Optum

Annual Regulatory Updates

Resources and Support for California Providers

Optum Behavioral Health remains dedicated to providing you with the best resources and the most efficient tools to help you care for members. We also want to share quality and member satisfaction achievements, remind you about state-required appointment availability standards and share network access updates.

Resources to Help You Care for Members

California Language Assistance Program

The California Language Assistance Program includes provisions for the provider network to ensure that members with limited English proficiency can obtain free language assistance when needed:

- Requirements for clinicians and facilities
- Tips for working with interpreters
- Tips for working with members with limited English proficiency
- Grievance forms and notices of language assistance

Free services to help work with members

- Interpreter services are available at no cost to members or providers: **1-800-999-9585**
- Assistance for those with hearing and/or speech impairment is available: **1-800-842-9489**

The Centralized Appointment Search Team (CAST)

The Optum Behavioral Health Centralized Appointment Search Team (CAST) provides an additional level of support for members who would like assistance identifying providers that best meet their individual needs and preferences. To help you support your patients, we want to make sure you're aware of this team.

When a member requests CAST assistance, our team researches providers and appointment availability using criteria provided by the member. This can include the provider's specialty, expertise working with certain age groups, what languages the provider speaks, gender, ethnicity and geographic location. The CAST team can also research whether evening or weekend appointments are available, and if the provider offers telehealth (virtual) sessions.

As part of their research, CAST representatives may contact providers by phone or email to confirm whether the provider is currently accepting new patients and if they have availability that aligns with the member's requested timeframe.

The information gathered is shared directly with the member so they can contact the provider and schedule an appointment that best fits their needs.

To request CAST assistance, members should contact Customer Service using the phone number on the back of their ID card.

Note: CAST outreach is conducted solely for appointment research purposes and does not constitute a referral, authorization, or guarantee of an appointment.

Provider Responsibilities

Verify Enrollee eligibility before every appointment

It's important to always verify enrollee eligibility before providing services, either by checking eligibility through the Provider Express secure portal or by calling Optum at **1-800-333-8724**. In addition, you are encouraged to check member insurance information at every visit and discuss all treatment options and their related risks and benefits with the enrollee, regardless of whether the treatment is covered under their benefit plan.

Use Optum's clinical criteria as you develop treatment plans

Optum uses Clinical Criteria and Guidelines established by leading industry organizations and nationally recognized associations to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency and well-being. Clinical Criteria are intended to standardize the interpretation and application of terms of the member's Benefit Plan, including terms of coverage, Benefit Plan exclusions and limitations.

Optum expects all member treatment to be outcome-driven, clinically necessary, evidence-based and provided in the least restrictive environment possible. Decisions for prior authorization and utilization management are based only on the appropriateness of care/service and existence of coverage. Optum does not reward its staff, practitioners or other individuals for issuing denials of coverage/services. Utilization Management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

For more information, review:

- Clinical criteria and guidelines
- Practice guidelines

Support Coordination of Care with other providers

Our mission is to help people live their lives to the fullest. One of the important ways we work toward that goal is by promoting ongoing coordination of care for patients. We take an active role in this process and expect our network providers to do so as well.

Resources are available about the importance of coordination of care as well as tools to make it easier for you to document it:

- Overview on the Providerexpress.com website
- Coordination of care checklist
- Coordination of care flyer
- Other coordination of care tips

Post the Enrollee Rights and Responsibilities in your office

Optum asks participating providers to prominently display the Enrollee Rights and Responsibilities in your waiting room or have some other way to inform Optum members of these standards. The ability to review these rights and responsibilities helps support informed patient care and promotes awareness of the member's rights in the treatment process.

A copy of the Enrollee Rights and Responsibilities, in English and in Spanish, can be found in the Appendices of the California Behavioral Health Network Manual.

Ensure after-hours emergency instructions, member messages and your response

- **After-hours messaging:** Your voicemail or answering service must include instructions to members regarding what they should do in an emergency.
- **Timely response to member messages:** Please return all member calls within 24 hours

Keep demographic information up to date

It takes just a few minutes to review and update your demographic information — such as your practice name, office location, email or whether you're accepting new patients — at any time. (You'll also get email reminders to review/update your information every 90 days, as required by federal law.) To update information:

- Log in to the Provider Express secure portal with your One Healthcare ID.
- Select **My Practice Info** > **Clinician Information** > **Edit** from the menu at the top of the page. Then select the type of information that needs to be updated from the drop-down menu. Review the training guide for assistance.

Facilities should call Optum Behavioral Health Provider Services for assistance in updating information: **1-877-614-0484**, Monday–Friday, 7 a.m.–7 p.m. CT.

Update your Appointment Availability and Office Hours status regularly

Keeping your office hours and appointment availability up to date through the Provider Express secure portal is essential to help members access care and schedule appointments. It's also required by California regulations.

- **If you're unable to see new members, update** your availability with Optum Behavioral Health **within 5 business days of your status changing**. You may indicate that you're not accepting new patients for up to 6 months from the date your status changes.
- **Office hours and any other practice demographic information** (such as phone numbers or addresses) must be updated within **10 days of any change**.

Follow all Appointment Availability standards

Providing members with timely access to behavioral health care continues to be a priority and a challenge throughout the healthcare industry. California Health and Safety Code Section 1367.03 outlines the appointment wait-time standards providers are expected to meet.

If a member is unable to schedule a timely appointment or obtain a referral to an appropriate provider, they may contact the California Department of Managed Health Care (DMHC) Help Center may be contacted at **1-888-466-2219** for assistance or to file a complaint.

Standard	Criteria	Compliance Target
Non-life-threatening emergency	A situation in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm to self or others	100% of members must be offered an appointment within 6 hours of the request for the appointment
Urgent	A situation where immediate care is not needed for stabilization but, if the situation is not addressed in a timely way, could escalate to an emergency	100% of members must be offered an appointment within 48 hours of the request for the appointment
Standard	**Criteria**	**Compliance Target**

Routine (non-urgent)	A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others	100% of members must be offered an appointment within 10 business days of the request for the appointment
Follow-up care Mental health or substance use disorder follow-up appointment with non-physician	10 business days from prior appointment	100%
After-hours answering system and messaging	Messaging must include instructions for obtaining emergency care	100%
Network clinician availability	Percentage of network clinicians (all license types) available to see new patients	90%
Counseling Non-Physician Mental Health Professional Accepting New Patients	For each county, percentage of Counseling Non-Physician Mental Health Professionals (MHPs) who must be accepting new patients	75%
	For each county, percentage of Counseling MHP practice locations that have MHPs who are accepting new patients	80%
Clinician timely response to enrollee messages	Clinician shall provide live answer or respond to enrollee messages for routine issues within 24 hours	90%

The time for a particular non-emergency appointment may be extended if it is determined and documented that a longer waiting time will not have a detrimental impact on the member's health. Rescheduling of appointments, when necessary, must be consistent with good professional care and ensure there is no detriment to the member. An extension to the time for a non-emergency appointment may be determined by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and is consistent with professionally recognized standards of practice.

Working with Optum Behavioral Health



California-specific resources

- Welcome page
- Network management contacts
- Mobile crisis resources
- Behavioral Health Network Manual

General resources

- Credentialing plan
- Reimbursement policies
- Provider training
- Optum Pay™ information



California Strengthens Mental Health Parity Standards

To improve access to mental health and substance use disorder services, the California Office of Administrative Law approved the Department of Managed Health Care's (DMHC) regulations implementing Senate Bill 855 in 2024. The updates further strengthen California's Mental Health Parity Act. They also reinforce requirements to ensure members have timely access to medically necessary behavioral health care and that health plans apply prior authorization and utilization management processes in accordance with DMHC requirements.

- **Network Gap Exceptions:** Optum Behavioral Health will arrange and cover medically necessary mental health and substance use disorder services from an out-of-network provider when appropriate behavioral health services are not available within required geographic or timely access standards. In these situations, members will pay only their in-network cost-sharing (copay, coinsurance deductible).

- **Clinical Criteria:** When making determinations of medical necessity, plan coverage and utilization review, Optum Behavioral Health applies generally accepted standard of care criteria developed by nonprofit professional associations. Depending on the member's condition and age, these criteria may include:
  - ASAM Criteria for substance use disorders,
  - LOCUS for adult mental health services,
  - CALOCUS-CASII for children and adolescents, and
  - ECSII for young children.

  Optum may use alternative criteria that have been reviewed and approved by the Department of Managed Health Care (DMHC).

- **Utilization Review:** Optum will not conduct utilization reviews more frequently than the intervals prescribed by the applicable criteria. Additionally, if a member meets criteria for a specific level of care but that level is unavailable, Optum will authorize the next higher level of care to ensure access to necessary treatment.



Quality Improvement Achievements

The Quality Improvement Program monitors four key areas: 1) access to care and availability of clinicians; 2) quality of care and services; 3) patient safety; and 4) appropriate utilization of resources. Each year, an in-depth evaluation of the Quality Improvement Program is performed. This includes a review of the processes that support these components of care along with overall the Optum structure.

The findings of the most recent evaluation conducted in 2025 include:

- Outstanding performance in the areas of network availability and accessibility
- High performance in the areas of customer service call response time and claims payment accuracy, as well as in turnaround times for claims processing, appeals, provider disputes and non-coverage determinations
- Appointments for emergent care (non-life threatening) offered within 6 hours was 100%
- Appointments for urgent care offered within 48 hours was 100%
- Member complaints remain below the performance threshold, with 100% of complaints resolved within 30 days of receipt

To request a copy of the Executive Summary of the most recent Quality Improvement performance evaluation, please call **1-877-614-0484**.



Members Highly Satisfied with Treatment and Services

Optum Behavioral Health administers the Member Satisfaction Survey to a sample of members who receive services from an Optum network clinician or facility. Results are analyzed annually. The findings from the survey are used to identify opportunities to improve the member experience.

The 2025 survey assessed member satisfaction in a number of areas, including:

- Obtaining referrals or authorizations
- Accessibility and acceptability of the clinician network
- Customer service and treatment/quality of care
- Overall satisfaction

Survey results indicate members experience high overall satisfaction with treatment received: 88% of surveyed members indicated that they would use Optum services again

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- 95% of members indicated that they were able to find care that was respectful of language, cultural, and ethnic needs

- 88% of those surveyed reported that the treatment they received from their clinician helped them better manage their problems
- 90% were satisfied with their overall experience with their behavioral health clinician
- Overall member satisfaction with services received was 87%

Network Adequacy Standards



Monitoring Network Availability

To help ensure timely and equitable access to behavioral health services, we have updated our Network Geographic Availability Standards to align with current California Department of Managed Health Care (DMHC) requirements. These standards establish travel time and distance expectations designed to ensure members have reasonable access to behavioral health clinicians and facilities within their service area.

Network geographic availability is evaluated on a quarterly basis across California to assess provider and facility accessibility and identify opportunities to improve member access to care. Our standards have been updated to reflect the DMHC network adequacy requirements from **APL-23-023** and support ongoing compliance with California access-to-care regulations.

By regularly monitoring network geographic availability, we strive to maintain an adequate network that promotes timely access to behavioral health services and meets the needs of members throughout California.

Note: A provider's region is based on county classification. The county classification for large metro, metro, micro, rural, and CEAC is based on county and the population size/density. It is also defined by Centers for Medicare (CMS) and Medicaid Services (CMS) in its published Medicare Advantage Network Adequacy Criteria, set forth in **42 CFR 422.116(c)**.

Geographic Standards

U.S. Behavioral Health Plan, California	Large Metro counties		Metro counties		Micro counties		Rural counties		CEAC counties		Compliance Threshold for Geographic Access Standards
Provider Types	**Miles**	**Min**	**Miles**	**Min**	**Miles**	**Min**	**Miles**	**Min**	**Miles**	**Min**	
Child/Adolescent Clinician (Prescriber, PhD, master's-level)											
	10	20	30	45	45	60	60	75	100	110	90%
Applied Behavior Analysis (ABA)											
	15	30	45	70	75	100	75	90	140	155	90%
Intermediate Care / Partial hospitalization / Residential (Mental health and SUD)											
	15	30	45	70	75	100	75	90	140	155	90%
Intensive Outpatient Care (Mental health and substance use disorder)											
	15	30	45	70	75	100	75	90	140	155	90%
Medication Assisted Treatment (MAT) (Prescribers with expertise in naltrexone injectable or buprenorphine, methadone clinics)											
	15	30	45	70	75	100	75	90	140	155	90%

Geographic Standards

Provider Type	Distance in Miles					
	Large metro counties	Metro counties	Micro counties	Rural counties	CEAC counties	Compliance Threshold for Geographic Access Standards
Specialist Physicians / Psychiatry						
	15	20	55	55	100	90%
Counseling non-physician mental health professional or Counseling mental health professional (Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, Psychologist)						
	15	15	35	35	65	90%
Mental health facilities (Acute psychiatric hospital, psychiatric health facility, or chemical dependency recovery hospital and/or residential detoxification facility. "Inpatient mental health facilities" also includes those facilities categorized as a general acute care hospital, where such hospital maintains an inpatient psychiatric unit)						
	15	35	90	90	120	90%

Provider Ratio Standards

Provider-to-enrollee ratio measurement is based on the number of providers per 1,000 members, determined overall and by county, in counties with greater than 500 members.

Provider Type	Standard
Child/Adolescent clinician (MD, PhD, master's level)	1 per 1,000 enrollees
Acute Inpatient Care (mental health and substance use)	1 per 20,000 enrollees
Intermediate Care/Partial Hospitalization/Residential (mental health and substance use)	1 per 20,000 enrollees
Intensive Outpatient Care (mental health and substance use)	1 per 20,000 enrollees
Medication Assisted Treatment (MAT)	1 per 20,000 enrollees

Provider-to-enrollee ratio for:

- Specialist Physicians-Psychiatry
- Counseling (non-physician mental health professional) or Counseling mental health professional

Provider Type	Standard
Specialist Physicians / Psychiatry	1 full-time equivalent per 5,500 enrollees
Counseling non-physician mental health professional (MHP) or Counseling MHP (Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Professional Clinical Counselor, Psychologist)	1 full-time equivalent counseling MHP per 1,000 enrollees

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