Molina Healthcare of California

Maternity Services and TCS Birthing Supports – APL 26-005

Provider toolkit – September 2026

This toolkit helps California providers understand and comply with DHCS APL 26-005 maternity care requirements. It outlines provider responsibilities for risk assessments, Transitional Care Services (TCS), care coordination, referrals, and postpartum support and includes Molina resources to help connect members to covered services and community supports.

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Purpose

California providers must understand and comply with the Department of Health Care Services (DHCS) APL 26-005 maternity care requirements for pregnant and postpartum Medi-Cal members which is necessary to support improved member care and outcomes. This toolkit outlines provider responsibilities for risk assessments, maternity services, Transitional Care Services (TCS), care coordination, referrals, and follow-up activities. It also includes Molina-covered resources and referral pathways to help connect members to needed services throughout pregnancy and the postpartum period.

At-a-glance

Who this applies to All pregnant and postpartum Medi-Cal managed care members	**Period of support** During pregnancy and through 12 months after the end of pregnancy
Minimum level of care Every member must receive at least moderate-intensity TCS	**Required tool** DHCS TCS Birthing Supports Checklist

Providers are expected to assess needs, build a care plan, coordinate support, complete follow-up and document the outcome.

1. Risk assessment

Complete a comprehensive assessment at the initial prenatal visit, each trimester, and postpartum. Include medical, behavioral health, substance use, safety, and social needs.

2. Individualized care plan

Create and maintain a care plan based on identified obstetric, nutrition, psychosocial, health education, behavioral health, safety, substance use, and social needs.

3. Transitional Care Services (TCS) support period

Provide coordinated support during pregnancy and through 12 months after the end of pregnancy, including transitions between settings or levels of care.

4. Minimum intensity

Ensure every member receives at least moderate-intensity TCS. Molina assigns the TCS category; members with higher clinical or social complexity receive high-intensity TCS.

5. Core follow-up

Coordinate the postpartum visit, the infant two-month well-child visit, and all recommended follow-up identified in discharge instructions.

6. Documentation & closure

Record screenings, checklist items, referrals, outreach attempts, care-team communication, closed-loop follow-up, outcomes, and unresolved needs.

1. Overview & provider responsibilities

Maternity services

Providers are responsible for implementing a comprehensive risk assessment tool for all pregnant and postpartum Members that is comparable to the American College of Obstetricians and Gynecologists (ACOG) standard and Comprehensive Perinatal Services Program (CPSP) standards.

Providers may also utilize standards for a comprehensive risk assessment from the American Academy of Family Physicians (AAFP), American College of Nurse Midwives (ACNM), and National Association of Certified Professional Midwives (NACPM).

As a maternity network provider, you must:

- Maintain the results of risk assessment in the Member's Medical Record
- Develop and maintain the Individualized Care Plan (ICP) including obstetric, nutrition, psychosocial, and health education interventions
- Provide appropriate follow-ups and referrals when indicated by identified risk factors
- Follow-up on all identified risks with appropriate interventions consistent with ACOG and CPSP standards and document those interventions in the Member's Medical Record
- Prescribe folic acid vitamins for Members trying to become pregnant, in alignment with current ACOG guidelines
- Prescribe prenatal vitamins (inclusive of folic acid) for pregnant Members and postpartum Members who are breastfeeding (covered by Medi-Cal Rx)
- Refer for dental screenings and offer or coordinate oral health assessments in alignment with current ACOG guidelines (covered by Denti-Cal)
- Based on clinical assessment, refer high-risk pregnancy members of poor pregnancy outcomes to appropriate Specialists or services
- Offer information to members for participating in the voluntary California Prenatal Screening (CA PNS) Program administered by CDPH to all pregnant Members who engage in care before 21 weeks 0 days gestation for the detection of pregnancies at increased risk for carrying a fetus with chromosomal abnormalities, sex chromosome aneuploidies, or neural tube defects
- Screen newborns for over 80 serious but treatable genetic disorders through the California Newborn Screening (CA NBS) Program administered by CDPH
- Provide member option for Critical Congenital Heart Disease (CCHD) screening conducted on newborns at least 24 hours of age as recommended by the American Academy of Pediatrics' (AAP) Bright Futures Periodicity Schedule
- Offer information to members for participating in the voluntary DHCS statewide Newborn Hearing Screening Program (NHSP) to help identify hearing loss in newborns and guide families to appropriate services
- Provide culturally and linguistically competent/humble health care and services to members as well as language services such as a qualified interpreter
- Follow all state laws governing provision of prenatal and newborn screening services, and compliance with all mandated genetic disorder reporting requirements

Transitional care services (TCS) birthing requirements

Provider responsibilities

Recognize needs	Coordinate support	Close the loop
Identify pregnancy, postpartum status and transitions. Complete or support the TCS checklist and assess whole-person needs.	Connect members to needed care through referrals, warm handoffs and coordination with the care team.	Document actions, outreach, follow-up, outcomes and unresolved needs.

DHCS has established Pregnancy and Postpartum **Transitional Care Services (TCS)** as the minimum standard for coordinated, whole-person support for every pregnant and postpartum Medi-Cal managed care member during pregnancy and through 12 months after the end of pregnancy.

TCS applies to transitions between settings or levels of care, including discharge to home or community-based care, and the end of pregnancy. Every member must receive at least moderate-intensity TCS; members with higher clinical or social complexity receive high-intensity TCS.[1] Pregnant and postpartum members are defined as any member who is pregnant or within 12 months postpartum, starting from the last day of pregnancy, regardless of whether the pregnancy ended in a live or stillbirth, or spontaneous or therapeutic abortion. TCS must be provided during transitional events throughout pregnancy and the postpartum period.

Providers serving as the assigned care coordination entity, or coordinating with Molina's TCS care manager, are expected to:

- Identify pregnancy, postpartum status, and transitions of care promptly, and notify or refer the member to Molina when TCS support is needed.[1]
- Complete or support completion of the DHCS TCS Birthing Supports Checklist for every pregnant and postpartum member and infant, avoiding duplication across care teams.[1]
- Assess and address medical, behavioral health, substance use, intimate partner violence, and health-related social needs.[1,2]
- Make timely referrals and warm handoffs to covered and community services and confirm that the member successfully connects to needed care.[1,2]
- Coordinate discharge instructions and required follow-up, including the postpartum visit, the infant's two-month well-child visit, and other recommended appointments.[1,2]
- Share relevant clinical information with the MCP, care manager, and other treating providers, consistent with privacy requirements.[1,2]
- Document screenings, checklist items, referrals, outreach attempts, closed-loop follow-up, and outcomes in the member's record.[1,2]

[1] California Department of Health Care Services. *CalAIM: Population Health Management Policy Guide*. July 2026.
[2] California Department of Health Care Services. *All Plan Letter 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members.* March 25, 2026.

Providers are expected to:

- Conduct comprehensive risk assessments at the initial prenatal visit, each trimester, and postpartum including screenings for behavioral health, substance use, IPV, and social determinants of health.
  - A comprehensive risk assessment is a standardized, whole-person evaluation of a pregnant or postpartum member's medical and obstetric history, current pregnancy-related risks, behavioral health and substance use needs, intimate partner violence and safety concerns, health-related social needs, and other barriers affecting access to care.
  - The assessment must be completed at the initial prenatal visit, during each trimester, and postpartum; findings must be documented and used to guide individualized care planning, medically necessary services, referrals, care coordination, and follow-up. When a risk or need is identified, the provider must connect the member to appropriate covered or community services and confirm follow-through when applicable.[2]
- Ensure timely access to prenatal, delivery, and postpartum care through 12 months postpartum, with postpartum visits scheduled in accordance with applicable ACOG and USPSTF guidelines.[3]
- Discuss physical health, behavioral health, and community-based services.
- Provide and facilitate prenatal and newborn screenings per state requirements.
- Maintain documentation of assessments, referrals, and care coordination activities.
- Promote equitable, culturally responsive care.

2. TCS requirements & care coordination

Key requirements

- TCS applies during pregnancy and through 12 months postpartum.
- All members must receive care coordination using the TCS Birthing Supports Checklist.
- Providers must ensure referral and/or warm handoffs for needed services.

IMPORTANT: Providers should complete the full TCS Birthing Supports Checklist for all pregnant and postpartum members experiencing a transition of care regardless of whether the member is categorized as moderate-intensity or high-intensity TCS. Molina is responsible for assigning the TCS category. Providers should complete required maternity and checklist activities regardless of intensity assignment.

[3] American College of Obstetricians and Gynecologists. *Optimizing Postpartum Care*. Committee Opinion No. 736, May 2018.

TCS care models & timeline requirements

Initiate pregnancy and postpartum TCS as soon as the member is identified and no later than the third trimester.

For postpartum follow up care, complete initial outreach after identification or referral within the applicable timeframe:

Care model	Who coordinates	Initial postpartum outreach timeframe
High-intensity TCS	An assigned Molina care manager is responsible for coordinating the member's care.	Within **7 calendar days**.
Moderate-intensity TCS	A provider or designated care coordination entity, such as a birthing clinic, OB Provider, Certified Nurse Midwife (CNM), or Licensed Nurse Midwife (LNM) is responsible for coordinating the member's care.	Within **21 calendar days**.

Minimum completion requirements

Complete and document each of the following:

Postpartum visit

Schedule or confirm the visit, assess maternal physical, behavioral, and social needs, address barriers, coordinate referrals, and document attendance and follow-up.

Two-month well-child visit

Link the infant to a pediatric provider, schedule and confirm the visit, support preventive care and referrals, address barriers, and document outcomes and next steps. Align pediatric visits to the American Academy of Pediatrics (AAP) Bright Futures Periodicity schedule.[4]

Discharge follow-up

Review maternal and infant instructions, reconcile medications and pending services, coordinate appointments and supplies, resolve access barriers, confirm completion through closed-loop follow-up, and document or escalate unresolved needs.

[4] American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care: Periodicity Schedule*.

End of Moderate-Intensity Pregnancy and Postpartum TCS

Moderate-intensity TCS ends when all member needs have been met and support has continued through at least 60 days following the end of pregnancy. In addition to the minimum time of support, the following three requirements must be met:

☐ Completion of the postpartum visit with a medical provider that aligns with ACOG guidelines.

☐ Completion of the two-month well-child visit that aligns with the AAP Bright Futures schedule.

☐ Completion of all recommended follow-up listed in the discharge summary and/or instructions.

3. Required services & clinical expectations

Providers must ensure access to comprehensive, whole-person maternity services.

Medical services

- **Prenatal and postpartum visits**: Schedule timely visits, complete required assessments and preventive care, address barriers, coordinate referrals, and document attendance and follow-up.
- **Behavioral health screenings**: Use validated tools during pregnancy and postpartum, assess safety when indicated, discuss results, refer for appropriate care, and confirm connection through closed-loop follow-up.[5]
- **Intimate partner violence (IPV)[6] screening**: Screen privately using a validated, trauma-informed approach; assess immediate safety, provide confidential resources and safety planning, follow reporting requirements, and document appropriately.
- **Reproductive life planning**: Use shared decision-making to discuss pregnancy intentions, contraception, birth spacing, preconception health, and patient preferences; provide or arrange chosen services and document the plan.[7]
- **Pediatric visits (through 2-month well-child visit)**: Link the infant to a pediatric provider, schedule and confirm visits, support screenings, immunizations, feeding and developmental needs, and document outcomes and referrals.[4]
- **PCP visit if not seen within past year**: Confirm primary care attribution and recent preventive care; schedule a visit when due, communicate maternity-related risks and follow-up needs, and document completion.
- **Ongoing screening throughout pregnancy and postpartum**: Reassess medical, obstetric, behavioral, substance use, safety, and social needs at clinically appropriate intervals; update the care plan and escalate new or worsening risks.
- **Referral and care coordination**: Refer or provide warm handoffs for identified needs, share relevant information with the care team, track referral status, resolve barriers, and confirm service connection.

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[5] American College of Obstetricians and Gynecologists. *Patient Screening*. Perinatal Mental Health Program.

[6] U.S. Preventive Services Task Force. *Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: Screening*. Final Recommendation Statement, June 24, 2025.

[7] California Department of Public Health. *Reproductive Life Planning*. Maternal, Child and Adolescent Health Division.

  - **Mental health services**: Coordinate timely evaluation and treatment, provide crisis escalation when needed, and monitor engagement and clinical follow-up.
  - **Substance use treatment**: Use a non-judgmental approach, coordinate appropriate treatment and harm-reduction services, support medication continuity when applicable, and confirm follow-through.
- **Access through appropriate care pathways**: Select the appropriate level and setting of care, assist with authorization and appointment navigation, arrange transportation or other supports, and escalate delays or unresolved gaps.

4. Referral resources & tools

Providers must assess each member's medical, behavioral health, substance use, safety, and health-related social needs throughout pregnancy and the postpartum period.

Based on identified needs and member preferences, providers must:

1. Explain available benefits and community resources,
2. Determine eligibility, obtain consent when required,
3. Initiate timely referrals or warm handoffs to the services listed below.

Providers must also address access barriers, coordinate with Molina and the member's care team, track each referral through completion, confirm that the member successfully connects to services, and document outreach, referral status, outcomes, and unresolved needs in the member record.

Food, nutrition & lactation

- **WIC**: Screen for nutrition and breastfeeding needs, refer eligible pregnant or postpartum members and infants, help complete enrollment, and confirm connection.[8]
- **CalFresh**: Screen for food insecurity, provide application assistance or a warm handoff, address documentation barriers, and follow up on enrollment status.
- **Lactation services**: Assess feeding goals and concerns, refer promptly to qualified lactation support, coordinate equipment needs, and document follow-up and outcomes.

[8] California Department of Public Health. *Women, Infants and Children (WIC) Program*.

5. Managed care plan benefits

Food & nutrition	Access to care	Complex care
Lactation services • Breast pumps	Transportation • Appointment assistance • Interpretation	Enhanced Care Management • Community Supports
Family support	**Behavioral health**	**Infant needs**
Doula services • Perinatal care • Community Health Worker services	Behavioral health services • Substance use treatment	Pediatric care • Medi-Cal enrollment

This section has information on our plan's covered benefits and how to refer members to services. Across all services, providers are expected to assess eligibility and needs, make referrals or warm handoffs, coordinate with the care team, document services, and confirm successful connection and follow-up.

For additional information and referral forms for Community Supports and Services, Doula services, or Care Management, visit Molina's **Frequently Used Forms** page on the provider website.

- **Transportation (NEMT/NMT)**: Assess transportation needs, select the appropriate benefit, submit required authorization or documentation, schedule rides, and confirm access to care. Molina has contracted with American Logistics for transportation services. For services, call customer service at (844) 292-2688.
- **Appointment assistance**: Help identify in-network providers, schedule or reschedule visits, arrange interpretation or transportation, send reminders, and verify completion. Contact your provider representative for more information (**Provider Relations Contact List**).
- **Lactation services**: Provide or facilitate access to prenatal and postpartum lactation education, assessment, counseling, and hands-on support from qualified professionals. Address feeding challenges, support informed infant-feeding decisions, coordinate medically necessary breast pumps or specialized feeding supplies, and refer for donor human milk when medically indicated. Document the member's feeding plan, referrals, equipment needs, and follow-up.
- **Breast pumps (with provider order)**: Assess clinical and feeding needs, submit the required provider order, coordinate fulfillment and education, and address delivery or equipment barriers.
- **Group perinatal care**: Offer or refer members to an available group perinatal care program that combines clinical prenatal care with education, peer support, and facilitated discussion. Programs may address pregnancy health, childbirth preparation, lactation, behavioral health, parenting, and newborn care while maintaining privacy and individualized clinical assessment. Document the referral, participation, and any needs requiring individual follow-up.
- **Enhanced Care Management (ECM)**: Screen for eligibility and complex needs, obtain consent, submit a complete referral, share relevant records, and confirm assignment and engagement. For members who qualify for ECM based on the Birth Equity and/or any other ECM population of focus criteria, providers can submit the ECM Referral Forms linked below in tools.

- **Community Supports (CS)**: Identify eligible health-related social needs, discuss available services, submit referrals with supporting documentation, and track service initiation. CS can help address SDOH needs, such as housing instability, food or nutrition, and other circumstances that may affect maternal or infant health. Use warm handoffs, coordinate with Molina and community providers, track authorization or service status, and confirm that the member successfully connects to the service. Referral forms are available on our website **Frequently Used Forms** and in the **Availity Essentials portal**. Providers can check the authorization status through Availity. For questions about a submitted authorization request, contact Molina customer service at (855) 322-4076. For inquiries related to CS services, please contact the CS team at **MHC_CS@MolinaHealthcare.com**.
- **Doula services**: Educate members about the benefit, discuss preferences, refer to an available doula early, coordinate with the care team, and document engagement. Doula services can support during pregnancy, labor and delivery, miscarriage, stillbirth, abortion, and up to 12 months postpartum. Services may include health education, advocacy, birth planning, lactation support, health navigation, and connections to community resources. Help members locate an enrolled doula, coordinate the referral, and document whether services were initiated. Providers can request doula services for their Molina patients by completing a **Doula Services Request Form** and submitting it to **MHCDoulaSupport@MolinaHealthcare.com**.
- **Community Health Worker services**: Identify education, navigation, advocacy, or social-support needs; refer with member consent, coordinate goals, and monitor engagement. Contact your **Provider Relations representative** for more information.
- **Behavioral health services** are covered under the plan and also with each County. Members may be eligible for Dyadic services and family therapy. For more information, please see our **Behavioral Health Toolkit**.

Family & social supports

- **Paid family leave**: Identify work and income-support needs, provide program information and required medical certification when appropriate, and refer for application assistance.
- **Home visiting programs**: Assess eligibility and family preferences, explain program options, make a warm referral, and confirm successful enrollment and initial contact.
- **Parenting resources**: Assess education and support needs, provide culturally and linguistically appropriate resources, refer to classes or peer support, and follow up.
- **Infant Medi-Cal enrollment**: Verify coverage status after birth, help submit required enrollment information promptly, coordinate with the MCP or county, and confirm active coverage.
- **WIC for infant**: Confirm the infant is added to the household case, support required documentation and appointments, coordinate nutrition or feeding referrals, and verify enrollment.

Example provider tool

- **ECM Member Referral Form**: Complete all required fields, include supporting clinical and social information, obtain member consent, submit through the designated channel, and track the referral to disposition.
  - For members under the age of 21, utilize the **Child/Youth** version of the referral form.

Other provider resources

- DHCS TCS Checklist
- DHCS TCS FAQ
- Medi-Cal Rx (Prenatal Vitamins and Drugs are carved out for MCP and covered under Fee-For-Service)
- CA NBS Program member education resources
- NHSP member brochures
- DHCS NHSP member education resources
- Medi-Cal Dental Benefits
- Women, Infants, & Children Program (WIC) Program

6. Documentation, compliance & support

Providers must maintain complete, timely, accurate, and auditable documentation to demonstrate compliance, support Molina and DHCS oversight, and drive continuous quality improvement. Records should clearly reflect the members' assessed needs, risk level, individualized care plan, services provided, referrals and warm handoffs, outreach attempts, care-team communication, member engagement, and outcomes. Providers must use current approved tools and workflows, complete required TCS checklist elements, protect confidential information, and share relevant records in accordance with applicable privacy and consent requirements.

Providers are also expected to respond to Molina requests for records or validation, participate in audits and monitoring activities, address identified deficiencies through corrective action, and use performance findings to close care gaps, improve timely follow-up, strengthen care transitions, and reduce disparities.

<table>
<tr><th>Documentation requirements:</th><th>Compliance expectations:</th></tr>
<tr><td rowspan="2">• Record all screenings, assessments & results
• Track referrals & closed-loop follow-up activities
• Document care coordination actions & outcomes
• Providers should maintain evidence of:
– Comprehensive risk assessments
– Individualized care plans
– TCS checklist completion
– Specialty and community support referrals
– Warm handoffs
– Postpartum visits
– Infant well-child visits
– Documentation of unresolved barriers</td><td>• Completion of TCS checklist for all members
• Coordination across care teams and services
• Alignment with DHCS and Medi-Cal requirements</td></tr>
<tr><th>Provider support:</th></tr>
<tr><td></td><td>• Contact your Provider Relations Representative
• Utilize MCP resources for:
– Care coordination assistance
– Referral support
– Member benefit navigation</td></tr>
</table>

TCS birthing supports checklist

For use by TCS care managers & care coordination entities

TCS birthing support coordination checklist (prenatal – postpartum period)

**Referral and/or warm handoff to any of the following services are required if the member has needs and meets eligibility for referral:*

Medical supports:

- ☐ Medical visit according to American College of Obstetricians and Gynecologists (ACOG) guidelines
  - ☐ Postpartum Depression Screening*
  - ☐ Intimate Partner Violence (IPV) Screening Using Evidence-Based Tool
  - ☐ Reproductive Life Planning
- ☐ Pediatric visits according to American Academy of Pediatrics (AAP) Bright Futures schedule through two-month well-child visit
- ☐ Other follow-up visits recommended by a provider or included in the discharge summary/instructions

Whole person needs:

Food, nutrition, education and breastfeeding supports	Family support services
☐ Women, Infant, and Children (WIC)	☐ Paid family leave
☐ CalFresh	☐ Home visiting^
☐ Lactation services	☐ Parenting resources**
Managed care plan (MCP) benefits	**Infant support**
☐ Transportation services	☐ Health insurance for infants
☐ Doula services	☐ WIC (including infant formula)
☐ Appointment assistance	
☐ Breast pumps	
☐ Enhanced Care Management (ECM)	
☐ Community Supports (CS)	
☐ Community Health Worker (CHW) services	

***DHCS Closed loop referral (CLR) policy requires MCPs to close the loop for ECM and CS services.*

^Home visiting service include (but are not limited to) California Department of Public Health (CDPH) California Home Visiting Program (CHVP), California Department of Social Services (CDSS) California Work Opportunity and Responsibility to Kids Home Visiting Program (CalWorks HVP), American Indian Maternal Support Services (AIMSS), and county First 5s, as eligible.

***Parenting resources include (but are not limited to) Home Visiting services, MCP educational information, First 5, and Black Infant Health.*

Behavioral health needs:

- ☐ Behavioral Health Supports (e.g., Non-Specialty Health Services (NSMHS), Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS), Drug Medi-Cal (DMC))
- ☐ Dyadic Services

Frequently asked questions (FAQ)

Q1: Who completes the TCS birthing supports checklist?

A: Providers should complete or support checklist activities within their scope and coordinate with Molina and other care-team members to avoid duplicate services and activities.

Q2: Which providers may coordinate moderate-intensity TCS?

A: A provider or designated care coordination entity may coordinate moderate-intensity TCS. Examples include a birthing clinic, OB provider, Certified Nurse Midwife, or Licensed Nurse Midwife.

Q3: When is a Molina care manager responsible?

A: For high-intensity TCS, an assigned Molina care manager coordinates the member's care. Providers should still share relevant information, complete assigned activities, make referrals, document care and coordinate with the Molina care manager.

Q4: How should providers determine TCS intensity?

A: Every pregnant and postpartum member must receive at least moderate-intensity TCS. Members with higher clinical or social complexity receive high-intensity TCS. Providers should identify complexity and notify or refer the member to Molina when Molina care-management support is needed.

Q5: When should pregnancy and postpartum TCS begin?

A: Pregnancy and postpartum TCS should begin as soon as the member is identified as pregnant and no later than the third trimester. Every pregnant and postpartum Medi-Cal member must receive at least moderate-intensity TCS.

Q6: When should I notify or refer a member to Molina?

A: Providers should coordinate with Molina when additional care coordination support is needed, when the member may require high-intensity TCS, or when barriers to care, referrals, or service access cannot be resolved.

Q7: What should be included in the comprehensive risk assessment?

A: Assess medical and obstetric history, current pregnancy-related risks, behavioral health and substance use needs, intimate partner violence and safety concerns, health-related social needs and other barriers affecting access to care. Use the findings to guide care planning and referrals.

Q8: Are referrals required for every service on the checklist?

A: No. Referrals and warm handoffs are based on the member's assessed needs, preferences and eligibility. Providers should explain available benefits and resources, initiate referrals when indicated and confirm connection to services.

Q9: What does closed-loop follow-up mean?

A: Closed-loop follow-up means tracking a referral or recommended service to determine whether the member connected to care, documenting the outcome and addressing or escalating unresolved barriers.

Q10: What if a referral cannot be completed?

A: Document the barrier and referral status, help identify an alternative covered or community service when available, coordinate with Molina or the care team as needed, and continue follow-up until the need is addressed or escalated.

Q11: What documentation should providers maintain?

A: Maintain complete, timely and auditable records of assessments, care plans, referrals and warm handoffs, outreach attempts, care coordination, follow-up activities, outcomes and unresolved barriers.

Q12: What must be completed before moderate-intensity TCS can end?

A: Support must continue through at least 60 days after pregnancy and include completion of the postpartum visit, infant's two-month well-child visit and recommended follow-up care.

Provider reminder: Use current Molina and DHCS forms, guidance and referral pathways. Document coordination, follow-up and unresolved needs in the member record.