Resources and Services for California Providers

Provider surveys reveal that providers prefer to receive Optum Behavioral Health updates via an e-newsletter rather than emails or faxes. Now you'll receive important updates all in one place with Top of Mind delivered to your inbox every month. Articles for 2024 are summarized in this quick reference guide and 2025 articles will be included in monthly Top of Mind issues throughout the year.

These tools and resources can help you do what you do best – care for members.

Satisfaction Surveys

Provider Satisfaction Survey Results

In 2023, **622** network clinicians in California responded to our California Provider Satisfaction survey which measures **clinician satisfaction** with areas of service including the authorization process, Network Services staff, claims/customer service, credentialing, website usage and Net Promoter Score (NPS).

Areas where improvement was noted:

- NPS rose from a score of 1 in 2022 to 13 for 2023 (Key positive drivers include clarification of the authorization process, assistance with resolving claims issues, and provider reimbursement)
- Credentialing/re-credentialing process satisfaction increased from 69% to 70%

Areas where satisfaction rate remains high:

- Provider Express website - 87%
- Cultural Competency education/training - 87%

Areas for Improvement:

- Overall satisfaction with Network Services decreased from 65% to 62%
- Satisfaction in reaching Network Services in a timely manner decreased from 61% to 59% (By the end of 2023, however, satisfaction in reaching Network Services experienced a significant increase)
- Awareness of Linguistic Assistance, decreased slightly from 70% to 69% (There continues to remain an infrequent use of these services by providers)

Thank you to all who took the time to participate in the survey. And thank you for your continued partnership to meet the behavioral health needs of our members.

Members Highly Satisfied with Treatment and Services

Optum 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 2024 survey assessed member satisfaction along multiple domains including:

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

Results of the survey indicate that members experience high overall satisfaction with treatment

received:

- 85% of surveyed members indicated satisfaction with helpfulness of Optum staff
- 88% of members indicated that they were able to find care that was respectful of language, cultural, and ethnic needs
- 93% of those surveyed reported that the treatment they received from their clinician helped them better manage their problems
- 92% were satisfied with their overall experience with their behavioral health clinician
- Overall member satisfaction with services received was 85%
- The findings from the survey are used to identify opportunities to improve the member experience

Member Resources

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. Call **1-800-999-9585**.
- Assistance for those with hearing and/or speech impairment is available at **1-800-842-9489** (TTY).

Plan Updates

Benefit administration change for Alignment Health Plan Medicare Advantage

- **Beginning Jan. 1, 2024,** Optum began administering behavioral health benefits for select Alignment Health Plan Medicare Advantage plans in California.
- For members assigned to select independent practice associations (IPA), claims for services provided with a primary diagnosis of mental health will be processed by Optum, while claims for SUD services will continue to be processed by the IPA the Alignment Health plan Medicare Advantage member is assigned.
- **Beginning Oct. 1, 2024**, members with Substance Use Disorder (SUD) benefits carved out to Independent Physician Associations (IPAs) will have an alert populate on Provider Express for providers when checking eligibility, advising that claims for SUD services will continue to be processed by the IPA the member is assigned to.

Members assigned to certain IPAs with a primary diagnosis of SUD should be redirected back to the IPA for SUD services.

Provider Care

Member messages including emergency instructions for all contracted Providers

- **Clinician Timely Response to Member Messages**: Please return all member calls within 24 hours.
- **After-Hours Answering System and Messaging**: Be sure your answering machine message includes instructions to members regarding what they should do in an emergency

Verifying Enrollee Eligibility

As a reminder, 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.

Guidelines

The **Clinical Criteria and Guidelines** are sets of objective and evidence-based behavioral health criteria used 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. You will find these, along with Best Practice Guidelines and the Supplemental and Measurable Guidelines, on our website

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

Coordination of Care

Our mission is to help people live their lives to the fullest.

One of the important ways in which 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.

Provider Express offers information regarding the importance of coordination of care and provides tools to make it easier for you to document it, such as:

- **Coordination of care checklist**
- **Coordination of care flyer**
- **Other coordination of care tips**

Enrollee Rights and Responsibilities

Optum requests that you display the Enrollee Rights and Responsibilities in your waiting room or have some other means of documenting that these standards have been communicated to Optum enrollees. All enrollees benefit from reviewing these standards in the treatment setting.

You can find a copy of the Enrollee Rights and Responsibilities, in English and in Spanish, in the Appendices of the **California Behavioral Health Network Manual.**

Quality Achievements

The Quality Improvement (QI) Program monitors access to care and availability of clinicians, quality of care and services, patient safety, and appropriate utilization of resources. Each year, an in-depth evaluation of the QI Program is performed. This includes a review of the processes that support these components of care along with Optum overall structure. The findings of the most recent evaluation conducted in 2023 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, and turn-around times for claims processing, appeals, provider disputes, and non- coverage determinations
- Appointment for emergent care (non-life threatening) offered within 6 hours was at 100%
- Appointment for urgent care offered within 48 hours was at 100%
- Member complaints remain below the performance threshold, with 100% of complaints resolved within 30 days of receipt

If you are interested in obtaining a copy of the Executive Summary of the most recent QI performance evaluation, please call **1-877-614-0484**.

Resources for Providers

You have 24/7 access to a wide variety of resources and information through the Provider Express website:

- **California Behavioral Health Network Manual**
- **Credentialing Plan**
- **Video channel**
- **Training information**
- **Optum Pay™ information**
- **California Network Contacts**
- **California Mobile Crisis Resources**
- **California Welcome**

Timely Access to Care

Updating Your Appointment Availability Status

If you're unable to see new members, please update your availability status online in the Provider Express secure portal. You may remain unavailable for up to six months. California regulations require you update your information within 5 days of changes to your availability, and within 10 days for any other demographic change to your practice (new phone #, hours of operation, etc.).

Appointment Availability Standards

Improving and expanding member access to care continues to be a priority and a challenge throughout the healthcare industry. Section 1367.031 of the California Health and Safety Code outlines the timelines within which members should be able to schedule appointments. The DMHC Help Center may be contacted at **1-888-466-2219** to file a complaint if the member is unable to obtain a timely referral to an appropriate provider.

For the CA Provider Appointment Availability Surveys (PAAS) Measurement Year 2023, Optum met the DMHC Rate of Compliance thresholds for Urgent, Non-Urgent and Non-Physician Mental Health Follow-up Appointments.

Please be aware of and comply with these appointment availability standards:

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 in which immediate care is not needed for stabilization but, if not addressed in a timely way, could escalate to an emergency situation	100% of members must be offered an appointment within 48 hours of the request for the appointment
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/Substance Use Disorder follow-up appointment Non-Physician)	10 business days from prior appointment	100%
After-Hours Answering System and Messaging	Messaging must include instruction for obtaining emergency care	100%
Network Clinician Availability	Percentage of network clinicians available to see new patients	90%

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[1] 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.

[1] 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

Availability Standards – Monitoring Network Availability

We have updated our standards shown below to ensure that members have appropriate availability of behavioral health clinicians and facilities within a defined geographic distance. California network geographic availability is reviewed quarterly, clinicians and facilities are in geographic positions of availability to provide services to membership in all large metro, metro, micro, rural and CEAC areas of California. Our standards have been updated to reflect the new DMHC requirements from APL-23-023.

Note: Provider's region is based on county classification. The county classification for large metro, metro, etc. is based on county and the population size/density. It is also defined on Centers for Medicare (CMS) and Medicaid Services (CMS) in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c) available at www.cms.gov.

USBHPC	Large Metro		Metro		Micro		Rural		CEAC		Compliance Threshold for Geographic Access Standards
Provider Types	**Miles**	**Min.**	**Miles**	**Min.**	**Miles**	**Min.**	**Miles**	**Min.**	**Miles**	**Min.**	
Child/Adolescent Clinician (Prescriber, Doctoral and Masters-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 substance use)	15	30	45	70	75	100	75	90	140	155	90%
Intensive Outpatient Care (Mental health and substance use)	15	30	45	70	75	100	75	90	140	155	90%
Medication Assisted Treatment (MAT)/ Emotional Wellbeing Solutions (EWS) (Prescribers with an expertise in buprenorphine or	15	30	45	70	75	100	75	90	140	155	90%

naltrexone injectable, methadone clinics)										

Note: Provider's region is based on county classification. The county classification for large metro, metro, etc. is based on county and the population size/density. It is also defined on Centers for Medicare (CMS) and Medicaid Services (CMS) in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c) available at www.cms.gov.

Provider Types	Large Metro counties (miles)	Metro counties (miles)	Micro counties (miles)	Rural counties (miles)	Counties with Extreme Access Consideration (CEAC) (miles)	Compliance Threshold for Geographic Access Standards
Specialist Physicians-Psychiatry	15	20	55	55	100	90%
Counseling non-physician mental health professional or Counseling MHP (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	45	90	90	120	90%

Ratio Standard: Provider-to-Enrollee Ratio-Measurement based on number per 1,000 members, 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)/Emotional Wellbeing Solutions (EWS)	1 per 20,000 enrollees

Ratio Standard: Provider-to-Enrollee Ratio for Specialist Physicians-Psychiatry and Counseling non-physician mental health professional or Counseling MHP.

Provider Type	Standard
Specialist Physicians-Psychiatry	1 full-time equivalent per 5,500 enrollees
Counseling non-physician mental health professional 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