C.14. Enrollee Grievances and Appeals

Describe the Vendor's proposed Enrollee Grievances and Appeals process, including a summary of methods for the following:

a. Compliance with State and Federal requirements.

b. Process for Expedited Review.

c. Involvement of Enrollees and their caregivers in the process.

d. Tracking grievances and appeals received by type and trending results for use in improving operations.

e. Reviewing overturned decisions to identify needed changes.

Passport Highlights: Enrollee Grievance and Appeals

How We're Different	Why It Matters	Proof
Local staff understand Kentucky and know the provider network.	• Minimizes administrative denials • Provides timely access to service approvals and care	• Twenty-two (22) years of established relationships with Kentucky providers
Member advocacy through the appeals process	• Minimizes burden on members, improving satisfaction • Increases member awareness and control over health care	• Advocacy specifically built into training materials for appeals coordinators • Member education built into procedures for appeals and grievance handling
Ease of use for members as a priority	• Process in place that allows members to contact the Plan and get concerns forwarded to the appropriate area, regardless of entry point • Members and caregivers can meet with us face-to-face in our office when needed	• Grievance submission can be made in multiple modalities: telephone, in writing, electronically, and in person • Staff assistance in completing forms • Interpreter/teletype (TTY) support

How We're Different	Why It Matters	Proof
Rigorous operational focus to ensure service level agreement (SLA) compliance	• Members are not delayed in receiving services they need • Continuation of benefits during the appeals process when requested	The average time for resolution for the past twelve (12) months has been: • Twenty-seven (27) days for member grievances • Twelve (12) days for member appeals • Two (2) days for expedited member appeals

Introduction

Providers are in our DNA. Formal participation by statewide Kentucky providers in our governance structure and open communication channels for informal ongoing input into our programs lead to greater provider and member engagement, and a more provider-focused, realistic approach to member and provider appeals and grievance processes. Passport's Partnership Council has deep ties to the community and allows us to develop innovative solutions through our thirty-one (31) members representing major categories of providers, members, and community services organizations. The breadth of the Partnership Council and its subcommittee structure can be measured by the nearly one hundred (100) community providers and volunteers that comprise this formal input forum. With this input, Passport ensures a high-quality member experience through a grievances and appeals process that is easy for members and providers to access, is fair and objective, and resolves issues in a timely manner.

C.14.a Compliance with State and Federal requirements.

Passport's Approach to Grievance and Appeals Ensures Compliance with State and Federal Requirements

Passport has policies and procedures and an operational process and system for identifying, tracking and analyzing member grievances, appeals and Medicaid Fair Hearings, as well as provider grievance and appeals, in compliance with all state and federal requirements.

Grievance and Appeals Training Program

Passport has a robust Grievance and Appeals training program for clinical and non-clinical staff. The continuum begins with new hire onboarding and initial training. It includes ongoing staff training as well as targeted remediation based on quality analysis and oversight findings by the QA and Auditing Department. Training includes classroom, side by side training, precepting and ongoing mentorship. New hire curriculum

includes workflow training that is based on Passport policy and procedures, Kentucky and federal regulatory requirements, and NCQA compliance. Staff performance variation is managed via root cause analysis. Targeted formal or informal staff remediation or communication is conducted as needed. The Training Department collaborates with the Quality Assurance (QA) department and managerial staff to assure that remediated performance outcome(s) have reached targeted level.

Quality Assurance Review Program

Passport also engages in a rigorous QA Review Program to ensure compliance with state and federal requirements. QA activities focus on a detailed review of clinical and non-clinical staff knowledge, understanding, and adherences to federal, state and national regulatory and client SLA program requirements for appeals and grievances. QA results are reviewed and approved by the Utilization Management Committee (UMC) and subsequently are reported up through the Quality Medical Management Committee (QMMC). Opportunities for improvement are identified and addressed by action plans to mitigate trends.

Continuation of Benefits During Appeal

A member may request continuation of benefits while an appeal is pending. The appeals team will inform members upfront that they may be liable for cost of services if the appeal is upheld. Benefits will continue until one of the following occur:

- The member withdraws the appeal/request for State Fair Hearing.
- The member fails to request a State Fair Hearing with continuation of benefits within ten (10) days from the date the adverse determination is mailed.
- A State Fair Hearing decision adverse to the member is made.

Member State Fair Hearing Process

Consistent with requirements, our policies allow a member (or the member's authorized representative) to request a State Fair Hearing if an appeal of an adverse benefit determination is not resolved in the member's favor.

If the member requests the State Fair Hearing within ten (10) days of receiving the notice of adverse determination, Passport will continue to provide the suspended, reduced, or terminated services until the conclusion of the State Fair Hearing.

Members will need to make a request for a State Fair Hearing within one hundred twenty (120) calendar days from the date of the appeal notice of resolution. Our Grievance and Appeals department adheres to all regulatory and contractual requirements and time frames and complies with the Department for Medicaid Services (DMS) ruling in such cases.

We work with the member, the member's provider and the member's advocate to prepare for the hearing.

Passport also cooperates with DMS in the event of a hearing. If a member requests a hearing, the DMS Administrative Hearings Branch contacts Passport's appeals coordinator to initiate the process and to request the denial and appeal files.

Once our appeals coordinator receives an email from the DMS Administrative Hearings Branch asking for the denial file for a specific member and service, the next steps are followed:

1. The appeals coordinator sends the electronic denial and appeal files (if applicable) by secure email to the DMS Administrative Hearings Branch.
2. The appeals coordinator receives an official email from the DMS Administrative Hearings Branch. This email states that a hearing has been requested and the date that the request was received. It also includes a copy of the entire file, including the denial file sent by Passport and the member's request to DMS.
3. The Passport appeals coordinator receives a Notice of Scheduled Hearing from the DMS Administrative Hearings Branch that is signed by the assigned hearing officer. This is received as an attachment to an email and by U.S. Postal Service (USPS) mail. The notice gives the date, time and location the hearing is to be held.
4. Passport files a Notice of Entry of Appearance of Counsel. The notice is faxed to the DMS Administrative Hearings Branch and is mailed by USPS to the Hearing Officer and the member.
5. An attorney represents Passport at all hearings. If the case warrants a medical or dental director or other expert testimony, he/she also attends the hearing.
6. Passport awaits the final order.
7. If the final order upholds Passport's denial, the appeal decision is final, and, at this point, the member has exhausted all appeal options with Passport. The member may also contact Kentucky's Ombudsman for assistance at any time during the appeal process.
8. If the final order overturns Passport's denial, the member receives a letter from DMS, and Passport approves the service.

If at any point Passport does not comply with hearing requirements, we understand that this will lead to an automatic ruling in favor of the member, and we would approve the service.

All hearing procedures are in compliance with Kentucky Revised Statute (KRS) Chapter 13B.

Our Grievance and Appeals department will process and resolve these inquiries fairly and quickly, in a manner that is fully compliant with all applicable federal, state, contractual and request for proposal (RFP) requirements. Our process, which is the same for all members, includes a grievance process, an appeal process and access to the DMS State Fair Hearing process. Passport's grievance and appeals process addresses members' oral and written requests. Our grievance and appeals process will be approved in writing by the Department before implementation and will be conducted in compliance with the notice,

timelines, rights and procedures in 42 C.F.R. 438 subpart F, 907 KAR 17:010 and other applicable Centers for Medicare & Medicaid Services (CMS) and Department requirements.

To ensure that all members have trouble-free access to our grievance and appeals process, our member service representatives (MSRs) and appeal coordinators educate members and act as advocates for members to support their submission of grievances and appeals via multiple modalities, including by telephone, in writing, electronically, and through staff available on-site. We assist members with completing the forms required to file a grievance or appeal. We offer free foreign language interpretation services and a bilingual call center staff to our members who call Member Services for assistance. Our Member Services Department also offers a TTY line and auxiliary aids upon request. Our policies allow members and authorized representatives, such as caregivers relatives, providers, care managers or any member-authorized individual, to file grievances and appeals.

The Grievance and Appeals staff categorizes grievances and appeals for tracking, trending, reporting and education purposes. Categorized grievances and appeals are brought to other departments to support resolution and to drive improvement where applicable. For example, the Grievance and Appeals coordinator routes all grievances related to the following to the Compliance Department for review:

- Potential Health Insurance Portability and Accountability Act of 1996 (HIPAA)/protected health information (PHI) violations
- Allegations of fraud, waste or abuse (FWA)

In addition, Passport staff refer quality-of-care investigations to the quality team, which, under peer review protection, completes a thorough investigation and, if applicable, identifies needed corrective actions for the provider or facility. The quality team can report substantiated quality-of-care grievances to Passport's Credentialing Committee and QMMC.

Clinical staff conduct the investigation of the appeal or grievance, researching documentation, member needs and medical necessity requirements to render a determination. Our clinical staff collaborate with physicians, social workers, case managers and other staff as required. Clinical staff and physicians may also be involved in the State Fair Hearing process and may attend the hearing if their knowledge and familiarity with the member or case warrants their attendance.

Sourced Operational Improvements for Grievance and Appeals

Grievance and Appeals system data is integral to our ongoing efforts to improve service to members and providers.

The director of utilization management (UM) appeals reports complaints and grievances and appeals on the Quality Work Plan, which is reviewed by the Quality Improvement Committee (QIC) on a quarterly basis. This information is used to direct quality improvements that can benefit members and providers, such as process improvements and changes to pre-authorization requirements. The Quality Work Plan outlines goals, timetables and individual accountability per task and status. The QIC also tracks provider audit data and

develops corrective action plans to address deficiencies that are likely leading to complaints and grievances. As appropriate, an annual quality improvement evaluation details studies, methodologies, results, improvement actions and overall impact. Reports are reviewed and discussed at monthly compliance steering committee meetings and are provided on a monthly and quarterly basis to our QMMC, Quality Member Access Committee (QMAC) and to DMS.

Medicaid Member Grievance and Appeals Review and Process

Passport has designed a process with ease of use for members as its priority. We have policies and procedures, and an operational process and system for identifying, tracking and analyzing member grievances, appeals and Medicaid State Fair Hearings, all with the member experience in mind.

Grievance Process

A grievance is an expression of dissatisfaction (orally or in writing) to the health plan about any matter related to the health plan other than an adverse benefit determination. As specified in 42 C.F.R. 438.400, possible subjects for grievances include the following:

- Quality of care or services provided
- Aspects of member interaction, such as rudeness of a provider or employee
- Failure of provider or employee(s) to respect a member's rights

Medicaid members or their representatives may contact Passport's Member Services for assistance with writing or filing a grievance or appeal (including an expedited appeal). Member Services also works with the member to monitor the process through resolution.

Passport:

- Cannot take any action against the member as a result of him/her filing a grievance.
- Will send an acknowledgment letter within five (5) business days of receiving the grievance.
- Will provide Member Services staff to help fill out the grievance form.
- Will answer the member's grievance and send the member a letter within thirty (30) days of receiving the member's grievance. This letter will tell the member what has been done to address the grievance.
- Will provide the member the opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing.

If the grievance is about an ongoing emergency or hospital stay, it will be resolved as quickly as needed for the urgency of the case, and no later than one (1) business day from when Passport receives the grievance. The member can also file a grievance with DMS by phone, mail or electronically.

If a quality-of-care issue or concern is identified, this information is captured electronically within our documentation tool. For quality-of-service concern with a provider, the Grievance and Appeals coordinator sends the issue to the Provider Network Management (PNM) team for investigation, which may include a site visit to the office. Once a thorough investigation is completed, the outcome is submitted to the Grievance and Appeals coordinator to complete the grievance and submit a resolution letter.

Passport's Grievance Resolution process can be found in **Attachment C.14-1_Grievance Resolution Process Workflow**.

Member Medical/Administrative/Benefit Appeal Process

Passport has established and maintains a system for resolving dissatisfaction of actions regarding the denial or limitation of coverage of health care services, filed by a member, provider on behalf of the member, or authorized representative with specific member consent.

If a determination is made to deny payment, , the member may have the right to ask for an appeal. Appeals may be requested by phone or in writing within sixty (60) days of the date of the letter of adverse benefit determination.

Examples of administrative/benefit:

- Noncovered services
- Lock-in program

Examples of medical necessity:

- Elective purchase of wheelchair
- Urgent inpatient admission
- Elective inpatient admission with surgery

Passport will send a letter to the member within five (5) business days of receipt of a standard appeal request. This letter will include all necessary instructions related to filing an appeal by contacting the provider. If the request was received telephonically, this letter will also include instructions to submit a written request within ten (10) days along with the standardized appeal request form.

A board-certified doctor who was not previously involved, nor is a subordinate of any physician previously involved in the case, will review the appeal and decide how the appeal should be handled (i.e., whether the initial adverse determination should be affirmed, overturned or partially overturned).

Passport will send the member a letter with the response to the appeal within thirty (30) calendar days from when Passport receives the appeal. A fourteen (14)-day extension may be granted to the member or the Plan if additional time is needed. If we require an extension, Passport will notify the member telephonically of the reasons for the extension by the end of the business day on the day the decision is made, and in writing within two (2) days. Information sent to the member includes information on the member's right to file a grievance.

Passport will send a final resolution letter, either within thirty (30) days or after the fourteen (14)-day extension. Passport will also provide the member and the member's representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by Passport in connection with the appeal of the adverse benefit determination.

We provide this information upon request, free of charge and sufficiently in advance of the resolution time frame for appeals as specified in 42 C.F.R. 438.408(b) and (c).

The member may also contact Kentucky's Ombudsman for assistance at any time during the appeal process. Members can refer to their Passport Member Handbook for complete details about filing pre-service medical appeals. Members may also call Passport's Member Services for help filing a medical appeal.

Passport's Appeals Resolution process can be found in **Attachment C.14.2_Appeals Resolution Process Workflow**.

Passport's Provider Grievance and Appeals Process

Passport allows providers the right to file an internal appeal for any of the following:

- A health care service
- Claim for reimbursement
- Provider payment
- Contractual issues

A provider may also have the right to file an appeal on the member's behalf. This would fall under the member appeal process.

Passport will offer a committee of at least three (3) qualified individuals who were not involved in the original decision to review the provider appeal. A written response to the appeal will be submitted to the provider within thirty (30) calendar days of receiving the request.

The provider may submit any information he/she would like Passport to review during the appeal process. The appeal will be reviewed by a physician of the same or similar specialty who was not involved in the original decision. Passport or the provider may request a fourteen (14)-day extension. Upon completion of the internal appeal process, Passport will send the provider a written determination letter.

The provider has the right to request an external third-party review after Passport has rendered its internal decision.

A provider has the right to file a grievance to Passport, including a complaint or dispute that may not require remedial action. Passport will render a decision and respond in writing within thirty (30) calendar days.

Passport will not retaliate or discriminate against a provider for filing an appeal or grievance.

Passport's Average Resolution Time for Member Grievance and Appeals

Passport consistently resolves member grievances and appeals within the regulatory timeliness thresholds set by DMS. The average time for resolution for the past twelve (12) months is as follows:

- Twenty-seven (27) days for member grievances
- Twelve (12) days for member appeals
- Two (2) days for expedited member appeals

During 2019, Passport received one hundred fourteen (114) member grievances. **Exhibit C.14-1** lists the top four (4) grievances received.

Exhibit C.14-1: Passport 2019 Top Four (4) Grievances

Member Grievance Description	Number of Grievances	Percent Completed Within Required Time Frame
Attitude/Service-Office Staff Unprofessional	18	100%
Access—Denial/Reduction of Services	15	100%
Quality of Care	13	100%
Access—Appointment Availability	7	85%

Passport reserves the right to perform on-site visits to provider offices if patterns that need to be investigated in person are identified through the grievance process. DMS or its contracted agent may conduct on-site visits to follow up on patterns of repeated grievances or appeals.

C.14.b. Process for Expedited Review.

Passport's Expedited Review Process

Passport understands that improving some members' health outcomes may demand that we resolve their appeals more quickly than our standard review time allows. Passport's expedited review process is available when we determine, or a member or provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Expedited appeals are available for prospective and concurrent services but are not available for those requests that are made retrospectively. For all expedited appeals, a physician other than the physician rendering the original denial decision, who is not a subordinate of the physician who rendered the original decision, must review the appeal request. If a provider requests an expedited appeal on behalf of a member, we will not require the provider to follow up with a written consent from the member.

If the member requests an expedited review, Passport will work closely with the member as well as the member representative/caregiver and provider to obtain all the necessary information to render a decision. We will render a decision within seventy-two (72) hours. We will call the member with our decision within one (1) business day or seventy-two (72) hours, whichever is shorter. We will also send a letter with the answer to the appeal within three (3) business days.

Our Expedited Appeals Resolution process is provided as **Attachment C.14-3_Expedited Appeals Resolution Process Workflow.**

C.14.c. Involvement of Enrollees and their caregivers in the process.

Advocating for Members and Caregivers in Resolving Grievances and Appeals

Passport has twenty-two (22) years of experience working closely with Kentucky Medicaid members to help resolve concerns through our grievance and appeals process. Our Kentucky-based staff are committed to advocating for members and caregivers throughout the grievance and appeals process with compassion and fairness. Whether our grievance and appeals representatives are assisting members over the phone or in person at our local office, we will work with our members and their caregivers throughout the grievance and appeals process. We take the time and care to ensure that members are actively involved in the process and understand what is going on with their appeal or grievance, and we encourage them to take an active role in their appeal as well as their health care in general. We work to ensure that our members and their caregivers have a voice during the process so that we may address their concerns appropriately. Our goal is always to provide a high quality member experience for members that is easy, fair, objective and timely.

To ensure that all members have trouble-free access to our grievance and appeals process, our MSRs and appeal coordinators educate members and act as advocates for members to support their submission of grievances and appeals via multiple modalities, including by telephone, in writing, electronically and in person. We assist members with completing the forms required to file a grievance or appeal. We offer free foreign language interpretation services and a bilingual call center staff to our members who call Member Services for assistance. Our Member Services Department also offers a TTY line and auxiliary aids upon request. Our policies allow members and authorized representatives, such as caregivers relatives, providers, care managers or any member-authorized individual, to file grievances and appeals.

Supporting Whole-Person Care with Member Advocacy

Passport member Anna* called the appeals department because her doctor said Passport will not cover her procedure. On investigation, no UM authorization request was found in the system.

When Passport G&A Coordinator Nancy* asked Anna for more details, she stated she was told the procedure is new and did not yet have a code, so the provider could not send the request to Passport. Because of this, the provider wanted Anna to pay thousands of dollars to have the procedure.

Nancy advised Anna that she could not file an appeal because there was no denied authorization request. Through further conversation, it became clear Anna was upset and very nervous about the procedure in question. She was scared it would not go well. Nancy explained that, while she could not offer medical advice, as a member, Anna is afforded a second opinion and that she should reach out to her primary care provider (PCP) to get that scheduled if she feels she needs help in doing so. Further discussion calmed Anna and gave her a clear understanding of her next steps.

A few months later, Anna called back to say how much she appreciated Nancy taking the time to talk with her that day. She had taken Nancy's advice and obtained a second opinion from a new specialist. Anna stated that the new doctor was very kind, and she felt comfortable about having the procedure done by the new doctor, who was able to approve the procedure with Passport. Anna stated she would never have enough words to express how grateful she will always be that Nancy took the time to help her.

**Names changed for privacy.*

C.14.d. Tracking grievances and appeals received by type and trending results for use in improving operations.

Improving Operations Through Grievance and Appeals Analysis

Sophisticated technology enables Passport to provide high levels of member service for grievances and appeals while identifying areas for improvement across our operations. Passport uses its Identifi℠ Grievance and Appeals module, a proprietary system that tracks, investigates and communicates all grievances and appeals. This system stores and maintains all documentation used in the internal and external appeal or grievance review.

Passport maintains all grievances and appeals files in a secure and designated area that is accessible to DMS, its designee or CMS, upon request, for review. Passport also retains all grievance and appeal files for ten (10) years following our final decision, Health Service Department (HSD) decision, an administrative law judgement, judicial appeal, or closure of a file, whichever occurs later.

Passport has procedures for ensuring that files contain sufficient information, as outlined at 42 C.F.R. 438.416, to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the member of receipt of the grievance or appeal, all correspondence between Passport and the member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the member, and all other pertinent information. Passport ensures that documentation regarding the grievance is made available to the member if requested.

Using Identifi, grievances are reported via both monthly and quarterly reports. The Identifi system is fully customizable, and all entered fields are reportable to assist in root-cause analysis, assessment of barriers and development of opportunities for improvement. The Grievance and Appeals leadership analyzes the data on a monthly and quarterly basis, with reports going to the compliance steering committee, QMAC and QMMC at a minimum. Passport also reports grievance data quarterly to DMS via statutory reports. These reports include the number of grievances, the nature of the grievances, their resolutions, and the time frame for resolution of each grievance. We also report any Quality Assessment and Performance Improvement (QAPI) initiatives or other changes made as a result of an analysis of grievances to DMS through the quarterly Quality Improvement Work Plan.

Passport appeals staff work closely with Passport medical directors and PNM as well as any other departments when any trends are identified with grievances and appeals. We analyze our results, looking for root cause with any trends, large or small, when they are identified or at a minimum of monthly and quarterly. Ongoing collaboration occurs for appeals that are overturned when the complete clinical information is submitted with the appeal request. Incomplete or missing clinical information is a large driver for UM adverse benefit determinations. The appeals team works closely with PNM to educate providers. PNM will work with offices as well as UM, when necessary, to understand the needed information for submission of UM requests to prevent the initial denial of services.

Passport uses the results of the analysis of grievance and appeal trending in formulating business decisions and improving operations. These decisions can include, for example, possible changes to internal processes, prior authorization requirements or simply provider education on Passport's medical management processes.

Passport's 2019 Appeal Results

During 2019, a total of 3,630 denials were issued, 412 of which were appealed, and 100% of all appeal requests were completed within the thirty (30) day requirement. For 2019, the ratio of appeals to denials was 1:8.8. The ratio of appeals to denials has remained consistent year to year.

Passport's 2019 appeal results are shown in **Exhibit C.14-2** for members and in **Exhibit C.14-3** for providers**.**

Exhibit C.14-2: Passport 2019 Member Appeal Results

Member Appeal Description	Number of Appeals	Percent Completed Within Required Time Frame
Lock In	31	100%
Outpatient/Outpatient Surgery	17	100%
Durable Medical Equipment	8	100%
Home Health Services	5	100%

Exhibit C.14-3: Passport 2019 Provider Appeal Results

Provider Appeal Description	Number of Appeals	Percent Completed Within Required Time Frame
Administrative Denial	204	100%
Hospital Length of Stay (LOS)	114	100%
Outpatient/Outpatient Surgery	5	100%

C.14.e. Reviewing overturned decisions to identify needed changes.

Engaging Medical Directors and Providers to Review Overturned Decisions to Improve Operations

Passport is committed to thoroughly reviewing overturned decisions to identify needed changes as part of our grievance and appeals processes noted earlier.

Passport reviews all appeal decisions, regardless of whether they have been overturned or upheld. We look for all trends and actions to identify any possible changes needed to our UM or appeals processes. We analyze data on a monthly, quarterly and annual basis to identify any trends in service requests or provider specialty types. We look for any changes that may need to be incorporated in UM and appeal processes, and also any opportunities to educate providers and help them better understand the UM and appeals processes.

Once trends have been identified, one of two things happen: (1) If the trend requires provider education and intervention, our Grievance and Appeals staff collaborates with our PNM department to work individually with the providers to help them understand our UM and appeal processes and hopefully avoid future concerns. (2) If the trend identifies a service that we are consistently overturning, our Grievance and Appeals team brings the issue to the attention of our medical directors. This group discusses the next steps on analyzing if we need to change our policies to align with the current best practices. All decisions are

brought to the Passport QMMC, where local providers are given the opportunity to provide input on any decisions that will be made to policies. Reports also go to Passport's QMAC, which allows us to gain further input from local members, providers and community partners.

Passport also participates on a UM committee with our subcontractor Evolent's national UM department. This allows us to identify trends, analyze our policy decisions and collaborate on solutions using national best practices from grievance and appeals experts from across the country.

Conclusion

Passport's Grievance and Appeals Department keeps the member experience at the forefront of all we do. The extensive provider participation in our governance structure and program development has shaped our streamlined, member-and provider-focused grievance and appeals approach, resulting in a process that is easy for members and providers to access, treats cases fairly and objectively, and resolves issues in a timely manner. We are committed to providing swift and fair resolution to member grievances/complaints and appeals to ensure our members know that they are heard and their issues have been fully considered. Our Grievance and Appeals Department and committees use processes and systems to resolve these inquiries fairly and quickly, in a manner that keeps the focus on our members.

Passport has been honored to serve the Kentucky Medicaid and foster care populations for 22 years and will continue to comply with all provisions of the Medicaid Managed Care Contract and Appendices (including Kentucky SKY) as we continue to serve them in the future.