



Provider Newsletter

For Molina Healthcare of California providers

Second quarter 2026

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Electronic funds transfer: ECHO Health

Note: There is no cost to the provider for EFT enrollment, and providers are not required to be in network to enroll. Providers who enroll in EFT payments will automatically receive ERAs as well.

Molina has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing.

EFT/ERA services give providers the ability to:

- Reduce paperwork
- Search ERAs, as well as historical explanation of payment (EOPs) by claim number, member number, etc.
- Receive payment and ERA access faster
- View, print, download and save a PDF version of the EOP

On this platform, the provider may receive payment via EFT, automatic clearing house (ACH), physical check or virtual card.

Virtual card:

- If no payment preferences have been specified on the ECHO platform, the payments will be made via a virtual card. This method may include a fee established in the agreement between the provider and the merchant and is not charged by Molina or ECHO.
- If a provider would like to opt out of receiving virtual cards, they should contact Molina and request to opt out of virtual cards before their first payment.
- To opt out of virtual cards after the first payment, providers can request that payment be reissued by following the instructions on the EOP and contacting ECHO Customer Service at **(888) 834-3511** or edi@echohealthinc.com.

Once the provider has enrolled in electronic payments they will receive the associated ERAs from ECHO. Providers should ensure that their practice management system is updated to accept the Molina payer ID. All generated ERAs will be accessible to download from the ECHO Provider Portal at providerpayments.com.

Find additional information on our provider website:

- [ERA/EFT enrollment information](#)
- [Frequently asked questions](#)



Understanding the Molina Care Connections Program

What is Molina Care Connections?

Care Connections is a team of Molina-employed nurse practitioners (NPs) and support staff who provide a reliable safety net, making sure Molina members can access essential care when they may not be able to get to a primary care provider's (PCP) office or there is a need for additional support. The goal is to ensure all members understand, and take active roles in, their own healthcare.

How Molina Care Connections supports you

- **Member engagement:** Care Connections NPs conduct annual preventive care as well as hospital and emergency post-discharge visits to identify any changes to member conditions, educational needs or social determinants of health (SDOH) to ensure they receive the care they need and are supported through care transitions.
- **Member connection:** Care Connections' intent is to reconnect members with their PCP for any needs beyond our scope, as well as to support their ongoing care. We assist members to schedule appointments with their providers and establish care should they not have a regular provider. By encouraging members to establish and maintain a connection with their PCP, Care Connections reinforces the importance of receiving their ongoing care within their community.
- **No impact on billing processes:** Care Connections visits are offered at no cost to members and DO NOT affect providers' ability to provide services or their billing processes.
- **Electronic record access:** Electronic records can be accessed by signing up for EpicCare Link, a HIPAA-secure web portal provided by Molina free of charge. Registration is easy at CCLink.MolinaHealthcare.com. Simply click "Request New Account" under the login box, then choose "Request a new site" to request access for a provider. From there, the provider will add their practice information, including NPI. Adding NPI is required and will ensure that HIPAA-appropriate access is granted to all records. Once logged in, the provider can click "Select Patient" for a list of all patient records available. If you need assistance with this process, please email Care Connections at CCEpicCareLink@MolinaHealthcare.com.

Key features of Care Connections

- **Advanced point-of-care services:** We offer testing and health education at the point of care to improve member understanding and health outcomes.
- **Addressing social determinants of health (SDOH):** We identify and address SDOH challenges by connecting members with appropriate resources.
- **Clinical advocacy:** Acting as “boots on the ground” clinical advocates, the team helps connect members with timely and appropriate care.
- **Care coordination:** We facilitate communication between members, their PCPs and their care managers to ensure a seamless care experience.
- **Care extenders:** By providing an additional access point to the health care system, we help meet members’ needs timely and effectively.

Care Connections exemplifies how collaboration, engagement and strategy translate into measurable impact. Together with our provider partners, we are shaping a future where every member has the tools, support and care they need to thrive. For support, please email ClinicalSupport@MolinaHealthcare.com.

Care for older adults

Many adults over 65 have comorbidities that often affect their quality of life. As this demographic ages, decreased physical function, cognitive ability and increased pain are common. Regular assessment of these additional health aspects can help ensure this population’s needs are appropriately met.

- Advance care planning – Discussions regarding treatment preferences, such as advance directives, should start before the member is seriously ill.
- Medication review – All medications the member takes, including prescription and over-the-counter medications or herbal therapies, should be reviewed.
- Functional status assessment – which includes those for functional independence or loss of independent performance.
- Pain screening consists of notating the presence or absence of pain.

Providers should include these components in their standard well-care practice for older adults to help identify unrecognized ailments and increase their quality of life.

Molina's utilization management

One of Molina's utilization management (UM) department's goals is to render appropriate UM decisions consistent with objective clinical evidence. To achieve this goal, Molina maintains the following guidelines:

- Our highly trained UM staff evaluates medical information received by our providers against nationally recognized objective- and evidence-based criteria. We also consider individual circumstances (at minimum age, comorbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable) and the local delivery system when determining the medical appropriateness of requested health care services.
- Clinical criteria for Molina Healthcare of California (MHC) includes:
 - MCG criteria that are utilized to conduct inpatient review (except when Change Healthcare InterQual® is contractually required)
 - American Society of Addiction Medicine (ASAM) criteria
 - National Comprehensive Cancer Network (NCCN)
 - Hayes Directories
 - Applicable Medicaid guidelines
 - Molina Clinical Policy (MCP) and Molina Clinical Review (MCR) (developed by designated corporate medical affairs staff in conjunction with MHC physicians serving on the Medical Coverage Guidance Committee)
 - UpToDate®
 - Other nationally recognized criteria, including technology assessments and well-controlled studies that meet industry standards, MHC policy, and when appropriate, third-party (outside) board-certified physician reviewers
- MHC ensures all criteria used for UM decision-making are available to practitioners upon request. The clinical policy website, [MolinaClinicalPolicy.com](https://www.molinaclinicalpolicy.com), provides access to MCP and MCR criteria. Providers can also access the MCG Cite for Care Guideline Transparency tool through our [Availity Essentials provider portal](#). To obtain a copy of the UM criteria, call our UM department at **(844) 557-8434**.
- As the requesting practitioner, you will receive written notification of all UM denial decisions. If you need assistance contacting a medical reviewer about a case, please call the UM department at **(844) 557-8434**.

It is important to remember:

- UM decision-making is based only on the appropriateness of care and service and the existence of coverage.
- MHC does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- UM decision-makers do not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.
- Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.

Molina's utilization management (continued)

- Medicaid members have the right to a second opinion from a qualified practitioner. If an appropriate practitioner is not available in-network, MHC will arrange for a member to obtain a second opinion out of network at no additional cost to the member. MHC provides for a second opinion from a qualified in-network practitioner. Members from all MHC lines of business and programs should refer to their benefit documents (such as schedule of benefits and/or evidence of coverage) for second-opinion coverage benefit details, limitations and cost-share information. If an appropriate practitioner is unavailable in-network, prior authorization (PA) is required to obtain the second opinion of an out-of-network provider. Claims for out-of-network providers without a PA will be denied, unless regulation dictates otherwise. All diagnostic testing, consultations, treatments and/or surgical procedures must be a benefit under the plan and meet all applicable medical necessity criteria to be covered.
- Some of the most common reasons for a delay or denial of a request include:
 - Insufficient or missing clinical information to provide the basis for making the decision
 - Lack of or missing progress notes or illegible documentation

MHC's UM department staff is available for inbound collect or toll-free calls during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a member of the UM staff, please call **(844) 557-8434**. You may also fax a question about an UM issue to MHC. The medical director is available to answer more complex medical decision questions and explain medical necessity denials.

MHC offers the ability to quickly and conveniently submit and check PA status through the [Availity provider portal](#).

MHC PA fax numbers include:

- **Advanced imaging: (877) 731-7218**
- **Medicaid: (800) 811-4804**
- **Marketplace: (800) 811-4804**
- **Medicare Outpatient physical health and behavioral health: (844) 251-1451**
- **Medicare Hospital inpatient and concurrent review requests: (844) 834-2152**
- **Medicare Part D pharmacy: (866) 290-1309**

For information about MHC's formulary PA and the exception process, please refer to the Drug Formulary and Pharmaceutical Procedures article.

MHC's regular business hours are Monday-Friday (excluding holidays), 8 a.m.-5 p.m. Voicemail messages and faxes received after regular business hours will be returned the following business day. MHC has language assistance and TDD/TTY services for members with language barriers, members who are deaf or hard of hearing and those with speech disabilities.

Case management

Molina Healthcare of California (MHC) offers a complex care management program designed to support both you and your patients. This program is available to members facing multiple or complex medical conditions, difficulty adhering to treatment plans, high levels of dependence or those requiring coordinated care across multiple specialties. It also supports individuals dealing with social, psychological or emotional challenges that may complicate their treatment or recovery.

The goal of the MHC Care Management program is to:

- Conduct a thorough needs assessment for the patient and their family or caregivers
- Provide care coordination and intervention services within the patient's benefit coverage
- Empower members to improve their health and daily functioning
- Ensure timely access to medically necessary services at the appropriate level of care
- Create and maintain a comprehensive care plan in collaboration with providers, staff, patients and families to ensure continuity of care

MHC also offers the following care management programs:

- Molina's CA Healthy Beginnings Maternity Program is available for individuals with healthy or high-risk pregnancies. Members are assigned a dedicated nurse (RN) care manager to provide education, care coordination and support to pregnant individuals interested in a healthy pregnancy, delivery and beyond. In addition, MHC utilizes a multidisciplinary care team model in which there is a focused effort in early identification and intervention for maternal mental health and SUD needs. MHC partners with perinatologists and addiction specialists for telehealth visits until the member is connected to in-network behavioral health or county behavioral health providers.
- The MyCare Palliative Care Program provides an extra layer of care and support to members with a prognosis of one year or less and who are not yet ready for hospice. The dedicated team of palliative care case managers work closely with the palliative care provider to deliver home-based palliative care to the member and family and when appropriate and the member is ready, successfully transition to hospice.
- The Transitions of Care (ToC) program provides post-discharge follow-up care to members discharged to the community or home after an acute hospitalization. A Transition of Care coach is assigned to the member and completes the post-discharge assessment to ensure the member has safely and successfully transitioned from the hospital. The ToC coach provides medication review, assists with scheduling follow-up appointments with the member's treating physicians and coordinates the member's care.

If you'd like to learn more, speak with a care manager or refer a patient for evaluation, please call us toll-free at **(833) 234-1258**.

To make a referral, please email or fax the completed referral form to us at:

Email: MHCCaseManagement@MolinaHealthcare.com

Fax: **(562) 499-6105**

[Case Management Referral Form](#)

Important message – Updating provider information

MHC needs to keep our provider network information current. Up-to-date provider information allows MHC to accurately generate provider directories, process claims and communicate with our provider network. Providers must notify MHC in writing at least 30 days in advance, when possible, of changes, such as:

- Change in practice ownership or Federal Tax ID number
- Practice name change
- Change in practice address, phone or fax numbers
- Change in practice office hours
- New office site location
- Primary care providers (PCP) only: If your practice opens or closes to new patients
- When a provider joins or leaves the practice

Changes should be submitted on the [Provider demographic update information form](#) which is located online. Send changes to:

- **Los Angeles/Orange**
- **Sacramento**
- **Inland Empire**
- **San Diego**

Contact your [provider relations representative](#) if you have questions.

Practitioner credentialing rights: What you need to know

MHC must protect its members by assuring their care is of the highest quality. One protection is assurance that our providers have been credentialed according to the strict standards established by the state regulators and accrediting organizations. As a MHC provider, your responsibility includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

MHC is also responsible to its providers to ensure that the credentialing information it reviews is complete and accurate. As a MHC provider, you have the right to:

- Strict confidentiality of all information submitted during the credentialing process
- Non-discrimination during the credentialing process
- Be notified of information obtained during the credentialing process that varies substantially from what you submit
- Review information submitted from outside primary sources (e.g., malpractice insurance carriers, state licensing boards) to support your credentialing application, except for references, recommendations or other peer-review protected information
- Correct erroneous information
- Be informed of the status of your application upon request by calling Provider Services at **(855) 322-4075**.
- Receive notification of the credentialing decision within 60 days of the committee decision or shorter timeframes as contractually required
- Receive notification of your provider's right to appeal an adverse decision made by the committee
- Be informed of the above rights
- Please review our Provider Manual for further details on all your rights as a MHC provider. You may review the Provider Manual on our website at:
 - [Medi-Cal Provider Manual](#)
 - [Medicare Provider Manual](#)
 - [Marketplace Provider Manual](#)

You also can contact your [Provider Relations representative](#).

Drug Formulary and pharmaceutical procedures

For CA Molina Medicaid, the drug formulary is determined by the state and state processes and is called the Covered Drug List (CDL). You can find more information on Medical-RX and their management of the state-covered drug list can be found [here](#). The drug formulary for CA Medicaid can be found on the state [Medi-Cal RX website](#).

At MHC, the Marketplace Formularies—sometimes referred to as a Preferred Drug List (PDL)—and pharmacy services procedures are maintained by the National Pharmacy and Therapeutics (P&T) Committee. This committee meets quarterly or more frequently if needed.

The P&T Committee is responsible for developing and updating drug formularies that promote safety, effectiveness and affordability where state regulations allow. The committee objectively reviews new Food and Drug Administration (FDA) approved drugs, drug classes, new clinical indications for existing drugs, new line extensions and generics, new safety information, new clinical guidelines and practice trends that may impact previous formulary placement decisions. Additional committee oversight includes PA, step therapy, quantity limits, generic substitutions, medical exception protocols to allow coverage for non-formulary drugs, other drug utilization management activities that affect access, and drug utilization evaluations and intervention recommendations for MHC health plans. Drug formulary activities are inclusive of prescriber-administered specialty medications as a medical benefit and pharmacy benefit services.

The drug formularies reviewed and approved by the P&T Committee are updated quarterly and include an explanation of quantity limits, age restrictions, therapeutic class preferences and step therapy protocols. These changes and all current documents are also posted on our website at [CA Marketplace](#).

Providers may request a formulary exception for coverage of a drug outside of the drug formulary restrictions. A formulary exception should be requested to obtain a drug that is not included on a member's drug formulary or to request that a UM requirement be waived (e.g., step therapy, PA, quantity limit) for a formulary drug.

Select medications on the drug formulary or drugs not listed on the formulary may require PA. PA is a requirement that a prescriber obtains advance approval from Molina before a specific drug is delivered to the member to qualify for payment coverage. The drug formulary/PDL is available online at [CA Marketplace](#).

The P&T Committee also promotes member safety. In the event of a Class II recall or voluntary drug withdrawal from the market for safety reasons, affected members and prescribing practitioners will be notified by MHC within 30 calendar days of the FDA notification. An expedited process is in place to ensure notification to affected members and prescribing practitioners of Class I recalls as quickly as possible. These notifications will be conducted by fax, mail and/or phone.

Resources available on Molina's provider website

Featured online at [MolinaHealthcare.com](https://www.molinahealthcare.com):

- Clinical practice and preventive health guidelines
- Health management programs
- Quality improvement programs
- Member rights and responsibilities
- Privacy notices
- Provider Manual
- Current formulary
- Cultural competency provider trainings

If you would like to receive any of the information posted on our website in a printed format, please call **(855) 322-4075**.



Translation services

Molina Healthcare of California (MHC) provides free language assistance services to help members communicate in their preferred language. Interpreter services are available 24 hours a day at no cost, including telephonic, video remote interpretation (VRI), and in-person interpretation, for members with limited English proficiency or who use sign language. To request interpretation services, call Hanna Interpreting Service at **(833) 739-6055**. You can also access interpretation services by visiting the Hanna Hub at [Molina.hannahub.ai](https://www.molina.hannahub.ai)

MHC also offers written materials in multiple languages and alternate formats, such as large print, Braille, audio, and electronic formats. To request alternative formats, please contact MHC at **(855) 322-4075**. You can also call **TTD/TTY: 711** if a member has a hearing or speech disability



Patient safety

Patient safety activities encompass appropriate safety projects and error avoidance for MHC members in collaboration with their PCPs.

The MHC patient safety activities address the following:

- Continued information about safe office practices
- Member education about members taking an active role in reducing the risk of errors in their care
- Member education about safe medication practices
- Cultural competency training
- Improvement in the continuity and coordination of care between providers to avoid miscommunication
- Improvement in the continuity and coordination between sites of care, such as hospitals and other facilities, to ensure timely and accurate communication
- Distribution of research on proven safe clinical practices

MHC also monitors nationally recognized quality index ratings for facilities from:

- **Leapfrog Quality Index Ratings**
- **The Joint Commission QualityCheck®**

Providers can also access the following links for additional information on patient safety:

- **The Leapfrog Group**
- **The Joint Commission**



Member rights and responsibilities

MHC wants to inform its providers about some of the rights and responsibilities of MHC members.

MHC members have the right to:

- Receive information about MHC, its services, its practitioners and providers and member rights and responsibilities
- Be treated with respect and recognition of their dignity and their right to privacy
- Help make decisions about their health care
- Participate with practitioners in making decisions about their health care
- A candid discussion of appropriate or medically necessary treatment options for their conditions—regardless of cost or benefit coverage
- Voice complaints or appeals about MHC or the care provided
- Make recommendations regarding MHC member rights and responsibilities policy

Molina members have the responsibility to:

- Supply information (to the extent possible) that MHC and its practitioners and providers need to provide care
- Follow plans and instructions for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- Keep appointments and be on time (If members are going to be late or cannot keep an appointment, they are instructed to call their practitioner.)

You can find the complete Molina Member Rights and Responsibilities Statement on our [website](#). Written copies and more information can be obtained by contacting Provider Services at **(855) 322-4075**.

Population health (health education, disease management, care management and complex case management)

The tools and services described here are educational support for our members. We may change them at any time to meet their needs.

MHC offers programs to help our members and their families manage a diagnosed health condition. As a provider, you also help us identify members who may benefit from these programs. Members can request to be enrolled or disenrolled in these programs. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular disease (CVD) management/
congestive heart failure
- Chronic obstructive pulmonary disease
(COPD) management
- Depression management

You can find more information about our programs at [here](#).

If you have additional question about our programs, please call Provider Services at (855) 322-4075 (TTY/TDD at 711 Relay).



Quality Improvement and Health Equity Transformation Program

MHC Quality Improvement and Health Equity Transformation (QIHET) Program provides the structure and key processes that enable the health plan to carry out our commitment to ongoing improvement in members' health care and service. The QIHET committee assists the organization in achieving these goals. It is an evolving program that is responsive to the changing needs of the health plan's members and the standards established by the medical community and regulatory and accrediting bodies.

The key quality processes include but are not limited to:

- Implementation of programs and processes to improve members' outcomes and health status
- Collaboration with our contracted provider network to identify relevant care processes, develop tools and design meaningful measurement methodologies for provided care and service
- Evaluation of the effectiveness of programs, interventions and process improvements and determination of further actions
- Design of effective and value-added interventions
- Continuous monitoring of performance parameters and comparing to performance standards and benchmarks published by national, regional or state regulators, accrediting organizations and internal MHC thresholds
- Analysis of information and data to identify trends and opportunities and the appropriateness of care and services
- Oversight and improvement of functions that may be delegated: claims, UM and/or credentialing
- Confirmation of the quality and adequacy of the provider and health delivery organization network through appropriate contracting and credentialing processes

The QIHET Program promotes and fosters accountability of employees, network and affiliated health personnel for the quality and safety of care and services provided to MHC members.

The effectiveness of QIHET Program activities in producing measurable improvements in the care and service provided to members is evaluated by:

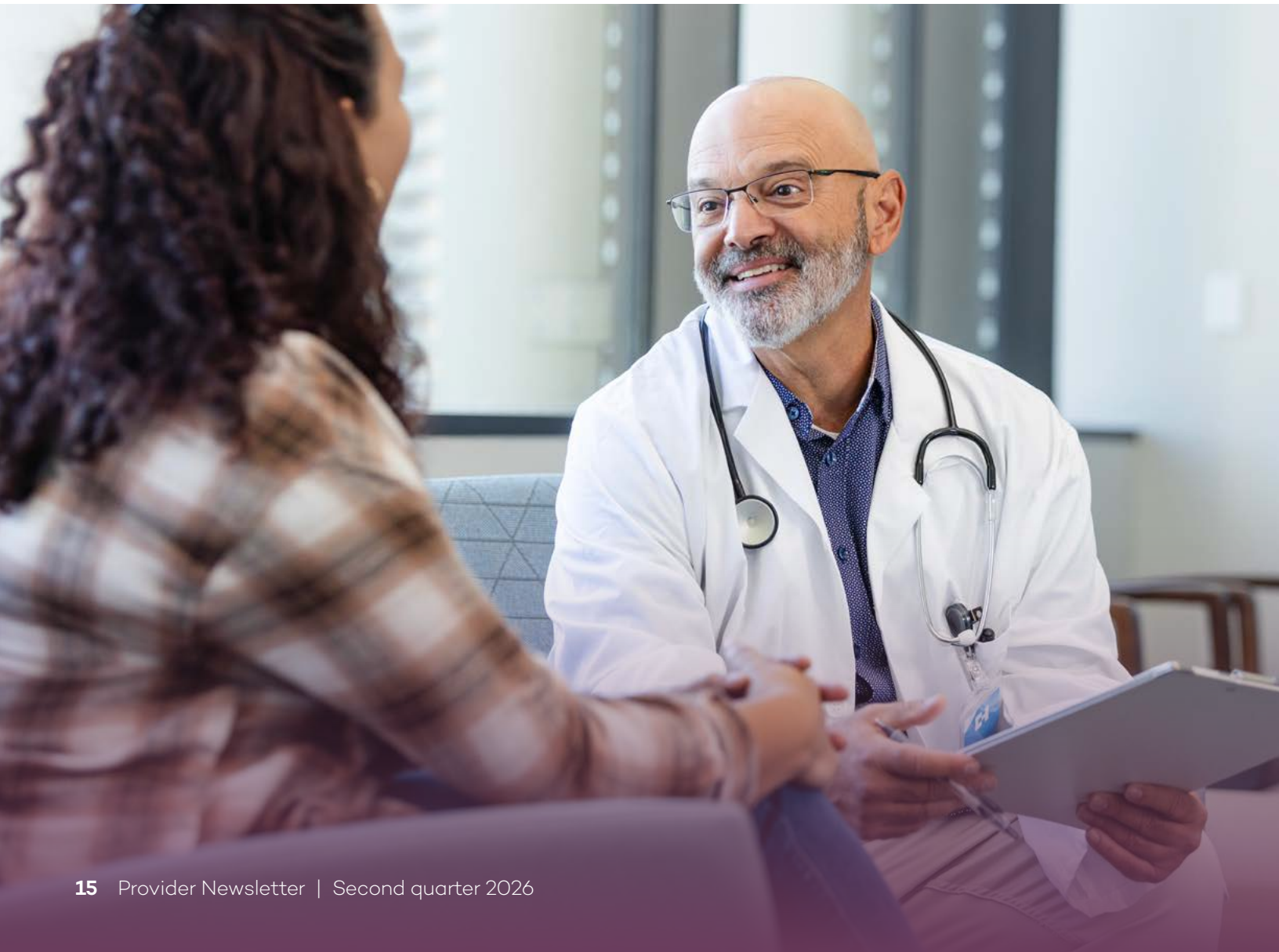
- Organizing multidisciplinary teams—including clinical experts—to analyze service and process improvement opportunities, determine actions for improvement and evaluate results
- Tracking the progress of quality activities and goals through appropriate quality committee minutes and reviewing/updating the quality work plan quarterly
- Revising interventions based on analysis when indicated
- Evaluating member satisfaction with their experience of care through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey

Quality Improvement and Health Equity Transformation Program (continued)

- Reviewing member satisfaction with their experience with behavioral health services through survey questions and/or evaluation of behavioral health-specific complaints and appeals
- Conducting provider satisfaction surveys with specific questions about the UM process, such as determining the level of satisfaction with getting a service approved, obtaining a referral and case management

MHC would like to help you promote the important care activities you have undertaken in your practices. If you would like to have your projects and programs highlighted on the MHC website, please contact the QI department at **(888) 665-4623**.

If you would like more information about our QI program or initiatives and the progress toward meeting quality goals, you can visit our [website](#) and access the Health Resources area on our provider website pages. If you would like to request a paper copy of our documents, please call the QI department at **(888) 665-4623**.



Standards for medical record documentation

MHC has established standards for medical record documentation to help assure the highest quality of care for our members. Medical record standards promote quality care through communication, coordination and continuity of care and efficient and effective treatment.

MHC medical record documentation standards include:

- Medical record content
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records
- Confidential patient information
- Standards and performance goals for participating providers

Below are commonly accepted standards for documentation in medical records and must be included in each medical record:

- History and physicals
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening
- Vaccinations and/or injections

For more information, please call the QI department at **(888) 665-4623**.

Preventive health guidelines

Preventive health guidelines can benefit providers and their patients. Guidelines are based on scientific evidence, a review of the medical literature or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations.

These guidelines are meant to recommend a standard level of care and do not preclude the delivery of additional preventive services depending on the member's needs.

You can view all guidelines by accessing the [Health Resources section](#) on our provider web pages. To request printed copies of preventive health guidelines, please contact Provider Services at **(855) 322-4075**.



Clinical practice guidelines

Clinical practice guidelines are based on scientific evidence and a review of the medical literature or appropriately established authority. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The care recommendations are suggested as guides for making clinical decisions. Providers and our members must work together to develop individual treatment plans that are tailored to the member's specific needs and circumstances.

MHC has adopted the following Clinical Practice and Behavioral Health Guidelines, which include but are not limited to:

- Acute stress and post-traumatic stress disorder (PTSD)
- Anxiety/panic disorder
- Asthma
- Attention deficit hyperactivity disorder (ADHD)
- Autism
- Bipolar disorder
- Children with special health care needs
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Heart failure in adults
- Homelessness - special health care needs
- Hypertension
- Obesity
- Opioid management
- Perinatal care
- Pregnancy management
- Schizophrenia
- Sickle cell disease
- Substance abuse treatment
- Suicide risk
- Trauma-informed primary care

You can also view all guidelines in the [Health Resources section](#) on the provider web pages. To request a copy of any guidelines, please contact Provider Services at **(855) 322-4075**.

Advance directives

Providers can assist MHC members in preparing an advance directive. Anyone 18 or older can have an advance directive, including a living will document and a durable power of attorney.

A living will is written instruction explaining the wishes of a MHC member regarding health care in the case of a terminal illness or any medical procedures that can prolong life. A durable power of attorney names a person to make decisions for our members if they cannot.

The following links provide free forms and information to help create an advance directive:

- [Caringinfo](#)
- [National Library of Medicine](#)

Members will need two witnesses for the living will and valid notarization for a durable power of attorney.

An advance directive must be honored to the fullest extent permitted under law. Providers should discuss advance directives and provide appropriate medical advice if the member desires guidance or assistance, including any objections they may have to a directive prior to service whenever possible. Providers cannot refuse treatment or otherwise discriminate against members because they completed an advance directive. Members have the right to file a complaint if they are dissatisfied with the handling of an advance directive and/or if there is a failure to comply with advance directive instructions.

Providers should have materials on advance directives for members to review. They should also put a copy of a completed advance directive form in a prominent section of the medical record. The medical record should also document if a member chooses not to execute an advance directive. Providers should inform members that advance care planning is a part of good health care.

Behavioral health

PCPs provide outpatient behavioral health services within the scope of their practice and are responsible for coordinating members' physical and behavioral health care.

Behavioral health services are a direct access benefit and are available with no required referrals; however, PCPs are responsible for assisting in coordinating access and treatment, if needed. If you or the member need assistance with obtaining behavioral health services, please contact Member Services at **(888) 665-4621**.

Our 24-hour Nurse Advice Line is also available to members 24 hours a day, 7 days a week, 365 days per year for mental health or substance use needs. The services received will be confidential.

Providers may refer to the [MHC Behavioral Health Toolkit](#) for providers online for additional clinical guidance, recommendations and training/education opportunities related to behavioral health conditions.



Care coordination and transitions

Coordination of care during planned and unplanned transitions for MHC members

MHC is dedicated to providing quality care for our members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a Molina member is discharged from a hospital. By working together with providers, MHC makes a special effort to coordinate care during transitions to avoid potential adverse outcomes.

MHC has resources to assist you in easing the challenge of coordinating care. Our staff, including nurses, can work with all parties to ensure appropriate care.

To appropriately coordinate care, Molina will need the following information in writing from the facility within one business day of the transition from one setting to another:

- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

This information should be faxed to MHC Prior Authorization Fax: (800) 811-4804