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November 2024

Medica | MEDICA CONNECTIONS

NEWS FOR MEDICA NETWORK PROVIDERS

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General News

Effective January 1, 2025:

Medica makes IFB product, benefit changes for next year

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica has finalized its offering for Individual and Family Business (IFB) plans next year. Here are Medica's IFB service area and benefit updates for 2025.

Changes to 2025 product and plan offerings

- **In Nebraska:** The Elevate by Medica℠ product is expanding into 10 additional counties for 2025: Adams, Buffalo, Clay, Fillmore, Hall, Hamilton, Kearney, Saline, Seward and York.
- **In North Dakota:** The Essentia Choice Care with Medica℠ product is expanding into Burleigh county for 2025.
- **In Arizona:** The Medica Pinnacle℠ product will no longer be offered for 2025. Medica is exiting Arizona for 2025.
- **In Iowa:** The Empower by Medica℠ product will no longer be offered for 2025. Members will be enrolled in the Medica InsureSM product.
- **In Kansas:** The Medica Connect℠ product will no longer be offered for 2025.

Benefit changes for 2025

- Aligning formularies for standard and non-standard plans
  - Combining generic tiers into one single generic prescription drug tier and removing "Preferred Generic" tier
- Introducing "+ Adult Eye Exam" plan designs for Medica with CHI Health℠ in Iowa (continuing in Nebraska) and Harmony by Medica℠ in Oklahoma
- Making the following updates to diabetes cost-sharing:
  - $0 cost-sharing for diabetes education (excludes Health Savings Accounts, or HSAs, and catastrophic plan offerings) and $0 for preferred diabetes supplies
  - Continuous glucose monitors (CGMs) will *only be covered* under the pharmacy benefit (see below for additional details)
  - Monthly insulin cap of $35 for the following states: Iowa, Kansas, Missouri, Nebraska and Wisconsin
  - Monthly insulin cap of $30 in Oklahoma
  - Monthly insulin cap of $25 in Minnesota and North Dakota
- Launching new Medica Easy Compare standard plan offerings in Minnesota

In addition, **see a list of continued IFB plan offerings for 2025** across Medica's 8-state IFB service area.

Fact sheets for these products will be updated soon with 2025 changes.

Effective January 1, 2025:

Medica makes MHCP product, benefit changes for 2025

(This applies to Medica direct-contracted providers in Minnesota.)

Medica is making changes to its existing Minnesota Health Care Programs (MHCP) plan benefits for next year.

SNBC

The Medica AccessAbility Solution® Enhanced (Integrated Special Needs BasicCare, or I-SNBC) product, featuring integrated Medicare and Medical Assistance services, has no change to the current 38-county service area in 2025 and remains aligned with the Medica AccessAbility Solution SNBC product that features Medical Assistance-only

services. Medica AccessAbility Solution Enhanced is not a 2025 participant in the Centers for Medicare and Medicaid Services (CMS) Value-Based Insurance Design (VBID) Model; this means members will no longer be eligible for the healthy foods allowance of $20/month starting in January 2025. Additionally, these members will again be responsible for Part D prescription drug cost-sharing based on their low-income subsidy (LIS) level. These members continue to have $0 cost-sharing for all other covered services in 2025.

Finally, Medica AccessAbility Solution Enhanced members will no longer have access to the One Pass fitness benefit in 2025, to include $0 rides to a participating One Pass fitness location. Medica will replace that 2024 fitness benefit with a new monthly allowance using their existing Healthy Savings card: $40/month that can be used to pay for eligible fitness expenses, to include sporting equipment, fitness accessories, and for a membership at any eligible fitness center/gym, as well as for eligible over-the-counter (OTC) items from a participating retailer. Since this $40/month allowance can be used for eligible OTC items, to include oral health toothbrushes and flossers, Medica will discontinue the 2024 oral health toothbrush kit benefit. Medica also newly offers these members in 2025 a personalized Reemo smartwatch that tracks steps and heart rate for them to view their health data and trends.

MSHO

The Medica DUAL Solution® (Minnesota Senior Health Options, or MSHO) product has no change to its current 50-county service area in 2025. Medica DUAL Solution continues as a 2025 participant in the CMS VBID Model with the following Healthy Savings benefits: $110/month allowance that can be used to purchase healthy foods from a participating retailer or pay for utility bills from an eligible utility company, in any combination; $60/month allowance for eligible OTC items and fitness expenses that include sporting equipment, fitness accessories, and expenses at eligible fitness centers. Medica will no longer offer up to one round trip per day to an approved Healthy Foods grocery location or the annual subscription to online courses that teach daily life skills.

Medica DUAL Solution continues to waive Part D cost-sharing for all members in 2025. This means that members in this product continue to have $0 cost-sharing for all covered services next year. In 2025, Medica DUAL Solution will no longer offer any Special Supplemental Benefits for the Chronically Ill (SSBCI): the 2024 telemonitoring kit and the FOODRx food box program will not be covered next year.

Families & Children

The Medica Choice Care℠ PMAP (Prepaid Medical Assistance Program) and Medica MinnesotaCare products have no change to the current 19-county service area in 2025. Medica will continue these plans' current additional services that include One Pass $0 fitness center memberships (with premium fitness partners Life Time and YMCA) and subscriptions to GEDWorks, for eligible members to obtain their high school equivalency diploma.

Fact sheets reflecting 2025 changes for these products **will soon be available on Medica.com**.

Availity update:

Claim inquiry + status functionality now live on Availity portal

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Claim inquiry and enhanced claim status functionality can now be accessed through the Availity Essentials portal. This latest functionality is available from Availity along with eligibility and benefits member data (HIPAA transactions 270/271).

As a reminder, Availity Essentials is Medica's preferred provider portal for Health Insurance Portability and Accountability Act (HIPAA) electronic data interchange (EDI) functionality. Transactions continue to migrate from Medica's secure portal to Availity. Future functionality will include prior authorizations, appeals, referrals and more. Watch for details as these become available with Availity. Providers who already use Availity Essentials should see Medica lines of business displayed as payer drop-down options to select for transactions once they're available from Availity.

For more information
To get started with Availity or learn more about Medica's transition to Availity, **visit Availity's Medica microsite**. Or see the **Availity Learning Center** for trainings on Essentials transactions. Still have questions? Contact Availity Client Services at 1 (800) 282-4548 for help with provisioning questions, transaction troubleshooting, interpreting response messages, and more.

(Update to "Eligibility, benefits functionality now live on Availity portal" article in **April 2024 edition of *Medica Connections***.)

Effective January 1, 2025:

CGM coverage changes: For most members, pharmacy benefit + prior authorization will apply

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica is making a coverage change to continuous glucose monitors (CGMs) and CGM supplies for commercial plan members and Individual and Family Business (IFB) members beginning January 1, 2025. These members will need to purchase CGMs and CGM supplies at a network pharmacy, rather than through durable medical equipment (DME) providers, for coverage. Medica's preferred CGMs and supplies are Dexcom and Freestyle products. *Claims for these products will be denied if these items are received from a DME provider* beginning on January 1, 2025, for a commercial or IFB member.

This change will apply to commercial and IFB members only. This benefit change will *not* apply to insulin pumps and supplies for insulin pumps, which members can continue to purchase from DME vendors.

CGMs will require prior authorization for coverage
Starting January 1, 2025, continuous glucose monitors (CGMs) will require prior authorization for most Medica members, in most situations. Submit a prior authorization request before prescribing a CGM. This step is necessary to secure coverage and avoid any delays in the patient receiving the device. It is advisable to initiate this process well in advance of the member's anticipated need. Prior authorization will *not* be needed for members currently utilizing insulin therapy.

This prior authorization change will be effective for Medica commercial and IFB members as of January 1, 2025.

Medicare CGM coverage
For Medicare Advantage and Medicare Cost plan members, CGMs and supplies will be available at a $0 out-of-pocket cost when they buy them from a network retail pharmacy, or a 20% coinsurance if they choose to purchase CGMs and supplies through a DME provider. The pharmacy-only benefit change will also *not* apply to insulin pumps or supplies for insulin pumps, as members can continue to purchase them from DME vendors. For Medica Medicare Advantage and Dual Eligible Special Needs Plan (D-SNP) members, prior authorization will be required for coverage

determinations for CGMs obtained through a medical supplier. However, if these members obtain their CGM through a pharmacy and are currently using insulin therapy, prior authorization will *not* be needed.

Effective January 1, 2025:

For services requiring prior authorization, post-service reviews will need to be submitted within 10 days

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Effective beginning with January 1, 2025, dates of service, providers will no longer have 60 days post-service to submit for a medical necessity review — *Providers will have 10 days post-service to submit medical necessity reviews*. Because Medica's authorization policy is based on a provider obtaining written authorization approval prior to services being rendered, post-service authorizations are only considered for coverage in limited and specific circumstances.

Medica requires providers to obtain prior authorization *before rendering* any services that are outlined on **Medica's prior authorization lists**. Network providers are responsible for submitting authorization requests to Medica. **Learn more** in the Medica Provider Administrative Manual.

Annual reminder:

Compliance, FWA trainings required for Medicare providers

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Each year, Medica requires that Medicare providers complete general compliance training and fraud, waste, and abuse (FWA) training. The training requirement applies to all organizations that provide health care services or administrative services for Medicare beneficiaries, and also applies to the organizations' downstream and related entities. Although Medicare certified (or deemed) providers are exempt from the FWA portion of the training, they are still required to complete general compliance training. *The trainings should be completed by December 31, 2024*.

Medica makes the Medica Standards of Conduct, Compliance Reporting Policy, and links to the Centers for Medicare and Medicaid Services (CMS) general compliance training and FWA training available on Medica.com. Providers may use the general compliance and FWA training materials created by CMS. **Learn more and take the trainings**.

As a reminder, training is required at the time of a Medicare provider's initial contract and then annually thereafter. Providers should maintain records of all training for 10 years. Records should include dates and methods of training, materials used for training, and training logs identifying employees who received training. Medica may request such records to verify that training occurred.

DHS requests input from MHCP providers

(This applies to Medica direct-contracted providers in Minnesota.)

The Minnesota Department of Human Services (DHS) is requesting feedback from Minnesota Health Care Programs (MHCP) providers about the tools and platforms DHS makes available to providers: **Take the MHCP Provider Survey**. DHS wants to hear what works well, what needs improvement, and what else DHS should consider when working with providers to accomplish shared goals.

Clinical News

Effective December 16, 2024:

Medical policies and clinical guidelines to be updated

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon update one or more utilization management (UM) policies, coverage policies and clinical guidelines. These upcoming policy changes will be effective December 16, 2024, unless otherwise noted.

Monthly update notifications for Medica's UM policies, coverage policies and clinical guidelines are available on an ongoing basis. **Update notifications are posted on Medica.com** at least 60 days prior to their effective date. The medical policy update notification for changes effective December 16, 2024, is already posted. Changes to policies are effective as of that date unless otherwise noted. ("Medical policy updates" notifications are available at Medica.com under For Providers, "Policies and Guidelines," then "Updates to Medical Policies.")

The medical policies themselves will be available online or as a hard copy:

- **View medical policies and clinical guidelines at Medica.com** as of their effective date; or
- Call the Medica Provider Literature Request Line for printed copies of documents, toll-free at 1 (800) 458-5512, option 1, then option 8, ext. 2-2355.

These policies apply to all Medica products including commercial, government, and individual and family plan (IFB) products unless other requirements apply due to state or federal mandated coverage, for example, or coverage criteria from the Centers for Medicare and Medicaid Services (CMS).

Note: The next policy update notification will be posted in November 2024 for policies that will be changing effective March 1, 2025. These upcoming policy changes will be effective as of March 1 unless otherwise noted. The affected policies will then be available as noted above.

Upcoming outreach:

Medica undertakes annual ACA chart review for coding integrity

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Each year, Medica undertakes medical record reviews for various types of members, and in November 2024 plans to begin reaching out to provider offices regarding Affordable Care Act (ACA) 2024 dates of service for office visits and hospital admissions by Medica commercial small group and Individual and Family Business (IFB) members. Medica is committed to improving the quality of care provided to our members and is required by the U.S. Department of Health and Human Services (HHS) to submit complete diagnostic data regarding members enrolled in certain ACA-covered health plans.

On Medica's behalf, Optum and Datavant are conducting the medical record reviews, coordinating record retrieval and reviewing clinical coding. Datavant representatives will contact providers directly to provide retrieval options and a list of the requested member records for services they received in calendar year 2024. Patient records being requested

include medical records, notes and reports. This outreach is expected to begin by late November 2024. Chart collection *must be completed by March 2025*.

This industry-standard commercial chart retrieval request is intended to identify any gaps in coding that are supported in the documentation. Reviewing medical chart documentation will enable Medica to identify conditions that may exist for plan members, but may not have been coded or previously captured. This enables the health plan to assess the health conditions of their members for effective care interventions and to improve health outcomes.

Providers who have questions may contact Datavant at 1 (877) 445-9293 or **chartreview@Datavant.com**.

Pharmacy News

Effective January 1, 2025:

Medica plans to update commercial, IFB member formularies

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica is reviewing several medications and will be making changes in coverage status to drug formularies (drug lists) effective January 1, 2025. These upcoming changes apply to the following drug formularies:

- 2025 Medica Commercial Drug List
- 2025 Medica Commercial Preventive Drug List
- 2025 Medica Individual and Family Business (IFB) Drug Lists

(**Drug lists are available at Medica.com** under For Providers, “Pharmacy,” then respective member types under “Pharmacy Resources by Segment.”)

Effective December 1, 2024:

Medica to soon update MHCP member drug list

(This applies to Medica direct-contracted providers in Minnesota.)

Medica will be making upcoming changes in coverage status to the 2024 Medica List of Covered Drugs for Minnesota Health Care Programs (MHCP), effective December 1, 2024. Any such changes are determined by the Minnesota Department of Human Services (DHS) since Medica follows the DHS drug list. As with all Minnesota managed care organizations (MCOs) that follow the DHS drug list for MHCP patients, DHS provides Medica with advanced notice of changes to the drug list, which Medica posts as soon as possible to Medica.com.

The Medica MHCP drug list applies to the following products: Medica Choice Care℠ (for Minnesota Senior Care Plus program, or MSC+), Medica AccessAbility Solution® (for Special Needs Basic Care program, or SNBC), Medica Choice Care PMAP, Medica MinnesotaCare, and both Medica DUAL Solution® (for Minnesota Senior Health Options program, or MSHO) and Medica AccessAbility Solution Enhanced, for non-Part D drugs. Any changes will *not* apply to Medica Medicare Part D drug formularies.

Effective January 1, 2025:

Medica to add 2 new drug UM policies for Mayo Medical Plan

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica will soon implement the following new medical pharmacy drug utilization management (UM) policies for Mayo Medical Plan members. These changes will be effective with January 1, 2025, dates of service. Prior authorization will be required for the corresponding medical pharmacy drugs.

Medical pharmacy drug UM policies — New
Prior authorization will be required.

Drug code	Drug brand name	Drug generic name
J0175	Kisunla	adonanemab-azbt
J9999	Rytelo	imetelstat

The new medical pharmacy drug UM policies above for Mayo Medical Plan members will be available online or on hard copy:

- **View drug management policies** as of January 1; or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Note: Magellan Rx Management has a new name. Magellan has rebranded as Prime Therapeutics Management, which is reflected on their website and on Medica's policies for medical pharmacy drugs.

Effective January 1, 2025:

Rawlings COB program to expand post-payment claim review to medications

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Previously, Medica announced its partnership with the Rawlings Group for medical claim overpayment related to coordination of benefits (COB), focusing on post-payment medical claim review. Beginning November 1, 2024, Rawlings will also work with Express Scripts, Medica's pharmacy benefit manager (PBM), to identify claim overpayments related to COB, focusing on post-payment pharmacy claim review. Members will be notified and educated on use of their primary insurance if other insurance is identified in the post-payment claim review process.

(Update to "New vendor to handle COB, post-payment claim reviews" article in **December 2022 edition** of *Medica Connections.)*

Effective January 1, 2025:

New prescription payment plan for Medica Medicare Part D

members

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medicare plans, including Medica, will be rolling out a Medicare Prescription Payment Plan (or "M3P"), to begin January 1, 2025, as required by the Inflation Reduction Act of 2022. This new program will be available to our Medicare Advantage members with Part D coverage. It will allow them to spread out their out-of-pocket costs for prescription medications throughout the plan year, during which they'll make monthly payments. The members won't pay anything at the point of service, but they will need to pay off the entire amount by January of the following plan year.

Medicare members can elect to join this M3P program at any time as long as they have enrolled in a Part D drug plan. The members who would most likely benefit are those who have a single copay of $600 or more for a prescription, or those who will reach a maximum out-of-pocket (MOOP) limit of $2,000 by August of a plan year. For these members, M3P may reduce their monthly costs by spreading them over the remainder of the plan year.

The M3P payment option might help members manage monthly expenses, *but it won't save them money or lower their out-of-pocket costs*. It may not be beneficial to all members. Even though they won't pay for the drugs at the pharmacy, members will still be responsible for all out-of-pocket costs.

Members can opt in to the program by calling Medica, using our member portal or submitting an election form by mail. After enrolling, members may have two bills to pay: one for their premium and one for the M3P program — The two payments are billed and paid separately. Members enrolled in M3P can remove themselves from the program at any time, but if they have a balance due, they will be billed until it is paid off.

Note: Once members enroll in the M3P program, *all the medications they fill* will then be included on the payment plan. Members cannot choose which drugs they want to include in the program.

To learn more about this program, **visit the CMS website**.

Effective January 1, 2025:

Medica to make annual update to Medica Part D drug formularies

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica has made annual decisions on drugs that will either be removed from the Medica Medicare Part D drug formularies or be subject to a change in preferred or tiered cost-sharing status effective January 1, 2025. Members are encouraged to review their formulary to see if any of their medications are changing.

Medica's Medicare Part D formularies are the Medicare Part D Closed Formulary and the Medica DUAL Solution® and Medica AccessAbility Solution® Enhanced List of Covered Drugs. The Medica Medicare Part D drug formularies are available online or on paper:

- **View Medica formularies**.
- **Download formularies for free at epocrates.com**.
- Call the Medica Provider Literature Request Line for printed copies of documents.

Providers can also refer to a comprehensive list of all previous Medica Medicare Part D drug formulary changes on

Medica.com. **View Medicare Part D drug formulary changes**.

Medication request forms

A medication request form should be used when requesting a formulary exception. It is important to fill out the form as completely as possible and to cite which medications have been tried and failed. This includes the dosages used and the identified reason for failure (e.g., side effects or lack of efficacy). The more complete the information provided, the quicker the review, with less likelihood of Medica needing to request more information. To request formulary exceptions, providers can submit an exception form or call Express Scripts.

Network News

Effective January 1, 2025:

Medica to make quarterly update to Medicare physician fee schedules

(This applies to Medica direct-contracted providers only.)

Effective with January 1, 2025, dates of service, Medica will implement the quarterly update to its Medicare physician fee schedules for applicable Medica products. This fee schedule change will implement updates from the Centers for Medicare and Medicaid Services (CMS) and have an impact on home infusion therapy and public health agency providers, as well as physicians and convenience care. Medica will make these updates within 30 days of the CMS quarterly files becoming publicly available. By day 10 after each effective date, in order to keep these quarterly updates timely, Medica will move ahead and post updated Medicare rates with the files CMS has published at that time.

This fee schedule change incorporates CMS relative value units (RVUs) and conversion factor as well as various Medicare non-RVU fee maximums (such as labs, injections, immunizations, etc.). In addition, Medica will update its Medicare fee schedules with rates for codes without a fee maximum established. Overall reimbursement for providers will depend on specialty and mix of services provided.

Details on Medicare changes to drug fees, which typically see the greatest impact from these quarterly CMS updates, **are available online from CMS**. Providers who have questions may contact their Medica contract manager.

Effective January 1, 2025:

Medica to make quarterly update to MHCP physician fee schedule

(This applies to Medica direct-contracted providers in Minnesota.)

Effective with January 1, 2025, dates of service, Medica will implement a revised physician fee schedule for its enrollees in Minnesota Health Care Programs (MHCP) products. The revised Medica MHCP fee schedule will be based on the fee schedule used by the Minnesota Department of Human Services (DHS) to pay providers for services

provided to its fee-for-service enrollees. Updates to Medica's MHCP fee schedule will follow DHS professional fee schedule updates.

The effect on reimbursement overall for specific clinics will vary by specialty and mix of services provided. Providers who have questions may contact their Medica contract manager.

Effective January 1, 2025:

Medica to make quarterly update to standard reference lab fee schedule

(This applies to Medica direct-contracted providers only.)

Effective with January 1, 2025, dates of service, or as soon thereafter as the CMS quarterly reference lab fee schedule updates are publicly available, Medica will implement the next quarterly update to its standard reference lab fee schedule, for all Medica products. This quarterly update will reflect any applicable Centers for Medicare and Medicaid Services (CMS) reference lab code or fee schedule updates that are effective January 1, 2025. The reimbursement impact of this CMS quarterly update will vary based on mix of services provided.

Details on Medicare changes to lab fees **are available online from CMS**. Providers who have questions may contact their Medica contract manager.

Effective January 1, 2025:

Medica to make quarterly update to standard home infusion therapy fee schedule

(This applies to Medica direct-contracted providers only.)

Effective with January 1, 2025, dates of service, or as soon thereafter as the Centers for Medicare and Medicaid Services (CMS) quarterly updates are publicly available, Medica will implement the next quarterly update to its standard home infusion therapy fee schedule, for all Medica products. This quarterly update will reflect any applicable CMS fee schedule updates that are effective January 1, 2025. The reimbursement impact of this CMS quarterly update will vary based on mix of services provided.

Details on Medicare changes to fees **are available online from CMS**. Providers who have questions may contact their Medica contract manager.

Administrative News

Updates to Medica Provider Administrative Manual

To ensure that providers receive information in a timely manner, changes are often announced in *Medica Connections*

that are not yet reflected in the Medica Provider Administrative Manual. Every effort is made to keep the manual as current as possible. The table below highlights updated information and when the updates were (or will be) posted online in the Medica Provider Administrative Manual.

Information updated	Location in manual	When posted
Due to a change in Minnesota state law focused on privacy of patient data, providers will confirm that they have a current patient consent form from Medica members that authorizes the disclosure of patient data (PHI) with Medica for the purposes of treatment, payment and health care operations.	"Supplementary Contracting and Regulatory Requirements" section under "State-Specific Contract Requirements" for Minnesota (**found here**)	October 2024
Updated Rural Health Clinics and Federally Qualified Health Centers FAQ to reflect new Interim Rate Letter (IRL) change in payment for RHCs	"Claim Tools" page, under "Specialty Guidelines" subsection (**found here**)	October 2024
Updated personal care assistance (PCA) references to include Community First Service and Supports (CFSS) program name	"Supplementary Contracting and Regulatory Requirements" section under "Personal Care Assistance" (**found here**)	October 2024

For the current version, providers may **view the Medica Provider Administrative Manual online**.

Tips & Training

SELF-SERVICE RESOURCES

Featured this month: E-learning on cultural differences

Understanding how to effectively communicate with people from different cultures is key to building trust in the health care industry. The "Working Across Cultures" e-learning explores how to build cultural awareness and have effective interactions with a diverse population of patients. **Take this provider training**.

Provider administrative training webinar for November

(This applies to Medica leased-network providers as well as direct-contracted providers.)

Medica offers educational sessions on various administrative topics. The following class is available by webinar for all Medica network providers, at no charge.

Training class topic

"Medicare 101"

This brand-new webinar will give providers a full overview of Medica's Medicare Advantage (MA) and Medicare Cost (Medica Prime Solution®) products. We'll share general information about MA and Cost products and service area updates for 2025, as well as highlight the impact to members and providers if members are switching their plan type — for instance, a transition from a Cost plan to MA plan, and what is required as a result. We'll cover the specific impact related to long-term care (LTC) facilities and skilled nursing facilities (SNFs), especially the use of prior authorization and transition-of-care regulations. And finally, this webinar will include an overview of provider resources — on claim submission, billing guidelines, prior authorization requirements and more.

Class schedule

Topic	Date	Time
Medicare 101	Nov. 21	Noon-1 p.m. CT

For webinar trainings, login information and class materials are e-mailed close to the class date. To ensure that training materials are received prior to a class, providers should sign up as soon as possible. The times reflected above allow for questions and group discussion. Session times may vary based on the number of participants and depth of group involvement.

Registration

The registration deadline is one week prior to each class date. **Register online for the class above**.

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Kristen Kopski, MD, Senior Medical Director

'Medica Connections' editor
Hugh Curtler III, Communications
Email: **Hugh.Curtler@Medica.com**

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