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General News

Details on the UCare Medicaid transition to Medica One Health Plan

(This applies to providers who serve Medica and UCare members in Minnesota.)



On Oct. 1, 2026, UCare Medicaid members will transition to Medica One Health Plan for plan administration. This means that Medica policies, procedures and tools must be used for dates of service beginning Oct. 1. (For all claims that have dates of service in 2025 or prior, please continue to refer to the [UCare Receivership website](#).)

Note: More details on the following topics *as well as updates to this information* will be posted to [our UCare provider hub](#). This is the best way for providers to stay up-to-date on the UCare membership transitions.

To help you manage 2026 UCare Medicaid claims with a date of service (DOS) between Jan. 1, 2026, and Sept. 30, 2026, after the member transition date of Oct. 1, 2026, please review the following categories to find the right path.

Claims submission

UCare Medicaid DOS 1/1/26-9/30/26: Submit claims under UCare payer ID 55413.

Medica One Health Plan DOS 10/1 and beyond: Submit claims under Medica payer ID 71890 or send via mail to Medica, PO Box 211435, Eagan, MN 55121.

Electronic transactions and provider portals

UCare Medicaid DOS 1/1/26-9/30/26: Eligibility and Benefits (270/271), Prior Auth Submission and Inquiry (278) and remittance advices can continue to be accessed via the UCare provider portal (through Dec. 31, 2026) or via electronic gateway.

Ongoing business related to these claims after submission will be managed by UCare, including administrative appeals submission and reviews. Answer your questions and obtain updates by contacting the UCare Provider Assistance Center at **1 (888) 531-1493**.

Medica One Health Plan DOS 10/1 and beyond: Electronic transactions can be conducted through the Availity gateway using EDI information exchange inquiries. To ensure that your electronic submission platforms are ready to receive members transitioning from UCare, connect with any vendor or clearinghouse involved in your claims management processes to ensure they have made appropriate adjustments to details like payer ID, electronic claim destination, and electronic remittance advice delivery method.

The following transactions will be available on Availity Essentials, Medica's preferred provider portal, using the "Medica Health Plan Solutions" payer drop-down option:

- Eligibility and Benefits
- Claims Status Inquiry (new function for UCare membership!)
- Prior Authorization Submission and Status Check with authorization requirement tool
- Appeals Submission and Status Check
- Provider Demographic Updates (available in Payer Spaces)
- Admission Notification (available in Payer Spaces)
- Fee Schedule Lookup/Download (available in Payer Spaces)
- Remittance Advices (see below for InstaMed registration information)

Register for [Availity Essentials](#) if you do not currently use this portal with other payers.

Payments

UCare Medicaid DOS 1/1/26-9/30/26: Records of payment like EOPs and remittance advices will be available in the UCare provider portal through Dec. 31, 2026. Additional information on those processes can be obtained by calling the UCare Provider Assistance Center.

Medica One Health Plan DOS 10/1 and beyond: Payment records are managed through InstaMed. Electronic payments are the preferred method of receipt. If you are already registered to receive electronic payments for Medica through InstaMed using payer ID 71890, no further action is required. If you are not, please register for this [using these instructions](#).

Claim Appeals

Medicaid DOS 1/1/26-9/30/26: Provider administrative appeals can be submitted for review to UCare and will follow their standard review procedures. The UCare provider portal will be available for these claims through Dec. 31, 2026.

Medica One Health Plan DOS 10/1 and beyond: Medica's standard appeals process will apply. [See more about this](#) in our Provider Administrative Manual.

Authorizations

UCare Medicaid DOS 1/1/26-9/30/26: UCare authorization and medical policies apply for dates of service completed pre-transition (i.e., before Oct. 1, 2026). All authorizations requested pre-transition for Oct. 1 dates of service and after must align with Medica policies and procedures and be submitted to any applicable service partner.

Pharmacy authorizations currently approved will be honored through Dec. 31, 2027 (note year).

Medica One Health Plan DOS 10/1 and beyond: Medical authorizations that have been approved for services at UCare for these dates of service will be transitioned over to Medica. Medica policies, procedures and partners apply to all dates of service requested for Oct. 1 and after. Review [Medica's authorization wayfinding guide](#) to ensure you're familiar with submission requirements and partners for both medical and pharmaceutical authorizations.

If you have a service scheduled on Oct. 1 or after and need to request an authorization for that service *prior* to the Oct. 1 transition date (so that it's in place when the service occurs shortly after the transition), submit your *medical* prior authorization requests to us by email at

caremanagement@medica.com or via fax at **1 (952) 992-3556**. (Be sure to include identifying information like full member name and date of birth.)

All behavioral health and chiropractic services are both contracted for and managed by Optum. Refer to your Optum contract and resources for submission information.

Portal availability

UCare Medicaid DOS 1/1/26-9/30/26: Due to UCare's receivership status, the UCare provider portal will be sunset on Dec. 31, 2026. It will be available through Dec. 31, 2026, for Medicaid dates of service ending Sept. 30, 2026. Inquiries on these claims after Dec. 31, 2026, will be managed by the Medica Provider Service Center. Due to this, we encourage providers to efficiently manage Medicaid claims run-out and related functions so that processes can continue uninterrupted on consistent tools.

Medica One Health Plan DOS 10/1 and beyond: Application services will be available on Availity Essentials as outlined under "Electronic transactions and provider portals" above.

Who to contact with questions

UCare Medicaid DOS 1/1/26-9/30/26: Address your questions on these claims by calling the UCare Provider Assistance Center at **1 (888) 531-1493**.

Medica One Health Plan DOS 10/1 and beyond: Call Medica's Provider Service Center at **1 (800) 458-5512** to manage all inquiries related to Medicaid claims beginning Oct. 1, 2026.



Sign up for electronic payments related to UCare membership migrations

(This applies to providers who serve Medica and UCare members in Minnesota.)

Providers should be sure to register with InstaMed to receive electronic payments for services provided to Medica Medicaid and IFB membership coming from UCare (to be administered under Medica payer IDs 71890 and 12422). If you're already registered, you're all set — But if you haven't done so, validate the registration for these two payer IDs and take steps to register, as needed. [Learn more to sign up](#). Providers not registered for electronic payments will receive paper checks for claims sent to payer IDs 71890 and 12422, which will apply for the new UCare membership after respective transition dates.

Effective Oct. 1, 2026:

EVV process still required for UCare Medicaid members who transition to Medica One Health Plan

(This applies to providers who serve Medica and UCare members in Minnesota.)

As a reminder, legacy UCare Medicaid members will transition to the new Medica One Health Plan effective Oct. 1, 2026. Providers serving these members should note that *Electronic Visit Verification (EVV)* will continue to be required for all in-scope services provided under Medica One Health Plan. Please continue to **follow all EVV requirements** to ensure compliance and support accurate claims processing. To support this transition, updates will be made within the **HHAeXchange system** — used by the Minnesota Department of Human Services (DHS) — to accommodate member and authorization changes.

What you will see in the HHAeXchange provider portal

Providers will notice the following updates:

- Legacy UCare client placements will discharge on Sept.30, 2026
- A new linked contract titled Medica One Health Plan
- New client placements under the Medica One Health Plan linked contract
- New authorizations from Medica One Health Plan with a start date of Oct. 1, 2026

For providers using a third-party EVV vendor

Providers utilizing a third-party EVV vendor will see updated Technical Specifications that include the new Medica One Health Plan payer initials and in-scope services. Be sure to communicate proactively with your EVV vendor regarding the upcoming Technical Specification changes to ensure any required system updates are completed before the transition date.

Provider next steps

To ensure a smooth transition, please take the following actions:

- Continue monitoring your email and HHAeXchange provider portal for additional communications and updates regarding this transition.
- If you do not currently have an HHAeXchange provider portal and provide in-scope services for legacy UCare members or future Medica One Health Plan members, please complete the **Minnesota Provider Enrollment Form**.
- Prior to Oct. 1, 2026, monitor your HHAeXchange Provider Portal for new client placements and authorizations from Medica One Health Plan. Please note that client placements and authorizations may not all be loaded on the same day.

For support during this transition

- Providers should continue using existing published EVV support contacts.
- Questions related to services before Sept. 30, 2026, should be directed to UCare.
- Questions related to dates of service on or after Oct. 1, 2026, should be directed to Medica.

Reminder:

Use Medica payer IDs for UCare membership that migrates to Medica One Health Plan

(This applies to providers who serve Medica and UCare members in Minnesota.)

Beginning with Oct. 1, 2026, dates of service, UCare's Medicaid membership will transition to Medica One Health Plan, after which providers should use Medica payer ID 71890 for these members. (Continue to use payer ID 55413 for UCare Medicaid members for dates of service prior to Oct. 1.)



As of Oct. 1, these are the new Medicaid plans that will be administered under payer ID 71890:

- Medica One Health Plan Special Needs BasicCare (SNBC)
- Medica One Health Plan Minnesota Senior Care Plus (MSC+)
- Medica One Health Plan Prepaid Medical Assistance Plan (PMAP)
- Medica One Health Plan MinnesotaCare

In addition, for Medica DUAL Solution® members — those participating in the Minnesota Senior Health Options (MSHO) program — providers should use Medica payer ID 94265. UCare's dual-eligible membership selected new coverage earlier this year.

UCare's Individual and Family (IFB) membership will transition to Medica beginning with Jan. 1, 2027, dates of service, so providers should use Medica payer ID 12422 for these members. (Continue to use payer ID 55413 for UCare IFB members for dates of service prior to Jan. 1.) Information on the IFB membership transition will be published in this newsletter and available on [our UCare provider hub](#) closer to Jan. 1 2027.

Matching payer IDs from member ID cards to Availity

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

Payer IDs are the doorway to an insurance company's electronic claims submission gateway. At Medica, we also use payer IDs to define certain pathways a provider should follow or systems they can use to complete a task. That's why we include the payer ID on all member ID cards.

Action required:

1. Secure a copy of the member ID card and confirm the plan name (not just payer name) at *each visit*.
2. Ensure that your claims management processes (such as practice management or RCM software) are accurate in details like payer ID. Make sure the "mnemonics" or "payer profiles" show the correct payer ID.
3. In the absence of a member's ID card, use our online resources:
 - [If you know the member's plan name and need payer ID information](#)
 - [If you know the payer ID and need plan information](#)

4. Select the proper payer ID in Availity Essentials, our preferred provider portal:
 - Medica Government Programs: Payer ID MEDM1 (moving to payer ID 71890 on Jan. 1; see p. 10)
 - Medica Individual and Family: Payer ID 12422
 - Medica Health Plan Solutions: Payer ID 71890
 - Medica (United HealthCare): Payer ID 94265
 - Medica – formerly WellFirst: Payer ID 41822
 - Prevea360: Payer ID 41822
 - Dean Health Plans: Payer ID 41822
 - WebTPA: Payer ID 75261
-

CMS conducting audits for certain Medicaid services in Minnesota

(This only applies to providers in Minnesota who serve Medicaid members.)

The Centers for Medicare and Medicaid Services (CMS) is conducting Program Integrity Audit activities involving certain Medicaid services in Minnesota. The audit is being conducted by CoventBridge, a CMS contractor, and may include requests for records and supporting documentation related to the following:

- Adult Day Services
- Adult Rehabilitative Mental Health Services (ARMHS)
- Early Intensive Developmental And Behavioral Intervention (EIDBI)
- Intensive Residential Treatment Services (IRTS)
- Non-Emergency Medical Transportation (NEMT)
- Peer Recovery Services (PRS)
- Personal Care Assistance/Community First Services and Supports (PCA/CFSS)

If your organization receives an audit request from CoventBridge regarding these services, please review the request carefully and respond by the specified deadline. Providing complete and timely documentation helps support an efficient audit process and may reduce the need for additional follow-up requests. We appreciate your partnership and cooperation in supporting program integrity efforts and ensuring compliance with CMS requirements.

Reminder:

Routing prior authorization requests appropriately + online

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

Availity Essentials is the go-to portal for submitting most prior authorization requests. While that is true, there are a few notable exceptions. This refresher on routing prior authorization requests should be especially helpful for assisting UCare members new to Medica and Medica One Health Plan.

Prior authorizations *should not be submitted* using Availity Essentials for medications or for radiology, cardiology or musculoskeletal services. Use Evernorth, Prime, or Carelon:

- Submit **prescription drug** prior authorization requests through the **Evernorth portal**. (Evernorth is the new name for Express Scripts, our pharmacy benefit manager.)
- Submit **medical drug** prior authorization requests via the **Prime Therapeutics portal**.
- For **radiology, cardiology and musculoskeletal services, as well as integrated pain management**, submit prior authorization requests using the **Carelon portal**.

As a helpful tip, whenever possible, please submit prior authorization requests electronically using the appropriate portal, whether Availity Essentials or one of the portals noted above. This is preferred over faxing of prior authorization forms since doing so expedites the processing of requests. Electronic requests also provide an authorization number upon submission, which can be used to easily check the authorization status online.

Note: Our new resource called “**Prior Authorization Pathways**” should also be helpful for routing prior authorization requests on behalf of Medica members.

Reminder:

Sign up for a ‘Welcome to Medica’ webinar

It’s not too late! Join us for one of the following web-based training sessions to learn more about UCare members' transition to Medica. Administrative staffs responsible for prior authorizations, claims, billing, or appeals should attend. In addition to covering these topics, we should have time for your “how to” questions, so plan accordingly!

Date	Time (CT)	Registration
Wednesday, Sept. 23, 2026	3:30-5 p.m.	<u>Sign up today.</u>
Tuesday, Oct. 6, 2026	1:30-3 p.m.	<u>Sign up today.</u>

A recording of the webinar, along with the slide deck, will be posted to **our Provider Training webpage** afterwards.

Coming in 2027: A more streamlined prior authorization experience

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

Beginning Jan. 1, 2027, Medica will offer a new electronic prior authorization (ePA) process designed to make submitting prior authorizations easier and more efficient for providers. With the new process, participating providers will be able to work directly within their electronic health record (EHR) to:

- Determine whether prior authorization is required for a medical service
- Complete applicable questionnaires and documentation requirements
- Submit prior authorization requests electronically

By bringing these steps into the EHR workflow, the new ePA process will reduce the need to navigate to a separate portal or submit requests through manual channels such as fax or email.

What providers can do now: Contact your EHR vendor to learn about its electronic prior authorization capabilities and any steps your organization may need to take to enable this functionality for 2027.

Additional information about Medica's electronic prior authorization process will be shared as we get closer to implementation.

Effective Jan. 1, 2027:

Payer ID 71890 to apply for existing Medicaid, Medicare Advantage plans

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

Effective Jan. 1, 2027, Medica will make payer ID changes for the following plan types, switching to payer ID 71890 from current payer ID MEDM1:

- Any Minnesota Health Care Programs (MHCP), or Medicaid, plans not already administered under payer ID 71890 will switch to payer ID 71890 from MEDM1.
- All Medicare Advantage plans will switch to payer ID 71890 from MEDM1.

Action required: We encourage all providers to update their practice management systems (such as practice management or RCM software) with this payer ID change in advance of Jan. 1.

The Medica DUAL Solution® product, for members enrolled in the Minnesota Senior Health Options (MSHO) program, is an exception. For our MSHO members, continue to use Payer ID 94265.

EDI Corner: Subscriber ID formats by payer ID

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

With “EDI Corner,” we share tips on electronic data interchange (EDI) transactions to help you stay informed, avoid common EDI errors, and achieve consistent, accurate EDI results.



This month’s update is a reminder on the proper subscriber ID format to use for electronic claims submitted to Medica for payer IDs 12422, 41822, 71890, and MEDM1. Sending the correct subscriber ID increases the likelihood that your submitted claim will be accepted cleanly.

Medica Payer ID	Subscriber ID number
Payer ID 12422	Subscriber IDs sent on claims for payer ID 12422 should always be 10 digits long and should always start with a 3.
Payer ID 41822	Subscriber IDs sent on claims for payer ID 41822 should always be 10 digits long and should always start with a 3.
Payer ID 71890	Subscriber IDs sent on claims for payer ID 71890 can have multiple formats. Medica-generated subscriber IDs will be 10 digits long and can start with a 1, 2, or 3. Providers can also send the government-issued Medicaid or Medicare ID associated with a member.
Payer ID MEDM1	Subscriber IDs sent on claims for payer ID MEDM1 can have multiple formats. Medica-generated subscriber IDs will be 10 digits long and can start with a 1, 2, or 3. Providers can also send the government-issued Medicaid or Medicare ID associated with a member.

Validating an ID before sending the claim

To make sure you have the correct subscriber ID before sending a claim, you can always send an Eligibility and Benefit Inquiry transaction to the Availity Gateway or through the Availity Essentials portal. [Availity Essentials](#) is our preferred provider portal for all of our secure electronic transactions for patient services and clinic administration.

Effective Jan. 1, 2027:

Medica makes Medicare product, benefit changes for next year

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

Medica continues to evolve its Medicare product portfolio to meet member needs and market demands. Effective Jan. 1, 2027, Medica will implement several service area, product, and benefit changes for our Medicare Cost, Medicare Advantage, and Medicare Dual-Eligible Special Needs Plans (D-SNPs).

Medicare Cost plans

We'll make the following service area changes on Jan. 1:

- **In Minnesota:** Medica Prime Solution® (Medicare Cost) will expand into 7 additional Minnesota counties currently served by Medica Medicare Advantage plans.
- **In South Dakota:** The Medica Prime Solution service area will be reduced by 9 counties. Affected members will receive a non-renewal notice and information about other available Medica coverage options.
- **In Wisconsin:** The Medica Prime Solution service area will be reduced by 5 counties. Affected members will receive a non-renewal notice. Medica will not offer a Medicare Advantage plan in Wisconsin in 2027, so impacted members will need to select alternative coverage.
- **In Iowa, Nebraska + North Dakota:** No Medicare Cost service area changes are planned for 2027.

We'll make these Cost plan changes:

- The Enhanced Rx plan will be discontinued after Dec. 31, 2026. Current members will have the opportunity to enroll in another available Medica plan during the Annual Enrollment Period (AEP).
- In addition, Medica will reduce the number of Medicare Cost plan benefit packages (PBP) options offered in North Dakota and South Dakota. The Core Rx and Premier Rx plans will be discontinued at the end of 2026.
- Members affected by these plan closures will continue to have access to other Medica plan offerings and may select a plan that best meets their needs during the enrollment period.

And we'll continue with these benefits or integrate these changes for our Cost plans:

- Medica Medicare Cost plans will continue to provide reimbursement allowances for vision services on applicable plans.
- We'll continue to provide semi-annual over-the-counter (OTC) allowances through CVS OTC Health Solutions.
- We'll introduce a medical deductible on Standard plans.
- We'll offer preventive-only dental benefits through Dental Benefit Providers (DBP).
- And we'll continue the EPIC hearing exam and hearing aid benefits.

Medicare Advantage plans

We'll make the following service area changes on Jan. 1:

- **In South Dakota:** The Medicare Advantage service area will expand by 9 counties.

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- **In Minnesota:** The Medicare Advantage service area will be reduced by 22 counties. Medica will discontinue its H6154 HMO-POS contract, whose service area is 25 counties in Minnesota.
- **In Nebraska:** The Medicare Advantage service area will be reduced by 8 counties and expanded by 1 county in the Omaha metro and surrounding area.
- **In Iowa:** Medica will no longer offer Medicare Advantage plans.
- **In North Dakota:** The Medicare Advantage service area will remain unchanged.

We'll make these Medicare Advantage plan changes:

- As part of these changes above, several Medicare Advantage plans in Minnesota and South Dakota will be discontinued. Members enrolled in certain affected plans will be automatically enrolled into a new Medica Medicare Advantage plan effective Jan. 1, 2027, through a CMS-approved crosswalk process. Members who qualify for an automatic enrollment will receive notification of the change and do not need to take any action to maintain Medicare coverage with Medica.
- In addition, Medica will discontinue several Medicare Advantage plans in Minnesota, South Dakota, and Nebraska that are not eligible for automatic crosswalks. Members enrolled in these plans, as well as members whose counties are no longer included in a Medicare Advantage service area, will receive a non-renewal notice along with information about other available Medicare coverage options. In most affected service areas, Medica will continue to offer alternative Medicare plan options. Members will have the opportunity to review and select coverage that best meets their needs during AEP.

Medica will continue to offer a broad portfolio of premium plans across all service areas, plus Medicare Advantage-only plans across all service areas. In addition, we'll make these benefit changes for our Medicare Advantage plans beginning in 2027:

- Medicare Advantage plans will offer dental benefits through Dental Benefit Providers (DBP).
- Some Medicare Advantage plans will continue to provide OTC and eyewear allowances through the Health+ by Medica card, allowing members to access supplemental benefits at a wide range of participating retail locations.
- All Medicare Advantage members will receive a new ID card for 2027.

Medicare D-SNPs

We'll make the following service area and benefit changes for dual-eligible Special Needs Plans (D-SNPs) on Jan. 1:

- **In North Dakota:** The Medica Advantage® Dual service area in North Dakota will expand by 15 counties. Medica Advantage Dual product will continue to offer an OTC and fitness monthly benefit allowance and add an additional food and utilities assistance monthly allowance via the Health+ by Medica benefit card.
- **In Minnesota:** The service area for the Medica DUAL Solution® (HMO D-SNP) product, for the Minnesota Senior Health Options (MSHO) program, will expand by 5 counties. Medica will no longer offer Medica DUAL Solution (HMO D-SNP) in Lac qui Parle county.

Providers are encouraged to review Medica's 2027 Medicare product updates and remain aware of service area and benefit changes that may affect your patients and practice operations.

See below for a required Model of Care training that applies to providers in both the Medica Advantage Dual (PPO D-SNP) network and the Medica DUAL Solution (HMO D-SNP) network.

Reminder:

Annual SNP ‘Model of Care’ training required for providers

(This applies to Medica direct-contracted providers in Minnesota and North Dakota only.)

As a reminder, each year providers who serve members enrolled in a Special Needs Plan (SNP) — such as Medica DUAL Solution® or Medica Advantage® Dual in North Dakota — must take the provider Model of Care training. Providers can [find this training and attestation link on Medica.com](#).

This requirement is necessary for Medica to comply with requirements put in place by the Centers for Medicare and Medicaid Services (CMS). More details about this requirement are available [in the Medica Provider Administrative Manual](#).

Each provider organization should maintain documentation of each provider’s completion of training (e.g., dated training attendance list, dated paper or electronic attestation, etc.) that can be provided upon request. One Model of Care training attestation can be completed on behalf of an organization, either by:

- Using the Online Provider Demographics Update Tool (PDOT) [at Availity Essentials](#)
- Or [completing our electronic attestation](#)

If you have questions about this training, contact us at MedicaSPPReqQuality@Medica.com. We appreciate your completion of this training.

Clinical News

Effective Jan. 1, 2027:

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 Jan. 1, 2027, 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](https://www.medicacom.com)** at least 90 days prior to their effective date. The medical policy update notification for changes effective Jan. 1, 2027, is already posted. Changes to policies are effective as of that date unless otherwise noted. ("Medical policy updates" notifications are available at [Medica.com](https://www.medicacom.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](https://www.medicacom.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 Business (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 October 2026 for policies that will be changing effective Feb. 1, 2027. These upcoming policy changes will be effective as of Feb. 1 unless otherwise noted. The affected policies will then be available as noted above.

Best practices:

Breast cancer screening: Addressing patient hesitancy + closing care gaps

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

Breast cancer screening remains one of the most effective tools for detecting cancer early, when treatment is often more successful and less invasive. Yet many women, particularly as they age, delay or forgo routine mammograms because they believe screening is no longer necessary if they feel healthy or have never had an abnormal result.

As trusted healthcare partners, providers play a critical role in reinforcing that breast cancer risk increases with age and that routine screening remains important for eligible women.

A simple conversation can make a difference

Common reasons patients decline screening include:

- "I've never had a problem before."
- "I'm too old to worry about breast cancer."
- "I don't have symptoms."
- Concerns about discomfort or inconvenience.

A recommendation from a trusted provider remains one of the strongest predictors of screening completion. Brief discussions during annual wellness visits, chronic care follow-ups, or preventive care appointments can help address misconceptions and encourage patients to schedule a mammogram.

Screening recommendations

The breast cancer screening (BCS-E) measure includes women ages 40-74 who have completed a mammogram within the recommended timeframe. Mammograms are recommended every 2 years for eligible women in this age group.

Member coverage information

Breast cancer screening is covered as preventive care when provided by an in-network provider, with no member cost-sharing for routine screening mammograms. If additional diagnostic testing is required following a screening mammogram, standard cost-sharing may apply.

Provider opportunities

- Review mammogram status during patient visits. If patient self-attests to completing a mammogram in the past 2 years, document the month and year in member's history. Fax record to the health plan at **1 (952) 992-3589**, "ATTN: Advocacy Team."
 - Example: *Mammogram completed on 08/2024*
- Encourage overdue patients to schedule screening before they leave the office.
- Address concerns related to age, symptoms, or prior normal screening results.
- Refer patients to in-network mammography providers.
- Use outreach opportunities to close identified care gaps.

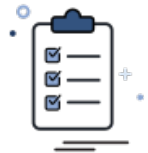
Early detection saves lives, and a simple recommendation from a provider can help ensure eligible patients receive this important preventive service.

Due by Oct. 15, 2026:

Quality complaint reports required by State of Minnesota

(This applies to Medica network providers in Minnesota only.)

Medica requires its Minnesota-based network providers to submit third-quarter 2026 quality-of-care complaint reports to Medica by Oct. 15, 2026. The State of Minnesota requires that providers report quality complaints received at the clinic to the enrollee's health plan. *All Minnesota-based providers should submit a quarterly report form*, even if no Medica members filed quality complaints in the quarter (in which case, providers should note "No complaints in quarter" on the form).



Providers can send reports by e-mail to QualityComplaints@medica.com, by fax to **(952) 992-3880** or by mail to:

Medica Quality Improvement
Mail Route CP405
PO Box 9310
Minneapolis, MN 55440-9310

Report forms are available by:

- [Downloading from Medica.com](#), or
- Calling the Medica Provider Literature Request Line, to obtain paper copies

Note: Providers submitting a report for multiple clinics should list all the clinics included in the report.

Providers who have questions about the complaint reporting process may:

- [Refer to Medica's Provider Administrative Manual](#), or
- Call the Medica Provider Service Center at **1 (800) 458-5512**.

Pharmacy News

Effective Nov. 3, 2026:

Medica to 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 Medica List of Covered Drugs for Minnesota Health Care Programs (MHCP), effective Nov. 3, 2026. 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 advance notice of changes to the drug list, which Medica posts as soon as possible [to Medica.com](https://www.medicacom.com).

The Medica MHCP drug list applies to the following products:

- Medica Choice CareSM (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
- Medica DUAL Solution[®] (for Minnesota Senior Health Options program, or MSHO) — *for non-Part D drugs only*

These changes will *not* apply to Medica's Medicare Part D drug formularies.

Effective Dec. 1, 2026:

Medica plans to update commercial + IFB member drug formularies, drug UM policies

(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 them on the commercial and Individual and Family Business (IFB) member drug formularies (drug lists) effective Dec. 1, 2026. These upcoming changes will apply to the 2026 Medica Commercial Drug List and to all versions of Medica's 2026 IFB Drug Lists. These changes will also be made to any related drug utilization management (UM) policies.

(Drug lists are available at [Medica.com](https://www.medicacom.com) under For Providers, "Pharmacy," then respective member types under "[Pharmacy Resources by Segment](#).")

Effective Sept. 15, 2026:

Medica adds new UM policy for medical pharmacy drug

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

Medica has recently implement the following new medical pharmacy drug utilization management (UM) policy, effective with Sept. 15, 2026, dates of service. Medica implements such policies as soon as possible after conducting a clinical review of new-to-market drugs and approving them for coverage with UM policies. Prior authorization is required for the corresponding medical pharmacy drugs.

Medical pharmacy drug UM policies — New

Prior authorization required.

Drug code	Drug brand name	Drug generic name
J9999	Sarclisa Escena	isatuximab-irfc

Member impact

This policy applies to Medica commercial, Individual and Family Business (IFB), Minnesota Health Care Programs (MHCP) and Medica Health Plan SolutionsSM (MHPS) members and to Medica Medicare members in Medica DUAL Solution[®] (Minnesota Senior Health Options, or MSHO) and all Medica Advantage Solution[®] plans. It *does not apply* to Medica Prime Solution[®] (Medicare Cost), Medica Signature SolutionSM (Medicare Supplement), Medica Select Solution[®] (Medigap) or Mayo Medical Plan members, unless otherwise noted. The drug is subject to pre-payment claims edit policies as well.

The new medical pharmacy drug UM policy above is available online or on hard copy:

- [View drug management policies](#); or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Effective Dec. 1, 2026:

Vyalev to require prior authorization for certain Medicare plans

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

We're implementing a prior authorization requirement for Vyalev (drug code J7356) effective Dec. 1, 2026, for certain Medicare plans.

Member impact

This will apply to our Medica Medicare members in Medica DUAL Solution® (Minnesota Senior Health Options, or MSHO) and all Medica Advantage Solution® plans. It will *not* apply to Medica Prime Solution® (Medicare Cost), Medica Signature SolutionSM (Medicare Supplement), Medica Select Solution® (Medigap), or Mayo Medical Plan members, unless noted below. The drug Vyalev may be subject to pre-payment claims edit policies as well.

For a listing of drugs that require prior authorization for Medicare, refer to our Medicare Part B prior authorization listing under drug management policies at the Prime website:

- [View drug management policies](#); or
- Call the Medica Provider Literature Request Line for printed copies of documents.

Effective Oct. 1, 2026:

Upcoming changes to Medica Part D drug formularies

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

Medica periodically makes changes to its Medicare Part D drug formularies and posts updated formularies on Medica.com by the effective date of change. The updated formularies may include negative formulary changes, such as drug removals or tier increases. The latest updates are effective Oct. 1, 2026.

In accordance with Centers for Medicare and Medicaid Services (CMS) requirements, Medica provides advance notice to affected members at least 60 days prior to the effective date regarding any negative formulary changes. Medica also notifies affected Medica members in their Medicare Part D Explanation of Benefits (EOB) statements mailed out monthly.

Medica's Medicare Part D drug formularies are the Medicare Part D Closed Formulary and the Medica DUAL Solution® List of Covered Drugs. Medica's 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.

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

Administrative News

Effective Jan. 1, 2027:

Medica to update obstetrical reimbursement policy

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

Medica will soon revise the existing obstetrical reimbursement policy, effective for dates of service on or after Jan. 1, 2027. Such policies define when specific services are reimbursable based on the reported codes.

Medica will align with the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) by moving to a phase-based billing and payment structure for maternity care. Effective Jan. 1, 2027, the current global obstetrical codes will be deleted in favor of codes that reflect each phase of maternity care: antepartum care, labor management, delivery care, and postpartum care. Learn more about this change [from the AMA](#) and [from ACOG](#).

Providers should switch to the phase-based billing for all members who begin antepartum care in 2026 and are expected to deliver in 2027. Antepartum visits in 2026 may be reported using codes 59425, 59426 or evaluation and management (E/M) codes, depending on the number of visits in 2026, but *providers must report antepartum visits provided in 2027 with E/M codes and the TH modifier*.

As of Jan. 1, 2027, *global codes for obstetric care services will no longer be valid*, since we will fully transition to the new AMA coding methodology.

This policy applies to claims for our commercial, Medicare, Minnesota Health Care Programs (MHCP), and Individual and Family Business (IFB) members. The revised Medica policy will be available online or on hard copy:

- [View reimbursement policies](#) as of Jan. 1; or
- Call the Provider Literature Request Line for printed copies of documents.

Reminder:

Up-to-date directories help members find providers

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

It is important that patients and members have access to accurate, up-to-date information when seeking care in their provider network. To ensure that members have the best experience possible when looking for care, health plans need providers' help to ensure provider details and clinic locations are up to date. Information in Medica's provider directories can be reviewed and edited through the secure Online Provider Demographics Update Tool (PDOT) at [Availability Essentials](#), our preferred provider portal, as part of the Payer Spaces feature.

Directory information to regularly review and keep current includes:

- Telehealth capability, at both practitioner and site level *(this should include whether an individual practitioner exclusively provides telehealth or provides both telehealth and services at a physical location)*
- Office locations where individual practitioners are actively seeing patients for appointments
- Practitioner names and credentials
- Specialties
- Location names
- Addresses, including suite numbers
- Phone numbers
- Clinic hours
- Practitioner status for accepting new patients *(accepting new patients means the practitioner can see the member within Medica's guidelines for appointment access, [outlined here](#))*
- Clinic services available
- Cultural competency training*
- Compliance with the Americans with Disabilities Act (ADA)*
- Website URL (optional)
- Termination of individual practitioner, closing of a site, or termination of a provider entity

* (Coming soon: Look for an annual update request specific to cultural competency training and compliance with the Americans with Disabilities Act, or ADA. We'll mail this out in the fall.)

It's required that provider directories be accurate and updated regularly, based on federal and state laws such as Centers for Medicare and Medicaid Services (CMS) rules and Qualified Health Plan (QHP) and Federally Facilitated Exchange (FFE) standards, and in accordance with applicable state laws, including Minnesota network adequacy statutes. As a result, providers need to update their practitioner and site-level demographic data — such as the items listed above — in Medica's directories as soon as they know of a change to that data, and to regularly review demographic information for accuracy. [See more about this.](#)

Note: Providers who are part of a leased network that contracts with Medica, such as a preferred provider organization (PPO), should work with their network's administrative office to update demographics with Medica, rather than make updates individually using Medica's PDOT tool. Doing so could override corrected data.

Reminder:

Providers need to keep national Medicare demographics data current

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

Medica wants to remind providers of the importance to review, update and certify existing provider information in the National Plan & Provider Enumeration System (NPPES). *Providers who see Medicare patients are legally required to keep their NPPES data current.* When reviewing provider data in NPPES, providers should update any inaccurate information in modifiable fields — including provider name, specialty, mailing address, telephone and fax numbers. [Refer to NPPES online.](#)

Reminder:

Oklahoma QHP providers need to verify demographic data as part of CMS directory pilot

(This applies to Medica network providers in Oklahoma only.)

The Centers for Medicare and Medicaid Services (CMS) requires that Oklahoma providers who participate in a Qualified Health Plan (QHP) [log into the directory pilot portal](#) and verify their data and correct any inaccuracies. This information should be re-verified every 90 days in accordance with federal and state guidelines. [Learn more](#) about this directory pilot.

Tips & Training



SELF-SERVICE RESOURCES

Featured this month: What you need, easier to find

Your day is made of specific tasks to accomplish. Now, our [Provider Training webpage](#) is organized by those specific tasks, too. We've arranged our training resources so they are easier for you to find, review, and share. Training just got easier.

Is there something you would like to learn more about? We're always working to expand our educational offerings. [Send us an email](#) to let us know what you'd like to learn more about.

Leadership in Provider Support Areas

Jennifer Alm, Vice President of Provider Partnerships and Solutions

Adam Hjerpe, Chief Operations Officer and Senior Vice President

Lee Mills McGrath, Chief Health Officer

Nick Rogers, PharmD, Vice President and Chief Pharmacy Officer

Kathryn Kading, Vice President of Health Services

Kristen Kopski, MD, Senior Medical Director

Angela Porter, MD, Senior Medical Director

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