Children's Medical Services (CMS) Plan by Molina Healthcare Provider Orientation

Behavior Analysis Services

BA

August 2026

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

CMS Plan Agenda

1. Overview
2. CMS Plan Transition
3. What is NOT Changing
4. What IS Changing
5. Provider Relations
6. Member Eligibility
7. Contracting & Credentialing
8. Billing & Claim Submissions

Agenda Continued

Agenda Continued

Session Guidelines and Expectations

- **How the CMS Plan trainings are organized** - Sessions are organized by topic and provider type
  - The General Orientation sessions are for providers without a dedicated session and cover topics that apply across the network
- **Attend the session built for you** – Specialty sessions cover the general orientation and requirements specific to your services. You only need to attend one session not both the general orientation and a specialty session.
- **Sessions are muted for participants –** Participants are muted during all training sessions to allow for content to be shared as efficiently as possible
- **Questions** – Submit questions in the Q&A at any time
  - As time allows questions will be answered at the end of the session
  - FAQs will be published after the session
  - For Behavioral Analysis providers a dedicated follow-up Q&A session will be scheduled at a later date, and providers will be notified to register for the Q&A session
- **Contracting timing** – Provider interest has been substantial. Applications are being reviewed in the order received, and we ask for your patience as we work through the volume
- **How you can help** – Submit complete, accurate contracting and credentialing packets, respond promptly to requests for information, and use the published channels rather than duplicate outreach
- **Our expectations** –
  - Continuity of care for members is required. Irrespective of contracting status on 10/1. Providers should not cancel previously approved services.
  - Molina contracts with fully credentialed, verified providers and holds every network provider to high compliance and quality standards

Overview

Effective **October 1, 2026**, Molina Healthcare of Florida will solely operate Children's Medical Services (CMS) Health Plan statewide, including coverage for **Behavior Analysis Services (BA)**

Molina Healthcare of Florida, as part of the Statewide Medicaid Managed Care program effective February 1, 2025, provides coverage for **BA services** for eligible members. Behavior Analysis services are medically necessary, evidence-based interventions designed to improve communication, social interaction, adaptive functioning, and other skills while reducing behaviors that interfere with daily living and learning.

The Behavior Analysis program emphasizes individualized treatment planning, measurable outcomes, and family involvement to support each member's unique needs. Molina partners with providers, caregivers, physicians, and community resources to ensure members receive coordinated, high-quality services that promote skill development, independence, and improved long-term outcomes.

CMS Plan Transition

Children's Medical Services Plan
BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

Children's Medical Services (CMS) Plan Overview

CMS Health Plan by Molina Healthcare is a Florida Medicaid specialty product for children and youth ages 0 through 20 with chronic conditions.

Eligibility

- **Medicaid: ages 0–20**, with a qualifying condition and eligibility for Medicaid
- **CHIP: ages 1–18**, with a qualifying condition and eligibility for CHIP
- A child must meet both clinical and applicable Medicaid or CHIP eligibility requirements to enroll

Program Administration

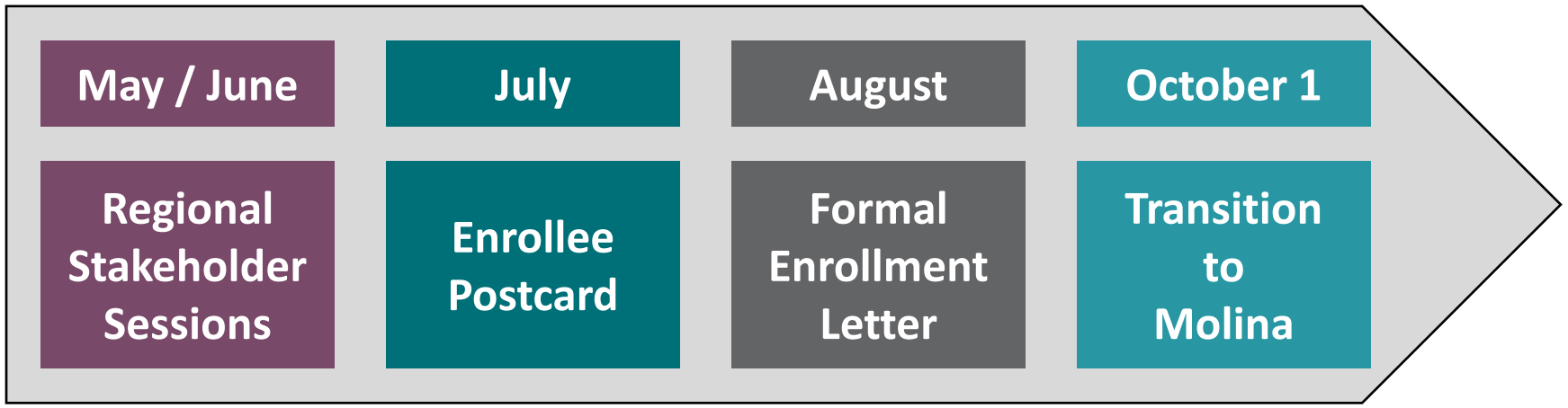
- The CMS Plan is solely administered by Molina Healthcare
- The contract applies to both Title XIX Medicaid and Title XXI CHIP recipients

Provider Takeaway

Confirm the member's CMS Plan enrollment and eligibility for the date of service. Eligibility is determined through the State's enrollment and clinical eligibility processes

CMS Plan Transition Timeline Snapshot

Effective October 1, 2026, the operation of the CMS Plan will move from Sunshine State Health Plan to Molina Healthcare of Florida



Transition Principles

- Continuity of medically necessary care
- Maintain important relationships
- Clear communication and issue resolution

About Molina Healthcare of Florida

- Molina has deep knowledge and experience having served Florida families throughout the state for more than 20 years
- Comprehensive Specialty Plan serving MMA, Long Term Care, and SMI / HIV Specialty Products
    - Offer ACA Marketplace in 20 Florida counties
- Care Management, Provider Relations, and Community Engagement staff located throughout Florida
- 4-Star Quality rating from NCQA
- Commitment to investing in Florida communities

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

What Is NOT Changing

What is NOT Changing?

CMS Plan Eligibility Requirements

Child & Family-Focus

Covered Benefits & Service Categories

Member Rights & Responsibilities

What is NOT Changing?

Member Eligibility Requirements

- Must meet financial and clinical eligibility
  - Medicaid: Under 21 years old, enrolled in Medicaid, and meet clinical eligibility (as determined by Florida Department of Health (DOH))
  - CHIP: Under 19 years old, enrolled in Florida Healthy Kids, and meet clinical eligibility (as determined by DOH)

Child & Family-Focus

- Supporting strong families
- Locally-based Care Management staff
- Availability of enrollee and family services, incentives, and supports to promote health and healthy behaviors

What is NOT Changing?

Covered Medical Benefits & Service Categories

- CMS Plan enrollees will continue to get the same medically necessary covered services as they do today (e.g., acute, behavioral, therapeutic services, including pharmacy and transportation services)

Dental Services

- Dental services will continue to be provided to CMS Plan enrollees
- Dental plans will not change as a result of the CMS Plan transition:
  - CHIP enrollees: Coordinated through Molina
  - Medicaid enrollees: Provided through State Dental Health Plan

Rights & Responsibilities

- Enrollee and family rights and grievance protections

What IS Changing

What IS Changing?

Enhanced Child & Family Benefits

Improving Well-Being & Quality of Life

Child & Family Programs

Administrative & Operational Changes

Examples of CMS Plan Expanded Benefits

Additional goods and services that support the child, caregiver and household. For a full listing and details of expanded benefits review the Provider Manual (Provider Handbook)

EFFECTIVE OCTOBER 1, 2026

Health, Equipment & Safety

- Adaptive and safety devices
- Biometric equipment
- Sensory and calming aids
- Wigs, medical makeup and adaptive clothing
- Medication safety kit
- Vision aid and service-animal supports

Home & Environmental Support

- Carpet cleaning
- HEPA air filter and replacement filters
- HEPA-filter vacuum
- Hypoallergenic bedding
- Pest-control services

Meals & Transportation

- Disaster-preparedness meals
- Meals after a change in condition
- Post-discharge meals
- Medically tailored meals
- Long-distance medical-trip meal support

Self Sufficiency

- Housing assistance
- Non-medical transportation
- Food assistance

Wellness & Daily Living

- Fitness benefit
- Swimming lessons for drowning prevention
- Cellular phone service
- Collaborative care
- Respite care

OTC, Education & Caregiver

- Over-the-counter medications and supplies
- Caregiver education and support
- Tutoring and education support
- Child-welfare and social-needs supports

Molina also offers expanded benefits for transition-age youth leaving the child welfare system such as education support and more

Reminder: Benefit eligibility, limits and authorization requirements vary. Coordinate benefit-specific questions through the member's Case Manager or CMS Plan Member Services

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Child & Family Programs

- Expanded coverage of evidence-based practices
    - High-fidelity wrap around services
    - First Episode Psychosis
    - Trauma-focused Cognitive Behavioral Therapy
- Tailored programs for families of enrollees receiving the following services:
    - Nursing Facility
    - Private Duty Nursing (PDN)
    - Statewide Inpatient Psychiatric Program (SIPP)
- Adolescent and young adult-focused digital support tools

Chronic Disease Management Programs

Specialized Chronic Disease Management team addressing physical health, behavioral health, & social needs of enrollees with chronic conditions.

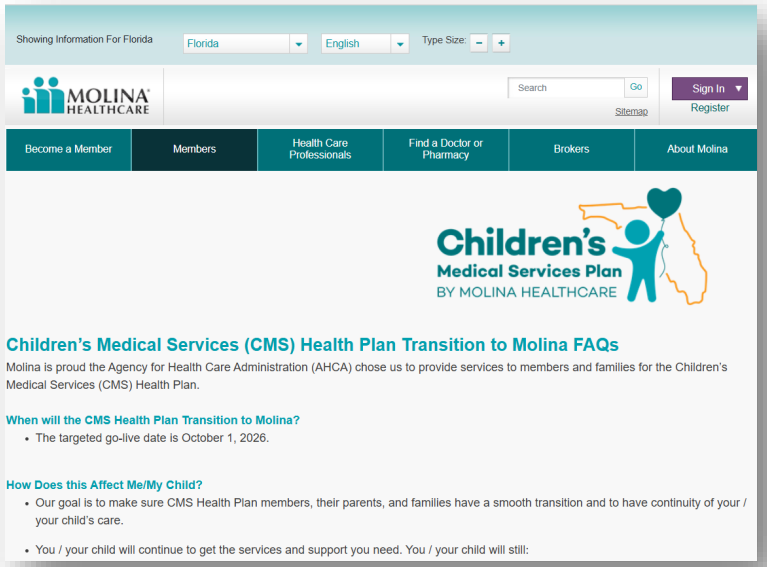
Goals

- Ensure understanding of provider treatment plan, connect to specialists
- Connect with resources & techniques to self-manage & prevent escalation
- Improve quality of life, education and social engagement, and independence
- Support young adults in establishing care with adult-serving providers

Key Chronic Conditions: Diabetes, Asthma, Cancer, Sickle Cell, Behavioral Health Conditions

Administrative & Operational Changes

- New contact information, websites, portals, and mobile apps
- Claims submission processes
- New enrollee ID cards
- Dedicated contracting and provider relations contact



Provider Relations

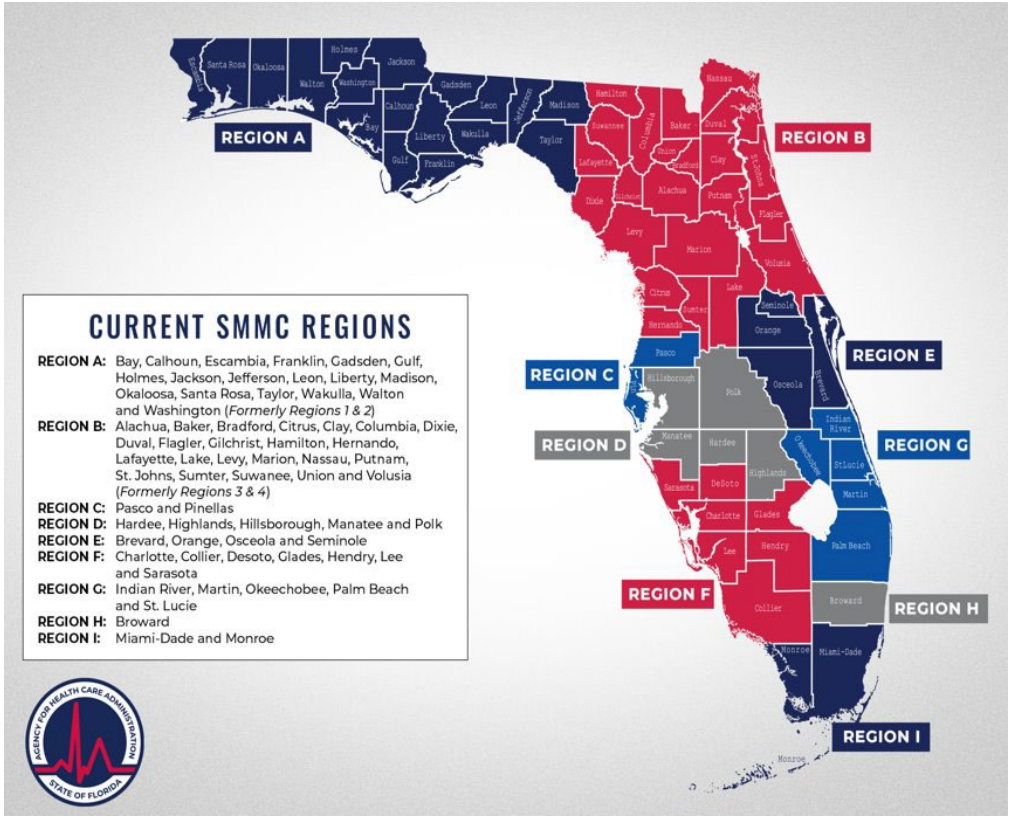
Children's Medical Services Plan
BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

Provider Relations

Provider Relations is the liaison for providers and the health plan to support engagement, compliance, access, quality, and performance across Molina plans and stakeholders.

Regions	Meet The Team
Region A	Tiffini Whiting: Tiffini.Whiting@MolinaHealthcare.com Angie Riviere: Angie.Riviere@MolinaHealthcare.com
Region B	Trevor Rodriguez: Trevor.Rodriguez@MolinaHealthcare.com Ariel Diaz Jr.: Ariel.Diazjr@MolinaHealthcare.com
Region C	Sydney Stacy: Sydney.Stacy@MolinaHealthcare.com Vanessa Lopez: Vanessa.Lopez3@MolinaHealthcare.com
Region D	Vilma Hernandez: Vilma.Hernandez@MolinaHealthcare.com Lauren Giordano: Lauren.Giordano@MolinaHealthcare.com Edward LaMarche: Edward.LaMarche@MolinaHealthcare.com
Region E	Rossiany Castro: Rossiany.Castro@MolinaHealthcare.com Megan Gonzalez: Megan.Gonzalez@Molinahealthcare.com
Region F	Dongdow Gordon(Dee Dee): Dongdow.Gordon@MolinaHealthcare.com Shanda Lerner: Shanda.Lerner@Molinahealthcare.com
Region G	Kayla Lavieri: Kayla.Lavieri@MolinaHealthcare.com Kashala Burse: Kashala.Burse@MolinaHealthcare.com
Region H	Veronica Bermudez: Veronica.Bermudez@MolinaHealthcare.com Kashala Burse: Kashala.Burse@MolinaHealthcare.com
Region I	Mackie Hicks: Mackie.Hicks@MolinaHealthcare.com Rafael Padierne: Rafael.Padierne@MolinaHealthcare.com
Provider Relations	Phone: (855) 322-4076



Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Member Eligibility

Children's Medical Services Plan
BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

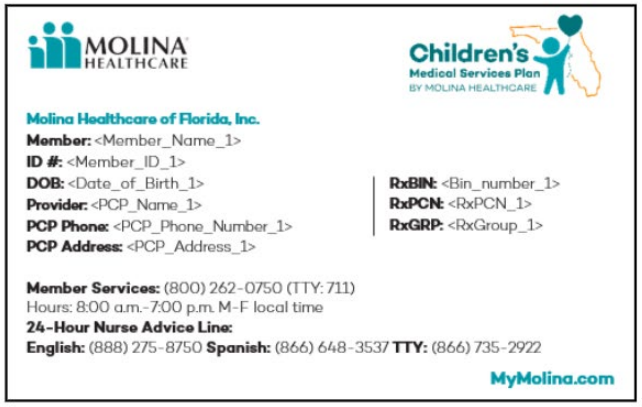
Member Services and Eligibility

Our Member Contact Center supports benefits, eligibility, pharmacy questions, PCP changes, and member complaints. Representatives are available Monday–Friday, 8AM–7PM local time, excluding state and federal holidays.

Member Contact Center		
	MMA, LTC, and HIV & SMI Specialty Plans	CMS Plan
Member Phone	(866) 472-4585 (TTY: 711)	(800) 262-0750 (TTY: 711)
Automated Voice Response	(800) 239-7560	(800) 239-7560

- Members receive a Molina Healthcare ID card in addition to their Florida Medicaid ID card and should carry both when accessing medical or pharmacy services.
- Title XIX (Medicaid) members receive dental services and associated materials from their chosen SMMC Dental Plan (not administered by Molina). Title XXI (CHIP) members receive a separate dental ID card from the CMS dental plan (administered via Molina). Dental services are verified and billed through that dental plan, not Molina.
- A Molina ID card does not guarantee eligibility or coverage. Providers must verify member eligibility before rendering services.

Verify Eligibility and Benefits (E&B) PCP Assignment through Availity
https://provider.molinahealthcare.com/
or
Call Molina FL Provider Services at (855) 322-4076


MOLINA HEALTHCARE

Children's Medical Services Plan BY MOLINA HEALTHCARE

Molina Healthcare of Florida, Inc.
Member: <Member_Name_1>
ID #: <Member_ID_1>
DOB: <Date_of_Birth_1>
Provider: <PCP_Name_1>
PCP Phone: <PCP_Phone_Number_1>
PCP Address: <PCP_Address_1>

RxBIN: <Bin_number_1>
RxPCN: <RxPCN_1>
RxGRP: <RxGroup_1>

Member Services: (800) 262-0750 (TTY: 711)
Hours: 8:00 a.m.-7:00 p.m. M-F local time
24-Hour Nurse Advice Line:
English: (888) 275-8750 **Spanish:** (866) 648-3537 **TTY:** (866) 735-2922

MyMolina.com


Emergency Services: Call 911 if you can. Or you can go to the nearest emergency room (ER). Call your doctor if you are not sure you need to go to the ER. Or call our 24-Hour Molina Healthcare Nurse Advice Line at (888) 275-8750, or (866) 648-3537 (Español), or (866) 735-2922 (TTY).
Call your doctor and your Care Manager after all ER visits.

Care Management or Member Services: Call (800) 262-0750 (TTY: 711)

Claims: Billing information and Claims Submission for participating and non-participating providers: Call (855) 322-4076 or submit to: CMS Plan, PO Box 22812, Long Beach, CA 90801

EDI Claims: Payer #51062 or Call (855) 322-4076

Transportation: To schedule a trip call (844) 399-9469

Pharmacy Help Desk: Call CVS Caremark at (855) 276-6580

Children's Medical Services (CMS) Plan
1030 W 49th St., Hialeah, FL 33012

MolinaHealthcare.com

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Contracting/Credentialing

How to Join Molina Healthcare of Florida's Network

! The Molina Provider Portal is a free tool for provider enrollment and credentialing; all network credentialing requests must be submitted electronically. Before you request to join the network for CMS Program participation, the provider must be enrolled in Florida Medicaid and have a valid, active Medicaid ID issued by AHCA

1 CONNECT

Connect with Molina by submitting a contract request to join the network here **View Join Our Network webpage →** and follow the instructions for your provider type

2 DOCUMENTATION

If accepted, use the portal credentials provided to complete contracting and credentialing information and upload requested documents

3 CREDENTIALING

Meet applicable credentialing requirements, including a complete CAQH profile for practitioners or licenses and accreditations for Health Delivery Organizations (HDOs)

4 CONTRACT

Provider signs the agreement, Molina countersigns the agreement and provides a signed copy to the provider and loads credentialed providers as in-network

Key Functions

- ✓ Adding practitioners to an existing group
- ✓ Submitting credentialing requests
- ✓ Tracking credentialing and participation status
- ✓ Providing additional or missing information for enrollment or credentialing
- ✓ Uploading provider rosters
- ✓ Adding new facility locations

Provider-type routing matters

- **Vision:** contracting may involve Molina and a vision vendor
- **Pharmacy:** contact the pharmacy benefits manager
- **Dental:** contract through Molina's dental vendor
- **Home Health/Home Infusion/DME:** contact Coastal Care
- **Therapies:** contract with Molina for CMS plan and HN1 for other Molina plans
- **Existing practices:** use the portal to add practitioners or upload a roster

Need Help?

Contact Provider Services:
(855) 322-4076

Contact your Provider Relations Representative
Provider Relations Contact List

Access Behavioral Health continues as the sole delegate to manage BH services in Region A

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Completing the Join Our Network Form

Have These Ready Before You Start

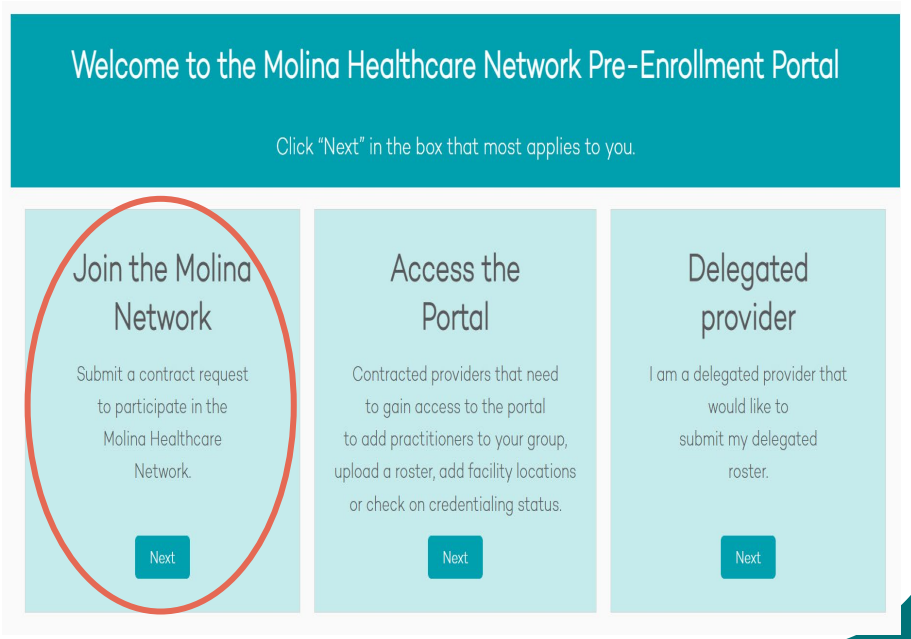
- Current W-9 matching your legal name and Tax ID
- Type 1 and Type 2 NPIs and Florida Medicaid ID
- State license, DEA where applicable, and malpractice coverage
- CAQH ID with a current attestation and Molina authorized to access it
- Accreditation, CLIA, or facility licenses for organizations
- Practitioner roster if you are adding multiple providers at once

Step-by-Step Instructions

1. Open the Join Our Network webpage and select the request form for your provider type
2. Identify the provider category: individual practitioner, group, facility or Health Delivery Organization
3. Enter organization details exactly as they appear on your W-9: legal name, Tax ID, and Medicaid ID
4. Add the Type 1 and Type 2 NPIs (where applicable), taxonomy, and specialty for the requested services
5. List every service location and the counties served, including hours and accessibility details
6. Add each practitioner to be included, with license number and CAQH ID
7. Provide a contracting contact: name, title, direct phone, and email for follow-up
8. Attach the requested documents, then review every field for accuracy before submitting
9. Submit the form and save the confirmation for your records

After You Submit

- Molina reviews the request against network need in your specialty and area
- If accepted, you receive portal credentials to complete contracting and credentialing
- Watch your email for document requests; incomplete forms delay the process
- **Right away:** save the confirmation, watch for an email acknowledging the request is in review
- **During review:** expect email updates at each stage - network decision, contract issuance, credentialing outcome
- **Once credentials are issued:** track status and document requests in the portal
- **Questions:** Provider Services (855) 322-4076 or your Provider Relations Representative



Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Already Contracted? Update Your Information Online

Choose the path that matches your portal status

FIRST-TIME USER

Get your portal credentials

First time user of our new online provider portal? Please click here to receive a username and password to update your information

Click here to register →

EXISTING USER

Sign in and make updates

Existing users of our online provider portal: Please click here to access our online provider portal to update your information

Click here to sign in →

What you can update online

- **Demographics:** address, phone, tax ID, or panel status updates
- **Practitioners:** add or terminate a provider, or upload a roster file
- **Locations:** add a new service site or specialty to your agreement

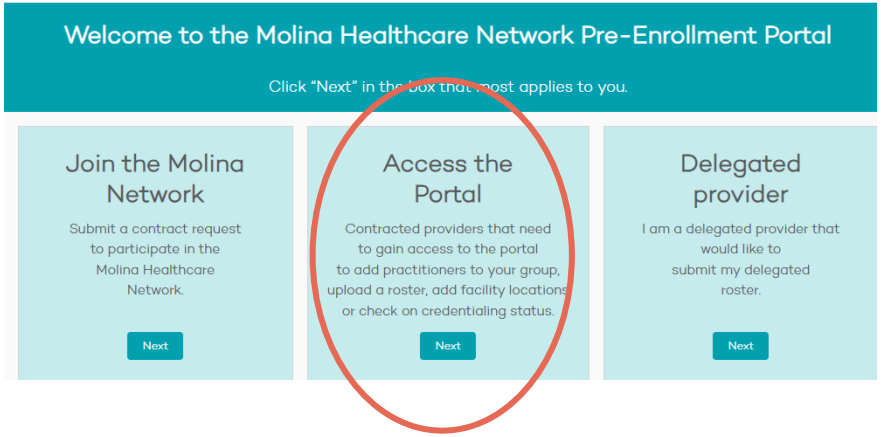
All other updates or Need Help?

- **Contact Provider Services: (855) 322-4076** or **Contact your Provider Relations Representative**
  Provider Relations Contact List

How to Update Your Provider Information

Participating Providers: Update in the Provider Portal

1. Go to the online provider portal sign-in page; first-time users select the registration link to request a username and password
2. Sign in and select the Tax ID or organization you are updating
3. Open your provider profile and choose the practitioner or location that needs to change
4. Update demographics: address, phone, fax, email, office hours, languages, and accessibility
5. Update panel status, such as opening or closing your panel to new members
6. Add or remove practitioners in the group, or upload a roster for multiple changes at once
7. Add a new service site or specialty that falls under your existing agreement
8. Attach supporting documents, including a current W-9 for any pay-to or Tax ID change
9. Submit the request and save the confirmation; updates appear in the directory after review



Submit changes as far in advance as your agreement requires so directory and claims routing stay accurate

Non-Participating Providers: Update Directly with Molina

1. Contact Provider Services at (855) 322-4076 or your Provider Relations Representative to request a data update
2. Provide a current W-9 that matches your legal name and Tax ID
3. Include your Type 1 and Type 2 NPIs (when applicable), Florida Medicaid ID, and taxonomy
4. Confirm the service location address and the remit or pay-to address
5. Give a contact name, phone, and email for follow-up questions
6. Submit the update before you file claims so payment and correspondence route correctly
7. Reference the authorization number on affected claims to avoid processing delays

Ready to contract? Use the Join Our Network request form to move to participating status and gain full portal access

How You Know It Is Moving

- **At submission:** save the confirmation number shown on screen
- **Within days:** an email confirms the request was received and is in review
- **In the portal:** the request shows as pending, then completed once applied
- **After review:** your profile and the online directory reflect the change
- **No movement?** call Provider Services with your confirmation number

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Credentialing and Recredentialing

Providers must maintain Molina credentialing and re-credentialing requirements throughout the life of the contract, consistent with state, federal, and accreditation standards. Providers are also expected to respond timely to credentialing-related information requests

Ongoing Practitioner Monitoring

- Molina is required to monitor practitioners for sanctions, exclusions, license issues, and other eligibility concerns using required federal, state, Medicaid, and specialty board sources

Follow-Up and Committee Review

- Potential matches are verified and reviewed by the Credentialing Committee, when applicable, and may result in further oversight action
- Providers and facilities approved for Molina's network are re-credentialed every 3 years

Process

- Providers receive a re-credentialing application approximately 6 months before the current credentialing period expires

Site Audit Requirement

- A site audit is required every 3 years for all rendering Primary Care, Obstetrics, and Gynecology provider service locations

Reminder: Credentialing is a requirement for services contracted through Molina vendors. Contact the vendor directly to credential and re-credential

Billing & Claims Submission

Children's Medical Services Plan
BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

Claim Submission

Providers may submit claims to Molina electronically using current Federal CMS 1500/UB-04 formats or approved equivalents, through the Availity Portal, or by paper submission.

Providers may register with SSI Claimsnet, LLC to submit claims using the Provider Registration Form available online at:
https://products3.ssigroup.com/ProviderRegistration/register

Marketplace/Medicaid/LTC/CMS Plan Claims Submission Address
Molina Healthcare of Florida
P.O. Box 22812
Long Beach, CA 90801

EDI Claims Submission – All Lines of Business
Payor ID# 51062

Availity Portal
Welcome to Molina Healthcare, Inc - ePortal Services

Participating vs. Non-Participating Claim Process

Participating (In-Network) Providers

- Verify eligibility, benefits, and PCP assignment in Availity first
- No prior authorization for routine office visits
  - Confirm requirements for other services
- Submit claims via Availity, EDI Payer ID 51062, or by paper
- Claims pay at your contracted Molina rate
  - Check status and remittance in Availity
- Use the claims dispute process for reconsiderations within contract timeframes

Non-Participating (Out-of-Network) Providers

- Prior authorization is required for all services and codes, with limited exceptions such as emergency services
- Confirm your NPI, TIN, W-9, and pay-to address are on file with Molina before billing
- Submit claims via Availity, EDI Payer ID 51062, or by paper
  - Include the authorization number on the claim
- Reimbursement is 100% of the Medicaid rate unless a single-case agreement applies
- Contact Provider Services to resolve claim issues or to join the network

Paper vs. Electronic Claims Submission

Submit electronically when possible; paper Federal CMS 1500/UB-04 claims must meet Federal CMS plan print standards or claims may be rejected/returned for correction

PAPER CLAIMS: Standard

In effect since June 1, 2026

Federal CMS redline paper claim form standards enforced for Federal CMS 1500/UB-04 paper claims.

Required

- Flint OCR Red J6983 ink or exact match
- Federal CMS layout, alignment and scanability standards
- Place double Z (ZZ) indicator in front of taxonomy codes

Do not submit

- Black-and-white or photocopied Federal CMS forms
- Downloaded/printed forms that miss Federal CMS color or scale standards
- Misaligned or poor-quality prints

Non-compliant paper claims will be returned with instructions for correction.

VS

ELECTRONIC CLAIMS: Preferred Path

Why it matters

- Promotes HIPAA compliance
- Reduces paper claim costs, mailing time and delays
- Increases data accuracy and information delivery
- Errors can be corrected and resubmitted electronically

Submission options

- Availity Essentials portal at no cost to providers
- EDI clearinghouse using Payer ID 51062

Availity also supports attachments, corrected/void claims, claim status checks, status notifications, saved drafts and claim templates.

Secondary Claim Submissions

Bill the primary payer first – Molina Healthcare of Florida is the payer of last resort. Identify other coverage at registration and submit to the primary carrier before billing Molina.

Wait for the primary payer's determination – Secondary claims cannot be processed without the primary Explanation of Benefits or remittance advice showing payment, denial, or patient responsibility. Molina will process these claims in accordance with Medicaid rule 59G-1.052, Third-Party Liability Requirements. Third Party Requirements - 59G-1.052

Submit the secondary claim electronically – Use the Availity Essentials portal or EDI payer ID 51062 with complete coordination of benefits data, including primary paid amounts, adjustment reason codes, and patient responsibility at the line level.

Paper submissions must include the EOB – Attach the primary payer's EOB to a compliant CMS 1500 or UB-04 and mail to Molina Healthcare of Florida, P.O. Box 22812, Long Beach, CA 90801.

Watch your timely filing window – Secondary claims must be received within the timeframe in your provider contract, measured from the primary payer's remittance date. Retain proof of timely filing. For non-contracted providers, a secondary claim must be received within 90 days from the primary payer's remittance date

Keep other-coverage information current – Report new or terminated primary coverage to Molina so eligibility records stay accurate and claims are not denied for missing COB information.

If the process is not followed – Claims submitted without primary payer information will be denied, delaying payment and requiring corrected resubmission within filing limits.

Encounter Data

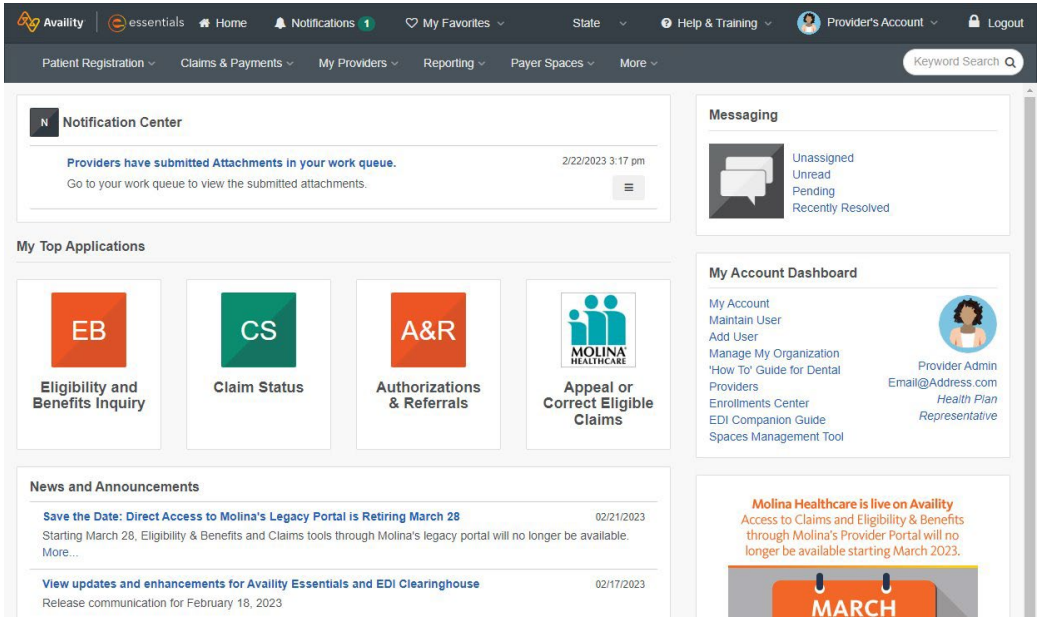
Encounter Data Submission

Providers with a Molina capitated agreement must submit encounter data for all adjudicated claims

- Encounter data must be submitted at least monthly and no later than 7 days after Molina adjudicates the claim
    - Use HIPAA-compliant transactions:
        - ANSI X12N 837I – Institutional
        - 837P – Professional; and
        - 837D – Dental
- Encounters rejected or denied due to provider errors (for example, invalid member or provider IDs, missing or invalid codes, or incomplete data elements) must be corrected and resubmitted within 15 days of the rejection or denial date
- Validate submissions before sending – verify member and provider data, NPI/taxonomy, service dates, and complete, current coding – to prevent rejections and denials
- Monitor encounter acceptance reports and address recurring error patterns to keep submissions accurate, complete, and timely

Availity Essential Portal Tools

- Verify Member Eligibility & Benefits
- Submit Authorization Requests
- Check Authorization Status
- Submit & Resubmit Claims
- Check Claim Status
- Access Remittance Viewer
- Use the Care Coordination Portal
- The Digital Correspondence Hub lets your organization manage communication preferences



What We're Asking You to Do

- Register with Availity so your organization has portal access Availity Essentials Portal
- Review the trainings on the Availity portal to learn how to use its tools
- Contact your Provider Relations Representative if you need assistance Provider Relations Contact List

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

How to Register with Availity

Registration Steps (All Providers)

1. Go to availity.com and select Register
2. Choose your organization type and identify who will serve as your Availity administrator
3. Enter your organization's legal name, tax ID, and NPI exactly as they appear on your W-9
4. Verify the administrator's identity and accept the terms of use
5. Watch for the confirmation email and complete the administrator setup
6. Add users, assign roles, and add Molina Healthcare of Florida as a payer
7. Log in and complete the Availity training resources under Help & Training

Participating (In-Network) Providers

- Register using the tax ID and NPI on your Molina contract so your data matches our system
    - Atypical providers use your Tax ID to register
- Full portal access: eligibility and benefits, authorizations, claim submission and status, Remittance Viewer, and the Care Coordination Portal.
- Claim and remittance detail reflects your contracted Molina rates

Non-Participating (Out-of-Network) Providers

- Register using your billing tax ID and NPI and confirm your W-9 and pay-to address are on file with Molina
- Use the portal to verify eligibility, submit prior authorization requests for all services, and check claim status
- Reimbursement displays at 100% of the Medicaid rate unless a single-case agreement applies
- Contact Provider Relations to request a contract and move to in-network access

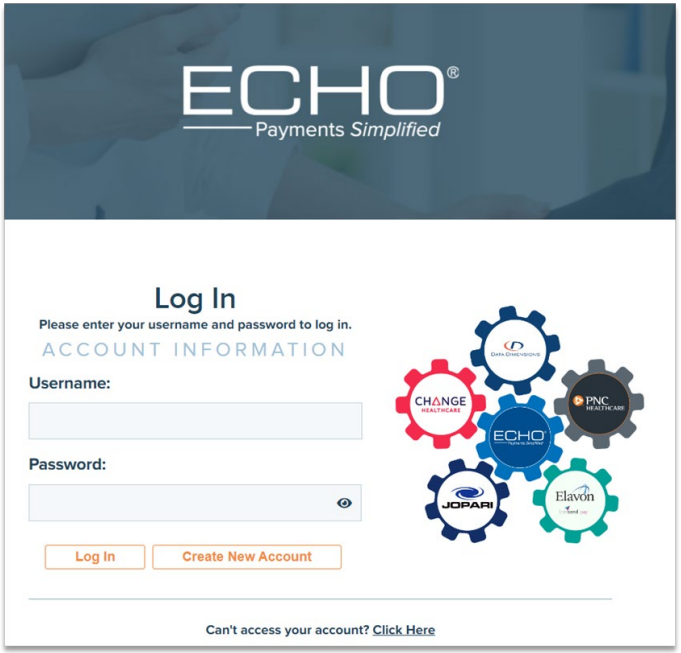
Reminder: Registration with Availity can be a time-consuming process. Register now

Electronic Payment Requirements

Molina partners with **Change Healthcare/ECHO Health** for electronic payments. To avoid receiving payments on a Molina Visa Card - **Providers are encouraged to enroll immediately with ECHO Health before** their first Molina payment.

Benefits of Electronic Remittance Advice (ERA)/ Electronic Funds Transfer (EFT) Enrollment:

- Faster payment turnaround via EFT
- Easy access to historical ERAs
- View, download, print & save ERAs
- Paperless Explanation of Payments (EOPs)



How to Enroll:

Visit: https://enrollments.echohealthinc.com/efteradirect/MolinaHealthcare
Questions: Contact ECHO Health at **(888) 834-3511. Molina Payer ID: 51062**
Additional registration instructions are available under the **EDI/ERA/EFT** section at MolinaHealthcare.com.

Appeals & Grievances

Children's Medical Services Plan
BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

Provider Disputes

- A provider dispute is any disagreement related to claim processing, payment, or non-payment.
- To submit a dispute, please contact Customer Service at (855) 322-4076. You can also submit your request through **Availity**, or mail a written request with any supporting documentation to:

Molina Healthcare of Florida Appeal and Grievance Unit
P.O. Box 36030
Louisville, KY 40233-6030
Fax: 877-553-6504

Provider disputes must be received within one (1) year of the date of payment or denial of the claim. Molina will issue a written decision within 30 days

- **Tips to avoid delays in processing:**
  - Ensure disputes/appeals include supporting documents
    - Proof of timely filing
    - Explanation of Benefits (COB claims)
    - Invoices
    - Medical Notes
    - Consent Forms

Documentation Should Include:

- ✓ Member Name
- ✓ Member ID
- ✓ Date of Service
- ✓ Billed Charges
- ✓ Amount Molina has paid
- ✓ Account Balance
- ✓ Rendering Provider NPI and Tax ID
- ✓ Pay to Group NPI and Tax ID
- ✓ Service code or CPT code
- ✓ Comments or category from the provider
- ✓ Line of Business
- ✓ Claim number

Provider Disputes vs. Appeals

Disputes	Appeals
Underpayments	Authorization denials
Overpayments	Medical necessity determinations
Timely filing	Clinical review decisions
Bundling	Supporting clinical documentation required

Additional Resources
Capitol Bridge
(800) 889-0549
FLCDR@capitolbridge.com

Reminder: Corrected claims are **not** considered disputes or appeals.

Health Care Services (HCS)/ Utilization Management (UM)

HCS Overview

Health Care Services (HCS)

Comprised of **Utilization Management (UM)** and **Care Management (CM)** working in an integrated, evidence-based model

HCS Model

Focuses on a high-touch, Member-centric approach shown to improve outcomes for Members

Provides care management for a wide range of needs, including chronic conditions requiring coordinated service

UM program includes:

- Pre-service authorization review
- Inpatient authorization management (pre-admission, admission, concurrent review)
- Medical necessity review
- Oversight of out-of-network or non-participating provider use

Utilization Management (UM)

- Ensures services are medically necessary, appropriate, and resource-efficient based on Member needs
- Promotes quality, cost-effective care across the full continuum of services
- Maintains flexibility to adjust to changes in a Member's condition
- Decisions are made by licensed clinicians and Molina Medical Directors, with peer-to-peer discussion and interdisciplinary team input available

Who Makes UM Decisions and How

Clinical Rigor Behind Every Decision

- Licensed clinicians conduct all medical necessity reviews using approved, evidence-based criteria
- Only a Molina Medical Director, unless excepted by AHCA, may issue an adverse medical necessity determination; non-clinical staff never deny for medical necessity
- Board-certified specialty reviewers and pediatric subject matter experts are used for complex and specialized cases
- Criteria are applied to the individual member, with review of the clinical record rather than codes alone
- Criteria used for a decision are available to you on request

Peer-to-Peer Review

- Treating provider or Molina Medical Director/ clinical expert may request to speak directly
- Peer-to-peer discussion available before or after a determination—often resolves questions faster than an appeal
- Request a peer-to-peer through instructions provided by UM with the adverse determination notification

Interdisciplinary Care Team and Collaboration

- Complex cases are staffed through an Interdisciplinary Care Team that includes UM, care management, behavioral health, and pharmacy
- The PCP, treating specialists, and the member and family are invited into the care plan discussion
- Clinical documentation submitted with the request keeps the review collaborative

Key Functions of the UM Program

All prior authorizations are based on a specific standardized list of services.

For more information about Molina's CMS Plan UM Program, or to obtain a copy of the CMS Plan HCS Program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Molina website or contact the UM department.

Eligibility and Oversight

- Eligibility Verification
- Benefit Administration and Interpretation
- Verification that authorized care correlates to Member's medical necessity need(s) and benefit plan
- Verification of current physician/hospital contract status

Resource Management

- Prior Authorization and referral management
- Pre-admission, Admission, and Inpatient Review
- Referrals for Discharge Planning and Care Transitions
- Staff education on consistent application of UM functions

Quality Management

- Satisfaction evaluation of the UM program using Member and Provider input
- Utilization data analysis
- Monitor for possible over- or under-utilization of clinical resources
- Quality oversight
- Monitor for adherence to Federal CMS, NCQA, State and health plan UM standards

Medical Necessity

Medicaid Reimbursement Determination

For Medicaid reimbursement, AHCA is the final authority to determine if a service is medically necessary. Determinations are based on information available at the time services were rendered and, when possible, use a physician in active practice with the same specialty/subspecialty as the physician under review.

Medicaid Rules and Medical Criteria

- Reviews apply Florida Medicaid rules and AHCA coverage policies first
- Nationally recognized, evidence-based criteria are used to support the decision where those rules do not address the specific request and are always applied to the individual member's clinical record

Provider Recommendation Alone Is Not Enough

A provider's prescription, recommendation, or approval does not, by itself, make a service medically necessary, a medical necessity, or a covered service/benefit

Inpatient Hospital Services

For inpatient hospital services, medical necessity means appropriate medical care cannot be provided more economically on an outpatient basis or in another type of inpatient facility

EPSDT for Members Under 21

Under Early and Periodic Screening, Diagnostic and Treatment, members under 21 are eligible for any medically necessary service that corrects or improves a condition identified through screening, including services beyond standard coverage limits

Special Services Process

- Services outside standard limits are requested through the special services process
- Submit the request with clinical documentation supporting medical necessity
    - A Molina Medical Director reviews it and written notice of the determination is issued

Requests should follow standard authorization processes and include all supporting medical necessity documentation

Prior Authorization (PA) Request

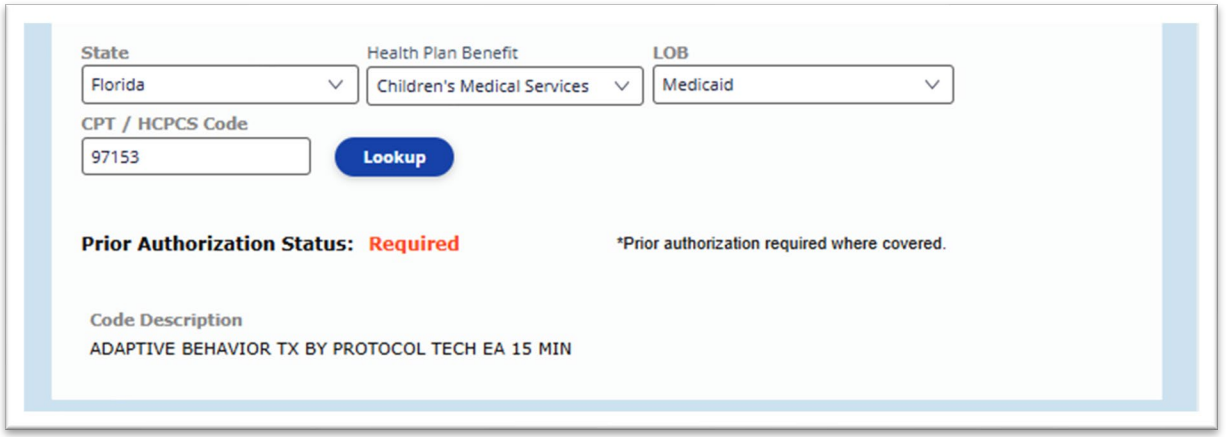
CMS Plan requires prior authorization for certain services to meet federal and state requirements and the terms of the Molina Hospital or Provider Services Agreement. A detailed list of services requiring authorization, including applicable CPT and HCPCS codes, is available for provider reference.

Prior authorization is not required for office visits with participating network providers. Non-participating providers require authorization for all services and submitted codes, except for emergency services, evaluation and management codes during non-elective observation or inpatient admissions, or when otherwise required by law.

Prior Authorization (PA) Look-Up Tool

Prior-Authorization Look-up Tool:
Florida Providers Home

Service Request can be submitted via the
Provider Availity Portal



Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Prior Authorization Submission

Providers must submit prior authorization requests through the Availity Portal. Requests must include enough information for Molina to review medical necessity and process the request timely

Required Information

- ✓ Member demographics: name, date of birth, and Molina ID number
- ✓ Provider details: referring provider and referred-to provider/facility, including address and NPI
- ✓ Diagnosis and ICD-10 code(s)
- ✓ Requested service/procedure with applicable CPT and HCPCS codes
- ✓ Service location
- ✓ Clinical documentation supporting medical necessity, including:
  - ✓ Pertinent history, treatment, diagnostic tests, examination findings
  - ✓ Inpatient length of stay when applicable
  - ✓ Rationale for expedited processing when requested

Additional Information

For full requirements and service-specific guidance, providers should reference the **Prior Authorization/Utilization Management** section of the Molina Provider Manual or refer to the Prior Authorization Tool on our website: Florida Providers Home.

Submitting an Authorization in Availity

Step-by-Step in the Portal

- Log in to Availity Essentials and select Molina Healthcare of Florida as the payer
- Confirm eligibility and benefits, then check the Prior Authorization Look-Up Tool to verify authorization is required
- Open Patient Registration and select Authorizations & Referrals, then Authorization Request
- Choose the request type and enter member demographics and Molina ID
- Add requesting and servicing provider or facility with NPI, diagnosis and ICD-10 codes, CPT/HCPCS codes, service location, and dates of service
- Mark the request urgent or routine and attach clinical documentation supporting medical necessity
- Submit and save the confirmation number, then track status under Auth/Referral Inquiry

Non-Participating Providers

- Authorization is required for all services and codes, except emergency services
- Register for Availity and follow the same steps as above
- Submit a current W-9 and NPI for payment set-up
- Active authorizations appear in the portal under the member's Molina ID

Missing a Sunshine Health Authorization?

- Active authorizations transferred from Sunshine Health should appear in the portal under the member's Molina ID
- If you do not see an existing authorization, do not delay care. Contact Molina before rescheduling or cancelling the service
- Have the member ID, service dates, CPT codes, and the prior authorization number ready when you call

Who to Contact

- Missing or transitioned authorizations: Molina Provider Services at (855) 322-4076
- Portal access, log-in, or submission errors: Availity Client Services, or your Provider Relations Representative
- Clinical or urgent authorization questions: Molina Utilization Management through Provider Services

Questions?

Call Provider Services for help at (855) 322-4076

Urgent vs Routine Requests

Definitions

- **Urgent:** Use when delay could cause serious health deterioration, prevent the member from regaining maximum function, or result in severe unmanaged pain
- **Routine/non-urgent:** Submit all requests that do not meet urgent criteria as routine/non-urgent

Processing Timeframes

- **Urgent:** Processed within 2 calendar days
- **Routine/non-urgent:** Processed within 3 calendar days of the initial request

Provider Review Options

- Providers may request the criteria used for the final authorization decision
- Providers may request to speak with the Medical Director who approved or denied the request

In-Network Specialist Referrals

Referral Guidance

- Refer members when services are outside the PCP's scope or specialty consultation/treatment is needed, except for emergency services
- PCPs and specialists should exchange information to support continuity of care; referrals must be documented in the medical record with specialty, requested service, and diagnosis

Network Use

- Direct members to Molina-contracted and credentialed providers/facilities when applicable. Out-of-network referrals require prior authorization, except for emergency services
- Specialists are to submit prior authorization requests directly to Molina and **should not** send members back to PCPs to submit on their behalf

No Referral Required

- Members may go directly to in-network Obstetrics and Gynecology, Dermatology, Chiropractic, Behavioral Health (routine outpatient), and Podiatry.
- Referrals are also not required for well-child visits, urgent care, family planning, or emergency services

Routine outpatient behavioral health may be self-referred; BNet referrals are coordinated through Molina CMS Plan Care Management. Prior authorization still applies where required

Continuity of Care (COC)

Molina will support a smooth CMS Plan transition by honoring existing approved services and treatment plans before October 1, 2026, until the member's ongoing care plan is finalized. **Continuity of care for CMS Plan enrollees is required during the applicable transition period.** The goal is to avoid interruption of medically necessary care that was already approved, authorized, prearranged, or supported by a treatment plan before the member's transition to Molina

COC Timeframes

Current transitioning CMS Plan members: up to 240 days

New CMS Plan members from another SMMC Health Plan or Medicaid Fee-For-Service delivery system: up to 180 days

Existing Authorizations

Molina will honor approved authorizations before October 1. Enrollees continue seeing current providers up to 240 days **or** until treatment plans with Molina are finalized, whichever is sooner

Your current authorization number from Sunshine **will not** change while that authorization is active. **You may, but are not required to submit a duplicate request**

Provider Action

Continue appointments and medically necessary services rendered in good faith and that have an existing approved authorization

Keep documentation supporting ongoing care

What Providers Should Do During COC

- Do **not** cancel appointments for CMS Plan members due to the transition
- Use the existing authorization number from the prior plan for billing when an authorization is already on file
- Submit requests for continued services **before** the current authorization or treatment period ends
- Submit a **new request** when services change, additional units are needed, or no authorization is on file
- **Submit the treatment plan with your claim** when no transition authorization is on file. Molina reserves the right to review all treatment plans
- During the COC period:
  - Contracted providers will be reimbursed at your Molina rate.
  - Non-Participating providers will be reimbursed at the rate they received immediately prior to transition (with proof). Default reimbursement is 100% Medicaid

When to Contact Molina UM

Contact Utilization Management for continued care requests, new or changed services, or questions about COC authorizations

Phone: (855) 322-4076

Reminder: COC supports continuity during transition. Requests for changed, additional, or ongoing services beyond the current authorization will require Molina review

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

COC Provider Scenarios: Authorizations & Payment

Existing CMS Member: COC up to 240 days

Current authorization is on file

Authorization
- Continue medically necessary services
- Use the existing authorization number from the prior plan
- **You may submit an authorization request, but you do not need to submit a duplicate request**

Payment
- Claims should align to the authorization on file

Modification to existing approved authorizations or additional services beyond approved authorization

Authorization
- Submit a new or updated authorization request through Availity
- Include clinical documentation and the reason for the change

Payment
- Claims should match the newly approved service, units and span
- Services beyond the current authorization may require Molina review

New CMS Member: COC up to 180 days

New member has prior Medicaid services

Authorization
- Submit prior authorization or COC documentation showing the member was already receiving the service
- Include treatment plan, medical records, or prior authorization correspondence
- COC covers the same service already in place; a new or different service is not COC and needs a standard authorization
- For services beyond the prior authorization or treatment plan, submit a re-certification request through Availity

Payment
- With supporting COC documentation, claims can be processed during the COC period
- If documentation is missing, Molina may request more information

No documentation or COC does not apply

Authorization
- Submit a standard authorization request before rendering a service that requires authorization
- Attach medical necessity documentation
- Use the PA look-up tool if unsure whether authorization is required

Applies in Every Scenario — the up to 240-day and up to 180-day windows set only the COC entry period

- **Non-participating providers:** default reimbursement is 100% Medicaid rate unless proof of another prior reimbursement rate is received
- **Documentation drives payment:** claims without required authorization or supporting documentation may deny
- **Never bill the member** for covered services

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Care Management

Children's Medical Services Plan
BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

Care Management Services

PCP/Provider Responsibilities in Care Management

- Coordinate care with the Care Manager
- Share changes in the member's health status and treatment plan
- Support the member's Individualized Care Plan (ICP)

Care Manager Responsibilities

- Coordinate care across providers and services
- Develop and monitor the Individualized Care Plan (ICP)
- Connect members with appropriate resources and support such as:
  - Evidence based programs
  - Transitions of care (inpatient to outpatient)
  - Statewide Inpatient Psychiatric Program (SIPP)
- Coordination of Interdisciplinary Care Team meetings

Care Management Provider Contact Information	
Provider Phone	(855) 322-4076
Provider Email	MemberSupportCMSFL@molinahealthcare.com

Pediatric Disease Management Programs

Asthma	Behavioral Health	Behavioral Health: Substance Use
Cancer	Diabetes	Digestive Disorders (IBD & Celiac Disease)
Heart Conditions	Hemophilia	HIV
Kidney Disease	Obesity	Sickle Cell Disease
	Advanced Therapies (Transplant & Gene Therapy)	

Providers may refer members by contacting the members Care Manager

Quality Program: A Shared Responsibility

Quality for CMS Plan members depends on what we do together, so here is what the program measures and what each of us are responsible for

The CMS Plan Quality Program

- A Quality Improvement Program built to regulatory and accreditation standards, with defined governance, scope, goals, and measurable objectives
- HEDIS is our clinical measurement standard, and results are reported to regulatory and accrediting agencies
- Quality is broader than HEDIS: we also measure member outcomes and track program goals beyond those metrics
- CAHPS surveys members each spring on getting needed care, getting care quickly, how well doctors communicate, and coordination of care
- Well-child and adolescent EPSDT measures set the state standard for children's preventive care
- Peer review, site visits, and medical record-keeping reviews support the program

What We Ask of You

- Engage in the Quality Program overall, including peer review and audits of care
- Share information with us proactively rather than waiting for a request
- Take part in program and process improvement work: PCMH, Behavioral Health Home, complex care management, value-based payment, Pay for Quality, and the Quality committee
- Help drive evidence-based practice in day-to-day care
- Meet access to care and appointment availability standards
- Complete well-child and EPSDT exams and file the AHCA Well Child Visit Tracking Form in the record
- Enroll in Vaccines for Children and keep an adequate vaccine supply
- Provide medical records for quality review, HEDIS, and appeals, and retain member records at least 10 years
- Support site and record-keeping reviews and cooperate with grievance investigations
- Close the care gaps you see when checking eligibility

What You Can Expect From Molina

- HEDIS care gaps visible in the portal when you verify eligibility and benefits
- A written copy of the Quality Improvement Program on request from Provider Services
- Clinical guidelines, quality reporting, and performance feedback
- Care Management partnership for members with complex or ongoing needs
- Decisions based only on appropriateness of care and coverage, with no incentives for denials or under-utilization
- Provider Relations education and support; Health Education line at (855) 322-4076

Questions about quality measures or reports? Contact Provider Services at (855) 322-4076 or your Provider Relations Representative.

CMS Plan Vendors and Telehealth Services

Telehealth Services

CMS Plan members may receive appropriate physical and behavioral health services through participating providers using telehealth or telemedicine.

Common Uses

- Lab or imaging results
- Therapy and counseling
- Recurring-condition follow-up
- Skin conditions
- Prescription management
- Urgent care concerns
- Post-surgical follow-up

Provider Requirements

- Use technology with applicable safeguards
- Comply with HIPAA and state and federal privacy law
- Follow CMS Plan telemedicine policies and procedures
- Complete required training and attestation before offering virtual care

Provider Takeaway

- Confirm the service is clinically appropriate and covered
- Verify member eligibility
- Check prior authorization requirements
- Document the encounter as you would an in-person service
- Not all participating providers offer telehealth

Reminder: Telehealth is generally delivered online using a computer, tablet, or smartphone

Pharmacy and Laboratory Partners

Use the partner assigned to the service and confirm CMS Plan coverage and authorization requirements before directing care

CVS Caremark | Pharmacy Benefit Manager

Supports the pharmacy network, formulary, and pharmacy claims

Provider actions:

- Verify the current formulary and prior authorization requirements
- Submit complete clinical information when authorization is required
- Contact CVS Caremark at (800) 237-2767 for pharmacy network or claims questions

Pediatric pharmacists on the CMS Plan team review complex pediatric regimens and advise on dosing, safety, and interactions

- Ask for pediatric pharmacist support through the members Care Manager

Quest Diagnostics and LabCorp | Laboratory Services

Direct outpatient laboratory work to participating laboratory providers unless an approved in-office test applies

Quest Diagnostics: (866) 697-8378
LabCorp: (800) 845-6167

Provider action: Use the Molina provider directory and CMS Plan guidance to confirm network participation and service requirements

Reminder: Verify member eligibility and use the Prior Authorization Look-Up Tool when applicable

Transportation and Vision Partners

Use the CMS Plan-specific routing shown below. Product routing from other Molina plans may be different

MTM Health | Non-Emergency and Non-Medical Transportation	Supports non-emergency transportation for covered services Scheduling line: (888) 298-4781 When coordinating a ride, have the member information, appointment date and time, provider location, and accessibility needs available Emergency transportation is not scheduled through this line
Vision Services | Confirm CMS Plan Network	Confirm the member's benefits and network before scheduling or billing Unsure on the vision network that applies call: Provider Services: (855) 322-4076

Home-Based Services: Coastal Care and HHAeXchange

The two partners support different parts of the CMS Plan home-based services workflow

Coastal Care Services | Network and Service Administration

Supports DME, home health, and home infusion

PDN services for the CMS plan are contracted through Molina Healthcare and **NOT** with Coastal Care

Practitioners: Order services and follow applicable authorization requirements.

DME, home health, and home infusion provider types contract and credential through Coastal Care rather than Molina.

Contact: (855) 481-0505

HHAeXchange | Electronic Visit Verification

Supports authorizations, scheduling, visit verification, and billing for applicable home-based services including home health, personal care, and private duty nursing

New agencies should self-register and complete required training.

Visits must be electronically verified for services subject to EVV. Providers should use the approved workflow for confirmed visits and billing.

Dental Services and Independent Review

These partners have distinct roles and should be used only for the function they manage

State Dental Health Plan | Dental Services

Medicaid dental services continue through the State Dental Health Plan.

CHIP dental is coordinated through Molina, consistent with CMS Plan guidance.

Providers should use the member's dental identification and verify dental eligibility and billing instructions with the applicable dental plan.

Capitol Bridge | Independent Review

Used when a provider requests independent review of an eligible appeal decision

Phone: (800) 889-0549
Email: FLCDR@capitolbridge.com

A corrected claim is not an appeal or dispute. Follow the standard corrected-claim process when claim data needs correction

Reminder: For routing questions, start with Provider Services at (855) 322-4076 or your Provider Relations Representative

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Language Access and Therapy Services

Two supports every CMS Plan provider should know how to use and how each is arranged with Molina

Interpreter and Translation Services

No cost to provider or member, 24/7

- Oral interpretation in any language by phone, on-site interpreters when needed, and American Sign Language
- Written member materials in Spanish, Haitian Creole, large print, braille, audio, and other alternate formats on request
- Do not rely on family members to interpret
- Request through the Provider Contact Center at (855) 322-4076; members may call CMS Plan Member Services at (800) 262-0750 (TTY: 711)
- Post the Nondiscrimination Notice and Tagline Document, offer auxiliary aids, and complete CLAS training in the Availity Learning Center within 30 days of onboarding

Therapy Services PT, OT and Speech

Arranged directly with Molina

- For the CMS Plan, therapy is managed directly by Molina Healthcare — HN1 / American Therapy Administrators does NOT apply to CMS Plan members
- Contract and credential with Molina, then submit prior authorization through Availity Essentials with supporting clinical documentation
- Check the Prior Authorization Code Look-Up Tool first, or call Healthcare Services at (855) 322-4076
- PT and OT, ages 0–20: one initial evaluation per year, up to 210 minutes of treatment per week, one initial wheelchair evaluation every five years
- Speech therapy, ages 0–20: one initial evaluation per year, up to 210 minutes per week, plus communication devices and services
- Coordinate with the member's Case Manager so therapy goals stay aligned with the plan of care

Reminder: For routing questions, start with Provider Services at (855) 322-4076 or your Provider Relations Representative

Administrative and Payment Partners

These partners support the provider workflow but do not replace CMS Plan eligibility, authorization, or billing requirements

Availity Essentials

- Eligibility and benefits
- Prior authorization submission and status
- Claims and corrected claims
- Claim status and remittance
- Care Coordination Portal

Register through Availity and add Molina Healthcare of Florida as a payer

SSI Claimsnet, LLC

- Electronic claims clearinghouse option
- Providers may register online to submit EDI claims
- Use Molina Payer ID 51062
- Claims must include complete provider, member, coding, and authorization information when applicable

Change Healthcare / ECHO Health

- Electronic funds transfer and electronic remittance advice
- Enroll with ECHO Health promptly and no later than 30 days after the first Molina payment to avoid virtual-card payment
- Questions: (888) 834-3511
- Payer ID: 51062

Understanding Behavior Analysis (BA) Services

Understanding Behavior Analysis (BA)

BA Services are Medicaid-covered services provided to eligible members who have a diagnosis consistent with autism spectrum disorder (ASD) or other qualifying conditions. BA services use evidence-based strategies to improve meaningful behaviors, build new skills, and support independence and participation in daily life.

BA Supports Members and Families

- Evidence-based behavioral assessments
- Individualized treatment to build meaningful skills
- Focus on communication, social, adaptive, and functional skills
- Caregiver training and family involvement
- Services delivered in the least restrictive, most appropriate setting

Building Foundations for a Brighter Future

BA services help members develop essential skills, reduce interfering behaviors, and improve daily functioning for long-term success.

Reminder: Behavior Analysis services are individualized and based on medical necessity. Services are provided in the least restrictive, most appropriate setting and require caregiver participation to support skill development across home, school, and community environments.

BA Covered and Non-Covered Services

BA Services Include:

- Comprehensive behavioral assessments
- Individualized treatment planning
- Direct behavior intervention
- Group behavior intervention
- Caregiver training and guidance
- Protocol modification
- Data collection and ongoing monitoring
- Care coordination

BA Services Do Not Include:

- Services that do not meet medical necessity criteria
- Services for recipients who are not eligible
- Services that unnecessarily duplicate another provider's service
- Seclusion or manual, mechanical, or chemical restraint
- Supervision, personal care, companion, chaperone, or shadow services
- Caregiver or childcare services
- Psychological testing, psychotherapy, or long-term counseling
- Services funded under section 110 of the Rehabilitation Act of 1973
- Services not listed on the fee schedule
- Same-day behavioral health overlay, TBOS, or therapeutic group care
- Simultaneous services by more than one BA provider, unless authorized
- Travel time

BA Member Eligibility

Behavior Analysis Member Eligibility

Member Must

- **Be under 21 years of age**
- Have a PCP referral for Behavior Analysis services
- Complete a comprehensive behavioral assessment demonstrating medical necessity
- Receive prior authorization from Molina Healthcare before treatment begins

Generally, Not Eligible

- **21 years of age or older**
- Lack a comprehensive behavioral assessment supporting the need for services
- Do not have the required PCP referral (if applicable under program requirements)
- Do not receive prior authorization from Molina when authorization is required
- Cannot demonstrate continued medical necessity or measurable progress for ongoing treatment

Working Together to Support BA Members

Working Together to Support BA Members

WHAT MOLINA EXPECTS FROM PROVIDERS

- ✓ Individualized, measurable treatment plans
- ✓ Complete clinical documentation
- ✓ Ongoing monitoring of progress
- ✓ Caregiver engagement and training
- ✓ Coordination across the care team
- ✓ Timely reauthorization requests
- ✓ Transition and step-down planning

WHAT PROVIDERS CAN EXPECT FROM MOLINA

- ✓ Clear authorization requirements
- ✓ Timely review of complete requests
- ✓ Provider Relations support
- ✓ Care Management coordination
- ✓ Authorization and claims resources
- ✓ Support during changes in care
- ✓ Connection to available resources

BA Provider Responsibilities

Provider Responsibilities and Requirements

Following initiation of services, BA providers should:

- Deliver services according to the approved treatment plan and authorization
- Maintain all required licensure and certification requirements
- Comply with supervision requirements for Board Certified Assistant Behavior Analysts (BCaBAs) and Registered Behavior Technicians (RBTs)
- Communicate significant changes in a member's condition or treatment needs
- Participate in care coordination with Molina and the member's care team
- Submit authorization renewal requests 30 days before services expire and no later than 10 days before expiration
- Update the Functional Behavioral Assessment/Behavior Intervention Plan (FBA/BIP) and treatment plan when the member’s needs, behaviors, or response to treatment change
- Comply with all Florida Medicaid and Molina Healthcare policies

Reminder: Behavior Analysis enhances—not replaces—the member's medical care. Providers remain an essential part of the care team throughout the member's enrollment

Documentation Requirements

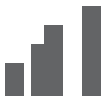
Maintain:

Comprehensive Behavioral Assessment

Individualized Treatment Plan

Measurable Treatment Goals

Session Notes for Each Visit



Objective Data Collection

Caregiver Training Documentation

Reminder: Accurate and complete documentation must be maintained in the member record and made available upon request

BA Referral Process & Authorizations

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

Behavior Analysis Referral Process

1 Identify members

Members who may be appropriate for BA services:

- Referred by PCP, specialist, or licensed practitioner
- Referral from PCP **must** accompany PA request
- Flagged by a CMS Plan Care Manager
- Referred by school, early intervention, or community
- Family raises behavioral or developmental concerns

2 Educate family

Educate members, parents, and caregivers on:

- What BA services are and how they help
- The assessment and authorization process
- Program goals and expected outcomes
- Supportive service options and family participation
- Attendance, consent, and communication requirements

3 Obtain consent and assessment

Confirm choice on BA services:

- Obtain signed and informed consent
- Assess medical necessity and needs
- Develop findings and recommendations
- Obtain releases of information
- Document in the member record
- **If declined:** document and offer alternatives

4 Prior authorization

PCM or specialist submits the request to Molina:

- Submit BA request with clinical documentation
- Include assessment and treatment plan
- Reviewed against Florida Medicaid criteria
- Decision sent to the provider and family
- Authorization dates and approved hours provided

5 Provide services and review

Deliver BA services and monitor progress:

- Initiate services per the approved plan
- Collect data on progress toward goals
- Communicate with caregivers and care team
- Submit reauthorization before expiration
- Reassess for continued medical necessity

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

Authorization Process

Prior Authorization Lookup Tool
Florida Providers Home

Enter Service Authorizations on the Portal
Provider Availity Portal

Authorization Workflow — Five steps from referral through approval

1 — Referral
PCP submits a referral for Behavior Analysis services

2 — Comprehensive Assessment (CDE)
A comprehensive assessment identifies needs and treatment goals

3 — FBA/BIP Treatment Plan Development
An individualized plan is developed from assessment findings and medical necessity

4 — Prior Authorization Review
The request is reviewed for medical necessity and Florida Medicaid criteria

5 — Authorization Approval
Approved services include authorized dates and hours based on the treatment plan

Provider Expectations

1	**Confirm authorization**	Prior authorization is required for Behavior Analysis services
2	**Build a specific plan**	Use measurable, individualized and data-driven treatment goals
3	**Submit complete support**	Include clinical documentation that supports medical necessity
4	**Follow submission guidance**	Use Molina prior authorization guidelines for submission and timelines

What Requires Prior Authorization?

Prior authorization is required for the below services:

Service	CPT code(s)
Behavioral treatment	97153, 97154, 97155
Caregiver training and guidance	97156, 97157
Group treatment with caregivers	97158

Reminder: Obtain authorization before services begin and submit complete clinical documentation

Children's Medical Services Plan BY MOLINA HEALTHCARE

MOLINA HEALTHCARE

What Makes a Clinically Complete Intensity Request?

- Current level of functioning: adaptive behavior, communication, social skills, self-care, and safety, informed by Vineland-3 and BASC-3 scores
- Scope of treatment: comprehensive (multiple developmental domains) vs. focused (specific skills or behaviors); comprehensive treatment typically requires greater intensity
- Member's actual availability: the schedule must reflect school hours, other therapies, naps, and family availability; hours requested cannot exceed hours the member is actually available
- Concurrent services: documented coordination to avoid unnecessary duplication
- Caregiver capacity: ability to participate and implement strategies
- Progress data at reauthorization: trajectory per behavior; if progress is slow, explain why and what will change; if strong, explain the clinical rationale for maintaining intensity
- A detailed & individualized Transition and step-down plan: how hours are projected to be titrated as goals are achieved

Hours Requested vs. Member Availability

If hours requested exceed the member's documented availability, the authorization request must include a written rationale, a coordination plan to address participation barriers, and documentation of efforts to accommodate the member's schedule.

Reminder: Requests where authorized hours significantly exceed hours actually delivered without documented explanation may prompt a clinical review of the member's ongoing need for the authorized level of service. Document fulfillment barriers proactively in monthly treatment plan updates.

Authorization Decision Turnaround Times by Product Line

- Prior authorization: Required for most BA services before initiation and at each reauthorization (at least every 180 days. Providers may submit reauthorization requests as early as 30 days prior to the authorization end date, but no later than 10 days before the end date.
- To verify code-specific authorization requirements, use the Prior Authorization Code Lookup Tool at Prior Auth Look Up Tool
- All BA service requests are reviewed by Molina BCBAs and Child and Adolescent Psychiatrists

Product Line	Population Served	Auth Timeline
MMA	Medicaid Managed Care	**4 calendar days**
SMI	Serious Mental Illness- children and adults with severe psychiatric conditions	**4 calendar days**
CMS Title 19	Children's Medicaid- standard Medicaid children	**3 calendar days**
CMS Title 21	Children's Health Insurance Program (CHIP)	**3 calendar days**
MKP	Molina Marketplace Plan	**15 calendar day**

Need to Know:

- An expedited (or urgent) Request is a prior-authorization or service request that requires a faster-than-standard decision due to a potential serious risk to the member's health or safety.

- Routine BA reauthorizations generally do not meet this standard and should be submitted as standard requests within the timeframes above. Submitting routine requests as expedited can cause unnecessary review delays.

Do not initiate services before receiving written authorization from Molina. Services rendered without authorization are not reimbursable

Comprehensive Diagnosis Evaluation (CDE)

What Is a CDE and Why Does It Matter?

The Comprehensive Diagnostic Evaluation (CDE) is the clinical foundation of every BA authorization request. It establishes why a member needs BA services, what the diagnosis is, and what treatment is clinically indicated. Per AHCA policy, the CDE must be performed according to national evidence-based practice standards and led by a licensed practitioner working within their medical, developmental, or psychological scope of practice. Providers must also hold certification and demonstrate competency in the administration, scoring, and interpretation of standardized psychological assessment tools used in ASD evaluation.

Who Can Perform a CDE?

- Primary Care Physician (PCP) with specialty in family practice, internal medicine, or pediatrics
- Board-certified or board-eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, or adult/child psychiatry
- Child psychologist (PhD or PsyD)
- Licensed School Psychologist (an unlicensed school psychologist may not conduct a CDE)
- Multidisciplinary team led by one of the above practitioners

Reminder: A CDE performed outside this practitioner list will not satisfy authorization requirements. Verify practitioner credentials before submitting

What must be included in the CDE

Required Element	What This Means
Formal Diagnosis	A formal diagnosis made by the evaluating practitioner, not just a score from a screening tool such as CARS or ADOS. The diagnosis must be stated explicitly by the clinician.
Background & Presenting Concerns	Developmental, behavioral, and medical history including relevant family history. Should reflect a thorough understanding of the individual child, not a generic template.
Direct Observation	Documentation that the evaluating clinician directly observed the member. Virtual-only assessments may miss critical behavioral cues; in-person evaluation is best practice for children.
Diagnostic Testing	Results of standardized diagnostic tools used: including scoring, interpretation, and clinical significance. School accommodation letters alone are not sufficient. Assessment Tool examples: Autism Diagnostic Interview-Revised [ADI-R], Autism Diagnostic Observation Schedule [ADOS-2], Childhood Autism Rating Scale [CARS-2], or Diagnostic Interview for Social and Communication Disorders [DISCO]).
Appropriate Assessment Instruments	All screening and assessment instruments used must align with the current standard of care for diagnosing the relevant condition(s).
Treatment Recommendations	Specific, individualized recommendations for BA services. Must justify that BA is clinically appropriate and medically necessary. Generic recommendations are insufficient. If there is indication the member may be better served by a different evidence-based treatment, see Section 12: Alternative Evidence-Based Programs.
Practitioner Signature & Date	The CDE must be signed and dated by the qualified licensed practitioner who led the evaluation.
Parent/Guardian Input	Background and status from a parent or guardian interview must be reflected in the evaluation findings.

Important CDE vs. Behavior Assessment Requirements

Providers sometimes submit a CDE that was obtained privately or paid out of pocket. Molina accepts CDEs regardless of how they were obtained, provided they meet the qualifications and content standards above. However, Molina recommends using an **In-Network preferred provider to help** ensure the CDE meets all required standards. In addition, a CDE (even one that includes Vineland-3 or BASC-3 scores within the diagnostic evaluation) does not satisfy the separate AHCA requirement for a behavior assessment submitted with the authorization request:

The CDE	The Behavior Assessment (Authorization Requirement)
• Broad, multi-disciplinary diagnostic evaluation • Establishes the diagnosis and confirms clinical indication for BA • May include Vineland-3 / BASC-3 as supporting diagnostic instruments • Performed by a qualified licensed physician or psychologist • Required once at initiation (no expiration for Medicaid recipients) but a new CDE may be needed when clinically indicated	• Standardized assessment of current adaptive and behavioral functioning • Supports the medical necessity determination at each authorization • Requires complete Vineland-3 and BASC-3 PRQ scoring reports with outcome measure scores • Administered and scored by the BA provider or authorized evaluator • Required at every initial authorization and every 12-month reassessment

Reminder: If Vineland-3 or BASC-3 scores appear only within a privately obtained CDE, a separate behavior assessment with complete scoring reports must still be submitted with the authorization request. Both documents are required; one does not replace the other.

CDE Pitfalls That Delay Approval

CDE-Related Pitfalls

- **Missing or unclear diagnosis,** scoring tools alone (CARS, ADOS, BASC-3) do not constitute a formal diagnosis. A clinician must state the diagnosis explicitly.
- **Diagnosis not connected to DSM-5 criteria,** the strongest CDEs show which criteria the member meets with examples from their presentation.
- **No severity level specified,** severity context supports individualized treatment planning; its absence leaves the intensity request without diagnostic grounding.
- **Functional impairment described in only one setting, or not at all.** Impairment evidenced across home, school, and community paints the complete clinical picture.
- **Insufficient background and history,** the CDE reads as generic or template-based rather than individualized to the specific member.
- **Lack of direct observation**, no documentation that the evaluating clinician directly observed the member's behavior.
- **School accommodation letters** submitted in place of treatment recommendations.
- **Treatment recommendations not individualized** to the member, identical recommendations across reports do not reflect individualized clinical judgment.
- **CDE performed by a practitioner outside the qualified list.**
- **Overly brief reports** that do not demonstrate thorough clinical assessment of the individual member.
- **Overlooking alternative treatments,** the CDE should reflect that the evaluating clinician considered other treatment options and determined BA is clinically indicated.

Common Snags. What Delays or Returns a Request - Authorizations

Authorization Request Snags

- Treatment goals that are **not observable or measurable.** Goals must include a definition of the behavior in observable terms, baseline data, mastery criteria, and anticipated date of mastery.
- FBA or treatment plan **without individualized member data.** Naming the function of a behavior (attention, escape, sensory, tangible) is not sufficient by itself. The documentation must show this member's actual data: how often the behavior occurs, at what rate or duration, and at what severity (for example, frequency of self-injurious episodes per hour or day, intensity, and resulting impact). Function definitions without member-specific measurement do not establish severity or support the requested intensity.
- **Missing FBA/BIP for any behavior reduction goal.**
- **Behavior plan does not cover the full authorization period being requested** (up to six months).
- **Reassessment missing required instruments.** Vineland-3 and BASC-3 PRQ must be included with every 12-month reassessment.
- **No data tables or graphs per behavior.** Each behavior under treatment must have its own data table and corresponding graph for reauthorization requests.
- **No narrative justification for continuation at the intensity level requested.**

Initial Authorization Requirements

Required Element	What This Means
CDE	Complete CDE meeting all requirements in Section 1. Performed by a qualified licensed practitioner.
Referral / Physician Order	Signed referral from the member's assigned Primary Care Provider (PCP). The PCP must be qualified to assess and diagnose disorders related to functional impairment, and the referral must specify ABA services.
Behavior Assessment	Vineland-3 Comprehensive Parent Interview Form (all members) and BASC-3 PRQ (ages 2- 18). Full administered and scored, including complete scoring reports with outcome measure scores.
Behavior Plan	Covers the full requested authorization period (up to 6 months). All goals in observable, measurable terms with baselines, mastery criteria, and anticipated end dates.
FBA/BIP	Required for any behavior reduction goal, with member-specific data on frequency, rate, duration, and severity of each targeted behavior.
Treatment Schedule	Proposed weekly schedule including all BA service codes, frequency, and units requested. Must reflect member's actual availability.
Place of Service & Schedule	Clearly identify the place(s) of service (home, clinic, school) and a clear weekly schedule. A clear schedule also helps confirm school-setting requirements and supports the intensity determination (for example, an RBT scheduled after a full school day from 3-9 PM may signal a clinical concern). See Section 5: Service Intensity for full detail.
Concurrent Services	All other services the member receives. i.e., School-based services, OT, PT, ST, counseling, psychiatric medication management, and how BA coordinates with them.
Caregiver Training Goals	Proposed caregiver training targets, procedures, anticipated mastery dates, and parent/guardian signature on the behavior plan.
Supervision Plan	Name(s) of authorized supervisor(s): BCBA for RBTs and BCaBAs.
Transition/Discharge Plan	Established at initiation with objective criteria, not deferred to a later date.

Reminder: *Molina issues authorizations in weekly hours*

Molina requires a referral from the PCP for the initiation of BA services and must be provided with the initial auth request*

Reauthorization Requirements

Molina applies Medical Necessity Criteria based on the documentation submitted, be specific and comprehensive

Required Element	What This Means
Updated Behavior Assessment	Vineland-3 and BASC-3 PRQ required every 12 months; updated assessment findings required for shorter periods.
Data Tables & Graphs	Each behavior under treatment has its own data table and graph showing progress from baseline to current.
Progress Narrative	Progress on all goals, barriers identified, and explanation of goals not achieved during the prior period.
Intensity Justification	Written statement of why continuation at the requested service level remains medically necessary based on clinical presentation and progress data.
Updated Goals	Mastered goals noted; new goals meet the same measurable standard as initial goals.
Updated FBA/BIP	Updated as often as necessary to achieve socially significant outcomes, any change in challenging behavior requires an updated BIP.
Updated Caregiver Training	Progress toward caregiver goals, barriers encountered, updated targets.
Attendance Documentation	Member and caregiver attendance; explanation and barrier-mitigation plan if attendance falls below expectations.
Transition Plan Update	Progress toward step-down goals and how hours are projected to be titrated.
Concurrent Services Update	Updated list of all other services the member is receiving.

Care Coordination & Changes in Member Condition

Care Coordination Expectations & Changes in Member Condition

Coordinate Care Across the Treatment Team:

- Coordinate BA services with the member's PCP, specialists, therapists, caregivers, and other treating providers
- Ensure BA services complement and do not duplicate concurrent services
- Share relevant treatment goals, progress, and changes with the interdisciplinary care team
- Identify and address barriers that may affect treatment participation or outcomes
- Engage Molina Care Management when additional coordination or member support is needed
- Molina requires a referral from the PCP for the initiation of BA services and must be provided with the initial auth request

Notify Molina When:

- Member is admitted to or discharged from a hospital
- Significant behavioral or functional changes occur
- Treatment goals, service intensity, or the treatment plan require significant modification
- Barriers are preventing the member from receiving the authorized level of service
- Member is discharged from Behavior Analysis services

Provider Requirements When a Member's Condition Changes

What Providers Must Do:

- Notify Molina CM within 1 business day of a hospital admission, discharge, ER visit, or crisis event
- Complete a new CDE when clinically indicated
- Submit an updated FBA and BIP when challenging behavior changes in type, frequency, or severity
- Request an authorization change before delivering a different level, intensity, or setting of service
- Update the treatment plan and goals, with supporting data, to reflect the member's current presentation
- Coordinate with the PCP, therapists, caregivers, and care team, and document that coordination
- Engage Molina Care Management when barriers prevent delivery of the authorized level of service

If These Steps Are Not Taken:

- Claims for services outside the current authorization will be denied
- Reauthorization may be denied or reduced when documentation does not support medical necessity
- Late notification creates gaps in authorization and interrupts member care
- Incomplete records are subject to audit findings and recoupment of paid claims

Concurrent Services & Care Coordination

BA providers are expected to function as part of the member's broader treatment team. The treatment team may include behavioral health providers, the assigned Primary Care Physician, other physical health providers, therapy services (OT/PT/ST), educational supports, and community supports, depending on the member's needs.

IEP Requirements When Services Are Delivered in a School Setting

Per AHCA BA Coverage Policy, when an authorization request includes BA services delivered in a school setting:

Situation	What Must Be Submitted
IEP exists and includes BA services	Submit the current IEP with the authorization request.
IEP exists but does not include BA services	Submit the IEP plus documentation justifying the requested BA services and an estimated timeframe for when BA will be added to the IEP. When requested services overlap with school instructional time, the documentation should explain why BA is needed during those hours.
No IEP, school uses a 504 Plan instead	A 504 Plan may be submitted in place of the IEP, along with documentation justifying the requested BA services.
School does not conduct IEPs or 504 Plans	Submit documentation including the name of the school and a written explanation confirming neither plan is available at that institution and why it is not available. And expected date of when an IEP or 504 Plan will be completed.
Member is not yet enrolled in school	Submit documentation confirming enrollment status and estimated timeframe; if school entry is imminent, include a transition plan addressing coordination with the school setting.

Reminder: *When BA services are NOT delivered in a school setting, IEP documentation is not required, but school records, IEP, and teacher reports may still be submitted as supporting evidence of functional impairment across environments.*

Transition Criteria and Discharge Planning

A transition and discharge plan must be established at the initiation of BA services. Not deferred until the member is ready to discharge and reviewed and updated throughout treatment.

Discharge Criteria (Per AHCA Policy)

- The recipient no longer meets medical necessity criteria
- The recipient no longer engages in maladaptive behaviors
- Data indicates the frequency and severity of maladaptive behaviors no longer poses a barrier to participation in major life activities
- The level of functional impairment no longer justifies continued BA services
- Parent or guardian withdraws consent for treatment

What a Strong Transition Plan Includes

- SMART goals outlining the specific skills needed to support a lower level of care, including the caregiver
- Progress toward transition goals documented at each reassessment
- Details on how hours are projected to be titrated as transition goals are achieved
- Community resources and respective supports to maintain gains after discharge
- Increased caregiver training frequency as the member approaches transition criteria
- For school-aged members receiving full-time ABA that prevents school attendance, a documented plan for transitioning to a school-based setting

Covered Codes & Services

Children's Medical Services Plan
BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

Covered Services, Modifiers, and Billing

Covered Behavior Analysis Services

- Behavior Analysis Coverage Policy
- Medicaid Fee Schedule: AHCA BA Fee Schedule.pdf

Applicable Modifiers

Use applicable modifiers as required

Billing Information

- Verify member eligibility prior to each date of service
- Prior authorization is required before services begin
- Submit claims using the appropriate professional claim format (CMS-1500/837P)
- Ensure documentation supports medical necessity and services billed

Coverage is subject to Florida Medicaid policy, medical necessity, and prior authorization requirements

Required Trainings

Children's Medical Services Plan
BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

Required Trainings: Self-Paced Modules

Training Resource	Training Topic	Who Should Complete	Timeline to Complete
Molina Provider Handbook Molina Florida Provider Handbook	• Fraud, Waste & Abuse (FWA) • Human Trafficking • Duty to Report	All contracted providers and applicable staff	Upon onboarding and as applicable thereafter
Availity Availity Learning Center	• Introduction to CLAS • Health Outcomes • Persons with Disabilities • Providing Culturally & Linguistically Appropriate Services (CLAS) • Behavioral Health Training	All contracted providers and applicable staff	Complete during onboarding (within 30 days) and must sign the attestation form
AHCA Website Office of Risk Management and Patient Safety | Florida Agency for Health Care Administration	• Adverse Incident Reporting • Serious Adverse Event (SAE) Reporting & Root Cause Analysis (RCA)	Providers serving CMS Health Plan members Providers subject to adverse incident reporting requirements	Prior to serving CMS members and ongoing
HHAeXchange Knowledge Center	• EVV Requirements/Missed Visit Reporting	Home Health Agencies, Private Duty Nursing (PDN), Personal Care, Family Home Health Aides (FHHA), and applicable providers	Prior to service delivery and ongoing

Provider Resources

Children's Medical Services Plan
BY MOLINA HEALTHCARE

MOLINA® HEALTHCARE

Important BA Links and Resources

- Molina Florida Provider Home (includes Prior Authorization Code Lookup Tool): Prior Auth Look Up Tool
- Molina BA QRG: Behavioral Analysis Services: Authorization & Documentation Guide Comprehensive Provider Quick Reference Guide
- Availity Essentials Provider Portal (authorizations, claims, eligibility): Molina Availity Provider Portal
- AHCA Behavior Analysis Services Information: Behavior Analysis Services Information | Florida Agency for Health Care Administration
- AHCA BA Services Coverage Policy (December 2024, PDF): Behavior Analysis Coverage Policy
- Medicaid Fee Schedule, Rule 59G-4.002, Provider Reimbursement Schedules and Billing Codes: Rule 59G-4.002, Provider Reimbursement Schedules and Billing Codes
- AHCA Rule 59G-1.010, Florida Medicaid Definitions Policy: 59G-1.010 Definitions Policy_FINAL.pdf
- Molina Provider Manual and Orientation: Provider Manual and Orientation
- Molina Provider Reference Tool: Resources & Training

Provider Resources

Resource	Use For	Contact
CMS Plan Provider Website	CMS Plan implementation updates, provider training, FAQs and transition resources	CMS Plan Providers
Molina Provider Portal	Manuals, forms, training and roster updates	Molina Provider Portal
Availity Essentials / Provider Portal	Eligibility and benefits, prior authorization submission and status, claims and remittance tools	Molina Healthcare | Availity
Agency (AHCA) Website	CMS Plan transition guidance and provider alerts	CMS Plan Transition | Florida Agency for Health Care Administration
Provider Services	Primary contact for eligibility, authorizations, claims, portal support and general operational questions	(855) 322-4076 Monday–Friday, 8:00 a.m.–7:00 p.m. local time
Care Management	Member care coordination, plan-of-care collaboration and changes in condition	MemberSupportCMSFL@MolinaHealthcare.com Provider line: (855) 322-4076
Provider Contracting & Relations	CMS Plan participation, contracting status, network requests, provider education and unresolved operational issues	Contact your Provider Relations Representative Provider Relations Contact List
Claims Submission	Electronic or paper CMS Plan claim submission	Availity or clearinghouse: Payer ID 51062 Paper: Molina Healthcare of Florida, P.O. Box 22812, Long Beach, CA 90801
Provider Disputes	Claim payment or processing disagreements and supporting documentation	Availity or (855) 322-4076 Mail: Molina Healthcare of Florida Appeal and Grievance Unit, P.O. Box 36030, Louisville, KY 40233-6030
Capitol Bridge	Independent review of appeal decisions when a provider disagrees with Molina	(800) 889-0549 Email: FLCDR@capitolbridge.com

CMS Plan Vendors and Delegated Partners

Molina works with these partners to deliver CMS Plan services. Contact the vendor directly for the services they manage.

Vendor	What They Do	How Providers Use Them
Availity Essentials	Provider portal and EDI gateway	Eligibility, prior authorizations, claims and remittance; register at availity.com
SSI Claimsnet, LLC	Claims clearinghouse	Register online to submit EDI claims; Molina Payer ID 51062
Change Healthcare / ECHO Health	Electronic payments (EFT) and remittance (ERA)	Enroll immediately before your first Molina payment; (888) 834-3511
CVS Caremark	Pharmacy benefit manager	Pharmacy network, formulary and pharmacy claims; (800) 237-2767
Quest Diagnostics / LabCorp	Laboratory services	Direct outpatient lab work to these vendors; Quest (866) 697-8378, LabCorp (800) 845-6167
Access2Care / MTM Health	Non-emergency transportation	Members and staff schedule rides at (888) 298-4781
VSP and iCare Solutions	Vision services	VSP for Marketplace (800) 615-1883; iCare for MMA, Specialty and LTC (855) 373-7627
Coastal Care Services	DME, home health and home infusion	Practitioners: Order and authorize DME and home-based services; (855) 481-0505. DME, Home Health and Home Infusion provider types contract and credential through Coastal Care not Molina Healthcare
HHAeXchange	Electronic visit verification (EVV) for CMS Plan home-based services	Authorizations, scheduling, visit verification and billing; new agencies self-register and complete the required training
State Dental Health Plan	Dental services	Medicaid dental through the state plan; CHIP dental coordinated through Molina

Not sure who to call? *Start with Provider Services at (855) 322-4076 or your Provider Relations Representative.*