1] National Kidney Foundation. (2024, 9 19). About Kidney Disease. Retrieved from National Kidney Foundation
[2] National Kidney Foundation. (2024, 9 19). About Kidney Disease. Retrieved from National Kidney Foundation

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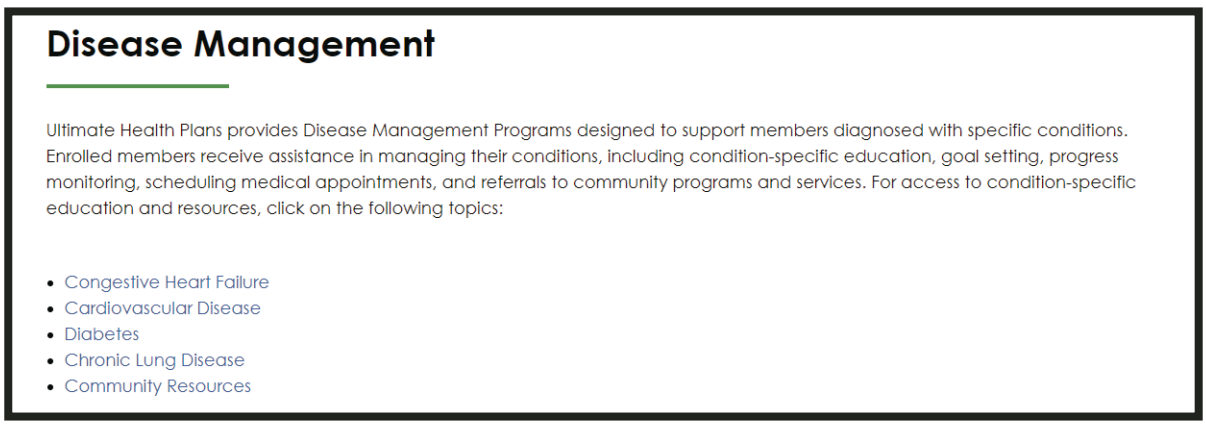
Empowering Members Through Self-Management

UHP promotes disease management through the use of self-management tools and resources. In 2024, the Care Management team created an online resource for members with diabetes, cardiovascular disease, congestive heart failure, and chronic lung disorder. These resources give our members access to additional self-management tools to support their disease management goals.

These resources can be found online at: www.chooseultimate.com/Member/CareManagement.

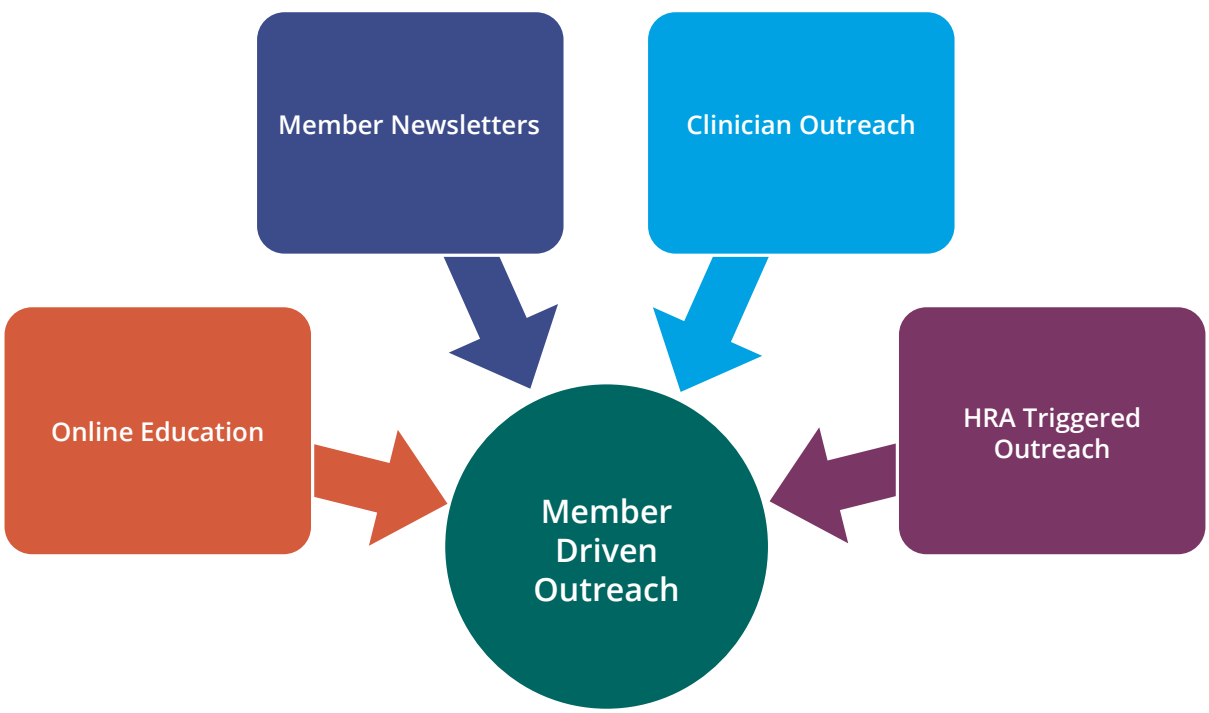


Disease Management

Ultimate Health Plans provides Disease Management Programs designed to support members diagnosed with specific conditions. Enrolled members receive assistance in managing their conditions, including condition-specific education, goal setting, progress monitoring, scheduling medical appointments, and referrals to community programs and services. For access to condition-specific education and resources, click on the following topics:

- Congestive Heart Failure
- Cardiovascular Disease
- Diabetes
- Chronic Lung Disease
- Community Resources

In addition, our members are provided further education and access to self-management tools through varying member driven outreach methods.



Our aim is to provide our members with a variety of resources to support their disease management journey. We understand that empowered, educated members have the tools and resources to succeed when navigating the challenges of chronic illness. UHP and the Care Management team are here to support our members through those challenges. For more collaboration with us, feel free to call our Care Management department at 1-866-967-3430.

ULTIMATE HEALTH PLANS

Part D: Provider Responsiveness Is Key To Ensure a Thorough Review of a Prior Authorization Request

Please remember the CMS required timeframes associated with **standard** and **expedited** Coverage Determination requests. The timeframes apply 7 days a week (including holidays).

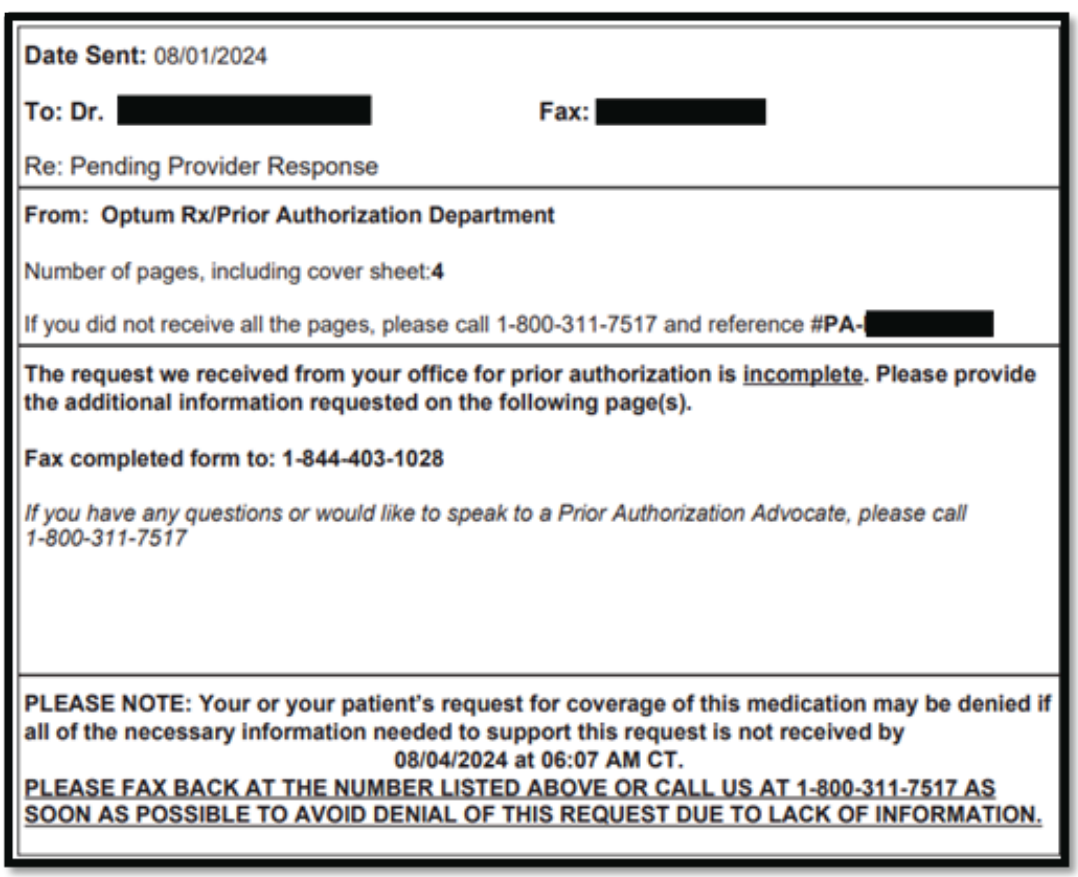
- 24 hours are allowed for expedited requests.
- 72 hours are allowed for standard requests.

Timeframes measured in hours must be met within the number of hours indicated.

- Example 1: A request for an expedited coverage determination is received on May 1 at 10:30 am. Given the 24-hour timeframe, the plan must make a determination no later than 10:30 am on May 2.
- Example 2: A request for a standard coverage determination is received on May 1 at 10:30 am. Given the 72-hour timeframe, the plan must make a determination no later than 10:30 am on May 4.

Provider responsiveness is key, if you receive a request for additional information (RFI) from Optum, please respond as soon as possible to avoid denial of the request due to lack of information. You can fax 1-844-403-1028 or call 1-800-311-7517.

Below is an example of what an *additional information* request will look like.



Date Sent: 08/01/2024

To: Dr. [redacted] **Fax:** [redacted]

Re: Pending Provider Response

From: Optum Rx/Prior Authorization Department

Number of pages, including cover sheet:**4**

If you did not receive all the pages, please call 1-800-311-7517 and reference #**PA-**[redacted]

The request we received from your office for prior authorization is incomplete. Please provide the additional information requested on the following page(s).

Fax completed form to: 1-844-403-1028

If you have any questions or would like to speak to a Prior Authorization Advocate, please call 1-800-311-7517

PLEASE NOTE: Your or your patient's request for coverage of this medication may be denied if all of the necessary information needed to support this request is not received by 08/04/2024 at 06:07 AM CT.

PLEASE FAX BACK AT THE NUMBER LISTED ABOVE OR CALL US AT 1-800-311-7517 AS SOON AS POSSIBLE TO AVOID DENIAL OF THIS REQUEST DUE TO LACK OF INFORMATION.

ULTIMATE HEALTH PLANS

2025 Updates

Formulary Tier updates: There are some changes to the formulary tiers for our plans for 2025. You will see those below. Please pay special attention to the addition of Tier 6. This tier only applies to CSNP and DSNP plans.

The Formulary is Divided into 5 to 6 Tiers, every drug on the plan's Drug List is in one of six cost-sharing tiers with a corresponding cost-sharing amount depending on the plan as shown below. In general, the higher the cost-sharing tier, the higher your cost for the drug.

	Premier by Ultimate MAPD - Medicare Advantage Plan	Advantage Care by Ultimate CSNP - Chronic Special Needs Plan	Advantage Plus DSNP - Dual Special Needs Plan
TIER 1 **Preferred Generic -** Includes generic drugs This t ieralso offers drugs at the lowest cost.	Preferred Generic	Preferred Generic	Preferred Generic
TIER 2 **Generic -** Inclu des generic or brand drugs.	Generic	Generic	Generic
TIER 3 **Preferred Brand -** Includes preferred brand drugsand some generic drugs offered at a lower cost than Non-Preferred drugs.	Preferred Brand	Preferred Brand	Preferred Brand
TIER 4 **Non-Preferred Brand -** Includes non-preferred brand drugs and some generic drugs offered at a higher cost than Preferred Brand.	Non-Preferred Drug	Non-Preferred Drug	Non-Preferred Drug
TIER 5 **Specialty Tier -** Includes high-cost drugs brand and generic drugs, which may require special handling and/or close monitoring. This is t he highest-cost tier.	Specialty Tier	Specialty Tier	Specialty Tier
TIER 6	n/a	**Select Care Drugs** **CSNP-Select Care Drugs -** Includes select generic and brand drugs that treat Diabetes.	**Excluded Drugs Only** **DSNP-Excluded Drugs Only-** Includes prescription drugs not normally covered in a Medicare Prescription Drug Plan. *(erectile dysfunct;on drugs & some vitamins}*

Tier updates on Formulary Exceptions: If you prescribe a drug that is not on our formulary you can request a formulary exception. If we agree to cover a drug that is not on the formulary, members will pay the cost share for Tier 5 (Specialty Tier) which is 33% of the cost of the drug.

Therapeutic classes in CSNP Select Care Tier

For CSNP Select Care Tier 6 will cover generic and brand drugs that only treat **Diabetes**. Select Respiratory drugs will no longer be covered under the Select Care Tier.

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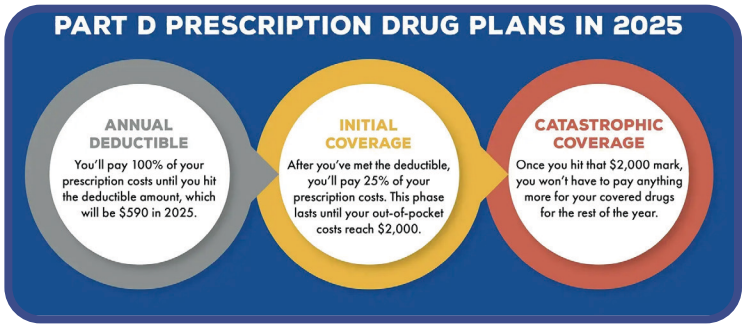
Elimination of the Coverage Gap

The Inflation Reduction Act requires CMS to establish a Part D manufacturer discount program beginning on January 1, 2025, as part of the redesign of Medicare Part D benefit. This program will replace the existing Coverage Gap Discount Program, which will end on December 31, 2024. The "coverage gap" or "donut hole" will be retired effective December 31, 2024.

While in the Initial Coverage Phase, members pay the co-pay or co-insurance for formulary drugs as determined by the tier level. Starting in 2025, annual out-of-pocket costs will be capped at the ICL ($2,000) for members. Once a member hits the $2,000 maximum, there will be no more copays for the rest of the calendar year if the drug is covered on the formulary.

Medicare Prescription Payment Plan



The Medicare Prescription Payment Plan can help members manage their Part D drug costs by spreading them out during the calendar year as monthly payments. This program is available for any members with Medicare Part D, especially members who, in a single claim, receive a cost share of $600.00 or more at the beginning of coverage.

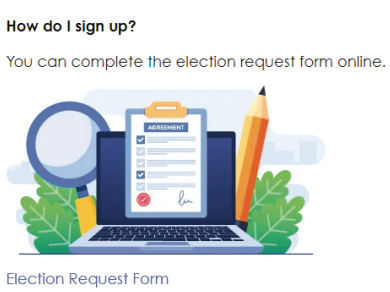
How does it work?

When members fill a prescription for a drug covered by Part D, they won't pay anything at the pharmacy (including mail-order and specialty pharmacies). Instead, they will get a bill each month from Optum with the Ultimate logo. Even though members won't pay for the drugs at the pharmacy, they will still be responsible for their copay costs.

How to enroll in Medicare Prescription Payment Plan

Website:

https://chooseultimate.com/Member/MedicarePayment



Election Request Form

Pharmacy Member Portal:

https://www2.optumrx.com/

*Portal function does not become live into 1/1/2025

Phone:

Optum Customer Service: 844-368-8729

Mail Election Forms:

Optum Rx
Attn: M3P Election Processes
PO BOX 650287
Dallas, TX 75265-0287

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Did you know?

Starting September 30, 2024, Medicare announced new guidelines on coverage for Preexposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention medications. Effective September 30, 2024 these services are covered without cost-sharing.

- **FDA-approved Pre-exposure Prophylaxis (PrEP) using antiretroviral drugs** to prevent HIV in individuals at increased risk of acquiring HIV
- **Administration of injectable PrEP** using antiretroviral drugs to prevent HIV
- **Supplying or dispensing the drug** regardless of the route of administration (oral and injectable)
- **Individual counseling** (up to 8 visits every 12 months), including:
    - HIV risk assessment (initial or continued assessment of risk)
    - HIV risk reduction
    - Medication adherence
- **HIV screenings** (up to 8 times every 12 months using FDA-approved laboratory tests and point-of-care tests)
- **Hepatitis B virus screening** (1 time only)

What's Covered by Part D and Part B?

Beneficiaries may have previously gotten PrEP for HIV drug coverage through Part D and paid a deductible and coinsurance or copayments. As of September 30, 2024, Part B covers these drugs.

If a beneficiary currently **has** HIV and uses antiretroviral drugs to **treat** HIV, Part D will continue to cover these drugs, even though these may be the same drugs that are used for HIV PrEP.

These medications will now be processed under your Part B coverage when used for PreP:

- Apretude injection (cabotegravir)
    - Will no longer be covered through Part D coverage.
    - Will be covered through Part B coverage with a $0 copay.
- Truvada oral (***emtricitabine 200 mg / tenofovir disoproxil 300mg***) and its generic
    - For HIV PrEP coverage,$0 Part B coverage call OptumRx 1-800-711-4555
- Descovy oral (***emtricitabine 200 mg / tenofovir alafenamide 25 mg***)
    - "For HIV PrEP coverage, $0 Part B coverage call OptumRx 1-800-711-4555

Prior Authorization will be required.

For more information visit:

https://www.cms.gov/medicare/coverage/prep

https://www.cms.gov/files/document/fact-sheet-potential-medicare-part-b-coverage-preexposure-prophylaxis-prep-using-antiretroviral.pdf

ULTIMATE HEALTH PLANS

Prescription Home Delivery

Members can use OptumRx as their home delivery mail-order service as a convenient way to save time and an outing to the pharmacy! With mail-order service the medication will arrive right to their front door- *with no charge for standard shipping.*

Home delivery mail-order- facts:

- Mail order is used for 90-days' supply of medication.
- The order will arrive within 14 days.
- Chronic a long-term medication can be delivered through home delivery.
  *** Opioid medications are not available through home delivery.**
- Auto refill service automatically reorders prescription medications before they run out!

Home delivery mail-order- benefits:

- **Savings:** Member may pay less for their medication with a 3-month supply.
- **Convenience:** Medications are delivered to the member's home – with free standard shipping.
- **24/7 pharmacist support:** Members can speak to a pharmacist any time, from the privacy of their own home.

Home delivery mail-order- getting started:

- Doctors may send an electronic prescription to OptumRx

ePrescribe to:
Optum Home Delivery (OptumRx Mail Service)

6800 W 115th St., Ste. 600

Overland Park, KS 66211-9838

NCPDP ID: 1718634

Call 1-800-791-7658

Provide a verbal prescription directly to Optum Rx pharmacists dedicated to our health care providers.

Fax 1-800-491-7997

Mail order FAQ:

Q. Is a Credit Card Required to place an Order?

A. No, a credit card is not required to set up a mail order or place a mail order.

Online: Yes, a credit card is required to place an order through the web portal.

Q. If no credit card is on file, does it limit my ability to order?

A. If there is no CC on file, then the member can only order with a live agent. The order will be limited to under a certain dollar amount. The member can ship and be invoiced as long the account is in good standing. For anything over $300, there will be a copay hold applied that an agent would have to remove after verifying the information with the member.

Q. Can members set up Automatic Shipment without a Credit Card on file?

A. No, Auto Ship requires a Credit Card on file.

The Value of Adherence

Encouraging members to take their medicine can be challenging. Members that are compliant and adhere to their drug therapy have better outcomes and experience an overall lower cost of care.

Studies have found that **prescribing a 90 to 100-day supply of maintenance medications** increases compliance to therapy, and members' ability to achieve healthier outcomes and reach the 80 percent adherence rate.

Frequently prescribed medications used to treat diabetes, cholesterol, and hypertension are inexpensive Tier 1 and Tier 2 generics with a $0 co-pay.

Consider using Optum Rx mail order to prescribe a three-month supply of Tier 1 and Tier 2 generic medications for a $0 co-pay.

ePrescribe to:

Optum Home Delivery
6800 W 115th St., Ste. 600
Overland Park, KS 66211
NCPDP ID: 1718634

Call 1-800-791-7658
Provide a verbal prescription directly to one of our provider dedicated pharmacists.

Fax 1-800-491-7997

Part C: Prior Authorization Process

Greetings! We would like to take this opportunity to provide an overview of the authorization process at Ultimate Health Plans, Inc. Below is a summary of our procedures:

Authorization Process Overview:

Step 1: Prior Authorization List – This list includes codes and procedures requiring prior authorization.

- **Submission Process:**
  - **Preferred Method:** Calypso Lite (Portal Entry) https://ultimate.mirrahealthcare.com
  - **Outpatient Part B Requests:**
    - Fax: 352-515-5975
    - Email: partbumrequests@ulthp.com
  - **Inpatient Part A Requests:**
    - Fax: 352-616-0943
    - Email: partaumrequests@ulthp.com
- Utilization Management staff are available from 0800-1700 EST and can be reached at 888-657-4170 (TTY 711). After-hours requests can be received via Calypso https://ultimate.mirrahealthcare.com and fax (listed above).

Step 2: Prior Authorization Request Status:

- **Expedited (72 hrs.)** – Must meet CMS definition: Threat to life or harm to the patient if delayed.
- **Standard (Part B Medication Expedited)** – 24 hours
- **Standard** – 14 days
- **Pre-Service** – 14 days
- **Retrospective** – 30 days (cannot be expedited)

Step 3: Submission Requirements:

- Requests must be submitted by the Primary Care Provider (PCP) or include a referral from the PCP if submitted by a specialist. Failure to comply may result in rejection of the request.
- **Exception:** Requests for Home Health Care (HHC), Durable Medical Equipment (DME), Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), or Long-Term Acute Care (LTAC) required as part of discharge planning can be submitted directly to UHP without a PCP referral.

Step 4: Clinical Documentation:

- Supporting clinical documentation must accompany the prior authorization request.

ULTIMATE HEALTH PLANS

Part C: Prior Authorization Process (continued)

Step 5: Clinical Review Process:

- Prior authorization requests are reviewed by a Registered Nurse (RN) using NCD/LCD/InterQual and Medicare Manual Guidelines.
- If criteria are not met, the request will be referred to a physician for further review.

Step 6: Peer-to-Peer (P2P) Review:

- P2P is offered for denied requests to allow for further discussion and clarification.

Step 7: Notification:

- **Expedited Requests:** UHP will make a verbal notification to the member regarding the prior authorization decision.
- **Approval:** If approved, the provider will receive a fax with authorization details, and an approval letter will be sent to the member.
- **Denial:** If denied, the member will be notified by phone, and a denial letter will be sent to both provider and member with the appeals process outlined. Providers may obtain the UM criteria to make the decision via the following methods: in person at the organization, telephone, email or mail.

Additional Information:

- All utilization management (UM) activity is available through the Calypso portal for providers with access. This allows tracking of prior authorization status from submission to completion.

We trust you will find this information useful. Our aim is to facilitate a smooth and efficient authorization process for our providers. We appreciate any feedback or suggestions you may have.

We would also like to point out that we receive a significant number of "expedited requests," some of which pertain to services already provided (retrospective requests). Please ensure that expedited requests are in accordance with CMS guidelines prior to submission.

Thank you, as always, for your ongoing commitment to delivering outstanding care to our members!

ULTIMATE HEALTH PLANS

Ultimate Health Plans and Carelon Behavioral Health

Here at Ultimate Health Plans, one of our priorities is ensuring that you as a provider have all the tools, we can share with you, to help bring our members the best care possible. To create those tools internally and in partnership with our delegated vendors, we use data from provider surveys, CAHPS and HOS, and HEDIS, to help educate and point providers in the right direction to optimize care to members. One partnership we value is with our MBHO, Carelon Behavioral Health. Carelon and Ultimate Health Plans, meet routinely to analyze and strategize on ways we can reach and help our members to provide behavioral health services.

Carelon provides many resources that you as a provider can use to help your patients, too!

Carelon Provider Toolkit:

Carelon has a provider toolkit, that is updated biannually. Here is the link to the toolkit:

https://www.carelonbehavioralhealth.com/providers/resources/provider-toolkit

Within this toolkit are tools to help assist in conversations and ways that may improve the dialogue between you and your patient.

Carelon Provider Newsletter:

Carelon's provider newsletter allows you to stay up to date on the latest findings and regional news. Below is the link to stay informed:

https://www.carelonbehavioralhealth.com/providers/resources/newsletter

Carelon Provider Education and webinars:

Carelon also values the importance of continued education on various topics with current information that can help you as the provider, bring that information to your patients, as well as new approaches when discussing mental health needs with your patients. Below is the link to those trainings and webinars:

https://www.carelonbehavioralhealth.com/providers/resources/trainings

Carelon Provider Handbook:

Lastly, Carelon has a detailed provider handbook for your reference should you have any questions. The link below will also allow you to drill down to state-specific resources:

https://www.carelonbehavioralhealth.com/providers/resources/provider-handbook