Summer 2026

ULTIMATE HEALTH PLANS

ProviderNews

Ultimate Health Plans

Quality Improvement Program

Coverage Decisions

APPEALS AND COMPLAINTS

HIV PREP MEDICATIONS

Formulary ADHERENCE

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.

Ultimate Health Plans Quality Improvement Program

Ultimate Health Plans (UHP) is committed to improving health outcomes, enhancing member experience, and supporting providers through a comprehensive Quality Management Program. The program uses data-driven strategies to identify opportunities for improvement, monitor performance, and implement targeted interventions that promote high-quality, coordinated care.

Key program activities include:

- Monitoring HEDIS®, CAHPS®, HOS®, pharmacy, and operational performance measures to evaluate quality and identify opportunities for improvement.
- Reviewing claims, encounter data, medical records, and member feedback to address care gaps, improve outcomes, and enhance member satisfaction.
- Collaborating with providers to support evidence-based care, quality improvement initiatives, and compliance with CMS and NCQA requirements.
- Implementing Quality Improvement Projects (QIPs) and Chronic Care Improvement Programs (CCIPs) to drive measurable improvements in care and service delivery.
- Identifying and addressing barriers to care, including health disparities and challenges affecting underserved populations.
- Partnering with delegated vendors, including Optum Behavioral Health and pharmacy partners, to coordinate interventions and improve member outcomes.
- Monitoring continuity and coordination of care to ensure members receive timely, appropriate services across the care continuum.
- Supporting Special Needs Plan (SNP) members through targeted quality initiatives, care coordination, and population-specific interventions.

Through ongoing collaboration with providers, delegated entities, and clinical leadership, UHP strives to improve quality performance, close gaps in care, strengthen care coordination, and ensure members receive the right care at the right time.

ULTIMATE HEALTH PLANS

Provider Update: Utilization Management Committee & Internal Coverage Criteria

As part of the Centers for Medicare & Medicaid Services (CMS) Final Rule CMS-4201-F, Medicare Advantage organizations are required to establish a Utilization Management (UM) Committee to annually review utilization management policies and ensure they remain consistent with Traditional Medicare coverage requirements, including National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and applicable Medicare laws and regulations.

The UM Committee also reviews any internally developed coverage criteria used when Medicare coverage criteria are not fully established. CMS permits Medicare Advantage organizations to develop internal coverage criteria only in these limited circumstances, and those criteria must be evidence-based, reviewed annually, and made publicly available to providers, members, and CMS.

Accessing Ultimate Health Plans' Internal Coverage Criteria

Ultimate Health Plans is committed to maintaining transparency regarding the clinical criteria used in medical necessity determinations.

Providers can access our Internal Coverage Criteria by visiting:
https://www.chooseultimate.com/Member/MedicalNecessity

This webpage contains the internal coverage criteria used by Ultimate Health Plans when applicable Medicare coverage criteria have not been fully established. Providers are encouraged to reference these criteria when submitting authorization requests to help facilitate timely and efficient medical necessity reviews.

Thank you for your continued partnership in providing high-quality, evidence-based care to our members

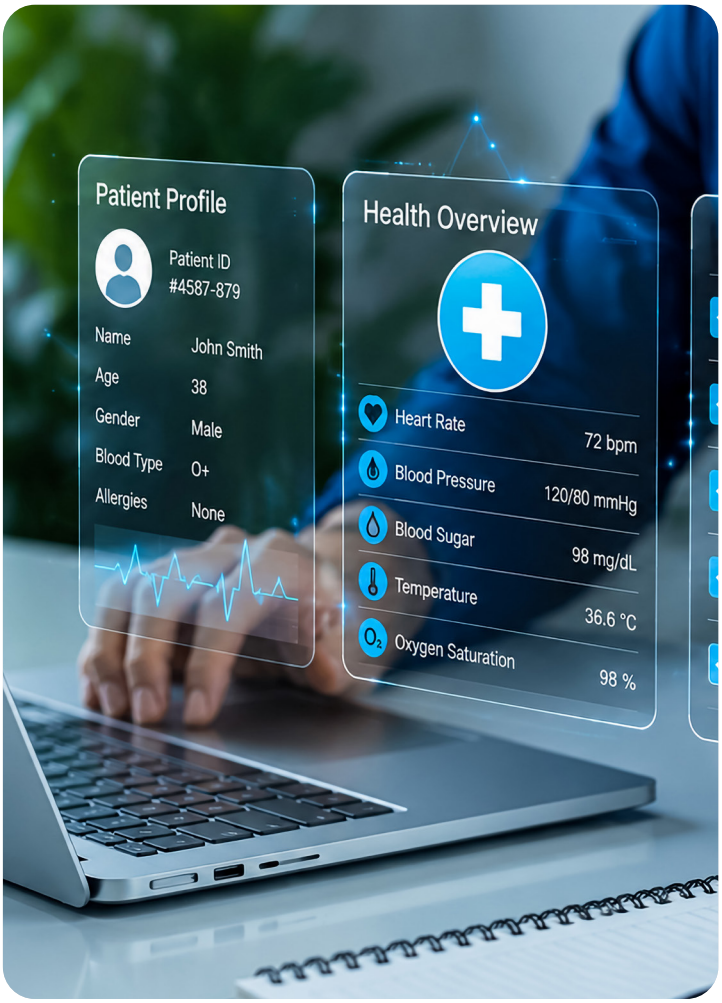
Utilization Management Department
Ultimate Health Plans

ULTIMATE HEALTH PLANS

Coverage Decisions, Appeals, and Complaints

Members and providers can learn about the processes for Coverage Decisions, Appeals, and Complaints by reading the following sections of Ultimate's Evidence of Coverage (EOC) or by reaching out to us. A copy of each plan's Evidence of Coverage is available online at www.ChoosUltimate.com/MemberDocumentsandForms. You may also call Provider Services at 1-888-657-4171 for additional information.

- Situations in Which You Should Ask Us to Pay Our Share of the Cost of Your Covered Services or Drugs (EOC Chapter 7, Section 1)
- How to Make a Complaint (EOC Chapter 9, Section 10)
- A Guide to Coverage Decisions and Appeals (EOC Chapter 9, Section 4)
- Independent Review Entity Step-by-Step: How a Level 2 Appeal is Done (EOC Chapter 9, Section 5.4)



Understanding Our Members' Benefits

Knowing the benefits available to our members is important. You can refer to the following sections of Ultimate's Evidence of Coverage (EOC) to learn about them in detail. A copy of each plan's Evidence of Coverage is available online at www.ChooseUltimate.com/Member/DocumentsandForms. You may also call Provider Services at 1-888-657-4171 for additional information.

- The Medical Benefits Chart shows your Medical Benefits and Costs *(EOC Chapter 4, Section 2)*
- Services that aren't Covered by our Plan - Exclusions *(EOC Chapter 4, Section 3)*
- Drugs with Restrictions on Coverage *(EOC Chapter 5, Section 4)*

ULTIMATE HEALTH PLANS

Member Rights and Responsibilities

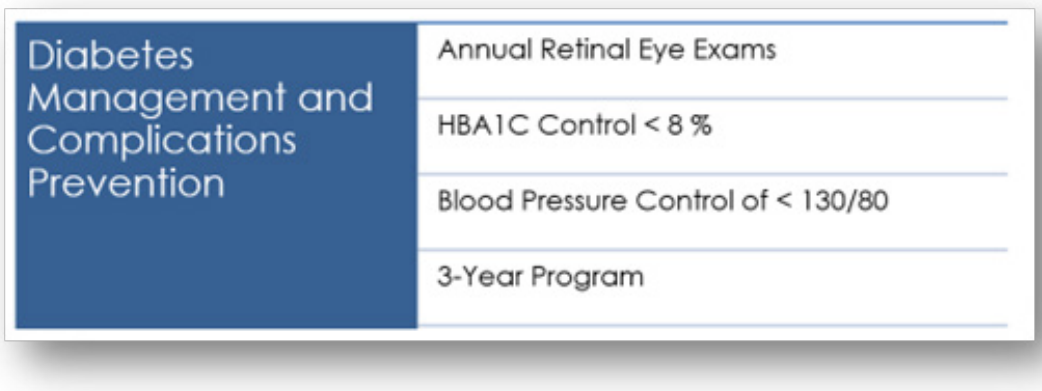
Ultimate Health Plans honors our members' rights. They have the following rights to help protect themselves:

- We must treat them with fairness, respect, and dignity at all times
- We must ensure that they get timely access to your covered services and drugs
- We must protect the privacy of their personal health information

For a full list of Member Rights and Responsibilities, please visit our website at www.ChooseUltimate.com/Member/RightsAndResponsibilities or call Provider Services at 1-888-657-4171 to request we mail you a copy.

Ultimate Health Plan's Chronic Care Improvement Program (CCIP)

Ultimate Health Plans is in the second year of its three-year Chronic Care Improvement Program (CCIP), a strategic initiative focused on improving health outcomes for members living with diabetes. Led through the collaboration of our Care Management and Quality teams, the program promotes evidence-based chronic disease management, emphasizes preventive care, and supports improved clinical outcomes. The CCIP is designed in alignment with the Centers for Medicare & Medicaid Services (CMS) requirements and quality improvement priorities.



Diabetes affects an estimated 38.4 million people in the United States, representing approximately 11 percent of the population. More than 97 million adults are also living with prediabetes, placing them at increased risk of developing diabetes (CDC, 2025). As the prevalence of diabetes continues to grow, Ultimate Health Plans remain committed to improving the health of our members through our Chronic Care Improvement Program (CCIP). The program focuses on evidence-based interventions that promote annual **diabetic retinal eye exams**, improved **hemoglobin A1C control**, and **effective blood pressure management** to help reduce complications and improve long term health outcomes.

The success of our Chronic Care Improvement Program (CCIP) depends on strong collaboration with our provider partners. We encourage you to continue reinforcing the importance of annual diabetic retinal eye exams, routine hemoglobin A1C monitoring, and blood pressure control during every appropriate member interaction. Your recommendations, patient education, timely documentation, and follow-up care play a critical role in helping members achieve better health outcomes while supporting high-quality, evidence-based care. Together, we can reduce preventable complications, improve quality of life for our members living with diabetes, and advance our shared commitment to delivering exceptional care.

ULTIMATE HEALTH PLANS

Consider Complex Case Management

We have a team of nurses within the Care Management department with the skill and expertise to help your patients navigate their diabetes diagnosis.

If your patients are struggling with HbA1c control, consider Complex Case Management.

In Case Management, we can provide the additional support and education patients may need to gain a clearer understanding of their diagnosis.

For more information about Ultimate Health Plan's CCIP or to enroll a member in Complex Case Management, please reach out to us at 1-866-967-3430. We look forward to assisting our members with these focused interventions

References

CDC. (2025, 5 27). Diabetes. Retrieved from CDC: https://www.cdc.gov/diabetes/php/data-research/index.html?utm_source=chatgpt.com

HIV Prep Medications:

HIV pre-exposure prophylaxis (PrEP) medications were previously covered under Medicare Part D and were generally subject to applicable deductibles and beneficiary cost-sharing, including coinsurance or copayments. Coverage for HIV PrEP medications has since transitioned to Medicare Part B. As a result, Medicare beneficiaries have no Part B cost-sharing obligations for covered PrEP drugs, including no deductible or copayment.

Antiretroviral medications used for the treatment of HIV infection continue to be covered under Medicare Part D, even when the same medications are also approved for use as HIV PrEP. To ensure accurate claim adjudication and payment, pharmacy claims must include the appropriate diagnosis code to distinguish whether the medication is being dispensed for HIV treatment or HIV PrEP.

Until planned system enhancements are implemented (currently expected in 2027), HIV PrEP pharmacy claims that require an override during adjudication will require the dispensing pharmacy to contact the appropriate support line 800-311-7517 at the time of claim submission to obtain the necessary override and ensure correct processing under Medicare Part B.

ULTIMATE HEALTH PLANS

Updated Mail Order Opportunity Reporting Available

Ultimate Health Plans has updated our 30-Days' Supply to 90-Days' Supply Conversion Opportunity reporting that is provided to you. Previously, the report was designed to query the adherence drugs being filled for 30-day supplies that have the potential opportunity to be converted from a 30-day supply to a 90-day supply. Now the reporting will help identify all the mail order opportunities available for your patients.

It is recommended that this list be reviewed on a monthly basis to capture all potential opportunities as they become available.

Key Messages

- Be on the lookout for a more comprehensive mail order opportunity report each month
- Providers are encouraged to review the reporting for affected patients and transition prescriptions to 90-day supplies and submit to the member's mail order benefit.
- Updating prescriptions to the mail order benefit will help increase compliance with medications providing a cost benefit for select medications.
- Adherence medications will still be flagged but the report will now be more encompassing

Submit 90-Day Prescriptions to Optum Home Delivery (ePrescribe):

Optum Home Delivery
6800 W 115th St., Ste. 600
Overland Park, KS 66211
NCPDP ID: 1718634
OR:
Fax 1-800-491-7997 / Call Physician's line: 1-800-791-7658

Formulary Adherence

At Ultimate, we know it can be difficult to recall which members are on specific plans and which products are preferred for one plan over another. We have created a resource to help you with this uncertainty by providing our preferred and often lower cost alternatives based on our formularies. This is beneficial not only for our members but also may benefit you as well.

Benefits of Formulary Adherence and Increasing Generic Utilization

- Cost Savings
- Improved Medication Access
- Enhanced Patient Outcomes
- Streamlined Coordination

ULTIMATE HEALTH PLANS

For members, decreasing member costs can be a factor in helping adherence with the prescribed regimen. Try to prioritize prescribing medications on lower tiers when appropriate. For providers, the use of formulary medications can help decrease overall financial burden of not only the medication but also administrative costs with decreased coverage determination requests.

The Generic Dispense Rate (GDR) is a key metric prescribers can track to identify how many generic medications are prescribed to members. Reviewing this metric and striving to increase your practice's GDR directly impacts cost savings, accessibility, medication adherence, and quality of care.

What Providers Should Do

- Proactively prescribe patients to lower cost alternatives
- Reassess current therapy for members utilizing non-formulary or higher cost alternatives
- The alternatives list can be reviewed
    - ◊ During routine office visits
    - ◊ With prescription renewals
    - ◊ When members call in with questions or concerns

Additional Information

In addition to the high-level alternatives list, you can also request specific alternatives unique to your population of members. Ask your Provider Relations representative for more information to ensure you are getting tailored alternatives reporting as well.

PreCheck Prior Authorization

PreCheck Prior Authorization simplifies the prior authorization (PA) submission and approval process for select medications by automating the clinical review process while maintaining strong safety and efficacy standards. The solution reduces administrative burden for providers, accelerates patient access to medications, and improves overall workflow efficiency.

Currently, PreCheck Prior Authorization supports automation for more than 45 medications, including therapies for:

- Glucagon-like peptide-1 (GLP-1) agonists for diabetes
- Attention-deficit/hyperactivity disorder (ADHD)
- Irritable bowel syndrome (IBS)
- Asthma
- Dry eye disease

The solution integrates with providers' electronic medical records (EMRs) to retrieve relevant clinical information, automatically populate prior authorization requirements, validate eligibility against clinical criteria, and issue an approval when all clinical requirements are met. Optum Rx and Surescripts continue to expand the solution by adding additional health systems and medication classes.

Measurable Impact

Automation has significantly reduced the time required to complete prior authorization requests, enabling faster patient access to prescribed medications.

For GLP-1 medications used to treat diabetes:

- Submission time decreased from 15–20 minutes to approximately 30 seconds.
- Prior authorization criteria are evaluated in ap proximately 29 seconds, allowing patients to receive paid claims more quickly.

Benefits

For Patients

- Faster prior authorization decisions.
- Quicker access to prescribed medications.
- Reduced delays in initiating therapy.

For Providers

- Automated retrieval of relevant clinical information directly from the EMR.
- Automatic completion and validation of prior authorization requirements.
- Reduced administrative workload, allowing clinicians and staff to spend more time focused on patient care.
- Fewer denials, appeals, and manual follow-up activities.

Transition to PreCheck Prior Authorization

If your organization currently does not use Surescripts for electronic prior authorizations, consider transitioning to take advantage of its automated clinical review capabilities. By reducing manual data entry and accelerating approvals, PreCheck can improve operational efficiency while enhancing the provider and patient experience.

While CoverMyMeds remains available for prior authorization submissions, it does not currently offer the automated PreCheck capabilities. Organizations seeking greater automation, faster approval times, and reduced administrative burden may benefit from adopting Surescripts for electronic prior authorizations.

Get started: surescripts.com/priorauthportal

Provider Relations Representative of the Quarter – Q2 2026

Congratulations, Maggie Carbonell!

Please join us in congratulating **Maggie Carbonell,** our **Q2 Provider Relations Representative of the Quarter!**

Maggie exemplifies what it means to be a trusted partner to our providers. Her dedication, professionalism, and unwavering commitment to delivering exceptional service have made a lasting impact on the providers, office staff, and members she supports. She consistently goes above and beyond to foster strong relationships, resolve challenges, and ensure our provider network has the tools and support needed to deliver outstanding care.

When asked what she enjoys most about working in Provider Relations, Maggie shared that **no two days are ever the same.** She thrives on the new opportunities each day brings and values the collaborative culture of the Provider Relations team.

"Everyone is committed to supporting one another, sharing knowledge, and working together, which I find very rewarding to be a part of this great team."

For Maggie, the most rewarding part of her role is building meaningful relationships with providers and serving as a reliable resource they can depend on.

"When providers receive support, clear communication, and effective problem resolution, they can focus on what matters most—caring for patients. Knowing my efforts help support a strong network and improve provider satisfaction motivates me to go the extra mile."

Get to Know Maggie

Favorite Food: Anything and everything with carbs! Her top choice? Spaghetti Carbonara.

Favorite TV Show: *Friends*

Dream Vacation Destination: Italy—because who can resist the food, scenery, and culture?

Outside of Work: Maggie enjoys spending quality time with her husband and daughter, traveling, and attending musical theater performances.

A Message from Maggie

"To the offices I support, I want to express my sincere appreciation for your dedication, engagement, and commitment to the members you serve every day. Your efforts—whether through direct patient care, coordinating services, or managing administrative tasks—make a meaningful difference in the lives of our members and their families.

Your commitment to delivering high-quality, compassionate care does not go unnoticed and is truly valued. Thank you for your hard work, dedication, and continued partnership. I look forward to strengthening our collaboration as we continue working together toward excellence and achieving our 5-Star goals!"

Congratulations again, **Maggie**, and thank you for your outstanding commitment to our providers, our members, and the entire UHP team. Your passion, positivity, and dedication truly make a difference every day!

ULTIMATE
HEALTH PLANS
Good health is where you live.

CONTACT US

BY PHONE:
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