Optum

Behavioral Health Providers

Senior Care Options and One Care Training

Welcome to Optum – Senior Care Options and One Care Training

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Senior Care Options and One Care

UHC Senior Care Options (SCO)

UHC Senior Care Options (SCO) is a Coordinated Care plan with a Medicare contract and a contract with the Commonwealth of Massachusetts Medicaid program. UHC SCO is a fully integrated Medicare Advantage Special Needs Plan, serving members who are age 65 and older, and are dually eligible for Medicare and Medicaid within the SCO service area.

UHC SCO is currently available in the following counties: Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester counties.

Members of UHC SCO must meet the following qualifications:

- Be 65 years of age or over or be turning 65 years of age during the month in which the SCO enrollment would first be effective;
- Reside in the Commonwealth;
- Be enrolled in Medicare Parts A and B and eligible for Part D;
- Be enrolled in MassHealth Standard;
- Have no other comprehensive private or public health insurance

Member ID Card – Senior Care Options (SCO)

UHC One Care

UHC One Care is a health plan that contracts Medicare and MassHealth (Medicaid) to provide combined benefits to eligible members

Current service area includes the following counties: Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester.

Eligibility Requirements: adults ages 21–64 with disabilities who reside in the Commonwealth.

- Must have: MassHealth Standard or MassHealth CommonHealth.
- Medicare Parts A and B, and be eligible for Medicare Part D.
- Must have no other comprehensive public or private health insurance.
- Must have a Physical disabilities or
- Intellectual or developmental disabilities (ID/D).
- Serious mental illness (SMI).
- Substance use disorders (SUD).
- Disabilities with multiple chronic illnesses or functional/cognitive limitations.
- Homeless individuals with disabilities.
- Gender-diverse, non-English speaking, and individuals who are deaf, hard of hearing, or deaf-blind.

Member ID Card – One Care

In-network and out-of-network

If you are currently contracted for ***both*** the Senior Care Options and One Care D-SNP networks

- You can begin providing mental health and substance use disorder services to members of both D-SNP plans in the 9 counties starting Jan. 1, 2026.
- No further action is required on your part to be eligible to work with this new membership.

If you are currently contracted for ***only one*** of these D-SNP networks

- You are eligible to provide services to members covered by your contracted D-SNP plan (Senior Care Options **or** One Care) beginning Jan. 1, 2026.
- If you would like to expand your participation to include the other D-SNP network, please call Provider Services at **1-877-614-0484** to initiate a contract update.
- The effective date of when you can see members as a contracted provider will depend on when the contract update is completed.

Integrated D-SNP Benefits

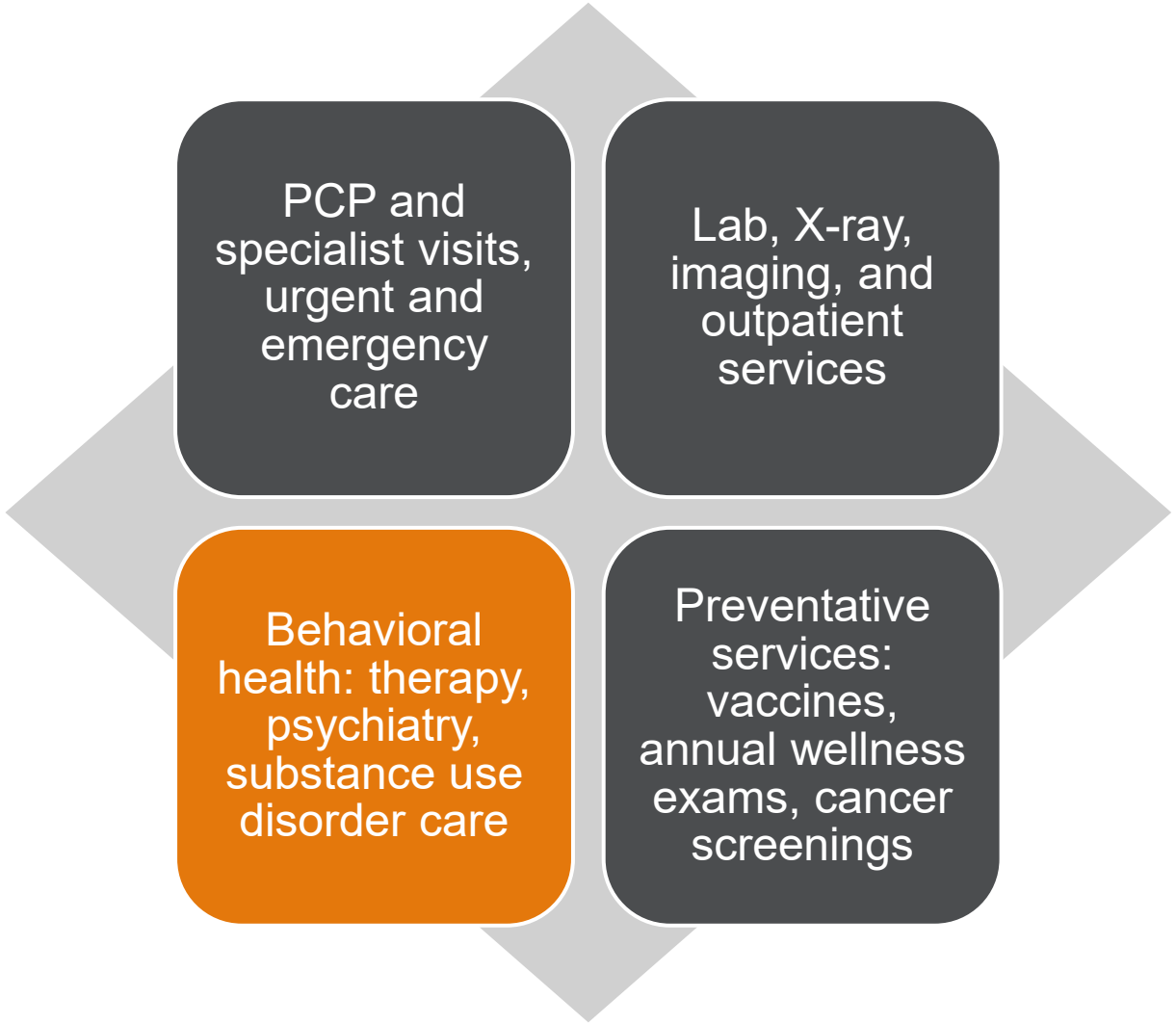
Understanding Integrated D-SNP Benefits

Combines Medicare (Part A/B/D), Medicaid (MassHealth), and supplemental services

Designed to support medical, behavioral, and social needs

Coordination led by the Interdisciplinary Care Team (ICT)

Behavioral Health is Part of the Integrated Core Medical Benefits



Accessing Benefits: The Care Planning Process

Initial assessment triggers care planning

Individualized Care Plan (ICP) developed by the ICT

Prior authorization required for many services

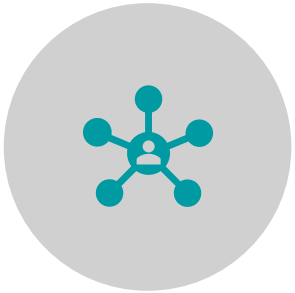
Care Coordinator is the member's main point of contact

Comparing Medicare Advantage, SCO and One Care

Category	Medicare Advantage (MA)	SCO (Senior Care Options)	One Care
Eligibility	Age 65+, Medicare entitlement	Age 65+, Medicare + MassHealth Standard	Age 21-64, Medicare + MassHealth Standard/CommonHealth
Medicaid Coverage	Not integrated (must enroll separately in MassHealth)	Fully integrated: MassHealth + Medicare	Fully integrated: MassHealth + Medicare
Behavioral Health	Limited/included depending on plan	Managed via vendor per state contracts	Integrated within care team and provider network
LTSS/HCBS Services	Not typically covered	Covered: PCA, homemaker, day health, respite, adult foster care	Covered + enhanced flexibility through One Care model
Supplemental Benefits	Varies: dental, vision, OTC	Dental, vision, hearing, transportation, OTC	All SCO benefits + flexible services (e.g., housing, meals)
Care Coordination	Member-driven, limited team-based coordination	Interdisciplinary Care Team (ICT), includes RN, LTSS Coord. GSSC	Full ICT including BH, LTSS, and member choice of providers
Service Area	Massachusetts-wide (varies by plan)	Dukes, Nantucket, Bristol, Norfolk, Plymouth, Middlesex, Essex, Suffolk	Same service area as SCO

Model of Care and Interdisciplinary Care Team

What is the Model of Care (MOC)?



A CMS required-framework for delivering coordinated, person-centered care

Designed specifically for individuals with complex medical, behavioral and social needs

“Provides guidance on supporting SCO and One Care members.”

Delivered through the Interdisciplinary Care Team (ICT)

Care Management Model

- Care coordination and care management are at the heart of our mission to advance compassionate, trauma-informed, equitable, person-centered Care
- UHC integrates primary, acute, specialty, behavioral health, transportation, prescriptions, dental, vision, and Long-Term Support Services (LTSS).
- Care coordinators and clinical care managers include licensed and non-licensed professionals (e.g., CHWs, LPNs, RNs, **behavioral health clinicians**, advanced practice clinicians).
- Interdisciplinary Care Teams (ICTs) collaborate with clearly defined roles to provide tailored support.
- Data-driven tools alert ICTs to care transitions and gaps, guiding proactive outreach and engagement.
- Initial comprehensive assessment and care plan completed within 90 days of enrollment, followed by ongoing assessments.
- Care coordinators are local experts in community resources for personalized support.

Providing person-centered care

Understanding the unique needs of One Care and SCO Members at an individual level is crucial. Both populations have complex care needs driven by chronic illnesses, behavioral health challenges, functional impairments, HRSN and social isolation needs, requiring a coordinated person-centered care model, and individualized care plan.

One Care

Focuses on recovery, behavioral health, and independent living for younger members with disabilities.

Serves younger adults (21-64) with disabilities and behavioral health needs; dual-eligible for Medicare and MassHealth; may transition to SCO at 65

Emphasizes behavioral health, developmental disabilities, and social determinants of health (e.g., housing, employment)

Members can choose to be assigned a LTSC (long-term service coordinator)

Integrated care with consumer-directed models, community and peer support, along with behavioral health specialists in ICT

At minimum annual assessments; documents LTSS care decisions and social needs

Tackles social instability (e.g., housing, employment); leverages telehealth and mobile services

Senior Care Options (SCO)

Emphasizes aging in place, chronic condition management, and LTSS coordination for elderly adults.

Serves elderly adults (65+), focusing on age-related needs; does not require Medicare eligibility; can include MassHealth-only or dual-eligible individuals

Focuses on chronic aging-related conditions (e.g., multiple comorbidities, mobility issues) and LTSS to support independence

Members are assigned a GSSC (geriatric support service coordinator)

Chronic condition management with care coordinators/GSSCs, emphasizing formal and informal support to receive home-based care

At minimum bi-annual assessments; documents GSSC assignments and FEW benefit administration, with a focus on preventing institutionalization

Addresses financial challenges (e.g., medications, co-pays) with programs and meal delivery services

One Care Interdisciplinary Care Team (ICT)

Core Team Members:

Primary Care Provider (PCP) – Oversees medical treatment and preventive care

Care Coordinator – Central point of contact for the members; coordinates across Medicare & MassHealth benefits

Long-Term Services & Supports (LTSS) Coordinator- Identifies and manages HCBS supports for members

Behavioral Health Clinician- Integrates mental health and substance use services into care plan.

Member and Caregiver – Set personal goals and guide care planning

Supporting Roles (as needed):

Specialists (e.g., cardiology, endocrinology)

Peer Support Specialists

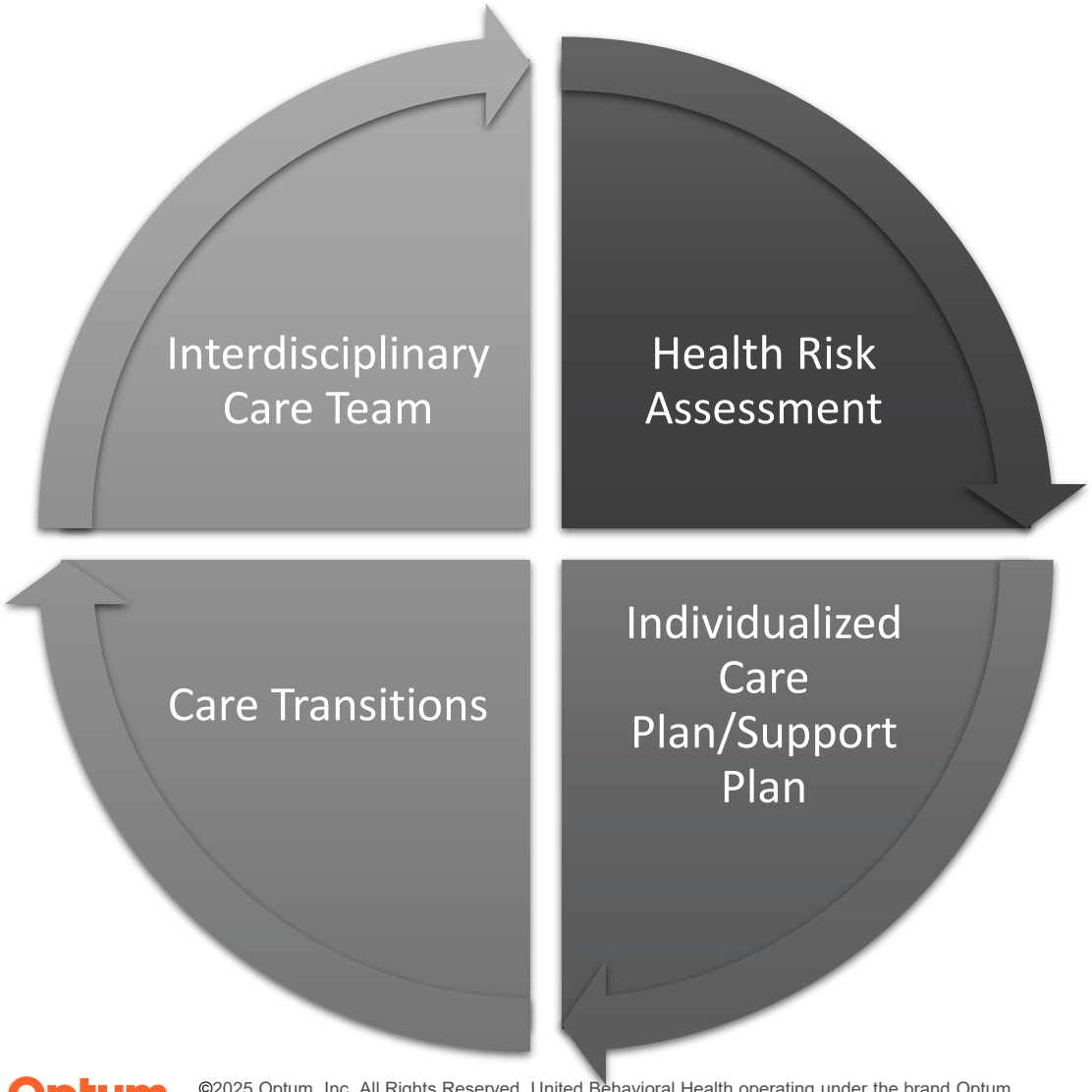
Pharmacist

Community-based organization representatives

Key Purpose:

Deliver integrated medical, behavioral health, and LTSS through a unified, person-centered Individualized Care Plan (ICP) that reflects both Medicare and MassHealth requirements.

D-SNP Care Coordination



- When the member enrolls, they are assigned a care manager to serve as primary point of contact and convene the **Interdisciplinary Care Team (ICT)**
- All enrollees should be assessed on an annual basis, at a minimum, to inform the care plan
- Working collaboratively with the ICT, the care manager is responsible for creating and updating an integrated **care plan** that supports members reaching their goals and improved outcomes
- D-SNPs offer comprehensive **transition of care** support to limit risk of readmission and ensure a safe return to community

Summary of Provider Responsibilities - MOC

- Communicate and collaborate with Case Managers, the ICT members, members and caregivers
- Coordinate care with Medicaid for any of the D-SNP members, which may include state agencies or other carriers
- Encourage your patient to work with your office, keep appointments and comply with all treatment plans, participate with the care team, and complete the health risk assessment.
- Review and respond to correspondence sent by case managers including the HRA results, the ICP and any request for information
- Participate in applicable quality measures

Mandatory – Senior Care Options/One Care Training Sessions and attestation

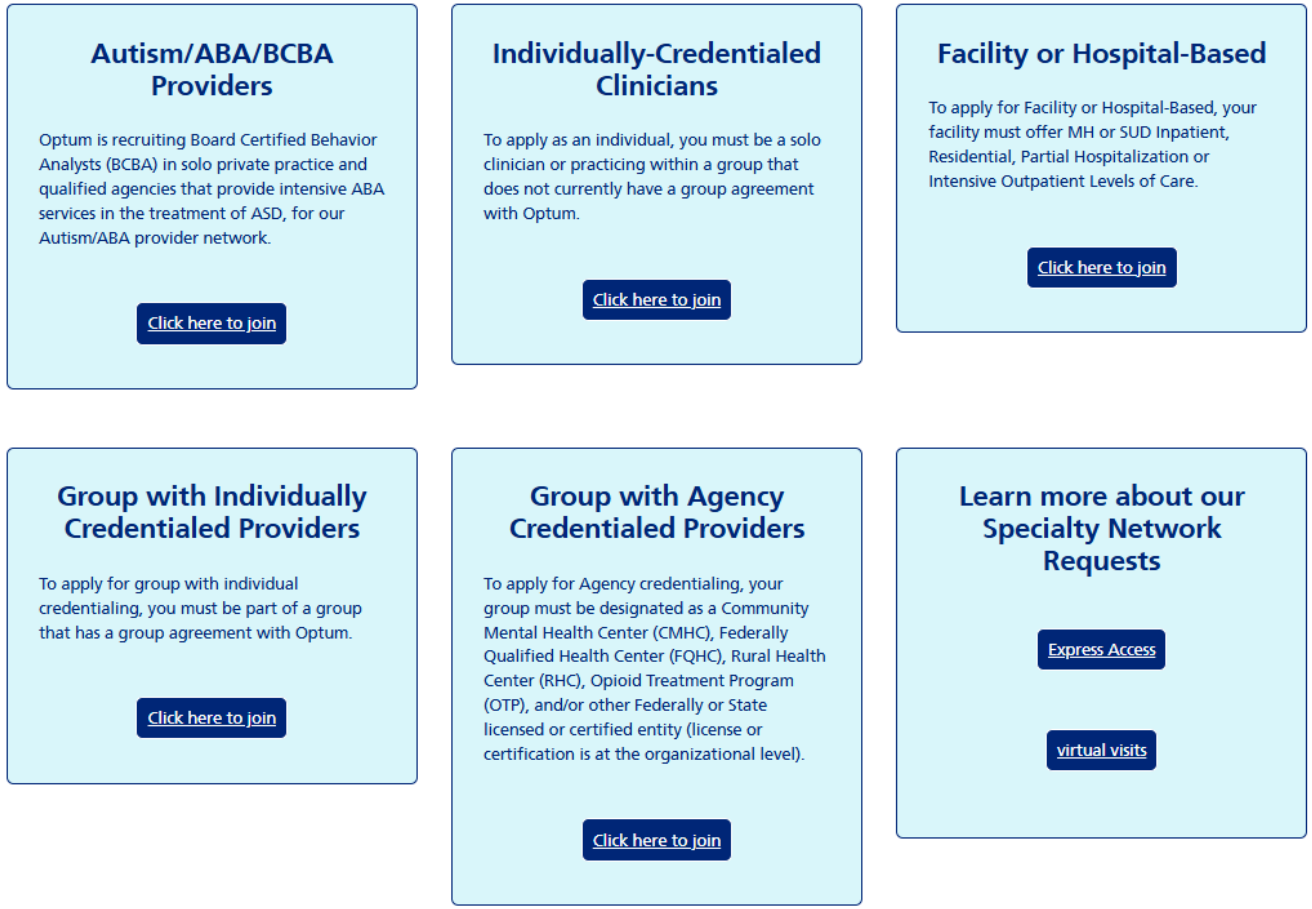
All providers must attend a Model of Care training or go through the self-paced Model of Care training deck and attest to completing it.

Please Note: The self-paced Model of Care training will be posted on provider express with attestation at the beginning of 2026. There may also be live training sessions for the 2026 Model of Care that will be announced in upcoming provider newsletters when/if they are scheduled.

Network

Enrolling Providers

If you would like to become a contracted provider, please visit our website Our Network



Enrolling Providers

CAQH Participation is required in the majority of the states to join our network. If your state requires it, you will be required to enter your CAQH ID # on the credentialing application. To participate in CAQH, please contact: www.CAQH.org

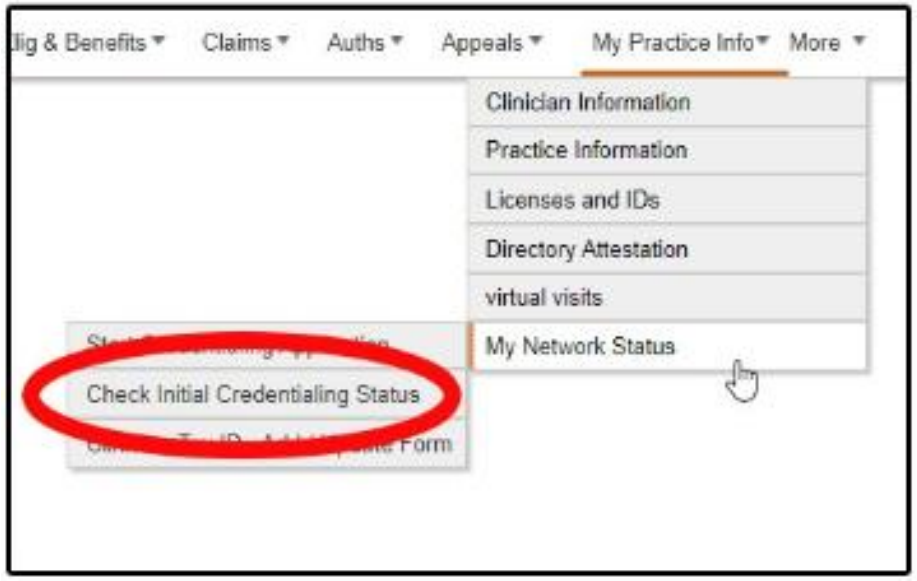
Improve the Speed of Processing - Tips for Applying to the Network

We recently conducted an audit of credentialing application issues. Here's an at-a-glance view of the most common issues that will slow down or lead to the cancellation of the credentialing of your application to join our network.

Category	Issues	Requirement
CAQH	• Your CAQH profile status is incomplete or expired • Your group information including but not limited to primary and practice locations listed on your UBH Network Participation form does not match what you have listed on your CAQH profile • We do not have authorization to access your CAQH application (log into the CAQH ProView Provider portal, go to the user account setting menu and review the Authorization section to update your preferences to authorize United Behavioral Health/US Behavioral Health Plan) • Information in your completed CAQH profile needs to be updated (Examples include Practice Information, Credentialing Contact information, License and Professional Liability Insurance effective and expiration dates)	The information on CAQH must match the information you provide on the Optum NPRF form.
Attached Documents	• Attaching the wrong document • Not signing the W-9 form or providing an incorrect Tax ID number or EIN • Current Professional Liability Insurance Certificate	Providing all the correct and completed documents is required.
Document Return	Slow response time to requested information. • Individual Contracts • Disclosure of Ownership documents	Missing documents are sent out via DocuSign. Sign and return as quickly as possible.

Enrolling Providers

Individual providers – Using the **Initial Credentialing Status Toolbar** you can easily track the status of your online submission as it moves along the approval process. Log into the secure transactions area of Provider Express, hover over *My Practice Info* >> *My Network Status* >> click on *Check Initial Credentialing Status*.



Agency or Group Practice – contact Network Management at: **1-877-614-0484**

Facility – contact Network Management at: **1-877-614-0484**

Autism/ABA - contact Network Management at: **1-877-614-0484**

Enrolling Providers

To link an existing provider to your TIN:

Clinician Tax ID - Add / Update Form

This form is used by credentialed providers to add a new Tax ID to their record, change an existing Tax ID or inactivate a Tax ID from their record. Add/Update Form

The combination of the Provider Name and Individual NPI (Type 1) uniquely identifies you and your requests in the system. Please use the same information each time so you can view all of your requests together.

REMINDER: If you are only making DEMOGRAPHIC CHANGES to an existing practice, you can add, modify and/or delete a practice, remit, mailing, credentialing or 1099 address on providerexpress.com under Transactions --> My Practice Info.

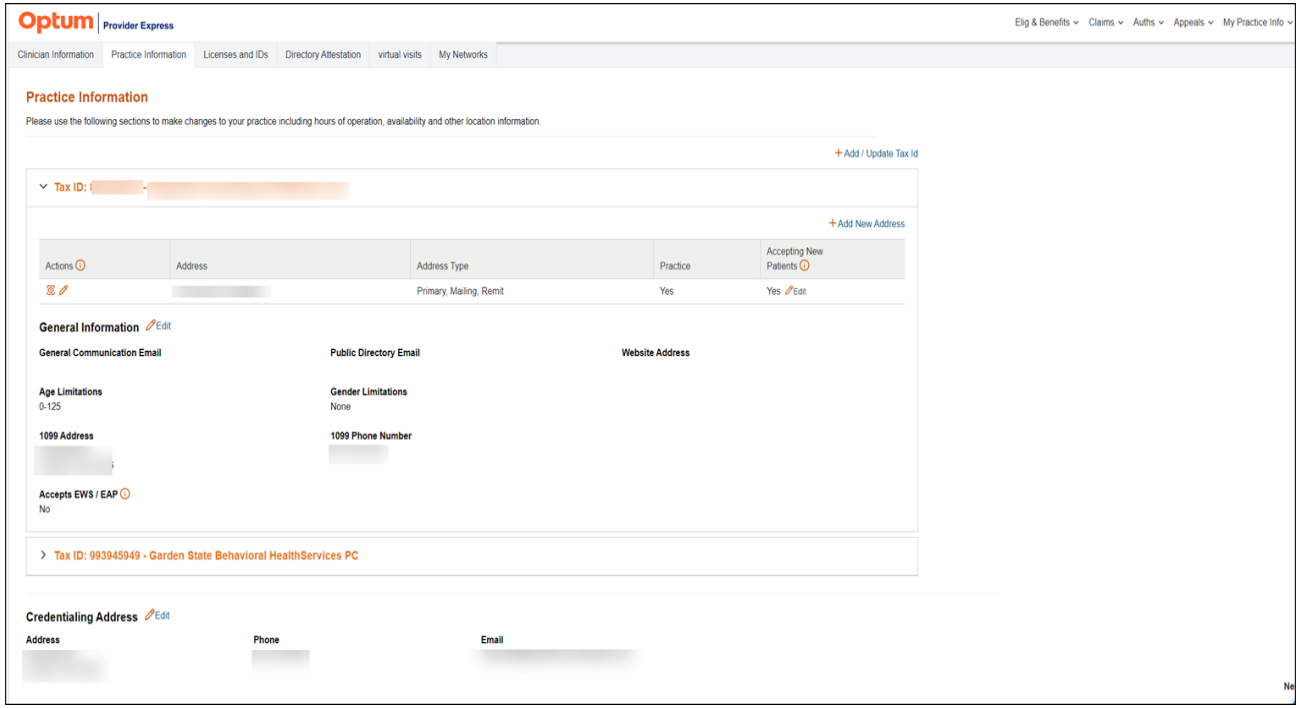
Staying current with "*My Practice Info*"

Having the most up-to-date information at Optum ensures that referrals can find you and that you get reimbursed promptly and accurately.

Change, add or modify your address and other demographic information

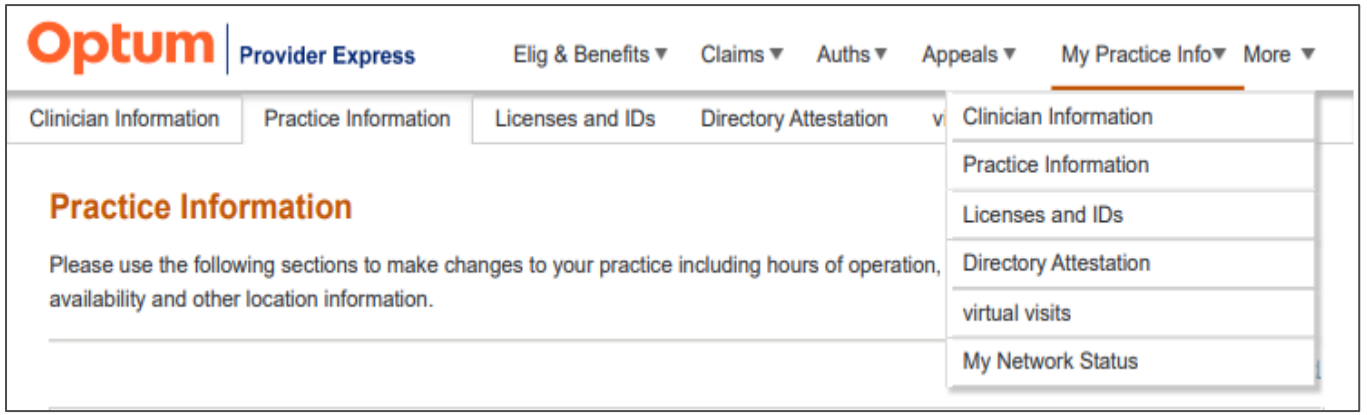
Indicate your availability to accept new patients into your practice

Let us know if you are going to be away for an extended period of time



Staying current with "*My Practice Info*"

Under the Consolidated Appropriations Act (CAA), Providers are required to attest to their data every 90 days, including updating your area of expertise (AOE). Individually contracted providers can add or delete expertise as well as submit the required documentation for attested area of expertise.



Updating Your Practice Information

To learn more about maintaining your practice information on Provider Express, please view our 3-minuted video, "My Practice Info."

Roster and Group Address Maintenance

Roster Maintenance

Groups/Agencies whose Agreement requires submission and maintenance of a provider roster are responsible to ensure their roster data is up to date and on file with Optum. Roster updates may be submitted through *providerexpress.com* secure “Transactions”.

For Groups/Agencies that are required to submit and maintain a roster, it is essential that providers who are independently licensed and may be acting in a supervisory role be promptly added to the roster for claims to process correctly.

Groups/Agencies that do not use Provider Express may maintain their rosters by submitting them to their Provider Relations Advocates.

Note: Non-independently licensed providers and paraprofessionals are not added to Optum rosters.

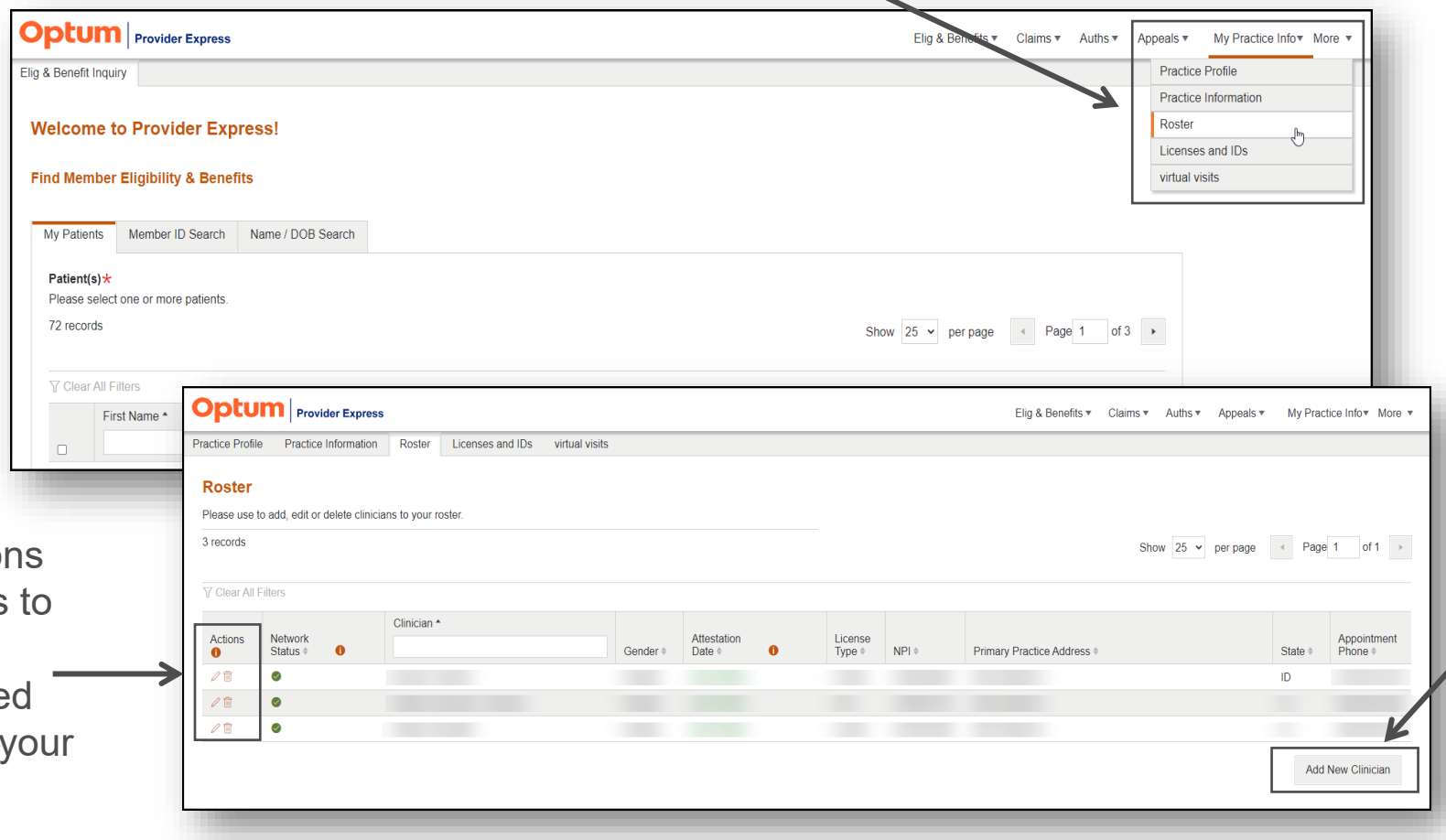
Notify us at providerexpress.com within ten (10) calendar days whenever there are changes to your provider roster.

Roster management is critical to timely and accurate claim processing. Failure to maintain your group roster creates risks for:

- **Timely claims adjudication**
- **Potential HIPAA violations**

Roster Maintenance

After logging in to secure transactions, select *My Practice Info* from the menu bar and then click on *Roster* from the drop-down menu.

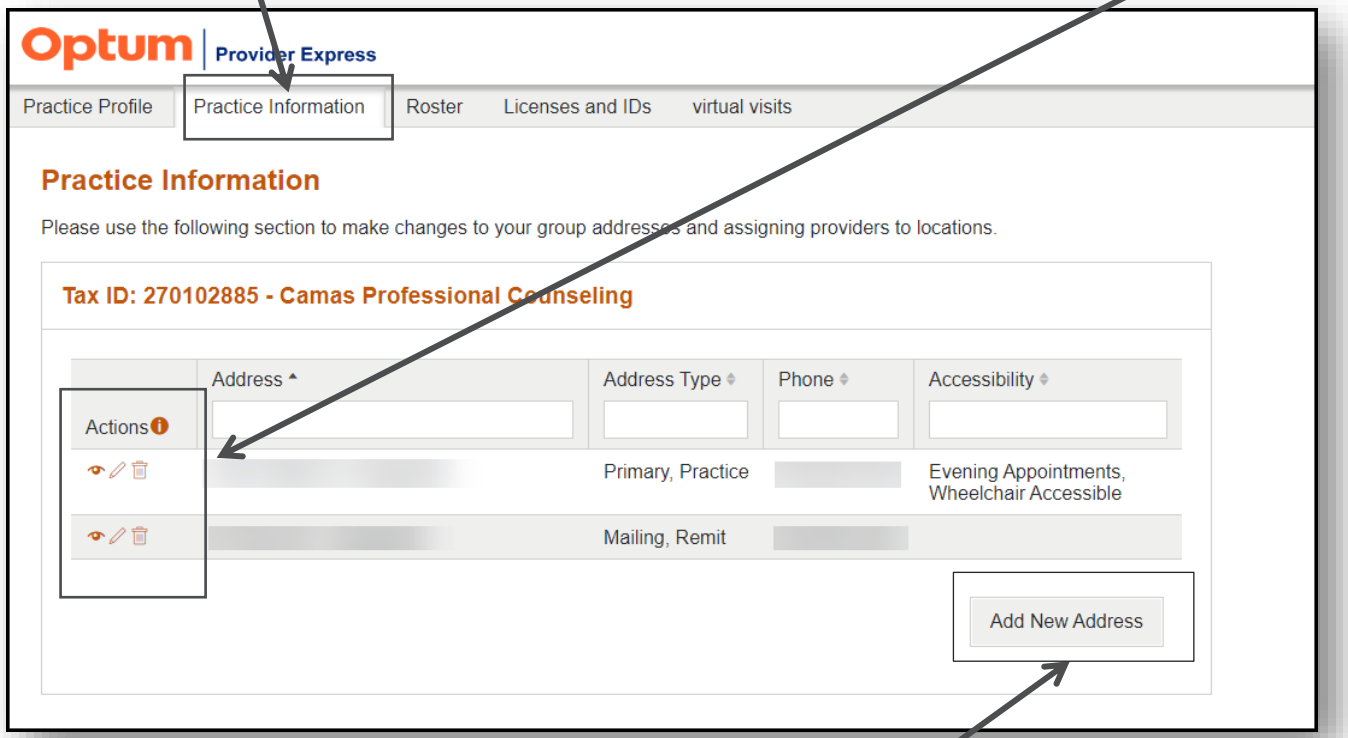


Use the options under Actions to view, edit or delete licensed providers on your roster.

Click on “Add New provider” to add a new licensed provider to your Roster.

Group Address Maintenance

To View or make updates to the Groups Addresses, click on the Practice Information tab and choose an option under Actions.



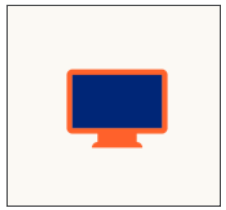
To add a new practice location or a new mailing or remit address, click on the “Add New Address” button.

Recredentialing

- Recredentialing is completed every 36 months (3 years):
  - Timeline is established by NCQA
- Several months prior to the recredentialing date, a recredentialing packet will be sent to the primary address on file for the provider
- Completion of the entire recredentialing packet is required for the recredentialing process to be completed
- Site audits will be completed for organizational providers as indicated by Optum policy
- Failure to complete the recredentialing paperwork or participate in the recredentialing site audit (when applicable) will impact the provider's status in the network

Benefits and Eligibility

Understanding covered benefits



Optum uses Clinical Criteria based on sound clinical evidence to make coverage determinations, including externally adopted clinical criteria such as American Society of Addiction Medicine (ASAM) Criteria to inform discussions about evidence-based practices and discharge planning. In using its Clinical Criteria, Optum takes individual circumstances and the local delivery system into account when determining coverage of behavioral health services.

Optum Members have a variety of benefits available to them

Check a Member's benefits and eligibility on *Provider Express* through secure Transactions or call the number on the back of the members ID card

***Always check benefits before providing services to an Optum member**

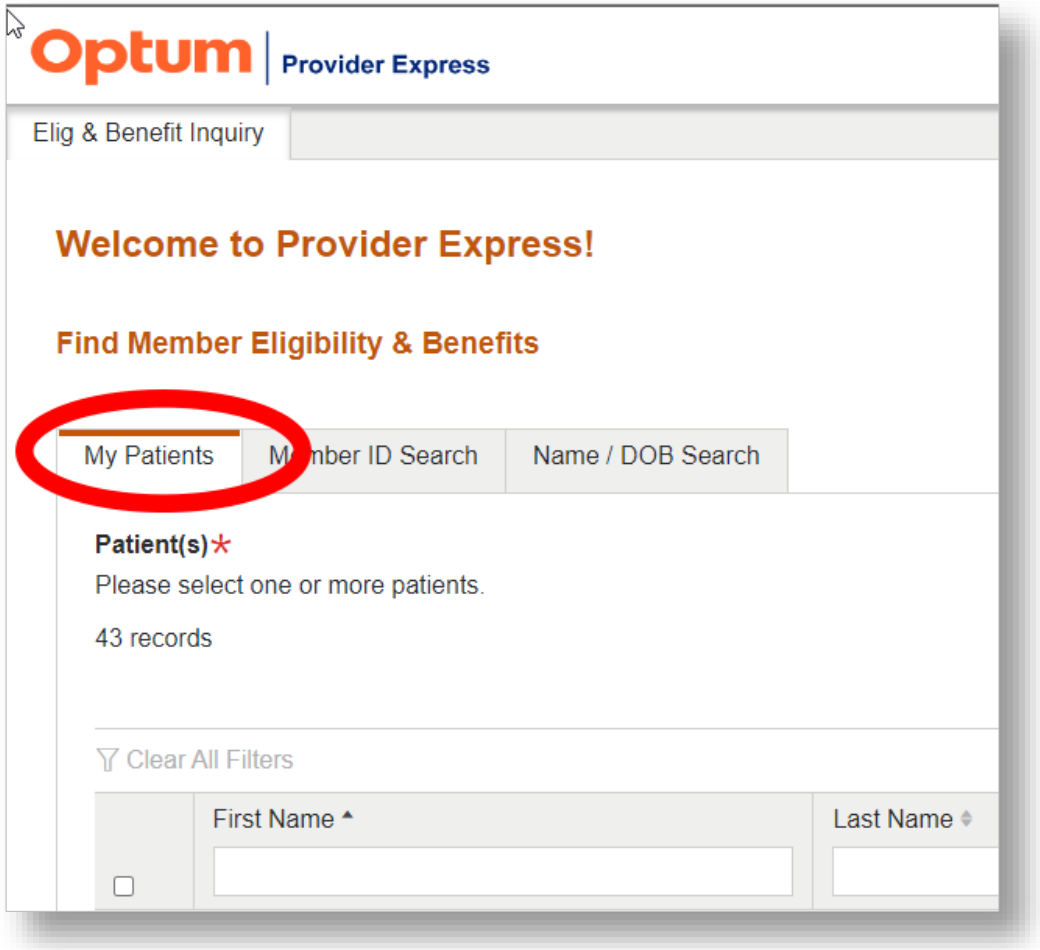
Eligibility and benefits verification using Provider Express

Provider Express

Our industry-leading provider website includes both public and secure pages for behavioral health providers.

“Eligibility & Benefits” allows users to search for a member’s eligibility by using My Patients list, Member ID Search or the Name/DOB Search. The My Patients list is also built using this transaction.

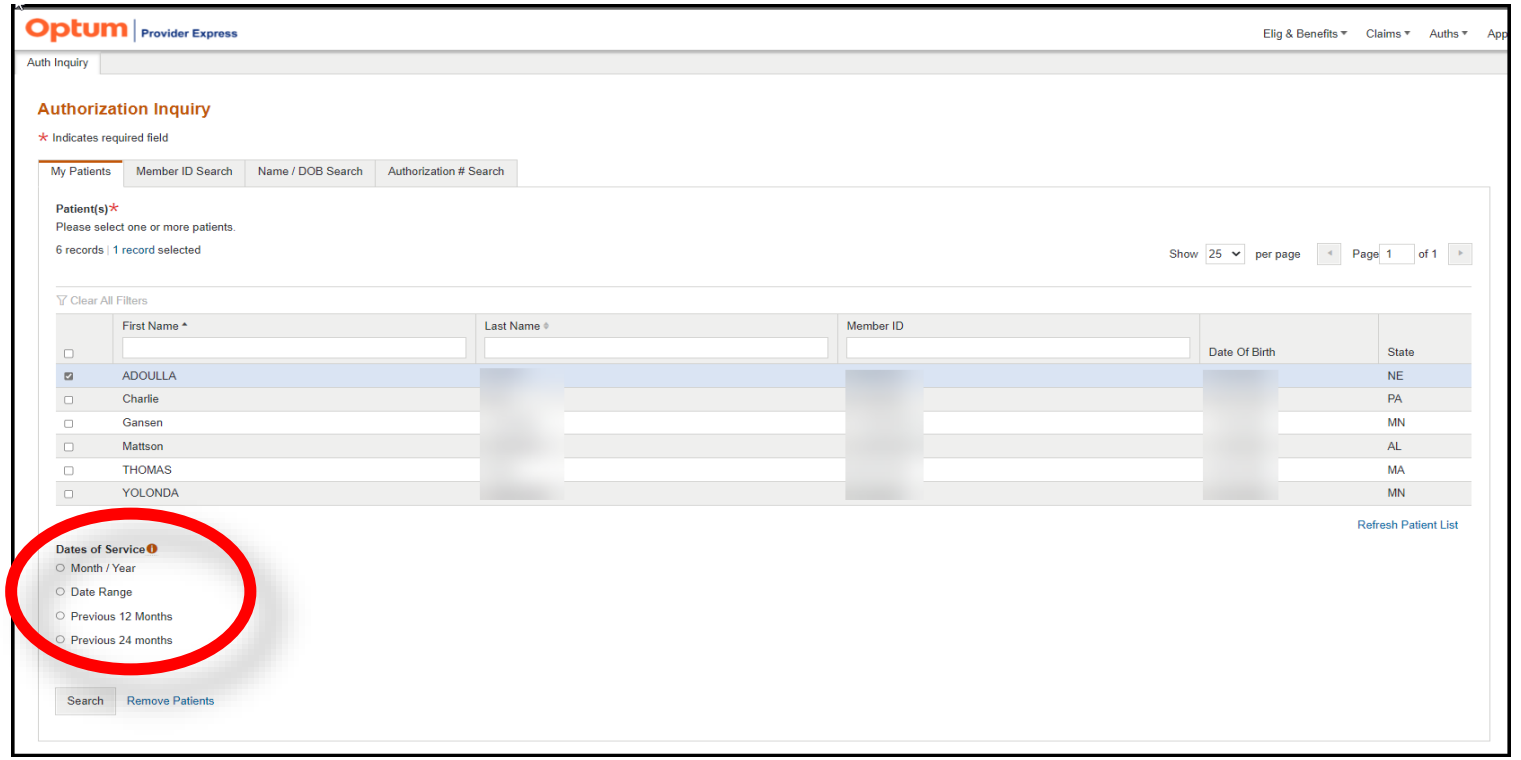
“My Patients” is a list of patients that can be stored on Provider Express and used for various online transactions without an additional search. The My Patients list is customizable at a User level.



Check authorization status online

There are several search options available for this feature:

- My Patients
- Member ID
- Name & Date of Birth
- Authorization #



The Authorization Inquiry searches for active authorizations within the past 180 days, but you can choose a more specific date range to search, as well.

Note: All of these search options will render the same viewable authorization detail information

Claim Billing Reference Guide

Claims filing made easy

File your claim electronically for a fast, secure and convenient claims experience

Benefits of Electronic Filing:

- **It's fast** - Eliminate mail and paper processing delays
- **It's convenient** - Easy set-up and intuitive process
- **It's secure** - Data security is higher than with paper-based claims
- **It's efficient** - Electronic processing helps prevent errors
- **It's cost-efficient** - you eliminate mailing costs, and the solutions are free or low-cost

Claims submission option 1, Online: Provider Express

Our network providers report the highest level of satisfaction when they submit claims online through *Provider Express:*

- Free
- Available 24/7
- Intuitive and easy-to-use
- HIPAA compliant
- Real-time, quick claims processing
- Available to providers and groups
- Outpatient behavioral claims

Get started today with your One Healthcare ID:

- Register for a One Healthcare ID today by clicking First-time User
- Need help registering for a One Healthcare ID? Watch this quick video

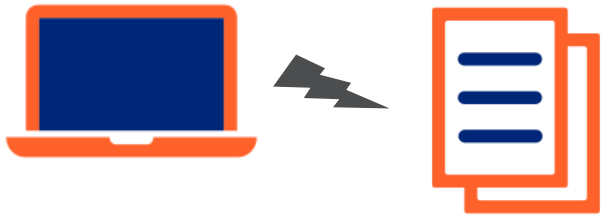
Tips for timely and accurate payments, Provider Express

Filing claims electronically on Provider Express can help prevent these common errors.

Missing or incomplete information	Member demographic info has errors	Unclear or illegible information
Provider Express “Claim Entry” prevents the submission of claim if required fields are blank Examples: NPI number, ICD-10 derived diagnosis code	Member information is auto-populated when you use “claim Entry” on Provider Express Examples: Name, DOB, ID number	The Claim Entry form on Provider Express ensures legibility Examples: Provider or Member information illegible, diagnosis code unclear

Claims submission option 2: EDI/ Electronically

Submit batches of claims electronically, right out of your practice management system software:



- Ideal for high volume Providers
- Can be configured for multiple payers
- Clearinghouse may charge small fee

Learn more about Electronic Data Interchange

Claims submission option 3: Paper

If you are unable to file electronically, follow these tips to ensure smooth processing of your paper claim:

- Use an original 02/12 Form 1500 claim form (no photocopies)
- Type information to ensure legibility
- Use a DSM-5 derived ICD-10 code for primary diagnosis (Hint: the DSM-5 includes ICD codes along with the DSM diagnostic info)
    - Please Note: BH preventive pediatric services only requires a symptom code to be billed (z code)
- Complete all required fields (including ICD indicator and NPI number)
- Institutional claims must be submitted using the UB-04 claim form
- Paper claims submitted via U.S. Postal Service should be mailed to:

Optum

P.O. Box 30760

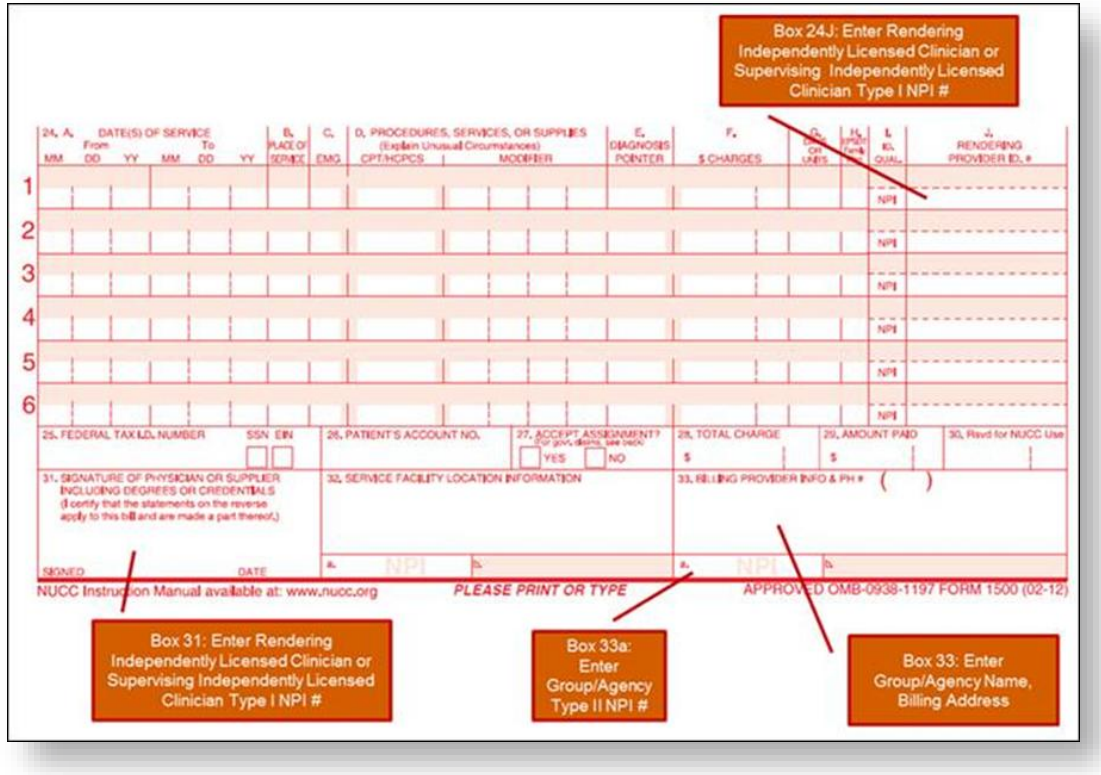
Salt Lake City, UT 84130-0760

Claim billing reference guide

Independently licensed providers employed by a licensed agency/CMHC.

When billing Optum for services rendered by an independently licensed provider the following guidelines apply for Medicaid plans:

- Claims must be billed listing the licensed provider in field 24J and field 31 on the 1500 form
- Independently licensed providers must be credentialed or rostered accordingly if they are affiliated with Groups/Agencies whose Agreement requires submission and maintenance of a provider roster
- When billing for an independently licensed provider employed by a group, payment is issued to the group

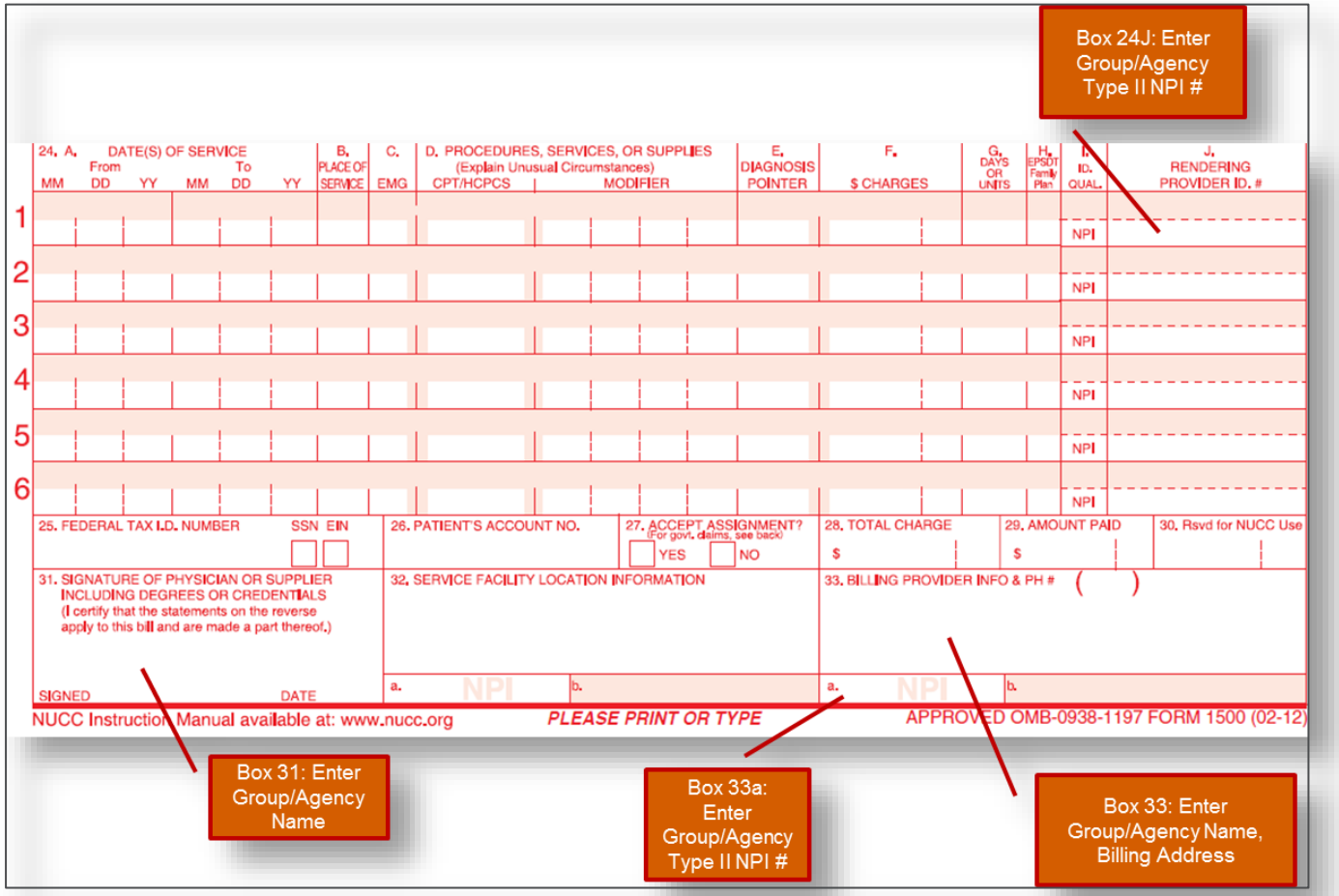


Claim billing reference guide

Group/Agency/Facility Agreements

Group/Agency/Facility – applies to groups/agencies/facilities who do not use provider rosters and do not credential providers individually.

- Providers who have group or facility Agreements for any line of business should bill according to your Agreement, that is, bill using your group/facility information not under specific individual providers.

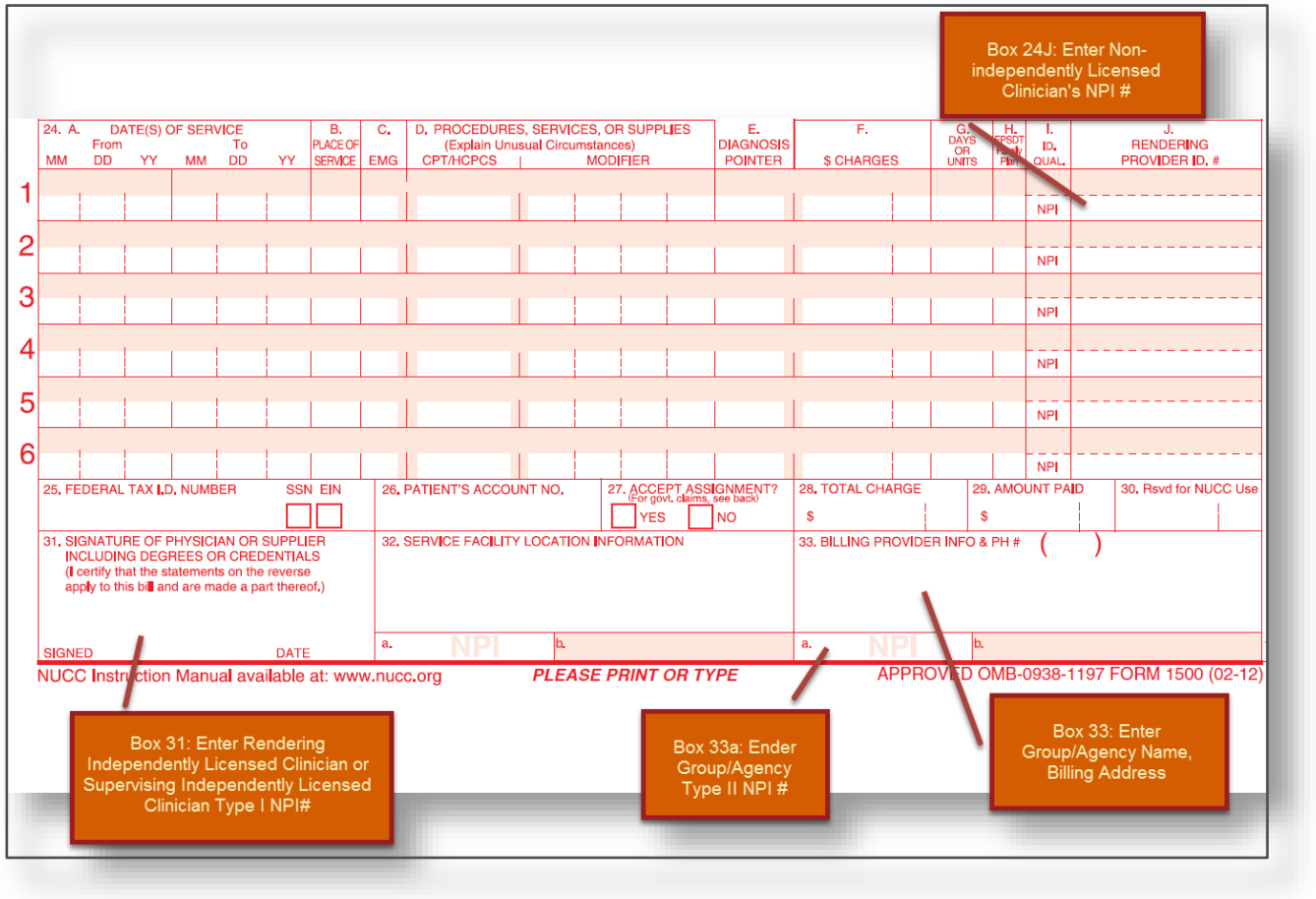


Claim billing reference guide

Non-independently licensed providers employed by a licensed agency/CMHC

When billing Optum for services rendered by a non-independently licensed provider for members, the following guidelines apply:

- Non-independently licensed providers are required to have a Type I (individual) NPI number
- Record the non-independently licensed provider's Type I NPI number in Box 24J
- Record the licensed supervising provider's NPI in Box 31
- When billing for a non-independently licensed provider, payment is issued to the group



Billing Supervision for Group Practices and Clinicians

Billing supervision allows non-licensed providers, working towards their license or licensed providers working towards a higher level of licensure to be reimbursed for services provided while under the supervision of an independently licensed provider.

- Providers rendering services must have a minimum of a master's degree
- All services that are rendered must be within the scope of the provider's training
- Optum may periodically conduct chart audits to ensure compliance with Optum policies and procedures
- Claims are submitted to Optum under the name of the licensed, contracted provider

Eligible Supervising Providers: Providers are required to practice within the scope of their license when providing supervision. Optum does not dictate these requirements. Requirements for providing supervision are detailed by the state licensing boards.

Appeals

Appeals

Provider Disputes

Optum has a formal process for handling practitioner/facility disputes that is compliant with the standards and regulations set forth by National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) and state/federal regulations. These standards and regulations serve as guidelines to ensure that:

- Review turnaround time requirements are met;
- Appropriately qualified professionals are involved in the review of practitioner/facility disputes;
- Relevant clinical/administrative information is consistently gathered and reviewed as part of the investigation;
- Practitioners/facilities are informed of the rationale for disputes that are upheld, in whole or in part.

One (1) level of internal dispute review is available through Optum, unless required by state law or contractual requirement.

Appeals: standard and expedited

Non-Urgent (Standard)	Urgent (Expedited)
• MassHealth must be requested within 60 calendar days from receipt of the notice of adverse determination. • Optum will make an appeal determination and notify the provider in writing within 30 calendar days of receipt of request.	• Practitioner/facilities can file an urgent appeal on behalf of a member • Must be requested as soon as possible after the adverse determination • Optum will make a reasonable effort to contact you prior to a determination on the appeal. If Optum is unsuccessful in reaching you, an urgent appeal determination will be made based on the information available to Optum at that time • Notification will occur as expeditiously as the member's health condition requires, not exceeding 72 hours of the receipt of the request.

Appeals: contact information

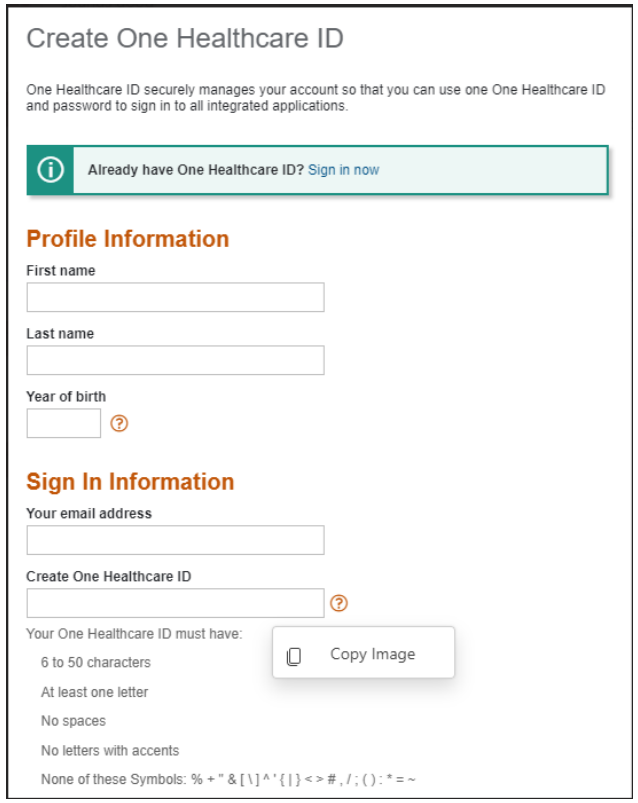
Optum
Appeals & Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512

Fax: **1-855-312-1470**
Phone: **1-866-556-8166**

Secure Provider Portal

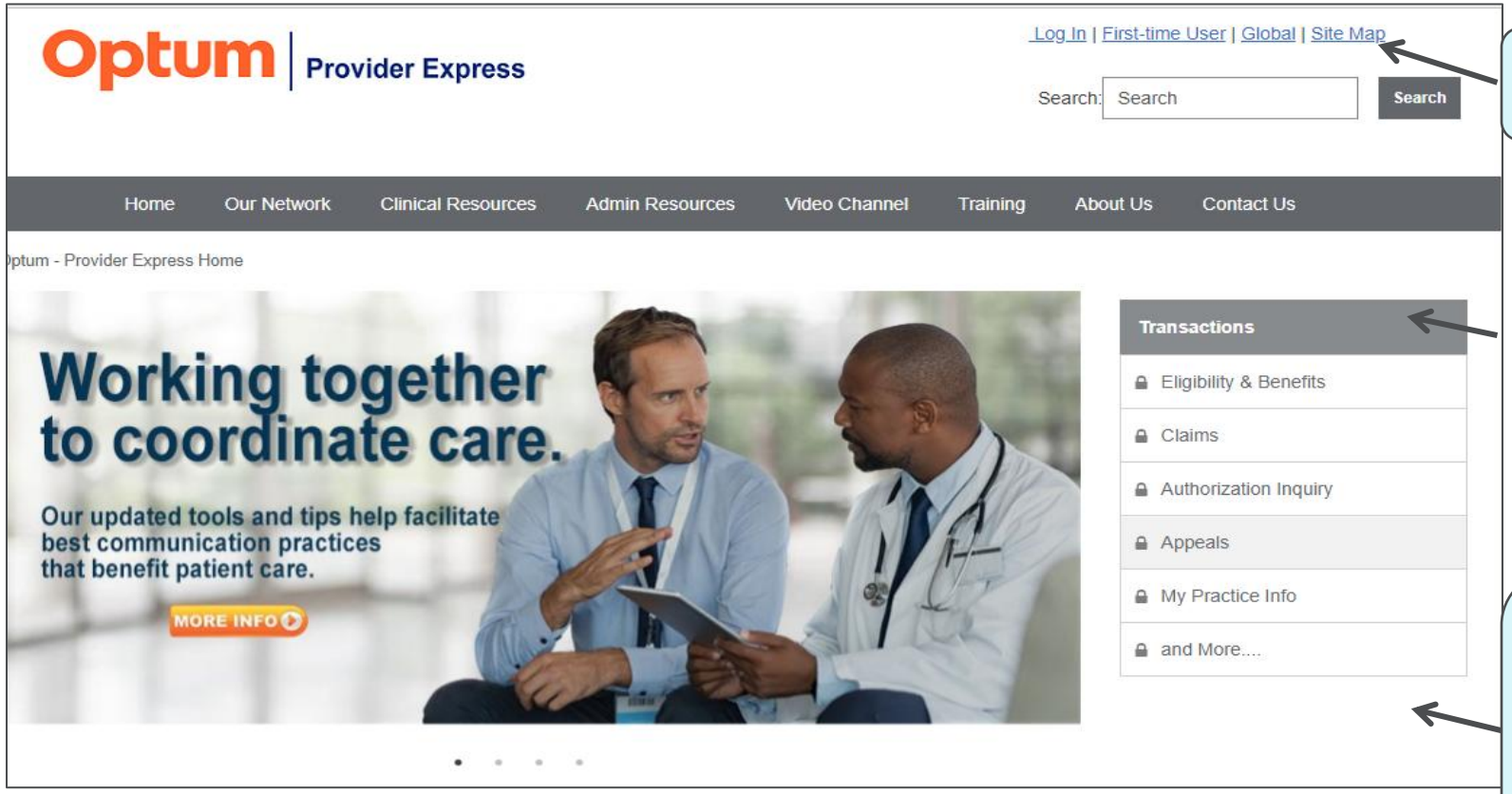
Provider Express: Secure Provider Portal

To register as a new user, click Log in and Select "Create Account"



You will be prompted to create a One Healthcare ID

Provider Express: Secure Provider Portal



Secure pages require registration

Secure "Transactions" gives you access to Member- and Provider-specific information

Quick Links give easy access to items providers commonly use

Provider Express: Secure Provider Portal

Provider Express offers a range of secure transactions

- Check eligibility and authorization or notification of benefits requirements
- Obtain authorization or complete notification for higher levels of care
- Create and maintain My Patients list
- Submit professional claims and view claim status
- Make claim adjustment requests
- Register for Optum Pay including Electronic Funds Transfer (EFT)
- Update practice information
- Check Participation status

Training on many of these topics is available on the Video Channel or through the Guided Tours

Receive payments faster

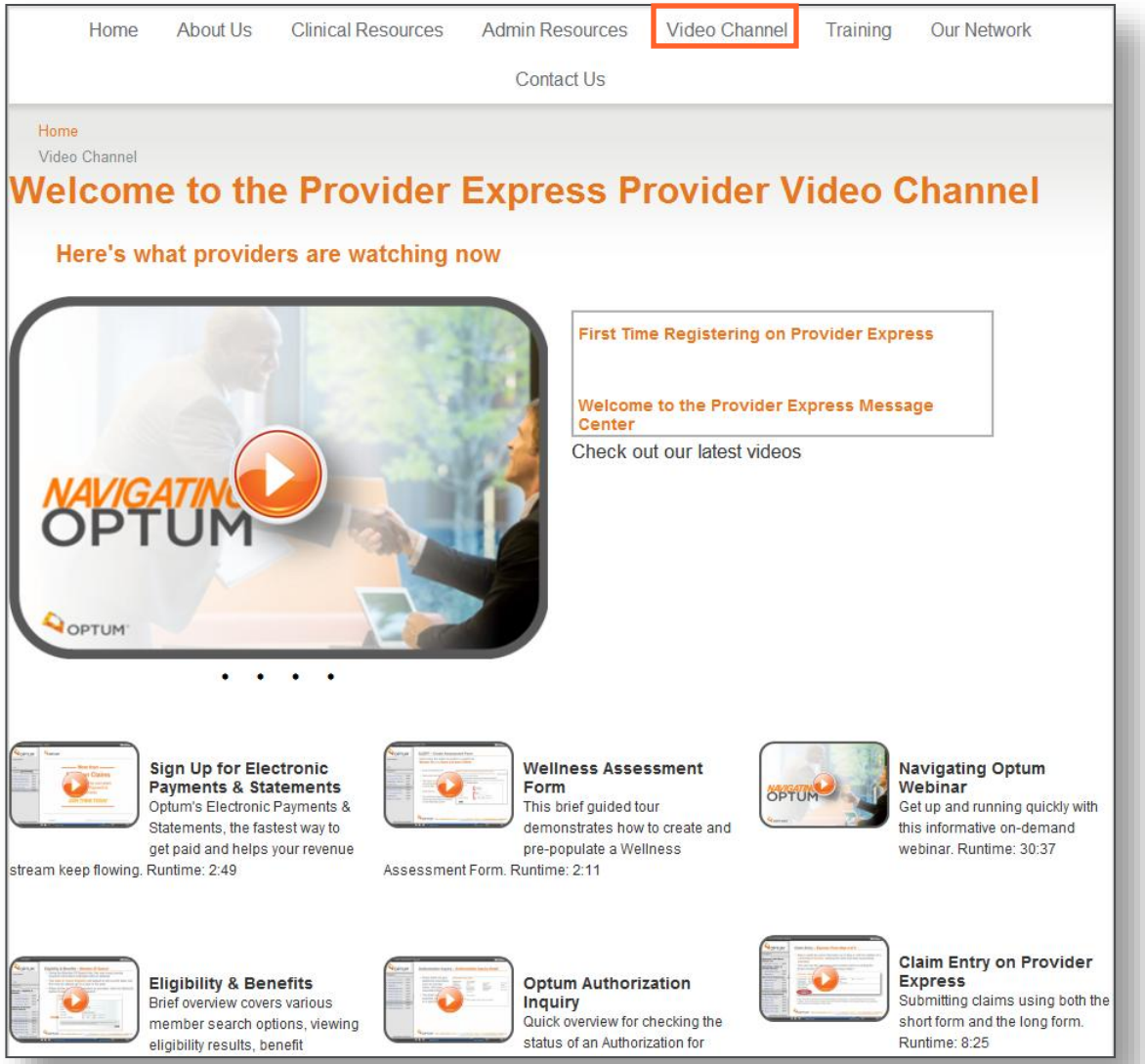
Benefits of Optum Pay™

- Easy setup, free to use
- Payments deposited into your bank
- Simplified claims reconciliation
- 24/7 access to your information
- Secure payment and remittance advice

Registering for Optum Pay is easy!

- Log in to *Provider Express* with your One Healthcare ID
- Select “Optum Pay” under the “More” heading and follow the prompts to enroll
- Contact Optum Financial Services for assistance: 1-877-620-6194

Provider Express Video Channel



Contacting Optum and Understanding the Service Model

Understanding the Service Model

Customer Service / Intake

Optum Behavioral Health has call centers and teams dedicated to supporting members and providers serve. For the best experience to resolve an inquiry related to one of your patients, **please call the Customer Service number on the back of the member's insurance card** for inquiries related to:

- Claims
- Patient Eligibility
- Benefit Information
- Authorizations
- ASO Funding Information

Provider Service Line

The Provider Service Line for behavioral health providers is **1-877-614-0484**.This department can best assist you with inquiries related to:

- Credentialing/Recredentialing
- Contracting/Fee Schedules
- Network Status

Helpful links

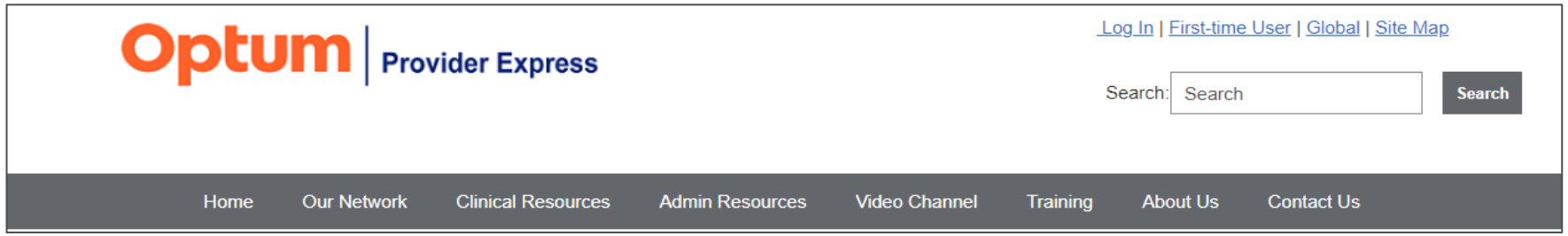
Massachusetts - Provider Express

National - Provider Express

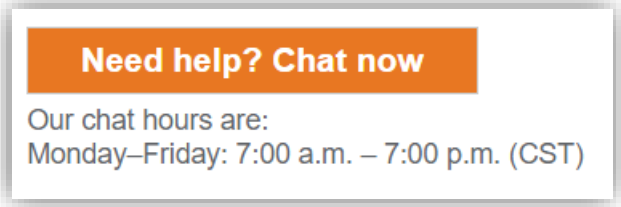
Provider Express Support - Contact Us

Optum Pay Support Team **1-877-620-6194**

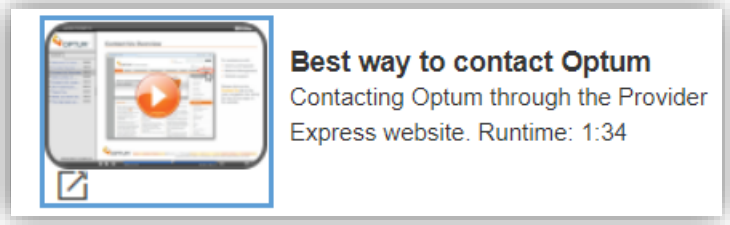
Best way to contact Optum



From the "*Contact Us*" page you can get help with claims, Network Management or website support



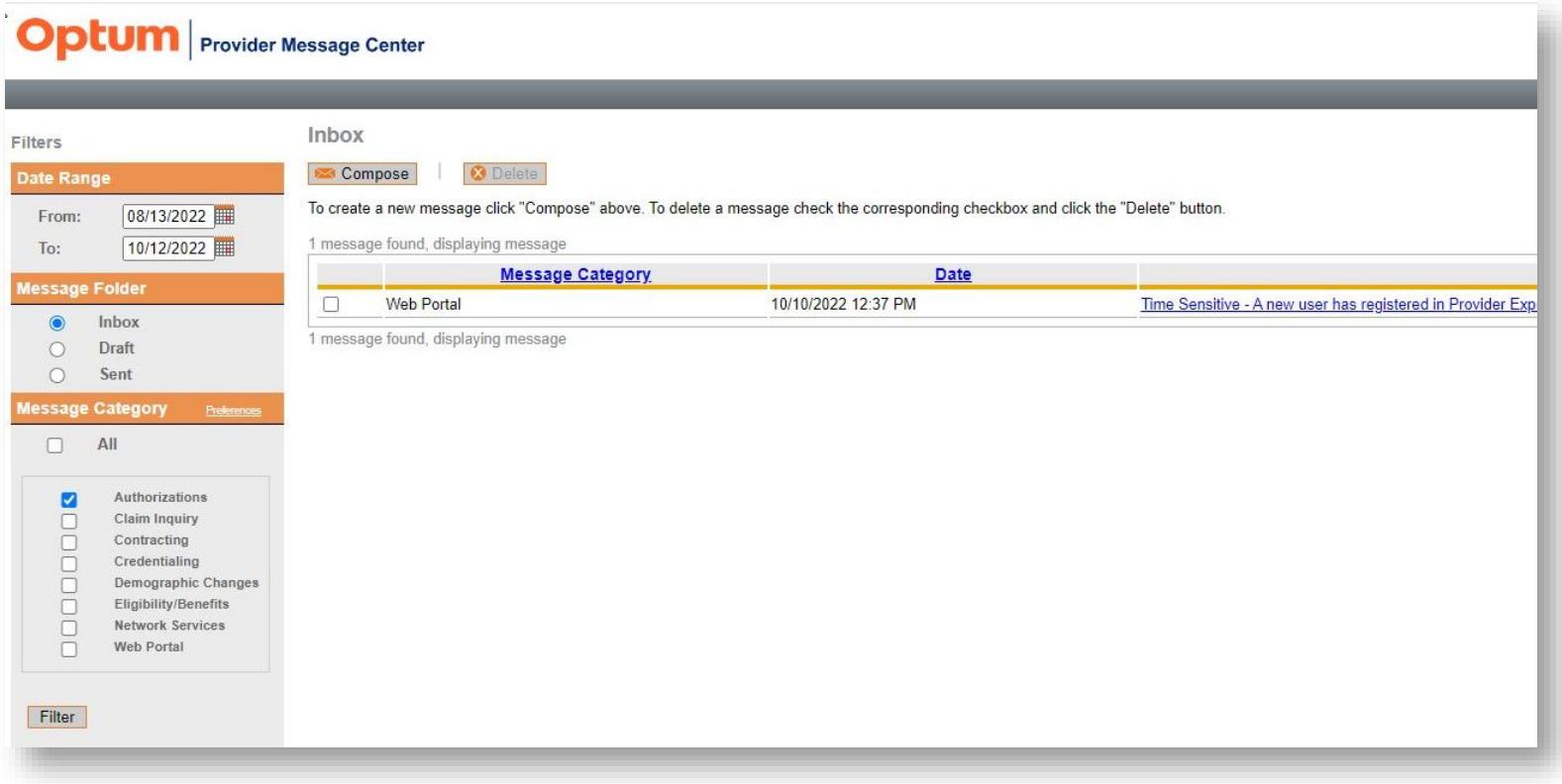
Live Chat is available for website technical support



Check out our brief *Contact Us* video

Send secure communications on *"Message Center"*

- "*Message Center*" is an online tool that enables you and Optum staff to communicate with one another within a secure channel
- The "*Message Center*" is located within the secure Transactions area



Thank You