3. Staffing

a. Describe the Vendor's proposed approach to staffing this Contract, including the following information at a minimum

Under the direction of chief executive officer for the UnitedHealthcare Kentucky health plan, Amy Johnston Little, we have already started hiring highly capable key personnel (executive team) to serve our Kentucky MCO program enrollees and providers. Our organizational structure, including our executive team, meets all contractual requirements as identified in Section 9.2 Administration/Staffing of Attachment C – Draft Medicaid Managed Care Contract. Ms. Johnston Little and her direct reports are fully accountable for coordinating all functions, both direct and delegated. UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) identifies Medicaid health plan leaders based upon our knowledge of market needs and their experience in the Commonwealth. Our key leaders are passionate about making a difference in the lives of the people we serve and are experienced in managing large health care delivery enterprises; including integrated Medicaid managed care programs and operations. All health plan personnel identified for leadership roles are currently local to and reside in the Commonwealth of Kentucky.

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).

Beyond our UnitedHealthcare structure, which we describe later, we are bringing the organizational framework and strength of the UnitedHealth Group enterprise and the many innovations that offer to meet the programmatic goals specific to Kentucky's Medicaid program, enrollees and support stakeholder groups. As part of our commitment to our enrollees, we focus our organizational structure on geographically dispersed, culturally competent employees who understand the diverse communities that make up the Commonwealth.

Ms. Johnston Little's philosophy is guided by her roots as a social worker and desire to improve the lives of those most in need. This philosophy is bolstered by UnitedHealth Group's values and culture: ***Innovation, Compassion, Relationships, Performance and Integrity***. This philosophy guides our organizational structure to foster collaboration among staff and with local partners to deliver innovative solutions that meet programmatic goals, including:

- Supporting ***local partners*** as key stakeholders in our service delivery model
- Delivering member services with an ***inclusive, diverse workforce*** in the local communities that understands Kentuckians and their needs
- Applying our ***local knowledge and national expertise***

Local Partners

Our unique organizational structure enables us to be innovative because our structure is designed to: 1) enable local partnerships, 2) engender a diverse workforce, 3) apply local knowledge with national expertise, and 4) provide a comprehensive and shared secure technology platform. At the local level, and in addition to working closely with DMS, we have dedicated staff that will develop and maintain key partnerships to deliver innovative solutions. These solutions support enrollee engagement and meet programmatic goals for improving quality and health outcomes in a cost-efficient and effective manner, engaging and empowering enrollees to improve their health, reducing or eliminating health disparities and advancing integrated care. A few of these innovative partnerships include:

- ***Goodwill Industries of Kentucky (Goodwill):*** We partner with Goodwill, based in Louisville, to develop a program that seeks to ***empower second chance participants to achieve economic independence.*** Reintegrating Individuals Successfully Every Day (R.I.S.E.) will provide a network of support services to address physical, mental and emotional health by giving them professional skills training and educational development tools to help them thrive in work and in life. R.I.S.E. will support 200 individuals in 1 year. The partnership also will support events, including expungement clinics, literacy classes, health and wellness presentations, and career development resources. This innovative solution supports goals to ***enable enrollees to better engage in their communities, improve employability and promote success through long-term independence***.
- ***Community Action Kentucky:*** To connect and support enrollees across their clinical and social needs and enhance their opportunity for maximum well-being, we have developed a unique partnership with Community Action Kentucky. This partnership combines their capacity to refer or provide community-based services with our case management approach and technology. We will work with local Community Action Agencies to create a direct referral linkage between our care coordinators and their case managers to identify, refer and confirm delivery of highly targeted services based upon the individual's needs to increase their likelihood and capacity to thrive. This innovative solution supports the programmatic goal to ***develop collaborative efforts and initiatives to improve the health of enrollees in a cost-effective manner***.
- ***Kentucky Health Resource Association (KHRA):*** We have been working with KHRA and their members to develop mechanisms that promote behavioral/physical health integration. Community mental health centers primarily provide behavioral health services, but their license also permits them to provide physical health services. In addition to supporting the programmatic goal of ***advancing integrated care, this initiative can help provide broader access to care for Kentuckians***.
- ***Kentucky Primary Care Association (KPCA):*** UnitedHealthcare and KPCA have a mutual commitment to provide outstanding care to those who need it most while ***improving quality and health outcomes through enrollee-centric, community-focused and cost-effective programs***. Collaboration and partnership with KPCA includes value-based payment (VBP) models specific to FQHCs and rural health clinics using a centralized VBP management system and case management projects. These case management projects include targeted case management and chronic case management.

Support from KPCA

"Solving the health challenges in Kentucky is paramount and we believe UnitedHealthcare's commitment to provide outstanding care to those who need it most will help the Commonwealth ***achieve its goal of increasing health outcomes and improving quality***."

– David Bolt, CEO, KPCA

Diverse Workforce

Our inclusive, diverse workforce supports the programmatic goal of ***delivering culturally competent services to enrollees***. By valuing diverse perspectives, we are able to fulfill our mission to help people live healthier lives and to help make the health system work better for everyone. To support inclusion and diversity, we seek to hire employees who reflect the communities and people we serve, including race, ethnicity, gender, gender identity, culture and language, veteran status and people of all abilities. Having a diverse workforce allows us to meet the needs of the multicultural communities we serve better. It also empowers our

employees to do their best work and build strong relationships with enrollees, providers and community and faith-based organizations in the communities we are privileged to serve.

Local Knowledge and National Expertise

Our organizational structure reflects a local hands-on approach and dedicated local leaders to coordinate services and support stakeholder groups, including the people we serve, providers, partners and others. We meet the people we serve where they are in their health care journey and work with them to achieve improved health outcomes. We consider all aspects of whole-person care, from their community environment (rural versus urban) to physical and behavioral health, and their needs related to SDOH.

Community Health Workers (CHWs) are uniquely positioned as trusted resources in their communities to educate Kentuckians on identifying risk factors and accessing preventive care and social resources. In December 2019, we announced a partnership in Perry County that provides free college tuition to students for CHW accreditation through the local community college. This innovative partnership between health care leaders, higher education and communities will help move the needle on health and health care access while removing barriers in communities and providing promising opportunities for our Kentucky youth.

Local staff are culturally sensitive, familiar with the health care delivery system and, most importantly, available and accessible in the local community. Our locally based team is available and accessible to DMS to understand and respond to the needs, issues and challenges for the MCO program population. Our senior leadership teams bring experience from other state Medicaid programs to support the implementation and continued steady state of our Kentucky health plan.

Using our local knowledge of Kentucky to serve the needs of the community, we will draw upon our breadth of local resources in the Commonwealth and supporting resources from UnitedHealth Group to serve the people of Kentucky. We have hired our chief executive officer and chief medical officer and have extended letters of intent to the majority of the remaining key personnel roles. All personnel who were extended letters of intent are currently local to and reside in Kentucky. UnitedHealth Group has the extensive experience, resources, and technology to support a blended model of medical, behavioral and social needs functions delivered locally and nationally. We have more than 775 employees in the Commonwealth, and UnitedHealth Group's family of companies enhances our capabilities with more than 200,000 employees operating in all 50 states. This extensive support and experience helps our executive team implement innovative solutions, address challenges and bring expertise to help the Commonwealth define new programs, modify existing ones and continually enhance our service offerings.

With very few exceptions, our ancillary and support functions are performed inside the Commonwealth by dedicated staff. The local health plan executive team verifies performance metrics and compliance with local regulations, oversees all functions. To operate our MCO program effectively, we have two primary Kentucky office locations in Louisville and Lexington, and a satellite office in each city. Our principal office is located at 9100 Shelbyville Road, Louisville, KY 40222. In addition to our primary and satellite offices, we will further economic growth and development in rural Kentucky by supporting telecommuting staff throughout the Commonwealth.

Our Kentucky-based executive team and supporting staff will provide the organizational structure needed to deliver culturally relevant and locally delivered services to the people we serve.

How We Integrate Our National Expertise

We have demonstrated coordination and collaboration between the Commonwealth and our national teams since 1986, when UnitedHealthcare began operations in Kentucky. We integrate our national expertise in a variety of ways, including tried and true methods of frequent and structured communication and information sharing. Our shared collaboration technology platforms are an example of enabling seamless communication among the Commonwealth and UnitedHealth Group national resources in other states.

In addition to being dedicated to the Kentucky health plan, Ms. Johnston Little is a member of UnitedHealthcare Community & State's national Medicaid leadership team, comprising senior leaders and functional leads from over 31 UnitedHealthcare Community & State government-sponsored state programs. While Ms. Johnston Little is responsible for executive oversight of Kentucky compliance metrics and performance results, sharing those results with our national leadership team gives her access to additional resources to make sure we are delivering our best for Kentucky. The national Medicaid leadership team provides opportunities for collaboration between UnitedHealth Group plans to identify best practices and overall program improvement and to bring innovations to DMS that have proven results in other states.

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.

Organizational Structure

Our organizational structure is based upon our recognition that enrollees benefit from collaboration among our staff, which allows for a holistic understanding of their medical, behavioral health and social needs. We meet enrollees where they are, with compassion and sensitivity, to confirm all aspects of **whole-person integrated care** are considered, including the need for increased preventive care and deficits related to social determinants of health (SDOH). We have carefully selected our executive team to reflect expertise in the areas of physical/behavioral health integration, SDOH, **population health** management and service quality improvement. These efforts are aligned to help us meet DMS's vision to deliver overall improvements in health outcomes in a cost-effective manner.

Our care management tools enable the enrollee's care team, which comprises the enrollee, their primary care manager, community-based behavioral/physical health providers, affiliate subcontractors (e.g., Optum behavioral health services), and community-based organizations (CBOs) to work together to develop and implement an individualized plan of care. The figure illustrates this approach to whole-person care through collaboration among the enrollee's care manager and multidisciplinary care team (MCT) using *CommunityCare* and *Link,* our provider portal. The success of our care model is based upon collaboration among providers, community organizations and our clinical teams to deliver coordinated care and integrated supports that meet each enrollee's needs. A strength of our integrated care delivery team is that we employ one clinical care platform, *CommunityCare*, an integrated, secure, web-based clinical care coordination platform. *CommunityCare* facilitates the coordination of services across the clinical continuum by sharing enrollee information with the enrollee's care manager and MCT. Together, *CommunityCare* and *Link* provide a timely flow of actionable enrollee information, as shown in the figure.

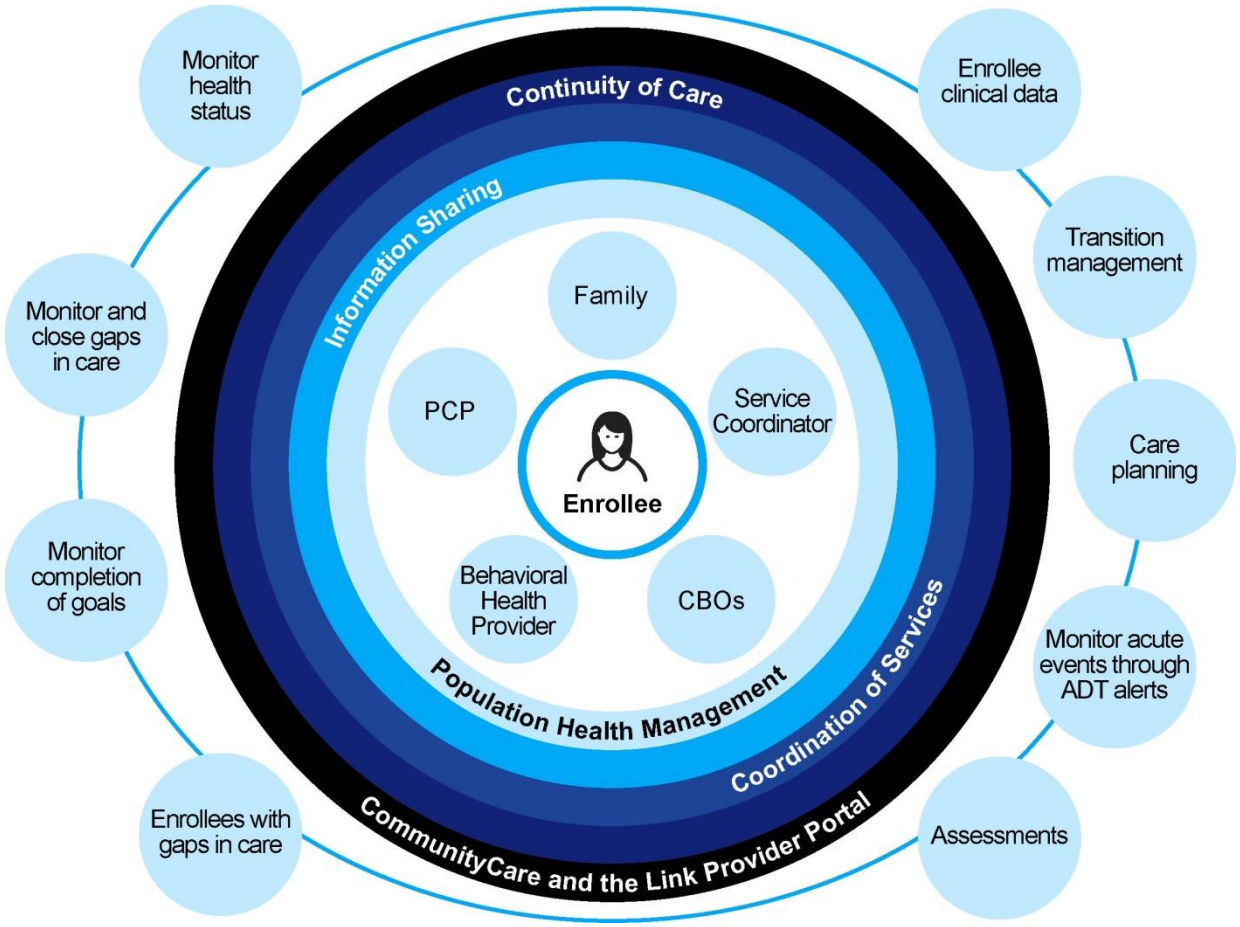

Figure 2. Collaborate to deliver integrated, coordinated care. Promoting collaboration among our affiliate subcontractors (such as Optum behavioral health services), providers, community organizations and our clinical teams to deliver coordinated and integrated supports that meet each enrollee's needs is central to the success of our model. We promote collaboration among the people and organizations that must coordinate the delivery of integrated enrollee care by implementing tools (such as *CommunityCare* and the *Link* provider portal) that share enrollee data and help implement targeted interventions based upon that data.

Oversight across Services and Functions

Our quality and oversight committees and programs are incorporated into our organizational structure to provide effective oversight of our operations to achieve program goals that improve health outcomes for enrollees while operating in an efficient and cost-effective manner. This integration includes quality programs, and behavioral and population health management of our clinical programs with a focus on outcomes and affordability. Oversight for quality and population health-management programs is the responsibility of our medical director/chief medical officer, population health management director and quality improvement director. The programs include, but are not limited to, the Provider Advisory Council (PAC), Quality and Member Access Committee (QMAC), Clinical Oversight Subcommittee (COS), Quality Improvement Committee, Joint Operating Committee, CAHPS (which tracks enrollee satisfaction), Steering Committee and others dedicated to key program functions.

Feedback for Continuous Improvement

We solicit feedback from our internal teams, from our state and local partners, from our providers and, most importantly, from the people we serve. This feedback provides critical data points for staff at all levels of our organization in improving the quality of our program and supporting population health and integration efforts across the Commonwealth, while doing so

in an efficient and cost-effective manner. We collect enrollee input from our QMAC, and provider input from our PAC.

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.

Governing Body

Our local Kentucky executive leadership team has full governing authority of the Kentucky Medicaid program. Overall, the governing body will be instrumental in guiding and overseeing UnitedHealthcare's critical Medicaid Managed care business operations to ensure the organization operates in good standing with the Commonwealth. Advising and counseling our executive team to assist in achieving this goal will be our Medicaid Advisory Board (Board). The Board will comprise of internal officers and external stakeholders. Amy Johnston Little, our CEO will chair the Board, which also will include our chief financial officer and Dr. Jeb Teichman, our health plan CMO. Our external stakeholders will be members of Kentucky's health care system, including no less than two health care providers and no less than community-based organizations. Other members of our health plan, such as the CMO, chief compliance officer and COO will attend regularly to provide updates across key areas. The officers are appointed on an annual basis. We will invite health care providers and community-based organizations to participate based upon the relationships our local health plan develops with them and work with organizations who serve a high volume of UnitedHealthcare enrollees. As part of their agreement, attendees will be required to agree to board responsibilities and confidentiality. The Board's main goals are to:

- Review and evaluate plan performance
- Assist plan leadership in identification of improvement and growth opportunities
- Make recommendations regarding member and provider engagement and satisfaction

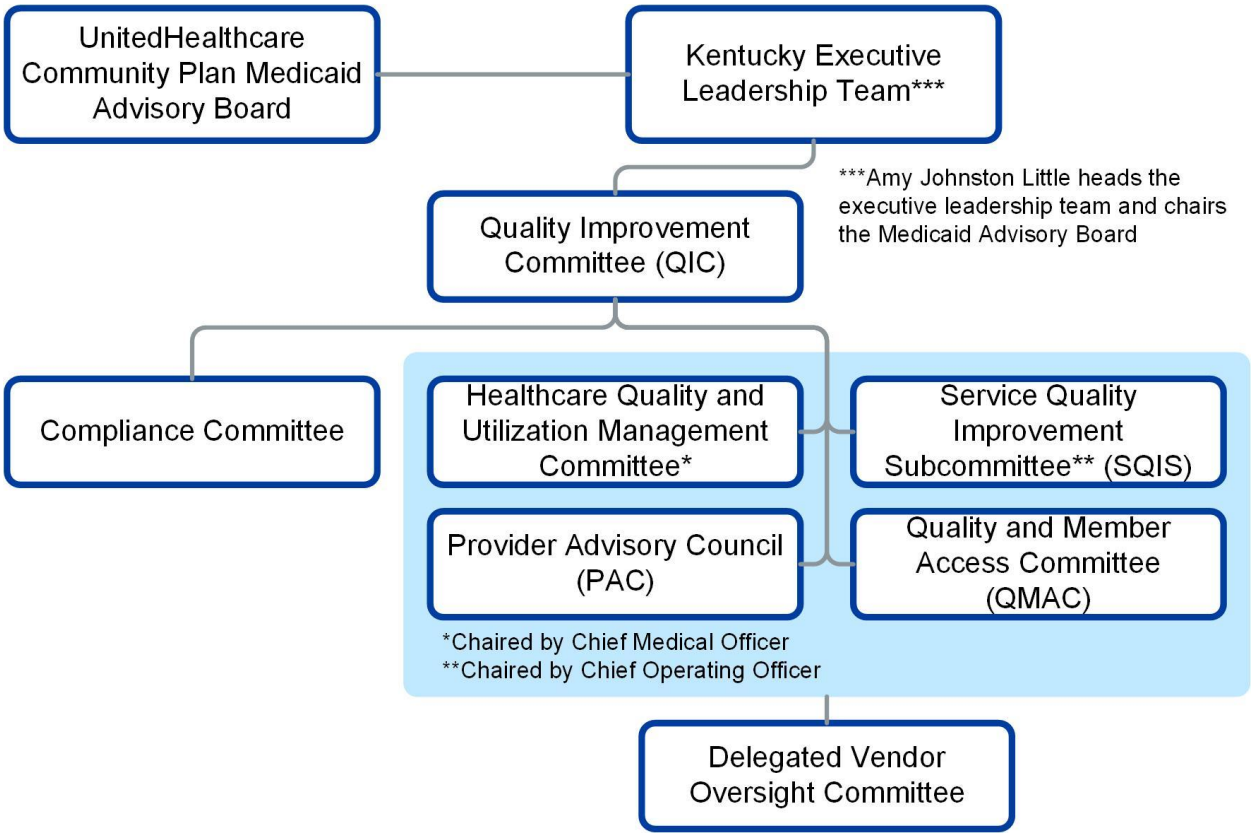

Figure 3. Our governance structure is led by our executive leadership team with input from plan functional areas and an advisory board made up of external stakeholders.

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.

Key Personnel

We identify and hire key personnel well in advance of new contract implementation. Amy Johnston Little, our CEO, and Jeb Teichman, our CMO are based in Louisville Kentucky and dedicated to the health plan. We have extended letters of intent to a number of key positions all of whom are located in Kentucky, including our chief compliance officer, health services director, chief financial officer, chief information officer, quality improvement director, behavioral health director, dental director and executive director for the Kentucky SKY program. These letters of intent have a flexible start date based upon contract award and go live to ensure we are able to bring permanent positions on board quickly. Our approach to recruit and retain executive team leaders entails first deploying executive leaders from our existing markets whose experience and qualifications align with the needs of the Medicaid experience in the Commonwealth. These interim executive team leaders remain dedicated to the MCO program until we onboard local, permanent staff and the operation is stable. As key personnel assume their roles, our interim executive leaders continue providing operational and administrative support — including mentoring, assimilation and job shadowing — until operational steady state is achieved. Having

these interim leaders on board throughout the implementation and into the operational stage of the contract confirms our staff has the foundational knowledge of our vision of Kentucky Medicaid and builds partnerships with our state partners.

Name	Title	FTEs	Office Location	Filled by Employee or Subcontractor
Amy Johnston Little	Chief Executive Officer	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Debra Sather	Chief Financial Officer (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Monique Beutel	Chief Compliance Officer (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Dr. Jeb Teichman	Medical Director/Chief Medical Officer	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Dr. Kellyann Light-McGroary	Medical Director/Associate Chief Medical Officer (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Jeanne Cavanaugh	Pharmacy Director (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Dr. Charles Stewart	Dental Director (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Lea Miller	Behavioral Health Director (interim)	1.0	9100 Shelbyville Road, Louisville, KY 402229	Subcontractor
Margaret Enlow	Provider Network Director	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Denise Damerow	Quality Improvement Director (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Karen Evans	Population Health Management Director (HSD) (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Glenn Walsh	Management Information System Director (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Additional Qualified Staff				
Kerri Balbone	Chief Operating Officer (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Dr. Ronald Beach	Psychiatrist (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Subcontractor
Charlene Brown	Complex Care Adult and Child Psychiatrist	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Whitney Allen	Community Relationship/ Marketing Director	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee
Moses Brutus	Enrollee Services Manager (interim)	1.0	9100 Shelbyville Road, Louisville, KY 40222	Employee

Job Descriptions and Qualifications
Chief Executive Officer (CEO)
The CEO is a senior executive leadership position, where the individual has demonstrated experience in strategic planning, organizational, people management, operational and technical skills. This individual directs the strategic development, growth and operations of the health plan in providing innovative care to the populations in the MCO program. The overall goal of this position is to provide executive oversight and leadership for UnitedHealthcare so the needs of the people we serve are met and contractual compliance is achieved. This position is a full-time administrator with clear authority over the general administration and

Job Descriptions and Qualifications
implementation of the contract requirements. *Qualifications:* ▪ Bachelor's degree or equivalent combination of education and experience; Master of Business Administration preferred ▪ Ten or more years of operations experience in a Medicare/Medicaid industry, at-risk managed care environment ▪ Previous profit and loss experience required ▪ Experience in strategic planning and development ▪ Demonstrated successful leadership skills in program execution and people management ▪ Proven leadership skills in both internal and external environments ▪ Must reside in, or be willing to relocate to, the Commonwealth of Kentucky
Chief Financial Officer (CFO)
The CFO oversees all aspects for strategic financial planning, analysis and operations for the health plan, including the budget and accounting systems. This position establishes a disciplined approach to financial performance management and oversees the budget, accounting systems, financial reporting, workforce planning budgeting, interest management, patient liability and audit activities. She/he conducts medical economic analytics to support joint projects with clinical teams and cost management initiatives. Under the guidance of the CFO, our finance personnel manage financial operations throughout the organization, including standardization of items to measure and related tools and processes for encounter data, analysis and reporting activities. During implementation, the CFO establishes the pro forma for the health plan and manages investment capital to become operational. During operations, she/he performs monthly trend analytics to evaluate unit and volume cost trends. Our chief financial officer sets incurred but not reported (IBNR) expectations and manages monthly financial closes. A key part of her/his job is managing capitation and reconciliation and accomplishing the timely completion and accuracy of all encounter submissions. *Qualifications:* ▪ Bachelor's degree in finance, statistics or related field required; CPA/CMA or MBA preferred ▪ Four to 6 years of management experience within total finance/professional experience base of approximately 10 years ▪ Background in benefit cost and other medical analysis or medical management preferred ▪ Strong strategic focus combined with operational, analytical and project management skills ▪ Excellent oral and written communication skills in all levels of the organization ▪ Demonstrate technical and financial understanding of physician and provider claim submission and contracts, claim system operations, and the resulting generation of data into financial and IBNR reporting information ▪ Must reside in, or be willing to relocate to, the Commonwealth of Kentucky
Chief Compliance Officer
The chief compliance officer reports directly to the chief executive officer and is the primary contact with DMS relating to contract compliance issues. She/he is responsible for and has authority to take all reasonable and necessary measures to implement the compliance program and the Principles of Ethics & Integrity. The chief compliance officer monitors changes to laws and regulations to comply with state and federal laws, regulations and mandates, and establishes and implements standard policies, procedures, processes and best practices to promote compliance with applicable laws and contractual obligations. The chief compliance officer collaborates with UnitedHealthcare legal counsel to conduct State-specific legal research and monitors changes to requirements to mitigate risks and achieve compliance. In addition, she/he supports the collection of data for regulatory filings and coordinates and develops reports, projects and assessment tools to verify compliance. The chief compliance officer also oversees implementation and evaluation of any actions required to correct a deficiency or address noncompliance with contract requirements as identified by DMS, including in response to external quality review (EQR) performance. The chief compliance officer may also develop compliance communications and drive problem resolution. *Qualifications:* ▪ Bachelor's degree or appropriate experience required

Job Descriptions and Qualifications

- Minimum of 3 to 5 years of experience in direct management of a compliance program
- Current and maintained knowledge of Federal and State legislation, legislative initiatives and regulations
- Solid experience in managed care and government programs
- Experience leading audits and major program initiatives
- Experience developing relationships with regulatory agencies
- Ability to identify root cause issues and ensure appropriate corrective action
- Must reside in, or be willing to relocate to, the Commonwealth of Kentucky

Medical Director/Chief Medical Officer (CMO)

The medical director/CMO is actively involved in all major clinical functions, health programs and quality management components of UnitedHealthcare's operations. The medical director/CMO oversees clinical operations initiatives that focus on clinical excellence, affordability and performance improvement. She/he oversees the development, implementation and review of quality improvement and quality of care (i.e., Internal Quality Assurance Plan), including implementation of and adherence to corrective action plans (CAPs). She/he is responsible for treatment policies, protocols, quality improvement activities, population health management activities and utilization management (UM) decision oversight, and for ensuring timely medical decisions. She/he is responsible for developing and implementing UM, disease management and quality management strategies to serve our enrollees. The medical director also oversees clinical directors, including those employed by subcontractors.

Qualifications:

- A medical physician with an active license in Kentucky is required
- At least 3 years of training in a medical specialty and 5 years of experience post-training providing clinical services; board certification in specialty preferred
- Previous successful experience in disease management/quality improvement/care management managed care program activities with a background in primary care medicine, family practice or geriatrics
- Available for after-hours consultation
- Previous work with service coordinators, including review of care plans
- Experience with integration of care for dual-eligible enrollees
- Must reside in, or be willing to relocate to, the Commonwealth of Kentucky

Medical Director/Associate Chief Medical Officer (ACMO)

The medical director/ACMO reports to the medical director/CMO and is actively involved in all major clinical functions, health programs and quality management components of UnitedHealthcare's operations. In coordination with the CMO, the position supports clinical operations initiatives that focus on clinical excellence, affordability and performance improvement. She/he also will support the CMO in the development, implementation and review of quality improvement and quality of care (i.e., Internal Quality Assurance Plan), including adherence to CAPs. The ACMO supports adherence to treatment policies, protocols, quality improvement activities, population health-management activities and UM decisions, and for ensuring timely medical decisions.

Qualifications:

- A medical physician with an active license in Kentucky
- At least 3 years of training in a medical specialty and 5 years of experience post-training providing clinical services
- Board certification in specialty preferred
- Managed Medicaid experience
- Previous work with service coordinators, including review of care plans
- Demonstrated ability to work with peers and other health care providers to resolve disease and quality management issues

Pharmacy Director

Our pharmacy director will coordinate, manage and oversee the provision of pharmacy services to the people we serve. She/he will have overall responsibility for instituting and coordinating, managing and overseeing provision of all components of the pharmacy program for the MCO program. This includes formulary

Job Descriptions and Qualifications
development and consultation, drug rebates; drug UM activities, enrollee and provider pharmacy issue resolution management, pharmacy network support, adherence to health plan policies and procedures and regulatory requirements, assisting with integrated care activities and attendance at all relevant meetings. The pharmacy director will be a member of the Kentucky Medicaid Pharmacy Director Workgroup. *Qualifications:* ▪ Kentucky-licensed pharmacist in good standing with at least 5 years of experience in pharmacy (any setting) is required ▪ Bachelor of Science or PharmD in Pharmacy from an accredited college or university required; master's degree preferred ▪ Experience in pharmacy managed care and pharmacy UM preferred ▪ Expertise in pharmacy coding, claims and reimbursement, medication management and formulary development preferred ▪ Must reside in, or be willing to relocate to, the Commonwealth of Kentucky
Dental Director
The dental director is actively involved in all oral health programs and is responsible for ensuring timely oral health decisions. They provide oversight and coordinate with our dental provider around all associated operational functions, including quality, authorization and any provider/enrollee concerns/complaints. The dental director also has accountability for ensuring that innovations and initiatives focusing on clinical excellence, quality ratings improvement, appropriate office and outpatient utilization, health care affordability, health system transformation including provider network issues, mandated provisions and compliance, growth and focused improvement are implemented and successfully managed to achieve goals. Additional responsibilities include affordability of dental services and compliance with contract requirements. *Qualifications:* ▪ Licensed to practice dentistry in Kentucky ▪ Available for after-hours consultation ▪ Five or more years of clinical practice experience ▪ Knowledge of managed care industry and the Medicaid line of business ▪ Familiarity with current medical/dental issues and practices ▪ Strong leadership skills, as demonstrated by continuously improved results, team building and effectiveness ▪ Must reside in, or be willing to relocate to, the Commonwealth of Kentucky
Behavioral Health Director
The behavioral health director is part of the executive team and is involved in all programs or initiatives related to behavioral health. The behavioral health director is responsible for overseeing all behavioral health activities and services, including UM, and participates fully in the medical management team's clinical and policy decisions. She/he will coordinate efforts to provide all behavioral health services under the contract and attend all meetings as required. *Qualifications:* ▪ Must have an active license to provide behavioral health services in Kentucky (MD, DO, RN with Advanced Practice Certification, psychologist, LCSW, LPC) ▪ Minimum of 5 years of experience providing and supervising treatment service for mental illness and substance use disorders ▪ Managed Medicaid experience ▪ Accessible and available for consultation ▪ Strong team orientation and contributor to collaborative efforts ▪ Must reside in, or be willing to relocate to, the Commonwealth of Kentucky
Provider Network Director
The provider network director is responsible for oversight of provider services and provider network development. The provider network director is responsible for the successful program design, compliance

Job Descriptions and Qualifications
with network requirements, network assessment and selection, and implementation of the MCO program. This includes clinically integrated network teams that focus on specific clinical area lines of service (e.g., cardiology, women's health, oncology) to improve quality and affordability. The provider network director provides oversight of required coordination with DMS's contracted Credentialing Verification Organization(s), and coordinates workforce development initiatives conducted by UnitedHealthcare and collaboratively with DMS and other contracted MCOs. In addition, she/he is responsible for the day-to-day oversight of the provider call and claims services and monitors the performance of the provider call center, claims processing units, and other provider servicing units that have an impact on the timely and accurate payment of claims. She/he also works in conjunction with the provider-relationship management team to identify and resolve issues related to provider satisfaction. *Qualifications:* ▪ Bachelor's degree required, major in business or health care preferred; master's degree preferred ▪ Five or more years working in the managed health care plan setting required ▪ Two or more years of experience working with physicians and other providers in contracting, servicing and network program design ▪ Demonstrated ability to act strategically about provider network design optimization and its impact on overall market competitiveness, quality and efficiency ▪ Must reside in, or be willing to relocate to, the Commonwealth of Kentucky
Quality Improvement Director
The quality improvement director is the key team leader of the Quality Improvement Program and is responsible for the development, implementation and oversight of the day-to-day operations of the quality improvement (QI) and quality management (QM) functions to verify compliance with all regulatory and accreditation requirements. The quality improvement director directs and guides QI and QM programs, including accreditation and regulatory requirements for Medicare and Medicaid programs. This position directs quality audits, projects and processes improvement activities, and is responsible for NCQA requirements inclusive of HEDIS and CAHPS. She/he also is responsible for responding to and correcting EQR performance findings in collaboration with the chief compliance officer and the development of performance improvement projects (PIPs). The quality improvement director leads and oversees complaints, grievances, appeals and fair hearings processes, and performance monitoring activities. Oversight responsibilities of the position include continuous QI initiatives such as process reviews, analysis of outcomes data and annual evaluations of the entire QM program. During implementation, the quality improvement director establishes the Quality Improvement Program structure and plans and continues to provide ongoing oversight of the quality program after go live. Ongoing operations include program committee reviews, quality of care management and continuously improving quality scores, ongoing review and update of the Quality Improvement Plan and steady state activities around HEDIS, CAHPS and PIPs. *Qualifications:* ▪ Bachelor's degree in nursing, science or business, or equivalent experience required; Master's degree preferred ▪ Eight or more years clinical practice experience or equivalent Demonstrated project management experience ▪ Four or more years working in managed care quality department required or equivalent experience in non-managed care setting ▪ Proven success managing, implementing and auditing clinical quality programs ▪ RN with current Kentucky licensure preferred ▪ Certified Professional in Healthcare Quality certification ▪ Experience with successful NCQA accreditation ▪ Must reside in, or be willing to relocate to, the Commonwealth of Kentucky
Population Health Management Director (HSD)
The population health management director is responsible for coordinating and overseeing the HSD/population health management program and services. The population health management director

Job Descriptions and Qualifications
strategizes, develops and directs operations of the health services department to ensure provision of high quality, cost-effective services. She/he is responsible for conducting the Clinical Oversight Committee, which reports out to the Quality Oversight Committee, developing and managing budgets and directing actions to control targeted costs for inpatient and outpatient services in conjunction with the site medical expense team. The role maintains compliance with state and federal regulations and contracts, and complies with company policies and procedures. *Qualifications:* ▪ Bachelor's degree in nursing required; master's degree preferred ▪ Current RN license in Kentucky required ▪ Five or more years of management experience with 2 or more years of experience in care management or home health ▪ Previous successful experience in disease management/QM/care management managed care programs ▪ Previous work with service coordinators, including review of care plans ▪ Demonstrated successful leadership skills in program execution and people management in both internal and external environments ▪ Must reside in, or be willing to relocate to, the Commonwealth of Kentucky
Management Information System (MIS) Director
The MIS director is the key team leader responsible for understanding the health plan's technology needs; DMS's requirements, needs and preferences regarding information technology (IT) systems; and for confirming they are addressed with appropriate resources. Partnering with enterprise technology solution groups, the MIS director delivers technology that enables the business and supports contract compliance. The MIS director oversees all IT functions including, but not limited to, establishing and maintaining connectivity with DMS information systems and providing necessary and timely reports to DMS. The MIS director is accountable for maintaining system availability and functionality for multiple claims platforms and operations across functions. During implementation, she/he will verify all system capabilities are operational according to Commonwealth contract requirements, including interfaces, system availability and backup. Post-implementations, she/he is responsible for break/fix corrections, verifying Sarbanes-Oxley compliance and meeting ongoing service level agreements. *Qualifications:* ▪ Bachelor's degree or higher level of education or equivalent experience required ▪ Five or more years of application development/support experience in a large enterprise environment ▪ Prior experience leading development or support for large, critical applications (preferably on multiple platforms) and managing a remote team of resources ▪ Ability to hold on-call responsibilities to respond to system issues at any time ▪ Previous health care industry experience and budgeting experience preferred ▪ Must reside in, or be willing to relocate to, the Commonwealth of Kentucky
Chief Operating Officer (COO)
The COO manages daily operations of multiple levels of staff and multiple functions/departments across the health plan to meet performance requirements. This position provides subject matter expertise in project management, project scope definition, risk identification, project methodology, resource allocation and other areas of expertise. The COO also is responsible for designing, coordinating and completing operational improvement projects across various functional areas within UnitedHealthcare. During implementation, the COO verifies that all new operational policies, procedures and desktops are in place. She/he verifies readiness through testing and evaluation. Once operational, the COO establishes operating metrics and daily, weekly and monthly scorecards to manage ongoing operations to confirm contractual compliance. She/he oversees and manages subcontractors in the same fashion. *Qualifications:* ▪ Bachelor's degree required ▪ A minimum of 10 years of related managed care experience, with a minimum of 5 years of people management experience

Job Descriptions and Qualifications
▪ Knowledge of and operational leadership experience related to publicly funded government health care programs and administration (e.g., Medicaid, Medicare or state health care programs for the uninsured) ▪ Ability to advise IT resources related to enterprise platform initiatives; provides direction on platform migration ▪ Evaluates outcomes based upon qualitative and quantitative measures and adjusts accordingly ▪ Must reside in, or be willing to relocate to, the Commonwealth of Kentucky
Psychiatrist
The psychiatrist provides oversight and direction of the behavioral health UM program and performs peer reviews as necessary. The psychiatrist will manage development and implementation of medical expense initiatives and advise leadership on improvement opportunities. She/he will collaborate with the SKY medical director, behavioral health director, and DMS, Department for Community Based Services and Department of Juvenile Justice to confirm the delivery of appropriate services to the people we serve, including foster youth served by the Kentucky SKY program. *Qualifications:* ▪ Kentucky licensed psychiatrist in good standing ▪ Certified by the American Board of Psychiatry and Neurology, with specialization in child and adolescent services ▪ Managed Medicaid experience preferred ▪ Available for after-hours consultation
Community Relationship/Marketing Director
The community relationship/marketing director is a senior leadership position that directs the strategic development, growth and community organizational engagement strategy of the health plan. This role fosters innovations with community-based partners and gains community engagement to support enrollees. The overall goal of this position is to create meaningful community relationships that will foster collaboration across a team of people to meet the needs of the people we serve and the Commonwealth. The director is responsible for market development of the health plan programs covering Kentucky. She/he executes strategies through a cross-functional structure to meet or exceed annual goals and objectives specific to the programs. *Qualifications:* ▪ Bachelor's degree or equivalent combination of education and experience required; MBA preferred ▪ Five or more years of operations experience in a Medicare/Medicaid industry, at-risk managed care environment ▪ Previous profit and loss experience ▪ Experience in strategic planning and development ▪ Demonstrated successful leadership skills in program execution and people management, in both internal and external environments ▪ Strong knowledge of the local provider population and facilities, and knowledge of community-based organizations
Member Services Manager
The member services manager is responsible for member services and for tracking/reporting issues and achieving problem resolution. She/he provides expertise and customer service support to the people we serve along with staff to coordinate all enrollee communications, advocate for our enrollees and provide timely responses. This individual directs phone-based customer interactions to answer and resolve a wide variety of inquiries. The member services manager provides leadership to and is accountable for the performance and direction through multiple layers of management and senior-level professional staff. *Qualifications:* ▪ Bachelor's degree ▪ Minimum 5 years of call center management experience, including knowledge of call center industry required ▪ Minimum 3 years of managed care supervisory experience required

Job Descriptions and Qualifications
▪ Bilingual strongly preferred ▪ Familiar with Rapid Resolution Experts model preferred ▪ Claims adjustment process experience preferred ▪ Familiar with health advisor model preferred ▪ Knowledge of call center systems

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.

Please see Attachment B.3.a.iv.c Key Personnel Resumes.

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.

We have hired our chief executive officer, Amy Johnston Little, and our medical director/chief medical officer, Dr. Jeb Teichman. We have extended letters of intent for seven positions – our chief operating officer, chief financial officer, quality improvement director, behavioral health director, dental director, and the executive director and quality director for the Kentucky SKY program. These letters of intent have a flexible start date based upon contract award and go live to ensure we are able to bring permanent positions on board quickly. For the key personnel positions currently filled by interim staff where we have not already extended offers, we have begun the recruitment process and are working to fill permanent staff positions through contract award according to the activities and timeline shown in the table.

Figure 4. Summary of Recruitment Timelines and Activities for Key Personnel. We will use interim staff to fill all open positions, so no positions will be open after contract award. Interim staff will remain in place until permanent hires are fully onboarded.

Our proven process to recruit and retain key personnel was born from our national experience and implementation of over 31 Medicaid health plans across the country. We select our key personnel after extensively reviewing UnitedHealthcare and national Medicaid, local managed health care and foster care experts. Our resulting executive team that remains with the health plan throughout and into a steady operational state comprises key personnel who are experts in the management of large health care delivery enterprises, including integrated Medicaid managed care programs and operations.

Using this model, no key personnel position will be open after contract award. As a contingency plan, should any key position remain vacant, our interim executive team leaders will remain engaged until we fill the position. Our national and regional organizational structures collaborate around unique state business requirements, enabling the local health plan team to focus on expansion of our operational infrastructure and seamless transition of the people we serve.

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.

Staff Training

Our Kentucky MCO curriculum will provide ongoing training on the regional demographics and care needs of Kentucky. Our instructional designers will collaborate with clinical subject matter

experts, community partners and advocates to develop state-specific training related to our enrollees' needs for each eligibility category.

All MCO program new hires and replacement staff will have appropriate training and orientation to fulfill all requirements and responsibilities of their positions to provide the highest level of service to the people we serve and the Commonwealth. We will tailor the training to the roles and responsibilities of staff, including distinct training for member services staff, provider relations staff, care management staff and other functional areas. New and existing staff receive training using a tiered approach that includes classroom instruction, web-based tutorials, role-playing, senior staff shadowing and on-the-job training. All of our employees and contractors receive training through a variety of modalities to accommodate different learning styles, which include classroom instruction, role-playing, shadowing senior staff, on-the-job training and web-based tutorials such as *LearnSource*, our companywide learning management system.

LearnSource is our web-based learning management system. Its courses focus on professional development, cultural competency, company policies, Commonwealth and federal regulations, and compliance for all of our employees. We use *LearnSource* to develop trainings tailored to particular populations and communities we serve. For example, employees take courses ranging from identifying fraud, waste and abuse, to courses detailing our models of care for enrollees with special health care needs. Supervisors track registration and completion using automated tools/reports.

Initial Onboarding Training

We will tailor our standard training approach to meet the Commonwealth's expectations and support the specific program requirements of the MCO program. Our comprehensive, multifaceted training program will include in-depth training about the MCO requirements and Kentucky Medicaid social, physical and behavioral health, and provide this training throughout all regions. We also will train all employees using a curriculum specifically developed for each region, which gives our staff the opportunity to truly understand and relate to the specific populations and communities they serve.

Our clinical philosophy training is provided as 12-week training for frontline health plan staff, managers/supervisors and leaders to provide a basic curriculum on trauma informed care, harm reduction, motivational interviewing, stages of change, addiction, positive psychology and mental health. This accredited and evidence-based training makes certain that frontline staff has the basic skills to work with homeless individuals and family, many of whom have experienced significant trauma.

Ongoing Training

We have learned from other markets that it is important to evolve our program to keep up with changes in health care delivery in general and as the local market shifts. By keeping the training current, detailed and Commonwealth-specific, we are able to provide up-to-date instruction on the MCO enrollee eligibility, services and benefits. We provide this training to staff based upon their roles and responsibilities, along with training on applicable policies and procedures. We conduct mandatory annual training on required subjects, such as code of conduct, compliance and fraud, waste and abuse, using online/web-based training modules.

Person-centered care is critical to the success of our care coordination approach and our health plan. As a result, we will have ongoing training that will focus on whole-person training for all staff. This focus will inform the ongoing person-centered training for all of our team. Additional required training topics may include, but will not be limited to, training focused on families and children; children and individuals with specialized health care needs; other service delivery

models; community integration and more. We also will develop numerous on-the-job tools to assist care coordinators and other staff while they are in the field, such as standardized checklists, screening and assessment tools.

Knowledge Transfer and Operations Continuity

Throughout our onboarding and ongoing training processes, we determine learning needs for staff transitioning to new roles. In addition to this training, at multiple organizational levels, we assign extensive training for new employees to enable effective knowledge acquisition and operations continuity. We use a direct work-sharing approach appropriate to the role to transfer knowledge for transitioning staff members. We assign mentors to new employees who serve as their "go-to" for assimilation and reinforcement of training concepts. We attempt to fill positions in advance of a departing employee's final work date, when possible, to enable direct work sharing and knowledge transfer for a smooth transition.

Our training program includes initial onboarding, ongoing, ad hoc and annual training tailored to the individual's function. In addition, our knowledge transfer process supports staff transitions and confirms operational continuity.

Staff Training Plans Specific to each Operational Area or Role

UnitedHealthcare has a training team that works with employees in all functional areas using a curriculum specifically developed for the Kentucky MCO program. Training will continue to be tailored to the roles and responsibilities of staff, including distinct training for, but not limited to, clinical and behavioral health services, member services call center and outreach, provider services call center and outreach, care coordination and all staff managers.

Enrollee Services Call Center Staff Training

Our member services advocates (MSAs) receive at least 12 weeks of initial training. Initial and ongoing training is focused on the unique needs of Kentucky MCO enrollees and all items contained in the Contract. In addition to in-depth telephone etiquette and systems training, curriculum focuses on the theme "*Through Their Eyes*," a UnitedHealthcare initiative that encourages all of our employees to see our work through the eyes of the people and families we serve. When we see health care through the eyes of individuals living with chronic conditions, disabilities, social and other challenges, we are better prepared to meet their expectations for a respectful, stress-free and fully supported experience. We teach MSAs how to identify and respond to each enrollee's needs with a first-call resolution as the goal.

Our MSAs receive training centered on the unique needs of our enrollees. In addition to in-depth telephone etiquette and systems training, we base our new hire curriculum on the theme, *Lives of the People We Serve.* Through this lens, our training programs include enrollee-driven scenarios grounded in the specifics of the plans they support. This helps MSAs identify the unique needs and challenges of the population they serve. Training allows MSAs to learn the specifics of benefits, health and social service resources, and provider networks. Through role-playing and mock calls, trainees practice cultural competency as they respond to our enrollees' needs. We train to specific protocols and provide ample practice to develop confidence with handling calls. Our goal is to provide complete, caring service, resolving the caller's issue on the first call. Training modalities include instructor-led presentation, online lessons, mock calls, role-playing, call observation and supervised calls. Ongoing training includes refresher courses and information on the very latest in program updates, related changes and requirements. Our call routing technology sorts calls into specific queues, which allows for a focused, on-the-job learning experience. Our employees truly advocate for our enrollees and are empowered to take action in the following ways:

- ***Enrollee Experience:*** From the beginning of our involvement in the Medicaid program, the enrollee experience is at the core of our customer care philosophy. We train our MSAs to respond to pre-enrollment questions, support enrollee welcome campaigns and conduct health risk assessments. MSAs learn to document calls appropriately, using a "5 W's" method (Who, What, Where, When and Why).
- ***Connecting with Network Providers:*** MSAs go beyond searching for network doctors and other providers by placing a call to verify the provider is accepting new patients for enrollees, and scheduling an appointment while the enrollee is on the call.
- ***Prevention and Wellness:*** We engage in efforts to improve health-outcomes-based HEDIS data and addressing gaps in enrollees' care. Our interactive Conversation Manager application prompts MSAs when the enrollee is overdue for preventive visits or screenings and educates the enrollee about their benefits and offers to schedule an appointment.
- ***Benefits and Services:*** MSAs view specific benefits, programs and services available and appropriate to the enrollee and can connect the enrollees to clinical and wellness programs.
- ***Community Services Referral:*** An online lesson "Health: Beyond the Clinic" introduces our MSAs to SDOH. Using online search tools, our MSAs refer enrollees with needs to local resource for food, housing, jobs, youth services, transportation and financial assistance.
- ***Creating Commitments:*** For enrollee issues that require time beyond the length of the enrollee's call for resolution, MSAs commit to following up with the enrollee — documenting the tasks required and assigning time to complete them.

Member Services Advocate (MSA) New Hire On-the-job Training

Our new hire training for MSAs consists of two phases of instruction. During the two learning phases, MSAs develop skills that enable effective, efficient performance.

In Phase 1 lasting seven weeks, MSAs learn the fundamentals of our operations and the Kentucky MCO program. We place particular emphasis on the enrollee experience and the impact our MSAs' performance and conduct has on our enrollees. Trainees master soft skills necessary for their role and task skills needed to handle the following types of calls:

- Eligibility and enrollment
- Noncomplex benefit inquiries
- Provider lookup and updates
- Enrollee materials requests
- Health risk assessments

In the second phase lasting six weeks, MSAs learn advanced soft skills, such as conflict resolution and personal resiliency, and the task skills necessary to resolve the following:

- Pharmacy benefits
- Behavioral health inquiries
- Inquiries, complaints, G&As
- Claims research and prior authorizations

Trainers and assistants provide daily feedback on their performance and use a variety of training modalities to address each topic, including:

- Online lessons
- Instructor-led presentations
- Mock calls, role-playing and simulations
- Side-by-side observation of MSAs on the phones
- Handling enrollee calls under direct supervision

We measure MSA trainees' knowledge, skills and abilities with a combination of live performance assessment and online testing. Our learning management system, *LearnSource,* enables automatic reporting of test data, and we compile performance-based data with the support of our trainers and quality coaches.

Provider Services Call Center Staff Training

We facilitate initial and ongoing training to foster high provider satisfaction. Our Kentucky-based provider services call center team, known as provider advocates, play a key role in delivering prompt and high quality service support to providers. Provider advocates receive extensive Kentucky MCO program-specific training to handle a broad range of complex topics. We conduct on-site trainings for our provider services call center team and their back-up counterpart teams. Claims supervisors, call center supervisors and provider advocates participate in monthly (and ad hoc) calls to discuss updates, issues and concerns as well as changes that occur in the network that may affect how we respond and resolve provider inquiries.

In concert with our standard new employee training and onboarding activities, initial training for our provider advocates includes segments that align with our member service call center training; plus a six-week provider services session covering benefits, eligibility, claims and two weeks of on-the-job training. We use a variety of methods such as facilitated lectures, role-playing/simulation, question-and-answer sessions and computer-based training. Seasoned staffs receive ongoing monitoring and training as well. Training topics and educational information cover all aspects of the Kentucky MCO program including:

Provider Services Call Center Staff Training Curriculum
▪ Kentucky MCO program covered services ▪ Cultural sensitivity and confidentiality training, diversity and inclusion ▪ Live training, during which the trainee listens to calls handled by a trainer ▪ Trainees directly answering live calls with supervision ▪ Medical claims and fraud, waste or abuse ▪ Professional and institutional claims handling ▪ Training on the provider-related systems ▪ Telephone etiquette and call quality ▪ Compliance requirements (e.g., HIPAA, confidentiality and protected health information [PHI]) ▪ Corporate integrity and compliance courses (e.g., fraud, waste and abuse) ▪ Fee schedules, contracts, and CPT, ICD-9/10 and other billing codes ▪ Accepting fraud, waste and abuse tips and respecting requests for anonymity

Before placement in the provider services call center occurs, trainees must demonstrate their ability to respond to provider inquiries, including complaints, grievances and appeals, and claims during their training period. Provider services staff receive annual refresher and ad hoc training. Once provider services staff work independently, we continue to monitor their performance and provide feedback for continuous quality improvement. Our call center supervisors routinely monitor provider services staff calls and provide coaching as applicable. Provider advocates work collaboratively with the provider services manager, who meets on a weekly basis with call center supervisors.

Provider Services Field-based Staff Training

We administer provider services staff training in a variety of formats, including modules that are self-taught, instructor-led classroom training and shadowing. Initial training consists of staff completing a multitude of curriculum modules before their assignment to a group of providers or geographic territory. Throughout the 2-month process, we provide on-the-job training and job

shadowing for on-site provider visits and meetings. Representatives attend a week-long intense training class with other new hires where they are immersed in coaching and instruction that prepares them to deliver the highest level of service so providers deliver the highest level of care for our enrollees.

Curriculum for Provider Services Field Staff Includes (key examples):
▪ Comprehensive information about Medicaid and the Kentucky MCO Contract ▪ How to access and navigate systems containing provider information (e.g., contracts, directories, network status, claims) ▪ Compliance requirements (e.g., HIPAA, confidentiality and PHI) ▪ Corporate integrity and compliance courses (e.g., fraud, waste and abuse) ▪ Fee schedules, contracts, and CPT, ICD-10 and other billing codes

Staff receives training throughout the year to keep them abreast of recent topics and changes in the industry. As policies change or new products become available, representatives are informed and trained on the new processes and policies. Staff independently seek specialized education relevant to the providers they serve.

Care and Service Coordination Staff Training

Our comprehensive curriculum for our clinical care staff includes a well-defined set of topics to facilitate understanding of all Kentucky MCO program requirements and clinical protocols. Designated trainers facilitate our programs for both current and new staff, using classroom, web-based, role-playing and person-centered teaching approaches.

We recognize that our staff members who influence enrollees' care either directly or indirectly must have the requisite knowledge and skills to meet the diverse and unique needs of our enrollees and providers across a spectrum of services and supports including type of specialty services and level of intensity. We have developed numerous tools to help our staff succeed. For example, we created a *Crisis Call Job Aid* as a reference guide for staff to refer to quickly during a crisis. We develop and augment numerous on-the-job tools to assist care managers and other staff while they are in the field, such as standardized checklists and screening and assessment tools.

As shown in detail in the table herein, clinical staff trainees undergo a three-week series of training modules followed by three to five weeks of job shadowing with senior staff to align with enrollee and caregiver needs. Our core clinical training has programmatic and administrative elements. Our clinical staffs receive ongoing, ad hoc and annual training. We provide staff with access to a comprehensive and up-to-date set of resources in our Clinical Reference Library, which is a support for all of our care managers.

Three-week series of training modules followed by three to five weeks of job shadowing with senior staff to align with enrollee and caregiver needs. Includes access to a clinical reference library of information.	
Orientation/Initial Core Training for Care and Service Coordination Staff	
Program-related Training	**Administrative-related Training**
▪ Introduction to managed care and the Kentucky MCO program including populations served, enrollee benefits, covered and non-covered services, and coordination between systems (foster care, adoption support, education, juvenile justice) ▪ Carved-out services, and collaboration with home and community-based service care managers	▪ Recovery and resiliency training ▪ State, federal and contractual requirements ▪ Introduction to our health plan departments including member services; telephone advice NurseLine provider relations; utilization, care, medical and quality management; and IT ▪ *Member Handbook*, *Provider Directory*, web-based enrollee and provider portals

- Continuity of care including member's ability to stay with existing in-network and out-of-network providers
- Collaborating with state agencies
- Integrated model: care management, disease management, health home, patient-centered medical home
- Provider types including specialty, availability and accessibility
- Enrollee demographics and at-risk conditions (e.g., neglect, physical or sexual abuse, parental substance abuse or mental illness and separation or loss associated with out-of-home care)
- Symptoms and treatment of medical and behavioral health conditions in the foster care population
- Medication management and enrollee medication adherence
- Transition support training to help youth transition from foster care to independence, including developing a transition plan, helping the enrollee build a support network, and working with public and private community agencies to enhance available services and supports
- Person-centered planning, such as identifying the individual's specific nonmedical goals
- Holistically assessing and engaging the enrollee in maintaining or improving their lifestyle
- Pharmacy services including formulary, preferred drug list (PDL) and 72-hour supply requirements
- Care management processes including referral and reciprocal sharing of information
- Integrated screening and assessment tools
- Utilization management (UM) guidelines, clinical practice guidelines and evidence-based practices
- Compliance including fraud, waste and abuse
- Confidentiality and HIPAA
- Reciprocal sharing of information
- Referral processes
- Authorization requests
- Access to and documentation in our care management platform
- Website availability for enrollee/caregiver, transitioning youth and provider information
- Provider reporting and incentive programs
- Provider claims, complaints and appeals
- Quality assurance and performance improvement
- Advisory groups and committees
- Available local and statewide resources
- Vital timelines in the evaluation and delivery of services to enrollees
- Cultural, linguistic, gender, sexual orientation or gender identity, socioeconomic, spiritual and disability diversity and sensitivity including agency expectations

Ongoing, Ad Hoc and Annual Training for Care Managers

- Program, policy and procedural changes such as changes related to care management, our care management platform clinical practice guidelines (CPGs) and medication utilization review program
- State, federal and contractual requirements
- Enrollee benefits/covered services changes
- Performance improvement initiatives
- ACEs, trauma-informed care, motivational interviewing, positive psychology, harm reduction
- Significant provider network changes
- Provider profiling and reporting
- Website changes and community resources updates
- Compliance including fraud, waste and abuse
- Cultural, linguistic, gender, sexual orientation or gender identity, socioeconomic, spiritual and disability diversity and sensitivity including agency expectations

Clinical Reference Library Resource for Care Managers

- CPGs and UnitedHealthcare's medical policies and evidence-based guidelines
- Web-based job aids, presentations and quick reference guides
- "Crisis Call Job Aid" reference guide for staff to quickly refer to during a crisis situation
- Bulletins and newsletters regarding key processes or theories in care management
- In-person and webinar-driven training for program changes or process improvements
- Care management receives weekly training through supervision, team meeting and clinical rounds
- In-person monthly staff trainings and monthly bulletins communicated via email for all staff
- Reminders of key processes or theories in care management
- Latest research on best practices for supporting children in foster care and adoption support

Utilization Management Staff Training

Our utilization management (UM) training program makes sure our medical director/chief medical officer and UM clinicians have appropriate knowledge and skills to serve the diverse populations that constitute our enrollees. Our training program facilitates understanding of Kentucky MCO program requirements, deployment of services and a holistic understanding of the unique care needs of enrollees. In addition to core training, we have numerous tools for use — such as standardized job aids and checklists — that help them follow key processes for determining medical necessity, authorizations, pre/concurrent/post review or conducting peer reviews.

Initial Orientation Training for All UM Staff

New UM staff members complete a three-week series of initial training modules and topics that include:

- Introduction to UnitedHealthcare
- New employee orientation
- Compliance with HIPAA requirements
- Fraud, waste and abuse
- Cultural competency
- Quality audits
- Harassment prevention
- Legal and compliance

Initial Clinical Training for All UM Staff

After the initial three weeks, new UM staff members spend at least three to five weeks in our clinical immersion program to experience real-life UM scenarios and train/educate on the following:

- UM, prior authorization, concurrent review and discharge planning processes; and updating, approving and denying services, including medical director review and rounds
  - ***Physical Health Services:*** Milliman Care Guidelines (MCG) clinical modules including Inpatient and Surgical Care Guidelines, Ambulatory Care Guidelines and Recovery Facility Guidelines
  - ***Behavioral Health Services:*** LOCUS, CASII, ECSII, CANS and ASAM guidelines
- Medical necessity concepts, including criteria; application of guidelines; consideration of individual enrollee circumstances when making decisions; variation in the application of medical necessity criteria; identification of potential avoidable or inappropriate services; and identification of potential risk due to inconsistency in the application of guidelines
- Covered services and delivering services in a managed care setting
- State-specific UM policies and requirements and our UM system to manage UM processes

Ongoing Training for All UM Staff

UM staff receives regular refresher training through weekly team meetings, monthly staff trainings and monthly bulletins. Monthly bulletins, communicated via email and during team meetings, provide reminders of key processes and applications in UM. We host in-person or webinar-driven training when changes to the program occur, such as implementation of new contractual requirements. UM staff has access to a clinical reference library of information for refresher training including job aids, presentations, quick reference guides, bulletins and newsletters pertaining to UM job functions.

Managers provide ongoing mentoring using job aids contained in the clinical reference library. Annual training includes information related to job-specific updates, process/workflow changes, internal review criteria updates and the maintenance of job-specific performance standards.

Grievances and Appeals Staff Training

After completing standard employee training and onboarding activities, every member of our Kentucky-based enrollee and provider grievances and appeals team for Medicaid programs undergoes intensive enrollee and provider grievances and appeals training. In new hire training, and annually thereafter, we educate grievances and appeals staff on the importance of adhering to notification processes and timelines, the rights of the enrollee and providers, a summary of our quality management program, critical thinking, compliance with HIPAA, the concepts of enrollee and provider grievance, appeals and the state fair hearing process; and using our grievances and appeals tracking system to manage enrollee and provider grievances and appeals from receipt to resolution.

Key Staff Training

We have a specific onboarding process for executives and key staff, and they receive additional support to help them have a successful start and create a solid foundation from which to lead. A dedicated team of respected leaders in our organization accountable for “onboarding” new leaders provides support to these new leaders. They place special emphasis on orientation within the first few months of joining our organization. The new leaders’ hiring manager and human capital manager help the employee gain an understanding of the organization and provide insight into how the leaders contribute to business goals. New leaders have a dedicated navigation coach who serves as a confidential adviser during their first months in our organization. We select our navigation coaches based upon effective communication skills, similar work requirements and strong performance.

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.”

Monitoring Subcontractors

For those services provided by subcontractors, our chief operating officer and vendor oversight manager will oversee and maintain accountability for subcontractor performance and progress in recruiting and training of staff to meet all contract requirements. As an example, within the clinical oversight process, a review of training and hiring policies is part of our formal annual audits performed by our clinical team for subcontractors, we use for utilization management and credentialing services. This audit includes, but is not limited to, review of training and policy documentation, metric compliances and misses, appeals and grievance cases, and claims. We submit audit results to our executive leadership team in written form for reviews for needed CAPs and interventions. We document these results for both the quality improvement subcommittee and compliance committees. The vendor oversight manager systematically will oversee all subcontractor relationships through our vendor management control processes that confirm our subcontractors meet contractual expectations.

We start monitoring subcontractor recruitment and training staff during implementation. As part of our implementation work plan, we assign and track subcontractor implementation and readiness tasks, deliverables and due dates, including their progress in recruiting staff. Our vendor management team verifies all aspects of subcontractor readiness, including the subcontractor’s confirmation that staff levels are adequate and staff is trained to meet the contract requirements. Our work plan includes a timeline with specific dates, events and dependencies that allow us to track progress. We monitor this progress through weekly meetings where subcontractors are required to participate and submit progress reports. Should there be any areas they are falling behind, we are able to put remediation plans into place in a timely manner.

After implementation, to monitor our subcontractors' progress in recruiting and training staff to meet all applicable Kentucky MCO requirements, we use a three-pronged approach that starts with having a dedicated accountable owner work directly with the subcontractor. The dedicated accountable owner for each subcontractor reports subcontractor performance to the appropriate health plan committee to validate compliance with health plan and Contract requirements. In addition, we have Joint Operating Committee (JOC) meetings with the subcontractor to discuss performance activities, results and hiring/training issues. The assigned accountable relationship owner for the subcontractor oversees the subcontractor performance and reports results and decisions to the health plan. As part of our annual compliance attestation process, we require our subcontractors to submit written confirmation that they have educated their employees on topics such as Code of Conduct and FWA.

While all subcontractor staff receives required training, staff for many of our affiliate subcontractors access the same training delivery tools as employees through our automated *LearnSource* training management program. This web-based training system easily records attendee participation and test scores for compliance oversight. *LearnSource* automatically assigns and tracks training, and then reports to the individual and their supervisor the successful completion of each training module, and when all of the training has been successfully completed. If the individual's required training is not completed on time, *LearnSource* sends a notification to the supervisor. If the training delinquency is not corrected in the specified time, a second notice is sent to the next level supervisor, and appropriate disciplinary action, up to and including termination, may result if the training is not completed.

viii. Retention approach for key personnel.

Retaining Key Personnel

We retain top talent by providing a positive work environment for employees. Rankings bear this out. UnitedHealth Group is the top-ranking company in the insurance and managed care sector on *Fortune*'s 2019 "World's Most Admired Companies" list for the 9th straight year. We deploy our practices, policies and procedures to create a valued work environment that attracts and maintains the highest quality employees. Integrity, compassion, relationships, innovation and performance are key cultural values among employees throughout our organization.

We maintain a positive workplace that meets the needs of our key personnel and employees — an inclusive and diverse workplace that celebrates the differences in employees' cultures, ages, ethnicities, genders and orientations, veteran status, physical and mental abilities and lifestyles. Harassment and intimidation are recognized forms of discrimination, which we do not tolerate. We are committed to affirmative action in our employment practices and we will comply with the Commonwealth's non-discrimination prohibitions, which align with our corporate practices. We received a perfect score of 100 on the Human Rights Campaign Foundation's Corporate Equality Index, recognizing UnitedHealth Group as among the best places to work for LGBTQ equality in its 2019 Corporate Equality Index. We comply with the provisions of the Americans with Disabilities Act, Public Law 101-336, and applicable federal regulations relating to prohibiting discrimination against otherwise qualified disabled individuals under any program or activity.

Approach to Minimizing Employee Turnover

Our **retention rate** *for key personnel across UnitedHealthcare Community & State (Medicaid) is* **98%** *(2% voluntary turnover).* We attribute our low employee turnover to our strong culture, fair hiring practices and our welcoming onboarding experience, coupled with thorough training for all employees. This sets the stage for a successful long-term employee-employer relationship. We deploy a proactive, high-touch, rapid-recruitment talent acquisition approach that has been

highly successful not only in hiring the right employees, but in keeping our employee turnover rates low. Our low turnover is exemplified with annual employee-satisfaction survey scores.

We are proud of our reputation as a premiere employer. As part of our efforts to measure and manage employee satisfaction, we partner with Qualtrics, an SAP company that works with hundreds of major employers. We measure our performance against the 90th percentile of all workplaces. Region II, of which Kentucky is a part, exceeded the 90th percentile on every question that is part of the employee satisfaction index. We also measure our managers' effectiveness as part of this effort and the survey. The ratings of our leadership team in Region II as reported by our employees also exceeded the 90th percentile of workplaces. These world-class employee satisfaction results contribute greatly to our ability to not only retain, but actively engage our employees in continually improving our business.

We encourage growth and development in all our employees and as a result sometimes lose employees to other roles in our enterprise, other employers or life events. We always consult our internal talent management and succession plan first to identify likely successors to these open roles. When we need to recruit externally, we deploy the same external recruiting resources to fill roles as we have deployed to support the start-up of the Kentucky plan.

Additional Benefits

Some of the ways in which we provide employee incentives are through additional benefits:

- ***Casual Dress Code:*** To increase morale and promote individuality, we offer employees the option of dressing casually on Fridays and special occasions.
- ***Career Development:*** An employee's belief that they can achieve their career goals drives employee engagement and retention. This focus on career development means we are continually encouraging and supporting our employee's career goals and dreams. This includes tuition reimbursement for outside educational courses related to their field through accredited institutions.
- ***United For Giving:*** Through our United For Giving program, employees make an impact when they donate their time or money to the causes they care about. We provide:
  - A 1:1 match for donations to eligible charities
  - A $500 charitable grant once an employee has volunteered 30 hours
- ***Flexible Work Arrangements:*** Recognizing that work from home and flexible work schedules result in happier, more productive employees, we offer this choice to our employees. The Kentucky health plan will support a flexible work environment.

Appreciation Programs

We recognize our employees are the lifeblood of our company. As such, some of the ways in we actively strive to show our appreciation include:

- ***Bravo!:*** All UnitedHealth Group employees are encouraged to take part in our Bravo! program to recognize fellow coworkers. Bravo! allows any employee to say thank you to another staff member for a job well done. Employees receive points they can use to shop in the Bravo! store, or they receive a bonus as recognition and thank you.
- ***Service Heroes:*** Each year, UnitedHealthcare recognizes individuals who make a positive difference in the lives of our members, providers and customers. These remarkable employees think outside the box, show they care, remove obstacles, own the solution and walk in the shoes of those they serve. Service Heroes are nominated by their colleagues and company leaders.

- ***Employee Appreciation Week:*** One week a year, we take the time to remind our employees, both those in the office and telecommuters, how special they are and how much their hard work is appreciated. Our different offices throughout the country celebrate in their unique way, paying homage to their local culture and community.

b. Provide a detailed description of the Vendor's organizational structure for this Contract, including an organizational chart that clearly displays the following:

Our proposed go-live organizational structure includes a mix of local, Kentucky-based leadership supported by our national team. This structure presents a highly qualified and dedicated staff of professionals who understand the strengths of the Commonwealth's health care market and the challenges faced by the people we serve. Our staffing plan provides the full organizational structure and appropriate staffing levels and roles needed to administer the MCO program successfully and to coordinate the delivery of high-quality services.

Led by CEO Amy Johnston Little and Dr. Jeb Teichman, our medical director/CMO, our executive team and our national infrastructure will provide effective oversight of the program and ensure contract compliance. As we build a comprehensive infrastructure in Kentucky to support the MCO program, the executive team will work together with UnitedHealth Group national experts to manage and be accountable for all functions and operations of the MCO program. We will apply our knowledge and experience, and enlist our other UnitedHealth Group affiliates and national teams, to help implement best practices in our Commonwealth operations.

The following organizational chart shows our executive team structure and additional functional areas.

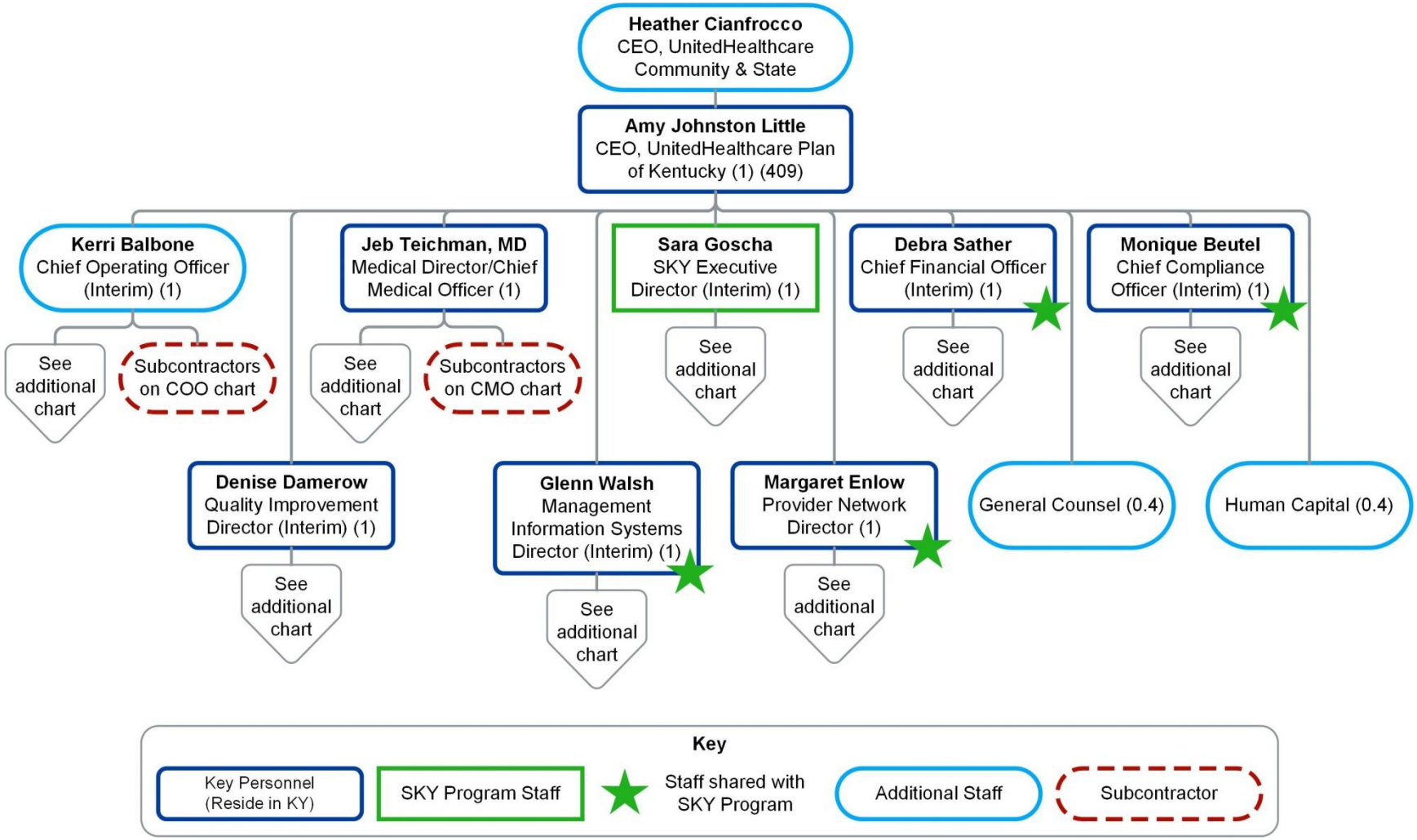

Figure 5. Organizational Chart showing executive team structure and other functional areas.

We have provided a more detailed organizational chart as Attachment B.3.b Organizational Chart, which shows the functional teams supporting the Commonwealth, including health services, quality improvement, finance, compliance, operations and member services, provider network and services, information technology and administrative operations. The chart illustrates management structure, lines of responsibility and authority for all operational areas of the contract; where subcontractors will be incorporated; and the number of proposed FTEs dedicated by position type and operational area. The chart also includes our reporting structure and staffing for the SKY proposal.

i. Management structure, lines of responsibility, and authority for all operational areas of this Contract.

As shown in the organizational chart previously and in Attachment B.3.b Organizational Chart, under the direction of Ms. Johnston Little, our executive team has full accountability and authority to manage, operate and administer, and seamlessly implement the MCO program contract. We engage in the crucial business issues and opportunities needed to manage the coordination and provision of health services effectively. The functional infrastructure and leadership staffing structure of our local health plan delivers effective oversight and contract compliance, continuous quality improvement and operational efficiency within a collaborative work environment that promotes our approach to service quality and responsiveness for the MCO program.

ii. How the RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices" fits into the overall organizational structure of the Parent Company

UnitedHealth Group, Inc. is the ultimate **corporate parent** to UnitedHealthcare health plans across the United States, serving Medicaid, commercial and Medicare beneficiaries. In Kentucky, UnitedHealth Group operates three major lines of business: Medicare & Retirement, Employer & Individual, and Community & State, which is the Medicaid business unit (inclusive of dual special needs plans). Our existing Kentucky lines of business serve over 409,000 Kentuckians, and we have more than 20,000 providers and 117 hospitals under contract. The governing body of UnitedHealthcare of Kentucky, Ltd.'s Medicaid program will be our executive leadership team in concert with our Medicaid Advisory Board. The Board is chaired by Amy Johnston Little, our CEO, and will include internal and external stakeholders to ensure well-rounded review and analysis of our operations.

The chart herein depicts where UnitedHealthcare of Kentucky, Ltd. fits within our ultimate parent UnitedHealth Group's organizational structure.

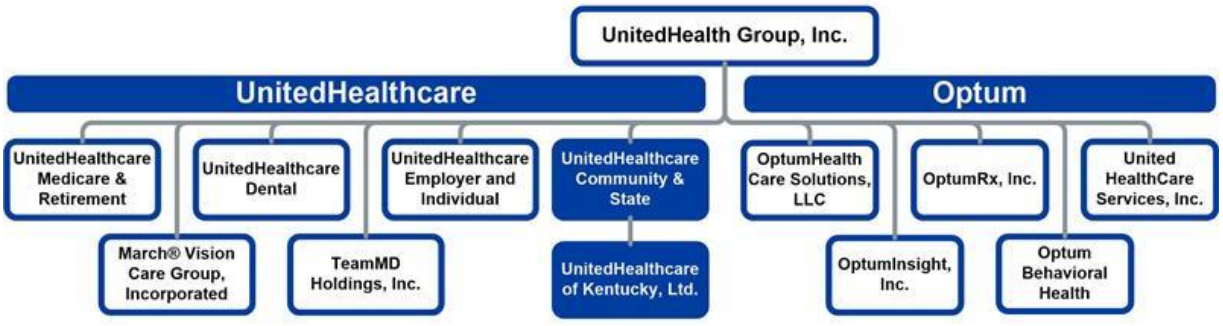

Figure 6. Relationship to Parent Organizational Structure: UnitedHealthcare of Kentucky, Ltd. will be responsible for performance of the MCO contract, supported by our parent company and the UnitedHealth Group family of companies.

iii. Where subcontractors will be incorporated.

As shown on the organizational chart in Attachment B.3.b Organizational Chart, subcontractors are incorporated into our organizational structure by operational area, accountable to either the

medical director/CMO or the COO. For example, our Healthcare Quality Utilization Management Committee (HQUM) and Provider Advisory Council (PAC) reports up to the medical director/CMO. Our Service Quality Improvement Subcommittee (SQIS) and Quality and Member Access Committee (QMAC) report up through our COO. These committees report results and corrective actions through the Quality Improvement Committee and ultimately to our executive leadership team.

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.

Summary of Subcontractor Integration

Optum behavioral health services, OptumRx, Dental Benefit Providers, MARCH Vision, OptumInsight, OptumHealth Care Solutions and United HealthCare Services are all part of the UnitedHealth Group family of companies.; DMS is gaining the strength of that enterprise to bring the most creative, innovative and fully integrated managed care to Kentuckians, which allows us to minimize additional subcontractors. While our internal employees deliver the majority of our services to our enrollees and providers through a management services agreement with our parent and affiliate United HealthCare Services, Inc., we subcontract certain services to vendors when the subcontractor has a particular expertise and experience in furnishing those services. For all subcontracted services, we maintain complete accountability and oversight for subcontractors' performance through our executive team, and our Kentucky-based CEO. Subcontractors are integrated into our performance obligations via accountability for their performance through ongoing collaboration with vendor relationship owners (VROs) and our local vendor oversight manager. In addition, our affiliate subcontractors use the same care-management technology platform as our staff and providers, enabling transparent integration across all members of the MCT. Non-affiliate subcontractors are integrated via structured reporting and collaboration activities.

Our vendor oversight manager is responsible for overall oversight of all subcontractor relationships. This role reports into the COO's reporting structure. We will assign VROs from each relevant functional area for subcontractor oversight purposes. The VROs hold regular meetings with our subcontractors at the local and national level as appropriate for the relationship type to validate the outcomes and quality of work performed. Functional area leaders, quality and compliance committees, and executive leadership, together with the subcontractors' staff performing the services, regularly collaborate to conduct monitoring activities locally. This regular collaboration and oversight helps to verify subcontractors are meeting performance metrics and confirms subcontractors' staff, policies and resources are appropriate to meet the requirements of their agreement. We also hold subcontractors accountable through our Joint Operating Committee (JOC) meetings. Our JOC monitors subcontractor performance at the local level, and clinical subcontractors are monitored additionally at the national level through the clinical delegation oversight committees. The JOC meets on a regular schedule. JOC membership includes Ms. Johnston Little and her executive team, national representatives and key business leads from UnitedHealthcare's Community & State (Medicaid) organization, and operational partners.

Results from the JOC and VRO meetings are reviewed by our quality committee structure, including the Healthcare Quality Utilization Management Committee (HQUM), Provider Advisory Committee (PAC), Service Quality Improvement Subcommittee (SQIS) and Quality and Member Access Committee (QMAC), and then presented at the Quality Improvement Committee (QIC) and ultimately to our Board. Once reviewed, feedback from these committees is funneled back

through the JOCs and VRO meetings. In addition, any action plans involving subcontractor activities stemming from member survey results or customer advisory board feedback will be provided to subcontractors at JOC and VRO meetings. During these meetings, VROs will work with the subcontractor to develop the action plan and ongoing tracking metrics to ensure implementation and success.

Our established oversight and compliance programs have further improved subcontractor performance by identifying any deficiencies and addressing them via action plans. We evaluate our subcontractors against criteria such as national standards and NCQA credentialing requirements, state-specific contracts, federal compliance program regulations and established claims processing protocols.

The longevity of our subcontractor relationships has allowed us to build strong oversight programs, operate with transparency, understand contractual requirements and apply compliance protocols effectively for both medical and nonmedical areas (e.g., behavioral health, pharmacy, dental, vision). Internal affiliates and external non-affiliate subcontractors have proven their ability to successfully perform delegated activities for Medicaid services and other public sector programs. Through these approaches, ***our subcontractor relationships have strengthened, and our program processes have aligned***, allowing us to provide superior, coordinated health care services — easily accessible to providers and the people we serve.

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.

We have more than 775 employees in the Commonwealth, employed through our commercial and Medicare lines of business and estimate **adding a staff of approximately 410 FTEs** across all operational areas to support the MCO program. The organizational chart indicates the proposed FTEs by position type and operational area.

Determination of Staffing Ratios

We build our staffing models by using with contractually required FTE models as a foundation and customize them for each state and program we administer, always seeking efficiency to balance between providing the right level of service and managing costs. We start with staffing ratio guidelines for our functional areas, such as care management staff, claims payment staff and provider relations staff. We use a standardized Workforce Management Projection Model (WMPM) that can accommodate membership changes and can project the number of FTE personnel required by functional area to support membership growth. These workforce models and planning tools help us determine staffing needs and ratios by role. We consider the project's scope of work — including, but not limited to, anticipated enrollment, geographic service areas, provider network, contract requirements, implementation timelines, and the Commonwealth's unique social and cultural challenges — before, during and after the operational start date. For example, we have metrics and planning models for member and provider call center, claims, appeals and disputes to calculate workforce projections. These models allow us to plan for the hiring, training and location of each required FTE, verifying we have the resources we need, when and where we need them.

Our business leaders develop projections based upon several key factors, such as known enrollment data or estimated membership size. Throughout the life of the plan, we monitor and assess staffing levels and adjust ratios proactively. These adjustments address changes or complexity in enrollee care needs, geographic location challenges, assurance of adequate provider support ratios, in response to new DMS requirements or an increase in membership or service levels.