

Welcome to Unison Health Plan

Unison Health Plan of Ohio, Inc. (Unison) is pleased to welcome you to our team of participating providers. The Unison family of companies consists of independent, investor-owned Health Maintenance Organizations (HMOs), otherwise known as a health insuring corporation in Ohio, that specialize in coordinating and financing quality, comprehensive, government-sponsored health care.

Recently, Unison Health Plan of Pennsylvania, our Pennsylvania affiliate, was ranked as one of the highest rated plans in the nation according to the U.S. News & World Report/NCQA America's Best Health Plans 2005.

Unison is an experienced and recognized leader in delivering quality public sector health care programs. Through ten years of experience in government sponsored health care, Unison has succeeded in making superior health care services available to thousands of individuals. Our commitment to excellence has been recognized by the NCQA, who has awarded our Pennsylvania affiliate with the highest NCQA accreditation available—Excellent.

Unison is dedicated to working together with our valued provider team to deliver premium and accessible health care services to each of our members. As Unison understands that you work hard to deliver quality health care services to our members, we are pleased to offer you the following benefits:

- Rapid and accurate claims payment system
- A Provider Services Department that can quickly answer your claims and billing questions
- Interactive Voice Response (IVR) eligibility capabilities
- Interactive website where you can access member eligibility and claims status information as well as submit requests and receive responses for prior authorization
- An award-winning Member Services Department that works with our members to promote health education and health plan awareness
- A Special Needs Unit that helps providers support members with special medical, behavioral and social conditions access their health care benefits and needed community resources
- Participation in a health plan that delivers a higher level of benefits to our members that they would not receive under traditional government fee-for-service health care programs.

With inclusion at the very heart of the Unison philosophy, we look forward to working with you to create a health care network that is unyielding in its commitment to serve our members.

The Unison Provider Services Department is pleased to answer any questions that you may have. Please call us at 800.600.9007. You can also learn more about Unison by visiting our website at www.unisonhealthplan.com. Our website now features on-line services to help you check claim and eligibility status. You can also access and download the provider manual, locate important phone numbers and view important billing alerts. Visit us today and see what's new with Unison.

About This Manual

This manual has been developed as a reference to assist you in delivering high quality health care to our members. It contains information regarding enrollment and eligibility, referrals and authorizations, claims submission, electronic data interface, specialty care and communication with Unison. Understanding Unison's policies and procedures is critical. This manual is our way of providing your office with information regarding our policies and procedures as well as helping you receive an understanding of our health plan.

Provider Information

Enrollment as a participating Unison provider requires that you execute a Network Participation Agreement and ODJFS Medicaid Addendum and be credentialed by Unison. Following Credentialing Committee approval, your name or practice name and address(es) are listed in our Provider Directory. The directories are made available to the provider and member community. It is extremely important to verify your information as it appears in the Provider Directory.

Please provide 90 days written notice of any changes to your practice name, address/phone number, age restrictions, or the addition/deletion of providers to your practice. You may communicate this information to the Unison at:

Unison Health Plan of Ohio
Attn: Provider Relations Department
2800 Corporate Exchange Drive
Suite 200
Columbus, OH 43231
Fax: 866.791.0271

Our Provider Network

Unison contracts directly with PCPs, Specialists, Hospitals, and Ancillary providers to provide care for our members. Physicians and Hospitals are recruited in a manner that allows existing referral patterns and member needs to be met. Participating providers treat Unison members in their offices as they do non-Unison members, and agree not to discriminate in the treatment of, or in the quality of services delivered to Unison members.

The Primary Care Physician's Role

Services other than those designated as (member) self-referred should be provided and arranged by the PCP in accordance with the Primary Care Physician Agreement. PCPs must be accessible 24 hours per day, seven days per week. PCPs must arrange for another provider to cover in his/her absence. See the Coverage Arrangement section in this manual for more detail. General responsibilities include, but are not limited to:

- Providing primary and preventive care and acting as a member advocate in recommending and arranging care, based on medical necessity.
- Maintaining continuity of the member's health care.
- Arranging referrals to Unison participating providers.
- Complying with the Unison HEALTHCHEK program for children up to age 21.
- Coordinating Mental Health/Substance Abuse services.

- Maintaining, copying or forwarding a member’s medical record; documenting all services provided to the member. The record must note execution of an advance directive for all adult patients. An advance directive constitutes written instruction such as a living will or durable power of attorney relating to the provision of health care if the patient is incapacitated.
- A willingness and ability to make distinctions between treatment methods consistent with the member’s cultural background; and to maintain consistency in providing quality care across a variety of cultures.
- Providing care to members without regard to race, color, creed, sex, religion, age, national origin, marital status, sexual orientation, language, health status, pre-existing conditions, and physical or mental handicap.
- The ability to admit or coordinate inpatient admissions.

Member Education

The Member Services Department provides Unison members with additional information on their health care benefits, along with answers to any questions and concerns that they may have. We encourage our providers to refer members to the Member Services Department.

Provider Relations Department

All providers have a dedicated, local Provider Relations Representative assigned to their practice. This representative is available to answer any questions regarding Unison and its policies and procedures as well as provide any necessary on-site training. Providers may also contact the Unison Provider Services Department with questions.

Unison will actively work with providers to ensure a thorough understanding of our policies, procedures and processes. In addition, our Provider Relations Department is available to answer questions and also provide training to providers.

Provider Relations Mission Statement

To develop and maintain a high quality Provider network capable of serving eligible members throughout the Unison service area. The Provider Relations Department is committed to superior customer service by meeting or exceeding Provider expectations through the highest level of dedication, advocacy and responsiveness.”

Our Structure and Administration

Unison is a member of a family of companies designed to arrange for comprehensive health care services to its members. Unison encourages appropriate treatment and efficient use of medical services in the provider’s office.

We offer members a comprehensive health plan (for Medicaid recipients) that includes additional benefits such as expanded vision care, transportation, a nurse help line and gift card rewards for keeping medical appointments.

Unison considers a physician-driven foundation to be the key to success. Therefore, we are committed to providing fair and prompt compensation and efficient service to our contracted providers.

Our Medical Directors will reach out to you if they have questions or require additional information.

Board of Directors

The Board of Directors is responsible for setting Unison's strategic direction, monitoring its course and approving the annual business plan.

Executive Quality Improvement Committee

The Executive Quality Improvement Committee (EQIC) is comprised of multi-disciplinary team members who hold top positions within Unison. These team members, including the CEO, CFO, Senior Vice President of Operations, Vice President of Marketing and Business Development, Medical Director, Senior Vice President of Medical Operations, Plan President, Senior Vice President and General Counsel, Director of Quality Improvement and Director of Utilization Management, monitor indicators and implement interventions necessary to improve the health care and services to members and providers. The EQIC is responsible for the performance and oversight of all functions related to the Quality Improvement Program. The specific functions of the EQIC include those represented in the following flow charts showing the structure of our utilization management program, its major activities, as well as a depiction of the Utilization Management appeals process:

**Executive Quality Improvement/Utilization Management Committee
Major Program Activities**

* Responsible for the performance and oversight of all functions related to the Utilization Management Program

Quality Improvement/Utilization Management Committee

* Makes recommendations to the Executive Quality Improvement/Utilization Management Committee concerning the following utilization functions:

- 1) Develop and adopt clinical practice guidelines based on scientific evidence and review and update the guidelines at least every two years
- 2) Review patient care management outcomes to ensure appropriateness, continuity, and coordination of care
- 3) Review the application of new technologies in the care of members
- 4) Develop, support, and review the outcomes of health management programs
- 5) Review and revise utilization management criteria, protocols, and policies
- 6) Monitor utilization practice patterns of providers and make recommendations for education or sanctioning
- 7) Ensure the continuity of care between members' physical health services and behavioral health services
- 8) Assess the utilization management program and develop/adopt utilization management criteria

Utilization Management Program

Purpose: Outline the structure, functions, responsibilities and authority of the program and provide a guide for coordinating a comprehensive program that ensures and continually improves the consistency and accountability for all Utilization Management activities with respect to its various product lines. Unison Health Plan does not financially encourage or offer incentives for the medical directors or Utilization Management team representatives to make decisions that result in underutilization or denial of services. Utilization Management decision-making is based only on medical necessity/appropriateness.

Supervision: The Medical Director, in consultation with the CEO, Senior Vice President of Medical Operations and the Utilization Director, will assist with the formulation and administration of the Utilization Management program and other organizational policies and goals. Additional medical directors within the plan are involved with the Utilization Management program implementation and oversee fair and consistent Utilization Management decision-making of day-to-day decisions. Unison Health Plan's medical directors make all final medically necessary clinical determinations concerning payment denials.

Scope: The scope of Unison Health Plan's Utilization Management program addresses a full range of Utilization Management activities, including:

- Medical services provided in outpatient and inpatient settings
- Utilization review and decisions including:
 - > Prior authorization review
 - > Concurrent review
 - > Retrospective review
 - > Referrals
 - > Case Management
 - > Discharge planning
- Denial and appeal decisions, including:
 - > Medical necessity and appropriateness of the decision
 - > Timeliness of the decision-making process
 - > Consistency of the decision making
- Member and practitioner satisfaction with the Utilization Management process
- Evaluation of new technology
- Under- and over-utilization of services

Clinical Case Management. Intensive clinical, high-risk pregnancy, asthma, diabetes and NICU

- Improve health outcomes and quality of life for members with complex medical needs
- Support the physician/patient relationship and physician treatment plan
- Collaborative approach that includes the member, family members and the health care team
- Emphasis on prevention of exacerbations and complications utilizing member empowerment strategies
- Educate members about the importance of compliance with their physician's treatment plan
- Facilitate member and providers' access to plan benefits and specialist/vendor services
- Educate members on available community resources and events related to their health issues
- Reduce the incidence of emergency room visits, inpatient admissions, and length of stay for medically complex members
- Provide physician education regarding current treatment standards
- Process and outcomes measurement, evaluation and management
- Routine reporting/feedback process that includes both the patient and the treating physician

Reinsurance reporting

Special Needs Unit
Social work-based case management

Pharmacy

Utilization Management Decision Process

All utilization decisions are based on relevant clinical criteria obtained from treating practitioners, providers and medical records and involve the treating practitioner and Unison Health Plan medical directors.

- > Medical Necessity
- > Review Decision Criteria (InterQual)
 - > Ohio Timeframes for Care
 - > Denial Notification

Quality Improvement and Utilization Management Committee

As a subcommittee of the EQIC, this QI/UM committee reviews clinical issues, policies affecting clinical decisions, utilization policies, utilization review criteria and clinical practice guidelines. It is comprised of network primary care and specialty care practitioners, Medical Directors, Senior Vice President of Medical Operations, the QI Director and the UM Director. The committee reviews quality indicators, utilization, satisfaction with plan activities, physician-related issues and advises the plan on clinical affairs.

The QI/UM Committee will make recommendations to the EQIC based on the following functions:

- Evaluate and analyze clinical care rendered to members
- Monitoring utilization and practice patterns of providers in conjunction with potential risk management and quality of care issues.
- Develop and adopt clinical practice guidelines based on scientific evidence and review and update the guidelines at least every two years
- Develop and adopt preventive care guidelines for prevention and early detection of illness and disease for all age categories and review and update guidelines at least every two years
- Assess the utilization management program and develop and adopt utilization criteria
- Review patient care management outcomes to ensure appropriateness, continuity and coordination of care
- Review the application of new technologies in the care of members
- Develop, support and review the outcomes of health management programs
- Review and revise utilization management criteria, protocols and policies
- Develop methods to improve and enhance preventive care programs and services
- Monitor utilization and practice patterns of providers and make recommendations for education or sanctioning
- Evaluate clinical QI Indicators
- Review clinical guideline and HEDIS measurements, develop interventions for improvement, provide follow-up and measure effectiveness of the interventions
- Monitor providers' compliance with medical record documentation practices and develop mechanisms for organization-wide improvement with respect to medical record documentation
- Ensure the continuity of care between members' physical health services and behavioral health services
- Monitor provider satisfaction with the UM process
- Evaluate and act in accordance with Consumer Assessment of Health Plans Survey (CAHPS) data.

In addition, the QI/UM Committee may convene task force or ad-hoc committee groups to accomplish clinical goals that may need special attention outside the time limitations or clinical expertise of QI/UM Committee meetings.

Credentialing Committee

The Credentialing Committee is a subcommittee of the Executive Quality Improvement Committee. The Credentialing Committee is comprised of network primary care providers, specialty care providers,

Medical Directors, Dental Director and the Credentialing Manager. This committee makes recommendations to the EQIC based on the following functions:

- Review the initial credentialing and recredentialing of providers to determine eligibility and qualifications to participate in the Unison network
- Ensure that providers' malpractice, sanction and adverse action history is satisfactory and within limits of Unison policy
- Ensure that primary care providers' offices are physically accessible to members, have adequate waiting and examining rooms and are compliant with ADA and office standards
- Ensure the availability and accessibility of providers
- Ensure the adequacy of medical recordkeeping
- Ensure that recredentialing is carried out at least every three years to review the continued eligibility and qualifications of providers
- Evaluate primary care providers' professional performance within the network at the time of recredentialing by reviewing available data elements from: member complaints, clinical study results, over-utilization/under-utilization of care patterns and medical record reviews
- Recredential health care provider organizations at least every three years
- Assess the quality of health care provider organizations that have not been accredited by a national accrediting body at the time of initial credentialing and recredentialing
- Oversee the credentialing and recredentialing of entities to whom those functions are delegated.

Pharmacy & Therapeutics Committee

This committee reviews plan formularies, pharmacy utilization and advises the plan on the composition of the formulary. It is composed of physicians practicing from physical and behavioral health, outside pharmacists and plan staff.

Confidentiality Committee

The Confidentiality Committee is comprised of representatives from each department of the company and is charged with improving Unison's confidentiality procedures. The committee makes recommendations to the Executive Quality Improvement Committee based on the following functions:

- Serve as a forum for the presentation and discussion of confidentiality issues
- Develop company-wide confidentiality policies and procedures
- Ensure timely dissemination of our evolving confidentiality policies throughout the company
- Review practices regarding the collection, use, and disclosure of medical information
- Ensure Health Insurance Portability and Accountability Act (HIPAA) and Gramm-Leach Bliley Act (GLBA) compliance.

Operations Committee

The Operations Committee reports to the Executive Quality Improvement Committee on issues relevant to multi-departmental service and operating issues. Committee members include the Director of FACETS Support, Director of Claims, Senior Vice President of Operations, Senior Medical Director, Director of QI, Director of UM, Senior Vice President of Medical Operations, Vice President of Marketing and Business Development, CFO, Plan President, Director of Provider Relations, Pharmacy Director, Director of Network Financial Strategies, Compliance Officer and Director of Internal Audit. The functions of the Operations Committee include:

- To creatively address operating issues that are creating problems for our providers and members

- Analyze and address issues related to the assessment of new members' understanding of the health plan
- Address issues that are creating substantial inefficiency in any company department
- Oversight of delegated operations functions such as claims processing and encounter submission
- Report to the EQIC concerning matters of delegation oversight, quality and service improvement activities

Asthma/Diabetes Health Management Committee

This committee is chaired by the Senior Medical Director, reports to the EQIC Committee and consists of the Utilization Management Director, Quality Improvement Director, Manager of Case Management and Durable Medical Equipment, Supervisor of Case Management, Asthma Case Managers, Diabetes Case Managers, pharmacist, Vice President of Marketing and Business Development, Director of FACETS Support and Manager of Health Data Analysis. The Asthma/Diabetes Health Management Committee analyzes clinical data and institutes improvement activities for its Health Management population.

Specific functions include:

- Providing barrier analysis and proactive quality improvement activities for Unison's asthma and diabetes population
- Presenting barrier analysis and recommendations to the Quality Improvement/Utilization Management Committee
- Proactively managing those members in diabetes and asthma case management
- Providing data analysis of outcome indicators for program evaluation.

Women's Health Issues Committee

The Women's Health Issues Committee reports to the Executive Quality Improvement Committee on issues relative to the health care for female members of the health plan including, but not limited to, preventive screenings for breast and cervical cancer, chlamydia screenings and pregnancy case management. The committee is chaired by the Medical Director and consists of the Senior Vice President of Medical Operations, Director of Utilization Management, Director of Quality Improvement, Vice President of Marketing and Business Development, Director of FACETS Support, Quality Improvement nurses, Supervisor of Case Management, Manager of Data Analysis, Member Services Department and team members who serve in our health management programs. Specific functions of the Women's Health Issues Committee include:

- Providing barrier analysis and proactive quality improvement activities for Unison's female member population
- Presenting barrier analysis and recommendations to the Quality Improvement/Utilization Management Committee
- Proactively managing those members in our high-risk pregnancy health management program
- Providing data analysis of outcome indicators for program evaluation.

Delegations Oversight Committee

The Delegations Oversight Committee performs oversight of all delegated plan representatives. The committee consists of the department director or representatives from Claims, Credentialing, Legal, Compliance, Provider Relations, Contracting, Senior Vice President of Medical Operations, Office of the Medical Director, Quality Improvement and Utilization Management and other departments as determined by the Chairperson. Specific committee functions include:

- Reviewing all proposed delegations and making recommendations on the appropriate action

- Receiving and evaluating reports and audit results of delegates on a regular basis, as required by the various state agencies with which Unison's affiliated health plans contract or report, and by NCQA standards
- Evaluating the need for additional reports or corrective action plans if opportunities for improvement are identified
- Determining need and assuring the communications to the delegated entities
- Reviewing and approving Unison policies and procedures related to delegation as well as the policies and procedures of the delegated entities as necessary.

Compliance Committee.

A Compliance Committee, chaired by the Compliance Officer, periodically meets to review the activities of the Unison Health Plan companies and assists the Compliance Officer with this significant function. The committee consists of representative from Legal, Finance, Human Resources, Medical Operations, Operations, Medicare, Network Management, and Pharmacy. The committee meets formally at least annually, and if needed, more frequently throughout the year. The committee reviews both past and future training efforts as well as a summary of the annual compliance report. The committee also reviews and approves all compliance department policies and procedures and provides input and suggestions on compliance issues.

