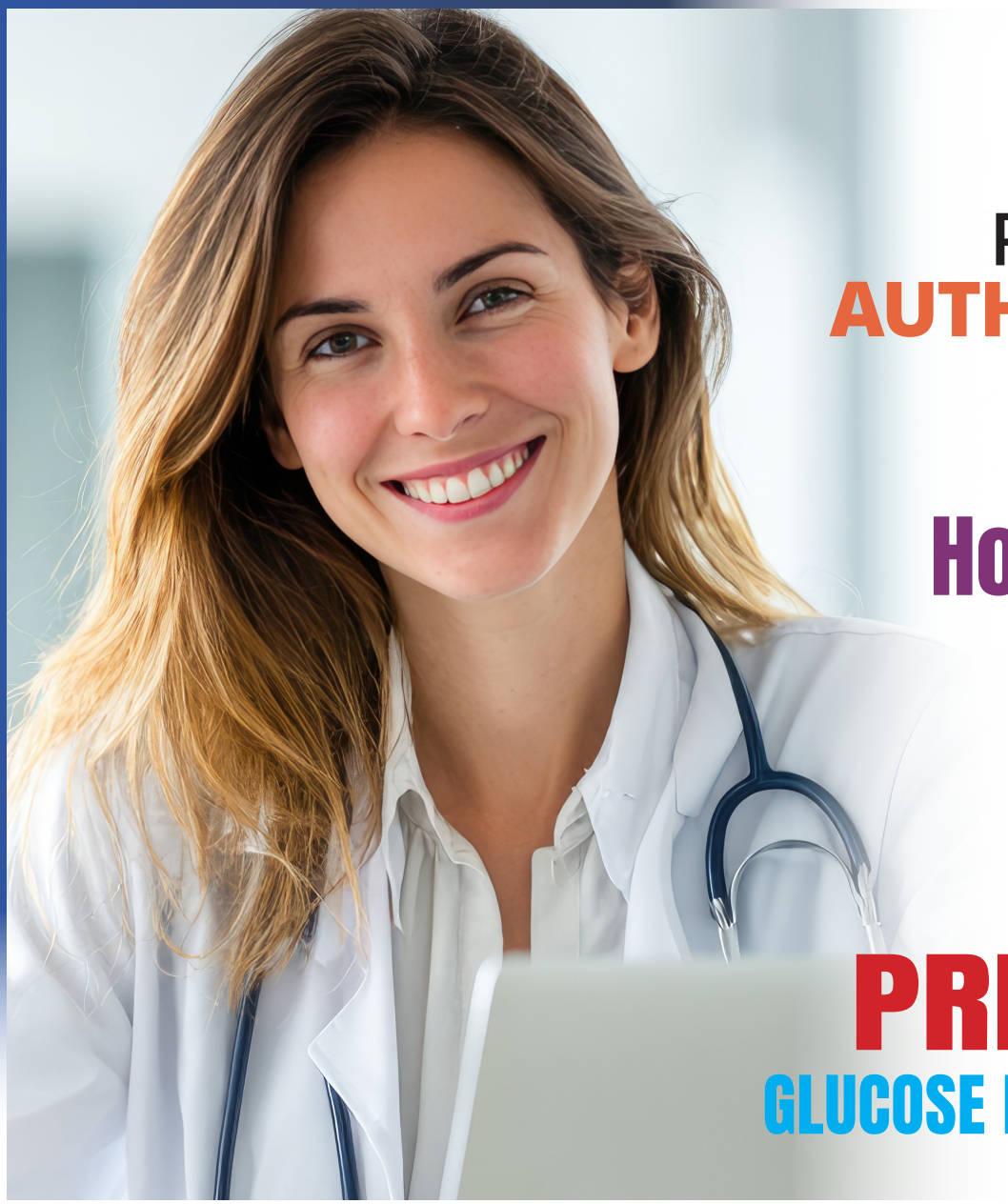
Winter 2025

ULTIMATE HEALTH PLANS

ProviderNews



Part C: PRIOR AUTHORIZATION Process

Prescription Home Delivery with OptumRx

Flu VACCINATION

PREFERRED GLUCOSE METER PRODUCTS

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.

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 (7 days as of 1-1-26)
- **Pre-Service –** 14 days (7 days as of 1-1-26)
- **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.

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Step 4: Clinical Documentation:

- Supporting clinical documentation must accompany the prior authorization request.

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 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!

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Part D

Streamlining the Prior Authorization (PA) Process

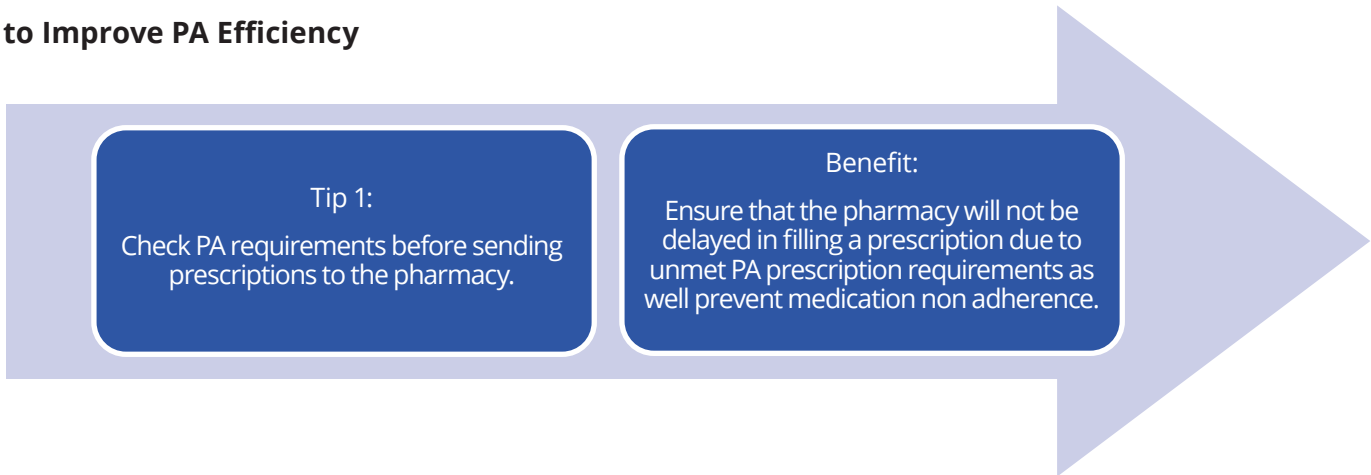
Prior authorization (PA) is an essential part of ensuring safe and effective care—but it can also be time-consuming and may delay treatment if not managed proactively. Ultimate Health Plans encourage provider offices to adopt best practices that reduce administrative burden and help patients receive their medications without interruption.

Why It Matters

PA delays can:

- Interrupt care delivery
- Increase patient frustration
- Lead to prescription abandonment

Tips to Improve PA Efficiency



Check PA Requirements Early

Before sending a prescription:

- Verify if the medication requires prior authorization
- Use plan resources or electronic tools to confirm coverage

Proactively verifying PA requirements before prescribing is both the best clinical practice and a smart operational strategy. For physicians, it prevents workflow disruptions caused by pharmacy callbacks and ensures patients receive their medications on time. For administrators, it minimizes administrative workload, enhances staff efficiency, and supports continuity of care.

When PA requirements are identified only after a prescription is sent, it often results in delays—or worse, patients not receiving their medication at all. Taking a proactive approach helps protect both patient outcomes and practice efficiency.

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Tip 2:

Establish a protocol to consistently document data required for PA in the Medical record.

Benefits:

- Avoid delays in patient therapy
- Prevent potential follow-ups with patients for additional information
- Minimize phisician time needed in PA process

Submit Complete & Accurate Documentation

Many PA requests are denied due to:

- Incomplete medical records
- Missing treatment history
- Simple data entry errors

Tip: Ensure documentation includes:

- A full medication history
- Clinical rationale for prescribed medication
- Any failed alternative therapies

Most of the prescription prior authorization (PA) criteria require documentation of previous therapies the patient has tried and failed or had suboptimal outcomes with. Maintaining thorough, up-to-date documentation—including a complete medication history—can significantly streamline the PA process. When this information is readily available, approvals are processed faster, minimizing delays in patient care. It also reduces the need for direct physician involvement in the PA process, allowing clinicians to focus more time on patient care and less on administrative tasks.

Tip 2:

Select the PA method that will be most efficent for you practice!

Benefits:

- Reduce the time your practice spends on PA
- Minimize workflow disruptions

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Standardize Your PA Process

Having a practice-wide protocol can help reduce errors. Consider:

- Designating trained staff for PA submissions
- Using electronic prior authorization (ePA) when available
- Tracking submissions and renewals

With the growing administrative demands surrounding PA, consistency is key. Submitting accurate and complete requests the first time reduces avoidable denials and enhances efficiency. Support your team by ensuring they have access to all relevant PA resources and plan guidance.

Empower Your Staff!

- Clinical criteria
- Training and resource materials

Ultimate Health Plans is committed to supporting your practice in delivering timely, effective care. If you have need support with the PA process, please contact Optum Rx at 1-800-311-7517.

Preferred Glucose Meter Products – Effective January 1, 2026

Beginning **January 1, 2026, Accu-Chek® (Roche) and Contour® (Ascensia)** glucose meters will become **Ultimate Health Plans' preferred glucose meter options.**

As previously communicated, this change is part of a broader strategic initiative aimed at addressing financial stability concerns surrounding LifeScan OneTouch, which has served as our sole preferred glucose meter in both retail and mail-order settings.

We recognize that many of our members currently use LifeScan OneTouch Ultra or Verio meters. To help ensure a smooth transition and prevent any disruption in care, we encourage you to begin discussing this change with your patients as soon as possible. Early conversations will help ensure members have time to successfully begin testing with their new preferred glucose meter before depleting their current OneTouch supplies.

Ultimate Health Plans will continue to provide:

- $0 member cost share for preferred glucose meters and test strips at retail and mail-order pharmacies
- Access to non-preferred glucose meters is still available through approved DME Providers, subject to applicable coverage criteria and prior authorization requirements

We truly appreciate your partnership and commitment to helping our members receive the diabetic supplies they need!

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Prescription Home Delivery with OptumRx

OptumRx offers a convenient home delivery mail-order service, allowing members to receive their medications right at their doorstep—with no charge for standard shipping. It's a time-saving option that helps members skip the trip to the pharmacy.

Mail-Order Fast Facts: Benefits of Home Delivery

- Designed for 90-day supplies of maintenance medication
- Up to 100-day supply is allowed for tier 1 and 2 products.
- Ideal for chronic or long-term medications
- Auto Refill is available to automatically reorder medications before they run out

Note: Opioid medications are not available through home delivery

Benefits of Home Delivery Getting Started is Easy

- Cost Savings: Members may pay less with a 3-month supply
- Convenience: Medications are shipped directly to the member's home
- 24/7 Support: Members have access to pharmacists at any time, from the comfort of home

Getting Started is Easy

- Providers can send an electronic prescription directly to OptumRx
- Members can also sign up or manage their prescriptions at: www.optumrx.com

ePrescribe-Fast and Secure Script Requests

eprescribe to:
Optum Home Delivery (OptumRx Mail Service)
6800 W 115th St. Ste. 600
Overland Park, KS 66211-9838
NCPDP ID: 178634
Call: 1-800-791-7658
Fax: 1-800-491-7997

Protect Your Patients This Season: The Importance of Flu Vaccination for Medicare Members

As flu season approaches, providers play a vital role in helping Medicare members stay healthy and avoid preventable complications. Influenza can lead to serious illness, hospitalization, and even death—especially among adults aged 65 and older and those with chronic conditions.

Why It Matters

Older adults account for the majority of flu-related hospitalizations and deaths each year. Vaccination remains the best defense against severe illness, helping to:

- Reduce flu-related hospitalizations
- Lower the risk of heart attack and stroke in high-risk patients
- Protect vulnerable populations, including those with diabetes, COPD, or heart disease

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Provider Action Steps

- **Recommend vaccination early:** A strong provider recommendation is the most influential factor in a patient's decision to get vaccinated.
- **Stock age-appropriate vaccines:** Offer high-dose or adjuvanted flu vaccines for adults 65+ per CDC guidance.
- **Document and code correctly:** Ensure flu vaccinations are properly recorded in the medical record and submitted with the correct CPT/HCPCS codes to support quality reporting and Star measure per formance.
- **Close care gaps:** Use reminder calls, portal messages, and standing orders to increase vaccination rates.

Key Reminder

Flu vaccines can be co-administered with COVID-19 or pneumococcal vaccines during the same visit—an efficient way to improve overall immunization coverage.

Resources

- **CDC Flu Vaccine Guidance:** https://www.cdc.gov/flu/professionals
- **Medicare Coverage:** Flu shots are covered at no cost for Medicare beneficiaries.

Bottom Line:

Your proactive recommendations make a difference. Encouraging flu vaccination protects your patients, supports community health, and improves quality outcomes across the Medicare population.

Preparing for the Medicare CAHPS Survey: Tools and Strategies for Providers

The **Medicare Consumer Assessment of Healthcare Providers and Systems (MCAHPS)** survey plays a major role in assessing the patient experience for Medicare Advantage (MA) members. Conducted annually by CMS, the survey captures members' perspectives on the care and service they receive from their providers, health plans, and care teams.

Strong MCAHPS performance reflects not only patient satisfaction but also the quality of communication, coordination, and trust between providers and their patients. With the next survey cycle approaching, now is the time to focus on tools and best practices that enhance the patient experience.

Understanding the MCAHPS Survey

The MCAHPS survey evaluates members' experiences over the past six months across several key domains, including:

- **Getting Needed Care**
- **Getting Care Quickly**
- **Customer Service**
- **Care Coordination**
- **Rating of Healthcare Quality**
- **Rating of Personal Doctor and Specialist**
- **How Well Doctors Communicate**

Results are incorporated into Medicare Advantage Star Ratings and directly impact both plan performance and provider recognition programs.

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Why MCAHPS Matters to Providers

While the survey is administered by CMS to health plan members, the questions center heavily around the provider–patient relationship. Members are asked about:

- How often their doctor listens carefully
- Whether their doctor explains things clearly.
- If they feel respected and involved in decision-making.
- How easy it is to get appointments or needed care.

Each patient interaction can shape how members respond to these questions. Consistently delivering compassionate, timely, and coordinated care builds trust — and improves MCAHPS outcomes.

Practical Tools and Strategies to Improve MCAHPS Performance

1. Strengthen Communication Skills

Clear, empathetic communication is one of the strongest predictors of positive survey results.

Tools:

- Use the **"Ask-Tell-Ask"** method: ask about understanding, explain clearly, and confirm comprehension.
- Make eye contact, use plain language, and avoid medical jargon.
- Provide after-visit summaries and written instructions to reinforce understanding.

Key MCAHPS Link: "How well doctors communicate."

2. Improve Access and Responsiveness

Patients value timely, coordinated access to care.

Tools:

- Offer same-day or next-day appointments when possible.
- Train front-desk and triage staff on warm handoffs and prompt callbacks.
- Use **patient portal messaging** to address routine questions and medication renewals quickly.

Key MCAHPS Links: "Getting needed care" and "Getting care quickly."

3. Enhance Care Coordination

Fragmented care can frustrate patients and lead to poor outcomes.

Tools:

- Document and share visit notes across care teams.
- Follow up after referrals, hospitalizations, or emergency room visits.
- Use care gap lists or population health dashboards to track follow-up needs.

Key MCAHPS Link: "Care coordination."

4. Build Personal Connections

Patients remember when they feel heard and valued.

Tools:

- Begin visits by asking about the patient's goals, not just symptoms.
- Acknowledge emotional or social concerns that may affect health.
- Express appreciation: "I'm glad you came in today. I want to make sure we're meeting your needs."

Key MCAHPS Link: "Rating of personal doctor."

5. Engage the Entire Care Team

Every team member shapes the patient experience — from front office staff to medical assistants and nurses.

Tools:

- Conduct team huddles focused on patient experience tips.
- Use shadow coaching or brief observation to reinforce best practices.
- Recognize staff who go above and beyond in patient interactions.

Key MCAHPS Link: "Customer service" and "Getting care quickly."

6. Promote Awareness of the MCAHPS Survey

Remind patients that their feedback matters and helps improve care for everyone.

Tools:

- Display posters or digital messages encouraging participation.
- Train staff to mention:
  "You may receive a Medicare survey in the mail about your care experience — your feed back helps us serve you better."

Note: Providers should never coach patients on how to respond, but **encouraging honest participation** is appropriate and effective.

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Putting It All Together

Improving MCAHPS performance isn't about changing what you do — it's about enhancing how patients experience the care you already provide. Each positive interaction builds trust and reinforces the quality and compassion at the heart of your practice.

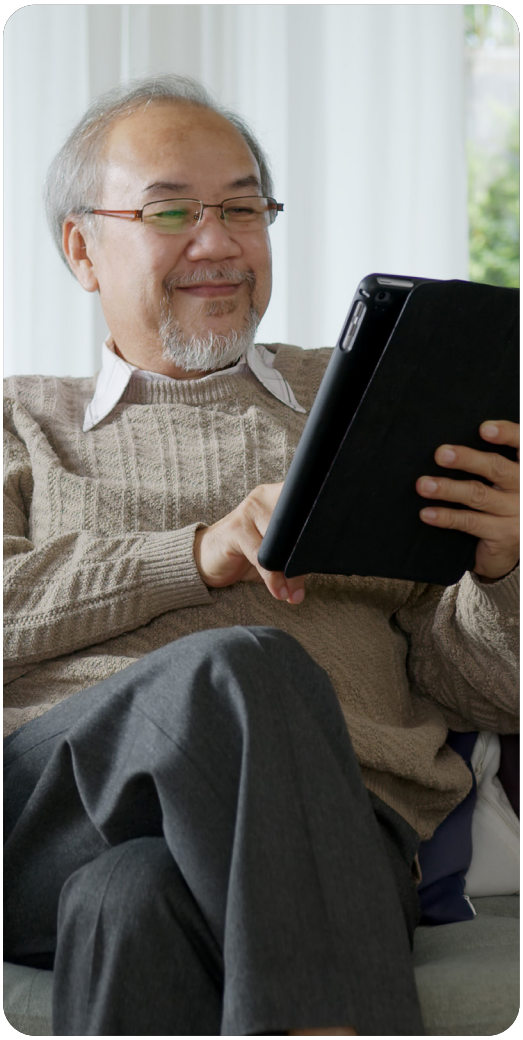
Focus on **listening, access, coordination, and empathy**. These fundamentals drive both excellent care and excellent survey results.

Next Steps and Resources

- Provider Training Tools:
  - CMS CAHPS Survey Overview: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS
  - AHRQ CAHPS Clinician & Group Toolkit: https://www.ahrq.gov/cahps
- Internal Support:
  Contact your Quality or Provider Relations representative for training opportunities, tip sheets, and patient experience resources.

Remember:
Every patient interaction is a CAHPS opportunity.
Small moments of empathy, clarity, and responsiveness can make a lasting impact.

Improving Health Outcomes Survey (HOS) Performance: Best Practices for Providers



The Medicare Health Outcomes Survey (HOS) is a vital tool used by the Centers for Medicare & Medicaid Services (CMS) to assess how well Medicare Advantage (MA) plans help members maintain or improve their physical and mental health over time. As a trusted partner in patient care, providers play a critical role in influencing the outcomes measured by the HOS.

Strong HOS performance not only reflects the quality of care your patients receive, but also contributes to higher Star Ratings, better patient experiences, and improved clinical outcomes.

Understanding the HOS

The HOS is administered annually to a random sample of Medicare Advantage members and measures changes in physical and mental health status over a two-year period. Key domains include:

- **Physical Health Functioning**
- **Mental Health Functioning**
- **Fall Risk Management**
- **Physical Activity**
- **Bladder Control**
- **Pain Management**
- **Medication Adherence**
- **Chronic Disease Management**
  (e.g., diabetes, hypertension, heart disease)

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Why HOS Matters

HOS results are directly linked to Star Ratings through the "Improving or Maintaining Physical Health" and "Improving or Maintaining Mental Health" measures. These scores are based on how members' self-reported health status changes over time.

Improving member outcomes begins with consistent, compassionate, and proactive care at the provider level.

Key HOS Improvement Strategies

1. Encourage Open Communication

Patients may underreport symptoms or health challenges. Ask open-ended questions during visits:

- "How are you managing your daily activities?"
- "Have you felt down, depressed, or hopeless recently?"
- "Do you feel steady when you walk or stand?"

Empathetic communication helps uncover issues that impact physical or mental well-being.

2. Promote Physical Activity

Regular physical activity supports mobility, independence, and mental health.

- Recommend age-appropriate exercise plans such as walking, stretching, or balance training.
- Provide community or wellness resources for seniors (e.g., SilverSneakers®, local recreation centers).

3. Screen and Manage Fall Risk

Falls are a major concern for older adults.

- Ask about any recent falls or balance problems.
- Review medications for side effects that increase fall risk.
- Recommend physical therapy or home safety evaluations when needed.

4. Address Mental Health

Depression and anxiety significantly affect quality of life and HOS scores.

- Use brief screening tools such as PHQ-2 or PHQ-9.
- Normalize conversations about mental health and encourage appropriate referrals.
- Follow up regularly to monitor progress and treatment effectiveness.

5. Support Medication Adherence

Help patients understand their medication purpose, dosing, and side effects.

- Simplify regimens where possible.
- Encourage use of pill organizers or medication synchronization programs.
- Coordinate with pharmacists to identify barriers and solutions.

6. Manage Chronic Conditions Proactively

Consistent monitoring and education can prevent health decline.

- Reinforce self-management goals for conditions like diabetes, hypertension, and COPD.
- Schedule regular follow-ups and lab testing.
- Encourage patients to report changes in their condition promptly.

7. Reinforce Preventive Care

Ensure members are up to date with annual wellness visits, vaccinations, and screenings. Preventive care supports long-term health and functional ability.

Engaging Patients Beyond the Clinic

Providers can also promote HOS improvement by partnering with care management teams and leveraging plan resources:

- **Care coordination:** Connect patients with disease management or behavioral health programs.
- **Education:** Provide written materials or handouts summarizing physical activity, nutrition, and medication tips.
- **Outreach:** Encourage patients to respond to HOS when they receive it and reassure them their feedback helps improve care.

Takeaway

Improving HOS results begins with the patient–provider relationship. Every conversation, assessment, and follow-up contributes to a member's perception of their health and their ability to maintain or improve it over time.

Your commitment to whole-person care—addressing physical, emotional, and social needs—directly impacts both quality performance and patient well-being.

For More Information:

Providers can access additional resources on HOS measures, coding tips, and patient engagement strategies through the CMS Medicare Health Outcomes Survey website:
https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS

Enhancing Member Outcomes Through the Interdisciplinary Care Team (ICT)

As part of our commitment to delivering high-quality, person-centered care, we want to highlight the critical role of the Interdisciplinary Care Team (ICT), a cornerstone of our Model of Care (MOC) and a requirement set forth by the Centers for Medicare & Medicaid Services (CMS).

What Is the Interdisciplinary Care Team?

ICT is a collaborative group of healthcare professionals, caregivers, and the members (or their representative) who work together to create, implement, and monitor an Individualized Care Plan (ICP). Depending on the members' needs, the team may include:

- Primary care providers
- Specialists
- Pharmacists
- Behavioral health professionals
- Social workers
- Care managers

This team-based approach ensures that care is coordinated, comprehensive, and tailored to the member's medical, behavioral, and social needs.

CMS Requirements and the Model of Care

CMS mandates that all Special Needs Plans (SNPs) maintain an ICT for each member. ICT supports the delivery of care in alignment with the plan's approved MOC by:

- Promoting cross-disciplinary communication and collaboration
- Identifying and addressing barriers to care, such as social determinants of health, transportation, or medication adherence
- Ensuring continuity and quality of care through shared decision-making
- This collaborative approach ensures that each member receives timely, appropriate care from a coordinated team of professionals.

ICT Meetings: Formal and Asynchronous

Formal ICT meetings are held quarterly or more frequently as needed to review high-risk members, update care plans, and ensure alignment with each member's goals. Provider participation is strongly encouraged, as clinical insights are vital to achieving optimal outcomes. Member involvement is also welcomed to support person-centered care and shared decision-making.

Asynchronous ICT meetings are facilitated through the ICT Attestation Form and ICP review. This process allows team members to review care plans, contribute insights, and make recommendations without convening in real time supporting timely updates while accommodating diverse schedules.

Each ICT Form submission:

- Captures provider and delegate input for Care Management review
- Documents actions taken and updates to the ICP
- Communicates follow-up and outcomes to the care team

This ensures all team members remain informed and actively engaged in the care coordination process.

Why the ICT Matters

Beyond regulatory compliance, the ICT represents the best practice in care delivery. Through effective collaboration, the ICT helps:

- Overcome barriers to care
- Enhance member engagement and satisfaction
- Improve health outcomes and support CMS compliance

Thank You for Your Partnership

Your involvement in the ICT process makes all the difference. By actively collaborating with your colleagues, you help us deliver the coordinated, high-quality care our members deserve. Thank you for your continued teamwork, dedication, and passion for improving the health and well-being of those we serve.

Have questions about the ICT process? We're here to help! Contact the Care Management Team at caremanagement@ulthp.com or call 1-866-967-3430.

Together, we turn coordinated care into meaningful results.
~ The Care Management Team

Your Provider Relations Support by County

County	PCP's	Specialists	Ancillary
Citrus	**Maggie Carbonell** mcarbonell@ulthp.com	**Jacob Yankus** jyankus@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
Hernando	**Maggie Carbonell** mcarbonell@ulthp.com	**Jacob Yankus** jyankus@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
Hillsborough	**Kendra Lake** klake@ulthp.com	**Candi Thompson** cthompson@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
Indian River	**Wendy Valley** wvalley@ulthp.com	**Wendy Valley** wvalley@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
Lake	**Cali Williams** cwilliams@ulthp.com	**Stephanie Vera** svera@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
Manatee	**Brian Halford** bhalford@ulthp.com	**Brian Halford** bhalford@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
Marion	**Eleana Coscarelli** erivera@ulthp.com	**Eleana Coscarelli** erivera@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
Orange	**Elcires Cruz** elcruz@ulthp.com	**Elcires Cruz** elcruz@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
Osceola	**Kelby Rodriguez** krodriguez@ulthp.com	**Kelby Rodriguez** krodriguez@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
Pasco	**Kendra Lake** klake@ulthp.com	**Kendra Lake** klake@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
Pinellas	**Brian Halford** bhalford@ulthp.com	**Candi Thompson** cthompson@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com
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Sumter	**Cali Williams** cwilliams@ulthp.com	**Stephanie Vera** svera@ulthp.com	**Brittany Vanzant** bvanzant@ulthp.com

Email: Provider-Relations@utlthp.com

Escalations can be sent to Jessica Crandall, Director of Provider Relations and provider Operations

Jecrandall@ulthp.com

813-838-6136

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Good health is where you live.

CONTACT US

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Monday - Friday, 8 a.m. to 5 p.m.
1-888-657-4171 (TTY 711)

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

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

Community Outreach Offices

600 N US Hwy 1, STE A
Fort Pierce, FL 34950

2713 Forest Rd
Spring Hill, FL 34606

303 SE 17th St, STE 305
Ocala, FL 34471