

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

Hospital

August 2026



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Required Trainings & Provider
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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
- **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.

This overview will introduce the Molina provider orientation, highlight key CMS Plan transition information, and review Hospital specific considerations providers need to understand ahead of go-live

- **CMS Plan:** Children under 21 with special health care needs
- **Enrollment:** Members may be Florida Medicaid or Florida KidCare
- **Hospital Services:** Deliver timely, medically necessary care across the full continuum
- **Care Management:** Supports safe transitions and prevents readmissions
- **Claims:** Ensures accurate, transparent billing for timely reimbursement
- **Authorizations:** Confirm medical necessity and right level of care



Mission Statement

- **Our Mission:** To improve the health and lives of our members by delivering high-quality health care.
- We serve Florida's most vulnerable populations, and our providers are how that mission reaches members every day.
- Why this training matters:
 - Clarifies what is changing and what is not, so care continues without interruption
 - Confirms eligibility, authorization, claims, and appeals processes so you are paid accurately and on time
 - Identifies your Provider Relations contacts and self-service tools for day-to-day support
 - Supports quality, compliance, and the member experience we are accountable for together

CMS Plan Transition



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

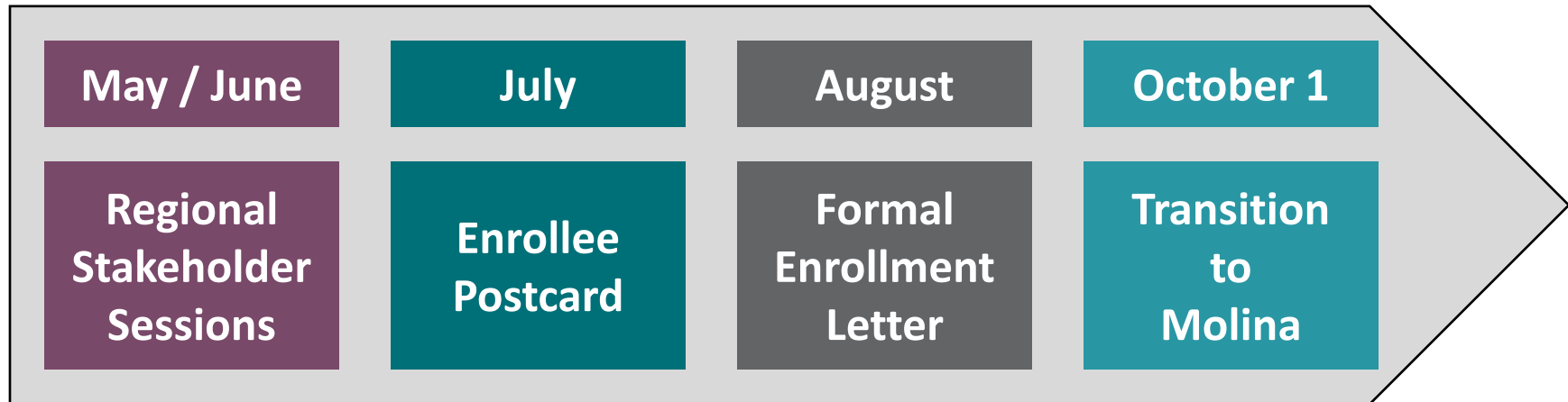
- The CMS Plan is solely administered by Molina Healthcare
- The contract applies to both Title XIX Medicaid and Title XXI CHIP recipients

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

Feb 24, 2026 8:00 AM Eastern Standard Time

**Molina Healthcare of Florida Announces a
\$70,000 Grant Funding NAMI's Behavioral
Health Peer Mentor Program**

**Molina Healthcare of Florida and The MolinaCares Accord Donate
\$170,000 to Support Health and Wellness in Florida Communities**

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



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.

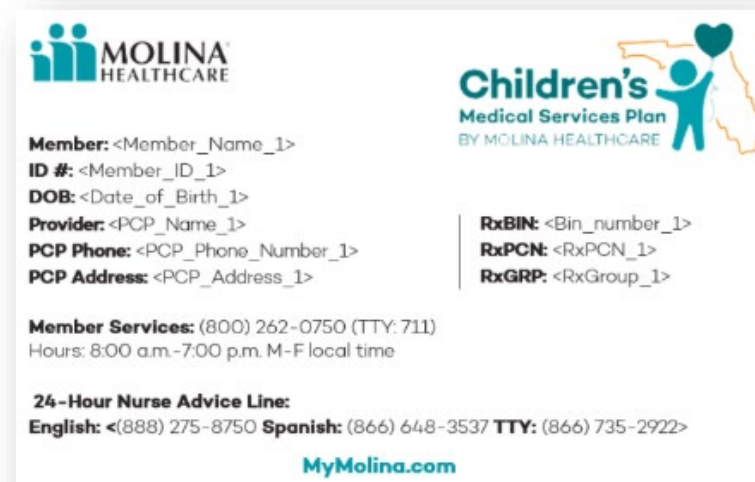
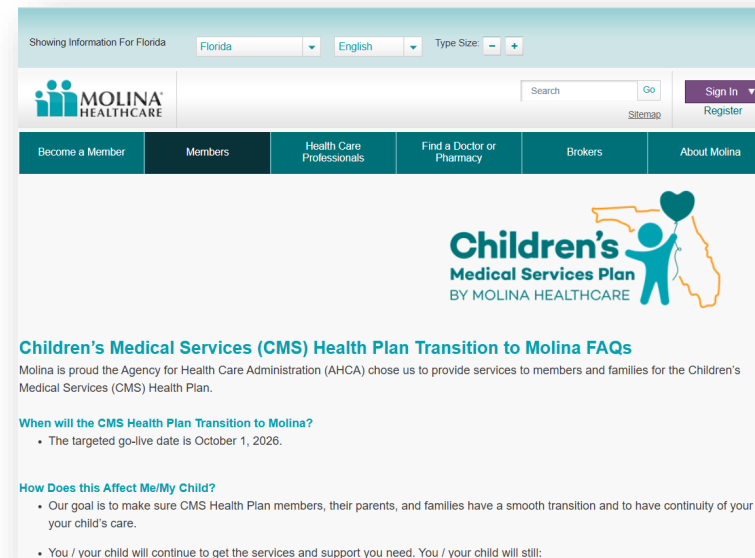
Goals

- 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



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. Specialist supports are available in areas such as Hospitals, Medical Foster Care, BNet and more, which are covered in each individual training based on that service/program.

Contracting and Relations:

Angela Rodriguez

Angela.Rodriguez@molinahealthcare.com

Jennifer Cordero

Jennifer.Cordero@molinahealthcare.com

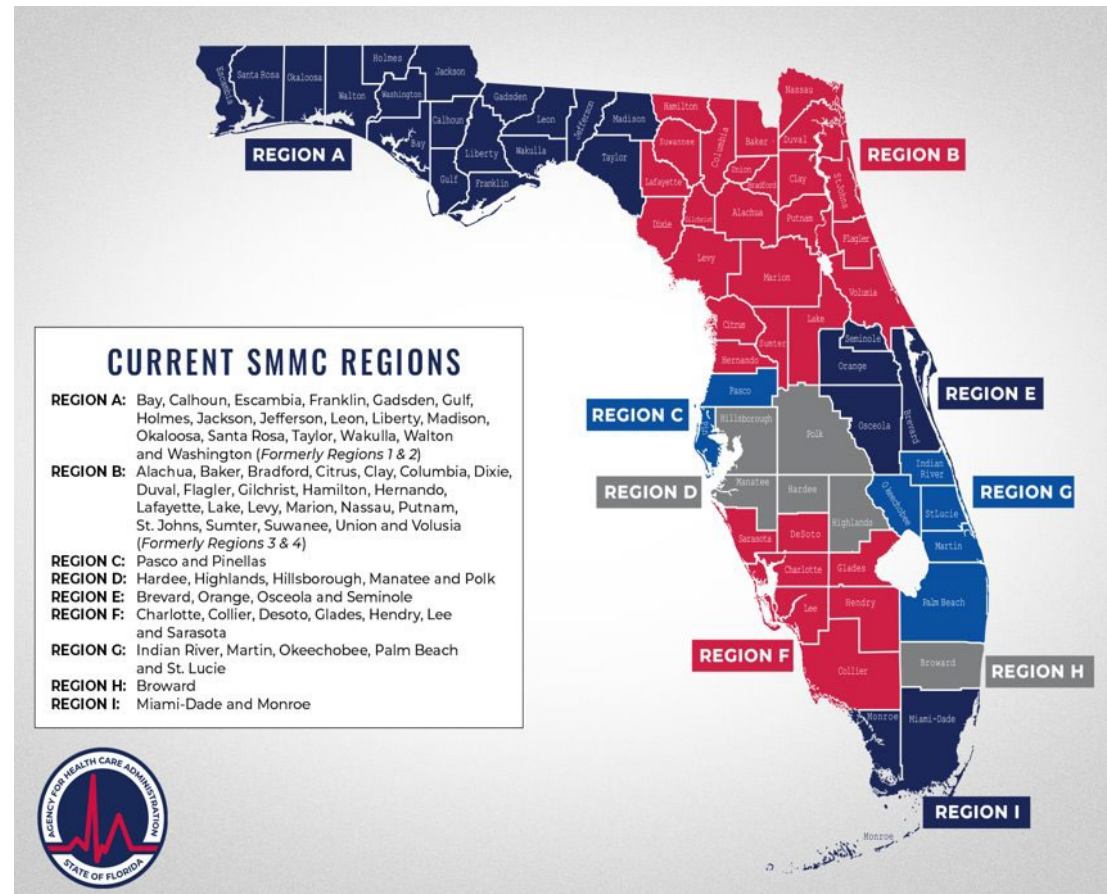
Care Management:

Members assigned Care Manager

Email: MemberSupportCMSFL@molinahealthcare.com

Provider Services Line:

Phone: (855) 322-4076



Member Eligibility



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 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>

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

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

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

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](#)

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

Welcome to the Molina Healthcare Network Pre-Enrollment Portal

Click "Next" in the box that most applies to you.

Join the Molina Network

Submit a contract request to participate in the Molina Healthcare Network.

Next

Access the Portal

Contracted providers that need to gain access to the portal to add practitioners to your group, upload a roster, add facility locations or check on credentialing status.

Next

Delegated provider

I am a delegated provider that would like to submit my delegated roster.

Next

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

Welcome to the Molina Healthcare Network Pre-Enrollment Portal

Click "Next" in the box that most applies to you.

Join the Molina Network

Submit a contract request to participate in the Molina Healthcare Network.

Next

Access the Portal

Contracted providers that need to gain access to the portal to add practitioners to your group, upload a roster, add facility locations or check on credentialing status.

Next

Delegated provider

I am a delegated provider that would like to submit my delegated roster.

Next

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

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



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 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 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



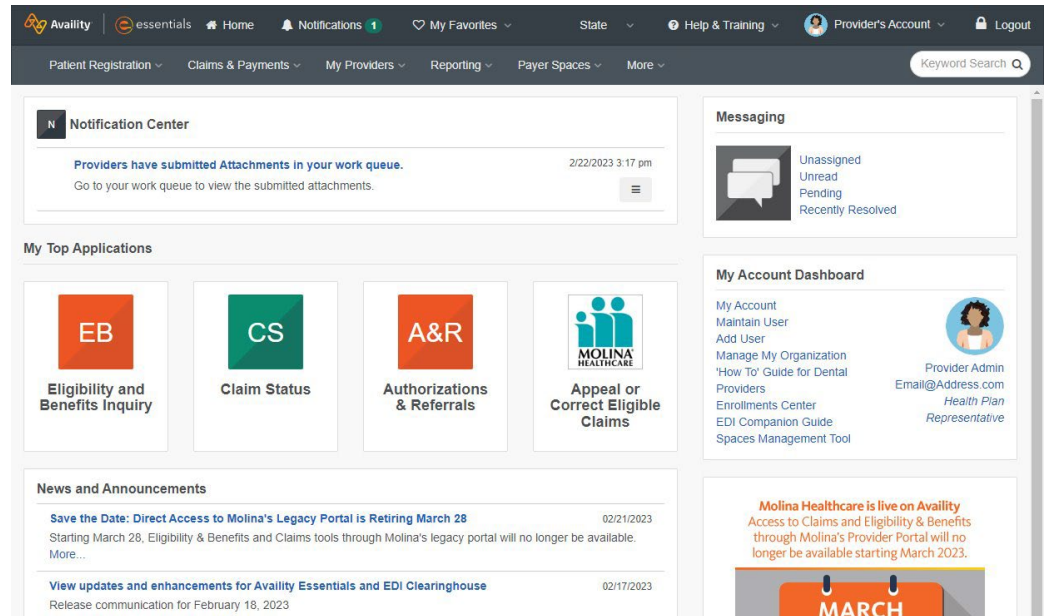
Encounter Data Submission

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](#)

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** after their first Molina payment, or within 30 days of your first payment.

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

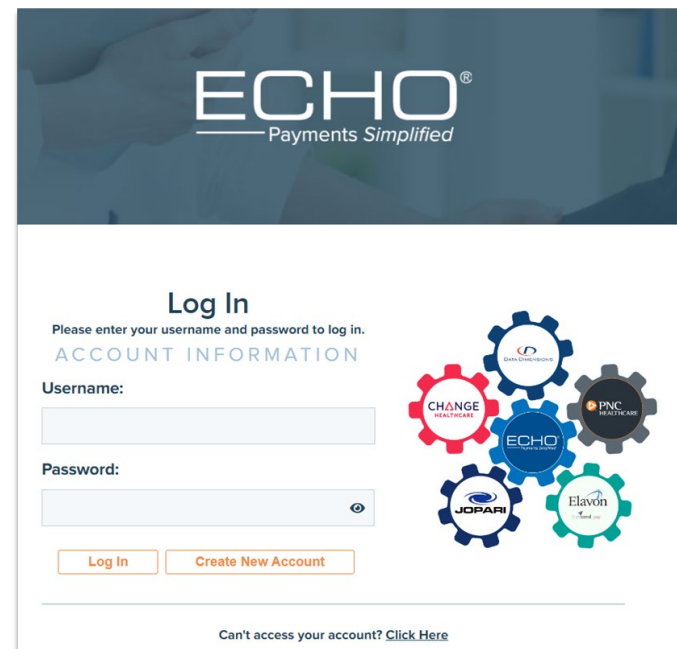
- Faster payment turnaround via EFT
- Easy access to historical ERAs
- View, download, print & save ERAs
- Paperless Explanation of Payments (EOPs)

How to Enroll:

Visit: <https://enrollments.echohealthinc.com/afteradirect/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



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](tel:8553224076). 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 Look-up Tool:

[Florida Providers Home](#)

Service Request can be submitted via the
[Provider Availability Portal](#)

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

Authorization Decision Turnaround Times by Product Line

- To verify code-specific authorization requirements, use the Prior Authorization Code Lookup Tool at [Prior Auth Look Up Tool](#)

Product Line	Population Served	Concurrent Review	Prior Auth Timeline
CMS Title 19	Children's Medicaid- standard Medicaid children	3 calendar days	3 calendar days
CMS Title 21	Children's Health Insurance Program (CHIP)	3 calendar days	3 calendar days
MMA	Medicaid Managed Care	3 calendar days	4 calendar days
SMI	Serious Mental Illness- children and adults with severe psychiatric conditions	3 calendar days	4 calendar days
MKP	Molina Marketplace Plan	24 hours initial and 72 hours for concurrent	15 calendar day

Need to Know:

- Timelines may vary depending on your individual contract for Concurrent Review.
- 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.

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

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

Continuity of Care (COC)

- For Members admitted to the hospital before October 1, 2026, please coordinate their continued stay with the prior plan and coordinate the discharge to home or lower level of care with Molina Healthcare.
- For Members admitted after October 1, 2026, please coordinate concurrent review and discharge to home or lower level of care with Molina Healthcare.

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
- 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

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

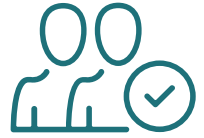
Applies in Every Scenario — the up to 240-day and up to 180-day windows set only the COC entry period

- **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

Care Management



Care Management Services



PCP Responsibilities in Care Management Referrals

- 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

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

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

Hospital Services and Coordination Overview



Hospital Services

CMS plan hospital services provide comprehensive care for children with special health care needs across all levels of medical complexity

Hospital Services Include



Emergency Care



Inpatient Admissions



Outpatient Surgery



Observation Services



Diagnostic Testing



Ancillary Services

Hospital: Responsibilities & CMS Plan Coordination

HOSPITAL RESPONSIBILITIES

Notify CMS Plan Case Manager at Admission

Notify the CMS plan case manager within 24 hours of admission; include diagnosis, expected LOS, and attending contact.

Obtain Prior Authorization for Inpatient Stays

PA required for non-emergency inpatient admissions; emergency PA due within 24 hours. Concurrent review applies to extended stays

Plan & Communicate Discharge Proactively

Start discharge planning at admission. Notify the case manager 48 hours prior and confirm home care, DME, and follow-up before discharge.

Transmit Discharge Summary Within 72 Hours

Send discharge summary to PCP and CMS plan case manager within 72 hours, including key clinical details and follow-up instructions.

CHILDREN'S MEDICAL SERVICES

Timely hospital communication during admission and discharge helps protect medically complex CMS plan children and reduce preventable readmissions.

- ✓ Verify CMS plan enrollment & authorization at admission
- ✓ Contact case manager within 24 hrs of any CMS plan admission
- ✓ Conduct concurrent PA review for stays beyond initial auth
- ✓ Coordinate home care, DME & follow-up before discharge
- ✓ Send discharge summary to PCP & case manager within 72 hrs

Observation or Inpatient?

Use the clinical record, not the bed location, to support the status selected

OBSERVATION

Short-term treatment, assessment and reassessment while deciding discharge vs. inpatient care



INPATIENT

Use when the record supports that a less intensive setting would significantly jeopardize the member's health or safety



DISCHARGE

When the member is clinically ready and follow-up needs are coordinated

What hospitals need to know

Observation is an outpatient status. A change to inpatient must be supported by medical necessity.

How to accomplish it

Document the order, severity of signs and symptoms, diagnostic needs, treatment response, and the physician's rationale for the selected level of care.

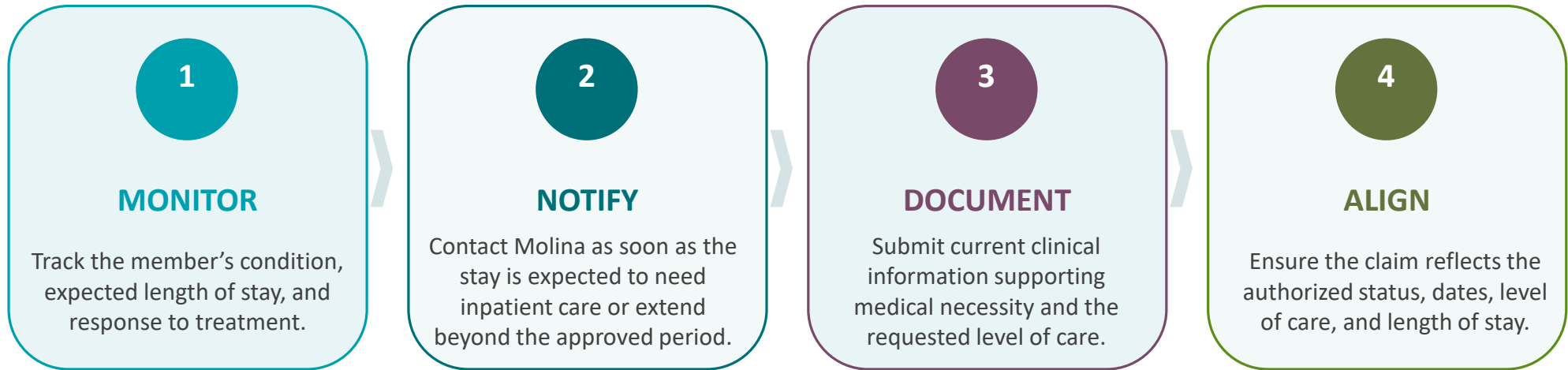
What Molina expects

Provide complete clinical information for review and update the request when the member's condition or expected level of care changes.

Reminder: Status follows clinical need and documentation. The physical bed location does not determine observation or inpatient status.

Extended Stays and Inpatient Review: Operational Expectations

Notify early, submit the clinical record, and keep the claim aligned to the authorization



Clinical documentation Molina may need

- ✓ History and physical
- ✓ Emergency department notes
- ✓ Physician orders and rationale
- ✓ Medication and treatment records
- ✓ Laboratory and diagnostic findings
- ✓ Severity and risk indicators
- ✓ Goals or reasons outpatient care is insufficient
- ✓ Updated plan when condition changes

MOLINA EXPECTS EARLY COMMUNICATION: Do not wait until discharge or claim submission to resolve a level-of-care or authorization issue.

Transition of Care: Hospital Expectations

Coordinating Discharge and Continuity with the CMS Plan

What Molina Expects from Hospitals

1

Engage the CMS Plan early

Notify the case manager at admission and include them in discharge planning from day one.

2

Coordinate with the plan

Discharge and transition planning should be conducted with the Plan. It is important the member's Care Manager and/or Transition Coach is involved in discharge and service planning at all stages.

3

Share clinical documentation

Send the H&P, discharge summary, medication list, and service orders before the member leaves.

4

Authorize services before discharge

Post-acute care, DME, and home health require plan authorization ahead of the discharge date.

5

Deliver a warm handoff

Confirm follow-up visits, transport, and the responsible provider 24-48 hours before discharge.

Out-of-State and Continuity

1

In-state care is preferred

Molina prioritizes Florida network hospitals so care stays local, coordinated, and close to family.

2

Out-of-state needs prior approval

Non-emergent out-of-state services require plan review and authorization before care begins.

3

Notify immediately for emergencies

For emergent out-of-state admissions, contact the CMS Plan right away so the case can be managed.

4

Document the clinical rationale

Show why in-state options cannot meet the need: specialty access, prior treating center, or urgency.

5

Repatriate when medically stable

Coordinate transfer back to an in-state facility with the plan as soon as the member can travel.

Discharge Coordination & Authorization Routing

Start discharge planning early and use the correct authorization channel

1

Start at Admission

Identify home health, DME, medications, specialty follow-up, transportation, and caregiver support needs.

2

Coordinate With Molina

Share discharge barriers and anticipated needs with the assigned CRC and member Care Manager.

3

Submit Service Requests

Use the service-specific route shown in the discharge coordination grid. Include supporting orders and clinical documentation.

4

Close the Loop

Confirm authorization status, services, equipment, medications, follow-up, and the safe handoff before discharge.

Hospital Discharge Coordination Grid

Use the service-specific route below and coordinate every discharge with the assigned facility CRC, TOC team, and member Care Manager.

Discharge Service Need	Where / How to Submit	Coordination Route
Therapies (PT / OT / ST)	Verify the code in the PA Look-Up Tool. Submit the prior authorization request through Availity Essentials.	Concurrent Review/ToC aligned with the Assigned Care Manager
Other Prior Authorization Services	Verify the code in the PA Look-Up Tool. Submit the prior authorization request through Availity Essentials.	Concurrent Review/ToC aligned with the Assigned Care Manager
Behavioral Health	Submit through Availity Essentials. Region A inpatient and outpatient requests: Access Behavioral Health, 866-477-6725; fax 850-353-6041.	Concurrent Review/ToC aligned with the Assigned Care Manager
DME, Home Health & Home Infusion	Coordinate through Coastal Care: 855-481-0505. Excludes PDN, FHHA, and Personal Care.	Concurrent Review/ToC aligned with the Assigned Care Manager
Personal Care Services	Coordinate with the member's Care Manager to initiate services: 800-262-0750 or MemberSupportCMSFL@molinahealthcare.com.	CM: 800-262-0750 MemberSupportCMSFL@Molinahealthcare.com
PPEC Services	Title XIX: submit to Acentra. Title XXI: submit through Availity Essentials.	Concurrent Review/ToC aligned with the Assigned Care Manager
Healthcare-Administered Drugs	Fax the authorization request to Molina: 866-236-8531.	Concurrent Review/ToC aligned with the Assigned Care Manager
Non-Emergent Transportation	Submit the transportation request to MTM: 844-399-9469.	Concurrent Review/ToC aligned with the Assigned Care Manager
PDN / Family Home Health	Submit through Availity using the electronic PDN Service Request Form.	Concurrent Review/ToC aligned with the Assigned Care Manager

Reminder: Before discharge, confirm authorization status, services, equipment, follow-up, and the safe handoff with the facility CRC and member Care Manager.

Observation Billing: Hospital Claim Requirements

Build the UB-04 from the documented observation order and actual observation hours

- 1 Use the outpatient claim path** Bill facility observation on the UB-04 using the applicable outpatient type of bill.
- 2 Report observation correctly** Use revenue code 0762 with HCPCS G0378. Units equal the documented observation hours.
- 3 Document start and end time** Start time comes from the nurse's documentation that observation began. End time follows the discharge order and completion of treatment.
- 4 Handle direct observation** Use G0379 only for a direct referral from the community, one unit, and report it with G0378.
- 5 Support extended observation** When observation exceeds 48 hours, submit medical records with the claim.

Avoid a preventable rejection

Do not bill 0762 with pre-labor monitoring revenue code 072x, except 0723, on the same claim.

Molina expectation

The billed status, hours, codes, units, and supporting record should tell the same clinical story.

Itemized Billing Requirements

Itemized Billing Includes:



Room & Board



Pharmacy



Supplies



Procedures



Diagnostics



Therapies

Itemized Billing Submission Process

Molina Healthcare of Florida Requirements

Inpatient Itemized Billing

1

Confirm the itemization trigger

Required on inpatient claims over \$100,000 and any stay Molina selects for high-dollar or DRG review.

2

Submit the UB-04 claim

File electronically via Availity Essentials or EDI Payer ID 51062 with admit, discharge, and bill type data.

3

Attach the full itemized statement

List room and board days, pharmacy, implants, supplies, OR time, and ancillaries with dates and units.

4

Match the inpatient authorization

Confirm level of care, approved days, and any transfers align with the authorization on file.

5

Track, correct, resubmit

Monitor status in Availity, answer record requests, and resubmit corrections within timely filing.

Outpatient Itemized Billing

1

Confirm when itemization applies

Applies to high-dollar outpatient, ASC, observation, and implant or drug-heavy claims flagged for review.

2

Submit the claim

File the CMS-1500 or outpatient UB-04 through Availity or Payer ID 51062 with the correct place of service.

3

Detail codes, units, and NDCs

Report valid CPT/HCPCS with modifiers, revenue codes, NDC numbers for drugs, and exact units billed.

4

Match the outpatient authorization

Verify procedure codes, service dates, and the rendering site match the approved authorization.

5

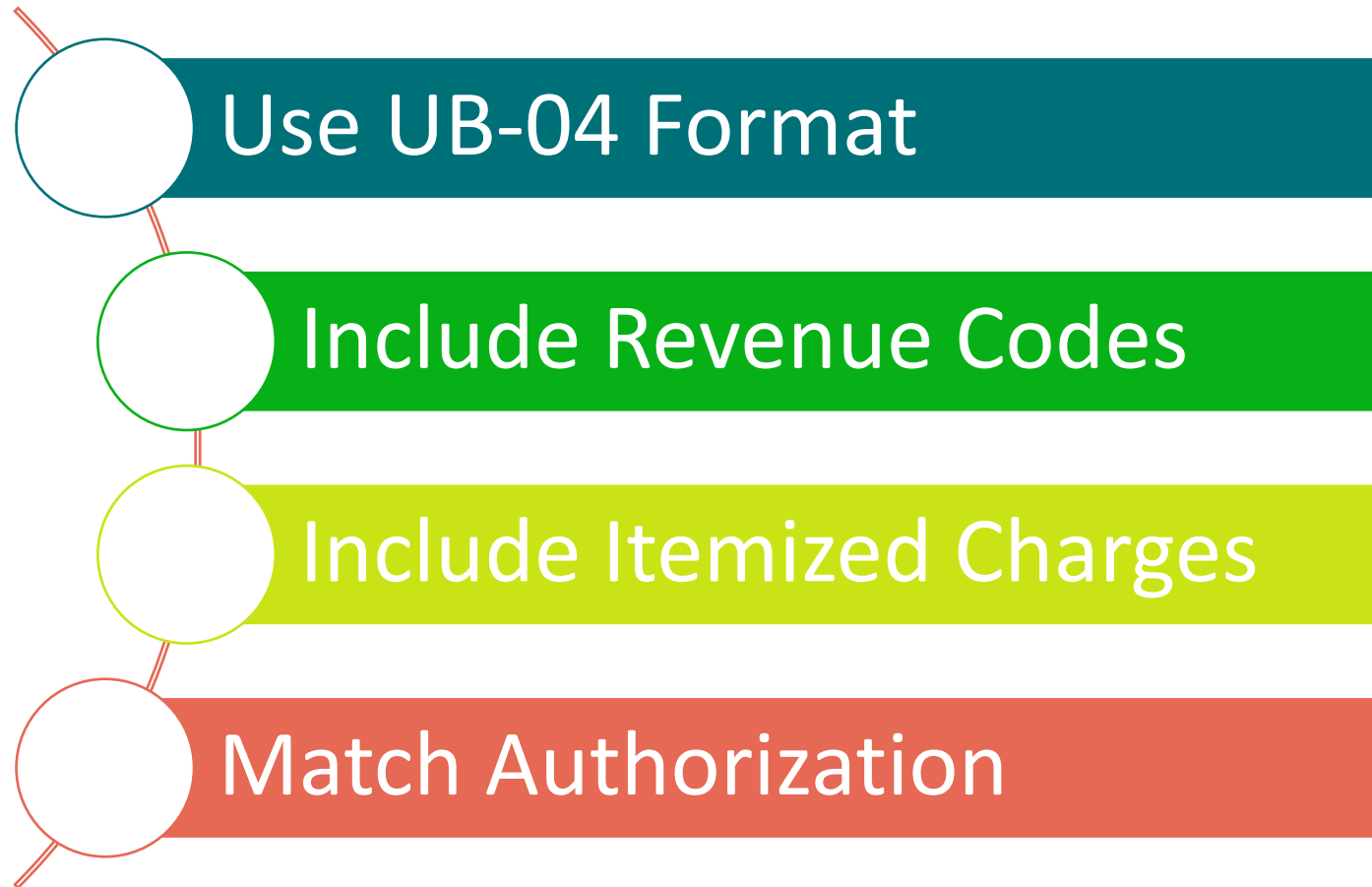
Track, correct, resubmit

Watch for itemized-record requests, correct denials, and resubmit within Molina's filing window.

Hospital Billing Quick Tips

CMS Plan hospital billing standards support accurate claims and timely reimbursement for services provided to enrolled Children with Special Health Care Needs (CSHCN)

Hospital Billing



AHCA Coverage Policies Hospitals Need to Know

Use the applicable AHCA policy to support coverage, medical necessity, authorization, level of care and discharge planning [Policy Library — AHCA](#). This is not an exhaustive list please refer to the AHCA policy site for all applicable policies.

MEDICAL NECESSITY & LEVEL OF CARE

Medical & Behavioral Health Coverage Policy
EPSDT Requirements
Inpatient vs. Observation Determinations

HOSPITAL & ACUTE CARE SERVICES

Hospital Services Coverage Policy
Ambulatory Surgical Center Policy
Anesthesia Services Policy
Ambulance Transportation Policy

BEHAVIORAL HEALTH

Behavioral Health Assessment
Behavioral Health Intervention
Behavioral Health Community Support
Behavioral Health Therapy

DISCHARGE & TRANSITION SERVICES

Home Health
Private Duty Nursing (PDN)
Personal Care
Therapy Services
Prescribed Pediatric Extended Care (PPEC)

Reminder AHCA coverage policies govern covered services and medical necessity. Molina applies Florida Medicaid rules and AHCA coverage policies first, then uses nationally recognized, evidence-based criteria when those rules do not address the specific request. Reviews are applied to the individual member's clinical record.

Required Trainings



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), Family Home Health Aides (FHHA), and applicable providers	Prior to service delivery and ongoing

Provider Resources



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 availability.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.



Q & A

Q: How are Case Managers assigned to members and/or facilities?

A: Case Managers (CMs) are assigned to individual members. Hospitals are assigned dedicated Concurrent Review Clinicians (CRCs) who are responsible for managing inpatient admission reviews and concurrent review activities. These assignments are generally consistent, allowing hospitals to maintain established contacts for admissions, authorization support, peer-to-peer coordination, and discharge planning. CRCs collaborate closely with the assigned Case Manager and Transition of Care (TOC) team to support seamless care transitions following hospitalization.

Q: How will hospitals be notified of the assigned Case Manager for a member or facility?

A: Hospitals are required to submit a Notification of Admission (NOA) to Molina. Upon receipt of the NOA, the CRC team coordinates internally with the assigned Case Manager regarding the member's admission. The assigned CRC serves as the primary point of contact for inpatient coordination, authorization approvals, and length-of-stay determinations.

Q: Will there be a standardized communication process for these notifications?

A: Yes. Hospitals should continue to follow the Notification of Admission requirements outlined in their contractual agreements. Molina's standard process for initial authorization requests and continued stay reviews is through the **Availity Portal**.

Q: What communication methods should providers use when contacting Molina regarding Case Management or CMS-related issues?

A: For authorization, utilization management (UM), and related inquiries, providers should utilize the **Availity Portal** and work directly with their assigned UM contacts. For Case Management-related matters, providers should follow established Case Management communication processes.

Q: Should requests be submitted via email, fax, phone, or another method?

A: The preferred method for authorization and utilization management requests is the **Availity Portal**. Additional communication methods, including phone, email, or fax, may be used as appropriate based on the nature of the issue and department-specific processes.