B.3 Staffing

REQUIREMENT: RFP Section 60.7.B.3

a. Describe the Vendor's proposed approach to staffing this Contract, including the following information at a minimum
   i. Description of how the organizational structure provides innovative solutions for meeting programmatic goals specific to Kentucky's Medicaid program and Enrollees and supports stakeholder groups (e.g., Enrollees, providers, partners, among others).
   ii. Description of how the organizational structure will support whole-person integrated care, population health and overall improvement in health outcomes in a cost-effective manner.
   iii. Description of the governing body, how members are selected, and envisioned role specific to the Vendor's support of the Kentucky Medicaid managed care program.
   iv. A listing of Key Personnel identified in Section 9.2 of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," and as otherwise defined by the Vendor, including:
      a. Individual names, titles, brief job descriptions, qualifications and fulltime equivalents (FTEs) dedicated to this Contract, as well as their office locations for this Contract. An FTE is defined as the ratio of the total number of paid hours divided by the total number of working hours in the period. Annually, an FTE is considered to be two thousand eighty (2,080) hours.
      b. Whether each Key Personnel position will be filled by a Vendor's employee or a Subcontractor.
      c. Resumes, including information such as degrees, credentials, clinical licensure as applicable, years and type of experience. Include as an Appendix or Attachment to the Proposal.
   v. Summary of recruitment timelines and activities for Key Personnel positions for which individuals have not been identified at the time of the proposal. Describe contingency plans should those positions continue to remain open after Contract Award.
   vi. Overview of the Vendor's proposed training of staff to fulfill all requirements and responsibilities of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," for all operational areas.
   vii. Overview of Vendor's approach to monitoring Subcontractors' progress in recruiting and training of staff to meet all requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."
   viii. Retention approach for key personnel.
b. Provide a detailed description of the Vendor's organizational structure for this Contract, including an organizational chart that clearly displays the following:
   i. Management structure, lines of responsibility, and authority for all operational areas of this Contract.
   ii. How the RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices" fits into the overall organizational structure of the Parent Company
   iii. Where subcontractors will be incorporated.
   iv. A summary of how each Subcontractor will be integrated into the Offeror's proposal performance of their obligations under RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," to ensure a streamlined experience for the Members, providers and the Department.
   v. Number of proposed FTEs dedicated to RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices," by position type and operational area and how the Vendor determined the appropriateness of these ratios.

Our local health plan staffing is designed to support truly integrated care—physical health, behavioral health, and social determinants of health—to coordinate high-quality benefits and services and drive positive health outcomes for Enrollees in Kentucky.

When considering a new MCO, the Commonwealth must have confidence not only in the company itself but in the personnel implementing and operating the program. Kentucky deserves an executive team and other key personnel who lead the industry in capabilities and relevant experience, and also lead their teams with compassion and drive, every day.

Throughout this Staffing section, we include a description of our approach to staffing, including key personnel, in accordance with the requirements listed in Attachment C, Draft Medicaid Managed Care Contract and Appendices, Section 9, Organization and Collaboration, and the number of FTEs associated with each position for key staff. We also discuss recruitment and retention of employees and staff training, and provide resumes, job descriptions, qualifications of staff, and organizational charts.

We describe how our managed care approach and team structure support whole-person integrated care, population health, and improvement in health outcomes for Enrollees, meeting all requirements in Proposal Section B.3, Staffing, and Draft Contract, Section 9.2, Administration/Staffing.

a. MOLINA'S APPROACH TO STAFFING

At Molina, we approach our staffing plans with the same precision and attention to detail we will use to ensure our Enrollees receive the care and support that works best for them. ***We have used our high-touch staffing model—tested and proven in Molina's affiliated health plans across the country—to determine we need approximately 445 Molina employees across the Commonwealth*** to support the Kentucky Medicaid program within the health plan office in Louisville and Molina One-Stop Help Centers located throughout the Commonwealth.

To build Molina's Kentucky Medicaid program on the strongest foundation possible, we will use a staffing approach that begins with an Implementation team comprising leaders with expertise in each specific operational area to manage all aspects of the program during the Implementation Phase. Molina's Kentucky health plan Implementation team will be led by three tenured professionals who will serve on an interim basis: ***Chief Executive Officer (CEO) Dwayne Sansone, Medical Director Dr. Jason Dees, and Behavioral Health Director Dr. LaTonia Sweet.*** As a lifelong Kentuckian who received her MD from the University of Kentucky, Dr. Sweet is Board Certified in Psychiatry and Addiction Medicine and will help ensure we hire the right individuals with the right combination of clinical expertise to work with Kentucky's most vulnerable population.

The Implementation team will work across the organization and with the Molina recruiting team to select and onboard candidates who meet or exceed the Commonwealth's high standards as well as our own stringent experience requirements, ensuring an in-place staff that is trained and ready for successful operations. ***Those selected for the permanent executive team and key staff roles, all of whom are subject to approval by the Commonwealth, will be solely dedicated to the Kentucky Medicaid program for the duration of the Contract.***

Under the direction of Mr. Sansone, an executive leader with more than 20 years of experience across various industries, including healthcare insurance and technology, our Implementation team will hire locally based and appropriately licensed candidates. Mr. Sansone, Dr. Dees, and Dr. Sweet will collaborate to select and onboard our team before the Contract start date. We further describe our approach to staffing our health plan in the sections below.

a.i. AN ORGANIZATIONAL STRUCTURE PROVIDING INNOVATIVE SOLUTIONS

Our staffing plan and organizational structure will ensure Molina runs smoothly and efficiently during Implementation, so Enrollees and providers have an excellent experience with the health plan once we Go-Live. We developed our staffing plan based on the national model created for all our affiliated health plans using input we gathered from key health plan and corporate leaders to ensure we build in the support needed within each functional area. We then customized this model to Kentucky to reflect Kentucky Medicaid Draft Contract requirements as well as the unique needs of Enrollees and providers identified through feedback we received from Enrollee focus group meetings, engagement with local providers, advocates and community-based organizations (CBOs).

Commitment to Making a Local Difference

Our localized solution provides 1,100 ***well-paying jobs and sustained positive economic impact*** throughout the Louisville metro area. This differentiates our dedication and commitment from our peers, as ***locally based support for key health plan operations*** are traditionally provided by MCOs at corporate headquarters located in other states.

For example, we have added housing specialists to our staffing plan to help address concerns expressed about housing stability, a key social determinant of health. For clinical staff, we used evidence-based standards to determine the type and number of positions to fill to ensure Enrollees will receive the level of care that is right for their needs.

Our Implementation team will work across functional areas to ensure that operations, systems, and staffing are in place, and we meet milestones and respond to the Department's requests in a timely manner. As part of our staffing model, we will employ individuals who reside in, understand, and reflect the communities they support. We are currently recruiting for key roles and will continue to finalize staffing throughout the Implementation Phase. The Operations team will be fully functional by the time operations begin, carrying out all activities required under the Kentucky Medicaid program Contract. As needed, the local Operations team can be supplemented by regional or corporate experts.

Regional Operations Center

We are bringing an innovative model to Kentucky to ensure even more operational areas are supported locally as well as creating jobs and economic opportunity in the Commonwealth. We ***will establish a Regional Operations Center in Louisville, creating approximately 700 new local jobs. Regional Operations Center jobs will be in addition to the 445 jobs created locally to operate our health plan.***

Our Regional Operations Center will be implemented in phases. The Center will initially serve Kentucky health plan operations, and then roll out services to support all Molina affiliated health plans in the Eastern Time Zone. The Regional Operations Center will provide many support functions such as claims and encounters processing and Enrollee and provider Call Center services, along with appeals and grievances functions.

The Center will be key to generating a number of significant long-term benefits for the Commonwealth, including demonstrating Molina's long-term commitment to serving Kentucky Medicaid program Enrollees by locating our base of operations for our parent company's entire Eastern U.S. market in the Commonwealth. This solution will provide ***locally based support for Enrollees and providers,*** which are traditionally provided by MCOs at corporate headquarters located in other states.

Molina One-Stop Help Centers

In addition to the Regional Operations Center***, Molina also will establish Molina One-Stop Help Centers for Enrollees and providers in areas accessible by public transportation.*** These Help Centers, strategically established in cities across the Commonwealth, including Louisville, Covington, Bowling Green, Hazard, Lexington, and Owensboro, will address rural needs and underserved communities by offering easy-to-access healthcare support and other resources and services.

Each facility will offer free Wi-Fi, meeting room(s), computer access, and translation services, and will be fully Americans with Disabilities Act (ADA) compliant. At Molina One-Stop Help Centers, providers can ask questions face-to-face with Molina provider services representatives; register complaints; receive training, education, and documentation; and attend meetings, as needed. For Enrollees, services may include assistance with choosing or changing their PCP; face-to-face healthcare assistance, including addressing concerns and questions and addressing barriers to healthcare access; access to telehealth capabilities; face-to-face meetings with a care manager to receive a private Health Risk Assessment and Enrollee Needs Assessment; information on standard and value-added services; access to programs that address social determinants of health, including job and education support, and help with food, housing, and utility assistance; help with signing up for other government programs such as SNAP; and more. A high-touch locally based approach creates opportunities for improving Enrollee health, reducing provider abrasion, and supporting social determinants of health innovations.

Supporting Stakeholder Groups and Relationships

Embedded in our operational structure are key outreach staff dedicated to supporting our Enrollees, engaging with Stakeholder Groups and forging partnerships with Community Based Organizations.

As required, our Community Engagement team will spearhead our Quality and Member Access Committee (QMAC). However***, to address the diverse perspectives across Kentucky, Molina will establish regional QMACs.*** As the healthcare landscape, available resources, demographics, and social determinants of health vary dramatically among Kentucky regions, regional QMACs will enable us to

capture Enrollee feedback and recommendations that reflect the nuances of each region. Our Community Engagement team will also invite and welcome participation from key CBOs or advocacy groups—many of whom we have already met—with experience serving Medicaid Enrollees to promote a broad perspective for the QMACs. We will invite participation from organizations that reflect the diverse array of issues facing our Enrollees, such as:

- **Kentucky Youth Advocates**, which represents issues related to children across Kentucky
- **Foundation for a Healthy Kentucky**, which focuses on a range of issues, including improving access to care, reducing health risks and disparities, and promoting health equity
- **Center for Women and Families**, which provides trauma-informed advocacy and support for individuals and communities affected by partner violence and sexual assault
- **Kentucky Foster and Adoptive Care Association**, which advocates and supports children in out-of-home care and the families that serve them
- **The ARC of Kentucky**, which provides advocacy, education, resources and training for people with intellectual and developmental disabilities
- **Children's Alliance**, which advocates on behalf of at-risk children, including those in foster care
- **Kentucky Voices for Health**, a coalition working together to improve Kentuckians' health across the Commonwealth We will establish and frequently convene stakeholder groups, including forums for Enrollees, caregivers, providers, and CBOs, to solicit feedback and promote meaningful improvements that positively impact those with whom we are partnering and those we are serving.

Additionally, our staff will continue our ongoing efforts to cultivate relationships with CBOs, including advocacy groups across Kentucky. Molina's organizational structure will incorporate regionally based community engagement representatives who will work closely with CBOs to collaborate on activities where our programs intersect. For example, we will use geo-targeting software to identify geographic clusters where there is a high rate of care gaps, such as well-child visits, and work with CBOs like Audubon Area Community Services to host pop-up clinics for back-to-school and other events. At health clinics, we will screen for food insecure individuals and families and provide food assistance through CBOs such as Dare to Care, Kentucky Heartland, and God's Pantry Food Bank.

Molina's community engagement representatives will also partner with their region's designated quality improvement (QI) intervention specialist (who will have a deep knowledge of regional data trends, including understanding Enrollee demographics, culture, public health statistics, and concerns). Extending the reach of our QI team into the community, QI specialists will team up with community-based provider services representatives and community engagement representatives to collaborate on quality interventions to address performance measures (including clinical outcomes, health disparities, and Enrollee and provider satisfaction) within their assigned regions.

Stakeholder Relationship Approach

Our stakeholder relationship approach merges two of our best attributes. The first is our staff. We carefully select our team members for their experience and their demonstration of our mission statement to provide quality healthcare services to families and individuals covered by government programs. We will build our Kentucky team based on their experience working with healthcare providers and populations similar to Kentucky Medicaid Enrollees.

The second is our commitment to fostering each unique relationship. For 40 years, our parent company has studied and implemented best practices in communications and relationship management, and every step involves thorough documentation and information-sharing. Our care managers oversee an interdisciplinary process that ensures each provider has access to the data needed for proper care and monitoring. We will form committees and work groups to bring together Enrollees, providers, the

Department, and other Commonwealth agencies, as well as other advocates and stakeholders to develop new initiatives and address program concerns, making changes where necessary.

Our plan for Kentucky Medicaid begins with education, with an emphasis on demonstrating how highly we value communication among all parties. We will engage community partners to explain our beliefs and procedures, as well as their benefits to each group. As Molina and the Department progress from implementation into operations, we will concentrate on establishing two-way interfaces to collect the best data available from all sources to measure quality and improve outcomes. This plan will meet the Commonwealth's needs and Kentucky Medicaid program goals, including focusing on quality goals, improving Enrollee health outcomes, and collaborating to find solutions that are effective and cost-efficient.

Provider-focused Engagement

We have particularly extensive experience working across traditional barriers with government agencies, providers, community organizations, and other stakeholders to educate and serve the population. Our stakeholder relationship approach further places special focus on our contracted providers, who are the key link to Enrollees and the group for whom incentive-based programs are targeted.

Molina provider services representatives will know their local providers and meet face-to-face with both physical health and behavioral health providers to build trust, foster open communication, and develop collaborative relationships. Provider services representatives will travel to provider locations to meet providers before go-live and will continue ongoing face-to-face contact with providers after implementation. Provider services representatives also will meet face-to-face with provider associations and present at regional association conferences.

This proactive engagement approach has proven to be a very effective way for our affiliated health plans to get our message out to the provider community and hear what is important to them. Providers will have a voice in program operations through ongoing participation in our Provider Advisory Workgroup and our Quality Improvement Committee as well as through our "It Matters to Molina" program, which will encourage providers to offer feedback. Exhibit B.3-1 shows how our Ohio affiliate has leveraged the "It Matters to Molina" program to create dialogue, generate actionable provider feedback, and maintain trust.

It Matters to Molina

Shortly after Molina Healthcare of Ohio began operations, a provider approached their director of provider services. "I made a suggestion to my provider services representative, and you actually took it!" the provider said. The comment was heartening but somewhat surprising. Collaborative problem-solving is part of the Molina culture, but we soon learned that providers in Ohio hadn't received that level of commitment from previous contractors.

In response, our organization created **"It Matters to Molina"** for use in all Molina affiliated health plans. We distribute comment cards for providers to evaluate us and suggest improvements. We know the importance—to all stakeholders—of meeting provider needs. "It Matters to Molina" reinforces that connection and often reaffirms what we're doing right.

Providers have been quick to praise us for service that goes above and beyond their expectations, including in the areas of greatest interest to the Department:

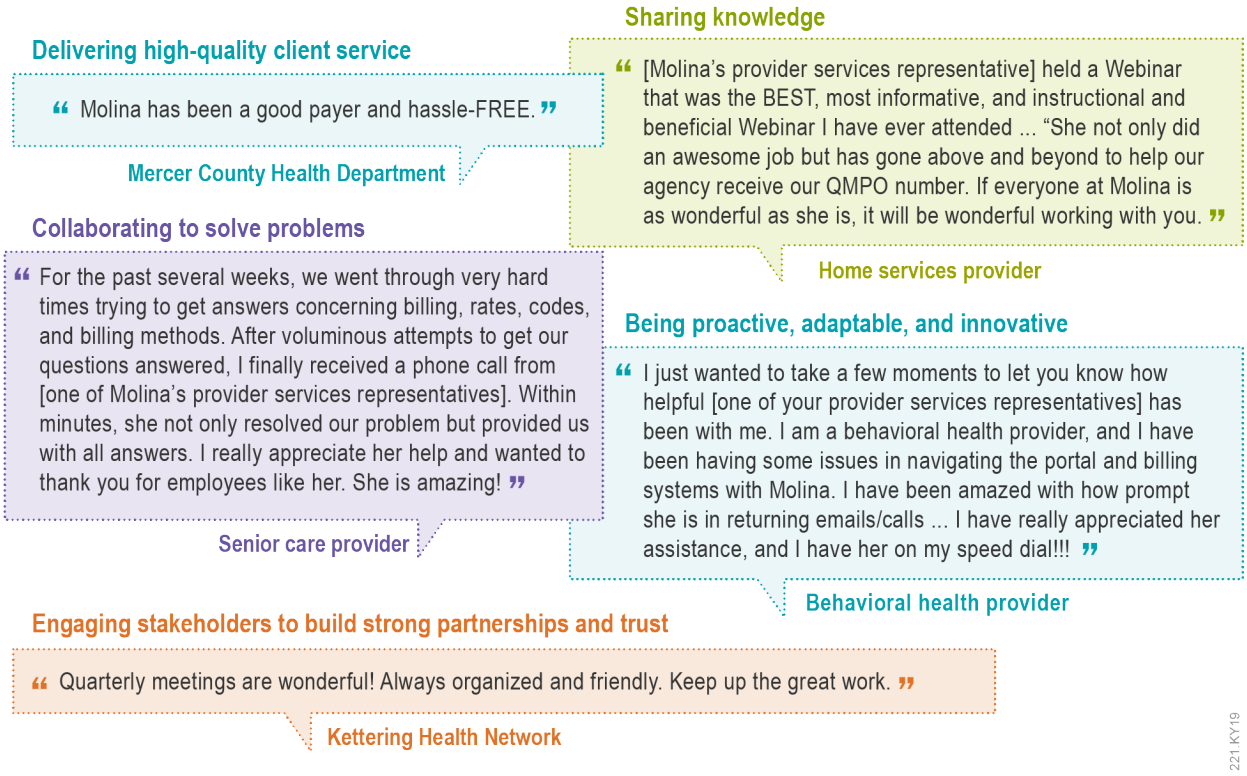

Exhibit B.3-1. "It Matters to Molina"

Moreover, our dedicated Provider Engagement Team will be a critical resource to help our provider partners achieve their performance goals. ***The Provider Engagement Team is a cross-functional group that will work in collaboration with our contracted providers, especially those serving our Enrollees under value-based payment arrangements, to improve quality outcomes and promote efficiencies through implementation and support of new programs/initiatives.*** The Provider Engagement Team will support providers by assessing and evaluating comprehensive cost, utilization, and quality data, identifying and proposing performance improvement opportunities and related resources. The Provider Engagement Team will work closely with our providers to achieve the following goals:

- Incentivize provider improvements in HEDIS scoring and performance
- Represent Enrollees' medical status appropriately, moving them into care management programs earlier when warranted

- Implement patient-centered medical homes in PCP offices, making the PCP function a more attractive and important component of the healthcare delivery model
- Increase provider satisfaction by targeting/assisting providers with billing/coding deficiencies
- Assist providers in adopting best practices to improve healthcare outcomes

One size does not fit all. At Molina, we will reflect this belief in how we provide care to each of our Enrollees, how we proactively engage our providers and other stakeholders, and how we partner with the Commonwealth. We will integrate a combination of Kentucky-specific knowledge with our organization's decades of Medicaid experience. Furthermore, we will have the capacity and internal controls to successfully serve Kentucky's initial enrollment and anticipated growth.

a.ii. ORGANIZATION TO SUPPORT INTEGRATED CARE AND POPULATION HEALTH

Molina's organizational structure centers on two key strategies to support whole-person integrated care: population health and overall improvement of health outcomes in a cost-effective manner. First, we will deploy a ***fully integrated care management model in which Molina directly administers behavioral health services without use of a subcontractor or affiliate***, so we can efficiently integrate care and services, including supports that address our Enrollees' social determinants of health. Second, our organizational structure will feature community-based teams and staff that enable us to more directly and personally connect with Enrollees and providers.

Kentucky seeks a new path to providing healthcare to its most vulnerable residents. These individuals need a system of care that integrates physical health and behavioral health, addresses population health and social determinants, and ensures access to primary and preventive care in traditional and non-traditional settings and in urban and rural areas.

Molina offers that path. Since 1994, our parent and affiliated health plans have specialized in working with states to provide government-sponsored healthcare. Of our 3.4 million covered lives nationwide, 87%—nearly 3 million—are through Medicaid, and the rest are through related programs such as Medicare, Medicare-Medicaid Plans (Duals), and Marketplace. Our organizational structure and product offerings have been built to address the issues of specialized populations and the providers who serve them.

- Our integrated care model will include in-house behavioral health operations and staff positions to address social determinants of health
- Regional offices will serve as help centers for Enrollees and providers
- Molina and the Commonwealth will collaborate regularly to improve service and information-sharing

Integrated Care Model

A hallmark of our commitment to specialized populations and administration of whole-person care is our in-house behavioral health operations including an addictionologist and substance use disorder (SUD) services. ***We are one of the nation's few MCOs that does not subcontract behavioral health services to either a third-party subcontractor or a separate corporate entity.*** This approach provides a focused, whole-person coordination of care which leads to better health outcomes overall.

Our affiliated health plans currently manage more than 1.2 million Enrollees diagnosed with behavioral health conditions. In the past year, these plans have also managed approximately 200,000 Enrollees with an SUD diagnosis. We have behavioral health practitioners and subject matter experts supporting all our clinical and business departments and provide mandatory regular training to all staff nationwide on various behavioral health concerns. Our new Substance Use Disorder Model of Care with Opioid Use Disorder Focus incorporates the latest research and an emphasis on population health and social determinants. We have experience working across the spectrum of behavioral health providers from major

health systems and community health systems, and we will offer value-based payment agreements that include incentives for Medication Assisted Treatment and other behavioral health-related capabilities.

Improvement in Health Outcomes through an Integrated Care Approach

Our Population Health Management teams will include care managers and support staff with expertise across the physical health and behavioral health spectrum. Using an integrated technology platform and under the direction of our Kentucky medical director, Dr. Jason Dees, Molina's integrated team will be able to nimbly adapt our operations to address the complex needs of Enrollees with comorbid physical health and behavioral health conditions as well as social determinants of health.

Our behavioral health director, Dr. LaTonia Sweet, is a lifelong Kentuckian who earned her MD from the University of Kentucky. Dr. Sweet is Board Certified in Psychiatry and Addiction Medicine and will oversee and retain responsibility for all behavioral health activities. She was named the 2016 Physician of the Year by Kentucky Medical News and received the 2016 Kentucky Medical Association Community Connector Award and the 2017 Kentucky Medical Association Leadership Institute Award. In addition, she holds positions on the board of directors for several Kentucky organizations including Molina Healthcare of Kentucky and the Kentucky Foundation for Medical Care, a charitable organization committed to improving the health of Kentuckians though medical education and public health initiatives. She has been a leader in the Commonwealth in developing treatment programs to address substance abuse and will lead the efforts to bring our integrated care model to Kentucky to improve whole-person care and the health outcomes of Kentucky Medicaid Enrollees.

Demonstrating the cost effectiveness of our care model, our Washington affiliate, which participates in the Washington State Health Care Authority's Integrated Managed Care program, has achieved notable successes in member health outcomes through their integrated care approach. Similar to our proposed Kentucky Medicaid model, our Washington affiliate designates a single point of contact within the health plan (e.g., care manager) who coordinates the exchange of information across the physical health / behavioral health continuum and helps maintain a "no wrong door" structure in support of whole-person, integrated care. Exhibit B.3-2 demonstrates some of the positive outcomes achieved by our Washington affiliate in their "Early Adopter" Integrated Managed Care program region in Southwest Washington.

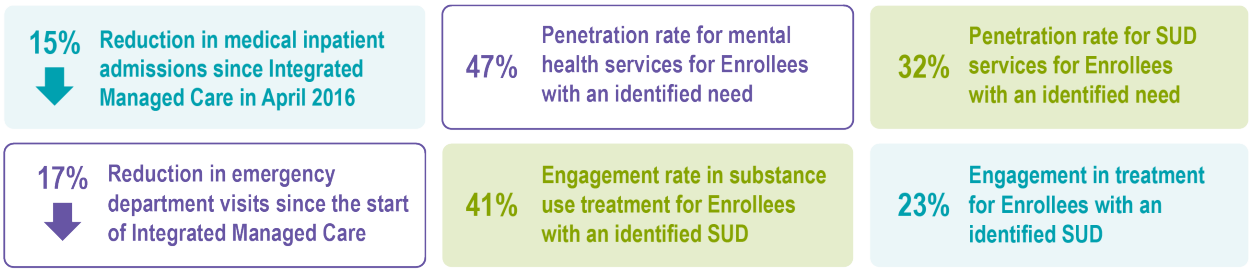

Exhibit B.3-2. Positive Outcomes in the Southwest Region of Washington

Molina will offer a similar practiced and proven approach to Kentucky to ensure Enrollees are connected to the right physical health and behavioral health services and supports regardless of where they enter the system of care.

Community-based Staff

Molina has structured our Kentucky Medicaid organization to foster close relationships with our Enrollees, providers, and other stakeholders such as CBOs. ***Central to that strategy will be our Molina One-Stop Help Centers located in Louisville, Covington, Bowling Green, Hazard, Lexington, and Owensboro, placing our staff near to our stakeholders.***

Exhibit B.3-3 shows the components of our organization. We will carefully select all components—staff, providers, subcontractors, systems, and community partners—based on their ability to meet the complex needs of the Kentucky Medicaid population.

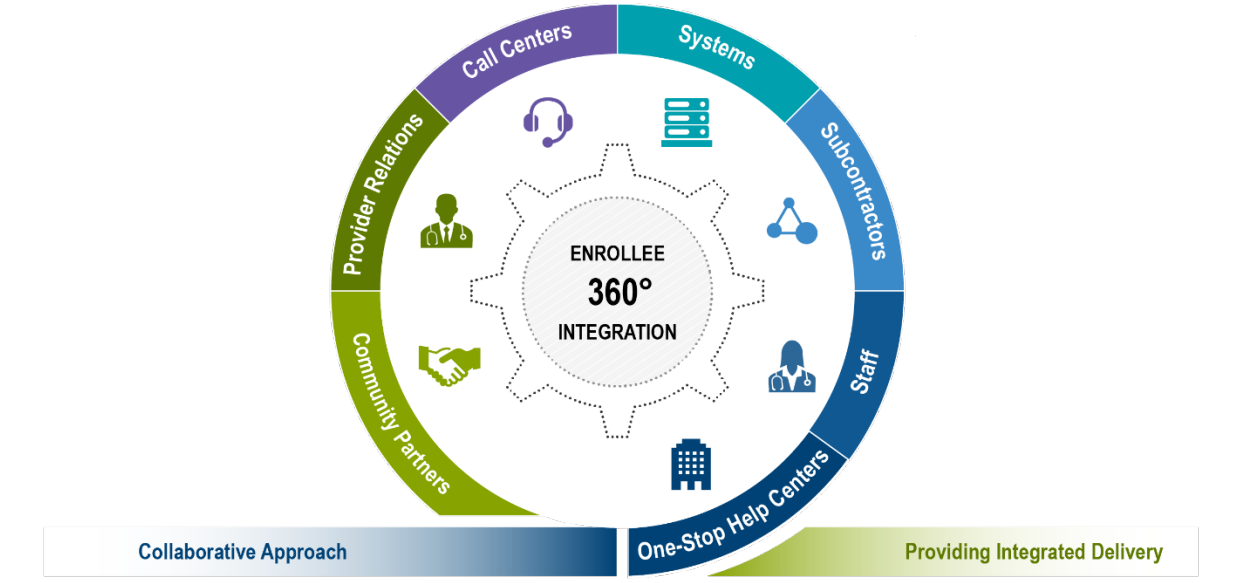

Exhibit B.3-3. Molina's Integrated System of Delivery

Under this organizational structure, we will implement innovative solutions, including the deployment of specialized staff to strengthen relationships with providers, Enrollees, and community organizations. Our organizational structure will feature the following community-based positions to support ***whole-person integrated care, population health, and overall improvement in health outcomes*** for the Kentuckians we will serve.

Care Connections Nurse Practitioners. Co-located at high-volume provider offices or CBOs, Care Connections nurse practitioners will empower Enrollees by linking them with the array of care and services they need to take charge of their health and obtain services to improve their health outcomes. In addition, Care Connections nurse practitioners will conduct annual comprehensive exams, comprehensive diabetes care, and postpartum visits through home visits, mobile clinics, or pop-up clinics in partnership with local community organizations. By emphasizing a community-based approach to cultivating relationships with Enrollees, we can better influence quality improvements, especially in rural communities that lack or have a limited number of traditional care providers.

Molina Community Health Workers. Molina Community Health Workers will play an important role in supporting Enrollees to access services appropriately and navigate the healthcare system. Molina Community Health Workers are longtime members of the community they serve and therefore understand the community's culture, language, and norms. Molina Community Health Workers will be able to assist Enrollees with housing, food, clothing, transportation, scheduling appointments, medication refills, obtaining durable medical equipment, and identifying community advocates for eligibility/financial needs. They will also help Molina locate Enrollees who may have an identified risk or need and have not responded to our telephonic and other attempts at outreach. The use of Molina Community Health Workers has proven beneficial in other affiliated health plans' Medicaid programs. For example, one affiliated Medicaid health plan achieved a 25% reduction in Enrollee emergency department (ED) visits and hospital admissions in the first year of the program for those Enrollees engaged by a Molina Community Health Worker.

Housing Specialists. Housing specialists will partner with local supportive housing and shelter programs. Molina's housing specialists will have expertise in working with individuals with mental health needs and SUDs. They will work one-on-one with Enrollees who are homeless or at risk of being homeless and gather information on their current living situations, urgency of housing needs, safety concerns, income, and any barriers they may face to securing appropriate housing. Housing specialists will assess Enrollee needs, connect them with CBOs, assist with housing and funding, and intervene with landlords, as needed, to help resolve disputes. Housing specialists also will assist Enrollees with obtaining and completing housing applications and other needs until housing is secured or rent and utility payment disputes are resolved. In addition, they will help Enrollees who have mental health or SUD concerns or other special needs to access specialized housing assistance funds and recovery housing resources.

SUD Navigators. The SUD navigator is a specialized care manager (or team) with advanced expertise in addiction, pain management, and mental health who assist in the management of complex members with SUDs and the varied co-morbid conditions affecting this vulnerable population. The SUD Navigator will be responsible for high level assessments and screens associated with SUDs. When appropriate, the SUD navigator will direct and connect members to available services in their community to address their needs.

Peer Support Specialists. Molina will employ peer support specialists to help our Enrollees with either mental health or SUD diagnoses. These specialists have a lived experience in recovery and formal training to deliver services that promote self-care, increased motivation, and improved overall health. The use of peer support specialists is an evidence-based practice, as it has been shown to be exceptionally successful in motivating people who are currently in recovery. ***Peer support specialists will work closely with the behavioral health director to address the development of recovery plans, assist in combined presentations on recovery principles in behavioral health, and meet with providers, specialists, and other stakeholders.*** They will provide recovery training for Enrollees, providers, and Molina staff. Peer support specialists will be participants in the Enrollee's care team, assist Enrollees with setting and pursuing their own recovery goals, and work with care managers and/or the treatment team to determine the steps needed to achieve these goals.

Transition of Care Coaches. As part of our Transition of Care program, Molina will deploy transition of care coaches in targeted communities, including embedding them in high-volume facilities. Working closely with facility discharge staff, transition of care coaches will support Enrollees for 30 days after discharge, coordinating follow-up care and services and building self-management skills to reduce the risk of readmission.

Provider Engagement Team. Cross-functional teams with representation from Medical Affairs, QI, Healthcare Services, and Provider Relations, Provider Engagement Teams will work with key provider offices to identify and address barriers to improved health outcomes, access, and Enrollee or provider satisfaction. Molina's Provider Engagement Teams will work closely with high-volume providers in each region to interpret and act on their quality data to improve Enrollee outcomes (both HEDIS and CAHPS scores). In our Ohio affiliate, aggregate HEDIS scores for providers who worked with Provider Engagement Teams exceeded aggregate scores for those who did not for most priority measures, such as Controlling High Blood Pressure (14% higher score), Adult BMI Assessment (6% higher), and Cervical Cancer Screening (7% higher).

Community-based Provider Services Representatives. Molina provider services representatives will know their local providers and meet face-to-face with both physical health and behavioral health providers to build trust, foster open communication, and develop collaborative relationships. Provider services representatives will travel to provider locations to meet providers before go-live and will continue ongoing face-to-face contact with providers after implementation. They will also meet face-to-face with provider associations (such as our partner, Kentucky Primary Care Association) and present at regional association conferences.

Embedded Care Managers. We will embed Molina care managers in PCP sites and other key care sites to engage Enrollees and provide education and assistance. This will prove especially beneficial to practices with high Enrollee admission/readmission rates, high rates of healthcare disparities, low rates of referral to Molina care management, and high rates of Enrollees with chronic conditions. Molina care managers will engage actively with Enrollees, providers, and provider office staff to identify and address Enrollee needs and barriers, including their understanding of their health and ability to navigate the healthcare system. Care managers will educate Enrollees on their health conditions, refer Enrollees to programs (e.g., diabetes disease management), ensure Enrollees' understanding of their provider visits and next steps, and make sure Enrollees understand information provided to them (e.g., prescription bottles, appointment slips).

Enrollee Locator Teams. Our Enrollee Locator Teams will deliver specialized support in locating difficult-to-reach Enrollees, like those experiencing homelessness. Our teams will mine data for high-risk/high-needs Enrollees from diverse sources (e.g., claims, authorizations, ED/hospital utilization, pharmacy, and state data). Our local teams will know where homeless individuals tend to sleep and congregate, and will reach out to shelters, the Salvation Army, Community Mental Health Centers, and CBOs. They will place at least one phone call for every phone number identified, including contacts for family members, emergency contacts, friends, shelters, or other identified sources.

The breadth and depth of our community–based teams will enable Molina to engage and connect Enrollees with the care and services they need to improve health outcomes while also fostering productive provider partnerships that will enhance their ability to drive toward achievement of the Department's goals.

a.iii. GOVERNING BODY

Molina's Board of Directors comprises interim chief executive officer (CEO), Dwayne Sansone, as well as two other board members who are senior leaders appointed from within the Molina Healthcare, Inc., family of companies. All individuals selected for the Board are seasoned professionals who have demonstrated excellence in the managed care environment in which Molina operates.

Description of the Board

The Board of Directors acts in accordance with the Bylaws of Molina Healthcare of Kentucky, Inc., which were drafted in accordance with the laws and regulations of the Commonwealth, including its corporation laws. The Board will exercise direction over the affairs of Molina through the appointment of qualified officers to manage day-to-day operations. Officers are appointed by the Board and serve at the pleasure of the Board. The Board of Directors will meet quarterly, or more frequently, as appropriate. At quarterly and ad hoc meetings, the Board will receive reports by senior officers and personnel, review, and, if appropriate, approve significant Molina policies, initiatives, and transactions. In accordance with the Draft Contract, Section 5.5 Governance, the Board will keep a permanent record of all proceedings that will be available to the Cabinet and/or CMS upon request.

How Members are Selected

Members of the Board will be selected annually through a vote by the Shareholders during their meeting at Molina's Kentucky headquarters each calendar year. Directors will be elected by a plurality of the votes cast, as long as there is a quorum present.

Role Specific to Molina's Support of the Kentucky Medicaid Program

Based on our parent company's decades of experience in managed care, we know that individuals closest to the members we serve are in the best position to make decisions about health plan operations, which is why a primary role of the Board is to facilitate the selection process of our local health plan leadership and provide support to the plan during start-up and operations. The Board will ensure the health plan has the resources and support needed to meet Kentucky Medicaid program goals and requirements. The composition of our Board reflects our philosophy that healthcare is local.

Board member, Dwayne Sansone, also our CEO, is an expert at health plan implementation and will spearhead efforts to identify experienced and qualified local candidates during the Implementation Phase. Board member Dora Wilson served as chief operating officer of a major Medicaid MCO in Louisville, gaining first-hand experience and understanding of the needs of both Kentucky Medicaid and foster care Enrollees. Our third board member, Dr. LaTonia Sweet, is, as mentioned previously, a lifelong Kentuckian who received her MD from the University of Kentucky and is Board Certified in Psychiatry and Addiction Medicine. Dr. Sweet's experience includes the development of treatment programs within the Commonwealth to address substance abuse, and she has received numerous awards and recognitions for her dedication and success.

All three of our Board members hold senior leadership positions within our parent company organization, whose focus is and has always been on serving the needs of members in government-sponsored programs, not commercial plans. The Board will approve the members of Molina's executive team, and their first order of business will be to ensure that qualified local candidates are located, hired, and approved to fill each role, starting with the permanent CEO. The Board will provide oversight and support, but the day-to-day operations of the health plan will be entrusted to the local leaders who know the needs of Kentucky Medicaid Enrollees best.

a.iv. KEY PERSONNEL

Our staffing approach for the Kentucky Medicaid program incorporates a highly qualified Implementation team during the Implementation Phase to ensure a permanent local team is hired and trained before go-live. They will ensure we employ the right balance of staff in all the right places to provide optimal service to Enrollees. To that end, our proposed executive team and key staff will serve in these Implementation team roles, leading the initial development while we continually look for local talent to permanently fill each role. These proposed individuals are leaders in their respective functional areas and will bring a wealth of experience to the critical planning and implementation phases of the program.

In addition to the executive and key personnel, we are also proposing additional staff for our operations phase. We believe these roles will be critical to the success of the Kentucky Medicaid program and will meet the needs of plan operations based on our experience enterprise wide as well as the specific needs of the Kentucky population. Additional roles will include Molina Community Health Workers and housing specialists, who will work within communities to address social determinants of health; peer support specialists, who will work with Enrollees who have a mental health or SUD diagnosis to promote recovery and help them access critical services; and transition of care coaches, who will be embedded in high-volume facilities and will follow up with Enrollees for 30 days after discharge to coordinate services and build self-management skills that prevent readmissions.

a.iv.a. Names, Titles, Job Descriptions, Qualifications, FTEs, and Office Locations

Because our health plan will not go live until January 2021, our Implementation team will use that time to fine-tune our Kentucky team by finding locally based and appropriately licensed candidates who not only meet, but also exceed, the Commonwealth's high standards as well as our own stringent experience requirements. Part of our success comes from having employees who reflect and are truly a part of the very communities they support. Our team of executive and key staff are leaders in their respective areas, and they each bring a deep understanding of what it takes to successfully serve Kentucky's Medicaid Enrollees.

Throughout the transition time frame, the proposed individuals will remain committed to ensuring the health plan is appropriately staffed with local, qualified hires and will serve on an advisory basis thereafter. They also will be available to the Department throughout the Implementation Phase to answer any questions and provide support during health plan start-up. Except for the management information system director, who will support both Molina and its affiliated health plans, those selected for the permanent executive team and key staff roles, all of whom are subject to approval by the Commonwealth, will be FTEs solely dedicated to the Kentucky Medicaid program for the duration of the Contract.

During implementation, our Kentucky Medicaid program team will be under the direction of interim Chief Executive Officer Dwayne Sansone, an executive leader with more than 20 years of experience across various industries, including health insurance and healthcare IT. Before joining Molina, Mr. Sansone served as regional vice president and national head of network, technology and innovation for Aetna's Medicaid enterprise. In that role, he was responsible for all provider network contracting, value-based solutions, population health, technology, and innovation divisions. He has also served as chief operating officer for Aetna's Medicaid division, where he oversaw the day-to-day operations, network, technology, integration, and strategy departments across Aetna's 17-state Medicaid line of business. He will work closely with Dr. Jason Dees, medical director, and Dr. LaTonia Sweet, behavioral health director, to ensure we hire the right individuals with the right combination of clinical expertise to work with Kentucky's most vulnerable population.

Our medical director, Dr. Dees, is an accomplished practicing physician and executive with experience working in states that are similar to Kentucky, including Mississippi and Tennessee. Dr. Dees' professional accomplishments include building effective organizations through market growth and development, operations, and medical management and managing large-scale projects on time and within budget. As interim medical director, Dr. Dees will support each department's strategic planning and operational improvement processes with emphasis on improved healthcare cost and quality. He will be responsible for day-to-day oversight and management of the Medical Affairs department and staff, including the medical directors, dental director, behavioral health directors, and pharmacy director. He will also maintain responsibility for clinical directors employed by subcontractors.

Mr. Sansone leads a team with extensive experience in implementations and is dedicated to working with the Commonwealth to address areas of need that have been identified now or will be identified in the coming years. All our implementation key staff are current Molina employees and are among our leading subject matter experts at the corporate or health plan level. Mr. Sansone and his leadership team are authorized to make decisions involving the health plan. With the full support of our parent company and corporate resources, Mr. Sansone is empowered to make contractual, operational, and financial decisions, including rate negotiations, claims payment, and provider relations/contracting.

The individuals named below in Table B.3-1 detail our executive leadership team during the Implementation Phase. We will fill all executive team and key staff positions with permanent, qualified hires before go-live in compliance with the requirements in Draft Contract, Section 9.1, Office in the Commonwealth and Section 9.2, Administration/Staffing.

Table B.3-1. Executive Team Key Personnel

Title	Name
Chief Executive Officer (CEO)	Dwayne Sansone
Chief Financial Officer	Daniel Gudz
Chief Compliance Officer	Chris Mardesich
Medical Director	Dr. Jason Dees
Pharmacy Director	Kimberly Broyles-Kpogli
Dental Director	Dr. Jacinto Beard
Behavioral Health Director	Dr. LaTonia Sweet
Provider Network Director	Kim Sweers
Quality Improvement Director	Deborah Wheeler
Population Health Management Director	Emily Higgins

In response to the language in the Draft Contract, Section 9.2 Administration/Staffing, which allows for other key personnel as defined by the Contractor to fully support implementation and ongoing plan operations, we have included additional staff beyond what is required, as shown in Table B.3-2. This is in recognition of the importance of these roles in Kentucky and our best-in-class model of care and approach to plan operations.

Table B.3-2. Additional Key Personnel Beyond Contract Requirements

Additional Staff Positions	
Care Management Director	Care Managers
Vice President, Government Contracts	Peer Support Specialists
Housing Specialist	Transition of Care Coaches
Addictionologist	Molina Community Health Workers

The job descriptions and corresponding qualifications detailed in Tables B.3-3 through B.3-29 describe all executive team key personnel and other key staff required in Draft Contract, Sections 9.1, Office in the Commonwealth and 9.2, Administration/Staffing, as well as other proposed key staff, including definitions of their responsibilities. Each table also includes the office location for every executive team and key position required by the Commonwealth.

Executive Team Key Personnel

Table B.3-3. Chief Executive Officer (CEO)

Job Description
• Employed by Molina in a dedicated, full-time role located in Kentucky, with clear authority over the general administration and implementation of requirements detailed in the contract, and authorized and empowered to make contractual, operational, and financial decisions, including rate negotiations for Kentucky Medicaid business, claims payment, provider relations/contracting, and Medicaid activities • Oversees day-to-day business activities pursuant to the Kentucky Medicaid contract located in Kentucky • Makes rapid-cycle, timely, and responsive decisions regarding health plan operations while ensuring high-quality care delivery to Enrollees • Formulates and implements business plans and strategies to ensure profitable operations, meet short-term objectives, and ensure long-term growth and success • Directs the growth of the health plan, including overseeing business development activities. Identifies, analyzes, and recommends strategic alliances and/or acquisitions to provide better products and services to Enrollees • Develops and implements adequate measures to meet company fiscal needs, conserve its assets, and maintain an effective system of budgetary control • Reviews forecasts and proposed capital expenditures. Recommends programs and policies by analyzing the changing needs of the membership and industry. Identifies and analyzes trends, and evaluates options • Amends existing policies to improve operations, and creates new policies as needed. Presents reports and recommendations on the operations and finances of the Kentucky health plan, and proposes changes to major policies • Ensures the overall level of quality for delivery of medical services meet or exceed appropriate standards • Provides personal leadership that encourages employee productivity and responsiveness to the needs of current and prospective Enrollees • Ensures programs are established to comply with all relevant federal, Commonwealth, and local regulations • Effectively represents Molina with Commonwealth regulators, legislators, advocates, and other constituents • Fosters and builds a collaborative working environment with internal and external colleagues and constituents • Attends all required meetings with the Department
Qualifications
Bachelor's Degree in Business, Health Services Administration or related field. 15-plus years of progressive experience in the managed healthcare industry, including 10 years of management experience. **Preferred:** Master’s Degree in Business, Health Administration, or related field. Direct experience with Medicaid and Medicare managed care plans
Office Location
Molina’s chief executive officer will be located at our Louisville, Kentucky headquarters.

Table B.3-4. Chief Financial Officer

Job Description
• Oversees budget and accounting system, and Molina's other financial-related functions • Delivers accurate and timely financial reports • Reviews and analyzes premium rates received from the Commonwealth for appropriateness. Develops analysis and arguments to support rate negotiations with the Commonwealth. Monitors risk adjustment factors applied to rates (as applicable), and evaluates the financial impact of periodic adjustments • Reviews and analyzes medical cost performance, including provider contract and medical management efficiency, identifying and implementing opportunities for improved profitability. Monitors and compares across regions, populations, provider panels, and external and internal benchmarks • Reviews and analyzes monthly claims reserves for accuracy. Assists corporate actuarial department in setting monthly claims reserves • Reviews and analyzes administrative costs, identifying and implementing opportunities for improved profitability • Reviews and interprets health plan financial performance with plan staff and corporate accounting staff. Monitors actual to budget performance. Identifies and implements appropriate responses to budget variances • Develops and prepares management reports • Manages health plan functional departments, including Reporting and Analysis, Project Management Office, Facilities Services, and Enrollment • Manages relationship with Commonwealth department of insurance and other regulators for all financial matters • Develops annual budget • Reconciles premium receipts to eligibility in claims system • Supports health plan strategic analysis and planning • Reviews and analyzes financial terms of provider contracts and recommends changes. Develops scenario modeling, and identifies cost savings • Responds to all utilization management data needs, facilitating care coordination • Works with and supports Molina Healthcare, Inc. (MHI), Healthcare Data Analysis department to support reporting, financial performance, common metrics, and formatting and increase quality in all healthcare data analytical activities. Coordinates activities with corporate personnel to avoid duplication of work. Ensures full data support with regard to data needs for quality improvement activities (HEDIS and CAHPS). Provides local plan support for provider report card/performance monitoring activities with regard to quality, pay-for-performance, and medical costs • Represents the finance function by participating on committees, task forces, work groups, and multidisciplinary teams as necessary • Acts as a liaison to both internal and external customers on behalf of Molina and data management areas • Manages the encounter process for the health plan, ensuring that all encounters are successfully submitted and that errors are resolved. Ensures the encounter process fully supports rate-setting exercises, collection of case rate payments, and maximization of risk scores while complying with all applicable Commonwealth guidelines
Qualifications
Required Education: BA, BS, in finance, accounting, or related field **Preferred Education:** CPA. MBA preferred in absence of CPA **Required Experience:** 10-plus years of accounting/finance experience, and 3-plus years of previous supervisory/management experience **Preferred Experience:** 5-plus years of managed care experience, preferably working with the Medicaid product
Office Location
Molina's chief financial officer will be located at our Louisville, Kentucky headquarters.

Table B.3-5. Chief Compliance Officer

Job Description
• Maintains current knowledge of federal and Commonwealth legislation, legislative initiatives, and regulations relating to Contractors, and oversees Molina's compliance with the laws and requirements of the Department • Serves as the primary contact for and facilitates communications between Molina leadership and the Department relating to Contract compliance issues • Monitors compliance with all the requirements of the Agreement; oversees Molina's implementation of and evaluates any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by the Department • Establishes audit controls and measurements to ensure correct processes are established. Develops and performs internal audits/risk assessments, monitoring program for Molina departments. Provides post-audit findings and recommendations to ensure Commonwealth and federal compliance • Coordinates development of written policies and procedures regarding compliance with local, Commonwealth, and federal guidelines • Selects and directs the Compliance Committee • Facilitates delivery of specialized education and training concerning compliance responsibilities • Develops and implements Anti-Fraud program • Establishes active relationships with third parties who have specific experience conducting fraud investigations • Responds to inquiries and reports concerning compliance or non-compliance • Assists management with enforcement and discipline in appropriate instances of non-compliance • Regularly informs Board of Directors of the status of and activities pertaining to compliance • Reports upon discovery incidents and issues of non-compliance related to HIPAA to the Privacy Official within 24 hours • Submits all PHI requests to privacy official for approval/processing • Works with all business segments to increase awareness of the importance of Compliance and Anti-Fraud plans • As a representative of key management, enforces in day-to-day responsibilities the Compliance Plan, Code of Conduct, and Anti-Fraud Plan • Provides leadership for the compliance function and serves as a resource to departments and health plans on compliance issues, including budgeting for activities related to implementation of the Compliance Plan
Qualifications
Required Education: Bachelor's degree required, Master's degree preferred. Five-plus years of previous compliance program and contract experience with Medicaid/Medicare programs, including conduct of internal and state audits **Required Experience:** Five-plus years of experience with healthcare regulatory agencies in development or implementation of compliance and fraud programs Five-plus years of experience with overseeing implementation of contract requirements Experience providing representation to the Board and senior management on health plan issues relating to compliance and fraud program management
Office Location
Molina's chief compliance officer will be located at our Louisville, Kentucky headquarters.

Table B.3-6. Medical Director

Job Description
• Responsible for day-to-day oversight and management of the medical affairs department and staff, including the medical directors, quality director, director of behavioral health, and director of pharmacy services. Also responsible for clinical directors employed by subcontractors. Supports each department's strategic planning and operational improvement process with emphasis on improved healthcare cost and quality • Licensed to practice in Kentucky • Oversees the health plan's clinical functions. Actively involved in all major health programs developed by Molina • Responsible for treatment policies, protocols, quality improvement activities, population health management activities, and utilization management decisions, devoting sufficient time to ensure timely medical decisions • Ultimately responsible for all of Molina's clinical decisions, and oversees and is responsible for the proper provision of covered services to Enrollees • Available to Molina staff for consultation on referrals, denials, complaints, grievances, and appeals; reviews potential quality of care problems, and participates in the development and implementation of corrective action plans; also available for after-hours consultation, if necessary • Attends meetings when requested by the Department • Works collaboratively with the VP of healthcare services to develop and implement clinical policies and provide clinical oversight • Directs the medical affairs team to work with the healthcare services team to develop and implement effective and efficient standards, protocols, decision-support systems, reports, and benchmarks that meet annual cost and quality targets • Supports credentialing processes and manages credentialing policies; oversees the Molina Credentialing Committee as Chair • Serves as the "clinical face" of Molina to the community • Responsible for meeting annual healthcare cost and quality targets for the plan and achieving/retaining NCQA rating • Provides oversight, support, and direction for health plan's quality programs in the areas of healthcare services, delegation oversight, credentialing, and NCQA (HEDIS & CAHPS) • Provides oversight, support, and direction to the quality director, and drives the HEDIS and NCQA processes to achieve and maintain an excellent rating • Provides oversight, support, and direction to the pharmacy director to develop cost-effective clinical protocols. Participates on the P&T Committee, and assists in the formulary management process • Supports provider network management activities that improve unit cost, access, and quality. Assists with contracting and solidifying relationships with key providers • Supports and supervises the medical directors for daily utilization management decision-making using evidence-based medicine guidelines, and monitors and improves productivity, healthcare cost, and quality. Provides clinical oversight, including inter-rater review annually • Oversees regularly scheduled claims review sessions (DCRR – denied claims review requests) between the medical directors and the internal provider network management staff • Drives integration of behavioral and physical health components in all aspects of service to Enrollees • Influences changes that benefit Molina and our Enrollees by participating in community committees and task forces with the Commonwealth, network providers, and community organizations. Develops advocates among the Commonwealth's clinical community that can be called upon to speak on behalf of issues that are important to Molina before legislators, regulators, and other key influencers • Chairs the Executive Quality Improvement Committee and participates in all quality committees, such as the Clinical Quality Improvement Committee, the Satisfaction Committee, and other internal task forces and work groups required by NCQA • Accountable for ensuring compliance with contractual, accreditation, and regulatory requirements for all medical affairs teams

Qualifications
Required Education: Doctorate Degree in Medicine
Required Experience: Two years of previous Medical Director experience; three years of Utilization/Quality program management; minimum five years of clinical practice experience; minimum two years of HMO/managed care experience; must possess expertise with Behavioral Health Services decisions for Enrollees, including after regular business hours
Preferred Experience: Peer review; medical policy/procedure development; provider contracting
Residency Requirements: Must reside in the Commonwealth of Kentucky
Required Licensure/Certification: Currently licensed in Kentucky under the Kentucky Board of Medical Licensure as an M.D. or D.O. with no restrictions or other licensure limitations
Office Location
Molina's medical director will be located at our Louisville, Kentucky headquarters.

Table B.3-7. Pharmacy Director

Job Description
• Coordinates, manages, and oversees the provision of pharmacy services to Enrollees • Licensed in Kentucky • Oversees pharmacy management, and coordinates and serves on the health plan's P&T Committee • Reviews Enrollee, physician, pharmacy, and drug utilization reports. Identifies trends affecting the pharmacy budget. Requests, reviews, and summarizes ad hoc reports as required. Provides regular summaries of activities to the medical director • Responsible for formulary development and maintenance. Participates in the evaluation of new drug products • Develops criteria for reviewing prior authorization requests. Assists in the review of prior authorization requests, and summarizes the approval and denial of such requests • Selects and maintains appropriate pharmacy reference resources. Researches and references drug-therapy-related questions • Recommends and implements appropriate actions and educational programs to influence prescribers. Ensures systems are in place to monitor results • Participates in quality improvement and health education programs related to pharmacy, including healthcare management and OHCA-required programs. In conjunction with health plan management, participates in management committee meetings • Participates in provider meetings as required • Performs audits of patient charts, provider sites, and pharmacies as required
Qualifications
Required Education: Bachelor's degree in pharmacy **Preferred Education:** Doctorate in Pharmacy (PharmD) is preferred. Completion of ASHP-approved residency program **Required Experience:** Minimum of two years in the healthcare industry or equivalent experience in managed care and/or retail pharmacy is preferred. Prior experience in the oversight of projects and managing people is desired. Must have prior work experience with vendors, outside contacts and other healthcare professionals to accomplish responsibilities. Knowledge of computer data extracting methods. Strong knowledge of pharmacological management of chronic disease states **License Credentials**: Licensed to practice pharmacy in the Commonwealth. Must be free of sanctions from Medicaid or any other government program and without restrictions that would affect job performance
Office Location
Molina's pharmacy director will be located at our Louisville, Kentucky headquarters.

Table B.3-8. Dental Director

Job Description
• Licensed to practice dentistry in Kentucky • Actively involved in all of Molina's oral health programs, devoting sufficient time to ensuring timely oral health decisions; available for after-hours consultation, if needed • Provides dental oversight in appropriateness and medical necessity of dental care services provided to health plan Enrollees, targeting improvements in efficiency and satisfaction for patients and providers, as well as meeting or exceeding productivity standards • Serves as a resource for all clinical interpretation and analysis and oversees all aspects of the health plan's utilization review and management activities related to dental care; provides oversight of dental quality programs (HEDIS and pay-for-performance). • Develops and implements clinical utilization processes and algorithms utilized in the authorization process; statistical methodology for use in utilization management and provider profiling analytics; dental policies and procedure; and Quality Improvement activities • Partners with Provider Network department to secure and maintain a network of dental consultants • Educates and interacts with network and group providers regarding utilization practices, guideline usage, and effective patient management; provides clinical representation for company presentations in partnership with provider relations • Provides guidance to staff regarding appeals, grievances, and Enrollee/provider complaints • Provides analytics and interpretation of dental benefit plan structures • Maintains accountability for Enrollee-related decisions for self and network of dental consultants • Ensures that the dental care provided meets the standards for acceptable dental care and that dental protocols and rules of conduct for plan personnel are followed • Participates in professional and community activities to provide input and become knowledgeable regarding regulatory, professional, and community standards and issues
Qualifications
Required Education: DDS or DMD degree **Required Experience:** 7-plus years in clinical dental practice. 3–5 years in a health plan, insurance, or benefits administration setting. Minimum of 2 years of experience with HMO/managed care **Preferred Experience:** Peer Review, medical policy/procedure development, provider contracting experience. Knowledge of NCQA, HEDIS, Medicare, Group/IPA practice, capitation, HMO regulations, managed healthcare systems, quality improvement, and medical utilization management **License Credentials:** Current, active, and unrestricted Dental License in the Commonwealth with the authority to complete job responsibilities in applicable location to meet scope of work.
Office Location
Molina's dental director will be located at our Louisville, Kentucky headquarters.

Table B.3-9. Behavioral Health Director

Job Description
• A behavioral health practitioner licensed in Kentucky who is actively involved in all programs or initiatives relating to behavioral health • Coordinates efforts to provide Molina's behavioral health services • Provides psychiatric leadership for utilization management and care management programs for mental health and chemical dependency services • Indirectly supervises Health Plan Psychiatric Medical Directors in implementing integrated behavioral health care management programs • Works closely with the MHI VP of Behavioral Health and National Medical Directors to develop standardized utilization management policies and procedures to be implemented enterprise-wide that will improve quality outcomes and decrease costs • Develops scorecard benchmarks for behavioral health clinical staff productivity. • Standardizes utilization management practices and quality and financial goals across all LOBs • Responds to behavioral health-related RFP sections and reviews behavioral health portions of Commonwealth contracts • Works with trainers to develop and provide enterprise-wide teaching on psychiatric diagnoses and treatment • Writes, refines, and approves behavioral health policies and procedures for utilization and care management • Provides second level behavioral health clinical reviews, behavioral health peer reviews, and appeals • Facilitates behavioral health committees for quality compliance • Works with VP Pharmacy to establish standard psychiatric formulary • Implements clinical practice guidelines and medical necessity review criteria • Tracks all clinical programs for behavioral health quality compliance with NCQA and CMS • Participates in the recruitment, placement, and orientation of new HP Psychiatric MDs • Ensures all behavioral health programs and policies are in line with industry standards and best practices • Assists with new program implementation and supports the health plan in-source behavioral health services • Assists with reviewing and evaluating behavioral health vendors
Qualifications
Required Education: Doctorate degree in Medicine (MD or DO) with Board Certification in Psychiatry **Required Experience:** 2 years of previous experience as a Medical Director. 3 years of experience in Utilization/Quality Program Management. 5+ years in clinical practice. 5+ years of HMO/Managed Care experience. Current clinical knowledge. Experience demonstrating strong management and communication skills, consensus building and collaborative ability, and financial acumen. Knowledge of applicable Commonwealth, federal, and third-party regulations **Preferred Experience:** Peer Review, medical policy/procedure development, provider contracting experience. Experience with NCQA, HEDIS, Medicaid, Medicare, and Pharmacy benefit management, Group/IPA practice, capitation, HMO regulations, managed healthcare systems, quality improvement, medical utilization management, risk management, risk adjustment, disease management, and evidence-based guidelines **Required License Credentials:** Active and unrestricted Commonwealth of Kentucky Medical License, free of sanctions from Medicaid or Medicare
Office Location
Molina's behavioral health director will be located at our Louisville, Kentucky headquarters.

Table B.3-10. Provider Network Director

Job Description
• Responsible for oversight of Provider Services and Provider Network Development, providing oversight of required coordination with the Department's contracted Credentialing Verification Organization(s) (CVOs) • Coordinates workforce development initiatives conducted by Molina and collaboratively with the Department and other contracted MCOs • Coordinates all communications and contractual relationships between Molina and our subcontractors and providers • Ensures providers are appropriately educated about Medicaid program participation • Ensures and maintains a sufficient provider network, developing and implementing provider and contract strategies, and identifying specialties and geographic locations on which to focus resources • Develops a market-specific provider reimbursement strategy consistent with reimbursement tolerance parameters across multiple specialties/geographies • Oversees the development of new reimbursement models • Tracks contract negotiation activity on an ongoing basis throughout the year • Prepares and negotiates provider contracts, and oversees contract negotiation in concert with established company templates and guidelines with physicians, hospitals, and other providers • Maintains all provider contract information and provider contract templates, and ensures that all contracts negotiated are configured in the claims system • Ensures contract templates comply with all contractual and/or regulatory requirements • Provides plan-specific fee schedule management • Implements strategies to improve EDI/MASS rates • Oversees provider services, including all provider services representatives, and coordinates activities with provider association(s) and joint operating committee management • Provides accountability for the health plan's delegation oversight function • Oversees the provider network administration area, including provider information management and business analyses of contracts and benefits to support accurate configuration for claims payment • Oversees all provider/Enrollee problem prevention, research, and resolution, as well as the provider/Enrollee appeals and grievance processes • Formulates and implements business plans, tactics, and strategies to provide for efficient, effective, and compliant operations to meet short-term objectives/obligations and ensure long-term growth and success • Develops and implements adequate measures to meet operational needs, efficiently use resources, and maintain an effective system of operational processes and outcome measurement • Creates new policies and amends existing policies to improve operations • Ensures the overall level of quality for operational and contractual obligations meet or exceed appropriate standards
Qualifications
Required Education: Bachelor's degree in Business, Health Services Administration, or related field, or equivalent experience **Preferred Education:** Master's degree **Required Experience:** 7–10 years' experience in healthcare administration, managed care, and/or provider services
Office Location
Molina's provider network director will be located at our Louisville, Kentucky headquarters.

Table B.3-11. Quality Improvement Director

Job Description
• Responsible for the operation of the Molina's Quality Improvement Program, including leading program development, implementation, and management of quality management and quality initiatives within the health plan • Collaborates with the chief medical officer in overseeing medical service delivery and quality of care for health plan Enrollees • Supports provision of high-quality clinical care by building strategic relationships with healthcare providers • Supports maintenance of marketable, high-quality, cost-effective provider networks • Coordinates, directs, and manages the activities of the department and the quality management program • Analyzes the quality of Enrollee care received—both individual and systematic—and the development of plans and programs to support continuous quality improvement • Develops strategic plans, policies, and procedures at all levels and with all critical operation departments to ensure quality programs are consistent with overall Molina Healthcare quality strategies • Investigates and resolves all quality-of-care grievances • Manages the collection and monitoring of multiple population data sources to ensure the needs of program Enrollees are assessed and met through the health plan
Qualifications
Required Education: BA/BS/BSN or equivalent work experience **Preferred Education:** Advanced clinical degree or advanced public health or healthcare administration degree **Required Experience:** Minimum of five years of experience in health plan quality improvement **Preferred Experience:** HEDIS reporting or collection, CAHPS improvement, State QI experience, NCQA Accreditation, Medicaid and/or Medicare QI
Office Location
Molina's quality improvement director will be located at our Louisville, Kentucky headquarters.

Table B.3-12. Population Health Management Director

Job Description
• Responsible for planning, consultation, strategic design, implementation, coordination, oversight, and evaluation of population health management program, services, and initiatives • Continuously updates health initiatives to ensure that all initiatives continue to meet Commonwealth and federal regulatory guidelines • Participates with senior managers, managers, supervisors, and team leaders across the organization to facilitate operational management of the service, including integrated service delivery, planning, quality assurance, risk management, and occupational health and safety • Provides leadership, motivation, and direction across Molina Healthcare of Kentucky to ensure that the organization supports population health best practices • Ensures programs and projects are evidence-based and tailored to local communities • Recruits, trains, and supports the professional development of population health staff in collaboration with the care management department • Represents Molina at relevant network meetings and other workgroups • Works in collaboration with senior managers, managers, the Board of Directors, staff, providers, and the community for improvement of Kentucky Medicaid population health outcomes • Forecasts and reviews trends and developments, both internally and externally, that affect current and future service for continued improvement of programs • Oversees all reporting and accountability requirements for programs in collaboration with care management department • Develops strategies for Molina staff and the local community to have input into the development of evidence-based health promotion planning and delivery tailored to local requirements • Works collaboratively with managers and team leaders to promote the pursuit of quality improvement and innovation • Works in collaboration with population health analytics, IT, and quality to ensure alignment of care management • Leads strategic effort in translating organizational goals into executable projects • Demonstrates a willingness to collaborate with others, and maintains a positive attitude • Analyzes reports and develops a strategy to improve outcomes and close gaps
Qualifications
Required Education: Bachelor’s degree in related field (i.e., nursing, public health, healthcare administration) **Preferred Education:** Master's degree in related field **Required Experience:** Minimum of two years of healthcare leadership experience. **Preferred Experience:** Participation in successful population health programs, including data management, performance management, and training
Office Location
Molina’s population health management director will be located at our Louisville, Kentucky headquarters.

Key Staff

Table B.3-13. Management Information System Director

Job Description
• Oversees, manages, and maintains Molina's IT and systems to support operations, including submission of accurate and timely encounter data • Provides technical and process knowledge within IT across silos and business partners to support consulting, problem resolution/facilitation, and effective intake and solutioning • Coaches and brings resources to bear on project deliverables including BRD, RRD, PR, and CR • Participates in IT service development and reporting of service SLAs to Business stakeholders. Champions ITSM processes; provides training and support for process rollout, monitoring of processes and Business feedback to IT, and effective rollout of revised processes • Identifies and documents changes to IT services and supporting processes and/or opportunities for service delivery improvement. Facilitates groups for problem solving and service improvement, including definition/documentation and business workflow analysis • Develops effective processes, forums, and tracking mechanisms to continuously improve process through Business feedback, proactive handling of Business complaints, and facilitation of resolution • Conducts semi-yearly service reviews of IT projects status/metrics and major milestones. Conducts bi-weekly Operations and Issues meeting • Works with SDM team to develop and enhance the ITIL Business Relationship Management (BRM) Model • Develops and maintains a Service Delivery Plan for individual health plans or corporate functions to include Business strategies/needs with corresponding IT strategies/plans, IT projects, IT performance measurements, customer satisfaction improvement plans, and other items as determined by the CIO or AVP • Communicates and facilitates issue resolution with third-party vendors • Presents to SDM team the Semi-Annual IT Report to include: IT Accomplishments, Performance Metrics, Project Intake, and Release Plan/Roadmap Status • Uses standard communication protocols and forums to consistently provide updates and promotion of IT services/projects, which includes support and maintenance of marketing plan to promote within IT organization, IT wins/major projects, and improvements in IT value perception both with IT employees and with our business community • Effectively manages business escalations within the IT organization by ensuring appropriate accountability, sense of urgency, communication, and follow-through to closure • Demonstrates SME knowledge of MCO contract compliance requirements that impact IT services or processes • Facilitates and leads processes and activities to complete deliverables on behalf of the Commonwealth including, but not limited to, RFQ/RFP responses, audit response/coordination, and evaluation of new contract requirements • Consolidates IT responses, and leads the walkthrough of IT responses with IT management • Participates in government meetings as well as coordinates additional MIT SME participation as necessary
Qualifications
Required Education: Bachelor's degree in Business, Healthcare, Computer Science, Information Systems or 10 years of related field or equivalent experience **Preferred Education:** Master's degree in Computer Science, Information Systems or Healthcare-related field **Required Experience:** 5-12 years business function or relations management experience and/or 5–7 years IT or system delivery or related experience. 3 years strategic planning experience with a project management background **Preferred Education:** 3-plus years of management experience and 3-5 years of managed care experience
Office Location
Molina's management information systems director will be located at our Louisville, Kentucky headquarters.

Table B.3-14. Enrollee Services Manager

Job Description
• Oversees Enrollee services functions; located in Kentucky • Coordinates all communications with Enrollees, and advocates for Enrollees • Ensures the provision of sufficient Enrollee services staff and oversees that staff to ensure response in a timely manner to Enrollees seeking prompt resolution of problems or inquiries • Performs strategic planning for Call Center operations and inter-departmental processes • Develops and drives a culture that is passionate about quality and delivering exemplary customer experience • Provides leadership oversight of multi-site Call Center operations and support functions • Establishes, reviews, and modifies standard performance metrics and benchmarks • Develops infrastructure related to staffing and process gaps to drive optimal Call Center operations • Travels to local sites to support oversight, conduct assessments, and audits/readiness reviews as needed • Ensures operational excellence through process improvements/promotes change management processes • Ensures and monitors compliance with implementation of standardized processes and best practices • Serves as a subject matter expert (SME) in support of customer experience strategy projects • Collaborates, reviews, and proposes recommendations to enhance training curriculum. Drives a culture that is passionate about coaching. Pursues continuous enhancements of the coaching experience • Tracks and trends data, identifying areas for improvement in support of improved customer experience and administrative efficiency
Qualifications
Required Education: Bachelor's degree and/or 5–7 years of equivalent work experience **Required Experience:** Minimum five years of supervisory experience. Minimum three years of hands-on experience in Medicaid, Medicare, or CHIP programs. Extensive knowledge of managed healthcare. Ability to coordinate activities of and interact with multiple constituencies. Excellent interpersonal and communication skills (verbal and written). Excellent leadership and managerial skills
Office Location
Molina's enrollee services director will be located at our Louisville, Kentucky headquarters.

Table B.3-15. Provider Services Manager

Job Description
• Responsible for the oversight of provider services and network development functions • Coordinates network development and all communications with Molina providers, out of network providers (as applicable), and subcontractors involved in clinical services • Ensures sufficient provider services staffing ratios to support network development, communications, and education and to respond in a timely manner to providers seeking prompt resolution of problems or inquiries • Oversees staff that coordinates communications between Molina and its providers • Performs strategic planning for Call Center operations and inter-departmental processes • Ensures staff is adequately trained to understand cultural, linguistic, and disability competencies • Focuses on effective and efficient provider education and outreach, expedient resolution of provider questions, and coordination with Community Outreach team members • Acts as a resource and ensures plan meets initiatives, regulatory requirements, and strategic goals • Designs and implements programs to build and nurture positive relationships between contracted providers, ancillary providers, hospital facilities, and Molina • Develops and implements strategies to reduce Enrollee access grievances with contracted network providers • Responsible for compliance with provider service procedures
Qualifications
Required Education: Bachelor's degree or equivalent work experience **Required Experience:** Minimum of 7 years of experience in provider services or similar background. 3 years of experience in Management, Supervisory, or Lead/Sr. role with demonstrated leadership ability or program management experience required. Extensive knowledge of managed healthcare environment
Office Location
Molina's provider services manager will be located at our Louisville, Kentucky headquarters.

Table B.3-16. Utilization Management Director

Job Description
• Responsible for the operation of Molina's utilization management program, including supervision and coordination of daily utilization management operations, such as concurrent review and discharge planning, in accordance with systems, processes, policies, and procedures • Responsible for overseeing the work of subcontractors performing services relevant to utilization management • Responsible for hiring, orienting, and training staff to ensure maximum efficiency and productivity • Responsible for development and implementation of projects, policies, and procedures as assigned to ensure utilization management program meets NCQA standards and all contractual requirements • Responsible for staff performance appraisals, ongoing monitoring of MIS data entry, and application of medical necessity review criteria and guidelines • Collaborates with and keeps the Medical Director apprised of operational issues, staffing, resources, system, and program needs • Uses clinical assessment skills and knowledge of patient care to assist staff with decisions regarding appropriateness or medical necessity of services, and determines which cases should be referred to the medical director for evaluation • Responsible for coordination and reporting of utilization management statistics, including health plan utilization, staff productivity data, cost-effective utilization of services, and triage activities • Identifies and reports under- and over utilization management issues, delays in service or treatment, and quality of service issues per policies and procedures • Acts as liaison to internal and external customers on behalf of the Utilization Management department to ensure open communication, effective interface, and prompt resolution of identified issues • Responsible for coordination of staff schedules to ensure adequate coverage during business hours, Monday–Friday (excluding after-hours triage nurses)
Qualifications
Required Education: BA/BS in business or related field **Preferred Education:** Master's degree in business or healthcare management (i.e., MBA, MHA, MPH) or other related field such as MSW, MSG **Required Experience:** 7 years of managed care experience with line management responsibility, including clinical operations. Has worked within applicable state, federal, and third-party regulations. Has operational and process improvement experience **Preferred Experience:** Familiarity and experience in the local market desirable
Office Location
Molina's utilization management director will be located at our Louisville, Kentucky headquarters.

Table B.3-17. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator

Job Description
• Coordinates and arranges for the provision of EPSDT services and EPSDT special services • Provides oversight and subject matter expertise to care coordination staff and network providers • Assists with directing Enrollees to providers who can deliver the medically necessary services • Provides outreach for EPSDT health checks and maintain appropriate documentation according to policies, procedures, and regulatory guidelines • Assists in education of Enrollees regarding health conditions, available benefits and providers, plan services, and EPSDT special services available • Contacts Enrollees who are overdue for EPSDT services to make necessary appointments • Provides education on how to access EPSDT services • Contacts Enrollees for appointment reminders and provides follow-up calls post-appointment • Arranges for home visits for Enrollees who have difficulty accessing a PCP • Monitors child Enrollee service utilization to confirm they meet critical milestones • Responsible for collaborating with the healthcare services team to develop and implement projects related to improving health outcomes • Accurately creates and maintains reports as needed • Accurately complete and maintain documentation related to Enrollee interaction, assessment(s), demographic data, and Enrollee follow-up for future appointments
Qualifications
Required Education: High School Diploma or GED **Preferred Education:** Associates degree or other formal medical education/certification **Required Experience:** Minimum of two years of healthcare experience **Preferred Experience:** Previous care management, pediatric, and/or Medicaid managed care experience
Office Location
Molina's EPSDT coordinator will be located at our Louisville, Kentucky headquarters.

Table B.3-18. Guardianship Liaison

Job Description
• Serves as Molina's primary liaison for meeting the needs of Enrollees who are adult guardianship clients • Serves as the direct plan contact for agency coordinators and service providers regarding Enrollees with court-appointed guardians • Monitors access (including access to trauma informed care) for Enrollees with court-appointed guardians • Available to address any issues for managed care Enrollees with court-appointed guardians • Assist with care coordination of Enrollees with court-appointed guardians • Assist with enrollment, disenrollment, and access to care issues for Enrollees with court-appointed guardians • Provides community resource information to guardians and disabled individuals • Corresponds with guardians to request documentation or provide information
Qualifications
Required Education: Bachelor's degree in Business/Public Administration or Social Sciences with one year of experience in an administrative support position, or an Associate's degree with three years of experience or an equivalent combination of relevant training, education, and/or experience **Required Experience:** Experience with various agency databases and proficiency in Microsoft Office Suite **Preferred Experience:** Familiarity with guardianship **Required Knowledge/Skills:** Ability to identify problems, provide solutions, and work with confidential and/or sensitive data. Excellent organizational and record-keeping skills
Office Location
Molina's guardianship liaison will be located at our Louisville, Kentucky headquarters.

Table B.3-19. Program Integrity Coordinator

Job Description
• Serves as the single point of contact with the Department whose job duties are dedicated exclusively to the coordination, management, and oversight of Molina's Program Integrity unit to reduce fraud, waste and abuse of Medicaid services within Kentucky; Molina will facilitate timely response to Department requests for information • Provides complete oversight of overpayment, fraud and abuse detection, prevention and recovery initiatives; identifies new opportunities, and provides monthly reporting of successes and barriers; Identifies and addresses potential areas of overpayment, fraud, waste, and abuse or payment integrity risks • Assists the Special Investigations in developing a departmental strategic and operating plan, complete with goals, objectives, and quality measures, which outline the departmental activities and staff goals for the year • Project manages cross-functional corporate and health plan business teams and meetings in the development of overpayment, fraud, and abuse detection, prevention and recovery initiatives, baseline targets, and results as they relate to specific corporate strategies and programs • Provides oversight of all overpayment, fraud, waste, and abuse and recovery requirements, including routine audits, reporting to third parties, investigations, education, outreach, publications, and effectiveness reviews • Directs and oversees all activity and projects within Payment Integrity; ensures staff are fully aware of financial recovery objectives including cost avoidance savings • Provides strategic planning and vision of the overpayment, fraud, waste, and abuse detection and prevention and payment integrity program to ensure Molina is in compliance with federal and Commonwealth statutes and regulations • Prepares and delivers well-organized and compelling presentations to reflect key findings, analytic methods to determine such findings, future analysis and implications, and the identifications of opportunities to drive business improvements • Develops and implements key metrics to drive performance in quality and productivity • Creates reporting that identifies trends and patterns of overpayments, fraud, and abuse through data analysis • Maintains accurate reporting for recoveries for all audits performed adhering to departmental policies and procedures • Performs cost benefit analysis for key organizational programs and initiatives impacting medical cost and performance • Ensures compliance with sound principles of economic assessment, and uses explanatory and predictive models in the development, support and analysis, and determining the value of future medical management initiatives • Advises and assists with the development and implementation of processes to reduce risk to the organization • Serves as the point person and advocate for fraud, waste, and abuse and payment integrity matters • Refines and sustains a mechanism to ensure timely and consistent reporting of overpayments, fraud, waste, and abuse activities as required by government agencies and federal contracts • Provides oversight and direct accountability to ensure all investigations and audits are conducted as required by law and federal contracts and performed in a continuous and systematic manner • Understands and communicates to leadership and the Corporate Compliance Committee the breadth and complexities associated with fraud, waste, and abuse regulatory requirements • Maintains a matrix and direct oversight and central reporting of vendors impacting healthcare affordability and medical/pharmacy trend management • Assesses preparedness for new and emerging fraud, waste, and abuse trends, schemes, and draft regulations • Directs and oversees all activities of the Payment Integrity team to ensure that all commitments are met, target budgets are achieved, and resources are used effectively and efficiently; organizes, coordinates, and ensures the team adheres to departmental standards, policies, and procedures. • Drives the development of best in class and forward-thinking methods/criteria for identifying and correcting overpayment, fraud and abuse issues; integrates information from multiple sources, discerns implications for future analysis, and identifies opportunities for enhancing integrity of medical/pharmacy/vendor data • Works in conjunction with external vendors to implement best-in-class programs that are needed within the organization

Job Description
• Coordinates with Compliance Department to satisfy governmental programs fraud, waste and abuse requirements (Medicare, Medicaid and Marketplace) • Ensures a competent and effective staff is fully aware of departmental guidelines, policies and procedures, and that their skills are developed and maintained through a studied selection of training opportunities • Partners with IT, Finance, Corporate Operations, Legal, Clinical, Compliance, Healthcare Services, Product Management, Claims, Pharmacy Services, Special Investigations Unit, Client Services, and areas within Network Management/Provider Relations to champion, develop, and monitor overpayment, fraud and abuse initiatives for medical/pharmacy/network management programs • Establishes strategies and policies for maximizing recoveries • Ensures recoveries from SIU and FWA are appropriately executed and integrated with other partner areas
Qualifications
Required Education: Bachelor's degree in business, finance, health administration, or other related field **Preferred Education:** Master's degree in business, finance, or health administration field **Required Experience:** Minimum of 7 years in a management role directing fraud and abuse and recovery programs or related activities for a managed care, health insurance, pharmaceutical, or other health-related organization. Minimum of seven years of experience leading staff in projects or supervisory/management position. Demonstrated experience with data interpretation, analysis, and reporting; clinical and financial data; predictive modeling and forecasting; and key performance indicators as it relates to medical cost data. Demonstrated vendor contract negotiations, oversight, and management experience. Demonstrated project management experience running corporate wide projects. Demonstrated ability with creative, "out-of-the-box" thinking to develop original solutions to overcome roadblocks and meet or exceed customer requirements and expectations. Knowledge of medical claims data and managed care membership data. Knowledge of business intelligence applications, data, and tools. Advanced technical skills. Knowledge of Medicare and Medicaid program integrity regulatory requirements.
Office Location
Molina's program integrity coordinator will be located at our Louisville, Kentucky headquarters.

Table B.3-20. Enrollee and Provider Complaint, Grievance, and Appeal Coordinator

Job Description
• Responsible for the processing and resolution of all Enrollee grievances and appeals and provider complaints, grievances, and appeals • Assists Enrollees throughout the complaint, grievance, and Department fair hearing processes • Plans, directs, and coordinates staff functions, including development and training of staff • Oversees research and documentation for each Provider (/Enrollee) Inquiry and/or Dispute (and/or Appeals) • Ensures resolution is compliant • Coordinates workflows between departments, and interfaces with internal and external resources • Manages Provider (/Enrollee) Disputes (and/or Appeals) database • Oversees preparation of the narratives, graphs, flowcharts, etc., to be utilized for committee presentations, audits, and any internal/external reports • Oversees necessary correspondence in accordance with regulatory requirements • Maintains call tracking system of correspondence and outcomes for Provider (/Enrollee) Disputes (and/or Appeals) • Oversees monitoring of each Provider (/Enrollee) Dispute (Appeal) to ensure all internal and regulatory timelines are met • Maintains well-organized, accurate, and complete files for all Provider (/Enrollee) Disputes (Appeals) • Interfaces with providers, and performs duties pertaining to participating network satisfaction (e.g., credentialing, education, communication) • Oversees claims policies and procedures specific to benefits, contracts, and Commonwealth requirements
Qualifications
Required Education: High school diploma and two-year degree or six-plus years of work experience in field Preferred Education: Bachelor's degree **Required Experience:** Minimum three to four years of experience in claims review, and provider and/or Enrollee dispute and/or appeal resolution
Office Location
Molina's Enrollee and provider complaint, grievance, and appeal coordinator will be located at our Louisville, Kentucky headquarters.

Table B.3-21. QAPI Coordinator

Job Description
• Oversees, plans, and implements new and existing healthcare quality improvement initiatives and education programs; ensures maintenance of programs for Enrollees in accordance with prescribed quality standards; conducts data collection, reporting and monitoring for key performance measurement activities; and provides direction and implementation of NCQA accreditation surveys and federal/Commonwealth QI compliance activities. Coordinator is responsible for updating QAPI work plan and ensuring activities occur according to required timeline • Under the supervision of the QI Director, acts as a lead to provide project-, program-, and/or initiative-related direction and guidance for QI specialists within the department and/or collaboratively with other departments • Implements key quality strategies, which may include initiation and management of provider, Enrollee, and/or community interventions (e.g., removing barriers to care); preparation for Quality Improvement Compliance surveys; and other federal and Commonwealth required quality activities • Monitors and ensures that key quality activities are completed on time and accurately in order to present results to key departmental management and other Molina departments as needed • Writes narrative reports to interpret regulatory specifications, explain programs and results of programs, and document findings and limitations of department interventions • Creates, manages, and/or compiles the required documentation to maintain critical quality improvement functions • Leads quality improvement activities, meetings and discussions with and between other departments within the organization • Evaluates project/program activities and results to identify opportunities for improvement • Surfaces to Manager and Director any gaps in processes that may require remediation • Other tasks, duties, projects, and programs as assigned
Qualifications
Required Education: Bachelor's degree or equivalent combination of education and experience **Preferred Education:** Graduate degree or equivalent combination of education and experience in Clinical Quality, Public Health, or Healthcare **Required Experience:** Minimum three years of experience in health plan quality improvement, managed care, or equivalent experience. Demonstrated solid business writing experience. Operational knowledge and experience with Excel and Visio (flow chart equivalent) **Preferred Experience:** Two years of experience in Medicaid and Medicare **Preferred License Credentials:** PMP Certification (and/or comparable coursework), Six Sigma Black Belt Certification, Certified Professional in Health Quality (CPHQ)
Office Location
Molina's QAPI coordinator will be located at our Louisville, Kentucky headquarters.

Additional Key Personnel

Table B.3-22. Care Management Director

Job Description
• Oversees and manages all Molina care management programs and functions, including case and disease management • Works collaboratively with the chief medical officer to develop and implement processes to effectively manage clinical policies that meet healthcare cost and quality targets • Works with the healthcare services management team to achieve the successful implementation of Molina clinical strategy and direction • Mentors, guides, and develops skills of management team members in a consistent and effective manner • Develops and implements effective and efficient standards, protocols, processes, decision-support systems, reporting, and benchmarks that support ongoing improvements of clinical operations functions and promote quality, cost-effective healthcare for all Molina Enrollees • Manages implementation of analytical studies that clearly quantify the benefits of healthcare services department programs to ensure that resources are appropriately allocated to programs; operational controls exist; and efficiencies are maximized • Continually refines operational processes and championing review of team processes, workflows, and activities • Ensures compliance with contractual, accreditation, and regulatory requirements for all healthcare services teams • Participates personally or assigns appropriate staff to Molina quality committees and external community committees where healthcare services departments require representation • Develops the healthcare services department budget and meeting budget targets, including administrative and healthcare costs • Ensures effective interdepartmental collaboration and interaction between healthcare services staff and other departments • Ensures monthly auditing of healthcare services staff is performed and appropriate actions and/or coaching takes place • Oversees clinical training activities and outcomes • Monitors healthcare services-related delegation oversight
Qualifications
Required Education: Graduate degree **Preferred Education:** Master's degree in Business or Healthcare management (i.e., MBA, MHA, MPH) **Required Experience:** 10 years of managed care experience with line management responsibility, including clinical operations; experience working within applicable state, federal, and third-party regulations; operational and process improvement experience; demonstrated experience meeting Quality Accreditation Standards (NCQA/HEDIS/STARS) **Preferred Experience:** Familiarity and experience in the local market
Office Location
Molina's care management director will be located at our Louisville, Kentucky headquarters.

Table B.3-23. Vice President, Government Contracts

Job Description
• Responsible for overall leadership in the strategic development and administration of contracts with the Commonwealth and/or federal government for Medicaid, Medicare, and other government-sponsored programs • Performs contracts and relationship management for Commonwealth and federal partners; serves as liaison between the health plan and the Department • Serves in a dedicated, full-time role, authorized and empowered to make decisions about program issues • Represents Molina at the Department and other Commonwealth meetings; attends all required meetings with the Department and other Commonwealth agencies as needed; develops strategies to advocate for best practices that demonstrably improve contract terms or facilitate business objectives • Attends and participates in stakeholder meetings • Responds to issues involving information systems and reporting, appeals, quality improvement, Enrollee services, service management, pharmacy management, medical management, care coordination, and issues related to Enrollee health, safety, and welfare • Serves as lead for contract knowledge, and ensures the health plan is compliant with Kentucky Medicaid program terms • Assists the CEO with various advocacy efforts in support of plan business operations • Provides leadership on emerging healthcare issues, new business implementation, and strategic planning for the health plan • Leads and supervises regulatory submissions and filings • Receives and responds to inquiries and requests made by the Department, Commonwealth, or federal agencies timely and in agreed-upon format • Works with key statewide advocacy groups and provider trade associations, and develops strategic partnerships; works cooperatively with other Commonwealth contracting partners • Represents the health plan within key industry groups, such as Commonwealth Programs and Legislative and Regulatory Affairs Committees; prepares and coordinates deliverables for the health plan with these groups • In coordination with Legal Affairs, assesses and provides analyses for proposed changes to Medicaid, Medicare, Exchange, and other government-sponsored healthcare program contracts, governing regulations, and new legislation and policy requirements • Oversees and monitors the implementation of new Medicaid and Medicare contractual and policy requirements, new legislation and regulations, and all Commonwealth requirements • Coordinates with the director of compliance to improve adherence to plan policies and procedures, and represents government contracts department on the Compliance Committee • Manages subordinate staff, acts as ombudsperson and coordinator with other Molina offices, and manages staff relationship with Commonwealth • With the policy and government affairs department, partners with contracted lobbyist to develop legislative plan and implement various tactics, including legislative and plan visits and PAC support • Partners with policy and government affairs department to provide updates on Commonwealth issues with federal impact, such as ACA implementation and CMS issues
Qualifications
Bachelor’s degree in related field or equivalent combination of education and experience. Five years’ experience in government programs
Office Location
Molina’s vice president, government contracts will be located at our Louisville, Kentucky headquarters.

Table B.3-24. Housing Specialist

Job Description
• Serves in a community-based role within Molina's Healthcare Services, Care Management department • Assists with housing search and placement along with leveraging supportive services that assists Enrollees at risk of homelessness with maintaining permanent housing and promoting self-sufficiency, including integration into the community • Assists with advocacy efforts related to broad-based solutions to help reduce barriers for Enrollees to access affordable housing • Provides a variety of office and field activities to manage and monitor a rapid re-housing/ transition-in-place program for Enrollees • Conducts intake interviews and assesses housing barriers of Enrollees experiencing homelessness to determine the Enrollee's housing and service needs, goals, and eligibility • Assists Enrollees with development of a strength-based, solution-focused individualized goal and action plan that promotes permanent housing and self-sufficiency • Develops an effective, timely referral network for the Enrollee to help ensure ongoing direction and support as needed (e.g., community agencies for assistance with budget counseling and education) • Provides a resource for mediation and advocacy with landlords on the Enrollee's behalf to develop a workable plan to obtain and/or maintain housing • Participates in housing collaborative and other housing outreach events with the purpose of expanding resource base • Creates and maintains consistent communication channels, both verbal and written, between involved parties (e.g., tenant, landlord, referral source, collaborating agencies, and public housing authorities) • Participates in the interdisciplinary care team (ICT) of Enrollees needing supportive housing services • Provides information and referral assistance regarding available support from appropriate social service agencies and/or community programs by maintaining a housing resource guide • Conducts proactive follow-up home visits to ensure stability and further progress towards Enrollee self-sufficiency, which may include support, advocacy, reducing isolation, listening, problem solving, and identification of resources to assist with reintegration of Enrollee into the community • Maintains accurate daily log records, monthly outcome reports, and files for each client. Collects and reports program data as required • 5 – 25% local travel required
Qualifications
Required Education: Bachelor's degree or equivalent combination of education and relevant experience **Preferred Education:** Bachelor's degree in a human services or healthcare-related field **Required Experience:** Minimum 2 years of experience working with underserved or special needs populations, with varied health, economic and educational circumstances. Experience with affordable housing and/or related community resources and social services. Knowledge of applicable Commonwealth and federal guidelines/regulations (e.g., the Fair Housing Act and the rights of people with disabilities under Section 504 of the Rehabilitation Act of 1973) **Preferred Experience:** Bilingual based on community need. Familiarity with healthcare systems/processes, NCQA, and InterQual a plus. Knowledge of community-specific culture. Experience developing care/case management plans. **Required Licensure/Certification:** Must have valid driver's license with good driving record and be able to drive within applicable state or locality with reliable transportation **Preferred Licensure/Certification:** Current Community Health Worker (CHW) Certification. Medical Assistant Certification
Office Location
Molina's housing specialists will be located throughout the Commonwealth.

Table B.3-25. Addictionologist

Job Description
• Reports to the Medical Director/Chief Medical Officer of the health plan • Provides Psychiatric leadership for utilization management and care management programs for mental health and chemical dependency services • Works closely with the MHI VP of Behavioral Health and National Medical Directors to develop standardized utilization management policies and procedures to be implemented enterprise-wide that will improve quality outcomes and decrease costs • Assists with implementing integrated behavioral health and physical healthcare management programs • Responds to SUD-related RFP sections, and reviews SUD portions of Commonwealth contracts • Works with trainers to develop and provide enterprise-wide teaching on SUD diagnoses and treatment • Provides second level clinical reviews, peer reviews, and appeals • Facilitates SUD committees for quality compliance • Implements clinical practice guidelines and medical necessity review criteria • Tracks all clinical programs for SUD quality compliance with NCQA and CMS • Participates in the recruitment, placement, and orientation of new health plan MDs • Ensures all SUD programs and policies are in line with industry standards and best practices • Assists with new program implementation and supports
Qualifications
Required Education: Doctorate degree in Medicine (MD or DO) **Required Experience:** 5 years of clinical experience in managing an addiction population. Minimum of 1 year of experience in treatment of opioid addiction **Preferred Experience:** Experience working with Medicaid, vulnerable populations, medication assisted treatment providers, community services and/or Kentucky systems of care **Required License Credentials**: Active, unrestrictive license to practice in the Commonwealth of Kentucky. Current Board Certification by the American Board of Psychiatry and Neurology, Addiction Psychiatry subspecialty OR Current Board Certification by the American Board of Preventive Medicine, Addiction Medicine subspecialty OR Certification by the American Society of Addiction Medicine, Addiction subspecialty. Current Buprenorphine x waiver certificate
Office Location
Molina's addictionologist will be located at our Louisville, Kentucky headquarters.

Table B.3-26. Care Manager

Job Description
• Completes clinical assessments of Enrollees per regulated timelines and determines who may qualify for care management based on clinical judgment, changes in Enrollee's health or psychosocial wellness, and triggers from the assessment • Develops and implements a care management plan in collaboration with the Enrollee, caregiver, physician, and/or other appropriate healthcare professionals and Enrollee's support network to address Enrollee needs and goals • Conducts telephonic, face-to-face, or home visits as required • Performs ongoing monitoring of the care plan to evaluate effectiveness, document interventions and goal achievement, and suggest changes accordingly • Maintains ongoing Enrollee caseload for regular outreach and management • Promotes integration of services for Enrollees including behavioral health care and LTSS to enhance the continuity of care for Molina Enrollees • May implement specific Molina wellness programs, i.e., asthma and depression disease management • Facilitates multidisciplinary care team meetings and informal ICT collaboration • Uses motivational interviewing and Molina clinical guideposts to educate, support, and motivate change during Enrollee contacts • Assesses for barriers to care, provides care coordination and assistance to Enrollee to address concerns • Collaborates with care managers/supervisors, and multidisciplinary care team as needed or required • Care managers in behavioral health and social science fields may provide consultation, resources, and recommendations to peers as needed • RNs provide consultation, recommendations, and education as appropriate to non-RN care managers • RNs are assigned cases with Enrollees who have complex medical conditions and medication regimens • RNs conduct medication reconciliation when needed • Local travel of up to 40% may be required, depending on the complexity level of the assigned Enrollees, particular Commonwealth-specific regulations, or whether the care manager position is located within Molina's Central Programs unit
Qualifications
Required Education: Any of the following: Completion of an accredited Licensed Vocational Nurse (LVN), Licensed Practical Nurse (LPN) Program, or RN program OR Bachelor's or Master's degree in a social science, psychology, gerontology, public health, or social work or related field **Required Experience:** 1-3 years in care management, disease management, managed care, or medical or behavioral health settings **Preferred Experience:** 3-5 years in care management, disease management, managed care, or medical or behavioral health settings **Required Licensure/Certification:** If licensed, license must be active, unrestricted, and in good standing. Must have valid driver's license with good driving record and be able to drive within applicable state or locality with reliable transportation **Preferred Licensure/Certification:** Any of the following: Licensed Clinical Social Worker (LCSW), Advanced Practice Social Worker (APSW), Certified Care manager (CCM), Certified in Health Education and Promotion (CHEP), Licensed Professional Counselor (LPC/LPCC), Respiratory Therapist, or Licensed Marriage and Family Therapist (LMFT)
Office Location
Molina's care managers will be located throughout the Commonwealth.

Table B.3-27. Peer Support Specialist

Job Description
• Provides peer support services for Enrollees with behavioral health issues, psychiatric disorders, drug and/or alcohol dependence, and physical illnesses • Serves as a consumer advocate by providing consumer information, resources, and peer support for clients in outpatient and inpatient settings • Assists Enrollees in setting and pursuing their own recovery goals and in working with their care managers and/or treatment team to determine the steps needed to achieve these goals
Qualifications
Required Education: Minimum high school diploma or GED **Preferred Education:** Graduate of a two-or-four-year allied Health Program **Required Experience:** Managed care exposure and knowledge of community resources; knowledge of HIPAA and confidentiality rules **Preferred Experience:** Experience in psychiatric unit or facility a plus **Required License Credentials:** Valid State Driver's License with proof of insurance **Preferred License Credentials:** Certified Peer Specialist
Office Location
Molina's peer support specialists will be located throughout the Commonwealth.

Table B.3-28. Transition of Care Coach

Job Description
• Follows Enrollee throughout a 30-day program that starts at hospital admission and continues through transitions from the acute setting to other settings, including nursing facility placement and private home, with the goal of reduced readmissions • Ensures safe and appropriate transitions by collaborating with hospital discharge planners, as well as with hospitalists, outpatient providers, facility staff, and family/support network, as needed or at the request of Enrollee • Ensures Enrollee transitions to a setting with adequate caregiving and functional support, as well as medical and medication oversight as required • Works with participating ancillary providers, public agencies, or other service providers to make sure necessary services and equipment are in place for a safe transition • Conducts face-to-face visits with all Enrollees while in the hospital and home visits of high-risk Enrollees post-discharge • Coordinates care and reassesses Enrollee's needs using the Coleman Care Transitions Model recommended post-discharge timeline • Educates and supports Enrollee focusing on seven primary areas (ToC Pillars): medication management, use of personal health record, follow-up care, signs and symptoms of worsening condition, nutrition, functional needs, and/or Home and Community-based Services, and advance directives • Uses motivational interviewing and Molina clinical guideposts to educate, support, and motivate change during Enrollee contacts • Assesses for barriers to care, provides care coordination and assistance to Enrollee to address concerns • Facilitates ICT meetings and informal ICT collaboration • RNs provide consultation, recommendations, and education as appropriate to non-RN care managers • RNs are assigned cases with Enrollees who have complex medical conditions and medication regimens • RNs will conduct medication reconciliation when needed • 40-50% local travel required
Qualifications
Required Education: Graduate from an Accredited School of Nursing **Preferred Education:** Bachelor's Degree in Nursing **Required Experience:** 1-3 years of hospital discharge planning or home health **Preferred Experience:** 3-5 years of hospital discharge planning or home health **Required License Credentials:** Active, unrestricted State Registered Nursing (RN) license in good standing. Must have valid driver's license with good driving record and be able to drive within applicable state or locality with reliable transportation **Preferred License Credentials:** Transitions of Care Sub-Specialty Certification and/or Certified Care manager (CCM)
Office Location
Molina's transition of care coaches will be located throughout the Commonwealth.

Table B.3-29. Molina Community Health Worker

Job Description
• Serves as a community-based Enrollee advocate and resource, using knowledge of the community and resources available to engage and assist vulnerable Enrollees in managing their healthcare needs • Collaborates with and supports the Healthcare Services team by providing non-clinical paraprofessional duties in the field, to include meeting with Enrollees in their homes, nursing homes, shelters, or doctor's offices, etc. • Empowers Enrollees by helping them navigate and maximize their health plan benefits. Assistance may include scheduling appointments with providers; arranging transportation for healthcare visits; getting prescriptions filled; and following up with Enrollees on missed appointments • Assists Enrollees in accessing social services such as community-based resources for housing, food, employment, etc. • Provides outreach to locate and/or provide support for disconnected Enrollees with special needs • Conducts research with available data to locate Enrollees Molina Healthcare has been unable to contact (e.g., reviewing internal databases, contacting Enrollees providers or caregivers, or travel to last known address or community resource locations such as homeless shelters, etc.) • Participates in ongoing or project-based activities that may require extensive Enrollee outreach (telephonically and/or face-to-face) • Guides Enrollees to maintain Medicaid eligibility and with other financial resources as appropriate • 50-80% local travel may be required. Reliable transportation required
Qualifications
Required Education: High school diploma/GED **Preferred Education:** Associate's degree in a healthcare related field (e.g., nutrition, counseling, social work) **Required Experience:** Minimum one year of experience working with underserved or special needs populations, with varied health, economic, and educational circumstances **Preferred Experience:** Bilingual based on community need. Familiarity with healthcare systems. Knowledge of community-specific culture. Experience with or knowledge of healthcare basics, community resources, social services, and/or health education **Required License Credentials:** Must have valid driver's license with good driving record and be able to drive within applicable state or locality with reliable transportation **Preferred License Credentials:** Current Community Health Worker (CHW) Certification. Medical Assistant Certification
Office Location
Molina's Molina Community Health Workers will be located throughout the Commonwealth.

a.iv.b. Positions Filled by Employees and Subcontractors

Each executive, key personnel, and additional personnel position described in the previous sections will be filled by a Molina employee.

a.iv.c. Resumes

In Attachments to B.3, Resumes, we provide resumes for our Implementation team for all Commonwealth-required executive staff. These resumes include relevant experience, degrees, credentials, and clinical licensure, if applicable.

a.v. RECRUITMENT TIMELINES AND CONTINGENCY PLANS

Our Implementation team personnel are presently working to identify and recruit qualified personnel for permanent positions. The team will continue its work in accordance with our Program Implementation Plan, which represents best practices established over the course of more than 25 years of successful program implementations and has been tailored to meet the unique needs of the Kentucky Medicaid program. Exhibit B.3-4 demonstrates an excerpt of our high-level Kentucky Medicaid Program Implementation Plan, showing our planned staffing phase for recruiting and training all health plan staff.

We provide an expanded view, along with our Implementation Plan, within Proposal Section D, Implementation Plan.

The Implementation Plan includes assumptions around contract award date and readiness dates. As these assumptions are confirmed, they will be updated to the baseline plan. The temporary support provided by the Implementation team will extend for approximately 90 days to ensure that local Kentucky staff are hired and fully able to support the program by go-live.

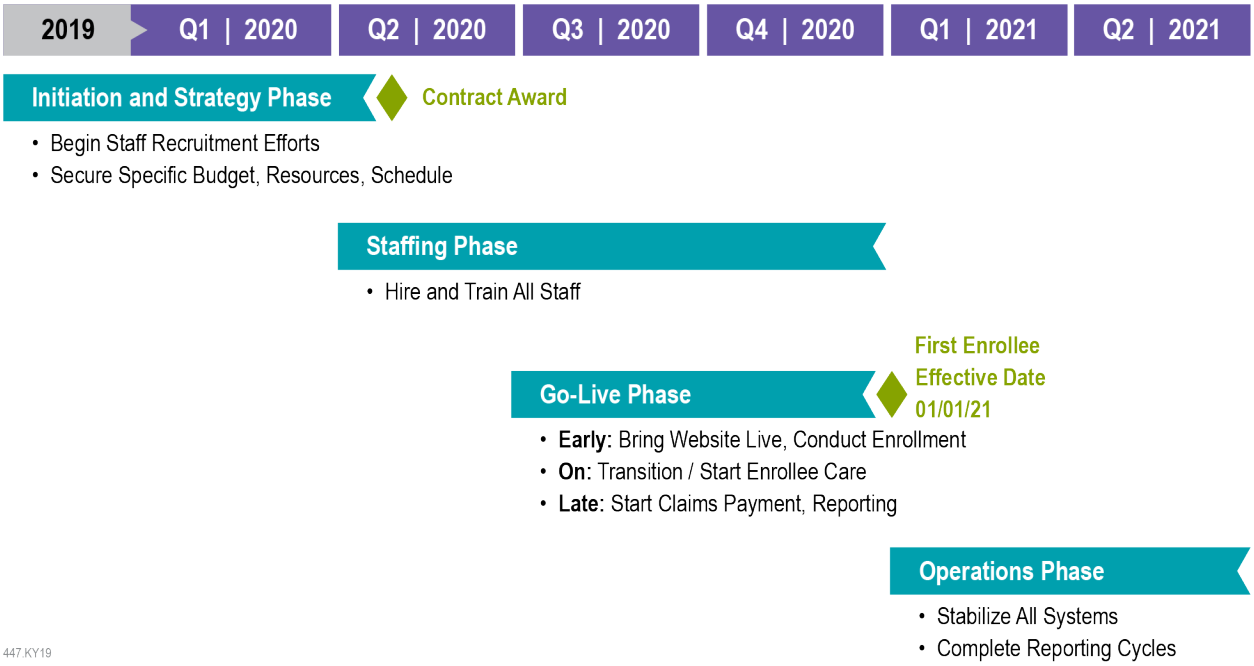

Exhibit B.3-4. Molina Staff Recruitment Timeline

As shown in the exhibit, local staff hiring and training will occur starting in Q2 of 2020 and extend through Q4 of 2020, leaving plenty of time to ensure any remaining staff needs are filled or contingency plans are put in place before go-live in January 2021. Our specific recruiting strategies and contingency plans are detailed in the sections below.

Recruitment Strategies

Our full-time, Kentucky-based team will comprise leaders in their respective areas who bring a deep understanding of what it takes to successfully serve Kentucky Medicaid program Enrollees. Molina believes that one of our strongest pillars for success is our human capital. Our corporate culture and our enterprise-wide commitment to a careful talent attraction process are the keys to workforce longevity. For example, our Puerto Rico affiliate was awarded Major and New Employer of the Year in 2016 by the Puerto Rico Department of Labor, recognizing the partnership between key government agencies and the affiliate.

We believe in recruiting from within the communities we serve, and ***we are fully committed and dedicated to hiring locally and providing positive economic impact in the Commonwealth***. We have already established recruiting and onboarding volume and timing efforts, the recruiting budget, and the senior leadership team staffing plan. We have a signed contract with a recruiting firm and have a secured relationship with an on-demand local recruiting firm for all levels of positions. We also have established priority hires (contractual and operational requirements) and a local recruiting plan. To support the local recruiting plan, we visited and confirmed sites for eventual local job fairs and established logistics (sites, marketing, and media opportunities) for a Molina Open House ahead of actual job fairs to raise awareness of Molina and our employment opportunities.

As part of our multi-pronged staffing approach, Molina has reached out to the Kentucky Education and Workforce Development Cabinet's Department of Workforce Investment (DWI) and its Career Development Office for guidance and assistance in recruiting and filling approximately 1,100 positions. Our goal is to fill these positions with people who reside in, understand and reflect the communities they support across the Commonwealth. Working with DWI staff specializing in the health care field and the Kentucky Career Centers (KCC) located across the Commonwealth, we will take advantage of their specialized services, such as the job posting portal "Focus Talent" to post job announcements and descriptions and search resumes for qualified candidates. We will also participate in KCC Career Fairs in order to meet face-to-face with candidates.

We recognize that one of the best ways to attract talent is to tap into the extensive network of talent already at our disposal: employee referrals. ***Through our Employee Referral program, an employee can receive up to $3,000 if we hire a referred candidate.*** It is a testament to our faith in our employees, and likewise to our employees' understanding of our culture. Our organization also will use qualified internal healthcare recruiters and external staffing agencies. We will host job fairs with hundreds of employers, which will enable us to meet professionals we have not found through other avenues to find the right candidates for any open positions.

We also will be active on the standard job sites both for the workforce at large (CareerBuilder, Indeed, LinkedIn) and will use local Kentucky workforce resources, such as iHireSocialServices! (a Kentucky website dedicated to recruiting staff in social services). We will host employment fairs in each region of the Commonwealth and will work with agencies and organizations such as the Kentucky Education and Workforce Development Cabinet Office and Kentucky Career Centers.

We will seek employees who not only have the proper qualifications and experience working in the healthcare industry but are also a "cultural fit" for our health plan and share with the Commonwealth and our company a deep and demonstrated passion for improving outcomes among underserved Enrollees. This will help ensure a workforce that understands the Commonwealth's vision and goals for its Medicaid populations. The result of these efforts will be a committed, highly professional workforce that will provide the highest level of service for the people of Kentucky.

Contingency Plans

We will be structured so that every service that touches an Enrollee, provider, or regulator is housed in the Commonwealth. Other functions that benefit from economies of scale will be provided through a corporate services agreement with our parent company. We will leverage the administrative experience and scalable systems of our parent to administer a cost-effective combination of local plan operations and shared corporate resources. Additionally, the size and breadth of our corporate operations means we will always be prepared to provide additional staff as required to perform the functions of the Kentucky Medicaid program Contract.

We will work diligently during the Implementation Phase to ensure that recruiting qualified, local talent is a top priority. If any key role remains open, we will ensure coverage of those positions by using an existing staff member from either our parent or an affiliated health plan who currently performs or has performed a similar role until we identify a permanent hire. For other positions, such as claims and Enrollee and provider Call Center roles, we may draw from existing staff or use a local contingent workforce until those roles are permanently filled. To staff these contingent roles, we will enlist the support of our managed services provider to work with temporary staffing vendors across the country to ensure vacant positions are filled with candidates who have the right experience and skills for the job until permanent, local hires are recruited.

a.vi. PROPOSED TRAINING OF STAFF

Molina supports the growth potential of each contributor within the organization and takes a comprehensive view toward employee training and development. Our training, education, and supervision of staff engages every employee in a proactive way. As we build our plan and our staff in Kentucky, we

will pay special attention to creating a culture of collaboration and accountability. Table B.3-30 below outlines a general training program for all staff across all operational areas in accordance with the Draft Contract.

Table B.3-30. General Staff Training Program

Description
New Hire Orientation and Molina Philosophy
Self-paced HIPAA and Compliance Courses
Kentucky Medicaid and SKY Program Overview
Customer Service Skills and Cultural Competency
Core Systems, Applications, and Processes
Covered Benefits and Services
Prevalent Health Conditions in the Kentucky Medicaid Population
Non-Medicaid Services Available to Enrollees
Grievances and Appeals
Fraud, Waste, and Abuse / Program Integrity
Functional-on-the-job Training*

*Functional on-the-job training will be ongoing and depend on the level of employee. Each employee will receive training that is tailored to their needs.

In addition to our formal training sessions, we also have a robust online offering of required and optional courses through our iLearn system. Training schedules and modules will be tailored to each position. Most training modules include a comprehension test at the end of the module to gauge the employee's understanding of the materials. There will also be ongoing training sessions for updates related to the healthcare industry and specific contractual requirements. These trainings will be facilitated by the Learning and Development team, the local management staff, and the local Compliance department. In addition to required courses, each employee may take advantage of other online training courses through the iLearn system. The topics available vary from computer skills to more advanced healthcare topics. Employees can schedule these courses at their convenience.

Enrollee and Provider Services Training

For Enrollee and Provider Services Call Center staff, Tables B.3-31 and B.3-32 depict general training topics for the Kentucky Medicaid program.

Table B.3-31. Kentucky Medicaid Enrollee Services Call Center Training Topics

Type	Description
Compliance	• HIPAA Law • HIPAA Criteria • HIPAA Privacy Incidents • PHI • Minor Consent • Fraud, Waste, and Abuse • Quality Assurance Call Monitoring

Type	Description
Systems, Applications, Websites	• QNXT/CRM System Training • Call Code • Call Routing • Call Documentation • FAD/CISCO Phones • CVS • Molina Public Website and Web Portal • Kentucky State Medicaid Website
Customer Service	• Service—The Molina Way • Phone Presence: Call Handling, Irate Calls, Crisis Calls • Probing for Understanding: The Art of Questioning • Heart of Communication: Building Rapport Through Empathy • Special Needs Sensitivity Training: Visual, Auditory, and Kinesthetic Simulation
Product Training	• Medicaid Introduction • Appeals and Grievances / Critical Events and Incidents • Training Resource Library • Eligibility Verification • Pharmacy • Benefits/Value-added and Incentives • Medicaid PCP Changes • Authorizations and Referrals • Medicaid Care Management • Crisis Calls • Demographic Changes • Material Requests
Role Play	• Call Scenario Simulation • Problem-solving • Demonstration of Skills • Accessing Resources • Call Handling • Documentation • Peer Review
Nesting / Live Call Listening	Transition to floor nesting area with supervisor and subject matter expert support

Newly hired staff for the Enrollee Call Center will be placed on an accelerated quality monitoring program where our Quality Assurance team and Enrollee Services supervisors monitor 10 calls over the first month answering calls. Our online Quality tools will allow us to identify specific areas of opportunity, such as building rapport with the Enrollee and product knowledge. Once identified, we will provide additional periodic training sessions on an individual and group basis based on what our quality data indicates. Training also will be prompted by changes in product or process details. All customer service representatives will receive behavioral health (comprising mental health and SUDs) training upon hire and annually on a wide range of topics, including call management processes, behavioral health tutorials, and best practices for crisis assessment and intervention. The training curriculum will include an SUD training

program, which will discuss how to assist Enrollees with opioid misuse or crisis and courses on depression, general mental health, suicide risk and assessment, and techniques to de-escalate calls.

Kentucky Medicaid program Provider Services staff will receive initial and ongoing training and information through iLearn self-paced courses; review of online and hard copy documents, manuals, and other communications; parent company-led training for QNXT, call tracking, the websites, and the Web portal; intra-plan departmental shadowing, and visits to affiliate health plans for onsite field visit training.

Table B.3-32. Kentucky Medicaid Provider Services Training Topics

Type	Description
iLearn	For new Provider Services staff, training includes: • Compliance • HIPAA in the Hi-tech Era • HIPAA Security • HIPAA Privacy • Provider Services the Molina Way
WebEx and Face-to-Face	For new Provider Services staff, training includes: • Website (corporate and health plan site) • Web Portal • QNXT: Three sessions—Overview, Claims, and Provider Modules • Call Tracking
Documentation and Face-to-Face	For new Provider Services staff, training includes: • Provider Manual • Forms • FAQs • Communications • Kentucky-specific Benefits and Programs
Shadowing Onsite at Molina or Affiliated Health Plan	For new Provider Services staff, training includes: • Enrollee and Provider Call Center • Enrollee Inquiry Research and Resolution / Provider Inquiry Research and Resolution • Utilization Management • Care Management For Provider Services directors, managers, and external representatives: • Field shadowing

Clinical/Functional Area Training

We will have local, qualified clinical training staff conduct utilization management and care management modules for Kentucky Medicaid. These sessions in Kentucky will educate clinical departments and care managers on how to improve Enrollee outcomes. The focus will be on teaching our professionals how to manage disease-specific conditions and the creation of individualized person-centered care plans, and the key aspects of utilization management and population health. Table B.3-33 provides a sample of additional training we will provide to our medical/clinical staff for the Kentucky Medicaid program.

Table B.3-33. Kentucky Medicaid Clinical Training Topics

Type	Description
General Clinical Training	Molina Clinical Operations and Philosophy
Clinical Process Training	• Utilization Management • Care Management • Care Coordination • Population Health Management • Provider Engagement • Patient-centered Care • Under- and Overutilization • Reporting Quality Events
Utilization Management*	**Utilization Management Operations Deep Dive** • Designated mentor / preceptor / subject matter expert (SME) will provide adjunctive specific job training that highlights Kentucky Medicaid resources, regulatory requirements, and the Contract. Training will include the following areas and are reinforced through assignment of a mentor / SME partner: – Demonstration and Parallel Practice. Demonstration of system use and accessing materials (such as policies, resources). Parallel practice is when the mentor / preceptor / SME demonstrates the function/concept in the system while the new staff follows step-by-step in the training environment – Knowledge checks will be conducted during the training concepts and system training to ensure transfer of knowledge – Feedback will be provided to validate understanding and application of utilization management concepts • Ongoing training to ensure specific Kentucky Medicaid population needs will be addressed, including cultural competency development, cultural sensitivity, and unconscious bias
Care Management*	**Care Management Operations Deep Dive** **IT Systems:** • Clinical CareAdvance • QNXT (claims operations) • Member360 **Care Management:** Specifics related to CMS, NCQA, and Commonwealth regulatory requirements following the care management process for screening, assessing, stratifying risks, planning, and implementation of a person-centered care plan as well as follow-up and evaluation: • Assessments – Comprehensive assessments – Condition-specific assessments – Closing the loop of identified conditions/concerns based on Enrollee assessment and motivational interviewing skills • Person-centered Care Plan Development – Elements of an individualized care plan – Enrollee-prioritized goals – Identification of individualized barriers to adherence and treatment goals – Person-centered care plan interventions designed to assist Enrollees in overcoming identified barriers to adherence or treatment goals – Measurable outcomes – Enrollee consent

Type	Description
	• Care Management Team – Enrollee care plan updates based on outcomes of multidisciplinary care plan team meetings – Advanced care planning – Social determinants of health – Motivational interviewing – Pre-call reviews • Letters: Enrollee and provider communication and collaboration regarding the care plan • Practice scenarios with live feedback based on audit findings used to identify any additional training needs
Behavioral Health Utilization Management / Care Management*	For Behavioral Health Care Managers and Supervisors/Managers: • iLearns, including: Required: – Confidentiality with Substance Abuse and 42 CFR Part 2 – Crisis Calls for Clinical Staff – Elements of Depression – Helping Enrollees with Challenging Behavioral Health Diagnoses and Behaviors – Verbal De-escalation Skills Optional: – Dementia – Perinatal Depression – Crisis Calls for Support Staff • Required taped or self-paced trainings (not exhaustive): – InterQual Behavioral Health – Red Flag List – Behavioral Health Benefits 101 – Assessment and Intervention Tools for Care Management – Addiction 101 – Social Determinants of Health – Crisis Management Prevention, Assessment, and Intervention – Peer Support Services – Trauma Informed Care – Medical Comorbidities to SUDs – Medication Assisted Treatment – Pain and Addiction – Pediatric SUDs – Psychiatric Co-occurring Disorders and SUDs – SUDs and Perinatal Addiction • Review of Utilization Management Quick Reference Guides • Completion of utilization management case scenarios • Meeting with behavioral health supervisor and manager for post self-training question-and-answer session to ensure completion/understanding • Completion of post-test For Non-Behavioral Health Care Managers and Supervisors/Managers: • iLearns, including: Required: – Behavioral Health 101—An Overview

Type	Description
	– Understanding Behavioral Health: Defining the Diagnosis and Treatment Options – Confidentiality with Substance Abuse and 42 CFR Part 2 – Crisis Calls for Clinical Staff – Elements of Depression – Helping Enrollees with Challenging Behavioral Health Diagnoses and Behaviors – Verbal De-escalation Skills Optional: – Perinatal Depression – Crisis Calls for Support Staff • Required taped or self-paced trainings (not exhaustive): – Assessment and Intervention Tools for Care Management – Addiction 101 – Behavioral Health Benefits – Social Determinants of Health – Crisis Management Prevention, Assessment, and Intervention – Trauma Informed Care – Medical Comorbidities to SUDs
Functional-on-the-job Training	Staff will be assigned a peer mentor; employee will be observed during Enrollee outreach and assessments, and trained on clinical criteria set and guideposts

* These training programs are specific to different care management teams

Supervisory Training

Employees in supervisory roles will participate in New Leader Orientation, which provides leaders with essential skills, knowledge, and resources to effectively engage and develop their team. The six-hour program consists of four 90-minute modules focused on Molina's core competencies for performance management, employee engagement, and transactional skills. Goals are to help participants apply leadership skills, knowledge, and resources in their daily activities and to recognize, understand, manage, and mitigate leadership challenges. We will follow this training with coaching and quarterly development sessions, each taking place on a one-on-one basis between the manager and his/her supervisor.

We will encourage managers to use documents when discussing their employees' performance and career goals. Our Intranet site provides quick access to a career development worksheet and an expectations and deliverables agreement, among other valuable communication tools. Our iLearn system also provides on-demand courses for supervisors.

a.vii. APPROACH TO MONITORING SUBCONTRACTORS' PROGRESS IN RECRUITING AND TRAINING STAFF

Ensuring subcontractor compliance and high-quality performance starts on the ground in Kentucky and will be supported throughout the health plan. Program subcontractors will be governed by our Delegation Oversight Committee that ensures compliance with all Commonwealth-approved subcontractor performance indicators as well as requirements in the Draft Contract, Section 6, Subcontracts.

Subcontractors will be audited based on an established timeline approved by the Commonwealth and will be required to maintain all required licenses and insurances in good standing and provide evidence upon request. Our Delegation Oversight staff will oversee the auditing and performance monitoring plan for each subcontractor, which will include performance requirements for all delegated functions; proof of insurance, licensing, and credentials; required reporting and interfaces; a review of the financial operation and amounts paid for covered services, if applicable; and a review of contract compliance, logged complaints, and functional performance measurements. Just as we will do with our own employees, we also will require subcontractor staff to meet appropriate credentials and licensing requirements in the Commonwealth of Kentucky.

Monitoring Subcontractor Recruiting Progress

Our approach to monitoring a subcontractor's progress in recruiting and training of staff will comply with the Contract and will be an integral part of our Kentucky Medicaid implementation activities. These will include required subcontractor preparation for and participation in Molina's internal Readiness Review process as well as readiness reviews as requested by the Department, including submission of status reports and other requested materials, participation in meetings, and onsite reviews.

As is standard practice for our affiliated health plans enterprise wide, Molina will also hold biweekly meetings with our subcontractors in the first year of our operations, and then monthly thereafter. These meetings will include regular conferences (at least quarterly) with contracted providers, Enrollees, and other stakeholders, and will be designed to ensure we and our subcontractor partners understand and can address any concerns or challenges, including potential subcontractor staffing issues.

Moreover, Molina will dedicate both corporate and local health plan Provider Engagement staff to each of our subcontractors, ensuring consistent lines of communication and collaboration, understanding of program requirements and deliverables, and identification of areas of concern / opportunities for improvement, including addressing potential staffing challenges. Beyond managing day-to-day subcontractor relationships, our Provider Engagement staff will facilitate monthly touch-base and quarterly Joint Operating Committee meetings and schedule ad hoc meetings, as needed, to review subcontractor performance and potential areas for improvement.

Monitoring Subcontractor Training Progress

Our approach to monitoring subcontractor training progress, an integral part of our overall subcontractor monitoring program, will also include assigning subcontractors training using our learning management system, and requiring the subcontractor to provide us weekly training status reports during implementation and then monthly thereafter. To ensure training is completed on time, we will closely track completion of training, and Molina management will be notified if training is not completed during the required time allotment. As we do with our own employees, we will use a multimedia approach to train subcontractor staff on a range of topics from HIPAA compliance to preventing fraud, waste, and abuse to specific clinical topics (e.g., opioid use disorders) to serving special populations. We will also train subcontractors about how to serve our Kentucky Medicaid Enrollees in full compliance with Contract requirements.

Our approach will include self-paced web-based learning; live webinars delivered by Molina content experts using web-based video and audio technology; in-person trainings conducted by dedicated clinical and nonclinical trainers; and trainings conducted by subject matter experts on specific topics.

Our subcontractor relations and monitoring policies and procedures will cover a comprehensive range of subcontractor oversight activities and protocols that support our ongoing collaborative subcontractor relationships, streamline subcontractor service delivery, and foster improved subcontractor performance and accountability. Moreover, ***these policies and procedures will support and ensure Molina's compliance with Contract requirements as well as document our full responsibility for all subcontractor performance and deliverables,*** including Department requests for reporting, data, and other information specific to Kentucky Medicaid program operations.

a.viii. RETENTION APPROACH FOR KEY PERSONNEL

At Molina, we will focus on employee retention as a key factor supporting our business model, ensuring that we retain the expertise and business acumen of our valued employees. Our approach to retention includes competitive compensation and a package of health benefits that are among the best in the industry. Committed to modernizing our workforce, Molina will also offer other nontraditional perks such as flexible work schedules, casual dress code, sponsored community events, leadership participation on various boards and councils, participation in pilots and studies to advance system and program improvements, and tuition reimbursement. We will promote career development though customized

programs and Education Reimbursement programs and strongly support and promote continued education programs for our clinical staff employees.

We are especially proud of our Volunteer Time Off (VTO) program, which allows employees to use company time (16 hours per year) to participate in events that bring them closer to their communities. We believe in being an active part of every community where we work. Community service is a focal point for our Molina staff. In 2018, employees across the enterprise volunteered approximately 34,488 VTO service hours. As part of our philosophy, we will partner with grassroots organizations in the communities we serve, making contributions that have lasting impacts. From corporate giving and partnerships to community champions to volunteerism, our Molina family will set out each day to have an impact. VTO successes at our parent and affiliates have included:

- **Molina HOPE Corporate Giving Program.** This program provides micro-grants directly to community partners and has ***invested more than $2 million in local communities***. Our affiliated health plans also donate money and supplies to a variety of CBOs. Molina has committed to investing an additional $625,000 annually in Kentucky in the form of community investment grants or partnerships. The dollars will be spent in various regions of Kentucky, where the need is greatest and where we think, as we further embed in the communities we serve, the investment will do the most good and help the most people.
- **Community Champions.** Our Community Champions Award program also helps us build community partnerships, honoring unsung heroes (such as volunteers, health professionals, advocates) in our neighborhoods. Each honoree receives a $1,000 grant to pass on to an organization of choice. ***Since the 2006 inception of the Community Champions Award program, 140 events have taken place in states where Molina operates.*** During this time, 797 Community Champions have been recognized for their efforts to go above and beyond in their local communities. As part of the Champions' opportunity to "pay it forward" with their $1,000 grant, $797,000 has been awarded to deserving nonprofit organizations throughout the United States.
- **Helping Hands.** Helping Hands provides employees with opportunities to invest time and energy in local charitable activities. Molina encourages employees to participate in Helping Hands activities by providing paid time off from work for their volunteer efforts.

States also recognize contributions from our parent and affiliates. ***Our Illinois affiliate recently received the Salvation Army of Alton's Social Service Partner Award,*** the first one granted in the organization's 128-year history. Many of our affiliate health plans, including those in Florida, Michigan, Ohio, and South Carolina, ***have also won awards for the Best Places to Work*** in a variety of local publications.

b. MOLINA'S ORGANIZATIONAL STRUCTURE

As previously described within this Proposal Section, under A. Molina's Approach to Staffing, Molina will use an Implementation team for the initial project phase tasked with getting operations and systems in place and hiring permanent staff for each Commonwealth-required and Molina-identified role. Following the practices at our affiliated health plans enterprise wide, all positions will be filled by permanent Molina employees. We have both the experience and a defined plan to ensure we have the right staff in place to administer the Kentucky Medicaid program.

On the following pages, we provide organizational charts that show Molina's relationship to our parent company, Molina Healthcare, Inc., including lines of responsibility, and our health plan staffing for the operations phase organized by functional area and position type, including titles and FTE counts.

b.i. MANAGEMENT STRUCTURE, LINES OF RESPONSIBILITY, AND AUTHORITY

Exhibit B.3-5, Molina's Operations Organizational Chart, displays the Molina organization and managed care administrative services to be performed for Kentucky Medicaid in alignment with the requirements in the Draft Contract.

Interim CEO Dwayne Sansone will have authority for all operational areas of the Contract during the Implementation phase and until a permanent CEO is hired. Mr. Sansone also will oversee end-to-end performance during implementation, expediting critical communication, escalation, and other actions between Molina, the Department, and other stakeholders.

Mr. Sansone will work with a team of proven, Kentucky-based executive leaders to oversee the entirety of the Kentucky Medicaid program. This team, comprising a provider network director, vice president of operations, quality improvement director, vice president of healthcare services, chief compliance officer, vice president of government contracts, medical director, and all other reporting lines for the plan runs either directly or indirectly to Mr. Sansone. Each leader applies their focused expertise to manage the key business functions necessary to ensure all Enrollees receive quality whole-person care in a cost-effective manner.

The chief financial officer, an executive role at Molina, will be employed by our ultimate owner (and material subcontractor), Molina Healthcare, Inc., but will be permanently domiciled at the Kentucky health plan and also will be accountable to Mr. Sansone for all matters pertaining to the Medicaid program in Kentucky.

Each Commonwealth-required executive team and key role identified in the Draft Contract, Sections 9.1, Office in the Commonwealth and 9.2, Administration/Staffing are all accounted for on the chart, which also includes the additional roles Molina has identified as critical to serving the needs of Enrollees and other roles that ensure smooth operations and efficient performance of all Contract duties.

Redacted as proprietary, confidential, and/or trade secret per RFP Section 40.29, Vendor Response and Proprietary Information, and the Kentucky Open Records Act, KRS 61.878. This material can be found in the sealed Proprietary Information and Data proposal.

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b.ii. HOW THE DRAFT CONTRACT FITS INTO OUR PARENT'S OVERALL STRUCTURE

Molina Healthcare of Kentucky, Inc. (Molina), is a wholly owned subsidiary of Molina Healthcare, Inc. (MHI). The chart in Exhibit B.3-6 shows how Molina fits into MHI's structure and executive-level lines of responsibility, authority, and oversight as well as the reporting relationship between MHI leadership and Molina. Our parent has spent 40 years intensely focused on improving access to healthcare for individuals receiving government assistance. A Fortune 500 company, ***MHI operates Medicaid health plans in California, Florida, Idaho, Illinois, Michigan, Mississippi, New York, Ohio, Puerto Rico, South Carolina, Utah, Texas, Washington, and Wisconsin.*** Collectively, MHI serves 3.4 million Medicaid, Medicare, CHIP, D-SNP, FIDE-SNP, MMP, and Marketplace members.

As illustrated in the organizational chart, Interim CEO Dwayne Sansone will be closely connected to the key personnel serving Kentucky to monitor the day-to-day and urgent needs of the Commonwealth until a permanent CEO is hired.

With only one functional layer between the Molina CEO role and MHI's CEO, Mr. Sansone will have immediate access to key strategic decision-makers at our parent company, up to and including CEO Joseph Zubretsky. Molina will have the authority to operate in a manner that reflects local understanding and needs, while also having access to all of MHI's corporate resources, innovations, and the deep knowledge and expertise of employees enterprise wide. Whenever issue escalation is necessary, Molina will be prepared to significantly mitigate risk by applying strategic, field-tested solutions that are most appropriate for our Kentucky Medicaid Enrollees.

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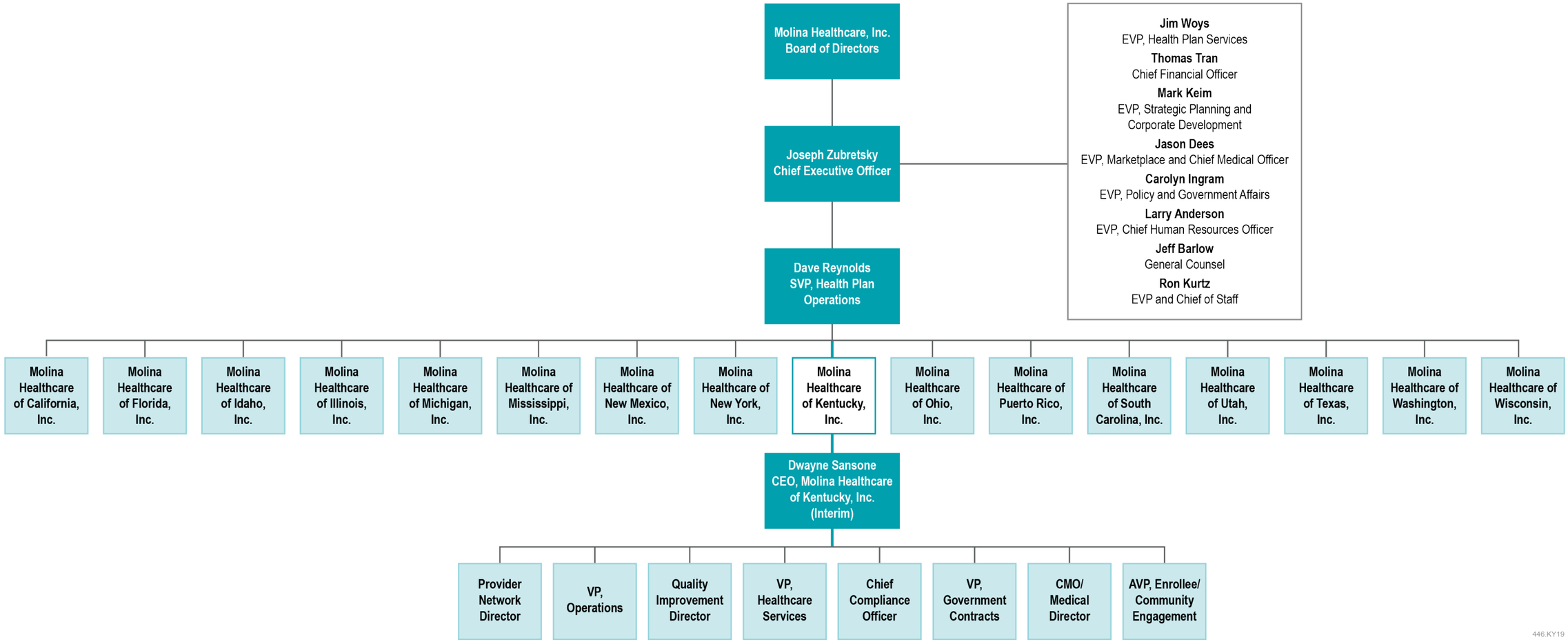

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Exhibit B.3-6. Molina's Relationship to its Parent, MHI

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b.iii. SUBCONTRACTOR INCORPORATION

Exhibit B.3-5, Molina Healthcare of Kentucky, Inc.'s Operations Organizational Chart, also illustrates how Molina key personnel will oversee subcontractors that provide centralized administrative functions, pharmacy benefit management, vision, dental, and data analytics for High-Risk OB care management services. We will ensure specific high-level Molina employees in the appropriate functional area are responsible for overseeing subcontractor performance, as noted below:

- Our provider network director will oversee Avesis and March Vision Care
- Molina's AVP of care management will oversee Lucina Analytics
- Our pharmacy director will provide oversight of our PBM, CVS Health
- Our CEO will oversee the performance of MHI and its administration of shared services

By establishing lines of accountability between Molina executives / key personnel and our subcontractors, we can ensure that high-quality services are rendered seamlessly to our Enrollees and providers throughout the duration of our Contract.

b.iv. INTEGRATING SUBCONTRACTORS INTO MOLINA'S HEALTH PLAN OPERATIONS

To best support our subcontractor partners in effectively serving our Enrollees, we will emphasize open communication and proactive problem-solving. Our subcontractor oversight program for Kentucky Medicaid will be guided by a proven framework of policies and procedures developed and customized by our affiliated health plans across all lines of business. Our established processes will support ***effective monitoring and continual evaluation of subcontractor performance to ensure compliance with all requirements while delivering a streamlined experience for Enrollees, providers, and the Department***.

Subcontractor selection, oversight, and management will be important elements to ensuring Medicaid managed care success. Delivering the full scope of covered Kentucky Medicaid services, including dental, vision, pharmacy benefit management, and others requires subcontractor partners with a deep understanding and experience working with the Commonwealth's Medicaid population and/or similar populations in other markets.

Molina will be responsible for subcontractor performance and has selected long-time partners with proven records of delivering high-quality service to Medicaid populations in Kentucky and other states. They further have the proven ability to meet all requirements set forth Draft Contract, Section 6, Subcontracts.

Ultimately, we will partner with the Commonwealth to maximize physical and financial resources for the benefit of Medicaid Enrollees. This partnership means we will hold ourselves and our delegates accountable for Enrollee outcomes, overall performance, and every dollar spent.

Through our comprehensive contract vetting process, we selected subcontractors with experience not only with our parent and affiliate health plans, but also with the needs of the Medicaid population. Our subcontractors for the Kentucky Medicaid program include:

- **Molina Healthcare, Inc.** Our parent company will provide resources for a variety of administrative functions, including claims processing, management information services functions, credentialing, nurse advice line, marketing assistance, professional liability insurance, legal, actuarial, human resources, government advocacy, and accounting services.
- **Avesis.** Our dental services subcontractor, Avesis, is currently contracted with four of the five Kentucky Medicaid MCOs and has more than twice the number of contracted dental providers in the Commonwealth than any other dental vendor.
- **CVS Health.** Our PBM operates more than 68,000 retail pharmacies, while also supporting 26 Medicaid health plans and more than 20 million Medicaid beneficiaries nationwide.

- **March Vision Care.** Our vision benefit subcontractor, March Vision Care, has partnered with our affiliate health plans since 2001 and currently administers vision services for D-SNP plans in the Commonwealth, which include Medicare- and Medicaid-eligible Enrollees.
- **Lucina Analytics.** Headquartered locally in Louisville, Lucina Analytics provides maternal, prenatal, and perinatal data analytics services and has experience working with other Kentucky Medicaid MCOs.

Subcontractor Performance

Molina accepts full responsibility for the performance of our subcontractors. We will hold our subcontractors to the same performance standards that we hold for ourselves and that are contractually required per the Kentucky Medicaid Proposal and Draft Contract. As part of subcontractor monitoring, we will have internal monitoring policies and procedures in place to ensure contract compliance. We will set clear expectations and reporting requirements with each subcontractor through our formal subcontractor agreements. Molina will remain responsible and accountable for ensuring all Contract requirements are met. We only use subcontractors based in the United States; we do not use offshore resources. We will seek approval from the Department for our proposed subcontractors.

Our chief compliance officer will oversee Molina's compliance with the requirements of the Department. The chief compliance officer will also serve as the primary contact for and facilitate communications between Molina leadership and the Department relating to contract compliance issues. We will make sure that data received from subcontractors is accurate and complete by regularly verifying through edits, audits, and other monitoring mechanisms, the accuracy and timeliness of subcontractor-reported data. We will also integrate subcontractor activities into our QAPI program.

Organizational Infrastructure Supporting Subcontractor Oversight

In addition to the accountability we build into our organization through indirect lines of reporting between each subcontractor and an executive-level or key individual at Molina, our chief compliance officer, in conjunction with our CEO, will oversee our subcontractor oversight program and will be supported by our Delegation Oversight department, Delegation Oversight Committee, and Quality Improvement Committee. The functions and structure of these entities are detailed in the following paragraphs.

Delegation Oversight Department. This department will oversee day-to-day subcontractor oversight and subcontractor auditing and performance monitoring of each subcontractor, including performance requirements for all delegated functions; required reporting and interfaces; and a review of contract compliance, logged complaints, and functional performance measurements. Our dedicated delegation oversight specialists will monitor subcontractor performance and contract compliance in their assigned functional areas of expertise. Reporting measures will detail data for internal and external performance metrics and flag out-of-compliance delegates for follow-up and intervention.

Delegation Oversight Committee. The Delegation Oversight Committee is the governing committee responsible for evaluating subcontractor performance. Delegation Oversight Committee leadership will include our medical director and managers and directors across key functional areas such as Quality, Compliance, Enrollee Services, Credentialing, and Provider Services. The Delegation Oversight Committee will review the evaluation of subcontractor performance and will be ultimately responsible for analyzing the information reported through regular dashboard reports, ad hoc reports, subcontractor audits, performance checks, and in-person, onsite monitoring. The Delegation Oversight Committee conducts a monthly review of subcontractor oversight activities and makes delegation decisions. The committee can recommend actions to take against non-compliant or underperforming subcontractors from corrective action plans up to contract termination.

Quality Improvement Committee. The Quality Improvement Committee will review regular monthly reporting on subcontractor performance, including any corrective actions implemented. The committee

will review auditing and monitoring activities in place and where necessary, providing quality improvement recommendations to the Delegation Oversight Committee.

Chief Compliance Officer. As a voting member of the Delegation Oversight Committee, our chief compliance officer also will work closely with subcontractors to ensure they implement, maintain, and monitor a compliance program based on Kentucky Medicaid Contract requirements. Subcontractors also must report program integrity issues to the chief compliance officer.

b.v. NUMBER OF PROPOSED FTES

Exhibit B.3-5, Molina Healthcare of Kentucky, Inc.'s Operations Organizational Chart, identifies all FTEs, defined in accordance with Proposal Section B.3, Staffing, who will be dedicated to the Kentucky Medicaid Contract by each position type and functional area. We have also included the number of FTEs (approximately 445) we propose to staff the entire health plan based on an assumption of 300,000 Enrollees.

We developed our staffing plan and determined the appropriateness of the ratios we used in our calculations based on the national model created for all Molina affiliated health plans. This national model included input we gathered from key health plan and corporate leaders across the enterprise to ensure we built in the support needed within each functional area and role. We then customized this model to Kentucky to ensure the local model not only reflects Kentucky Medicaid Contract requirements, but, importantly, reflects the unique needs of Kentucky Medicaid Enrollees through the deployment of specialized roles identified through feedback we received from engagement with local provider groups and CBOs. For example, we have added housing specialists to our staffing plan to help address housing stability, a social determinant of health. For clinical staff, we used evidence-based standards to determine the type and number of positions to fill to ensure Enrollees will receive the level of care that is right for their needs.

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