ATTACHMENT B.3.A.IV.C KEY PERSONNEL RESUMES

Executive Team Key Personnel

- Amy Johnston Little, Chief Executive Officer
- Debra Sather, Chief Financial Officer
- Monique Beutel, Chief Compliance Officer
- Dr. Jeb Teichman, Medical Director/ Chief Medical Officer
- Dr. Kellyann Light-McGroary, Medical Director/Associate Chief Medical Officer
- Jeanne Cavanaugh, Pharmacy Director
- Dr. Charles Stewart, Dental Director
- Lea Miller, Behavioral Health Director
- Margaret Enlow, Provider Network Director
- Denise Damerow, Quality Improvement Director
- Karen Evans, Population Health Management Director (HSD)
- Glenn Walsh, Management Information System Director

Additional Qualified Staff

- Kerri Balbone, Chief Operating Officer
- Dr. Ronald Beach, Psychiatrist
- Charlene Brown, Complex Care Adult and Child Psychiatrist
- Whitney Allen, Community Relationship/Marketing Director
- Moses Brutus, Enrollee Services Manager

AMY JOHNSTON LITTLE – CHIEF EXECUTIVE OFFICER

Overview

- Dedicated professional with integrity
- Strong work ethic
- Excellent leadership and communication skills
- Motivated, energetic self-starter

Professional Experience

Company:	**UnitedHealthcare Community Plan of Kentucky – Louisville, KY**
Title:	Chief Executive Officer
Timeframe:	April 2019 – Present
Role and Responsibilities:	Accountable for the operations of the Kentucky Medicaid Health Plan, supporting Kentucky's Youth (SKY) Program and Dual Special Needs (D-SNP) program. Responsible for: ■ P&L and affordability ■ State relationships, compliance and adherence ■ Growth, business development and innovation ■ Leadership

Company:	**UnitedHealthcare Community Plan of Tennessee – Brentwood, TN**
Title:	1. Executive Director, Complex Product(s) and Programs: April 2018 – April 2019 2. Executive Director, Dual Eligible Special Needs Product: 2015 – August 2018
Timeframe:	2015 – April 2019
Role and Responsibilities:	Executive Director, Complex Product(s) and Programs: Retained all accountabilities as the Dual Eligible Special Needs executive director and took on an expanded role encompassing additional complex populations including private duty nursing (PDN), HEDIS/STARS for all Medicaid and D-SNP, reporting and analytics for the health plan, ORR/RFI strategy and deliverables, and population health accountability and reporting. Executive Director, Dual Eligible Special Needs Product: ■ Profit loss owner for the D-SNP product in the State of Tennessee. Responsible for all operational aspects of the product and the coordinated oversight of shared service partners. ■ Accountable relationship owner to our State partner, TennCare, for the D-SNP MIPPA contract and oversight of all contractual obligations. ■ Responsible for the development, maintenance and enhancement of the enterprisewide Medicare quality, including profit loss owner for STARS. ■ Accountable for defining, implementing and supporting product strategy, as well as analyzing and communicating market characteristics and needs. ■ Responsible for the statewide marketing budget and activities in conjunction with the development and oversight of sales and marketing strategies related to the D-SNP product.

	■ Accountable for the development and implementation of product programs/releases and member benefit packages. ■ Sole oversight of sales and retention performance in the Tennessee market for DSNP. Profit loss owner for product growth and development. ■ Profit loss owner accountable for achieving targeted operating income and operating cost targets through effective product oversight, inclusive of meeting enrollment growth goals and medical loss ratio projections. ■ Set team direction, resolve problems and provide guidance to members of own team. ■ Oversee the work activities of managers responsible for direct staff supervision in clinical care coordination, retention, sales and marketing activities. ■ Adapt departmental plans and priorities to address business and operational challenges. ■ Influence or provide input to forecasting and planning activities. ■ Led the team for implementation of the FIDE SNP product for the State of Tennessee and remain profit and loss owner for the product.

Company:	**Anthem (Amerigroup) – Norfolk, VA**
Title:	Director (AVP), Clinical Quality Medicare (Corporate QI)
Timeframe:	2013 – 2015
Role and Responsibilities:	■ Responsible for the development, maintenance and enhancement of the enterprisewide Medicare Quality Program Description, Medicare Work Plan and Medicare Quality Program Evaluation. ■ Responsible for State audits as it relates to Medicare Improvements for Patients and Providers Act (MIPPA) contracts. ■ Oversee the development of quality improvement strategies for the enterprise and clinical program development for population-based clinical quality measures. ■ Oversee the Medicare training for all new hires in the quality and other departmental areas. ■ Critique and oversee the updating of all training documents related to Medicare, SNP and quality. ■ Develop training plans for staff development and career pathing. ■ Evaluate industry best practices and assist in the strategic implementation of HEDIS initiatives targeted to drive STARS and quality of care outcomes. ■ Manage a call center focused on preventive care and closure of gaps in care, as well as concierge outreach initiatives. ■ Attest to all new Medicare contracts and assume Medicare leadership for all quality activities related to new request for proposal contracts and product expansions. ■ Responsible for the submission of 90 Chronic Condition Improvement and Quality Improvement Projects to CMS on an annual basis, as well as presentations to CMS' corporate headquarters on the progress and outcomes of the projects. ■ Responsible for CAHPS and HOS analysis oversight and strategic planning for improvement of scores.

	■ Chair of the Enterprise Medicare Quality Management Committee and responsible for presentations to the Board of Directors and overseeing Quality Improvement Committee. ■ Head cross-functional teams of case management, pharmacy, utilization management, provider relations, complaints and grievances, customer service and other supporting business areas focused on STARS initiatives and interventions. ■ Convene and drive synergy between regional, plan and corporate initiatives/interventions focused on quality improvement activities. ■ Train and supervise a team of 11 staff. Assess workload of staff and redirect resources as needed to meet department deadlines, goals and objectives. Review work products and provide feedback to staff on performance. Work with staff to identify areas for growth. Mentor staff as needed to meet job requirements and to assist in reaching developmental goals, conduct performance evaluations. Identify and monitor corrective action plans for departmental audit findings and as needed staff performance.
Company:	**Coventry Health Care – Louisville, KY**
Title:	Director, HEDIS (Corporate QI)
Timeframe:	2013 – 2013
Role and Responsibilities:	■ Provide corporate oversight of HEDIS related quality improvement activities – including medical record review and outreach initiatives. ■ Spearhead Coventry-wide interventions to improve HEDIS measures and create synergy between regional, plan and corporate initiatives/interventions. Establish strategic plans, policies and procedures as they relate to HEDIS on a regional and corporate level. ■ Interface with all business areas to ensure quality programs will meet or exceed guidelines and requirements. ■ Assist local plans in provider and member engagement strategy and provide resources for outreach. Oversee the development of HEDIS mailers for member and provider as well as engagement scripts. Provide plans resources for accessing best practices company wide. ■ Conduct Medical Record Review and Medical Record Review Validation, including abstraction and audit analysis for numerator compliant members. Assess enhancements for the Medical Record Review process and implement corporate training and technology strategies for improved data collection methods. ■ Assist as interim management at the local plan level for HEDIS related activities. Serve on steering committees and aid in the implementation of 2014 Medicaid Adult Preventive Measures, HEDIS Task Force meetings and Senior Leadership HEDIS Steering Committee meetings. ■ Oversee system testing of the supplemental data entry system and ensure plans receive adequate training. Perform regular rate analysis and monitor HEDIS activities related to the improvement of Medicaid metrics. ■ Participate in local plan Quality Improvement Committees and offer guidance as it relates to NCQA accreditation. ■ Train and supervise corporate and plan staff on departmental performance

	improvement initiatives. Work with staff to identify areas for growth and to assist in reaching developmental goals, conduct performance evaluations. Identify and monitor corrective action plans for departmental audit findings and as needed staff performance improvement. ■ Train and supervise a team of six direct reports and 10 indirect reports. Assess workload of staff and redirect resources as needed to meet department deadlines, goals and objectives. Review work products and provide feedback to staff on performance. Work with staff to identify areas for growth. Mentor staff as needed to meet job requirements and to assist in reaching developmental goals, conduct performance evaluations. Identify and monitor corrective action plans for departmental audit findings and as needed staff performance**.**
Company:	**UPMC Health Plan – Pittsburgh, PA**
Title:	Senior Manager, Performance Improvement Medicare Division: 2011 – 2013 Coordinator, Training and Testing for Clinical Operations: 2009 – 2011 Business Analyst – Senior Business Analyst: 2006 – 2009 Social Worker: 2005 – 2006
Timeframe:	2005 – 2013
Role and Responsibilities:	Senior Manager, Performance Improvement Medicare Division, responsibilities: ■ Obtain input from product, clinical and finance staff to develop performance goals related to any pay for performance programs. Ensure provider pay for performance programs, member incentives and health plan clinical interventions are designed to maximize the rates for measures included in these performance plans. ■ Direct the clinical team in the development and implementation of sound interventions with related work plans that address the unique characteristics of each of the products and are designed to improve outcomes for clinical programs, quality, STARS, CAHPS and HEDIS measures. ■ Manage the oversight and in-depth reviews of current interventions to determine which are most effective. Develop methodologies to conduct barrier analysis, track the interventions and to measure their effectiveness, and assign work to performance improvement staff to support the work plans. ■ Establish, implement and oversee a structured performance improvement process to ensure that applicable product clinical program and HEDIS data, interventions and results are reviewed on a frequent basis and analyzed to determine effectiveness. Based on the results of the analysis, direct corporate work groups to maximize the opportunity to reach product specific goals via provider and member interventions for all lines of business. ■ Collaborate with the IT staff and clinical staff on the development of new tools or reporting documentation required to support programs related to demographics, prevalence of diseases, cost and utilization of services per product, and identify any applicable health plan-adopted practice guidelines and internal/external benchmarks. Based on analysis of data, assist the clinical team in developing performance improvement activities. Including the rationale for the project, goals and identification of the population, stratification, barriers, interventions, communications and

	measurement of success. ■ Manage external quality audits, performance improvement activities and related reporting requirements for the applicable products that may be required by the Department of Health, CMS, DPW, Pennsylvania Insurance Department or other external review agencies. ■ Develop and present HEDIS, quality and NCQA lectures and training for internal and external audiences. ■ Speak at inter-agency collaboration functions and provide reporting on joint initiative ventures between the Insurance Division, Hospital Division and other community agencies. ■ Contribute to overseeing the Delegation for HEDIS, quality and regulatory compliance components for clients in Maryland and Washington DC. Participate in training, staff development and regulatory preparation for licensure and audit. Provide ongoing oversight of performance improvement components of the Delegation. ■ Train and supervise performance improvement staff and departmental performance improvement initiatives. Assess workload of staff and redirect resources as needed to meet department deadlines, goals and objectives. Review work products and provide feedback to staff on performance. Work with staff to identify areas for growth. Mentor staff as needed to meet job requirements and to assist in reaching developmental goals, conduct performance evaluations. Identify and monitor corrective action plans for departmental audit findings and as needed staff performance improvement.

Company:	**Renewal Inc. – Pittsburgh, PA**
Title:	Corrections Counselor/ Drug and Alcohol Program Counselor
Timeframe:	2001 – 2005

Company:	**Gateway Braddock – Pittsburgh, PA**
Title:	Corrections Counselor/Drug and Alcohol Rehabilitation Counselor
Timeframe:	2000 – 2001

Education / Licensure / Credentials

- Florida Institute of Technology**,** Masters in Business Administration, Specialization in Project Management
- University of Pittsburgh, Pittsburgh, PA**,** Bachelor of Arts in Social Work, Dual Minor in Psychology and Criminology

Professional Accomplishments

- 2017 Nashville Medical News Woman to Watch honoree, awarded to ten women in health care making a mark on the industry.
- Integrity and Innovation awards UnitedHealthcare for exemplifying core values in all work practices.
- Executive Development Program Alumni.

- Awarded recognition for achieving over 10,000 D-SNP sales three consecutive years, 2015 through 2017.
- Medicare Division team awarded the 2013 Senior Choice Gold Award from HealthMetrix Research of 2013 Medicare Advantage Plans for Exceptional Benefit, Value and Overall Performance.
- Under the direction of my team, we achieved a 4.5 STAR rating in 2012 in our PPO Product Part C ratings, up from a 4 STAR in 2011. Maintained an overall 4 STAR raking (with an increase in the actual percentage that was achieved) in both our HMO and PPO product lines.
- Achieved US News and World Report rankings to the top 50 Medicare plans.
- UPMC's Award for Commitment and Excellence in Service (ACES). Awarded to less than 1% of UPMC staff across the health system.

DEBRA SATHER – CHIEF FINANCIAL OFFICER

Overview

An experienced health plan professional with diverse managed care financial and actuarial management experience in Medicare and Medicaid products. Qualified and experienced in the following financial areas:

- Accounting: Financial statements and budgeting
- Actuarial: Claim reserves/IBNR; Medicare Advantage bid process; Medicaid rate setting; trend analysis/forecasting
- Analytics: Medical cost savings initiatives, provider contracting; value-based contracting.

Works closely with senior management to develop short rand and long term business plans, including implementing and overseeing business and finance operations and initiatives. Has in-depth knowledge and experience serving in leadership roles in the west region of the United States — specific to finance and actuarial management of Medicaid and Medicare programs — which will provide the Commonwealth with a fiscally responsible program for the Kentucky Health Program.

Professional Experience

Company:	**UnitedHealthcare Community & State – Seattle, WA**
Title:	Regional Chief Financial Officer
Timeframe:	January 2020 – Present
Role and Responsibilities:	▪ Provide financial leadership for diverse multi-state region. ▪ Drive regional strategies, budgets, execution of key initiatives, and results. ▪ Mange financial and business risk of the region.

Company:	**UnitedHealthcare Community & State – Seattle, WA**
Title:	Chief Financial Officer
Timeframe:	July 2014 – December 2019
Role and Responsibilities:	▪ Provided financial leadership for Washington State Medicaid health plan including monthly financial reporting, analysis, and forecasting. ▪ Developed systems for key financial and operating initiatives. ▪ Worked with cross functional business team to ensure understanding of financial goals and objectives. ▪ Provided analysis and support for developing ideas, programs and projects.

Company:	**Group Health Cooperative – Seattle, WA**
Title:	Executive Director, Finance Administration
Timeframe:	January 2007 – September 2013

Role and Responsibilities:	Provided strategic financial leadership for Group Health's Medicare product line, overseeing more than $1 billion in annual revenue. Managed multiple finance division departments including Medicare finance, decision support and risk adjustment services. ■ Led the on-time and successful submission of the organization's Medicare Advantage bids. Managed the team which prepared all actuarial documents, analyzed strategic scenarios, and ensured compliance with federal submission requirements. ■ Organized and directed new team responsible for risk adjustment support services. Accountable for accurate and timely health risk data submissions to the federal government. Developed and monitored clinical care quality improvement strategies. ■ Developed leaders and other staff.

Company:	**Group Health Cooperative – Seattle, WA**
Title:	Chief of Staff to CFO and Administrative Officer
Timeframe:	January 2009 – September 2012
Role and Responsibilities:	Concurrently served as Chief of Staff and Executive Director of Finance Administration. The Chief of Staff role was eliminated as a result of an organization restructure that eliminated the Chief Administrative Officer role. ■ Led development and deployment of strategic plan for the Strategic Business Services Division of 1,600 employees to assure alignment and support for key organizational objectives. ■ Managed a team of Lean consultants that support improvement efforts using established Lean practices, standard work processes, methods and tools. ■ Directed large complex cross-functional projects on behalf of the CFO/CAO. ■ Supervised and guided staff responsible for strategy and development of the organization's data governance program.

Company:	**Group Health Cooperative – Seattle, WA**
Title:	Director, Medicare Finance
Timeframe:	January 2005 – January 2007
Role and Responsibilities:	Responsible for financial oversight of the Medicare Advantage product line. Managed the rating, forecasting, accounting and reporting for the Medicare line of business. ■ Led highly complex Medicare competitive bidding process to set government rates and enrollee premiums. Negotiated $700,000,000 annual contract with Federal government. ■ Developed and implemented new products for 60,000 enrollees in collaboration with other business line leaders and successfully increased market share and contributed to membership growth of 20%.

	■ Exceeded product line margin targets consistently. ■ Recognized by internal leaders and external contacts as an expert on financial, reimbursement, strategic and contractual issues. ■ Managed numerous significant regulatory audits without any material findings sited. ■ Responsible for gaining Board approval of Medicare benefits and rates.

Company:	**Group Health Cooperative – Seattle, WA**
Title:	Senior Medicare Analyst
Timeframe:	June 1996 – January 2005
Role and Responsibilities:	Accountable for analyzing financial performance, forecasting revenue, and preparing rate filings and regulatory reports supporting the Medicare program. ■ Responsible for accounting of annual revenue in excess of $450,000,000. ■ Developed and implemented internal processes to more accurately and efficiently report revenue, expenses, and enrollment. ■ Managed staff responsible for Medicare claim reconciliation, hospital cost reporting and other regulatory reporting.

Education / Licensure / Credentials

- Masters of Business Administration, Seattle University, 2010
- Graduate Leadership Formation Certificate, Seattle University, 2010
- Bachelor of Science, Finance, Arizona State University, 1990
- Certified Health Insurance Executive (CHIE), 2012 – present
- America's Health Insurance Plans (AHIP) Executive Leadership Program Fellow, 2011 – 2012
  - Selected to participate in this year-long program that included training at Kellogg Graduate School of Management

MONIQUE BEUTEL, CHC – CHIEF COMPLIANCE OFFICER

Overview

Accomplished, results-oriented professional skilled in analyzing a variety of people and process-related issues. Extensive experience in managed-care, including compliance, medical economics, financial planning and analysis, data analytics and operational improvement. Positive, organized, dependable problem-solver. Selected Accomplishments:

- Subject matter expert for several key financial turnarounds
- Consistently created and implemented processes, policies and procedures that improve operational efficiency and financial controls
- Successfully partner with senior management to create and execute strategic plans
- Develop and maintain strong and collaborative relationships with both state and federal agencies

Professional Experience

Company:	**UnitedHealthcare Community & State – Columbia, MD**
Title:	Compliance Officer (Director)
Timeframe:	2016 – Present
Role and Responsibilities:	▪ Develop and execute compliance strategies across multiple markets ▪ Key relationship owner with both federal and state agencies ▪ Ensure compliance with regulatory requirements/standards, create/manage risk assessments and develop corrective action plans to remediate issues ▪ Functional subject matter expert for Request for Qualifications (RFQs) and Request for Proposals (RFPs) for new market/product entry ▪ Facilitate the MIPPA and state contract roadmap process in the Mid-Atlantic region ▪ Team of Teams Lead – mentor, thought-leader and counselor to Compliance Officers across the enterprise focused on providing cross-coverage, solving complex issues and ensuring appropriate protocols are in place ▪ Train and develop compliance support teams

Title:	Compliance Officer (Associate Director)
Timeframe:	2012 – 2016
Role and Responsibilities:	▪ Primary compliance resource for the District of Columbia D-SNP product, Delaware Medicaid Health Plan, and the Maryland Medicaid Health Plan – provide guidance and support for operational compliance with regulatory requirements ▪ Implemented and administered the compliance program for the Delaware Medicaid Health Plan and Maryland Medicaid Health Plan ▪ Conducted health plan risk assessments -- collaborated with business leadership to identify, assess, mitigate, communicate and monitor health plan operations compliance with contractual requirements ▪ Key point of contact for engagement with regulatory agencies/entities –

	DHCF, DMMA, HHS, MDH, MIA, OIG, OAG, CMS, Hilltop Institute, MHCC – ensured all reporting requirements and inquiries were escalated appropriately and completed correctly/timely ▪ Reviewed, communicated and implemented all new regulatory requirements and standards that were applicable to service operations.

Title:	Medical Economics Lead
Timeframe:	2008 – 2012
Role and Responsibilities:	▪ Managed the Flash process for the Maryland Medicaid market – measured utilization metrics; defined/researched drivers and calculated how performance impacted financials ▪ Developed forecast models that outlined impact of both past and present outcomes on future performance scenarios ▪ Conducted and distributed analysis to ensure that senior leadership could manage effectively and make timely decisions – quantified market initiatives (Medical Management Scorecard), REM member tracking, case management reporting, daily membership, daily utilization review and ad hoc reporting

Title:	Senior Financial/Medical Economics Analyst
Timeframe:	2004 – 2008
Role and Responsibilities:	▪ Managed the national Flash process – ensured accuracy of information that was pre-populated across 12 markets and met associated deadlines ▪ Created financial models that outline impact of hospital and physician contracting scenarios for both the Pennsylvania and Maryland Medicaid markets – generated cost savings of $50 million ▪ Prepared and presented financially viable and innovative solutions to pricing issues – providing cost avoidance scenarios worth $15 million ▪ Collaborated with senior management to identify, analyze and address medical cost drivers

Company:	**ARINC – Annapolis, MD**
Title:	Quality Management System (QMS) Coordinator
Timeframe:	2003 – 2004
Role and Responsibilities:	▪ Monitored the QMS database to evaluate data validity for root cause analyses and tracked follow-up actions for open audit findings ▪ Compiled monthly open/overdue findings report to track the status of audit finding action items – distributed report to executive management and board of directors ▪ Liaison between document control staff and business segment to ensure user requirements were met and operation was in compliance with ISO 9001:2000 standards ▪ Developed and updated schedules on the department's homepage for both domestic and international audits

Company:	**CIGNA Healthcare – Columbia, MD**
Title:	Planning and Analysis Manager
Timeframe:	2001 – 2003
Role and Responsibilities:	▪ Financial leader for 180,000 member HMO ▪ Directed annual planning process including growth, earnings, quality and service ▪ Implemented operational improvements – efforts yielded approximately $1.2 million (20% enhancement) ▪ Member of regional finance team that generated earnings turnaround of $26 million in one year ▪ Prepared and presented monthly financial results and related analysis to senior management

Company:	**Kaiser Permanente – Rockville, MD (1994 – 2001)**
Title:	Strategic Business Analyst
Timeframe:	1997 – 2001
Role and Responsibilities:	▪ Member of select team that developed, facilitated and managed $100 million turnaround in one year ▪ Developed and communicated organizational performance metrics to senior management allowing concise presentation of current performance and clear focus on key performance indicators ▪ Coordinated cross-functional elements to facilitate regional business planning process ▪ Redesigned corporate credit card and travel protocols to increase financial controls and reduce fraud – achieved cost savings of $200,000 and identified abuse of corporate funds ▪ Consolidated resources of two regions – generated $900,000 of savings

Title:	Management Engineer
Timeframe:	1996 – 1997
Role and Responsibilities:	▪ Analyzed task allocation of regional clinic support – redefined appropriate task allocation for clinical staff to shift activities downward ▪ Identified skill mix efficiencies and best practices by analyzing operations of regional laboratories ▪ Shortened time-span of long-distance data collection through barcode technology and facilitated quick turnaround of data analysis for the Northwest region

Title:	Management Engineering Technician
Timeframe:	1994 – 1996

Role and Responsibilities:	▪ Achieved cost savings and improved material management through analyzing material order patterns – established par-levels and improved contracting relationships ▪ Established processes and procedures for Employee Suggestion Program ▪ Improved operational efficiency of facility services and increased accountability of material management by evaluating task allocation and recommending transfer of activities

Education / Licensure / Credentials

- B.S., Business Administration; Bryant College; Smithfield, RI; 1993
- Certifications/Honors/Awards
  - Certified in Healthcare Compliance, 2019
  - UnitedHealthcare Culture Ambassador; 2013, 2014, 2015, 2016, 2017, 2018, 2019
  - UnitedHealthcare Culture Ambassador Summit Site Lead; 2015, 2016, 2017, 2018
  - UnitedHealthcare Order of the Rock Compliance Leadership Program; 2016
  - UnitedHealthcare Compliance Rock Star Award; 2016
  - UnitedHealthcare Compliance Rock Band Award; 2015Professional and Community Affiliations

JEB S. TEICHMAN, M.D. – MEDICAL DIRECTOR/ CHIEF MEDICAL OFFICER

Overview

Dr. Teichman is a board-certified pediatrician. He will be responsible for driving clinical innovation and developing strategic provider partnerships with a focus on strategies to address the opioid crisis, increase access to high quality addiction treatment and support integrated behavioral and physical health.

Professional Experience

Company:	**UnitedHealthcare Community & State, Louisville, KY**
Title:	Chief Medical Officer
Timeframe:	2019 – Present
Role and Responsibilities:	■ Makes clinical decisions related to the provision of care ■ Manages, influences and delivers communications of clinical decisions, programs, cases and results ■ Develops and implements initiatives requiring clinical expertise ■ Assesses and manages clinical operational capability in medical management ■ Educates others on clinical and operational topics and programs ■ Responsible for implementation and management of the quality improvement (QI) program, and leads and executes medical expense management and clinical quality activities ■ Collaborates with clinical operations staff, service coordinators and other staff to implement programs to support and meet clinical goals and contract requirements ■ Responsible for implementation and management of the quality improvement (QI) program, and leads and executes medical expense management and clinical quality activities ■ Collaborates with clinical operations staff, service coordinators and other staff to implement programs to support and meet clinical goals and contract requirements ■ Supports local market data-sharing activities, reviews completed data analysis and establishes a process for sharing data with hospitals and physicians ■ Monitors and tracks program performance indicators to validate that cost-effective care is provided with defined quality standards ■ Participates in audits when appropriate ■ Responsible for the development of corporate clinical care standards and medical practice guidelines and protocols ■ Completes peer-to-peer communications as required; manages/monitors the results of service coordination interventions to achieve utilization goals; and collaborates with service coordinators as necessary to maintain focus on achieving targets

Company:	**Aetna Better Health of Kentucky d.b.a CoventryCares, Louisville, KY**

Title:	Medical Director Deputy Chief Medical Officer
Timeframe:	Medical Director: January 2019 – May 2019 Deputy Medical Director: October 2017 – January 2019
Role and Responsibilities:	*Medical Director* ■ Primary responsibility was utilization management, including concurrent review for pediatric and neonatal intensive care unit (NICU) admissions ■ Led the high-risk OB and NICU case management team ■ Authored our team approach model that we implemented for concurrent review, which includes concurrent review nurses, case managers and discharge planners ■ Lead the effort to implement the NICU utilization management/care management program in Pennsylvania and West Virginia and mentored their nurses and medical directors in managing NICU babies • Within six months of implementation of the concurrent review program the average length of stay (ALOS) for NICU decreased by 0.7 days. Pennsylvania and West Virginia sas similar results ■ Assisted in the creation of the plan's case management program for pregnant women with substance use disorder (SUD) and their infants ■ Used both Interqual and Milliman ■ Worked in utilization management/care management for self-insured accounts *Deputy Medical Director* ■ Led a team of 5 medical directors ■ Supported the chief medical officer by filling in for him in his absence ■ Conducted outward facing duties with the state

Company:	**Humana/CareSource – Louisville, KY**
Title:	State Medical Director, Kentucky Market
Timeframe:	December 2012 – August 2013
Role and Responsibilities:	■ First state medical director for CareSource Kentucky ■ Leadership for case management (6 nurses) and ownership for Quality Assurance (one direct and one indirect report) ■ Chaired Quality Improvement Committee ■ Clinical face of the plan in state interactions with the State Technical Advisory Committee and weekly Operational Committee

Company:	**MDwise Hoosier Alliance, AmeriHealth Merc – Louisville, KY**
Title:	Consultant
Timeframe:	October 2008 – January 2012
	■ Responsible for all NICU authorizations, concurrent review and pediatric

	prior authorizations for state wide Medicaid plan with 165,000 members. ■ Used both Interqual and Milliman ■ Mentored case manager nurse on NICU concurrent review ■ Lead a work group of market neonatologists in creating feeding and apnea guidelines

Company:	**Passport Health Plan, AmeriHealth Mercy – Louisville, KY**
Title:	Consultant
Timeframe:	August 2003 – June 2009
	Responsible for all pediatric appeals

Education / Licensure / Credentials

- 1980-1983, University of Louisville, School of Medicine, Doctor of Medicine
- 1977-1979, University of Louisville, M.S. Anatomy
- 1971-1975: Adelphi University, B.A. Biology, magna cum laude
- Internship:
  - State University of New York at Buffalo; The Children's Hospital of Buffalo, School of Medicine – Department of Pediatrics
- Residency:
  - State University of New York at Buffalo; The Children's Hospital of Buffalo, School of Medicine – Department of Pediatrics
- Licensure and Certification:
  - Kentucky Board of Medical Licensure
  - State of Indiana, Health Professions Bureau
  - West Virginia
  - New York (inactive)
  - Pennsylvania (inactive)
  - 1997 – lifetime: Diplomat, American Board of Pediatrics
  - 1984 – Diplomat, National Board of Medical Examiners
  - Fellow, American Academy of Pediatrics
- Professional:
  - 2011, President, Clark County Medical Association
  - 2010 – 2012, Delegate, Indiana State Medical Association House of Delegates
  - 2007, President Medical Staff, Kosair Children's Hospital
  - 2006-2011, Associate Clinical Professor of Pediatrics, University of Louisville School of Medicine
  - 1999-2006, Assistant Clinical Instructor of Pediatrics, University of Louisville School of Medicine
  - 1983 - 1986, Assistant Clinical Instructor, State University of New York at Buffalo School of Medicine, Department of Pediatrics

KELLYANN LIGHT-MCGROARY, MD, MHCDS, FACC – MEDICAL DIRECTOR, ASSOCIATE CHIEF MEDICAL OFFICER

Overview

- Implemented the Iowa Community & State Program (a greenfield market) in 2016 as the Chief Medical Officer.
- Developed and executed a strategic affordability plan for the Iowa market in collaboration with the Chief Financial Officer to ensure fiscal discipline and the highest standards of care.
- Led the day to day activities to manage the clinical needs of over 400,000 Iowans on Medicaid, working with members, providers and our state partner to ensure the highest quality care for members.
- Effectively engages with other Medicaid health plans as a national leader to provide support for the clinical teams on execution of day to day work, affordability and policy development.

Professional Experience

Company:	**United Health Group, United Healthcare Community & State: Minnetonka, MN**
Title:	Senior Physician Advisor, National C&S Clinical Strategy & Quality
Timeframe:	July 2019 – Present
Role and Responsibilities:	▪ Leadership role on the national Medicaid clinical operations and quality team ▪ Leads the redesign of the national clinical model including medical/behavioral integration ▪ Serves as a national expert on clinical affordability and working with individual markets to create and execute on comprehensive affordability strategies. ▪ Creates and implements national clinical programs and policies that support local markets. ▪ Syntheses utilization data nationally and locally to refine utilization management strategies.

Company:	**United Health Group, United Healthcare Community & State: West Des Moines, IA**
Title:	Chief Medical Officer
Timeframe:	July 2016 – June 2019
Role and Responsibilities:	▪ Provided clinical leadership for 400K member Medicaid health plan, 70% of the total market share including 30K Long Term Supports and Services members. ▪ Partnered with the health plan CEO to represent UHC within the legislative branch to educate and influence stakeholders within the Iowa community. ▪ Successfully managed through both the expansion of the membership by over 215K members in December 2017 and the exit of UHC from the Iowa

	Medicaid market in July 2019 by ensuring aggressive oversight and innovation to maintain member safety and provider/member/state satisfaction. ■ Engaged in negotiation and execution of multiple value based/ACO contracts as well as supported the clinical integration of community partners and UHC. ■ Oversaw all aspects of utilization management, quality management and clinical regulatory requirements for the health plan. ■ Drove clinical affordability analysis and initiatives for the Iowa Health plan, facilitating over $18M in savings for acute medical/surgical admissions/readmissions and $25M in savings in the Long Term Supports and Services population through effective and member centric strategies over 2018-19. ■ Effectively integrated multiple areas of the organization into a single Iowa clinical team that used national strategies to support local market initiatives.

Company:	**University of Iowa Hospitals and Clinics, Iowa City, IA**
Title:	Clinical Associate Professor (2017-2018); Clinical Assistant Professor (2010-2017)
Timeframe:	August 2010 – July 2018
Role and Responsibilities:	■ Clinical responsibilities: • Attended the inpatient/outpatient Cardiomyopathy Treatment Program with responsibility for the advanced heart failure, transplant and mechanical circulatory support services • Specialized in Cardiac MRI in coordination with the Director of the Body MR Program in Radiology • Established a new clinical service for the integration of hospice and palliative medicine into advanced cardiac disease including development of preparedness planning, effective use of advanced directives and deployment of shared decision making ■ Teaching responsibilities: • Direct education of cardiology and palliative medicine fellows, internal medicine residents and medical students • Developed and deployed curriculum for cardiology and palliative care/hospice for the Carver College of Medicine and the Physician Assistants' Program at UIHC ■ Research responsibilities: • Principal Investigator on 5 Industry Sponsored Multi-Centered Clinical trials in heart failure ■ Sub investigator on 42 Industry Sponsored Multi-Centered Clinical trials in heart failure, pulmonary hypertension and mechanical circulatory support.

Education / Licensure / Credentials

- Bachelors in Science: College of Mount Saint Vincent: Major: Nursing
  Riverdale, NY: 1992: Graduated Magna Cum Laude

- Masters in Science: Advanced Nurse Practitioner: Hunter College-Bellevue School of Nursing; *New York, NY: 1998-2000 (did not graduate as transitioned to medical school)*
- Doctor of Medicine: Georgetown University School of Medicine; *Washington, DC: 2004*
- Masters in Health Care Delivery Science (MHCDS*)*: Dartmouth-Tuck School of Business; *Hanover, New Hampshire: 2016*
- Internship/Residency in Internal Medicine: Hospital of the University of Pennsylvania; *Philadelphia, PA: 2004-2007*
- Fellowship: Cardiovascular Diseases: University of Iowa Hospitals and Clinics; *Iowa City, IA: 2007-2010: Served as Chief Fellow 2009-2010*
- Medical License: State of Iowa: #37240: Renewal date: 07/01/2020
- Board Certifications:
  - Internal Medicine: 2007-2017
  - Cardiovascular Disease: 2010 –
  - Hospice and Palliative Medicine: 2012 –
  - Advanced Heart Failure/Transplant: 2014 –
- Professional:
  - Fellow of the American College of Cardiology (FACC): 2011 –

Professional and Community Affiliations

- American College of Cardiology: 2007-present
- Iowa Board of Medicine: appointed as a board member 2016-2019: Served as Vice Chair 2018-2019
- Iowa Medical Society: 2007-2017
- American Heart Association: 2007-2016
- Heart Failure Society of America: 2011-2017
- American Academy of Hospice and Palliative Medicine: 2010-2015
- American Society of Transplantation: 2011-2011
- International Society of Heart & Lung Transplantation: 2010-2017

JEANNE M. CAVANAUGH, PHARMD – PHARMACY DIRECTOR

Overview

Highly motivated, professional Pharmacy Director with extensive management and operational experience working in a rapidly growing, multi-state, managed care environment. Skills include pharmacy benefit management, regulatory/contract management, utilization management, team developmen, and product development with a focus on building new business, increasing market share and assuring the efficacy of the pharmacy program.

Professional Experience

Company:	**UnitedHealthcare Community and State – Southfield, MI**
Title:	Regional Pharmacy Director
Timeframe:	December 2009 – Present
Role and Responsibilities:	■ Manage Medicaid and CHIP pharmacy benefits of over 1.2 million members in central United States covering six states ■ Primary interface with health plan, state regulators, consumer advocates and internal corporate teams ■ Responsible for the identification/implementation of procedures, technologies, systems and programs that contribute to the increased effectiveness and efficiency of the pharmacy program, which includes, but is not limited to: • Monitor market trends, regulatory and competitor landscape • Develop strategic initiatives to position the health plan favorably in the market environment and lead to increased market share • Recommend and implement initiatives to manage expense trend • Communicate pharmacy information, reporting and trends regularly to health plan • Pharmacy health plan budget • Adapt departmental plans and priorities to address business and operational challenges ■ Develop and implement state and federally compliant pharmacy programs and pharmacy benefits, including RFP responses, product development, implementation and ongoing operations ■ Coordinate with and manage/audit Pharmacy Benefit Manager (PBM) to implement pharmacy programs and initiatives ■ Participate in formulary development, maintenance and utilization management strategies ■ Support health plans in the processing of grievances, appeals and fair hearings ■ Support integration of pharmacy with interdisciplinary teams, including medical and care management ■ Develop and facilitate pharmacy training for health plans' member services, health services, case management and behavioral health areas ■ Participate in pharmacy education of key targeted physician groups in conjunction with network management teams ■ Oversee pharmacy audits of state, operational, peer review and consulting

	organizations ■ Manage, validate, and submit accurate pharmacy reports and deliverables required of the health plan or state regulators ■ Manage a regional team of pharmacists and pharmacy technicians

Company:	**Blue Care Network – Southfield, MI**
Title:	Medicare Clinical Pharmacy Manager Pharmacy Manager, Commercial Benefit
Timeframe:	December 2001 – December 2009
Role and Responsibilities:	Medicare Clinical Pharmacy Manager: Managed clinical/operational aspects of the Part D benefit of a 44,000-member Medicare Advantage Prescription Drug Benefit (MAPD) within a commercial, nonprofit HMO; co-managed Michigan Medicaid Pharmacy Benefit (20,000 members) ■ Formulary Management: • Managed all formulary communications with CMS, members, physicians and pharmacists • Managed annual submission to CMS • Participated in Pharmacy and Therapeutics committee activities • Trained and supervised staff on Part D benefit, formulary principles, utilization management ■ Coordinated MTMP program implementation, maintenance and enhancements ■ Coordinated pharmacy external and internal Part D audit submissions ■ Managed day-to-day activities related to pharmacy management of Medicaid benefit Pharmacy Manager, Commercial Benefit: ■ Provided managed care pharmacy services within a managed care organization with over 500,000 covered lives ■ Clinical pharmacy liaison for over 27 plan-affiliated physician groups across Michigan ■ Assisted in the development of several plan-affiliated physician group initiatives ■ Implemented and developed a statewide generics sampling program ■ Implemented and developed a statewide physician managed care toolkit ■ Developed managed care communications ■ Managed regional and statewide pharmacy pilot programs, including a step-up/step-down program for GERD therapy, a pharmacy authorization educational program, and a generics sampling pilot programs

Company:	**Genesys Medical Equipment Services – Flint, MI**
Title:	Home Infusion Staff Pharmacist
Timeframe:	August 2000 – April 2001

Role and Responsibilities:	Perform staff pharmacist duties in a hospital-based, JCAHO accredited pharmacy home infusion service, including clinical assessments, ongoing monitoring, education and follow up for a variety of home care patients

Company:	**IVonyx, Inc. – Lansing, MI**
Title:	Pharmacy Manager
Timeframe:	October 1998 – July 2000
Role and Responsibilities:	▪ Managed a JCAHO-accredited pharmacy infusion service, including clinical assessments, ongoing monitoring, education and follow up for a variety of home care patients ▪ Managed daily activities of the pharmacy, including parenteral compounding, prescription management, quality control/quality assurance activities and inventory control

Company:	**Binson's Hospital Supplies, Inc. – Center Line, MI**
Title:	Director of Pharmacy Infusion Services
Timeframe:	November 1994 – October 1998
Role and Responsibilities:	▪ Managed a JCAHO-accredited home infusion department as part of a durable medical equipment and supply corporation; developed and implemented pharmacy policies and procedures ▪ Managed staff of the home infusion department, including nurses, pharmacists and pharmacy technicians

Education / Licensure / Credentials

- University of Michigan; Ann Arbor, MI; Doctor of Pharmacy, 1989

CHARLES L. STEWART, M.ED., D.M.D. – DENTAL DIRECTOR

Professional Experience

Company:	**UntiedHealthcare Clinical Services**
Title:	Director, Clinical Services
Timeframe:	July 2018 – Present
Role and Responsibilities:	Responsibilities include oversight of dental grievances and appeals for all product lines; all utilization management activities, quality of care and peer review.

Company:	**Solstice Dental Benefits – Plantation, FL**
Title:	Dental Director (part-time contractor telecommute position)
Timeframe:	May 2011 – July 2018
Role and Responsibilities:	Dental director for a URAC HUM certified PPO and managed care dental benefits company. Responsibilities include all aspects of utilization management, including consultant claims auditing and utilization management adjudication guidelines. Additional duties include chairing Credentialing Committee and Quality Improvement Committee, appeal and grievance resolution, provider trend analysis and meeting with clients as required.

Company:	**Wiregrass Georgia Technical College – Valdosta, GA**
Title:	Dentist Instructor
Timeframe:	November 2011 – Present
Role and Responsibilities:	Position includes all aspects of didactic and clinic instruction and supervision for a dental hygiene and dental assisting program. Duties include supervision of dental hygiene clinic operations and direct patient care for a school-sponsored indigent patient care program.

Company:	**Community Smiles AEGD Program – Miami, FL**
Title:	Volunteer Faculty
Timeframe:	November 2010 – November 2011
Role and Responsibilities:	A good friend and colleague was the dental director of a CODA-approved residency program, Community Smiles. As the residency was being revised, I was invited to be a volunteer faculty member, teaching oral medicine. I used the opportunity to update my clinical skills and awareness of current trends in dentistry.

Company:	**HealthCare Insight (Verisk Health) – South Jordan, UT**

Title:	Vice President of Dental Service
Timeframe:	April 2008 – November 2010
Role and Responsibilities:	HealthCare Insight provides medical and dental health care payers with a comprehensive portfolio of clinically validated fraud and abusive billing surveillance services. Provide oversight and management of all aspects of the company's dental product. Responsibilities include product development, sales and sales support, claim review, regulatory compliance and management of all aspects of dental operations, including the management of dental consultants and dental analyst team. Developed provider profiling analytics program and fraud, waste and abuse detection tools.

Company:	**CompBenefits Corporation/Humana Dental – Roswell, GA**
Title:	Clinical Director
Timeframe:	October 2006 – April 2008
Role and Responsibilities:	CompBenefits is a dental and vision benefit plan. As clinical director I was responsible for all utilization management and utilization review for all dental products, including DHMO, PPO, EPO and Medicaid. Duties included maintaining credentialing unit for all dental networks and meeting all state and federal regulatory requirements.

Company:	**Brio Consulting Partners, LLC – Ft. Lauderdale, FL**
Title:	President and Managing Partner
Timeframe:	January 2001 – October 2006
Role and Responsibilities:	Brio Consulting Partners, LLC is a management consulting firm. Brio Consulting Partners worked with a wide variety of small to mid-sized businesses, including health care professionals and dental benefit companies, to enhance profitability and improve company operations. This results-driven process helps establish the client's goals and objectives, provides strategic development, implements and measures results, reinforces progress towards achievement of stated goals, and trains the client in the process of continuous improvement.

Company:	**PacificDental Benefits, Inc. / SpecteraDental, Inc. – Houston, TX**
Title:	Vice President and Chief Operating Officer
Timeframe:	May 1998 – October 2000
Role and Responsibilities:	PacificDental Benefits was a dental benefits plan acquired by UnitedHealthcare. The COO, as a Vice President of PacificDental Benefits, was responsible for leading all aspects of the acquisition integration and managing the daily activities of SpecteraDental, which included utilization review, provider recruiting and credentialing, claims operations, and regulatory compliance. Position required active involvement in utilization reviews and claim reviews.

Company:	**CIGNA Dental – Ft. Lauderdale, FL**
Title:	Director, Dental Utilization Review
Timeframe:	May 1997 – May 1998
Role and Responsibilities:	Managed dental consultant review activities and service delivery for all CIGNA dental products. The position was accountable for continuous quality and service improvements in claim consultant review policies and procedures, dental care delivery cost, account persistency and business growth. This position required national travel to evaluate company claims operations, and making client and industry presentations.

Company:	**Delta Plans Service Corporation (Delta Dental Plans Association) – Chicago, IL**
Title:	President and Chief Executive Officer
Timeframe:	1994 – 1997
Role and Responsibilities:	Delta Plans Service Corporation was a consortium of Delta Dental Plans focused on managed care. Responsibilities included managing and directing the development of operational standards between the company and 17 member plans, designing national managed care products, providing support for major sales and marketing efforts, and all aspects of dental network management.

Company:	**Delta Dental Plan of Kentucky (Delta Dental Plans Association) – Louisville, KY**
Title:	Senior Vice President and Chief Operating Officer
Timeframe:	1994
Role and Responsibilities:	Responsibilities included managing all aspects of the operation for Delta Dental Plan of Kentucky.

Company:	**The Prudential Insurance Company of America –**
Title:	Southwestern Group Operations ■ Executive Director of Dental Operations, Vice President of Prudential DMO of Texas, Inc. ■ Director of Dental Relations Southern Group Operations ■ Senior Dental Consultant
Timeframe:	1988 – 1994
Role and	Executive director of dental operations for the second largest dental region in the

Responsibilities:	group benefits business unit. Managed all aspects of dental products and operations for both managed care and indemnity dental plans. Director of dental relations responsibilities included recruiting and maintaining a dental provider network for a seven-state region, which included over 1000 dentists in 760 contracted offices. Position accountable for provider compensation, credentialing, utilization review and network quality improvement. This position required regional travel for network recruiting and management. Senior dental consultant responsibilities included state and local dental director activities for an eight-state region including provider recruitment and retention, and claims review.

Company:	**Gwinnett Area Tech – Lawrenceville, GA**
Title:	Clinic Director
Timeframe:	1985 – 1988
Role and Responsibilities:	Position included all aspects of didactic and clinic instruction and supervision for a dental assisting program. Duties included direct patient care for a school-sponsored Head Start children's dental care program.

Company:	**DeKalb Community College (Perimeter College) – Atlanta, GA**
Title:	Adjunct Professor
Timeframe:	1983 – 1988
Role and Responsibilities:	Position included dental hygiene clinic supervision and teaching didactic classes in periodontology and pathology.

Company:	**Emory University School of Dentistry – Atlanta, GA**
Title:	Assistant Professor
Timeframe:	1982 – 1985
Role and Responsibilities:	Position included all aspects of didactic and clinic instruction and supervision for dental students and dental residents in the Department of Oral Medicine. Duties included direct patient care supervision.

Company:	**University of Louisville School of Dentistry – Louisville, KY**
Title:	Assistant Professor
Timeframe:	1977 – 1980
Role and Responsibilities:	Position included all aspects of didactic and clinic instruction and supervision for dental students, dental residents, dental hygiene students and dental assisting students in the Department of Oral Medicine, Department of Oral Pathology and

	Department of Oral Radiology. Duties include direct patient care supervision.

Education / Licensure / Credentials

- 1982, Residency Training, Oral Medicine/Oral Pathology, Indiana University, School of Dentistry, Indianapolis, IN
- 1977, D.M.D., University of Louisville, School of Dentistry, Louisville, KY
- 1976, M.Ed. (Organizational Development), Temple University, Philadelphia, PA
- 1971, B.A., Zoology, Tampa, FL
- Private Practice/Dental License
  - Actively involved in the clinical practice of dentistry in a variety of clinical situations from 1977-1991 and 2011-current
  - Georgia Dental License – DN009783 (Active)
  - Florida Dental License – DN19548 (Active)
  - NPI 1881965546
  - Kentucky Dental License – 4799 (Inactive)
- Previous Hospital Privileges
  - Consulting Staff, Emory Hospital
  - Indiana University Hospital System
- Previous Consulting
  - Fulton County Medical Examiner's Office
  - Consultant for the Southern Regional Testing Agency
  - Consultant to the Georgia Board of Dentistry
  - Consultant to the United States Army Dental Corps
  - Consultant to the American Dental Association, Commission on Dental Accreditation
- Research Grants
  - National Research Service Award, National Institute for Dental Research (NIH),
  - Two-year research Fellowship Award (#1F32DE0536-01)
- Publications
  - Stewart, C.L., Standish, "Osteoarthritis in Teenaged Females; Report of Cases," JADA, Vol. 206, May 1983
  - Stewart, C.L., "Bacterial Endocarditis: How to Recognize At-Risk Patients," Dentistry Today, Vol. 5, October 1984

Professional and Community Affiliations

- American Dental Association
- Georgia Dental Association
- Northern District Dental Association
- American Association of Dental Consultants

LEA K. MILLER – BEHAVIORAL HEALTH DIRECTOR

Professional Experience

Company:	**OptumHealth Behavioral Solutions, Public Sector – National**
Title:	Vice President, Solution Design/Proposal Architecture Vice President, Clinical Program Development
Timeframe:	2009 – Present
Role and Responsibilities:	Provision of subject matter expertise in the development of Medicaid, Medicare and federal business proposals, and implementation of new business opportunities; facilitate creation of dual eligible demonstration pilots and health homes that integrate medical and behavioral health services; and replicate and refine existing healthcare programs in multiple states.

Company:	**UnitedHealthcare Community Plan (formerly AmeriChoice), Tennessee**
Title:	Executive Director, Behavioral Health Services
Timeframe:	2007 – 2009
Role and Responsibilities:	Design and performance management of behavioral health services rendered within an integrated health care plan with a focus on holistic care for members; oversight of provider relations, contracting, management, and claims processing; and ensuring contract compliance with behavioral health content and deliverables.

Company:	**Tennessee Department of Mental Health and Developmental Disabilities**
Title:	Assistant Director, Division of Managed Care
Timeframe:	2003 – 2006
Role and Responsibilities:	Performance monitoring and reporting on behavioral health organizations (BHOs) serving children and adults with mental illnesses enrolled in Tennessee's Medicaid program, completion of departmental bill analyses, procurement and contracting with BHOs, staff supervision, and interface with stakeholder and advocacy groups.

Company:	**Tennessee Department of Mental Health and Developmental Disabilities**
Title:	Mental Health Program Specialist, Adult Services
Timeframe:	2001 – 2003
Role and Responsibilities:	Program oversight and performance reporting for 50 drop-in centers and eight Projects for Assistance in Transition from Homelessness (PATH) sites, grant writing, completion of departmental bill analyses, and interface with stakeholder and advocacy groups.

Company:	**AdvoCare of Tennessee, Inc.**
Title:	Forensic Coordinator/Services Manager

Timeframe:	1996 – 1999
Role and Responsibilities:	Account management and staff supervision for statewide reporting of utilized services, claims adjudication, appeals coordination, case reviews for clinical quality and legal requirements, and coordination of aftercare following hospital discharge for individuals deemed incompetent to proceed or not guilty by reason of insanity in criminal court proceedings.

Company:	**Mental Health Care, Inc., Florida**
Title:	Case Manager/Forensic Specialist
Timeframe:	1993 – 1996
Role and Responsibilities:	Provide assistance to persons with mental illnesses at various stages in the legal process through diversion to community treatment, coordination of services while in custody, and arrangement of services for proper care upon release.

Education / Licensure / Credentials

- Middle Tennessee State University, May 2000, Master of Arts Degree in Clinical Psychology
- University of South Florida, May 1993, Bachelor of Science Degree in Elementary Education
- Psychological Examiner – Tennessee (#11739), 2001 – Present

MARGARET ENLOW – PROVIDER NETWORK DIRECTOR

Overview

- Over 20 years of managed care experience in provider network management and strategy

Professional Experience

Company:	**UnitedHealthcare of Kentucky, Ltd. – Lexington, KY (1996-present)**
Title:	Vice-President, Network Management-Kentucky
Timeframe:	November 2011 – Present
Role and Responsibilities:	Statewide responsibility to develop, negotiate and support hospital, physician and ancillary provider agreements

Company:	**St. Joseph Health System (KYONE Health) – Lexington, KY**
Title:	Regional Director, Managed Care
Timeframe:	November 2009 – October 2011
Role and Responsibilities:	▪ Responsible for managed care contracting for commercial, Medicare and Medicaid for health system of six facilities and their employed physicians ▪ Implemented and developed financial model for hospital and physician agreements ▪ Managed contract payment variance team

Company:	**UnitedHealthcare of Kentucky, Ltd. – Lexington, KY (1996-present)**
Title:	Vice-President, Network Management
Timeframe:	May 2007 – October 2009
Role and Responsibilities:	Statewide responsibility for hospital, physician, and ancillary provider agreements and service

Education / Licensure / Credentials

University of Kentucky, B.H.S, Health Administration

DENISE DAMEROW, RN, BSN – QUALITY IMPROVEMENT DIRECTOR

Overview

- Strategic planning
- Business development and retention
- Solutions building and problem solving
- Project and time management
- Dedication to high quality standards
- Competitive market intelligence
- Staff development
- Expertise in all aspects of health plan management and operations

Professional Experience

Company:	**UnitedHealthcare Community Plan – Pittsburgh, PA**
Title:	Vice President of Clinical Quality and D-SNP Stars Operations
Timeframe:	October 2000 – Present
Role and Responsibilities:	▪ National oversight of the Community & State D-SNP quality budget, including ensuring visibility of budget items and charge backs to local market leaders. ▪ Collaborate with local and national team(s) across Community & State and Medicare & Retirement to develop overarching D-SNP Star strategy. ▪ Monitor and assist with the facilitation of national, regional and local efforts aimed at improving Star results. ▪ Identify market-specific priorities and determine the appropriate strategic approach to drive Stars improvement. ▪ Provide thought leadership and recommendations for new programs; lead and oversee the development of innovative and scalable approach to achieving Five Stars. ▪ In collaboration with a cross-functional team (clinical, IT, business intelligence, operations, compliance, national CAHPS, national HRA leaders, etc.) review existing tools to support and monitor D-SNP performance, identify enhancements, and plan and develop a robust system to provide needed meaningful visibility into performance status.
Title:	Regional Vice President, Clinical Quality
Timeframe:	September 2014 – May 2018
Role and Responsibilities:	▪ Directed and provided leadership for implementing, monitoring and evaluating a comprehensive region-wide Quality Management Program for eight health plans with Medicaid, Managed Long-Term Care and Medicare products across the Northeastern United States. ▪ UnitedHealthcare Community & State leader in understanding the CMS system for evaluating MA plans, including Star ratings, display measures, Part C/D reporting and any future modifications to the methodology.

	Educated local teams on these topics to drive understanding of Star performance data and Star improvement efforts across their region. ■ Provided leadership in the design and implementation of leading performance measurement and improvement strategies. ■ Planning, administration and monitoring of consistent readiness of all quality management, regulatory requirements and quality-improvement processes. ■ Manage regional quality improvement program for Medicare product, including preparation for National Committee for Quality Assurance (NCQA) accreditation and CMS audits. ■ Manage Medicaid projects, including value-based MCO pay-for-performance and performance improvement projects. ■ Responsible for data related to HEDIS performance, pay for performance programs and HIE/EMR expansion.
Title:	Senior Director of Quality Management and Performance
Timeframe:	January 2014 – September 2014
Role and Responsibilities:	■ Built quality management department to include member outreach and education, member complaint processing, medical appeal, health promotion and policy development programs for each health plan that meets or exceeds state contract and NCQA standards. ■ Oversaw and maintained compliance with regulatory and accrediting agencies, which include NCQA, Department of Health (DOH), and CMS, Pennsylvania Insurance Department, and Department of Public Welfare. ■ Responsible for directing the development of and execution of quality improvement activities for Medicaid and CHIP products in the Commonwealth of Pennsylvania. ■ Directed annual HEDIS audit and performance measures, including in house abstractors. ■ Responsible for improvement strategy for HEDIS measures and preventive health care. ■ Preparation and presentation of quarterly and annual evaluation of quality management programs and plan to the Physician Advisory Committee, Quality Management Committee and Board of Directors. ■ Developed initiatives that achieve budgeted reductions in medical expenses and increases in quality scores.
Title:	Chief Operating Officer
Timeframe:	November 2010 – December 2013
Role and Responsibilities:	■ Responsible for leading, directing and managing initiatives focused on affordability and quality, innovation, and growth. I focused on our TANF. CHIP and Medicare populations and led initiatives to attain and succeed internal operating income targets. Presented several solutions to our state customer and secured necessary approval for implementation. ■ Assessed monthly financial performance and identified risk and opportunities. Worked with various leaders to develop plans to mitigate risk and maximize opportunity. Drove Healthcare Quality Affordability Initiatives (HCQAI) to control cost. Analyzed monthly enrollment, inpatient,

	readmission and SG&A reports to determine trends and areas of focus. Built initiatives with Chief Medical Officer and other leaders to support affordability goals. ■ Responsible for managing the development and implementation of internal and external marketing/communication strategies associated with profitable membership growth, community relations and member experience. Additional responsibilities included analyzing economic considerations, developing marketing forecasts, estimating costs and managing program/project budgets. Other duties included managing staff and tracking and trending programs to ensure viability. ■ Enhanced business systems, processes and controls in a manner that systematically improved operational execution and improved operational excellence and enhanced productivity. ■ Established and oversaw controls to ensure operational efficiency. Created a proactive management by exception mindset. ■ Initiated and oversaw development and refresh of detailed business plans and initiatives related to operational excellence and customer/member satisfaction.
Title:	Director of Health Plan Operations
Timeframe:	October 2005 – November 2010
Role and Responsibilities:	■ Spearheaded successful implementation of new lines of business. ■ Directly responsible for operational compliance and proficiency in the following areas: utilization management, data acquisitions, health care informatics, member and provider services, enrollments and claims department. ■ Developed corporate implementation plans, policies and processes. ■ Chairperson of internal operations committees. ■ Successfully achieved a passing CMS audit for Unison's Medicare Advantage product. ■ Direct oversight of six Operations Managers and administrative staff.
Title:	Various clinical positions with UnitedHealthcare
Timeframe:	October 2000 – October 2005
Role and Responsibilities:	*March 2004 to October 2005: Manager of Inpatient and Outpatient Utilization Management:* ■ Ability to incorporate clinical skills in the development of workable healthcare programs in a managed care environment. ■ Operational and strategic planning responsibilities for clinical and ancillary personnel in a call center environment. ■ Integral in the formation and management of six product lines for a managed care organization. ■ Instrumental in streamlining utilization management procedures in compliance with NCQA and regulatory governing bodies while achieving significant cost savings and health plan profitability.

	September 2001 to March 2004: Supervisor of Health Management: ■ Assisted in the development and institution of successful preventive health guidelines and disease management programs to achieve full NCQA accreditation while improving the quality of life for the members of the plan. ■ Analyzed statistical information to assess outcomes of the asthma, diabetes and pregnancy health management programs. ■ Direct oversight of eight case managers. *March 2001 to September 2001: Diabetes Case Manager:* ■ Developed Quality of Life assessment tool for the diabetes health management program. ■ Telephonic assessment and education of members participating in the diabetes health management program. ■ Analyze and stratify membership into levels based on specific utilization of services over a six-month period. *October 2000 to March 2001: Utilization Management Coordinator:* ■ Performed admission and concurrent review for emergent and elective inpatient services. ■ Efficiently and effectively managed a high-volume hospital assignment. ■ Performed utilization management for outpatient services requiring authorization.

Company:	**Charter Behavioral Health Associates – Pittsburgh, PA**
Title:	Utilization Review Nurse Specialist
Timeframe:	June 1999 – October 2000
Role and Responsibilities:	■ Perform pre-certification of behavioral health treatment for Aetna/US Healthcare members utilizing clinical expertise, Magellan Medical Necessity Criteria and Aetna Level of Care Assessment Tool. ■ Developed and successfully implemented policy and procedure for non-authorization requests for all levels of care. ■ Successfully negotiated rates for service with non-participating providers and facilities.

Company:	**Olsten Health Services – Camp Hill, PA**
Title:	Intake Specialist
Timeframe:	November 1998 – June 1999
Role and Responsibilities:	■ Possess exceptional knowledge of managed care and Medicare guidelines and reimbursement criteria. ■ Negotiated home health care contracts with national, regional and local payer sources. ■ Developed tracking tool for patient care, authorization for services and referral sources.

Company:	**Family Home Health Services – Jeannette, PA**
Title:	Home Healthcare Registered Nurse
Timeframe:	July 1996 – November 1998
Role and Responsibilities:	▪ Exceptional clinical assessment skills and documentation ▪ Policy and procedure development ▪ Supervisory responsibilities: clinical and non-clinical staff

Company:	**Greensburg Nursing and Convalescent Center – Greensburg, PA**
Title:	Full-time Staff Registered Nurse
Timeframe:	November 1994 – July 1996
Role and Responsibilities:	▪ Provided nursing care on skilled nursing unit ▪ Functioned as charge nurse on evening and night shifts

Education / Licensure / Credentials

- August 2018 - Expected Graduation 2020: Master's in Business Administration, Waynesburg University
- May 2009, Bachelors of Science Nursing, Waynesburg University
- May 1995, Associate of Science in Nursing, Westmoreland County Community College
- Licensure: Pennsylvania Licensed Registered Nurse
- Award: 2015 Business Women First Awardee

KAREN EVANS – POPULATION HEALTH MANAGEMENT DIRECTOR

Professional Experience

Company:	**UnitedHealth Group**
Title:	Director Clinical Operations, Community & State
Timeframe:	March 2012 – Present
Role and Responsibilities:	Member of national clinical team responsible for defining clinical strategy and model for all Community & State products, including Medicaid, Dual Special Needs Plans (D-SNP) and Medicare Medicaid Plans (MMP). Responsibilities include review of requirements for existing and new business and end-to-end model development and implementation for 24 - health plans. Medicare subject matter expert on team.
Title:	Associate Director Clinical Program Development, Community & State
Timeframe:	October 2008 – February 2012
Role and Responsibilities:	Member of clinical program development team with primary responsibility for program development and support for Medicare product, including development and implementation of 2010 model of care, participation in development of Medicare integrated care coordination team strategy and processes, national clinical lead for CMS audit preparation. Other responsibilities include defining and testing system enhancement to support clinical programs, development of and revisions to policies and procedures and standard operating procedures to support new and existing programs, as well as to support training team in the training on new and revised programs.
Title:	Health Service Director, Evercare Alabama
Timeframe:	December 2006 – September 2008
Role and Responsibilities:	Responsible for implementation and oversight of Evercare clinical model for Secure Horizons enrollees in Alabama. Model includes community case management for high-risk enrollees; also implemented onsite review at high volume facilities. Hired and trained staff for community case management and onsite review Participated in work group to develop Clinical Care Manager Learning Path, and group to revise tool used to assess clinical competency of field care managers. Participate in medical expense management team for market.
Title:	Health Service Director, South Region, Senior and Retiree Services
Timeframe:	January 2003 – December 2006
Role and Responsibilities:	Responsible for providing leadership for clinical programs in the South Region (Alabama, Florida, North Carolina and Tennessee) for Medicare Complete enrollees. This included implementation and operational oversight of the Personal Service Delivery Program, a community-based case management program for the frail elderly. Participated in development of IT system to support program (CareOne) to track and manage activities, developed policy and procedures,

	operational reports, staff auditing process and training to support program. Piloted the Transition Coach Initiative, developed workflows, policy and procedures, and identified needed system enhancements and reporting to support pilot. Hired and trained staff for all programs and initiatives. Mid-2006 began the transition of clinical staff and programs to leadership of local markets. Participated in medical expense management teams in each market.
Title:	Various positions with UnitedHealth Group
Timeframe:	May 1995 – January 2003
Role and Responsibilities:	*August 2002-January 2003: Care Coordination Account Director* Responsible for managing relationship between care coordination program and ovations. *April 2000-August 2002: Director, Care Coordination* Responsible for all care coordination activities for the Alabama health plan. Lead team of clinical and non-clinical staff to successful implementation of all care coordination activities. Performances in all metrics exceeded targets. Participated in medical expense reduction activities and successful JCAHO accreditation. *October 1999-April 2000: Manager, Care Coordination* Responsible for management of staff performing risk management activities within care coordination (Welcome Home, Impact and Predictive Model) *July 1997-October 1999: Director, Medicare Care Management* Responsible for development and implementation of care management program for Medicare Complete membership with goal of managing needs across the continuum of care while positively impacting both quality of care and utilization of resources, Interacted with provider community for success with initiatives. Participated in development and implemented CHF disease management program. Responsible for assessment and oversight of delegated care management services for Medicare. *January 1996-July 1997: Manager, Case Management and Concurrent Review* Responsible for concurrent review and case management for health plan membership (commercial and Medicare) in Alabama, Tennessee, Mississippi, Arkansas and Florida panhandle. Medical management lead for Medicare. Assisted with development of Medicare Health Risk Assessment. Member of team coordinating the decentralization of medical management to Florida, Tennessee and Arkansas. *May 1995-January 1996: Supervisor, Case Management* Responsible for case management activities for commercial and Medicare health plan members in Alabama, Tennessee, Arkansas, Mississippi and Florida panhandle. Responsible for development and implementation of case management for Medicare membership. Managed staff in nine satellite offices.
Company:	**Visiting Nursing Association – Birmingham, AL**

Title:	Director of Operations, Comprehensive Care
Timeframe:	October 1993 – April 1995
Role and Responsibilities:	Responsible for management of all private insurance home care clients as well as four federally funded homemaker programs. Supervised staff of 80 paraprofessionals and four administrative staff.

Company:	**Various**
Title:	Various
Timeframe:	August 1979 – October 1993
Role and Responsibilities:	■ **Complete Health, Inc.**, Birmingham, AL (purchased by UnitedHealthcare 1994): • June 1992-October 1993, Case Management Supervisor: Responsible for case management activities for health plan members in Alabama, Tennessee, Arkansas, Mississippi and Florida panhandle. Developed and implemented case management program, including development of policies and procedures and creation of a database for documentation and reporting. Hired trained and supervised staff of four case managers. • April 1992-June 1992, Quality Assurance Coordinator: Performed quality improvement activities for health plan membership. Included physician office and hospital record review for quality of care issues as well as investigation of member complaints. • June 1988-March 1992, Utilization Review Manager: Responsible for all utilization review activities for health plan, including pre-certification, concurrent review and case management. Hired, trained and supervised staff of 25 clinical personnel. • August 1986-May 1988, Utilization Review Coordinator: Performed pre-certification, concurrent review and case management for health plan members. ■ **Visiting Nursing Association**, Birmingham, AL: December 1984-August 1986 Staff Nurse/Case Manager ■ **St. Margaret's Hospital**, Montgomery, AL: • July 1982-December 1984 Staff Nurse, Cardiovascular Surgical Intensive Care Unit • December 1981-June 1982 Staff Nurse, Orthopedics/Urology/Oncology ■ **Fairfax Hospital**, Falls Church, VA: May 1981-July 1981 Staff Nurse, Oncology ■ **LDS Hospital**, Salt Lake City, UT: August 1979-April 1981 Staff Nurse, Oncology/Bone Marrow Transplant Unit

Education / Licensure / Credentials

- Masters of Business Administration, November 2015, University of St. Thomas, Minneapolis, MN
- Bachelors of Science in Nursing, April 1981, Brigham Young University, Provo, UT

- Associate Degree in Nursing, August 1979, Brigham Young University, Provo, UT
- Registered Nurse, Alabama Board of Nursing, 1-040889
- Certified Case Manager, June 1996
- Evercare Sage Award Recipient 2006

Professional and Community Affiliations

- Case Management Society of America
- American Nurses Association
- Alabama Nurse Association
- Utah State Nurse Association

GLENN WALSH – MANAGEMENT INFORMATION SYSTEMS DIRECTOR

Overview

- Information systems regional leader with a broad technical, application and analytic skillset
- Twenty years of experience with UnitedHealthcare and direct engagement in the Medicaid market since December 2011
- Long-term information technology (IT) leader who has been engaged in UnitedHealthcare Medicaid, Medicare and commercial business areas and system deliverables and brings a broad understanding of the managed care industry

Professional Experience

Company:	**UnitedHealthcare Community & State – Brentwood, TN**
Title:	Chief Information Officer
Timeframe:	December 2011 – Present
Role and Responsibilities:	▪ Senior leader and manager of four regional IT directors and responsible for all markets with state leaders to help drive project deliverables ▪ Coordinate and communicate with the health plan and the state department on key IT deliverables

Company:	**UnitedHealthcare – Brentwood, TN**
Title:	Senior Director of UMR DW/Claims Systems/July 2009 – December 2011 Senior Director of UMR DW/Analytics/July 2008 – July 2009
Timeframe:	July 2008 – December 2011
Role and Responsibilities:	Initially accountable for more than 60 telecommuters who were responsible for developing a consolidated data warehouse and reporting solution for utilization management review business segment while maintaining existing production solutions. In July 2009, this role expanded to lead more than 140 IT leaders, developers, analysts and operational staff who support four operational claims system environments. Responsibilities included: ▪ Accountable for consolidation of five separate acquisition workgroups into a single team. The team focus was a three-year, $4.5 million initiative to consolidate the data warehouses and customer reporting environments from the seven legacy solutions into a single source. ▪ Maintained accountability for the local IT leader and vendor staff that supported commercial business in Miami on a legacy Amisys platform. The goal was to maintain the aged environment until the transition to UnitedHealthcare's strategic platforms in 2010.

Company:	**UnitedHealthcare – Brentwood, TN**
Title:	Director of National Healthcare Analytics/November 2003 – June 2008 Director, South Division/National Queue/April 2002 – October 2003

	Regional Director, Southeast Florida Region, IT/March 2001 – April 2002 Regional Director, Southeast Region, Information Systems/March 2000 – March 2001
Timeframe:	March 2000 – June 2008
Role and Responsibilities:	Accountable for 70 to 75 remote staff who are responsible nationally for legacy and acquisition strategic analytic reporting, audit and recovery operations, acquisition and legacy staff/operational consolidations, and warehouse/data integration and strategies. Responsibilities included: ■ Primary delivery and tracking resource group for more than 15,000 manually generated regulatory and non-regulatory ad hoc requests and production/automation volumes of more than 200,000 annual deliverables. ■ Applied METRICS reporting to provide the strategic direction and standardized analytic solutions for self-service, providing more than 20,000 reports monthly at reduced costs, improved single-day turnaround time and reduced staff required for reports by 50%. ■ Managed and monitored more than $10 million in annual CPU charges and implemented efficiency methods to reduce annual spend by $2 million to $3 million annually. ■ Provided improved processes, algorithms and automation that audit and recovery operations applied to improve annual recoverable claims from $200 million in 2005 to $460 million in 2007. ■ Facilitated the data migration and integration of newly acquired businesses into UnitedHealthcare's environment. From 2003 to present, acquired companies such as MAMSI, Oxford, PacifiCare, John Deere Health, Fidelity, Touch Point and Midwest Security. ■ Consolidated and streamlined four regional warehouse environments (2000 – 2003) into two environments, and migrated business solutions to the standardized solutions on the enterprise warehouse (2002 – present), enabling sunset of regional data marts. ■ Accountable for assessing delivered value of the $125 million worth of products and services delivered through UnitedHealthcare's affiliate, Ingenix (2005).

Company:	**UnitedHealthcare of the Midlands – Omaha, NE**
Title:	Director, Information Systems, EDI and Claims Administration/April 1997– March 2000 Director, Information Systems, EDI/September 1996 – April 1997 Manager, Information Systems, EDI/Clinical Systems/September 1995 – September 1996
Timeframe:	September 1995 – March 2000
Role and Responsibilities:	Accountable for 25 to 35 staff members who are responsible for local health plan claims processing, EDI administration, hardware/software/telecomm infrastructure support and application/analytic reporting. Additional responsibilities included: ■ Accountable for management of both local and remote service centers responsible for commercial, Medicare and Medicaid claims. Improved claims turnaround times from highs of 18 to 23 days to 10 to 12 days in the first year.

	■ EDI staffing improved electronic percentages from 22% to more than 50% and an annual net savings for UnitedHealthcare of the Midlands of $312,000, $712,000, $952,000 and more than $1 million from 1996 to 1999, respectively. ■ Managed and facilitated the standardization of software and operating systems, the migration to Windows NT, Lotus Notes, and maintained a single workstation solution to connect mainframes ($254,000 savings in 1996). ■ Streamlined T1 configurations and implemented a plan-wide integrated phone switch allowing reduction of overall support costs by $150,000 and annual maintenance costs by $50,000. ■ Introduced "Claims Outcomes and Trends" reporting for hospital/physician networks to facilitate the process improvements for claims. These reports help identify key process issues for both groups. ■ Completed data conversion of two UnitedHealthcare-owned clinics from multiple existing billing and physician office systems to a single standardized solution.
Company:	**Inacom Information Systems – Omaha, NE**
Title:	Client Services Manager
Timeframe:	July 1994 – September 1995
Role and Responsibilities:	Overall accountability for eight technicians and engineers to service, repair and integrate PC-based technology**:** ■ Improved service order process, reducing open calls by 50%, increased average sales 55% and earnings by 78% ■ Improved customer satisfaction from 80% to 93%, and increased staff certification 62% ■ Awarded for most improved service revenue performance in the third and fourth quarters in 1994

Education / Licensure / Credentials

- Bachelor of Science, Management/Data Processing, Northwest Missouri State University

KERRI BALBONE – CHIEF OPERATING OFFICER

Overview

Experienced health care executive with broad-based experience in new business development, operations management, strategic planning, delivery innovation and tactical execution across multiple functional areas. A trusted leader who drives persistent value and improved business performance through:

- Advancing network, operational, clinical and technology capabilities
- Developing, managing and refining end to end business processes
- Leading with influence, developing teams and cultivating strong relationships
- Embracing customer feedback; anticipating needs

Professional Experience

Company:	**UnitedHealthcare Community & State – Cypress, CA**
Title:	Chief Operating Officer
Timeframe:	2017 - Present
Role and Responsibilities:	▪ Serve as operations executive for UnitedHealthcare's Medi-Cal business supporting operational performance to meet and exceed contractual obligations of the Department of Managed Health Care and the Department of Health Care Services including all call center, claim, enrollment, encounter, delegation and network functions. ▪ Drive operational plans supporting growth and an enhanced consumer experience across additional Medi-Cal counties and new product expansion including Medicare/Medi-Cal Dual Special Need Plans. ▪ Lead the implementation of initial contracts in Sacramento and San Diego and deepened UnitedHealthcare's understanding of Medi-Cal.

Company:	**UnitedHealthcare Networks – Cypress, CA**
Title:	**National Vice President, Provider Experience and Network Services**
Timeframe:	2014 – September 2017
Role and Responsibilities:	Continued Provider Relations and Communication leadership with added responsibility including: ▪ Leadership of UnitedHealthcare wide Provider Net Promoter Score and Satisfaction improvement strategy resulting in a 22 point NPS improvement from 2015 to 2017. ▪ Medicare Star efforts including: creating incentives, increased shared risk, provider engagement strategy and clinical data exchange resulting in membership in 4 + star plans increasing to over 80%. ▪ Operations liaison driving end to end coordination with provider service, provider data, credentialing and provider claim performance. ▪ Enhancing support functions including UHN Policy, Procedure and Learning including the creation of UHN University focused on strategic

	leadership and career development for 2,100 UHN staff. ■ Improving network access & availability monitoring, CMS submissions and audit preparation. ■ Leading Provider Delegation Oversight and management of contract and payment standards.

Company:	**UnitedHealthcare Networks – Cypress, CA**
Title:	**National Vice President, Provider Relations**
Timeframe:	2008 – 2014
Role and Responsibilities:	■ Established Provider Relations model from pilot initiation to full national deployment of over 550 field resources focused on improving UnitedHealthcare's provider relationships resulting in: • 25% increase in provider satisfaction • 26% reduction in DOI complaints and 34% reduction in appeals • 20% reduction in annual provider settlements and 18% reduction in claims rework • Strengthened account management and quality and HEDIS engagement. ■ Enhanced provider communications through creation of focus groups and advisory councils; provider impact analysis; centralized content management; and audience tailored messaging. ■ Network liaison to external societies and associations including the American Medical Association, Medical Group Management Association and the American Association of Medical Society Executives.

Education / Licensure / Credentials

- Master of Business Administration, Health Administration – Sacred Heart University, Fairfield, CT
- Bachelor of Science, Health Systems Management – University of Connecticut, Storrs, CT
- Executive Development Program – UnitedHealthcare/Wharton
- General Manager Program – UnitedHealthcare

Boards

- West Hollywood Public Safety Commissioner: 2019 – present
- Sacred Heart University Board of Visitors: 2016 – present
- UnitedHealthcare Executive Lead for Project Sunshine: 2014 – 2017
- Quality Institute for Health Care Leadership Committee: 2010 – 2012
- University of Connecticut Health Systems Alumni Committee: 1996 – 2006

RONALD L. BEACH, M.D. – PSYCHIATRIST

Professional Experience

Company:	**United Behavioral Health – Optum Behavioral Health**
Title:	■ United Behavioral Health - Optum Behavioral Health, Medical Director, July 2015 to present ■ United Behavioral Health St. Louis Care Management Center, Associate Medical Director; May 1999 to July 2015 ■ St. Louis West Behavioral Health Clinic, Urgent Care Psychiatrist, August 1997 to May 1999
Timeframe:	August 1997 – Present

Company:	**COMTREA – Festus Behavioral Health Clinic**
Title:	Retainer Psychiatrist
Timeframe:	October 1998 – July 2009

Company:	**Places for People – St. Louis City**
Title:	Medical Director, January 1999 to August 2002 Retainer Psychiatrist, October 1998 to January 1999
Timeframe:	October 1998 – August 2002

Company:	**BJC Health System – BJC Behavioral Health Services, Great Rivers, St. Louis and Park Hills**
Title:	Medical Director
Timeframe:	May 1997 – October 1998

Company:	**Missouri Department of Mental Health**
Title:	■ St. Louis Mental Health Services • Medical Director, 1994 to May 1997 ■ Great Rivers Mental Health Services • Medical Director, January 1990 to May 1997 • Consultant – St. Louis County Correctional Facilities, Gumbo & Clayton Jails, November 1990 to November 1992 • Contract Vendor – St. Louis County, 1985 to December 1996 ■ Four County Mental Health Services • Medical Director, 1982 to May 1984

	• Staff Psychiatrist, 1981 to 1982 ▪ Franklin County Satellite Clinic – St. Louis State Hospital • Chief Psychiatrist, 1980 to1981
Timeframe:	1980 – May 1997

Company:	**St. Louis Veteran Affairs Medical Center**
Title:	▪ Alcohol and Substance Abuse Program • Acting Section Chief, February 1990 to March 1993 • Detox & Screening Ward, August 1987 to March 1990 • Detox & Rehab Ward, December 1984 to August 1987 Consultation and Liaison Program • Emergency Room Coverage,1982 to 1984 • C&L to Medical Units, 1977 to 1978 Mental Health Clinic Program • Emergency Room Coverage, screen all discharged veterans, followed individual clients, 1978 to 1982
Timeframe:	1997 – 1993

Company:	**Missouri Division of Family Services**
Title:	Franklin County Division of Family Services, Contract Physician
Timeframe:	March 1984 – June 1985

Company:	**Private Practice**
Title:	Office in St. Louis County, 1985 to June 2002 Mental Health Clinic of Franklin County, Director, 1984 to 1985
Timeframe:	1984 – June 2002

Education / Licensure / Credentials

- Diplomate in Psychiatry; May 1983
- St. Louis University – Resident in Psychiatry; 1974-1977
- St. Louis University Medical School – M.D. Degree; 1974
- St. Louis University – B.S. (Biology); 1970
- NNSF Summer Course on Psychology & Statistics; Grinnell, Iowa; 1956
- Licensure
  - State of Missouri (R6715); 1974 to present
  - State of Illinois (036-099474); 1998 to 2015
  - State of Kentucky (37368); 2002 to present

  - State of Oklahoma (34202); 2018 to present
- Special Training
  - Inaugural Session of Missouri Physician Leadership Program; Innsbrook Conference Center; Wright City, MO; May 15-18, 1997
  - DOD Contingencies – PTSD and Desert Storm; Long Island, NY; January 8-11, 1991
  - Quality Assurance in Substance Abuse: A Commitment to Excellence; VA/JACHO – Chicago, IL; July 25-26, 1990
  - Accreditation Standards for Psychiatric and Substance Abuse; Services under the AMH; JACHO – New Orleans, LA; March 8-9, 1990

Professional and Community Affiliations

- St. Anthony's Hospital; January 1989 to May 2002
- St. Louis University; 1978 to 1993
- United Behavioral Group HMO; August 1996 to May 1999
- Merit Group HMO; August 1996 to May 1999
- Prudential HMO; August 1996 to September 1998
- GenCare HMO; August 1996 to September 1998

CHARLENE BROWN, M.D., M.P.H – COMPLEX CARE ADULT AND CHILD PSYCHIATRIST

Professional Experience

Company:	**UnitedHealth Group – Lakeland, TN**
Title:	Psychiatrist
Timeframe:	February 2019 – Present
Role and Responsibilities:	▪ Perform psychiatric consults for Tennessee stabilization program ▪ Provide psychoeducational trainings for staff ▪ Assist in the development collaborative care program

Company:	**Professional Care Services – Covington, TN**
Title:	**Medication Assisted Treatment Director**
Timeframe:	July 2018 – January 2019
Role and Responsibilities:	▪ Developed program and hired for a buprenorphine treatment clinic to serve rural west Tennessee. ▪ Assess and treat patients with opioid use disorder.

Company:	**Professional Care Services – Covington, TN**
Title:	Medical Director
Timeframe:	January 2015 – January 2019
Role and Responsibilities:	▪ Performed essential administrative and leaderhip duties for the clinic including strategic planning for changes in Tennessee's transition to value-based payment model and a new case management model ▪ Supervised and provided education for nurse practitioners ▪ Played a key role in transitioning clinical staff from paper documentation to the implementation of an electronic health record system

Education / Licensure / Credentials

- Master of Public Health, Saint Louis University
- Medical Doctorate, University of Tennessee
- Bachelor of Science – Biology, Tennessee State University
- Board-certification in Psychiatry and Child and Adolescent Psychiatry

WHITNEY ALLEN – COMMUNITY RELATIONSHIP/MARKETING DIRECTOR

Overview

- Over six years' experience in the healthcare field; liaison with community groups/coalitions
- Strong public speaking, facilitation and networking skills; ability to clearly and precisely express context ideas in written and graphical form
- Over three years' experience in direct contract management, overseeing five subcontracting organizations, 17 personnel, and a budget of $1 million
- Aptitude to take ownership and drive projects from beginning to end, working with multiple groups on multiple projects, concurrently

Professional Experience

Company:	**UnitedHealthcare Community & State, KY**
Title:	Community Engagement/Marketing Manager
Timeframe:	March 2019 – Present
Role and Responsibilities:	▪ Operated through the National Business Development Team to drive relationship building on the ground in KY. ▪ Established and utilized social capital developments to fuel innovative pilots in local communities. ▪ Collaborated in development of marketing strategies to support products, drive membership growth and support innovation. ▪ Helped to establish UHC as a thought-leader and innovative partner in KY.

Company:	**Kentucky Primary Care Association, Frankfort, KY**
Title:	Coordinator of Community Development & Outreach
Timeframe:	August 2015 – March 2019
Role and Responsibilities:	▪ Administrator of Application Assister contract with Kentucky Health Benefit Exchange to oversee contracted Assister outreach and enrollment efforts in Eastern/Southeastern KY; Advocacy Coordinator team lead to help organize advocacy efforts across the state; Program Administrator of CMS Accountable Health Communities project; Recipient of the 2018 Grassroots Advocacy MVP Award from NACHC, Washington D.C.

Company:	**Grace Health, Gray, KY**
Title:	Outreach Worker/Patient Navigator
Timeframe:	August 2013 – August 2015
Role and Responsibilities:	▪ Assisted in establishing Grace's Outreach Program by building community partnerships and developing internal policies and procedures ▪ Provide enrollment assistance to individuals through Kentucky Health

	Benefit Exchange and coordinate community outreach events to provide education and information ▪ Collaborate with community partners to provide better health outcomes ▪ Educate patients on preventive screenings and diabetes management; Recipient of Outstanding Outreach Efforts Award

Education / Licensure / Credentials

- Master of Public Health, Emphasis in Community Health Education, Eastern Kentucky University, Richmond, Kentucky, August 2016
- Bachelor of Science in Business Administration & Health Science, Georgetown College, Georgetown, Kentucky, May 2012

MOSES H. BRUTUS – ENROLLEE SERVICES MANAGER

Overview

Over 10 years of contact center experience with proven senior leadership performance records. Nominated "Top Talented Operations Manager" within the Optum CSS enterprise 2017. Directly responsible for developing and maintaining favorable client relationships leading to the growth and strength of the UnitedHealthcare Community & State vendor partnership. Robust mathematical and analytical background resulting in rapid assessment and resolution to operational challenges. Dedicated to building and sustaining high-performing teams.

Professional Experience

Company:	**Optum, Inc. (previously Connextions, Inc.) August 2006 – Present**
Title:	UnitedHealthcare Operations Manager
Timeframe:	February 2014 – Present
Role and Responsibilities:	▪ Influence and provide input to forecasting and planning activities ▪ Review phone support data/metrics and communicate trends to internal stakeholders ▪ Set team direction and resolve problems while providing guidance to supervisors ▪ Ensure team is aligned to and meeting service center metrics in relation to quality and service
Title:	FedEx Sales Coach
Timeframe:	December 2013 – February 2014
Role and Responsibilities:	▪ Responsible for day-to-day supervision of the FedEx Secondary program, including client calibrations, account reporting, weekly agent reviews, coaching and mentoring agents to continually improve selling capabilities and resolving customer escalations
Title:	FedEx Account Executive
Timeframe:	August 2006 – December 2013
Role and Responsibilities:	▪ Developed B2B relationships with new and existing clients ▪ Drove customer loyalty through specialized consultative selling methods ▪ Estimate $7 million in revenue per year through up-selling FedEx services over the competitor

Education / Licensure / Credentials

- University of Central Florida, August 2010 – December 2013, Bachelors in Science in Civil Engineering, GPA: 3.01 cumulative
- Valencia College, August 2006 – May 2010, Associate in Arts – Civil Engineering, GPA: 3.00 cumulative

Professional and Community Affiliations

- Optum Employee Community Council (ECC) Leader responsible for overseeing general a council committee; organize 6-10 annual site events for Health and Wellness and Social Responsibility volunteerism, March 2016 – Present
- Former member of the FedEx Purple Promise team, which conducts various employee engagement activities to boost employee morale and increase motivation, September 2007 – November 2009
- Assistant editor bi-yearly publication of the Valencia College Phoenix Magazine, January 2006
- Member of the Phi Theta Kappa Two Year College Honor Society, May 2005 – May 2010