Provider Manual
Section 2.0
Administrative Procedures

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PASSPORT HEALTH PLAN

2.0 Administrative Procedures

2.1 Medicaid Eligibility

Most individuals who meet the DMS eligibility criteria for Medicaid are assigned to an MCO in the region, and include individuals in the following categories:

A. Temporary Assistance to Needy Families (TANF);
B. Child and family related;
C. Aged, blind, and disabled Medicaid only;
D. Pass through;
E. Poverty level pregnant women and children, including presumptive eligibility;
F. Aged, blind and disabled receiving State supplementation;
G. Aged, blind, and disabled receiving Supplemental Security Income (SSI); or
H. Under the age of twenty-one (21) years and in an inpatient psychiatric facility.
I. Foster Care ages 0 – 18 and Former Foster Care ages 18 – 26
J. ACA Expanded Population ages 18-64
K. Presumptive Eligibility - Pregnant

DMS does not allow certain categories of Medicaid beneficiaries to participate in managed care. Beneficiaries in the following categories are not eligible for assignment to an MCO:

A. Individuals who shall spend down to meet eligibility income criteria;
B. Individuals currently Medicaid eligible and have been in a nursing facility for more than thirty (30) days*;
C. Individuals determined eligible for Medicaid due to a nursing facility admission including those individuals eligible for institutionalized hospice;
D. Individuals served under the Supports for Community Living, Michele P, home and community-based, or other 1915(c) Medicaid waivers;
E. Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLMBs) or Qualified Disabled Working Individuals (QDWIs);
F. Timed limited coverage for illegal aliens for emergency medical conditions;
G. Working Disabled Program;
H. Individuals in an intermediate care facility for mentally retarded (ICF-MR); and
I. Individuals who are eligible for the Breast or Cervical Cancer Treatment Program.

* If you have any questions regarding eligibility criteria, contact Provider Services at (800) 578-0775.

2.2 Passport Health Plan Assignment

DMS assigns eligible beneficiaries to Passport when the beneficiary selects Passport on their enrollment application or as part of an automatic assignment process developed by DMS.

Once assigned to Passport, a member receives a welcome kit from Passport, which includes a

welcome letter, member identification card, a Health Risk Assessment (HRA), and a Member Handbook.

2.3 Choosing a Primary Care Provider (PCP)

Making sure our members have a medical home is at the heart of Passport's approach to managed care. The PCPs, in their role as the Medical Home, provide our members with primary and preventive care and arrange other medically necessary services for members. Therefore, Passport acts quickly to make sure members are linked to a medical home.

Passport has a multifaceted PCP assignment process that meets all DMS requirements. The process is based on our current Medicaid experience and computer generated assignment of an accessible PCP.

Our plan and process to assign our members a PCP will occur as follows:

- If known, DMS will send member's selected PCP via the daily/monthly 834 files. Passport will validate the transaction and assign the PCP if appropriate (i.e. PCP meets all Passport criteria for assignment) ensuring the member's satisfaction and smooth transition to Passport.
- If the member requires assignment, our process will be as follows:
    - Identify members who require a PCP including SSI adult members (the process recognizes the need for longer timeframes for adult SSI members)
    - Review for historical claims data for PCPs
    - Review for prior PCP assignments for member
    - Review for PCPs for other family members

Final step, if no assignment can be made, based on the above criteria, PCP assignment will be based on the member's address.

At the time of assignment, Passport members will be informed of their assigned PCP in the New Member Welcome Kit and their confirmation letter. The member will also be notified at this time of his/her right to change his/her PCP if he/she is not satisfied with our assignment. The member will also receive an ID card with the practice name and phone number printed on the ID card. If the member is not required to have a PCP, he/she will receive an ID card with "No PCP required or Medicare Primary" printed on the card.

The above processes will be adapted as necessary to effectively assign PCPs to beneficiaries eligible for coverage (and assigned to Passport) through the Medicaid ACA Expansion population.

2.3.1 Changing PCPs

Members can change PCPs twice in a 12 month period, and PCP changes are effective on the day the change is requested. To change a PCP, members must call our Member Services department. Upon receiving an existing member's request to change a PCP, our Member Services Representatives (MSRs) will:

- Assist the member in finding a new provider (if requested), using methodologies outlined above,
- Perform the requested change in our system, and
- Advise the member of the effective date of the new PCP assignment.

The member will then receive a new ID card with the PCP practice name and phone number printed on the ID card.

Exceptions to the change of provider rule will apply in cases of provider termination, provider office closing, provider panel limitations and member re-location. In the case of voluntary provider termination, we will notify the member no less than thirty (30) days prior to the effective date of voluntary provider termination. The member will be sent a letter explaining that his/her provider is leaving Passport's network and the member will need to contact Member Services to select a new PCP or to receive assistance selecting a new PCP. If the provider notifies Passport of voluntary termination with less than thirty (30) days from the effective date of voluntary termination, we will notify affected members as soon as Passport receives notification.

Fortunately, due to our long history of superior provider satisfaction, most voluntary terminations are the result of providers retiring or moving out of the service area, not the result of provider dissatisfaction with Passport's administration.

In the case of involuntary provider termination, where Passport has decided to remove a provider from its network, Passport will notify affected members at least fifteen (15) days prior to the effective date of involuntary termination. Affected members will be sent a letter advising them to contact Member Services to select a new PCP or to receive assistance finding a new PCP.

In either of these cases, if the member does not contact us to select a new PCP, Passport will use the auto-assignment process to assign the member to a new PCP.

The goal of Member Services is to always provide satisfactory resolution, but if a request for a change in PCP is denied and the member is dissatisfied, the member will be advised of their appeal rights. The member will receive a written notice of the decision made by Passport.

Passport also reviews member activity related to PCP transfers on an ongoing basis and works in conjunction with Health Management, Quality Improvement, and the Provider Realtions Specialists to provide education and assist if any areas of improvement are identified.

Each PCP receives a monthly member panel list of those members who have selected or been assigned to his or her panel. The monthly member panel list is not to be used as a confirmation of eligibility. To confirm eligibility, call Provider Services at (800) 578-0775 option 3.

2.4 Identification Cards

Passport issues an identification card for each family member enrolled. Members are advised to keep the ID card with them at all times.

ID cards contain the following information:

- Member's name and date of birth.
- PCP group name and telephone number (if applicable).
- Passport identification number.
- Kentucky Medicaid identification number.
- Gender.

2.4.1 Member Identification and Eligibility Verification

Passport member eligibility varies by month. Therefore, each participating provider is responsible for verifying member eligibility with Passport before providing services. Providers may verify eligibility using any of the following methods:

- **Online** – check member eligibility by logging into Passport's Provider Portal.
- **KyHealth Net System -** Use the State's website to verify eligibility for all five (5) managed care organizations (MCOs) – including Passport – in one central location. Using your Medicaid ID (MAID) number, you may log directly onto this system at https://sso.kymmis.com, or find more information at www.chfs.ky.gov/dms/kyhealth.htm.
- **Telephone** – you may also check member eligibility by calling our interactive voice response (IVR) system at (800) 578-0775.
- Utilizing Passport's real-time member eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system-to-system eligibility verification, including point of service (POS) devices.
- Asking to see the member's Passport ID card and Kentucky Medicaid ID card**. Please note that Passport cards are not returned to Passport when a member becomes ineligible.** Therefore, the presentation of a Passport ID card is not sole proof that a person is currently enrolled in Passport.

Providers should request a picture ID to verify that the person presenting is indeed the person named on the ID card. Services may be refused if the provider suspects the presenting person is not the card owner and no other ID can be provided. If you suspect a non-eligible person is using a member's ID card, please report the occurrence to Passport's Fraud and Abuse Hotline at (855)512-8500 or the Medicaid Fraud Hotline at (800) 372-2970.

2.5 Member Release for Ethical Reasons

A participating provider is not required to perform any treatment or procedure that may be contrary to the provider's conscience, religious beliefs, or ethical principles. If such a situation arises, the provider should contact Provider Services at (800) 578-0775. A Provider Services representative will work with the provider to review the member's needs and transfer or refer the member to another appropriately qualified provider for care.

2.6 Health Education and Special Programs

Passport may refer members to health education classes provided by health agencies and providers or to Passport-provided programs. Providers who identify members who could benefit from education for a specific condition, such as pregnancy, asthma, congestive heart failure or diabetes, for example, may call (877) 903-0082 for class information and schedules. Members also have access to health topics through an audio health library. Pre-recorded messages on topics provide information on preventing illness, identifying warning signs and administering self-care. A member may call the 24-Hour Nurse Advice Line to access the audio health library (see Section 2.6.3).

2.6.1 Language Assistance for Members

Federal law requires providers to ensure that communications are effective.

Providers who render health services, medical services, or social service programs to Passport members benefit from a program that receives federal financial assistance and are, therefore, subject to the requirements of Title VI of the Civil Rights Act of 1964. This act prohibits recipients of benefits from a program receiving federal financial assistance, such as Medicaid, from being prohibited from or refused service on the grounds of race, color, or national origin. The term "on the grounds of national origin" has been interpreted to include persons with limited-English proficiency (LEP).

Title VI requires every Medicaid provider, including Passport providers, to offer members equal access to benefits and services by ensuring that each LEP (limited English proficiency) person can communicate effectively in his or her language of choice. This law also requires providers to take necessary steps to provide language assistance at no cost to Medicaid members, including those enrolled with Passport.

Providers may contact Passport's Cultural & Linguistics Services Program at (502) 585-7303 for additional information and/or questions.

2.6.2 Help for Those with Impaired Vision or Hearing

The Member Handbook is available in alternative formats for members with visual impairments. Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf, Passport's TDD/TTY number for Member Services is (800) 691-5566.

2.6.3 24-Hour Nurse Advice Line and Audio Health Library

PCPs can encourage their patients to talk with a nurse 24 hours a day, 7 days a week by calling the

24-Hour Nurse Advice Line at (800) 606-9880. Passport wants to make certain that you are aware that through the same number, Passport members may access an audio health library of over 35 categories of health care topics, including:

- Allergies and Immune System
- Blood and Cancer
- Bones, Muscles, and Joints
- Brain and Nervous System
- Cancer
- Heart and Blood Vessels
- Children
- Mouth and Teeth
- Diabetes
- Diet and Exercise
- Digestive System
- Ear, Nose, and Throat
- Eyes
- General Health
- Hormones
- Infectious Disease
- Injuries
- Medicines
- Mental and Behavioral Health
- Men's' Health
- Pain Management
- Physical and Sports Medicine
- Pregnancy
- Preventive Health
- Respiratory and Lung Problems.
- Sexual and Reproductive Health
- Skin
- Sleep Disorders
- Social and Family
- Surgery
- Tests and Diagnostic Procedures
- Urinary Problems
- Women's Health

Members with limited English proficiency (LEP) can also access the 24-Hour Nurse Advice Line.

Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf, the TDD/TTY number for the Nurse Advice Line is (800) 648-6056.

NOTE: The 24-Hour Nurse Advice Line is not meant to take the place of the PCP and may not be used for after-hour coverage. However, it is an effective communication mechanism for dissemination of disease specific educational information as well as an alternative method for receiving information on self-care techniques in clinically appropriate circumstances.

2.7 Credentialing/Re-Credentialing

2.7.1 Initial Application Process

To join the Passport network an application and credentialing process must be take place. This can be initiated by calling our Provider Services department at (800) 578-0775. We will send you a provider application packet and work with you to become credentialed and, if approved, contracted as a Passport network provider. Providers can also fill out a Provider Enrollment Request form online at **http://www.passporthealthplan.com/providerEnrollment.aspx**.

Passport participates with the Council for Affordable Quality Healthcare (CAQH). Providers who are participating with this common credentialing application database should include their CAQH provider ID number with documents submitted to Passport.

The policies and procedures regarding selection and retention do not discriminate against providers who service high-risk populations or who specialize in conditions that require costly

treatment or based upon that Provider's licensure or certification.

2.7.1.1 Practitioners

New practitioner applicants are required to complete their residency program and be eligible to obtain board certification prior to joining Passport. A practitioner is considered hospital based if they practice exclusively in a facility setting. These practitioners undergo a condensed review as it is the responsibility of the facility to verify their full credentials.

Passport enrolls providers in compliance with the "Any Willing Provider" statute as described in 907 KAR 1:672 and KRS 304.17A-270. Passport enrolls providers in the network who are not participating in the Kentucky Medicaid Program as long as provider is deemed by the Department of Medicaid Services (DMS), eligible to enroll with Kentucky Medicaid Program in accordance with the state's Provider Credentialing and Re-credentialing standards. A provider cannot enroll in Passport network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process.

Passport enrolls providers in compliance with the "Any Willing Provider" statute as described in 907 KAR 1:672 and KRS 304.17A-270. Passport enrolls providers in the network who are not participating in the Kentucky Medicaid Program as long as provider is deemed by the Department of Medicaid Services (DMS), eligible to enroll with Kentucky Medicaid Program in accordance with the state's Provider Credentialing and Re-credentialing standards. A provider cannot re-enroll in Passport network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the re-credentialing process. New practitioners must include the following as applicable:

- A letter adding practitioner to each group.
- Completed Provider Application either a CAQH (Council for Affordable Quality Healthcare) universal credentialing application or the most current version of KAPER1 (Kentucky DMS application), including:
    - Additional copies of pages from the application (as needed);
    - Disclosure questions, as applicable, including but not limited to:
        - Documentation of any malpractice suits or complaints.
        - Documentation of any restrictions placed on practitioner by hospital, medical review board, licensing board, or other medical body or governing agency.
        - Documentation of any conviction of a criminal offense within the last 10 years (excluding traffic violations); and,
        - The attestation page (including the practitioner signature and current date).
- Original, complete, and signed MAP Forms per the Kentucky DMS provider enrollment web page, http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm.
- Copy of current State License Registration Certificate.
- Copy of current Federal Drug Enforcement Agency Registration.
- Copy of CLIA.

- Copy of collaborative agreement between an Advance Practice Registered Nurse and supervising practitioner.
- Copy of MAP 612 Statement of Authorization for Payment signed by both the physician assistant and supervising practitioner.
- Curriculum vitae or a summary specifying month and year, explaining any lapse in time exceeding six months.
- Copy of a W-9 with the legal and doing business name of the entity, Tax Identification Number, and mailing address for all 1099 tax information signed by an authorized agent for the entity.
- Copy of claim history form for each malpractice activity within the past five years.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.
- A copy of Medicare Certificate (a letter from the Centers for Medicare & Medicaid Services (CMS) with your unique Medicare provider identification number and practice location).
- Copy of social security card (If applicant has as social security card stating "valid for work only with DHS/INS Authorization," please refer to additional requirements at http://www.chfs.ky.gov/dms/provEnr/).
- ECFMG (Education Council for Medical Graduates).
- FOX verification documentation for National Provider Identifier (NPI) and Taxonomy Code(s).

2.7.1.2 Organizational Provider

New applicants must submit a completed application, which includes the following as applicable:

- Two signed Participating Provider Agreements.
- Completed facility/ancillary service application including the credentials verification release statement.
- Original, complete, and signed MAP Forms per the Kentucky DMS provider enrollment web page, http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm.
- Copy of current State License Registration Certificate.
- Hearing aid dealer current license for specializing in hearing instruments.
- Copy of CLIA, if applicable.
- Copy of a W-9 in the name of the facility/group, including the Tax Identification Number and mailing address for all tax information.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.
- A copy of Medicare Certificate (a letter from the Centers for Medicare & Medicaid Services (CMS) with your unique Medicare provider identification number and practice location), as applicable.
- Copy of current facility accreditation or certification.
- Model Attestation Letter for Psychiatric Residential Treatment Facilities (PRTF).

- DME Accreditation Certificate- exempt organizations need to submit a signed statement attesting to the exemption and documentation from CMS outlining the exemption.
- HME license issued by the KY Board of Pharmacy (per HB 282 and 201 KAR 2:350) (As of September 30, 2012) - exempt providers need to submit a signed statement attesting to the exemption.
- Medicare certification letter less than three years old with effective date of certification and physical location of where DME number is to be used. Medicare requires DME providers to re-enroll every 3 years.
- Independent labs must have a laboratory director, who must satisfy requirements set forth in 907 KAR 1:028 Section 1(8) and KRS 333.090 (1), (2), or (3) and supply documentation thereof.
- If not accredited or certified, a copy of the most recent CMS or state review.
- A copy of the mechanism that the organizational provider uses to monitor and improve patient safety.
- A copy of the transfer policy.
- FOX verification documentation for National Provider Identifier (NPI) and Taxonomy Code(s).

Failure to submit a complete application may result in a delay in Passport's ability to start the initial credentialing process.

Practitioners may contact the Provider Enrollment department at (502) 588-8578 to check the status of their application.

2.7.2 Credentialing Process

Passport assesses practitioner applicants through Passport's credentialing process. With the receipt of all application materials, primary source verification is conducted by Passport's Provider Enrollment department. Following the verification of credentials, Passport's Chief Medical Officer/designated Medical Director and/or Credentialing Committee reviews each application for participation.

Passport will not initiate the credentialing review until a completed and signed application with attachments has been received. The normal processing time is between 60 to 90 days from date of submission of a completed application for medical providers. For behavioral health providers, the enrollment process is complete within 45 days including credentialing.

A provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process.

2.7.3 Reimbursement and the Credentialing Process

Providers seeking participation in the Passport network and in the credentialing process will be reimbursed at the participating provider rate, starting from the date Passport receives a completed

and signed application packet and confirmation that the provider has been issued a Kentucky MAID number. If the Credentialing Committee denies participation, any claims paid during the interim will be recouped, and unpaid claims will be denied.

Providers may begin submitting claims for services provided to Passport members once they have been notified of the receipt of their completed application and have been assigned a Provider ID number. Providers are required to submit all claims within 180 days of service, but no payment is made until Passport receives confirmation that the provider has been issued a Kentucky MAID number. Please note, claims submitted without a Kentucky Medicaid Identification (MAID) number will initially deny.

Providers will receive notification from DMS when a MAID number is assigned. Providers are encouraged to notify Passport of receipt of a MAID number assignment.

After Passport receives notification of a provider MAID number assignment, all claims received from the provider will be automatically reprocessed, starting from the date Passport received a completed and signed provider application.

Providers will be considered participating Passport providers once they have met Passport's credentialing requirements. Providers will be notified by Passport when they have been successfully credentialed by Passport. Providers applying for participation are excluded from the *Provider Directory* until the credentialing process has been completed in its entirety.

2.7.4 Providing Services Prior to Becoming a Credentialed Passport Provider

If a provider determines a member must be seen prior to the assignment of a Provider ID number and notification of the receipt of a completed and signed application by Passport, the provider must obtain an authorization from Passport's Utilization Management department in order to receive payment for services. Please note that an authorization for service does not guarantee payment.

2.7.5 Re-credentialing Process

Passport re-credentials its providers, at a minimum, every three years. In addition, Passport conducts ongoing monitoring of Medicare and Medicaid sanctions as well as licensure sanctions or limitations. Practitioners who become participating and subsequently have restrictions placed upon their license will be reviewed by the Credentialing Committee and evaluated on a case-by-case basis, based upon their ability to continue serving Passport's members.

Member complaints and adverse member outcomes are also monitored and Passport will implement actions as necessary to improve trends or address individual incidents. If efforts to improve practitioner performance are not successful, the practitioner may be referred to the Credentialing Committee for review prior to his/her normally scheduled review date.

2.7.5.1 Practitioners

Passport will generate a re-credentialing application on all practitioners with current CAQH applications on file. Practitioners without a CAQH on file will be notified by telephone or letter

to submit a re-credentialing application (most current version of the KAPER 1 or CAQH) with the following list of attachments:

- Disclosure questions, as applicable, including but not limited to:
    - Documentation of any malpractice suits or complaints.
    - Documentation of any restrictions placed on practitioner by hospital, medical review board, licensing board, or other medical body or governing agency.
    - Documentation of any conviction of a criminal offense within the last 10 years (excluding traffic violations).; and,
- The attestation page (including the practitioner signature and current date).
- Copy of current State License Registration Certificate.
- Copy of current Federal Drug Enforcement Agency Registration - if applicable.
- Copy of current collaborative agreement between an Advance Practice Registered Nurse and supervising practitioner, as applicable.
- Copy of MAP 612 Statement of Authorization for Payment signed by both the physician assistant and supervising practitioner, as applicable.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.

2.7.5.2 Organizational Provider

Passport sends a facility/ancillary service application to the organizational provider for completion. The re-credentialing application must include the following as applicable:

- Completed facility/ancillary service application including the credentials verification release statement.
- Copy of current State License Registration Certificate.
- Copy of CLIA, if applicable.
- Copy of a W-9 in the name of the facility/group, including the Tax Identification Number and mailing address for all tax information.
- Copy of current professional liability insurance Certificate of Coverage, including the name and address of the agent and the minimum amount, in accordance with existing Kentucky laws at the time of the application submission.
- Copy of claim history form for each malpractice activity within the past five years.
- A copy of Medicare Certificate (a letter from the Centers for Medicare & Medicaid Services (CMS) with your unique Medicare provider identification number and practice location), as applicable.
- Copy of current facility accreditation or certification.
- If not accredited or certified a copy of the most recent CMS or state review.
- A copy of the mechanism that the organizational provider uses to monitor and improve patient safety.
- A copy of the transfer policy.

Failure to return documents in a timely fashion may result in termination. If the termination period is longer than 30 days, the initial credentialing process would need to be completed in

order to re-enroll as a participating provider.

Practitioners or providers may contact the Provider Enrollment department at (502) 585-8578 to check the status of their re-credentialing application.

Should Passport decide to deny or terminate a provider from participation with Passport, the provider will receive notification of the decision. The notification will include the reasons for the denial or termination, the provider's rights to appeal and request a hearing within 30 days of the date of the denial notice, and a summary of the provider's hearing rights.

2.8 Provider Terminations/Changes in Provider Information

2.8.1 Provider Terminations

A provider desiring to terminate his/her participation with Passport must submit a written termination notice, to his/her assigned Provider Relations Specialist, at least ninety (90) days prior to the desired effective date of the termination.

For terminations by primary care providers, the assigned Provider Relations Specialist will coordinate member notification and assignment to another PCP based on the PCP's member panel.

If a solo specialist or an entire specialty group decides to terminate the contract, a list of members receiving ongoing health care from the specialist and/or group must be sent to Passport within 60 days of the termination date for member notification to occur. The specialist's Provider Relations Specialist will work with the specialist to ensure a smooth transition for the member's continued care.

2.8.2 Changes in Provider and Demographic Information

Providers are required to provide a 90-day prior written notice to both Passport's Provider Network Management department and DMS of any changes in information regarding their practice. Such changes include:

- Address changes, including changes for satellite offices.
- Additions/deletions to a group.
- Changes in billing locations, telephone numbers, tax ID numbers.

Reimbursement may be affected if changes are not reported in accordance with Passport policy.

Please note that providers are required by DMS to annually submit a copy of current license and annual disclosure of ownership. If these documents are not provided, the provider's Kentucky Medicaid (MAID) number may be terminated. Your office will receive notice from the DMS when these documents are due for submission. Please respond timely to these requests.

2.8.3 Change in Location

If a provider working in multiple offices discontinues working in one or more locations, written

notification must be provided to Passport within 30 days detailing the locations where he/she will no longer see patients, as well as the specific offices where he/she will continue to see patients.

2.8.4 Panel Closings

Passport recognizes that PCPs may occasionally need to limit the number of patients in their practices in order to deliver quality care. Passport will evaluate any requirements for minimal members per practitioner panel. (For additional information regarding member to practitioner ratios, see Section 4.3.)

Once a PCP has accepted the number of Passport members agreed upon in the Primary Care Provider Agreement, a written request must be forwarded to Passport to impose panel restrictions. Please send your request to your Provider Relations Specialist at 5100 Commerce Crossings Drive, Louisville, KY 40229.

Passport requests a 90-day advance written notice to change panel status.

2.8.5 Panel Limitations

Panel limitations and/or removal of panel restrictions must be submitted in writing to the Provider Relations Specialist. Providers are notified by their Provider Relations Specialist of the approval or denial of the request. Approved panel limitations and/or removal of restrictions become effective the first of the following month after a request is approved by Passport.

2.8.6 Member Dismissals from PCP Practices

Primary care providers (PCP) have the right to request a member's disenrollment from their practice and request the member be reassigned to a new PCP for the following circumstances:

- Incompatibility of the PCP/patient relationship;
- Member has not utilized a service within one year of enrollment in the PCPs practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year or;
- Inability to meet the medical needs of the member.

PCPs do not have the right to request a member's disenrollment from their practice in the following situations:

- A change in the member's health status or need for treatment.
- The member's utilization of medical services.
- A member's diminished mental capacity.
- A member's disruptive behavior that results from the member's special health care needs unless the behavior impairs the PCP's ability to provide services to the member or others.

Disenrollment requests shall not be based on the grounds of race, color, national origin, handicap, age or gender.

Disenrollment requests must be submitted to Passport and sent via fax to Provider Enrollment at (215) 937-5304. Requests must include provider name, provider group ID number, member

name, member ID number, reason for disenrollment request, and effective date. Members are not disenrolled from the PCP's practice until all required information is received. Questions regarding this process may be directed to Provider Services at (800) 578-0775 or contact your Provider Network Management Specialist.

Disenrollment requests meeting Passport's requirements as stated above are reviewed, determined to be appropriate, and processed within five business days of receipt by Provider Services. The disenrollment effective date must be at least 30 days from the request date to allow for the member's transition to a new PCP unless extenuating circumstances necessitate an immediate effective date.

The initial PCP must continue to serve the member until the new PCP assignment becomes effective, barring ethical or legal issues. The member has the right to appeal such a transfer via Passport's formal appeal process.

If a PCP's request does not meet the above stated requirements, the appropriate Provider Relations Specialist will contact the PCP directly to discuss.

Please note this process does not apply to "age-out" disenrollment for pediatric practices.

2.8.7 Locum Tenens

According to Passport policy, participating providers may utilize the services of a locum tenens provider, under temporary circumstances, for a maximum period of sixty (60) consecutive days. When locum tenens services are needed, participating providers must register the substitute provider. This process must be completed prior to the provision of any services by a locum tenens provider.

To register a locum tenens provider, the participating Passport provider must complete a one-page *Registration of Locum Tenens Physician* form (available in Section 20 of this Provider Manual). Both the participating Passport provider and the locum tenens provider must sign the form. To complete the registration process, the signed form must be returned to Passport by mail or by fax to:

Mail:
Passport Health Plan
Attn: Provider Relations
5100 Commerce Crossings Drive
Louisville, Kentucky 40229

Fax:
Attn: Provider Enrollment
(502) 585-6060

Services rendered by a locum tenens provider must be billed utilizing the absent provider's Passport ID number and the Q6 modifier with the applicable procedure code(s). The Q6 modifier signifies that the service was provided by a locum tenens provider. According to the Passport Provider Agreement, the absent provider remains liable and all contractual terms remain effective throughout the employ of a locum tenens provider.

If services by a locum tenens provider remain necessary beyond the period of sixty (60)

consecutive days, the locum tenens or substitute provider must apply for participation with Passport and complete the credentialing process and have or apply for a Kentucky Medicaid number. Upon becoming credentialed with Passport, the provider will be assigned a provider ID number for billing purposes.

2.9 Provider Appeals and Grievances

2.9.1 What is Appealable?

Passport providers have the right to file an appeal for any adverse benefit determination which includes:

- Denial of a health care service;
- Denial of a claim for reimbursement;
- A provider payment issue; or
- A contractual issue.

2.9.2 How do Provider's File an Appeal?

2.9.2.1 Method of Appeal

All provider appeals must be submitted in writing.

Submit Provider Appeals to:

Type of Appeal	Timing of Appeal	Address
Behavioral Health	**Must be submitted within sixty (60) calendar days of the adverse benefit determination.**	**Passport Health Plan** **Attn: Beacon Appeals Coordinator** **500 Unicorn Park Drive Suite** 103 **Woburn, MA 01801** **(855) 834-5651** **TDD/TTY** **(866)834-9441**
Claims Payment Issues	**Must be submitted within two (2) years of last process date of claim.**	**Passport Health Plan** **Claim Appeals** **PO Box 7114** **London, KY 40742**
Contractual Issues	**Must be submitted within sixty (60) calendar days of the occurrence of the contractual issue being appealed.**	**Passport Health Plan** **Legal Services / Contractual Appeals** **5100 Commerce Crossings Drive** **Louisville, Kentucky 40299**
Credentialing Denial or	**Must be submitted within**	**Passport Health Plan**

Type of Appeal	Timing of Appeal	Address
Credentialing or Quality Network Termination	**thirty (30) calendar days of the adverse benefit determination.. Provider may request a hearing.**	**Attn: Credentialing Appeals 5100 Commerce Crossings Drive Louisville, Kentucky 40299**
Dental	**Must be submitted within thirty (30) calendar days of adverse benefit determination..**	**Avesis Attn: Appeals Department PO Box 7777 Phoenix, AZ 85011-7777 (866) 909-1083**
Medical	**Must be submitted within sixty (60) calendar days of the adverse benefit determination..**	**Passport Health Plan Appeals Coordinator 5100 Commerce Crossings Drive Louisville, KY 40229 (502) 585-7307 Fax (502) 585-8461**
Overpayment Recovery and Recoupment	**Must be submitted within thirty (30) calendar days from postmark date or electronic delivery date of written notice of overpayment recovery request.**	**Passport Health Plan Attn: Recovery Letter Appeal 5100 Commerce Crossing Drive Louisville, KY 40229**
Pharmacy	**Must be submitted within sixty (60) calendar days of the adverse benefit determination.**	**Passport Health Plan Phone: (844) 380-8831 Fax: (844) 802-1406**
Radiology	**Must be submitted within sixty (60) calendar days of the adverse benefit determination..**	**eviCore Appeals Department 730 Cool Springs Blvd., Suite 800 Franklin, TN 37067 (877) 791-4099**
Outpatient Therapy, Chiropractic, Pain Management	**Must be submitted within 60 days (60) calendar days of the adverse benefit determination.**	**eviCore Healthcare Attn: Clinical Appeals, Mail Stop 600 400 Buckwalter Place Blvd. Bluffton, SC 29910**

Type of Appeal	Timing of Appeal	Address
		Phone: (800) 792-8744 option 4
Vision	**Must be submitted within thirty (30) calendar days of adverse benefit determination..**	**Superior Vision** **939 Elkridge Landing Road, Suite 200** **Linthicum, MD 21090** **Attn: Provider Appeals** **(800) 879-6901**

At no time will punitive or retaliatory action be taken against a provider for filing an appeal or a provider for supporting a member appeal.

2.9.2.2 Conduct of the Review

For appeals related to a medical necessity denial, a board-certified physician, who was not involved in the initial denial, will conduct the clinical review. The provider can also request that the reviewing physician have clinical expertise in treating the member's condition or disease. Providers may submit documents in support of the appeal.

2.9.2.3 Resolution of the Appeal

All provider appeals except those related to credentialing denials or terminations, are resolved within thirty (30) calendar days of receipt of the appeal unless the time period is extended by fourteen (14) calendar days upon request of the provider or pursuant to our request. Providers will receive a written notice of the resolution of the appeal. Appeals of credentialing denials or terminations include the right to a hearing before a hearing panel. Passport will work with the provider to schedule the hearing.

2.9.2.4 Independent Third Party Review

Pursuant to KRS 205.646 and 907 KAR 17:035, a provider may request an external independent review of an adverse final decision of a denial, in whole or in part, of a health care service regarding medical necessity determinations, whether the service is covered by the Medicaid program, or whether the provider followed Passport's requirements for the covered service. To request an external independent third-party review, a provider must submit a written request to Passport within sixty (60) calendar days of receiving the final appeal decision. Requests must identify each specific issue and dispute related to Passport's adverse final decision and state the basis on which Passport's decision on each issue is believed to be erroneous. The request must include your designated contact information including a name, phone number, mailing address, fax number, and email address. Requests for external independent third party reviews may be sent:

Electronically: ReviewRequests@passporthealthplan.com

By fax: (502) 585-8334
By mail: Attn: Provider Review Requests
Passport Health Plan
5100 Commerce Crossings Drive
Louisville, KY 40229

2.9.2.5 Administrative Hearing

Pursuant to KRS 205.646 and 907 KAR 17:040, a provider who receives an adverse final decision from an independent third party review may appeal that decision by requesting an administrative hearing. Requests for administrative hearings must be sent to DMS within thirty (30) calendar days of receiving the written notice of the right to appeal from DMS.

2.9.3 Provider Grievances

A grievance is defined by federal and state law as an expression of dissatisfaction about any matter other than an adverse **benefit determination.**.

Passport providers have the right to file a grievance of any Passport decision that does not involve an adverse **benefit determination.**

2.9.3.1 How do Providers File a Grievance

Timing:

Providers have thirty (30) calendar days from the date of an event causing dissatisfaction to file a grievance.

Method of Filing a Grievance:

Provider grievances may be submitted orally or in writing.

Submit Provider Grievances to:

Type of Grievance	Address
Dental	**Avesis** **Attn: Appeals Department** **PO Box 7777** **Phoenix, AZ 85011-7777** **(866) 909-1083**
Radiology	**eviCore Healthcare** **Appeals Department** **730 Cool Springs Blvd., Suite 800** **Franklin, TN 37067** **(877) 791-4099**

Type of Grievance	Address
Outpatient, Chiropractic, Pain Management	**eviCore healthcare** **Attn: Clinical Appeals, Mail Stop 600** **400 Buckwalter Place Blvd.** **Bluffton, SC 29910** **(800)792-8744 option 4**
Vision	**Superior Vision** **939 Elkridge Landing Road, Suite 200** **Linthicum, MD 21090** **(800)879-6901**
Pharmacy	**Passport Health Plan** **5100 Commerce Crossings Drive** **Louisville, KY 40229** **(800) 578-0775**
All Other Provider Grievances	**Passport Health Plan** **5100 Commerce Crossings Drive** **Louisville, KY 40229** **(800) 578-0775**

2.9.3.2 Resolution of the Grievance

All provider grievances are resolved within thirty (30) calendar days of receipt of the grievance unless the time period is extended by fourteen (14) calendar days upon request of the provider or pursuant to our request. For any extension not requested by the Provider, Passport will mail the Provider written notice of the reason for the extension within two (2) business days of the decision to extend the timeframe. Providers will receive a written notice of the resolution of the grievance.

2.10 Members' Rights

Members are informed of their rights and responsibilities through the Member Handbook. Passport providers are also expected to respect and honor members' rights.

The rights of our members include, without limitation, the right to:

A. Respect, dignity, privacy, confidentiality and nondiscrimination;
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;
C. Consent for or refusal of treatment and active participation in decision choices;

D. Ask questions and receive complete information relating to the member's medical condition and treatment options, including specialty care, presented in a manner appropriate to the member's condition and ability to understand;
E. File a grievance or an appeal and to receive assistance in filing a grievance or appeal;
F. Request a state fair hearing from the Department;
G. Timely access to care that does not have any communication or physical access barriers;
H. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;
I. Access to and the right to request corrections and amendments to the member's medical records in accordance with applicable federal and state laws, including KRS 422.317;
J. KRS 422.317;
K. Timely referral and access to medically indicated specialty care; and
L. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
M. Receive information about Passport, benefits, services, providers and a member's rights and responsibilities.
N. Make suggestions about a member's rights and responsibilities.
O. Ensure any Indian members may receive services from I/T/U providers (Indiana Health Services, Tribally operated facility/program, and Urban Indian clinics) signed up with Passport.

The responsibilities of Passport members include the responsibility to:

A. Become informed about member rights;
B. Abide by the Contractor's and Department's policies and procedures;
C. Become informed about service and treatment options;
D. Actively participate in personal health and care decisions, practice healthy lifestyles;
E. Report suspected Fraud and Abuse; and
F. Keep appointments or call to cancel.

2.11 Member Appeals and Grievances

2.11.1 What is Appealable?

Members have the right to appeal any Passport decision involving an **adverse benefit determination.**. An **adverse benefit determination.** is defined by federal and state law.

An Adverse benefit determination. is as defined in 42 CFR 438.400(b), the

A. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;

B. Reduction, suspension, or termination of a service previously authorized by the Department, its agent or Contractor;

C. Denial, in whole or in part, of payment for a service;

D. Failure to provide services in a timely manner, as defined by Department;

E. Failure of an MCO or Prepaid Health Insurance Plan (PHIP) to act within the timeframes required by 42 CFR 438.408(b); or

F. For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside a Contractor's Network; or

G. Denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

No Retaliation for Filing an Appeal

At no time will punitive or retaliatory action be taken against a member for filing an appeal or a provider for supporting a member appeal.

2.11.2 How do Members File an Appeal?

Timing
Members have sixty (60) calendar days from the date of receiving a notice of adverse **benefit determination,** to file an appeal.

Method of Appeal
Member appeals can be either oral or in writing. An oral appeal must be followed by a written

appeal, signed by the member and received by us within ten (10) calendar days of the member's oral appeal.

Authorized Representatives of Members May File an Appeal:
An authorized representative may file an appeal on behalf of the member. An authorized representative is a legal guardian of the member for a minor or an incapacitated adult, or a representative of the member as designated in writing by the member to Passport.
The personal representative of a deceased member may file an appeal on behalf of the member.

A provider may be an authorized representative for a member only with the member's written consent. The written consent must include a statement that the member is giving the provider the right to appeal and must also include a specific statement of the adverse **benefit determination.** that is being appealed. A single written consent shall not qualify as a written consent for more than one:

a. Hospital admission;

b. Physician or other provider visit; or
c. Treatment plan.

Help for Members with Filing an Appeal:
Passport members may call Passport member services for help filing an appeal. For Behavioral Health, Passport members may call Passport Behavioral Health Hotline at (855) 834-5651.

LEP persons will be given interpretation / translation assistance when necessary to navigate the appeals process.

Submit Member Appeals to:

Type of Appeal	Address	To Expedite a Member Appeal
Behavioral Health	**Beacon Health Strategies** **Appeals Coordinator** **500 Unicorn Park Drive** **Suite** 103 **Woburn, MA 01801**	**(855) 834-5651** **TDD/TTY** **(866) 834-9441**
Denial, in whole or in part, of payment for a service	**Passport Health Plan** **Claim Appeals** **PO Box 7114** **London, KY 40742**	**N/A**
Dental	**Avesis** **Attn: Appeals Department** **PO Box 7777** **Phoenix, AZ 85011-7777**	**(866) 909-1083**
Medical	**Passport Health Plan** **Appeals Coordinator** **5100 Commerce Crossings Drive** **Louisville, KY 40229** **(502) 585-7307** **Fax (502) 585-8461**	**(502) 585-7307, or (800) 578-0603, option 0, Extension 7307**
Pharmacy	**Passport Health Plan**	**(844)380-8831** **Fax: (844)802-1406**
Radiology	**eviCore Healthcare** **Appeals Department**	**(877)791-4099**

	730 Cool Springs Blvd., Suite 800 Franklin, TN 37067 (877) 791-4099	**Appeals Department**
Outpatient Therapy, Chiropractic, Pain Management	**eviCore healthcare Attn: Clinical Appeals, Mail Stop 600 400 Buckwalter Place Blvd. Bluffton, SC 29910**	**(800)792-8744 option 4**
Vision	**Superior Vision 939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090 Attn: Member Appeals (800) 879-6901**	**(800)879-6901**

Acknowledgement of Receipt of the Appeal:
Within five (5) working days of receiving an appeal, we will send the member a written notice that the appeal has been received and the expected date of resolution.

Continuance of Services during an Appeal:
Passport will provide for continuation of services in accordance with 42 CFR, while the appeal is pending; if the member requested a continuation benefits, until one (1) of the following occurs:

A. The member withdraws the appeal or request for a Stae Fair Hearing;
B. The member does not request a Stae Fair Hearing with continuation of benefits within ten (10) days from the date the Contractor mails an adverse appeal decision; or
C. A State Fair Hearing decision adverse to the member is made.

Expedited Appeals
An expedited review process is available for a member when the standard resolution time frame could place the Member at risk or seriously compromise the Member's health or well-being seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain or regain maximum function. Expedited appeals are resolved within three (3) working days of receipt of the request. The three (3) working days timeframe will be extended for up to fourteen days if the member requests the extension or we demonstrate to the Department that there is need for additional information and the extension is in the member's interest. If we request the extension, we will give the member written notice of the reason for the extension. If we deny a request for a Member request for an expedited appeal, the appeal will be resolved within thirty (30) calendar

days of receipt of the original request for appeal. We will give the Member prompt oral notice of the decision to deny expedition of the appeal. We will follow up with a written notice within two (2) calendar days of the denial.

Conduct of the Review

The review will be conducted by an individual who was not involved in the initial decision. Appeals involving denials for lack of medical necessity, the denial of expedited resolution of the appeal or clinical issues will be conducted by health care professionals who have the appropriate clinical expertise concerning the condition or disease under appeal.
Members shall be given an opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing and will take into account all comment, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

Resolution of the Appeal

All member appeals are resolved within thirty (30) calendar days of receipt of the appeal, unless the time period is extended by fourteen (14) calendar days upon request of the member or a request made by us. If we request the extension, we will provide the member with written notice of the extension and the reason for the extension within two (2) working days of the decision to extend. Members will receive a written notice of the resolution of the appeal. The notice will include the right to request a State Fair Hearing.

Member Requests for a State Hearing

If a member is not satisfied with the appeal resolution, the member has the right to request a State Fair Hearing. The member must exhaust the Passport internal appeal process prior to requesting a State Fair Hearing. Requests for a State Fair Hearing must be made in writing postmarked or filed with the Kentucky DMS, within one hundred twenty (120) days of the notice of the appeal decision. Requests for a State Hearing should be forwarded to:

Kentucky Department for Medicaid Services
Division of Program Quality & Outcomes
275 East Main St., 6C-C
Frankfort, KY 40621

(800) 635-2570
TDD/TTY (800) 775-0296

Kentucky Ombudsman

Members may also contact the Kentucky Ombudsman at any time at the following address:

Cabinet for Health and Human Services
Office of Ombudsman
275 East Main St., 1E-B
Frankfort, KY 40601

(800) 372-2973

TDD/TTY (800) 627-4702

What is a Grievance?
A **grievance** is defined by federal and state law as an expression of dissatisfaction about any matter other than an adverse **benefit determination.**.

Passport members have the right to file a grievance concerning any Passport decision that does not involve an adverse **benefit determination.**.

No Retaliation for Filing a Grievance
At no time will punitive or retaliatory action be taken against a member for filing a grievance or a provider for supporting a member grievance.

How do Member's file a Grievance?

Timing:

Members may file a grievance with Passport at any time.

Method of Filing of Grievance:

Grievances can be submitted either orally or in writing.

Submit Member Grievances to:

Passport Health Plan
5100 Commerce Crossing Drive
Louisville, KY 40229

(800) 578-0603

Help for Members with filing a Grievance:
Members may call Passport **Member Services at (800) 578-0603** for help filing a grievance. LEP persons will be given interpretation/translation assistance when necessary to navigate the grievance process.

Acknowledgement of Receipt of the Grievance:
Within five (5) working days of receipt of a grievance, we will provide the member with a written notice that the grievance has been received and the expected date of resolution.

Conduct of the Review
The grievance review will be conducted by an individual who was not involved in the initial decision.

Resolution of the Grievance
All member grievances are resolved within thirty (30) calendar days of the date the grievance was received. Members will receive a resolution letter that includes the information considered in

investigating the grievance, findings and conclusions based on the investigation and the disposition of the grievance.

Resolution may be extended by up to fourteen (14) calendar days if the member requests the extension, or if we determine there is a need for additional information and the extension is in the member's interest. For any extension not requested by the member, Passport will mail the member written notice of the reason for the extension within two (2) business days of the decision to extend the timeframe.

Member Request for a State Hearing
Passport will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, but not later than 72 hours from the date the Passport receives notice reversing the determination, if the services were not furnished while the appeal was pending and the State Fair Hearing results in a decision to reverse Passport's decision to deny, limit, or delay services. Passport will pay for disputed services received by the Member while the appeal was pending and the State Fair Hearing reverses a decision to deny authorization of the services.

2.12 Title VI Requirements: Translator and Interpreter Services

Title VI of the Civil Rights Act of 1964 is a Federal law that requires any organization receiving direct or indirect Federal financial assistance to provide services to all beneficiaries without exclusion based on race, color, or national origin.

All Passport providers indirectly benefit from Federal financial assistance (via Medicaid). Therefore, under Title VI and the Culturally and Linguistically Appropriate Services (CLAS) Standards 4 - 7, as outlined by the Office of Minority Health, U.S. Department of Health and Human Services (DHHS), **all Passport providers are required by law to:**

- Provide written and oral language assistance at no cost to any patient, including, but not limited to, Passport members with limited-English proficiency or other special communication needs, at all points of contact and during all hours of operation. **Language access includes the provision of competent language interpreters.**

Note: The assistance of friends, family, and bilingual staff is not considered competent, quality interpretation. These persons should not be used for interpretation services except where a member has been made aware of his/her right to receive free interpretation in their preferred language and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

- Provide patients, including Passport members, verbal or written notice (in their preferred language or format) about their right to receive free language assistance services.

- Post and offer easy-to-read member signage and materials in the languages of the common cultural groups in your service area. Vital documents, such as patient information forms and

treatment consent forms, must be made available in the preferred language or format of patients, including Passport members.

Additionally, under the CLAS Standards, Passport providers are **strongly encouraged** to:

- Provide effective, understandable, and respectful care to all patients, including Passport members, in a manner compatible with his/her cultural health beliefs and practices of preferred language/format.
- Implement strategies to recruit, retain, and promote a diverse office staff and organizational leadership representative of the demographics in your service area.
- Educate and train staff at all levels, across all disciplines, in the delivery of culturally and linguistically appropriate services.
- Establish written policies to provide interpretive services for patients, including Passport members.
- Routinely document each patient's preferred language or format, such as Braille, audio, or large type, in all medical records.

Potential penalties of non-compliance with Title VI may include:

- Loss of federal and state funding, including future funding (i.e. providers may be prohibited from participating in Medicaid, Medicare, and/or incentive programs such as the Electronic Health Records incentive).
- Legal action against providers from the DHHS, legal service organizations, and private individuals.
- "Informed consent" issues which may also lead to medical malpractice charges.
- Change in participation status with Passport.

Providers may contact Passport's Cultural and Linguistics Services Program Coordinator at (502) 585-8251 or e-mail cals@passporthealthplan.com for additional information or to schedule an on-site training.

2.12.1 Title VI Training/Resources

Passport's Cultural and Linguistics Services (CLSP) Program offers the following training materials and resources. Contact the CLSP Coordinator at (502) 585-8251-, e-mail cals@passporthealthplan.com, or visit our web site, www.passporthealthplan.com/provider/services/cals, for more details.

- **Onsite Trainings/Resources**

  Our CLSP staff is a resource for Title VI/CLAS Standards, Cultural Diversity and assists providers in reaching and maintaining compliance. We offer free on-site trainings for office staff, an informative Provider Toolkit, and web-based information and resources.

- **Provider Office Materials**

  In addition to the Provider Toolkit and other educational resources, Passport also offers provider office signage to assist office staff in complying with Title VI. These materials are

available online or by calling the CLSP coordinator.

- **Translated Member Materials and TDD/TYY Lines**
  Many member materials, including the Passport ***Member Handbook***, are available in other languages and alternative formats such as Braille, audio, and large type. Members may call Member Services for copies.

  Additionally, for members with hearing impairments who use a Telecommunications Device for the Deaf (TDD), Passport's TDD/TYY number for Member Services is:
  Passport - (800) 691-5566

- **Discounts for Telephonic and Video Interpretation**
  Passport also contracts with a telephonic and video interpretation vendor, InterpreTalk by Language Services Associates (LSA), to offer our providers a discounted rate. To set up an account and receive InterpreTalk services, please call (800) 305-9673 and ask for Client Services. It may take 48 to 72 hours to set up an InterpreTalk account to begin receiving interpretive services.