C.17. Provider Services

a. Summarize the Vendor's overall approach to Provider Services, including initiatives and processes for providing effective services to providers to support the Kentucky Medicaid program. In the response, address the following at a minimum:

   i. A description of how provider representatives engage with providers initially and on an ongoing basis, including level of local presence and onsite visits to provider locations.

   ii. Description of formal committees, workgroups, or other forums, if any, in which Providers can receive updates and instruction from the Vendor and offer input about the overall program and Vendor initiatives.

   iii. Methods and metrics used to collect provider feedback and to measure overall provider satisfaction, including frequency of doing so.

   iv. Methods the Vendor will use to minimize provider complaints and escalations to the Department.

b. Describe the Vendor's proposed Provider Services call center, including an overview of the following at a minimum:

   i. Approach to assuring the call center is fully staffed during required timeframes.

   ii. Location of proposed operations.

   iii. How the Vendor will meet and monitor call center standards, and how the Vendor will use monitoring results to adjust operations, as needed.

c. Provide an overview of the Vendor's proposed provider website, including examples of information that will be provided through the website and any functionality that will be included to communicate with providers. Provide sample screenshots of provider websites currently maintained by the Vendor.

d. Provide a proposed table of contents for the Provider Manual and a brief description of the type of information the Vendor will communicate via the manual.

e. Provide the Vendor's proposed approach to provider orientation and education.

f. Describe the Vendor's support of providers in Medicaid enrollment and credentialing, including the following:

   i. Methods for assisting providers who are not enrolled in Medicaid with the enrollment process.

   ii. Proposed process for conduct of credentialing until such time that a Credentialing Verification Organization (CVO) is contracted by the Department.

   iii. Proposed process for transitioning credentialing activities to and coordinating with the Department's contracted CVO(s) to educate and assist Providers in completing the credentialing process with the CVO(s).

iv. Approach for a timely contracting determination of providers upon receipt of information from a CVO that a provider's credentialing is complete, specifying timeframe for uploading a credentialed and contracted provider into the claims payment system to allow for payment of adjudicated claims. Include copies of the Vendor's proposed credentialing policies and procedures, and procedures for coordination with the CVO(s).

g. Provide the Vendor's proposed approach for processing provider grievances and appeals. Include at a minimum:

i. The overall process to include description of interaction with providers, required correspondence and timeframes for acknowledging and resolving grievances and appeals.

ii. Process for tracking reasons for grievances and appeals to identify trends, and how the Vendor will use this information to improve internal operations, provider relations, and provider satisfaction.

iii. Process for ensuring transparency to DMS of grievance and appeal types, resolutions, and any Vendor actions to decrease such grievances or appeals in the future.

Passport Highlights: Provider Services

How We're Different	Why It Matters	Proof
Passport's provider-driven model, facilitated through the unique structure of our various committees, allows for a breadth of practical experience that positively impacts the broader provider community.	• A provider community that is engaged in an intimate, meaningful way leads to better outcomes for our members.	• Passport employs Provider Relations Representatives to serve all regions of Kentucky and the unique needs within each region. • In 2019, Passport's provider satisfaction score increased by 3.9% to an overall satisfaction score of 71.4%, which is notably above benchmark.
Passport is continuously evolving its engagement model to ensure information is shared with our provider community in a manner that will positively impact outcomes.	• Providers need to receive information impacting their business and their members as quickly as possible, in a manner that suits them.	• In direct response to provider feedback, Passport has implemented multiple innovations within the last year, including, but not limited to, a real-time message center on the Provider Portal as well as enhancements to provider reporting.
Passport takes a highly collaborative, cross-functional approach to evolving our provider servicing capabilities and processes.	• Passport works across domains to ensure those who service our providers have a 360° view into their experience. • Call center staff is trained cross-functionally in claims, authorizations, eligibility and other areas, which greatly decreases the number of instances in which a transfer to another department is needed.	• Passport has organized a provider-focused internal workgroup with representation from all functional areas that impact or are impacted by the provider experience. Here, innovative ideas are shared, new processes are developed and teams are cross-trained. • First-call resolution for the provider call center is 99.2%. In the event that a provider needs to be transferred, the Provider Services team will perform a follow-up call to ensure that the provider was able to reach a successful result to their inquiry.

Introduction

Passport has a twenty (20)-year history of collaborative provider partnerships across the Commonwealth. Our comprehensive statewide provider network includes all major health systems, independent practice associations such as the Kentucky Primary Care Association, Kentucky's children's hospitals, critical access hospitals and teaching hospitals throughout the Commonwealth. Our network also includes health systems in border states, including Cincinnati Children's Hospital.

C.17.a. Summarize the Vendor's overall approach to Provider Services, including initiatives and processes for providing effective services to providers to support the Kentucky Medicaid program. In the response, address the following at a minimum:

Our Approach to Provider Services

As a provider-driven organization, building strong relationships between providers and members is the cornerstone of all our activities. Passport's service model has been founded on the belief that locally based staff, embedded in communities through the Commonwealth with intimate knowledge of provider, community and member issues, is the best way to ensure access, high service standards and an integrated approach to health.

Our Provider Relations Team

Provider Relations is at the core of ensuring that the needs of our provider network are not just met but exceeded. While our Provider Relations Representatives (PRRs) are often the primary conduit for providers into Passport's operations, Passport takes a multifaceted approach to ensuring responsive provider support that extends beyond the Provider Relations Department and encompasses cross-functional departments to timely and effectively respond to provider needs. **The total number of Provider Relations staff servicing Passport's network providers is twenty-six (26),** comprised of Provider Relations Representatives (12) and Other Provider Relations Staff (14).

Provider Relations Representatives (12)

Passport has twelve Provider Relations Representatives (12), including:

- Five (5) PRRs for medical providers
- Three (3) PRRs for behavioral health (BH) providers
- Three (3) PRRs for major health systems
- One (1) PRR for ancillary providers

Other Provider Relations Staff (14)

In addition to the twelve (12) PRRs described above, there are fourteen (14) other Provider Relations staff members:

This deeply experienced department has over 297 combined years of provider relations, claims, and customer service experience.

- Five (5) Provider Relations managers, who are former PRRs and serve as account managers when needed. These managers lead teams organized by major health systems, BH, and Eastern and Western Kentucky regions.
- Three (3) Specialist 1s, who are behind-the-scenes claims subject matter experts. The Specialist 1s research and help resolve issues reported by the PRRs. The Specialist 1 concept is unique because Passport created the concept when we expanded statewide in 2014. With their depth of knowledge, the Specialist 1s are an integral part of the team. Each Specialist 1 is dedicated to a small group of PRRs and assists the PRRs as they personally onboard new providers and resolve issues for providers throughout the Commonwealth.
- Six (6) team members who provide administrative support: a program strategist, business analyst, trainer, communications manager, director and an Administrator. Our Provider Relations leaders ensure that all PRRs follow all contractually-required provider relation functions including, policies, procedures and scope of services.

Our PRRs complete comprehensive training and regular refresher programs to optimize service levels across a wide range of topics. The initial required training takes place over the course of approximately thirty (30) days and includes systems training, as well as job shadowing to gauge level of knowledge. Covered topics include, but are not limited to, the following:

- Claims processing and provider data
- Kentucky Health Information Exchange
- Passport Provider Portal
- Passport Health Plan website
- Department for Medicaid Services (DMS) fee schedules
- Kentucky HealthNet
- Provider contracting
- Value-based contracting
- Passport Provider Manual
- Passport's policies and procedures
- Provider site visits

Additional Local Support

The Passport Provider Relations team is supported by, and supports, a variety of departments within Passport through a formalized cross-functional provider-focused internal workgroup. Participants in this forum include but are not limited to:

Passport's Provider Services Call Center Representatives: Our Provider Call Center representatives are often the first contact for our providers when they reach out with a question or an issue that needs to be addressed. Our local, Kentucky-based Provider Call Center staff focus on first-call resolution. Providers can also call our Provider Claims Service Unit (PCSU) with claims questions, concerns or issues and speak directly

with one of Passport's highly skilled provider-focused customer service agents. The PCSU staff, based in Kentucky, can provide claim status, answer provider questions regarding the claims process, and quickly reprocess and correct claim payment errors in real time with the provider on the phone for single-call resolution. Passport's ability and willingness to reprocess claims real-time is a point of distinction in the market.

Population Health Managers (PHMs): Passport's team of disciplined PHMs engage with providers around clinical solutions and practice transformation for all clinical areas of their practice–including quality and risk management. They meet with providers on-site and telephonically and share regular updates on Passport's various initiatives that might support providers and their patients. The PHMs educate the providers on the data available to them that empowers them to better serve their Passport patients and show them which of our members are stratifying for our care management programs. As part of a cooperative approach, providers help our PHMs prioritize which members we should engage first, based on their interpersonal experiences. We strive to let providers understand they can engage and collaborate with us in a two-way communication and partnership feedback loop about members on an individual level and at a practice level.

- **Care Advisor**: Passport's Care Advisors coordinate and collaborate with providers to work individually with Passport members to help them manage their health conditions. Passport has Care Advisors embedded in hospitals and select provider offices to work with providers and support them in the care of its members.
- **Substance Use Disorder (SUD) Program Manager**: Passport SUD program manager provides consultations to SUD providers across the Commonwealth. Our manager works with providers and community partners to facilitate SUD treatment for our members by identifying gaps in the services available in the community, then collaborates with providers on ways to eliminate those gaps. The manager has worked on projects to bundle payments as a way of decreasing the administrative load for providers and removing barriers to treatment for our members.
- **Claims and Provider Payment**: Under the direction of Shawn Elman, Passport's chief operating officer (COO), the dedicated Kentucky Claims Team includes approximately one hundred (100) staff members in Front End Claims Processing, Funding and Recovery, Root Cause, Provider Claims Rework, Quality Assurance, Pre and Post Payment Auditing, and Provider Claims Services. Dedicated to first-call resolution, the Provider Claims Services Unit leverages their claims expertise to increase payment accuracy and process claims in real time during provider calls, and supports Provider Relations staff during collaborative, on-site provider visits.

Initiatives and Processes for Effective Provider Services

Throughout this response, we describe our Kentucky-based team and the processes they use for onboarding new providers and conducting ongoing educational activities, and the structure and frequency of our many provider committees, workgroups and forums, provider credentialing, and provider grievances and appeals. We describe the resources we use to engage with providers every day, including our provider call center (PCC) and provider portal. We detail initiatives we undertake to deliver high quality service to more than 32,000 Kentucky Medicaid unique providers, in over 21,000 locations.

C.17.a.i. A description of how provider representatives engage with providers initially and on an ongoing basis, including level of local presence and onsite visits to provider locations.

Passport Provider Relations Representative Engagement

Passport has a "no wrong door" policy when servicing our providers. "No wrong door" means that no matter what medium a provider uses to communicate to Passport, the recipient will ensure that the problem is solved without needing to transfer the provider elsewhere. Passport's cross-functional teams are dedicated to enhancing relationships with our more than 32,000 network providers and ensuring positive day-to-day experiences and interactions with Passport. At the center of our Provider Relations team are our PRRs. This team of twelve (12) talented and experienced individuals deliver the functions required in Draft Contract Section 27.1 including:

- Providing assistance and coordination in network participation, credentialing and recredentialing
- Responding to provider requests and inquiries within two (2) Business Days of a request
- Conducting provider performance reviews
- Assisting providers with enrollment status questions, prior authorization and referral procedures, including consulting with a requesting provider on authorization decisions, when appropriate; claims submissions and payments; and coordination of care for child and adult members with complex and/or chronic conditions
- Developing, distributing and maintaining a provider manual
- Developing, conducting and assuring Provider orientation and ongoing education
- Encouraging and coordinating the enrollment of primary care providers in the Department for Public Health and the DMS Vaccines for Children Program
- Providing necessary technical support to providers who experience unique problems with certain members in their provision of services

Pursuant to our "no wrong door" policy, when a PRR is notified by a network provider of a concern, they will be accountable to resolve it no matter the subject. PRRs are also accountable for educating providers on the variety of resources available to them, both internal to Passport and within the community at large. Passport also recognizes that ensuring our providers have awareness of a wide range of resources helps to ensure that their members will as well. In addition, as described earlier in this section, each PRR is assigned to specific provider types and receives specialized training enabling each PRR to offer expert assistance in addressing the unique needs of their assigned provider type.

Initial Engagement

Upon assignment of a newly contracted provider, the PRR reaches out to the provider with a welcome telephone call or e-mail to introduce themselves as their dedicated PRR and to make sure they are aware of the many resources Passport makes available to them. During the welcome call or e-mail communication, the PRR will schedule an initial in-person orientation within thirty (30) days of the provider becoming a participating provider in our network. The PRRs use this time to establish themselves as points of contact for

the provider on any issues that may arise. Passport's approach to orientation and ongoing education are further described in the response to question **C.17.e**.

Ongoing Engagement

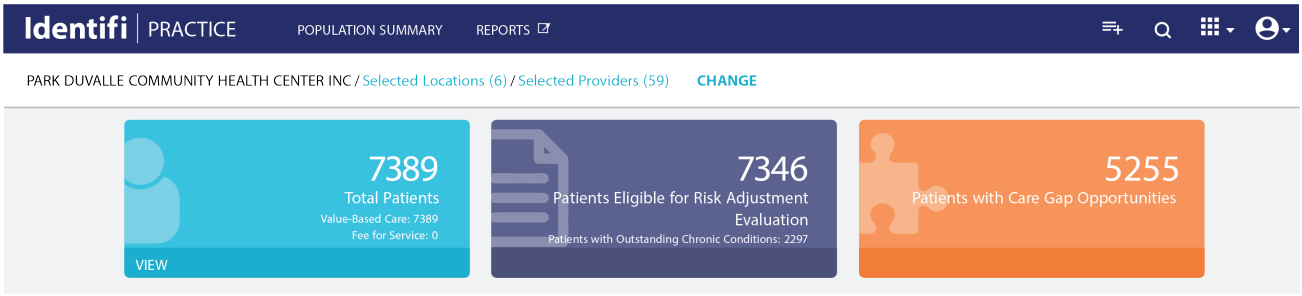
PRRs visit providers at their offices on a regular basis. Depending on the providers' needs, the PRR may schedule monthly on-site visits and be available on an ad hoc basis to visit providers at any time. The PRR stays engaged with the provider via telephone, email or other provider-preferred methods. Upon request, the PRR will return to the provider's office to conduct an in-person orientation refresher course, or to onboard new provider staff at any time.

PRRs document all provider contacts into our database to maintain a record of the visit and ensure all required aspects of the visit type are captured. For example, the Passport Site Visit form prompts the PRR to validate compliance with waiting times, appointment standards and confidentiality of member information, among other site-visit criteria.

Ongoing Technological Engagement

Passport leverages Identifi Practice, illustrated in **Exhibit C.17-1**, an integrated, proprietary technology platform to provide physician practices with workflow and analytics to enable greater engagement in value-based care activities. Identifi Practice allows users to access actionable electronic intelligence at the point of care and provides a physician-centric view of real-time patient insights such as gaps in care and quality measures, care program engagement and current care plan.

Exhibit C.17-1: Identifi Practice



Local Presence

Passport's PRRs work in all regions of Kentucky, which enables them to respond quickly and participate in field-based activities such as provider visits and meetings. PRRs consistently share their experiences and provider perspectives with other Passport Departments.

Onsite visits

Positive relationship building with network providers is the highest priority for Passport's Provider Relations division. Every provider in our network has a Provider Relations Representative assigned to them. PRRs are assigned either through regions where they live, ZIP codes or provider type, such as ancillary. Provider Relations also assigns reps who focus on major health systems, Eastern and Western Kentucky, and BH teams so that education to these providers is highly focused. Providers are then divided into three (3) tiers based on claims and panel volumes, with corresponding cadence of outreach.

- Tier 1: monthly
- Tier 2: quarterly
- Tier 3: semiannually

PRRs travel throughout the Commonwealth to meet personally with providers on a daily basis, logging over 109,000 miles in 2019. They also conduct site visits, represent Passport at provider-sponsored events (seventeen [17] in 2019), such as the Kentucky Health Information Exchange (KHIE) EHealth Summit, Kentucky Pharmacist Association (KPHA) Opioid Summit, and Kentucky Medical Equipment Suppliers Association (KMESA), Kentucky Primary Care Association (KPCA) and KY Public Health Conference. These local community affairs allow PRRs to network with the provider community. Not only do the PRRs conduct numerous personal visits, in 2019 there were approximately four hundred (400) Joint Operating Committee (JOC) meetings and related conference calls, and innumerable e-mails and phone calls with our vast network. Our outreach success is proven by the 2019 highest score on the annual Provider Satisfaction Survey conducted by SPH Analytics, an independent national leader in health care analytics:

Composite Area: Provider Relations

Attribute: Have you had contact with the PRR assigned to your practice?

Score Increase: +7.3%

We achieve this goal with intentional touch points including:

- Initial orientation of new groups within thirty (30) days using the long site visit form. Several items are NCQA- and DMS-required, as noted on the form
- Scheduled, drop-in and "on-demand" personal site visits using the short site visit form
- Conference calls
- E-mails
- Provider events
- Annual workshops and DMS forums

We also monitor network growth to ensure we are engaged with our entire network.

C.17.a.ii. Description of formal committees, workgroups, or other forums, if any, in which Providers can receive updates and instruction from the Vendor and offer input about the overall program and Vendor initiatives.

Committees, Workgroups and Forums

Passport participates in any Medicaid Provider Educational Forums designated by the Department to be held throughout the Commonwealth as enhanced education efforts related to Medicaid Managed Care. We remit our required fee at the start of each fiscal year and have been participating in these forums since Passport's inception. Providers are invited, encouraged and often required, to participate on a significant number of committees that encompass a variety of goals and objectives for our health plan. The contributions of our providers on these committees, workgroups and forums benefit the provider network by maintaining representation and a voice at the table.

Our Governance Structure

Passport's provider-driven governance structure is part of Passport's DNA, cascading through our committee structure and into the daily operations of our health plan. Passport's current and ongoing governance structure reflects a provider governance/ownership philosophy; our provider-owners hold Board seats, and all key strategic and operational governance issues, such as the hiring and firing of the health plan CEO, budgeting, and approval of significant innovations or resource extensions, must be approved jointly by the provider-owner Board members. This is unique among national Medicaid Managed Care companies and ultimately leads to stronger physician loyalty and higher member engagement in their health.

Committees–with Partnership Council Oversight

The Partnership Council, which reports into Passport's Board of Directors, is comprised of thirty-two (32) members representing a broad coalition of local consumers and providers, including physicians, nurses, hospitals, health departments and ancillary providers. In support of our ongoing provider engagement, the Council recommends policy decisions, reviews the results of quality activities, recommending actions and overseeing follow-up. An overview of the Partnership Council's committee structure is shown in **Exhibit C.17-2**.

Exhibit C.17-2: The Partnership Council Structure

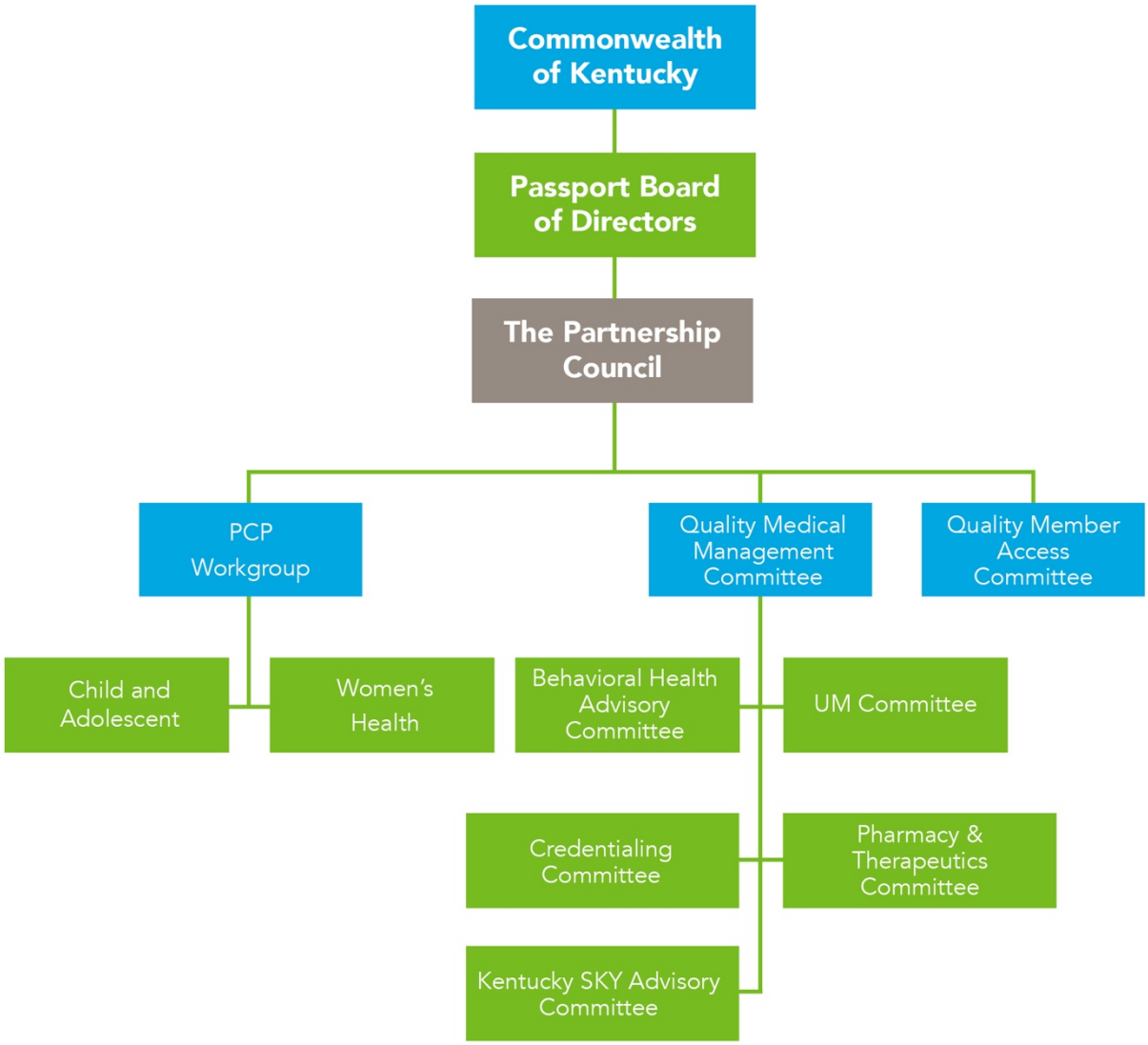


Exhibit C.17-3 reflects the committees in which providers participate, and the purpose or objective of each.

Exhibit C.17-3: Passport Committees and Workgroups with Provider Representation

Passport Committee with Provider Participation	Chair	Purpose of Committee	Frequency
The Partnership Council	CEO of Bridgehaven, an organization servicing the needs of individuals living with severe mental illness (SMI)	The Partnership Council is a committee under the direction of the Passport Board of Directors and is comprised of a full spectrum of providers and consumer representatives working together to govern Passport Health Plan operations.	Every other month
QMMC	Chief Medical Officer	The purpose of the QMMC is to provide direction to, and oversight of, management and subcommittee functions responsible for the provision of clinical care and services. The QMMC is Passport Quality Improvement Committee (QIC).	Every other month
Credentialing Committee	Chief Medical Officer or delegate (another Medical Director)	A subcommittee of the Quality Medical Management Committee (QMMC). The purpose of Passport's Credentialing Committee is to review each provider applicant and vote for acceptance for participation, denial for participation, request additional information, provider corrective action plan and/or a modifying provider's participation status (i.e., a re-credentialing date of less than three [3] years).	Monthly
Quality Member Access Committee (QMAC)	Long-time advocate for the elderly and disabled	The purpose of the QMAC is to facilitate a means for consumers, advocates, and public health representatives to provide input regarding the ability of Passport to provide access to care and services to the Passport membership and identify opportunities for improvement.	Four to six (4-6) times per year (NCQA requires at least four [4] times per year)

Passport Committee with Provider Participation	Chair	Purpose of Committee	Frequency
Child and Adolescent Committee (CAC)	Chief Medical Officer or delegate (another Medical Director)	A subcommittee of the Primary Care Provider (PCP) Workgroup. The purpose of the Child and Adolescent Committee is to provide direction to, and oversight of, the management of care for members under the age of twenty-one (21). This includes EPSDT and EPSDT special services, children with special health care needs, and children in foster care or receiving adoptive services, to name a few.	Ad hoc
Women's Health Committee	Chief Medical Officer or delegate (another Medical Director)	A subcommittee of the PCP Workgroup. The purpose of the Women's Health Committee is to provide direction to, and oversight of, the management of the care given to women throughout their lives, including pregnancy.	Ad hoc
Pharmacy and Therapeutics Committee	CMO of Centerstone Kentucky (Seven Counties Services)	A subcommittee of the QMMC. The purpose of the Pharmacy and Therapeutics Committee is to provide direction to, and oversight of, pharmaceutical issues concerning members, using pharmacological, economic and clinical information.	Monthly
Utilization Management (UM) Committee	Chief Medical Officer or delegate (another Medical Director)	A subcommittee of the QMMC. The purpose of the UM Committee is for overall oversight of Passport's UM Program, to monitor utilization trends and issues, and evaluate and recommend criteria and guidelines to identify opportunities to improve the quality of care and services provided to Passport members.	Monthly

Workgroups

Passport providers are often engaged in the design, development and implementation of Passport programs and initiatives.

PCP Workgroup

The purpose of the PCP Workgroup is to provide a platform for key primary care providers to provide feedback and recommendations to Passport on issues concerning PCPs and their members. Passport's PCP Workgroup meets quarterly and is facilitated by Passport's Chief Medical Officer. Other participants include

a variety of key PCPs in Passport's network, Passport's vice president of health integration, its BH program manager and the Provider Relations leadership team. Topics of discussion include, but are not limited to, DMS rate changes, our value-based payment programs, and the integration of physical and behavioral health.

Behavioral Health Advisory Committee

Passport has partnered with **Beacon Health Options (Beacon)**, the largest independently held BH organization in the country, which serves more than 40 million individuals across fifty (50) states. Beacon maintains full NCQA Managed Behavioral Health Organization accreditation and provides a full spectrum of high quality care for a wide range of partners including regional and specialty health plans; employers and labor organizations; and federal, state and local governments. Beacon's Medicaid programs serve 14 million members and have been instrumental in transforming the way in which BH performance is measured and care is delivered.

To successfully provide seamless, integrated care for our members, Passport created the provider-led Behavioral Health Advisory Committee (BHAC). The BHAC is made up of community providers, advocates and members, who meet quarterly to provide input on policy, clinical practice guideline adoption, proposed models of care inclusive of new innovative approaches, and overall performance. The BHAC is accountable for ensuring that Passport and Beacon work collectively to create a seamless experience for our members with no handoffs. Members of our BHAC include:

- CEO, outpatient BH and housing provider organization
- Rural psychiatric nurse practitioner in independent practice
- Chief clinical officer for a community mental health center
- University-affiliated child and adolescent psychiatrist and faculty member
- Outpatient BH service organization president/CEO
- Licensed psychologist, advocate and Kentucky Mental Health Coalition executive director
- Peer-support specialist for adult members with SMI

The BHAC has made recommendations that have helped shape Passport policy in many ways. For example:

Drug formulary changes: The BHAC provided solid clinical evidence for having stimulants be a non-preferred choice for members, except in children and adolescents with active prescriptions. The Pharmacy and Therapeutics (P&T) Committee adopted the recommendation.

Social Determinants of Health (SDoH) communications: BHAC committee members assisted Passport in designing a new communication to our members about SDoH that emphasized connection to community and opportunities (versus support) to promote member empowerment. Their feedback included perspectives from providers, advocates and members and helped to increase the receptivity to the message of members with SMI.

Support for holistic care for foster care members: The BHAC helped Passport design the accountability processes in implementing the evidence-based model of care, provider interactions and member

experience. This input resulted in the use of more unlicensed staff at a time when care had traditionally been thought of as predominantly clinician-driven.

The BHAC reports directly to the QIC alongside the Credentialing, P&T, and UM Committees. Child and Adolescent and Women's Health committees report up through the PCP Workgroup. The QMMC provides input and oversight for all Quality Improvement (QI) activities throughout the health plan and provider network, and is directly accountable to the Partnership Council, which is responsible for quality and outcomes of the services provided by the network, Passport or any subcontractors. Oversight of the Partnership Council is provided by Passport's Board of Directors. The Board of Directors is our highest internal level of oversight and includes the important provider voice to hold us accountable in the work we do every day.

Our providers are not just advisors; they have true accountability through participation in each level of this governance structure. Several of our BHAC provider members have moved to the QMMC to ensure an integrated approach that improves health and quality of life. Furthermore, the chair of the Partnership Council is a BH provider in the community. Having provider input is critical to ensure that our services are integrated at each rung of the ladder from the bottom to the top. The BHAC reviews and provides feedback on compliance reports, with the option to escalate any concerns through the QMMC up to the board.

Forums

We recognize that a positive provider experience directly impacts the experience of our members. We emphasize regular and active engagement with our providers to ensure an informed provider network, strong relationships, regular feedback and continuous quality improvement. For example, our Provider Relations team has multiple planned, recurring meetings with providers, including in-person JOC meetings, routinely scheduled conference calls and quarterly webinars to ensure the entire network has regular touch points for education and communication. Our PRRs host annual provider educational workshops across the state which are also presented as webinars and posted on the provider website. Our PRRs' attendance at all DMS forums deepens provider engagement.

Passport and its cross-functional teams work to ensure successful and productive meetings with the network. We also share feedback from our Value-Based Provider (VBP) programs and our JOCs and Credentialing Committee meetings with our provider-led PCP Workgroup and Partnership Council as part of our regular program governance. For example, Passport attendance and participation in JOC meetings, care conferences and monthly meetings with our VBP partners offers executive leadership and other key leaders insight into group financial performance and opportunities for top-down interventions. These touch points foster provider engagement; improve provider satisfaction; provide actionable guidance for risk, quality, care management, and medical expense analysis; and improve health outcomes and experience for the members we serve.

C.17.a.iii. Methods and metrics used to collect provider feedback and to measure overall provider satisfaction, including frequency of doing so.

Collecting Provider Feedback

Passport's "No Wrong Door" policy allows providers to share their input, insights and feedback during all interactions with staff supporting Passport. Every provider contact is an opportunity to collect feedback and deepen engagement. Passport strives to engage with providers face-to-face to gain an intimate understanding of their holistic pain points and help solve them through informal consultation and advisory services that often go beyond the business relationship with our plan.

In addition to these regular interactions, we formally collect provider feedback through the methods and metrics described below.

Methods and Metrics Used to Measure Provider Satisfaction

Passport collects provider feedback through our annual Provider Satisfaction Survey, provider service call center trends, provider grievances and complaints, direct feedback received through the PRRs, and via providers themselves.

Annual Provider Satisfaction Survey

Background: Passport recognizes that a highly effective provider network is a critical foundation for a cost-effective and quality-driven delivery system. Passport monitors provider satisfaction levels annually to measure how well we meet our network providers' expectations and needs. Our intended use of the survey results includes the following:

- Determine how satisfied practitioners are on all key drivers and opportunities.
- Benchmark performance against other managed care organizations (MCOs) within Kentucky and nationally.
- Identify actionable information to drive improvements.
- Create a culture of high practitioner satisfaction and member quality of care.

Methodology: SPH Analytics (SPH), an NCQA Certified Vendor, administers the Provider Satisfaction Survey to providers participating in Passport's Medicaid Managed Care program. The survey meets NCQA Standard Q14 (Member Experience) and Q15 (Continuity and Coordination of Medical Care) and targets providers to measure their satisfaction with Passport.

SPH follows a one-wave mail and internet with phone follow-up survey methodology to administer the Provider Satisfaction Survey the fourth quarter of each year on behalf of Passport.

Attributes represent individual questions that relate to specific characteristics of the health plan groups for each composite area. Each composite area generates a summary rate that represents the percentage of respondents who chose the most favorable response option(s).

SPH compares Passport's scoring to the SPH Aggregate Book of Business benchmarks, which contains aggregate data from other plans' respondents in primary care, specialty and BH areas of medicine in the survey year.

Success: 2019 was an outstanding year for provider satisfaction. Satisfied providers are an overall indicator of MCO performance. Meaningful provider engagement and a culture of continuous improvement fulfill a common goal of improving the lives of members we serve. Our top attribute improvements are shown in **Exhibit C.17-4**. Our key strengths, as reflected in the 2019 results of the satisfaction survey, include:

- Eighty-one percent (81%) of providers would recommend Passport to other physician practices.
- Providers are consistently "completely satisfied" or "somewhat satisfied" with Passport, as reflected by an exceptionally high loyalty score; averaging 70% + over the past three (3) years.
- Year over year, Passport receives outstanding feedback from providers regarding our dedicated Kentucky-based call center staff.
- Engrained in our culture, multi-channel interactions with providers are a priority, resulting in a significantly high score compared to the SPH Medicaid and Aggregate Book of Business Benchmarks.
- Annual survey results are critical insights that serve as indicators of our network provider pulse. Survey results are used to establish enterprise-wide coordination for actionable improvements to maintain and build stronger provider relationships.

Exhibit C.17-4: Top Attribute Improvements

Composite Area	Attribute	Score Increase
Provider Relations	Have you had contract with the PRR assigned to your practice?	+7.3%
Claims	Resolution of claims payments or disputes	+6.3%
Call Center	Overall satisfaction with health plan's call center	+6.0%

Passport uses additional methods to evaluate provider satisfaction and provide opportunities for provider feedback including:

Monthly Provider Call Center Report

- Passport's Provider Services Call Center produces a monthly report that captures call reasons and high-call providers. Our PRRs use this information to identify opportunities for provider education, process improvements or needed provider outreach.

Passport's Provider Portal

- We evaluate our Provider Portal on an annual basis using SurveyMonkey capabilities to assess the providers' online experience. The information garnered informs Passport regarding current and future portal-user enhancements and improved functionality.

Provider Payment Inquiries

- Passport's interdepartmental tracking tool, Provider Payment Inquiries (PPI), is utilized to document, research and resolve provider inquires and global issues (issues that impact more than one provider). Any Passport associate who interacts with our providers through our many engagement channels, such as on-site visits, phone calls or e-mails, logs issues in the PPI. The PPI reports are reviewed and triaged within three (3) business days by Passport's Root Cause Team to the appropriate functional area to investigate and resolve. Progress and details are documented until the issues have been fully resolved.

Providers are Loyal to Passport

In 2019, Passport realized very low provider attrition, with a **ninety-six percent (96%) Provider Retention rate**.

This is evidence of our passion and commitment to maintaining strong relationships with our network providers and with the communities we serve.

Provider Grievances and Complaints

- In addition to the methods detailed further in the Provider Grievances and Appeals section of this response, Passport participates in monthly meetings with the Kentucky Hospital Association (KHA) to discuss Passport membership, health plan and industry updates, and issues that the hospitals may be experiencing. The issues are documented, tracked and discussed in the regular cadence of the KHA meetings until resolved.

Frequency of Methods and Metrics

Our frequency of methods and metrics for collecting provider feedback are shown in **Exhibit C.17-5**.

Exhibit C.17-5: Frequency of Methods and Metrics

Method	Frequency
Formal satisfaction survey	Annually
Call Center report	Monthly
Provider Portal surveys	Annually
PPI tracking	Daily
KHA Grievances and Complaints	Monthly

C.17.a.iv. Methods the Vendor will use to minimize provider complaints and escalations to the Department.

Methods Used to Reduce Provider Complaints and Department Escalations

We regularly solicit provider input and feedback from the PCP Workgroup, BHAC and other sources to collaboratively develop policies and procedures that are mutually effective and efficient. Our PRRs regularly

participate in recurring meetings with large provider groups and KHA meetings. These standing sessions with providers open a clear channel to submit questions and concerns as well as get the status of priority working items. Working in partnership with providers also helps enhance provider satisfaction, minimize provider abrasion and mitigate complaints and escalations to DMS.

Passport Medical Director Support and Consultation

Dr. Stephen Houghland, Passport's CMO, and other Medical Directors have established provider relationships, attend various meetings with them, offer direct contact through e-mails and calls, and are exceptionally available to the network for all questions and concerns.

Provider Relations Engagement

Our network providers have access to key local Passport associates at varying levels within our health plan for day-to-day support, as well as assistance when issues arise. On-site visits and provider meetings are scheduled for days and times that are most convenient for the providers. Our cross-functional teams often coordinate to schedule a combined meeting with the provider and will make introductions to other Passport associates to offer provider support, such as our PHMs.

Cross-functional Passport Teams

We are dedicated to timely issue resolution and use specific workflows to support intake and resolution and engage multidisciplinary teams. The PRRs work closely with operational teams including, but not limited to, reimbursement, community engagement, regulatory affairs, program integrity, compliance, marketing, claims, provider data, credentialing, UM, contracting and call center staff to understand drivers, impacts, status and resolution plans.

"As practicing physicians with over 55,000 active patients in the Louisville Kentucky market, it has been a privilege to work with the dedicated physicians, advocates, and staff that have made Passport successful over the last two decades.

Our impression throughout the years of caring for Passport members, has been that Passport remains highly committed to the partnership to improve health outcomes for the Kentucky Medicaid population as demonstrated in our Quality Care conferences at each of our seven practices. This, as well as the ancillary services the Plan provides substantiates the consistent high satisfaction level awarded to them by their members."

- One Pediatrics Board of Directors

Participation in Forums Where the Provider Voice is Heard

Passport's operational and provider network teams regularly attend forums such as the KHA monthly meeting, more than ten (10) Technical Advisory Committee meetings, and stakeholder forums such as the Kentucky Mental Health Coalition and Pediatric Behavioral Health Alliance of Kentucky for a broad view of provider needs and concerns.

C.17.b. Describe the Vendor's proposed Provider Services call center, including an overview of the following at a minimum:

Provider Services Call Center

Passport has more than twenty (20) years of combined experience offering PCC support to Medicaid providers. Our PCC assists providers on over four hundred (400) calls per day.

C.17.b.i. Approach to assuring the call center is fully staffed during required timeframes.

The Passport PCC is a toll-free provider call center that meets standards as determined by the Department. The PCC is available, at a minimum, from 8:00 a.m.-6:00 a.m. Eastern Time, Monday through Friday, including federal holidays.

Our BH provider crisis line that is triaged by a Member Services Representative is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, to triage provider requests and handle inquiries about eligibility and treatment/UM planning.

During non-business hours, a caller has the option to leave a voice mail message for a return call within one (1) business day, or the caller may follow interactive voice response (IVR)-prompted functionality that relays a message that the caller should contact 911 in cases of emergency or crisis. Callers may request to be routed to an on-call manager within a department, or check member eligibility through the IVR.

Both during and after business hours, providers are also given the option to use our comprehensive Passport website or the Provider Portal. The website includes the Provider Manual, provider communications and forms information, to name just a few of the available resources. The secure Provider Portal allows providers to verify eligibility, view PCP assignments or claim status, or submit appeals or grievances. Appeals and grievances, along with supporting documentation, are encrypted following federal and state laws.

All messages are returned within one (1) business day.

Passport has policies and procedures for PCC operations that address staffing requirements and ratios, orientation and education of call center staff, hours of operation, performance standards and methods we use to monitor calls and comply with standards. PCC staff use scripts for common questions to provide consistent responses to provider inquiries.

We track and report call management metrics in our Cisco Finesse system. Passport ensures that our PCC meets or exceeds department metrics. In the fourth quarter of 2019:

- Our call abandonment rate was less than 1.5%.

- Ninety percent (90%) of calls were answered by a live voice within thirty (30) seconds, with the remaining 10 percent (10%) answered by a representative within an additional thirty (30) seconds.
- Our blocked call rate, or rate of calls that were not allowed into the system, did not exceed one percent (1%).

In addition, Passport will ensure it provides:

- An accurate response rate to call center phone inquiries by call center representatives of ninety percent (90%) or higher.
- One hundred percent (100%) of call center open inquiries resolved within seventy-two (72) hours.

Passport also maintains that all targets are hit or exceeded for our BH and pharmacy provider lines.

Ensuring Full Staffing During Required Timeframes

Passport ensures we are fully staffed and available to support our providers. Our call center staffing formula uses call volume, call handle times and goals. This allows us the number of staff necessary to focus on first-call resolution and take the time necessary on each call, rather than using a staff to membership ratio, which results in staff being required to handle a minimum number of calls daily.

Passport's call center includes representatives who are cross-trained; for example, member service representatives who can back up the provider service team if available and as needed. Support staff, such as team supervisors, also jump in as needed to ensure calls are handled in a timely manner. Using our dashboard with real-time statistics, we adjust staffing throughout the day to keep wait times to a minimum.

Promoting Quality vs Quantity

Most call centers demand a minimum number of calls be taken by each representative, but our focus is on quality and **first-call resolution with 99.2 % of calls resolved immediately.** For those calls that require additional research, a return call to the provider is always completed to ensure it is resolved to the provider's satisfaction. Supervisors holds daily stand-up meetings with staff that allow staff to collaborate on any trends they may be hearing and quickly act for solutions.

Passport's PCC team uses its Cisco Finesse system reporting for workload-balancing assessments and analyzing call volumes and call patterns throughout the day. Using these processes, the manager of provider service analyzes recommendations for the best allocation of staff based on call trends, anticipated call volumes and the available trained staff.

C.17.b.ii. Location of proposed operations.

Call Center Location

For over two decades, Passport has had one (1) centralized call center based in Louisville. Both our Member and Provider Services call centers operate at this location. Our address is as follows:
5100 Commerce Crossings Dr., Louisville, KY 40229

C.17.b.iii. How the Vendor will meet and monitor call center standards, and how the Vendor will use monitoring results to adjust operations, as needed.

Monitoring and Meeting Call Center Standards

In the fourth quarter of 2019, our call center answered ninety percent (90%) of all calls in less than thirty (30) seconds. Our average speed of answer was thirteen (13) seconds.

Providers reach a live person in these time frames. Cisco Finesse manages our member/provider call centers where incoming calls are routed through an automatic call distributor (ACD) to the first available Provider Services representative and call documentation is logged in Identifi Health Plan Administration (HPA) for tracking/reporting. To expedite routine eligibility-verification calls, we use IVR technology, so providers can verify eligibility by entering the member's identification or social security number when prompted. Once the member's ID is entered, the IVR system provides the member's status as either eligible or not eligible for benefits as well as the member's PCP.

Quality auditors provide scores and feedback on a weekly basis. This information is used by our supervisors to provide one-on-one feedback and education, as well as our training team to identify trends across the team and develop refresher trainings. Refreshers are held quarterly at a minimum and include review of all provider-relations policies, procedures and the general scope of service that must be met. Supervisors perform side-by-sides with staff on a weekly basis to provide immediate feedback and answer any questions staff may have. Our management team frequently listens to live calls and provides feedback to the supervisors and trainers for additional opportunity for improvement.

The PCC supervisor holds stand-up meetings with staff, which allow staff to collaborate on any trends they may be hearing and quickly act for solutions.

Using Monitoring Results to Adjust Operations

When we identify issues through Passport's many channels for provider feedback, we evaluate them and bring them to the appropriate committee, such as our PCP Workgroup or JOC, for problem solving and action planning. As action plans are developed, they are codified into education tools and resources such as the Provider Manual, the Provider Portal and website, and Passport's eNews. We also develop training and job aids to ensure appropriate provider education to address identified updates, issues or new information. This messaging is then incorporated into Passport's ongoing training and education curriculum, and reviewed and updated as appropriate to ensure our providers continually have the knowledge and information needed to best care for our members in the most effective and efficient manner.

Successful Live Call Monitoring

As a result of management listening to live calls, we saw an opportunity to improve our services by offering an extension specifically for claim appeal questions. Providers can now call and speak directly with a claims appeal coordinator or leave a message and receive a return call next business day.

For example, Passport's cross-functional team, including Provider Relations, Clinical, Quality and Population Health Management, to name a few, collectively participate in JOC meetings with providers. During these meetings, Passport and the provider have productive discussions to understand concerns, issues and opportunities for improvements. The Passport representatives listen intently and capture each item discussed in a JOC Provider Interaction Log. The log captures the details of each item discussed, big and small. Passport's cross-functional teams collaborate to assess and formulate a plan to address each item. Progress is logged and updates are discussed with providers. While the issues identified are predominantly remediated in a timely fashion by Passport's cross-functional teams, they are also escalated within Passport's governance structure, up to and including the Board of Directors or the Partnership Council, as needed for full resolution.

C.17.c. Provide an overview of the Vendor's proposed provider website, including examples of information that will be provided through the website and any functionality that will be included to communicate with providers. Provide sample screenshots of provider websites currently maintained by the Vendor.

Passport maintains a **website** available to all providers regardless of their network participation status.

Information Provided

On the providers tab of our website at www.passporthealthplan.com, providers will find links to:

- Contact information
- Important forms
- Claims information
- Searchable Provider Manual and Provider Directory
- Prior authorization requirements, Pharmacy Preferred Drug List (PDL), pharmacy conditions for coverage and utilization limits
- Orientation and training materials
- Current and previously released eNews
- Member rights and responsibilities
- Passport Provider Portal
- Care coordination programs
- Quality improvement/Healthcare Effectiveness Data and Information Set (HEDIS)
- New and pertinent information including, but not limited to, information regarding KHIE
- Other websites, including those of the Department and NCQA.

Participating network providers also have access to the **Passport Provider Portal** via a secure log-in. Providers may register for access at any time, and it is open to all office staff. Within the Provider Portal, providers are able to access eNews, the Provider Manual, important forms, the Provider Directory and important links to Kentucky HealthNet, dental and vision subcontractors, and more, as well as receive real-

time messages regarding important updates or initiatives via the homepage. Providers can also perform various functions within the Provider Portal such as:

- Member eligibility and PCP assignment search.
- Claims detail, along with the ability for providers to file and review status of grievances and appeals.
- Access paid claims listings and other important documents via the document list feature.
- View their current and historic panel rosters.

Provider Communication Functionality

Passport has a thorough process for reviewing content and functionality prior to releasing to the provider via the website or the portal. We use Compliance 360 (C360) for internal content reviews, ensuring approval from all applicable parties prior to sending to DMS for final communication approval. Prior to the rough draft, our communications manager works with informing departments to research and understand all provider-related information that is timely and relevant, and basic, easy-to-understand facts are presented in one (1) page. The content produced is an average of one or two (1-2) notifications weekly. Reviewers are selected based on their expertise and information is then released with an e-mail notification for each to edit and/or approve. Once internal consensus is reached, the communications manager monitors the submission and feedback from DMS, before releasing to the provider network. We use *e*News to target specific provider types, based on their preferences when they initially sign up. In other words, information applicable only to PCPs would not be sent to hospitals. Providers have access to current and previously submitted eNews via the Passport website and the Provider Portal. Passport also uses the *Plan Messages* section of the Provider Portal homepage to relay any important messaging to providers in real time. These messages can include policy changes, billing and reimbursement updates, upcoming events (workshops, webinar, educational opportunities) or information regarding Passport's initiatives (e.g., smoking cessation). **Exhibits C.17-6 and C.17-7** illustrate our provider public web page and Provider Portal page, respectively. Please see **Attachment C.17-1_Provider Web Screenshots** for additional screen shots.

Exhibit C.17-6: Current Provider Website Screenshot

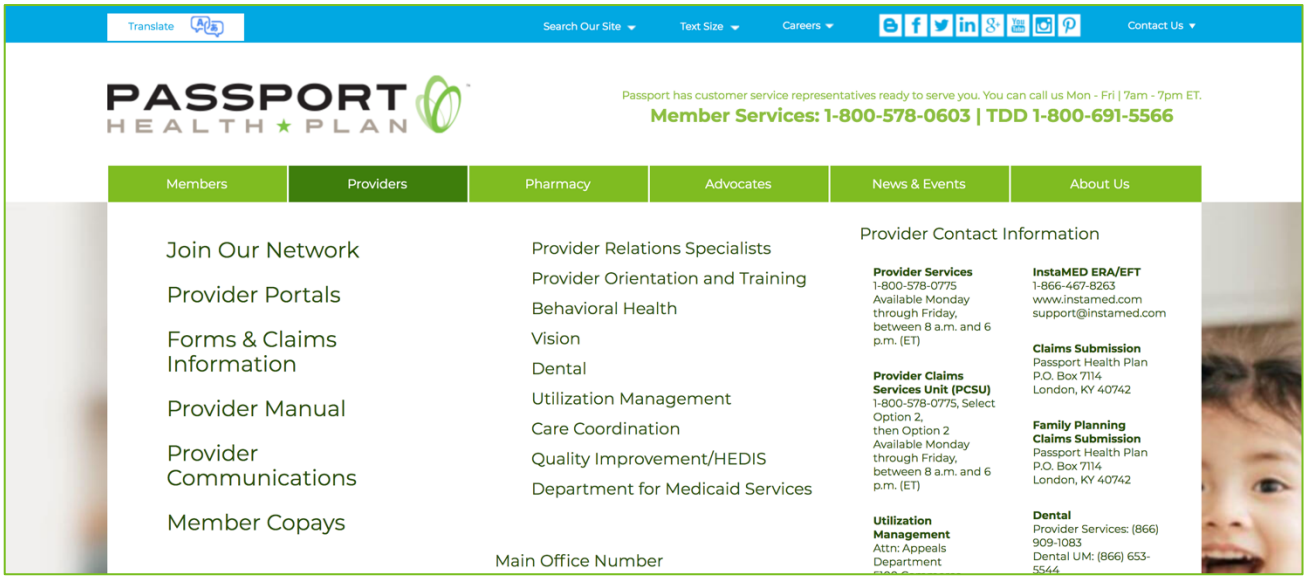
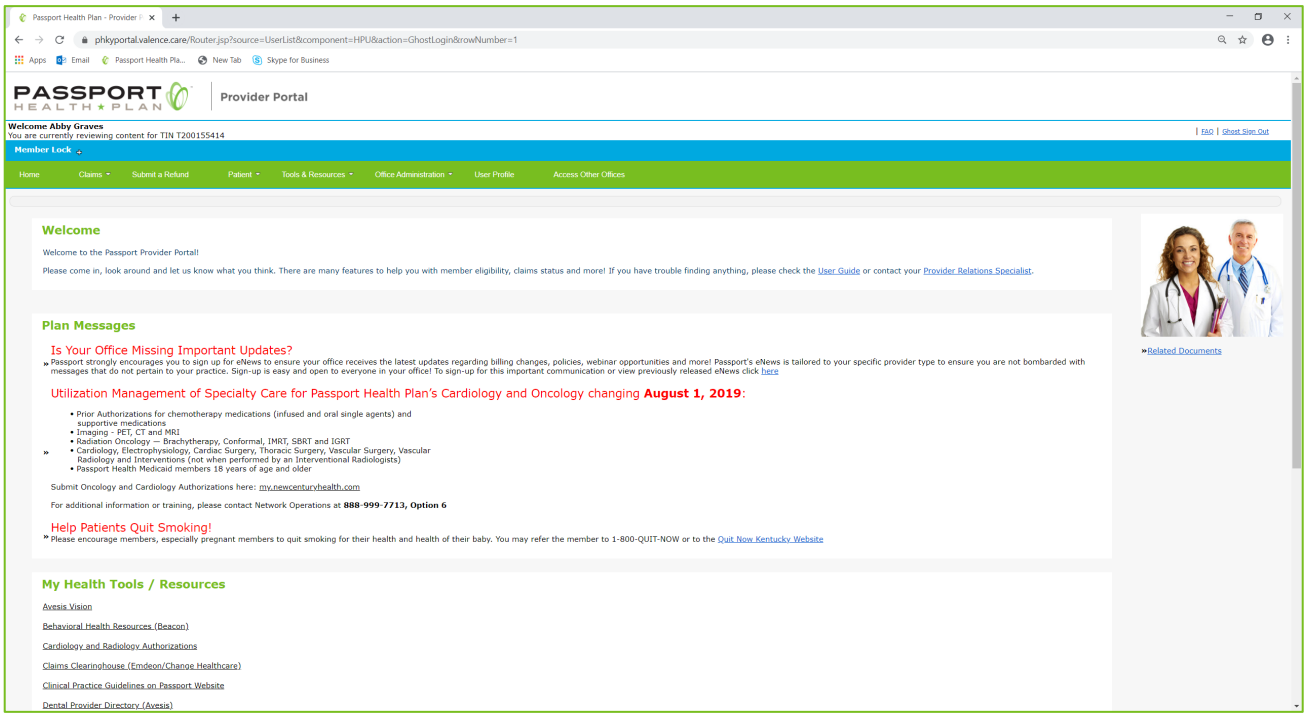


Exhibit C.17-7: Current Provider Portal Screenshot



C.17.d. Provide a proposed table of contents for the Provider Manual and a brief description of the type of information the Vendor will communicate via the manual.

A copy of Passport's Provider Manual is included as **Attachment C.17-2_Passport Provider Manual**.

Provider Manual

Passport prepares and issues a Provider Manual, including any necessary specialty manuals (such as BH, pharmacy, dental and vision) to all network providers. For newly contracted providers, we provide online access to the Provider Manual and any changes or updates to it within five (5) business days from being placed on active status. We make hard copy manuals available to providers upon request.

Passport will submit our Provider Manual and any subcontractor manuals to DMS prior to publication and distribution to providers.

Provider Information

Our Provider Manual has invaluable information about our policies and procedures and DMS requirements to providers upon joining our network. Statutes, regulations, and state and federal requirements are referenced throughout the Provider Manual. As shown in **Exhibit C.17-8**, our Provider Manual meets all DMS information requirements.

Exhibit C.17-8: Passport Meets DMS Provider Manual Information Requirements

DMS Requirements	Passport Health Plan Complies at this Location
Provider rights and responsibilities	Provider Manual Sections 1, 2, 3, 4 ,19
Covered services	Provider Manual Sections 1, 4, 6, 7, 8
Enrollee rights and responsibilities and cost-sharing requirements	Provider Manual Sections 2, 12
Information for PCPs about Advance Medical Directives and their responsibilities for informing Enrollees;	Provider Manual Sections 3, 19
Contractor's policies and procedures	Provider Manual Section 2
Information for accessing the Contractor and program materials through the Contractor's call center(s), toll-free hotlines and website	www.passporthealthplan.com/providers
Provider credentialing and recredentialing	Provider Manual Sections 2, 18, 19
Provider and Enrollee Grievances and Appeals process	Provider Manual Sections 2, 16
Claims submission process and requirements	Provider Manual Sections 8, 15, 18
Provider Program Integrity requirements and reporting suspected Fraud and Abuse;	Provider Manual Sections 1, 2, 3, 9, 10, 15, 19
Utilization Management and Prior Authorization procedures	Provider Manual Sections 1, 5
Medicaid federal and state laws and regulations	Provider Manual Sections 2, 3, 6, 7, 15, 19
Overview of the QAPI program	Provider Manual Sections 9, 16, 18
Overview of value-based payment (VBP) models, when implemented	Provider Manual Sections 3, 9

We update the Provider Manual as changes occur and notify providers at least thirty (30) days prior to implementing changes. The Provider Manual is available online, and it can be distributed in hardcopy upon request. We review the Provider Manual with each provider during orientation, during annual provider workshops, in smaller venue roundtables/trainings, and during routine calls.

Table of Contents

Our Provider Manual contains twenty (20) chapters of information, which are listed in **Exhibit C.17-9.**

Exhibit C.17-9: Passport Health Plan Provider Manual Table of Contents

Passport Provider Manual Chapter Listing
• Section 1: Introduction • Section 2: Administrative Services • Section 3: Provider Roles and Responsibilities • Section 4: Office Standards • Section 5: Utilization Management • Section 6: Referrals • Section 7: Benefits Summary and Exclusions • Section 8: Early and Periodic Screening Diagnosis and Treatment (EPSDT) • Section 9: Quality Improvement • Section 10: Emergency Care/Urgent Care • Section 11: Special Programs • Section 12: Outpatient Pharmacy Services • Section 13: Obstetrical • Section 14: Family Planning • Section 15: Provider Billing Manual • Section 16: Behavioral Health • Section 17: Forms • Section 18: Dental Network • Section 19: Vision • Section 20: Acronyms

C.17.e. Provide the Vendor's proposed approach to provider orientation and education.

Our Approach to Provider Orientation and Education

We have an established onboarding, training, education and support program for our providers that is managed by our local Kentucky-based PRRs. Our program is designed to ensure that all providers receive the training, tools and support needed to deliver the highest quality of care to our members, while remaining compliant with our DMS contract and applicable federal requirements. Passport will comply with the draft Medicaid Managed Care contract provision to submit Passport's provider and orientation plan, including methods, topics and dates for completion of activities to DMS. **Exhibit C.17-10** details the location for providers to find information related to DMS requirements.

Exhibit C.17-10: Passport Meets DMS Orientation and Education Requirements

DMS Requirement	Passport Location
Passport coverage requirements for Medicaid services, prior authorization requirements, EPSDT preventive health screening services, and EPSDT special services	Provider Orientation Kit Provider Manual Sections 5, 8
Passport policies and procedures, administrative clinical practices and updated information when modifications to existing services occur	Provider Orientation Kit Provider Manual Sections 1-4
Medicaid policies and procedures, including state and federal mandates and any new policies and procedures	Provider Manual Section 1 KHIE in Provider Orientation Kit
How to report suspected fraud and abuse, and annually addressing fraud, waste and abuse with providers	Provider Orientation Kit Provider Manual Sections 1-3, 12, 18, 19
Medicaid populations and eligibility	Provider Orientation Kit Provider Manual Sections 1, 2
Standards for preventive health services	Provider Orientation Kit Provider Manual Sections 2, 4, 8, 12, 15, 18
Telehealth services	*To be added by Q3 2020 (Teladoc implementation)*
Special needs of Enrollees in general that affect access to and delivery of services	*Passport* eNews Provider Manual Sections 4, 11, 16, 18
Advance medical directives	Provider Orientation Kit Provider Manual Section 3
Claims submission and payment requirements	Provider Orientation Kit Provider Manual Sections 8, 15, 18, 19
VBP (if implemented)	Included for VBP-participating providers
Special health/care management programs in which Enrollees may enroll	Provider Orientation Kit Provider Manual Section 11
Provider role in population health management program	Provider Orientation Kit Provider Manual Section 4, 11
Cultural sensitivity	Provider Orientation Kit Provider Manual Sections 2, 16
Responding to needs of Enrollees with SUD or behavioral health, developmental, intellectual and physical disabilities	Provider Orientation Kit
Integrated health care, addressing SDoH and population health management initiatives	Provider Manual Section 16
Reporting of communicable disease	Provider Manual Sections 4, 5
Passport's QAPI program, the EQRO, and the provider's role in impacting quality and health care outcomes, including ongoing education about QAPI program findings and interpretation of data when deemed necessary by Passport or the Department	Provider Manual Sections 3, 9
Medical records review	Provider Manual Section 4

Passport will develop and submit its provider orientation and education plan—which includes orientation and education methods, topics and dates for completion of activities, as well as educational workshops or other types of training sessions—to the Department within sixty (60) days of contract execution, when material changes are made, and annually.

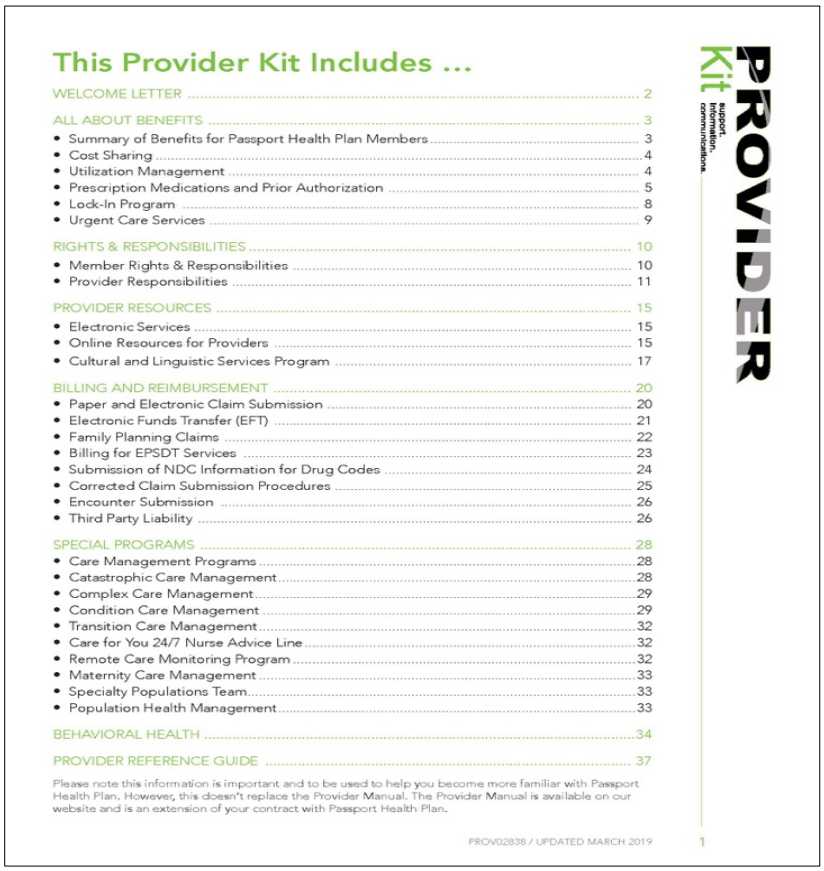
Orientation

Our onsite provider education and training program educates and informs new and existing providers on topics relevant to them within thirty (30) days of their credentialing date. This can include information that may be new to providers, as well updates and changes to existing information. We actively seek input and feedback from our providers to help inform the subjects of the content of our training and education via program surveys. We provide the topics of the education and training through formal training methodologies, as well as with one-on-one support from cross-functional areas within Passport.

Passport recognizes that engaging and communicating with network providers within the first thirty (30) calendar days of active status with our plan is not only required by DMS but is also invaluable in the onboarding process to immediately relieve administrative burdens providers may face. Our orientation activities begin with a letter welcoming the provider to Passport's provider network. The personalized welcome letter includes (i) Passport contact information for help with any onboarding questions providers may have, (ii) contact information specifically for BH providers, and (iii) a link to the Passport Provider Manual, which details all of Passport's plan benefits, policies and administrative procedures.

The welcome letter is followed by an introductory phone call or email from a PRR, who coordinates the onsite orientation training. During this initial touch point, the Passport PRR confirms that the provider has been able to successfully access Passport's provider website, Provider Portal and Kentucky HealthNet, all of which are critical in the provider's relationship with Passport and the Department. We make providers aware of the many tools available to them on the provider website, such as the Provider Orientation Kit (see **Exhibit C.17-11**), and how to access them.

Exhibit C.17-11: Provider Orientation Kit



This Provider Kit Includes ...

Please note this information is important and to be used to help you become more familiar with Passport Health Plan. However, this doesn't replace the Provider Manual. The Provider Manual is available on our website and is an extension of your contract with Passport Health Plan.

PROV02838 / UPDATED MARCH 2019 1

PROVIDER Kit
support. information. communications.

Our PRRs follow up with the provider following the orientation session to answer any questions that the provider and their staff may have.

Please find our Provider Orientation Kit in **Attachment C.17-3_Provider Welcome Kit**.

Ongoing Education

Through our cross-functional teams that are out in the community meeting our providers, our PCC staff and Provider Relations staff, and our committees and workshops with which we engage providers, we gather provider feedback and monitor for education and communication opportunities. Issues that are identified through Passport's many channels for provider feedback are evaluated and brought to committee, such as our PCP Workgroup or JOCs for problem-solving and action-planning. We develop training and job aids to ensure appropriate provider education to address identified updates, issues or new information. This messaging will then be incorporated into Passport's ongoing training and education curriculum, and it is reviewed and updated as appropriate to ensure our providers continually have the knowledge and information needed to best care for our members effectively and efficiently.

Passport's ongoing provider education uses the following communication channels:

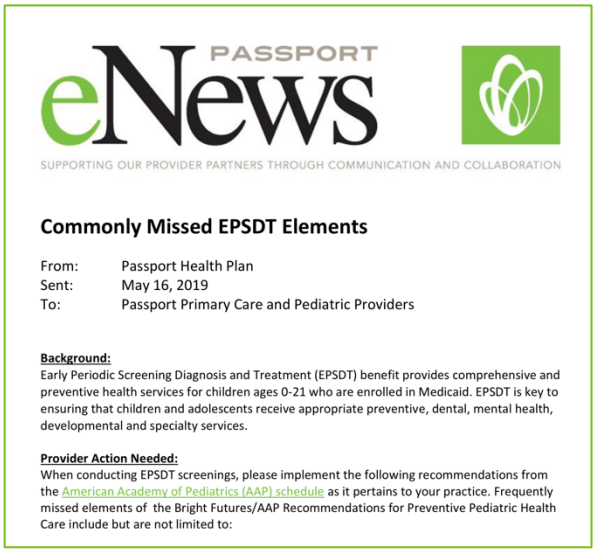
- Provider letters and bulletins
- PDL drug changes and distribution
- Point-of-service (POS) messaging
- Training sessions, webinars, quarterly newsletters and other training activities as requested by the Department
- Billing instructions and claim resolution communication
- Website postings of the PDL
- Prior authorization processes and procedures

As required, these are all provided to pharmacy providers.

Passport maintains enrollment or attendance rosters dated and signed by each attendee or other written or electronic evidence of training for each provider and their staff. We will make evidence of provider training available to DMS upon request.

We regularly conduct outreach to providers with new information and updates to keep our providers informed. Outreach activities include updates through our electronic communication. Passport eNews, represented in **Exhibit C.17-12**, is a key communication method that the Provider Relations team uses to share timely information with participating providers in our network. Timely operational updates, announcements and information are shared with providers in real time via email. The distribution can be tailored to specific provider types for targeted messaging, or sent to all providers with communications that have a broader impact. Passport eNews communications are sent out as needed with a weekly average in 2019 of one (1) or two (2) per week, or approximately eighty-six (86) Passport eNews newsletters in 2019. Certain eNews newsletters that have a higher priority or significant impact may also be sent out through the mail.

Exhibit C.17-12: *Passport eNews*



PASSPORT eNews

SUPPORTING OUR PROVIDER PARTNERS THROUGH COMMUNICATION AND COLLABORATION

Commonly Missed EPSDT Elements

From: Passport Health Plan
Sent: May 16, 2019
To: Passport Primary Care and Pediatric Providers

Background:
Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit provides comprehensive and preventive health services for children ages 0-21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services.

Provider Action Needed:
When conducting EPSDT screenings, please implement the following recommendations from the American Academy of Pediatrics (AAP) schedule as it pertains to your practice. Frequently missed elements of the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care include but are not limited to:

Workshops and Webinars

Passport Health Plan offers annual provider workshops and quarterly webinars to educate our provider network on recent or upcoming changes, as well as new initiatives and yearly compliance training. Some recent workshops topics include:

- Intro to Medicaid Quality & Risk Adjustment Programs 2019—CME Eligible
- 2019 Fraud, Waste and Abuse Training
- Risk Adjustment 101 Webinar—CME Eligible
- ED Utilization Presentation
- Medication Assisted Treatment for Opioid Dependency
- Understanding Credentialing and Enrollment
- Understanding Authorizations
- Understanding HEDIS and Quality
- Understanding Women's Health and EPSDT
- Understanding Referrals and Establishing a Medical Home
- Behavioral Health Provider Training: Program Overview and Helpful Information
- Behavioral Health Service Organization (BHSO) Guidelines

C.17.f. Describe the Vendor's support of providers in Medicaid enrollment and credentialing, including the following:

Passport Current Credentialing Process

Our NCQA-certified credentialing approach is a provider-friendly and efficient credentialing/recredentialing process that is in strict compliance with NCQA standards 907 KAR 1:672, KRS 205.560(120) and federal law, and RFP Attachment J in its entirety. We incorporate Centers for Medicare and Medicaid Services (CMS) and EQRO recommendations. Passport also currently delegates credentialing to one provider organization that has passed all NCQA delegation requirements. In the event that a non-Medicaid certified provider contacts our representatives, we will work with them to complete the enrollment and credentialing application for forwarding to the designated CVO or designated organization meeting the requirements of KRS 205.5321)(c)2. Throughout our credentialing process will comply with and take all necessary actions to implement the requirements of 2018 KY Acts Ch. 69 as well, and all other applicable federal and state laws.

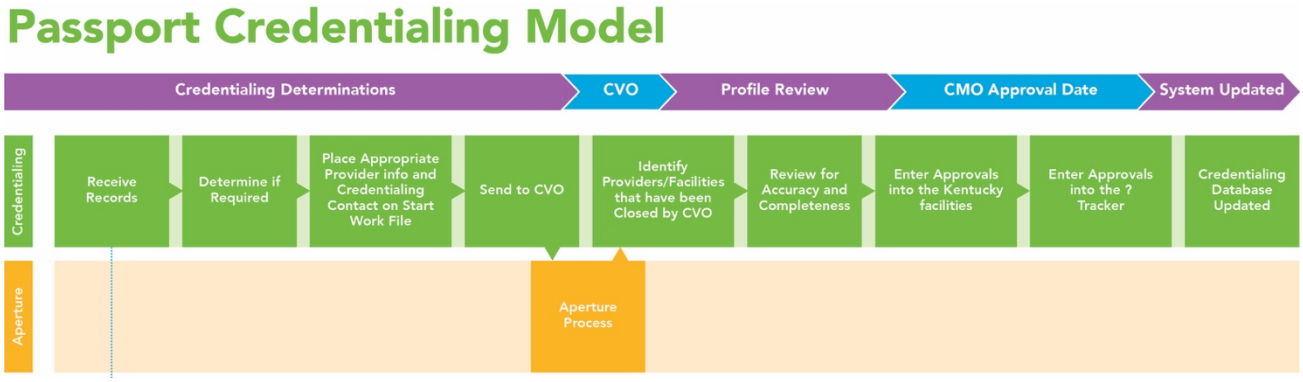
Aperture CVO

Passport uses Aperture for credentialing application review and identification of deficiencies and missing information. Aperture credentials a wide variety of providers and facilities by providing compliance-driven, software and professional service solutions.

Passport completes credentialing or recredentialing of a provider within ninety (90) days of receipt of all required information from the provider, or within forty-five (45) days if the provider is providing SUD services as documented in our established policies and procedures, provided in **Attachment C.17-4_Practitioner Credentialing and Recredentialing**. Our policy describes the credentialing criteria to be verified, the validation source, and a description of the decision-making process to credential provider applicants and to verify the qualifications for recredentialing practitioners and organizational providers. The policy details the consequences if a network provider does not meet the expectations and requirements related to quality and care of services rendered to a Passport member, such as altering the condition of the provider's participation in our network (as necessary), reporting the provider to the appropriate authorities (including DMS), or taking action, up to and including suspension or termination. The policy is reviewed and updated annually and as needed to remain in compliance with the current DMS policies and procedures.

Our credentialing and recredentialing process is illustrated in **Exhibit C.17-13**.

Exhibit C.17-13: Passport Credentialing Model



Our Member Services and Provider Relations teams participate in our credentialing process in support of ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles. Provider Relations and Member Services forward-identified provider sanctions, complaints, and quality issues the director of Provider Network Management (PNM), who investigates prior to forwarding the issue to the Credentialing Committee to take appropriate action.

Provider Application Review

Aperture reviews all credentialing applications in accordance with the most current NCQA standards and guidelines, and they are noted for any deficiencies or missing information. Aperture contacts each applicant, in writing and by phone, for any incomplete or missing information within five (5) business days after receipt. Passport credentialing provides support through additional outreach if Aperture is unable to contact the provider after at least three (3) documented attempts, in writing or by telephone.

Providers can call the Aperture call center to receive real-time status of their application. Aperture can also warm transfer providers to Passport credentialing for additional assistance. Passport credentialing maintains a direct line for this type of inquiry.

Provider Types Requiring Credentialing/Recredentialing

Credentialing of new network providers is performed prior to contracting, and recredentialing is conducted at least every three (3) years. The following provider and facility types must participate in our credentialing process:

- Medical doctors
- Doctors of podiatric medicine
- Doctors of psychology
- Psychiatrists and other physicians
- Doctors of dental science
- Oral surgeons
- Doctors of dental medicine
- Registered dietitians or nutrition professionals

- State certified/licensed doctoral/ master's-level psychologists
- Addiction medicine specialists
- Physician's assistants
- Family nurse practitioners
- Certified nurse midwifes
- Certified registered nurse anesthetists
- Advanced practice registered nurses
- Nationally/state certified/licensed masters-level clinical nurse specialists or psychiatric nurse practitioners
- Medical facilities such as inpatient hospitals, ambulatory surgery centers, home health
- agencies, and skilled nursing facilities
- State certified/licensed doctoral/ master's-level clinical social workers
- Doctors of chiropractic
- Doctors of osteopathic
- Physical therapists
- Occupational therapists
- Qualified speech language pathologists
- Qualified audiologists
- Other BH care specialists who are licensed/certified/registered by the state for independent practice
- BH facilities such as inpatient psychiatric hospitals, inpatient SUD facilities, BHSOs, community mental health centers, psychiatric residential treatment facilities and residential SUD treatment centers

Primary Source Verification

In compliance with DMS Program Integrity Policies and Procedures and NCQA guidelines, we require new applications to include the credentialing artifacts listed in **Exhibit C.17-14**.

Exhibit C.17-14: Validation Sources for Primary Source Verification

Criteria	Validation Source(s)	Credentialing	Recredentialing
Education	Medical or Professional School, American Medical Association (AMA) Physician Masterfile, Educational Commission for Foreign Medical Graduates (ECFMG), American Osteopathic Association (AOA) Physician Profile, or state licensing agency specialty board or registry (if it performs primary source verification [PSV]).	✓	
Training	Confirmation from residency program, AMA Physician Masterfile, AOA or Federation of State Medical Boards for closed residency programs FSMB and Federal Credentials Verification Services (FCVS).	✓	
Professional experience/work history/hospital affiliations	Five (5) years' relevant work history obtained through the application or CV, that includes the beginning and ending month and year for each position of employment experience, unless the practitioner has had continuous employment for five (5) years or more with no gap. Any gaps exceeding six (6) months must be explained in writing. Hospital affiliation as attested to on the application.	✓	✓
Board certification	American Board of Medical Specialties (ABMS) or official ABMS Display Agents, AMA Physician Masterfile, AOA Physician Profile, boards in the United States that are not members of the ABMS or AOA, if the organization documents which specialty boards are accepted and obtains written annual confirmation from the board that it performs PSV of completion of education and training, registry that performs PSV of board status, if the organization obtains annual written confirmation that the registry performs PSV of board certification.	✓	✓
Kentucky and/or Indiana licensure	Letter or printout from state licensing board or certification agency.	✓	✓
Sanctions	Sanctions, restrictions and limitations must cover the most recent five (5) year period for all states in which the provider practiced through the appropriate state agencies, including National Practitioner Data Bank (NPDB), FSMB, State Board of Chiropractic Examiners, Federation of Chiropractic Licensing Board's Chiropractic Information Network—Board Action Databank (CIN-BAD), State Board of Dental Examiners or State Medical Board, State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, state licensure or certification board, or appropriate state agency.	✓	✓
Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS)	DEA or CDS agency, DEA or CDS certificate, documented visual inspection of the DEA or CDS certificate, National Technical Information Service (NTIS) database, AMA Physician Masterfile (DEA only), AOA Physician Profile (DEA only), or state pharmaceutical licensing agency, where applicable.	✓	✓
Malpractice insurance	Proof of current malpractice insurance coverage, including dates and amounts of coverage; a copy of the Certificate of Insurance face sheet and past five (5) years of history of malpractice settlements from the malpractice carrier or the NPDB.	✓	✓

Criteria	Validation Source(s)	Credentialing	Recredentialing
Medicare and Medicaid sanctions or exclusions	Medicare and Medicaid sanction and exclusion status must be verified to note participation/exclusion status through the state Medicaid agency or intermediary, Medicare intermediary, List of Excluded Individuals and Entities (maintained by OIG and available over the internet), Medicare Exclusion Database (MED), Federal Employees Health Benefits Plan (FEHB) published by the Office of Personnel Management, Office of the Inspector General (OIG), AMA Physician Masterfile, FSMB or NPDB.	✓	✓
Health status	Current and signed attestation that addresses reasons for any inability to perform the essential functions of the position, with or without accommodation.	✓	✓
Ability to perform the essential functions of the position, with or without accommodation	Current signed and dated attestation.	✓	✓
Lack of present illegal drug use	Current signed and dated attestation.	✓	✓
History of loss of license and felony convictions	Current signed and dated attestation.	✓	✓
History of loss or limitation of privileges or disciplinary actions	Current signed and dated attestation.	✓	✓
Current malpractice coverage	Current signed and dated attestation.	✓	✓
Current and signed attestation confirming the correctness and completeness of the application	Current signed and dated attestation.	✓	✓
Accreditation/certification	Nationally recognized accrediting body, such as The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP), or DNV GL Healthcare (DNV) for Hospitals; Home Health Agencies, Skilled Nursing Facilities and Ambulatory Surgical Centers; Accreditation Association for Ambulatory Health Care (AAAHC) or American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) for Ambulatory Surgical Centers; AOA for Hospitals and Ambulatory Surgical Centers; Council on Accreditation for Children and Family Services (COA) for Child and Family Services Hospitals; or Accreditation Commission for Health Care Inc. (ACHC).	✓	✓
Transfer policy	Copy of documented procedure for transferring patients with complications or conditions arising as a result of treatment that would constitute the need for additional medical or surgical care.	✓	✓
Monitoring and improving patient safety	Copy of the mechanism used to monitor and improve patient safety within their organization.	✓	✓

Credentialing Decisions

The credentialing team forwards all clean application files to the Credentialing Committee. Passport's Credentialing Committee, which reports directly to the QIC, is comprised of participating network providers of varying specialties who meet monthly. The Credentialing Committee, with its provider representation, is tasked with objectively reviewing and discussing de-identified summary reports to determine whether the applicant meets the criteria for network participation. Committee members cannot vote for network acceptance or denial based on race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or type of patients. Clean claims submitted during the credentialing process will not require resubmission once credentialing has been completed.

Passport's CMO, designated Medical Director, or the Credentialing Committee makes the final determination regarding the provider's participation in our provider network.

The Credentialing Team notifies providers of Credentialing Committee decisions within ten (10) calendar days of their decision to ensure that no provider's application exceeds one hundred and eighty (180) days from application to becoming a participating provider. If a provider is denied participation, the letter will give the committee's reason for the denial as well as instruction for appeal. Providers accepted into the network are not currently reimbursed (and will not be in the future) for services rendered until they provide their Kentucky Medicaid identification number along with begin and end dates, as assigned by DMS. Passport will fully comply with the new requirements set forth in HB 69 and HB 110, as implemented by DMS.

C.17.f.iii. Proposed process for transitioning credentialing activities to and coordinating with the Department's contracted CVO(s) to educate and assist Providers in completing the credentialing process with the CVO(s).

Proposed CVO Transition Process

Passport will fully support the transitioning of credentialing activities to the CVO when contracted by DMS. We suggest a collaborative relationship between the CVO, Passport and the other MCOs be established for a common process that includes coordinated efforts with the CVO's implementation plan.

Coordinating with the CVO

Passport will work with any identified CVO designated by the Department and will have a documented process that addresses the following at a minimum:

- Refer providers to the CVO to complete credentialing prior to contracting and provide information to network providers about the recredentialing process.
- Detail methods for receiving verified credentialing packets from the CVO.
- Render contracting decisions within thirty (30) days of receipt of the verified credentialing packet from the CVO.
- Enroll and assign active status to accepted providers within ten (10) days of an executed contract.

- Notify the provider if additional time beyond the required ten (10) days is needed to load and configure the provider contract. Configuration of any new provider contract will not exceed an additional fifteen (15) days.
- Work with the CVO as needed for documentation re-evaluation if necessary to maintain participation status.
- Meet with the Department or the CVO about the credentialing process monthly during implementation activities, quarterly during ongoing operations, or at a different frequency as requested by the Department, Contractor or CVO.

Passport will accept provider credentialing and verified information from the Department or the Department's contracted CVO. We will not request that a provider submit additional credentialing information without the Department's written prior approval.

A university hospital, as defined in KRS 205.639, may perform the activities of a CVO for its employed physicians, residents and mid-level practitioners where such activities are delineated in the hospital's Passport participating provider contract. The provisions of KRS 205.532 (3), (4), (5) and (6) with regard to payment and timely action on a credentialing application apply to a credentialing application that has been verified through a university hospital. Passport will work with any providers who are interested in becoming delegated for credentialing.

Educating and Assisting Providers with CVO Credentialing

To prepare Passport providers for the CVO process, Passport will implement key touch points to help new and existing network providers navigate credentialing or recredentialing and enrollment activities. Touch points may include, but are not limited to:

- Provider outreach via mailed letter or email communicating what providers may expect as part of the transition to the new CVO
- Proactively documenting and distributing the new end-to-end credentialing process, from interest in joining Passport's provider network through credentialing approval and achieving status as an active network provider
- Development and distribution of frequently asked questions (FAQ) to providers, key Passport provider support teams, and other cross-functional Passport teams
- Enhanced PCC training to promptly address provider questions or concerns, with appropriate escalation paths in place to mitigate provider abrasion

C.17.f.iv. Approach for a timely contracting determination of providers upon receipt of information from a CVO that a provider's credentialing is complete, specifying timeframe for uploading a credentialed and contracted provider into the claims payment system to allow for payment of adjudicated claims. Include copies of the Vendor's proposed credentialing policies and procedures, and procedures for coordination with the CVO(s).

Time Frame for System Configuration and Timely Claims Payment

Passport currently uses a CVO, Aperture Credentialing Inc., for collection of new provider applications and credentialing/recredentialing of nondelegated providers and facilities. We will leverage our proven process with Aperture for a timely contracting determination of providers upon confirmation from the DMS-designated CVO that a provider's credentialing is complete. As documented in **Attachment C.17-9_Aperture Credentialing LLC Primary Source and Provider Credentialing**, DMS requires uploading of a credentialed and contracted provider into Passport's claims systems within ten (10) days but averages only seven (7) days.

Passport Timely Contracting Determination

Credentialed and contracted provider into Passport's claims systems is completed within an average of **seven days**.

Identifi System Configuration and Provider Onboarding

The Passport network development team issues an email notification to the provider enrollment team when executing a contract for a new provider in the Passport provider network, which includes a contract cover sheet and the provider enrollment forms. This email notification triggers the turnaround time calculation for claims adjudication system loading. The provider enrollment team enters the enrollment applications into the Identifi Tracking System, which uses an Access database with a SharePoint user interface (UI). Each phase of the process—including confirmation of receipt of an application, application is being worked and enrollment has been successfully completed—is documented. The UI triggers a nightly automated data validation process to ensure the quality of data standards prior to loading of the provider to the claims adjudication system. If all data validations are met, provider data is moved to the core claims adjudication claims system. The provider enrollment turnaround time for this process is no more than ten (10) business days after receipt.

Provider data that errors out of the automated data validation standards appears on a daily error report, which identifies the reason code for exception. The provider enrollment team updates the UI so that the data validation process reattempt occurs the next evening. If the issue is so complex that the team will not be able to resolve it within our SLA of ten (10) business days, the provider enrollment team proactively communicates with the provider via email to notify the provider of the need for an extension. All provider data exceptions and system configuration will be complete as soon as possible, but no later than fifteen (15) business days after notification to the provider.

Upon completion of the provider enrollment process, a personalized welcome letter is sent to the provider within seven (7) business days, which serves as formal notification of the provider being active in the

Passport provider network. The welcome letter includes the provider's effective date(s) in the Passport provider network by service location under their employer group.

Credentialing Policies and Procedures

Our established policies and procedures are provided in the following attachments:

- **Attachment C. 17-4_ Practitioner Credentialing and Recredentialing**
- **Attachment C. 17-5_Practitioner Credentialing Rights**
- **Attachment C. 17-6_Organizational Provider Credentialing and Recredentialing**
- **Attachment C. 17-7_Ongoing Monitoring of Sanctions, Complaints and Quality Issues**
- **Attachment C. 17-8_ Practitioner Sanctioning and Reporting**
- **Attachment C. 17-9_Aperture Credentialing LLC Primary Source Verification and Provider Credentialing**
- **Attachment C. 17-10_Responsibilities of Chief Medical Officer, Designated Medical Director, and Credentialing Committee**

Procedures for CVO Coordination

Our policies and procedures for CVO coordination are provided in **Attachment C.17-9_Aperture Credentialing LLC Primary Source Verification and Provider Credentialing**.

C.17.g. Provide the Vendor's proposed approach for processing provider grievances and appeals. Include at a minimum:

Our Approach to Processing Provider Grievances and Appeals

Passport deploys a provider grievance and appeals process, distinct from that offered to members. We use policies and procedures and an operational process and system for identifying, tracking and analyzing provider grievances and appeals, in compliance with all State and federal requirements. Passport will submit a Provider Grievances and Appeals Policy and Procedures document to the Department for review ninety (90) after contract execution. Changes to policy and procedures will be submitted to the Department for review prior to implementing any change. Our grievance process includes use of a standard, Department-provided Provider Grievance Form in order to initiate the grievance process. Providers may submit the form in an encrypted format, which complies with Federal and State law.

C.17.g.i. The overall process to include description of interaction with providers, required correspondence and timeframes for acknowledging and resolving grievances and appeals.

Passport's Provider Grievance and Appeal 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

Acknowledgment of the receipt of an appeal or grievance occurs by the next business day. A provider may also have the right to file an appeal on the member's behalf. This would fall under the member appeal process. Our data gathering includes:

- Date filed
- Type of issue
- Identification and contact of the individual filing the grievance or appeal
- Identification of the individual recording the grievance or appeal
- Disposition of the grievance or appeal
- Corrective action required
- Date resolved

Provider Grievance and Appeals Committee

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. Providers may request an expedited resolution or support a member's appeal with the understanding that there will be no punitive actions as a result of this action path. We will refer all inquiries outside of Passport's scope to the Department.

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. All correspondence with the provider concerning the appeal will be directed to the designee filing the appeal. 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 our internal decision. Upon receiving a denial from the third-party review, the provider has the right to appeal a final decision to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulation. If the provider prevails, in whole or in part, then Passport will comply with any final order within sixty (60) days unless the final order designates a different time frame.

A provider has the right to file a grievance, including complaint or dispute to Passport, which 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.

Interaction with Providers

Passport offers providers the opportunity to contact our Provider Services Call Center to check the status of or discuss their claims appeal. Passport established a separate phone queue managed by a claims appeal coordinator to help make it easier for providers to obtain answers to their questions and understand their appeals. These interactions are completed either at the time of the call or by next business day if additional time is needed by the claims appeal coordinator to review the request. A voice-mail is available for providers to leave a message with their request outside of our normal business hours of 8 a.m. to 6 p.m. Monday through Friday; the claims appeals coordinator returns provider calls by the next business day.

C.17.g.ii. Process for tracking reasons for grievances and appeals to identify trends, and how the Vendor will use this information to improve internal operations, provider relations, and provider satisfaction.

Improving Operations Through Grievances and Appeals Analysis

Sophisticated technology enables Passport to provide high levels of service for grievances and appeals as well as in identifying areas for improvement across our operations. Passport uses its Identifi G&A 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 grievance and appeal files in a secure and designated area that is accessible to the Department, its designee or CMS upon request for review. Passport retains all grievance and appeal files for ten (10) years following our final decision, HSD, an administrative law judge, judicial appeal or closure of a file, whichever occurs later.

Passport has procedures for assuring that files contain sufficient information, as outlined at 42 C.F.R. 438.416: (i) identify the grievance or appeal, (ii) the date it was received, (iii) the nature of the grievance or appeal, (iv) notice to the member of receipt of the grievance or appeal, (v) all correspondence between Passport and the member, (vi) the date the grievance or appeal is resolved, (vii) the resolution, (viii) the notices of final decision to the member, and (iv) 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. Grievances and appeals leadership analyzes the data on a monthly and quarterly basis with reports going to both 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 QAPI initiatives or other changes made as a result of an analysis of grievances to DMS through the quarterly Quality Improvement Work Plan.

Appeals staff work closely with Passport medical directors and the Provider Network team, as well as any other departments when any trends are identified with appeals and grievances. We analyze our results, looking for root causes with any trends, large or small, when they are identified or at a minimum 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 the Provider Network team to educate providers, and the Provider Network team will work with offices, as well as UM when necessary, to understand the needed information for submission of UM requests, working with them to prevent the initial denial of services.

Passport uses the results of the analysis of G&A 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.

Using Grievance and Appeal Trends for Improving Operations

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

The director of UM appeals reports complaints, grievances and appeals on the Quality Work Plan, which is reviewed by the 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 also provided on a monthly and quarterly basis to QMMC, QMAC and DMS.

C.17.g.iii. Process for ensuring transparency to DMS of grievance and appeal types, resolutions, and any Vendor actions to decrease such grievances or appeals in the future.

Ensuring Transparency to DMS

As noted above, Passport uses its proprietary Identifi G&A module to track, investigate and communicate all grievances and appeals. This system stores and maintains all documentation used in the internal and external appeal or grievance review. From Identifi G&A, Passport develops both monthly and quarterly reports. Grievances and appeals leadership analyzes the data from these reports on a monthly and quarterly basis with reports going to both QMAC and QMMC at a minimum to ensure transparency among leadership and to identify opportunities for improvement.

To ensure transparency to DMS, Passport submits a quarterly report to DMS that includes number received, type, provider type, average days to resolution, number upheld and overturned. We also report any QAPI initiatives or other changes made as a result of an analysis of grievances to DMS through the quarterly Quality Improvement Work Plan. Passport maintains all grievance and appeal files in a secure and designated area that is accessible to the Department, its designee or CMS upon request for review.

Passport Actions to Decrease Grievances or Appeals in the Future

Overall, Passport receives very few provider grievances or appeals outside of claims disputes. This is a testament to how we listen to providers and work with them to address any issues in a timely, coordinated way so that issues do not require formal escalation. Still, Passport has taken a number of actions – especially around claims – to prevent future grievances and appeals from providers:

- **Dedicated Phone Queue for Claims Appeals:** Passport dedicated a phone queue within our Provider Services Call Center to enable providers to call in and speak directly to a claim appeals coordinator about their claims appeal. This ensures that providers speak with a knowledgeable staff member who can discuss the status of the appeal and the associated outcome, ensuring that providers understand our justification, which helps to prevent future appeals. Because the phone queue connects directly to the claim appeals coordinator, it also helps to decrease the amount of time providers spend on the phone waiting to be routed to have their questions answered.
- **Elimination of Required Referral Forms**: Passport received feedback from providers that completing a form for referrals was administratively burdensome. Requiring this form resulted in a great number of appeals; if providers did not complete a referral form when required, the claim would be denied. As a result, Passport eliminated the referral form as a requirement and integrated the referral information into the claims payment process, which reduced the number of denials and made it more seamless for providers to refer their patients and obtain timely payment.
- **Ongoing Process for Quality Improvements:** The director of UM appeals reports provider complaints, grievances and appeals on the Quality Work Plan, which is reviewed by the 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.

Conclusion

Throughout this response, we have shown how Passport is meeting and exceeding DMS requirements for provider service excellence, comprehensive dedication to anticipating and resolving provider issues, and ensuring full compliance with state and federal requirements. Our tenure providing Medicaid services on behalf of the Commonwealth and our experienced Kentucky-based Provider Services team will positively impact Passport's deep provider relationships and foster increased provider satisfaction. In support of our continuous quality improvement culture, we use the information we learn from our people, our systems, and our more than 32,000 participating Kentucky providers to remain a provider-recommended health plan for Kentucky's Medicaid Managed Care Services program.

Excellence in provider services is of the utmost importance to Passport, to our Board of Directors, and to the Partnership Council, which consists of both providers and members of the community.

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.