

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

Key Staff Job Descriptions

Contract Compliance Officer (Chief Operating Officer)

Purpose of Job

The Contract Compliance Officer will serve as the Chief Operating Officer for UnitedHealthcare Community Plan and be the primary point of contact for all CCN operational issues. This position is responsible for formulating sound business strategies and operational plans. The incumbent reports to and works closely with the Chief Executive Officer to address strategic issues revolving around the business and help chart the direction for the organization's future.

Job Responsibilities:

- Co-lead business executive team, with primary responsibility to build the organizational support and infrastructure to translate business vision and strategy into operational tactics
- Establish business metrics required to meet state partner, member and care provider requirements and achieve key goals
- Coordinate the tracking and submission of all contract deliverables
- Field and coordinate responses to Contractor inquiries
- Coordinate the preparation and execution of contract requirements such as random and periodic audits and ad hoc visits
- Coordinate the preparation and execution of the health plan policy development and annual review process
- Assess operating business risks/opportunities and identify strategies to mitigate/capitalize as appropriate
- Works with the Compliance Officer to provide interpretation and education to the Health Plan on contract, rules, and regulations
- Facilitate and cooperatively manage with the business new law implementation and acceptance into the business
- Consistent with company division of responsibility develops regulatory relationships and active interaction with regulatory agencies
- Provide consultative expertise, guidance and promote compliance with laws & regulations, with business partners ensuring business responds effectively to changing laws
- Answer questions and inquiries from business areas; satisfy requests for research related to specific legislation/regulations
- Ability to identify issues for resolution and work closely with compliance functional areas, and cross-functional/ cross segment departments necessary to resolve issues.
- The position will also include those listed for the Business Continuity Planning and Emergency Coordinator.

Job Qualifications:

- Bachelor's Degree
- Experience within a regulatory and/or healthcare compliance environment
- Ability to communicate clearly with internal partners and external regulatory agencies and effectively represent the company's interests. Leads inspirationally, nurtures commitment to a common vision and shared values

- Anticipates and pushes change through the organization, equipping staff to adapt quickly
- Establishes challenging goals and delivers results
- Facilitates holistic thinking/problem solving and integrates efforts/results
- Structures business disciplines to facilitate quick and data based decisions and ensure accountability for execution
- Evaluate outcomes based on qualitative and quantitative measures and adjusts accordingly
- Maximizes customer linkages and leverage resources, collaboration and efficiency
- Aligns people and resources with our strategic priorities

Director, Quality Management (Quality Management Coordinator)***Purpose of Job***

The Quality Management (QM) Director reports to the Chief Medical Officer. The position ensures individual and systematic quality of care by integrating quality disciplines throughout the organization and consistently implementing process improvement. The position also will be involved in resolving, tracking and trending quality of care grievances. The responsibilities will also include those listed for the Performance/Quality Improvement Coordinator.

Job Responsibilities:

- Ensure individual and systemic quality of care
- Integrate quality throughout the organization
- Implement process improvement
- Resolve, track and trend quality of care grievances
- Ensure a credentialed provider network
- Establish and maintain a Quality Improvement program that encompasses all programs
- Direct Company Quality Program structure and participate in Regional, National, and Executive Quality Committees
- Drive and support agendas of QMC, PAS, HQUM and SQIS committee's
- Respond to all Quality related regulatory requirements
- Direct and provide oversight of Medicaid and Medicare performance improvement activities (DHH Performance Metrics) of care and coordination of quality service
- Prioritize recommendations, develop, and effectively lead and assist national quality improvement teams in improving health and implementing business strategies, and exceeding State and Federal regulatory requirements and national accreditation guidelines
- Prioritize areas of business risk and incorporate into the strategy of the clinical quality improvement
- Coordinate quality efforts between Shared Services and other United segments to leverage strengths and achieving efficiencies in improving outcomes
- Develop, coordinate, and lead plan quality committees operational standards and Policy and Procedures to meet the objectives of Quality Improvement Projects and regulatory requirements
- Identify opportunities and best practices to standardize processes to improve business efficiencies and health outcomes across programs
- Support implementation of CMS and State required improvement initiatives pertinent to government programs
- Evaluate the effectiveness of the Quality Program by organizing the delivery and evaluation of annual Quality documents, program descriptions, work plans, and evaluations.
- Monitor and respond to regulatory changes related to quality
- Performance improvement of government programs through the tracking and trending of aggregate data related to quality analysis metrics (DHH Performance Metric's, HEDIS, quality indicators, satisfaction and Health Outcome Surveys (HOS) scorecard dashboards
- Coordinate and lead plan provider credentialing functions and lead quality analytics.

Job Qualifications:

- LA licensed RN, MD or similar professional credential/certification in health outcomes, clinical quality measurement and improvement

- Minimum of five years health plan quality management experience
- Six Sigma background including population based clinical analysis
- Clinical orientation, managed health care industry experience preferred
- Certified Professional in Healthcare Quality (CPHQ) preferred
- Knowledge of LA State Medicaid requirements preferred as well as CMS
- Experience in preparing for and leading accreditation surveys
- Demonstrated project management experience required

Grievance System Manager

Purpose of Job

The Grievance Systems Manager reports to the Contract Compliance Officer (COO). The position and its associated staff shall be qualified by training and experience, to process and resolve complaints, grievances and appeals and be responsible for the CCN's grievance system.

The Grievance Systems Manager will have sufficient support staff (clerical and professional) to process grievances and appeals within the required time frame and to assist complaints in properly filing grievances.

Job Responsibilities:

- Responsible for completion of member, provider, and regulatory complaint cases in specified time frame.
- Responsible for preparing appeal and grievance cases for presentation at the monthly Level I Committee Meeting.
- Works with internal departments to resolve complaints.
- Acts as liaison with regulatory agencies regarding member complaints.
- Maintains accurate information in unit database

Job Qualifications:

- Minimum of five years of management/supervisory experience in the health care field.
- Experience with Medicare, Medicaid and managed care in a variety of health care settings
- Working knowledge and experience in cross-functional business segments and their integrated influences and relationships
- Effective and experienced in motivating and mentoring others who are not in a direct reporting relationship.

Case Management Administrator

Purpose of Job

The position reports to the Chief Executive Officer and oversees the case management function, including the assessment, planning, facilitation and advocacy for options and services to meet member needs through communication and available resources. It promotes high quality, cost-effective outcomes.

Job Responsibilities:

- Provide services through qualified staff to members to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support.
- Plan and execute individual needs assessments and diagnostic assessments, individual treatment plan development. Establish member treatment objectives and monitor outcomes.
- Ensure compliance with State and Federal regulations, compliance with company policies and procedures
- Form internal and external strategic relationships, which will support program expansion and continuing success.

Job Qualifications:

- Minimum of five years of management/supervisory experience in the health care field.
- Experience with Medicare, Medicaid and managed care in a variety of health care settings
- Working knowledge and experience in cross-functional business segments and their integrated influences and relationships
- Effective and experienced in motivating others who are not in a direct reporting relationship.

Maternal Child Health/EPSTD Coordinator

Purpose of Job

Positions in this function report to the Director, Quality Management. They are RNs and other clinical professionals who consult on various processes. The function includes roles which manage development and implementation of medical expense management initiatives. The position advises leadership on improvement opportunities regarding medical expense programs and clinical activities that impact medical expense.

Job Responsibilities:

- Program management
- Serve as a high level liaison among members
- Member advocacy
- Ensure contract compliance of state program
- Create and maintain various reports
- Develop innovative approaches
- Strategy development and execution on a large scale level
- Data analysis
- Ensuring receipt of EPSTD services
- Ensuring receipt of maternal and postpartum care
- Promoting family planning services
- Promoting preventive health strategies
- Identification and coordination assistance for identified member needs
- Interface with community partners.
- Ensuring receipt of maternal and postpartum care
- Promoting family planning services
- Promoting preventive health strategies
- Identification and coordination assistance for identified member needs
- Interface with community partners.

Job Qualifications:

- Must be an LA licensed nurse, physician or physician's assistant; or have a Master's degree in health services, public health, health care administration or other related field, and/or a Certified Professional in Health Care Quality (CPHQ). (current license required)
- Minimum of two years experience managing a government health program
- Minimum of three years experience in one of the following areas: NICU, pediatrics, maternity or obstetrics
- Minimum of two years experience in health care operations
- Computer proficient in Microsoft Office Suite.

Medical Management Coordinator

Purpose of Job

The position reports to the Case Management Administrator. It strategizes, develops and directs operations of the health services department to ensure provision of high quality, cost-effective medical services.

Job Responsibilities:

- Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria
- Ensure appropriate concurrent review and discharge planning of inpatient stays is conducted
- Develop, implement, and monitor the provision of care coordination, disease management and case management functions
- Monitor, analyze, and implement appropriate interventions based on utilization data, including identifying and correcting over and under utilization of services
- Responsible for the development and management to budget related to medical care, directs actions to control targeted costs for inpatient and outpatient services in conjunction with the site medical expense team
- Ensure compliance with State and Federal regulations, compliance with company policies and procedures
- Form internal and external strategic relationships which will support program expansion and continuing success.

Job Qualifications:

- Registered Nurse degree with active license, physician or physician's assistant if required to make medical necessity determinations
- Master's degree in health services, health care administration, or business administration if not required to make medical necessity determinations
- Three to five years leadership and management experience in an organization that serves the elder population
- Experience with Medicare, Medicaid and managed care in a variety of health care settings
- Strong negotiation skills, budget management experience and regulatory knowledge
- Leadership and management experience in effective team building and continuous quality improvement programs
- Working knowledge and experience in cross-functional business segments and their integrated influences and relationships
- Effective and experienced in motivating and mentoring others who are not in a direct reporting relationship.

Provider Claims Educator

Purpose of Job

Reporting to the Director, Provider Services (provider services manager), this is a fully integrated position with the Grievance, Claims Processing, and Provider Services departments, which facilitates the exchange of information between these departments and contracted/non-contracted providers. This position is full-time and is based in Louisiana.

Job Responsibilities:

- Educate contracted/non-contracted providers (both institutional and professional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available Contractor resources such as provider manuals, websites, fee schedules
- Interfaces with the call center to compile, analyze, and disseminate information from provider calls
- Identifies trends and assesses data to guide the development and implementation of strategies to improve provider satisfaction
- Frequently communicates with providers (telephonically, on-site, or via email) to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices
- Develops educational materials and presentations for internal and external purposes.

Job Qualifications:

- Bachelor's degree or equivalent work experience; background in insurance or managed care preferably in a customer service and/or claims environment
- Experience and demonstrated ability to effectively resolve problems with other departments and at all management levels
- Excellent communication skills
- Ability to create and implement strategic plans
- Proven problem solving skills and ability to translate knowledge to the department
- Experience with the latest claims tools and technologies as well as an understanding of emerging customer care solutions.
- Demonstrated track record of generating results and having an impact on organizations
- Knowledge of telecommunications equipment and capabilities to identify, recommend and implement new or improved technology for the call center environment
- Innovative in problem solving, planning and strategizing
- Articulate and persuasive in presenting business-case for change-management, where required.

Information Management and Systems Director

Purpose of Job

The Information Management and Systems Director will be a full-time position, accountable to the Chief Executive Officer. This position will be trained and experienced in data processing, data reporting, and claims resolution, as required, to ensure that computer systems reports provided to DHH and its agents are accurate, and that computer systems operate in an accurate and timely manner.

The Information Management and Systems Director will have a trained staff that is experienced in data reporting as required to provide necessary and timely reports to DHH.

Job Responsibilities:

- Understanding business strategy, translating that strategy into an IT agenda, and driving execution against the agenda through the enterprise technology solution groups
- Developing key relationships across the business and contributing to business and technology strategy as a member of both the technology and business leadership teams
- Optimizing accuracy of estimation processes and ensuring consistent on schedule, on cost, on scope, on benefit implementation and within quality goals
- Ensuring effective alignment of technology to support business strategies and delivering business results through technology
- Holding end-to-end accountability for making the IT service chain work to deliver to the business, including application delivery, maintenance and systems operations
- Integrating architecture to simplify application landscape and architecting shared solutions to deliver business functionality
- Ensuring implementation readiness and creating/enhancing operational processes to increase efficiencies
- Continually driving innovation and creative solutions to business challenges and applying industry standard methodologies and best practices
- Leading technology integration and simplification initiatives on an ongoing basis
- Appropriately leveraging resources to deliver solutions
- Providing an end-to-end constituent experience that exceeds expectations
- Identifying and mentoring technology professionals, to build and maintain a high performance team