



Exhibit A: Opt-Out Process

UCare Medicare MTM Program (MTMP) Targeted beneficiaries are enrolled using an opt-out method only as required in §423.153(d)(1)(v). Patients may refuse or decline individual services without having to disenroll from the MTM program, or they may choose to opt out of the program in its entirety. Opt-out decisions can only be made by the patient. Refusing an individual service for any reason or lack of responsiveness does not automatically disenroll the patient from future MTM services. Definitions are as follows:

| | Definition |
|--------------------|---|
| Decline CMR | Patient declines a CMR but allows TMRs. The patient remains enrolled in the MTM program. |
| Opt Out | Patient declines both a CMR and TMR and opts out of the MTMP for the remainder of the contract year. The member can still re-enroll in the MTM program if they wish in the future |

A decision to “opt-out” must be documented and reported to Ucare as detailed in this Amendment within 30 days of the member’s decision. Members who “Decline CMR” do not need to be reported. The following parameters should be sent securely via email to pharmacyliaison@ucare.org, or through an alternatively agreed upon process (SFTP).

- Member ID Number
- Member First Name
- Member Last Name
- Date of Birth
- Opt-Out Date
- Opt-Out Reason

Example Scripting:

MTM Program Explanation: Medicare recommends a visit with a pharmacist to review your medications each year. This is called a comprehensive medication review (CMR). This is included with your Ucare Medicare Part D insurance at no cost to you. The pharmacist will review how your medications work and what you are taking them for. They will also make sure your medicines are safe and affordable for you, working well, and answer any questions that you have. After the visit, the pharmacist will mail you a personalized medication list and medication action plan that you can keep for your records. Additionally, the pharmacist may contact your doctor periodically if any medication-related concerns are identified. This is called a targeted medication review (TMR). I can help get you scheduled with one of our pharmacists. What time of the day would be best for you?

- If member responds No to CMR: remind them of purpose, benefits, and annual recommendation. If they are still not interested let them know they can call back at any time during the year if they change their mind. Then, offer the automated TMRs (as described above).
- If member responds Yes to TMR: TMRs will be completed throughout the remainder of the year. The member can still receive a CMR if they wish at a later date. **Document in the medical record that the member “Declined CMR”.**
- If member responds No to CMR and TMR: Inform the member that they will not be contacted during the rest of the year and their doctor will not receive automated outreach (TMRs). **Document in the medical record “Opt Out*”.** Inform the member that they may be re-eligible for the service each year and that they can choose to opt back in at any point if they change their mind.



*In rare instances, a member may wish to opt out of CMRs and TMRs permanently for future years. In these cases, document as "Permanently Opt Out" and submit information to UCare as described above. The member can still re-enroll in the MTM program if they wish in the future. UCare discourages offering permanent opt outs and they should be an exception to usual workflow.



Exhibit B –File Format Submission

Providers are required to maintain and submit a continuity of care document (CCD) for all Medicare visits. Providers shall abide by the CCD file format in accordance with CMS rules and standards. The CCD file must be submitted to UCare within 45 days of the original visit.

Continuity of Care Document

Specifications/Input:

File Type: .txt

Delimiter: "|" (pipe)

Header: N/A

| Field Number | Field Name | Format | Description | Required? |
|--------------|----------------|------------|---|-----------|
| 1 | Patient ID | ##### | UCare's patient ID number | Y |
| 2 | First Name | Char Text | The First Name of the patient that is associated with the record | Y |
| 3 | Last Name | Char Text | The Last Name of the patient that is associated with the record | Y |
| 4 | Birth Date | MM/DD/YYYY | The DOB of the patient that is associated with the record | Y |
| 5 | Pharmacist NPI | ##### | Type 1 NPI of Pharmacist that provided MTM service | Y |
| 6 | Record Type | ### | A three digit number used to describe the type of record being transmitted (see Code Set – Record Type) | Y |



Record Type

| Record Code | Record Type | Description |
|-------------|-------------------------|--|
| 001 | Lab | Patient's Lab and Lab Result Information |
| 002 | Prescriber Intervention | Count of Physician Outreaches and Drug Therapy Problems Identified |
| 003 | Assessment | Assessment information |
| 004 | Smoking History | Patient's smoking history |
| 005 | Blood Pressure | Patient Blood pressure |

File Specification – Lab Segment (001): Note – Lab segments are not required segments, however, all available lab data that indicates drug indication, efficacy, and safety should have the most recent values (as of the date that the CCD is created)

| Field Number | Field Name | Format | Description | Required? |
|--------------|------------|------------|--|----------------------------|
| 7 | Date | MM/DD/YYYY | The date of the Lab that was completed | Y – if lab segment is sent |
| 8 | Lab Type | ## | The Lab type completed See below table (* Lab Types) (EX. 1 = total cholesterol) | Y – if lab segment is sent |
| 9 | Lab Value | | The Value of the lab completed See below table (* Lab Types) (EX. 1 = total cholesterol= mg/dl) | Y – if lab segment is sent |



* Lab Types

| Corresponding Lab Type # | Lab Type | Value |
|--------------------------|-----------------------------------|--------|
| 1 | Total Cholesterol (TC) | mg/dl |
| 2 | HDL | mg/dl |
| 3 | LDL | mg/dl |
| 4 | TG(triglycerides) | mg/dl |
| 5 | HbA1c | % |
| 6 | Hgb (hemoglobin) | g/dl |
| 7 | SCr (Creatinine) | mg/dl |
| 8 | AST | IU/L |
| 9 | ALT | IU/L |
| 10 | Alk (Alkaline Phos.) | U/L |
| 11 | Phosphorus (Phos) | mg/dl |
| 12 | Thyroid Stimulating Hormone (TSH) | mIU/ml |

File Specification – Prescriber Intervention Segment (002): This is a required segment

| Field Number | Field Name | Format | Description | Required? |
|--------------|---|------------|---|-----------|
| 7 | Date | MM/DD/YYYY | Date the recommendation was made | Y |
| 8 | # of Medication Therapy Problems identified | ## | Number of Medication Therapy Problems identified by provider on specified date | Y |
| 9 | # of Medication Therapy Problem Resolutions | ## | Number of medication therapy problem resolutions (from 1 day after last assessment in the present calendar year through day that # of drug therapy problem resolutions is recorded) | Y |



File Specification – Assessment Segment (003): This is a required segment

| Field Number | Field Name | Format | Description | Required? |
|--------------|----------------------------------|------------|--|---|
| 7 | Date | MM/DD/YYYY | Date of assessment/visit | Y |
| 8 | Recipient of assessment | ## | 01- Beneficiary 02- Beneficiary's Prescriber 03- Caregiver 04- Other | Y |
| 9 | Method of Delivery of assessment | ## | 01- In-Person 02- Synchronous Telehealth- telephone 03- Synchronous Telehealth- video conferencing 04- Other real time method | Y |
| 10 | Cognitive Status | Y, N, U | Patient cognitively impaired? Y = Yes N = No U = Unknown | Y If N: Recipient of assessment must be 01- Beneficiary If U: Recipient of assessment must be 01- Beneficiary |



| | | | | |
|----|---|------------|--|---|
| 11 | CMS Standardized summary | MM/DD/YYYY | Date CMS standardized summary delivered | N – only required if patient has Medicare insurance AND received CMS Standardized summary; May be left blank for TMR services |
| 12 | Is the patient in a nursing home at the time of the visit? | Y, N, U | Y = Yes N = No U = Unknown | N - optional |
| 13 | Service Location NPI | ##### | NPI of the service location in which the provider completed the visit | N - optional |

File Specification – Tobacco Use History Segment (004): Not a required segment. If sending tobacco use history segment, please send the most recent assessment date as of the date the CCD record is created. If no tobacco use assessment exists, no tobacco use history segment should be sent.

| Field Number | Field Name | Format | Description | Required? |
|--------------|--------------------------|------------|--|-----------|
| 7 | Date | MM/DD/YYYY | Date tobacco status assessed | Y |
| 8 | Current Tobacco User? | Y, N, U | States if patient is a current smoker or smokeless tobacco user Y = Yes N = No U = Unknown | Y |

File Specification – Blood Pressure Segment (005): Not a required segment. If sending a blood pressure value, please send the most recent blood pressure on record as of the date the CCD record was created. If no blood pressure value exists, no blood pressure segment should be sent.



| Field Number | Field Name | Format | Description | Required? |
|--------------|-----------------------------|-------------------------------------|--|--|
| 7 | Date | MM/DD/YYYY | Date of blood pressure Reading | Y |
| 8 | Systolic | ### (max 3 digits, 2 digits ok) | Measure of blood pressure when heart is beating - Top number of blood pressure | N- required if field 10 not populated |
| 9 | Diastolic | ### (max 3 digits, 2 digits ok) | Measure of blood pressure when heart is relaxed – bottom number of blood pressure | N – required if field 10 not populated |
| 10 | Systolic/Diastolic combined | ###/### (max 3 digits, 2 digits ok) | Alternative reporting of BP if can't report as a separate systolic and diastolic value | N – required if fields 8 and 9 not populated |