

2026 Provider Manual Annual Update Cycle Significant Updates by Section/Chapter – Medicaid Provider Manual

The items listed in this document outline content section-by-section where significant updates have been made to the Molina Healthcare of Ohio, Inc., Medicaid Provider Manual. Format changes, removal of redundant information and/or streamlining of language have been made throughout the document. Additionally, content has been added to the Provider Manual that has been previously communicated in Provider Manual Addendums and Provider Bulletins posted to the Molina Provider Website.

Material changes to content are called out in the information below:

Table of Contents

- Refreshed section names to align with changes in the Provider Manual.

II. Basic Plan Information

- Updated the EDI Payer ID grid in the “Provider Services Department Section” with the new Payer IDs for 2026 throughout the Molina Medicaid Provider Manual.
- Added an address for the Compliance Official in the “Compliance and Fraud AlertLine” section.
- Updated “Health Care Services Department” section with Availity portal-only language and the removal of the fax submission option for Prior Authorization submissions.
- Removal of the “Health Management” section. Moved it to the IX. Care Coordination/Care Management” chapter, “A. Description of Molina’s Care Coordination and Care Management Programs.”
- Updated the “B. Provider Representative Information” section with updated provider types for the designated email addresses.

III. Provider Resources

- Updated “D. Provider Advisory Council” section with updated Provider Engagement Council name and language defining the Provider Engagement Council’s purpose.
- Updated “G. Provider Trainings” section with new name for Cultural Competency, now called Culturally and Linguistically Appropriate Services (CLAS), and the new location for Molina CLAS training. Note: This name change is updated throughout the Molina Medicaid Provider Manual.

IV. Provider Responsibilities

- New information added to the “Artificial Intelligence (AI)” section, including information on AI voice technology.
- Updated “Confidentiality of Substance Use Disorder (SUD) Patient Records” section with SUD Records definition and requirements.

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- Changed “Access to Interpreter Services” section name to “Access to Language Services.”
- Added additional information in the “Access to Language Services” section to help define additional barriers and requirements for Limited English Proficiency (LEP) individuals.
- Update of the “Linguistic Services Background” section to combine gender terms under a single description called “sexes.”
- Updated the “Linguistic Services Background” section to provide directions to the new location of CLAS training in the Availity Essentials portal.
- In the “Nondiscrimination in Health Care Services Delivery” section, a new bullet point “4” was included, providing the requirements for accessibility-related services.
- Added a new bullet point in the “Program and Policy Review Guidelines” section describing the requirement for the Language Description of Membership HEDIS® measure.
- Addition of a new “Availity Essentials Portal” section with information on the new tools available in the Availity Essentials portal.

V. Provider Enrollment, Credentialing and Contracting

- Updated the “Provider Enrollment (ODM Functions)” section to reflect the 2025 registration fee.

VI. Covered Services

- Updated the “Health Education/Disease Management” section with information on chronic conditions programs and healthy lifestyle programs.
- Update the “Medicaid Value-Added Benefits for Members” with 2026 value-added benefits for members.
- Updated the email address for the transportation vendor in the “C. Transportation Vendor Contact Information” section.
- Added additional information on NDC requirement in the “National Drug Codes (NDC)” section, to note that an NDC must be valid and currently marketed on the date of service.
- Added a new “Private Room Add-On Payment” section in the “K. Medicaid Billing Guidelines.”

VII. Utilization Management

- Updated the “Behavioral Health Utilization Management and Prior Authorization” section to include substance use disorder residential services, psychiatric residential treatment and select outpatient treatments as services that can be requested by submitting a prior authorization.

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- Added new clinical information requirements on emergency psychiatric services in the “Behavioral Health Utilization Management and Prior Authorization” section.
- The removal of fax as an option for submission of inpatient admission requests in the “Emergency Services and Post-Stabilization Services” section.
- Updated language in the “ProgenyHealth” section, including contact email addresses and requirement information for the Notification of Admission.
- Added new “ProgenyHealth: Transfers and Readmission” section.
- Added new “ProgenyHealth: Utilization Management Cases” section.
- Added new “ProgenyHealth: Care Management Program Review” section.
- Updated the “Evolent” section with details on where to submit cardiovascular professional service PA requests, and the process for inpatient service reviews.
- Added new “Medical Oncology” section for Evolent.
- Added new “Radiation Oncology” section for Evolent.
- Added a new “PA Request Submission” header for Evolent information, including phone Interactive Voice Response (IVR) steps.
- Moved the “Peer-to-Peer” section for Evolent to the “1. Peer-to-Peer Consultations” section, under “D. Provider Appeal Procedures.”
- Updated “Evolent Authorization Appeals and Retro-Authorization Reviews” section with additional information for cardiology.
- Added a new “CAR-T” section.
- Updated the “B. Prior Authorization Submission Process and Format” section with Digital First language, removing the fax submission option for prior authorization requests.
- Clarified the clinical documentation requirements when submitting prior authorization in the Availity Essentials portal in the “B. Prior Authorization Submission Process and Format” section.
- Added additional Availity Essentials portal benefits in the “B. Prior Authorization Submission Process and Format” section, including the ability to access prior authorization letters.
- Added a new “PA Request Submission (Evolent)” section.
- Added a new “NICU Utilization Management (ProgenyHealth)” section.
- Updated the “C. Timeframes for Responding to Standard and Expedited PA Requests” section, providing details on the standard request timeframe and on how providers will receive notifications or denials via fax or the Availity Essentials portal.
- Added a new “ProgenyHealth: Peer-to-Peer Review” section in “1. Peer-to-Peer Consultations” section.

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- Moved the “Evolent Peer-to-Peer Review” section to the “1. Peer-to-Peer Consultations” section.
- Updated the “Authorization Appeal (Pre-Claim),” “ProgenyHealth Authorization Appeal” and “Evolent Authorization Appeal and Retro-Authorization Review” timeframes from 30 calendar days to 60 calendar days in the “Authorization Appeal for Medical Necessity” section.

VIII. Claims Information

- Updated the Payer ID grid for all lines of business.
- Updated the “Availity Essentials Portal” section with additional features available in the Availity Essentials portal.
- Updated the “Ordering, Referring and Prescribing (ORP) Providers NPI” section with a Jan. 1, 2026, effective date for Molina to reject claims that lack the appropriate ORP information.
- Additional bullet point added to the “Required Elements on Claims” section to include the requirement for 10-digit National Provider Identifier (NPI) of the Billing Provider or Group to be included on a claim.
- Added in a table with claim frequency code information in the “Corrected Claim Process” section.
- Added additional information on NDC requirement in the “National Drug Codes (NDC)” section, to note that an NDC must be valid and currently marketed on the date of service.
- Changing the Molina clearinghouse information from Change Healthcare to the SSI Group in the “19. Electronic Payment Requirement” section.
- Updating the “Overpayment Dispute Process” section from 30 calendar days to 60 calendar days from the date on the notice to submit a written response disputing overpayment or requesting an extended payment arrangement.
- Updating the “F. Process and Requirements for Appeal of Denied Claims (Provider Claim Dispute Resolution Process)” section to include additional information on the required inclusion of necessary documentation when submitting a verbal clinical claim dispute.

IX. Care Coordination/Care Management

- Updated the “Care Management (CM)” section to include additional individuals who can refer members with high-risk medical conditions into Care Management.
- Moved the “Health Management” section from “II. Basic Plan Information” section to the “A. Description of Molina’s Care Coordination and Care Management Programs” section.
- Added new “Access to Records and Information to Support Member Care Coordination and Care Management Activities” section.

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X. Reporting

- No significant changes.

XI. Next Generation Managed Care Program

- No significant changes.

XII. Member Enrollment, Eligibility, Disenrollment

- Updated Member Cards to align to 2026 programs.
- Added new “Involuntary Disenrollment” section.
- Added new “Primary Care Provider (PCP) Dismissal” section.
- Added new “Missed Appointments” section.

XIII. Quality

- Updated “F. Clinical Practice and Preventive Health Guidelines” with new Clinical Practice Guidelines and Preventive Health Guidelines from the Molina Provider Website.

XIV. Compliance

- No significant changes.

XV. Members’ Rights and Responsibilities

- No significant changes.

XVI. Pharmacy

- No significant changes.

XVII. Risk Adjustment Accuracy and Completeness

- Updated chapter title from “Risk Adjustment Management Program” to “Risk Adjustment Accuracy and Completeness.”
- Removal of the “Why is Risk Adjustment Important?” section.

XVIII. Delegation

- Removal of bullet point “Sanction Monitoring for employees and contracted staff at all levels.”