

## **COVENTRY HEALTH CARE JOB PROFILE**

( 4 . 1 . 6 . 1 ADMINISTRATOR )

Last Updated: 08/12/08

<b>TITLE</b>	VP, General Manager (Medicare/Medicaid)	<b>JOB CODE</b>	902131
<b>JOB FUNCTION</b>	Marketing - Government Programs	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Top operations job with oversight for Medicare and/or Medicaid within a single or multiple site health plan. Responsible for the development and execution of the annual operating plan, including profit and loss accountability. Provides day-to-day oversight for operation of the Medicare/Medicaid health plan including Sales, Marketing, Provider Relations, Network Development, Utilization Management and Quality. Ensures compliance with applicable state, federal and regulatory requirements through the development, implementation and maintenance of departmental policies and procedures in coordination with the Medicare/Medicaid Compliance and Legal Departments.

### **ESSENTIAL RESPONSIBILITIES**

- Ø Responsible for the overall financial performance of the Medicare and/or Medicaid plans within the market.
- Ø Directs managers and/or directors of specific functional areas as assigned. Functional areas may include operations, sales, marketing, provider relations, network development, utilization management, and/or quality improvement. Coordinates and monitors functional integration of these areas in cooperation with corporate departments to achieve planned business results.
- Ø Oversees and directs activity in the key areas of contracts and communications.
- Ø Directs all departments in the development, implementation and maintenance of policies and procedures to ensure compliance with the State and Federal regulatory requirements.
- Ø Responsible for the plan performance related to all required Federal audits.
- Ø Responsible for the management and organization of plan activities at the health plan.
- Ø Monitors budget in assigned function areas and takes corrective action.
- Ø Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including, employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Ø Performs other duties as required.

### **JOB SPECIFICATIONS**

- Ø Bachelor's degree or equivalent experience. Master's degree preferred.
- Ø Significant (10+ years) management experience required.
- Ø Previous health plan experience preferred.

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## COVENTRY HEALTH CARE JOB PROFILE

( 4 . 1 . 6 . 4 COMPLIANCE OFFICER )

Last Updated: 08/20/08

<b>TITLE</b>	Director, Government Relations & Regulatory Compliance	<b>JOB CODE</b>	736131
<b>JOB FUNCTION</b>	Regulatory – Regulatory	<b>FLSA STATUS</b>	Exempt

### GENERAL SUMMARY

Represents the health plan's interest regarding legislation and regulatory matters. Responsible for overall regulatory compliance with state and federal laws and regulations for all aspects of the plan. Develops and maintains relationships with common organizations for mutual goals/benefits. Serves as a resource for federal and state legislators on health care issues and concerns. Responsible for establishing and overseeing a review process for bills introduced in legislation. Analyzes and determines the potential importance and effect of the bills on the health plan and Company and recommends response strategies. May act as primary health plan liaison with CMS, the Department of Insurance, and the Department of Labor.

### ESSENTIAL RESPONSIBILITIES

- Ø Coordinates, strategizes and recommends policy positions with senior management regarding legislative issues and regulatory concerns.
- Ø Maintains an awareness of trends, developments and governmental regulations in health care and managed care organizations.
- Ø Coordinates legislative efforts and manages contracted lobbying entities. Monitors political candidates and campaigns regarding evolving health care issues.
- Ø Oversees process for changes to standard forms, marketing materials, advertising and contracts, including, but not limited to; Evidences of Coverage, Schedules of Benefits, enrollment forms, provider contracts, and group applications. Creates new documents as needed and files new and revised documents with the Department of Insurance and CMS.
- Ø Implements tracking mechanism for all outstanding issues with state and federal regulatory entities.
- Ø Tracks legislative issues and regulatory changes and analyzes impact on the Plan. Coordinates with state trade associations and other industry groups and participates in trade association and organized alliances. Develops new procedures required as the result of newly effective regulatory requirements or changes to existing health plan policies (e.g. HIPPA and GLBA).
- Ø Responsible for all regulatory filings for government programs.
- Ø Oversees Market Conduct process and CMS biannual monitoring visits, including pre-exam/visit preparation, actual exams/visits, mock exams/visits, responses to draft audit reports, and follow-up issues raised by regulators with respect to the Plan. Ensures recommended changes are implemented.
- Ø Oversees process for market service area expansion for commercial and government products.
- Ø Works in close coordination with Coventry counsel and corporate governmental affairs pertaining to regulatory matters.
- Ø Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Ø Performs other duties as required.

### JOB SPECIFICATIONS

- Ø Bachelor's degree or equivalent experience. Master's degree preferred.
- Ø Significant (7-10 years) experience and participation in the legislative process. Prior work experience in the managed care field or in a service organization.
- Ø Significant (5-7 years) experience in insurance and HMO laws and rules compliance. Prior QI experience a plus.
- Ø Familiarity with regulations and statutes impacting the managed care environment.
- Ø Ability to perform analysis and research to identify and clarify issues.
- Ø Excellent organizational and analytical skills required.
- Ø Excellent interpersonal skills and effective communication and presentation skills.
- Ø Proficient with standard PC applications.
- Ø Able to effectively coordinate multiple projects and work independently.
- Ø Demonstrated leadership and team building skills.

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## COVENTRY HEALTH CARE JOB PROFILE

(4.1.6.5 GRIEVANCE SYSTEM MGT)

Last Updated: 08/19/08

<b>TITLE</b>	Manager, Appeals	<b>JOB CODE</b>	720111
<b>JOB FUNCTION</b>	Medical Management - Appeals	<b>FLSA STATUS</b>	Exempt

### GENERAL SUMMARY

Responsible for managing the appeals and grievance activities of a staff. Ensures compliance with all State and Federal regulations and national accrediting body requirements.

### ESSENTIAL RESPONSIBILITIES

- Ø Responsible for the direct management of an appeals staff.
- Ø Responsible for compliance with State and Federal laws regarding the handling of appeals. Ensures compliance with national accrediting body standards regarding grievances.
- Ø Ensures compliance with the applicable accreditation agency's standard section regarding member rights and responsibilities.
- Ø Produces all appeals and grievance reports. Researches customer information including applicable medical records in response to difficult inquiries, including authorizations, payments, denials, and coordination of benefits.
- Ø Assesses, investigates, and resolves difficult issues to achieve customer and member satisfaction when possible. Receives all legal correspondence that is not directed to any specific individual.
- Ø Manages all complaints and inquiries for the Department of Insurance, legislators and elected officials.
- Ø May write and review policies to ensure compliance with all regulatory and applicable accreditation agency's requirements.
- Ø May work in conjunction with Legal Department to ensure all legal issues are addressed regarding appeals.
- Ø May oversee regulatory audits.
- Ø May identify, analyze, report, and insure implementation of all new and revised CMS and other applicable compliance requirements related to quality improvement and new CMS coverage.
- Ø May ensure compliance and quality improvement through periodic oversight reviews of critical plan processes. May assist in the development, implementation, and evaluation of quality improvement plans.
- Ø May develop and maintain quality improvement policies and procedures required by Federal contracts, statutes and regulations. May review processes for continued improvement and efficiencies.
- Ø Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews, and disciplinary actions
- Ø Performs other duties as required.

### JOB SPECIFICATIONS

- Ø Bachelor's degree or equivalent experience.
- Ø Licensed Registered Nurse preferred.
- Ø Previous (1-3 years) supervisory or project lead experience preferred.
- Ø Previous (1 – 2 years) direct customer service experience preferred.
- Ø Experience in processing and working with all types of products including HMO, PPO, CCPPO and Indemnity under both fully insured and self-funded arrangements.
- Ø Expert knowledge of medical terminology required.
- Ø Knowledge of product specific regulations.
- Ø Ability to train employees on all products, procedures, and systems.

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## **COVENTRY HEALTH CARE JOB PROFILE**

( 4.1.6.7 CONTRACT COMPLIANCE OFFICER )

Last Updated: 08/20/08

<b>TITLE</b>	Manager, Contract Issuance and Compliance	<b>JOB CODE</b>	736151
<b>JOB FUNCTION</b>	Regulatory - Regulatory	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

In coordination with Coventry counsel, works to ensure compliance of group contract issuance and self-funded business activities with state and federal laws and regulations. Oversees day to day group contract issuance activities. Coordinates audits of self-funded group plans.

### **ESSENTIAL RESPONSIBILITIES**

- Ø Manages subordinate staff involved in group contract issuance activities for fully-insured and self-funded employer groups.
- Ø Coordinates a variety of personnel actions including: recruitment, employment, termination, performance reviews, salary reviews, coaching, professional development, training and disciplinary actions.
- Ø Develops and oversees implementation of policies and procedures to support and ensure regulatory compliance of group contract issuance activities.
- Ø Coordinates activities to support the development and timely execution of Plan Documents and Administrative Service Agreements for self-funded groups.
- Ø Develops processes and procedures to support self-funded business audits and coordinates audit activities, including analysis of findings and timely responses.
- Ø Coordinates special projects as assigned, including analysis of regulatory requirements, development of policies and procedures, forms and member notifications.
- Ø Analyzes legislative, regulatory and business changes, determines impact on group contract issuance and self-funded business and develops new or modifies existing policies, procedures, forms and member notices to ensure compliance.
- Ø Develops special agreements, contracts and plan documents as needed.
- Ø Performs other duties as required.

### **JOB SPECIFICATIONS**

- Ø Bachelor's degree or equivalent experience.
- Ø Previous (7-10 years) experience in insurance and HMO regulatory compliance and/or underwriting.
- Ø Previous (1-3 years) experience in a supervisory or management position required.
- Ø Excellent interpersonal, organizational, managerial and analytical skills.
- Ø Proficient with standard PC applications.
- Ø Familiarity with IDX or similar claim processing systems.

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## **COVENTRY HEALTH CARE JOB PROFILE**

(4.1.6.9 PERFORMANCE QUALITY IMPROVEMENT)

Last Updated: 08/21/08

<b>TITLE</b>	Manager, Business Reporting	<b>JOB CODE</b>	755131
<b>JOB FUNCTION</b>	Medical Management – Medical Reporting	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Manages a team of Healthcare Analysts/Consultants who are responsible for performance measurement, standardization, and economic analysis. Coordinates informational and regulatory requirements for corporate sales and/or administrative reporting and development. Manages the process of data validation and integrity.

### **ESSENTIAL RESPONSIBILITIES**

- Ø Manages a team of Healthcare Analysts and Consultants. Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including, employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Ø Monitors expansion of databases/tool implementation throughout the company as necessary to insure consistency of use. Coordinates response to health plan(s) needs as required.
- Ø May oversee the data collection of provider information for the development of provider directories. May ensure coordination of the information with the webmaster for access on the provider search functions of the plan web site.
- Ø Ensures collaboration with the Data Warehouse team to ensure integrity of data as well as process while conducting ongoing validation efforts. Completes audits and reconciliation as necessary. Supports standardization among transactional and data warehouse systems.
- Ø Supports the health plan operations by ensuring reports (standardized and ad hoc requests) are timely, professional, and meet the needs of the client. Actively pursues continued report development.
- Ø Ensures compliance with department/organization policies and procedures.
- Ø Assists in developing departmental vision structure. Assesses external environment and determines next steps in implementing information framework.
- Ø Actively involved in leading the team in outcomes measurement tool development including HEDIS, HCFA, HIPAA, NCQA, EURA and others as required. Stays current with requirements
- Ø May develop and implement corporate-wide training schedule and implementation on essential tools and underlying concepts.
- Ø Performs other duties as required.

### **JOB SPECIFICATIONS**

- Ø Bachelor's degree or equivalent experience. Master's degree preferred.
- Ø Significant experience (usually 4+ years) in department management.
- Ø Demonstrated ability to navigate among economic, clinical, research and technology disciplines.
- Ø Substantive knowledge of managed care policy and direction. Excellent business knowledge and skills.
- Ø Ability to effectively coordinate multiple projects, use time management and independent judgement.
- Ø Strong written and verbal communication skills.

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## **COVENTRY HEALTH CARE JOB PROFILE**

( 4.1.6.10 MATERNAL CHILD HEALTH/EPSTD COORD. )

Last Updated: 04/15/10

<b>TITLE</b>	Manager, Health Services	<b>JOB CODE</b>	725131
<b>JOB FUNCTION</b>	Medical Management – Health Services	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Responsible for the daily management in one or more of the various health services areas (Pre-authorization, Concurrent Review, Complex Case Management, Appeals, and/or Disease Case Management). Serves in an active managerial role to assist in the development, implementation, and evaluation of the utilization management process.

### **ESSENTIAL RESPONSIBILITIES**

- Ø Provides management and direction to one or more health services areas (Pre-authorization, Concurrent Review, Complex Case Management, Appeals, and/or Disease Case Management); including, staffing, training, monitoring, and evaluating.
- Ø Reviews the timeliness, appropriateness, and medical necessity of the utilization processes performed by the staff. Prepare reports detailing the monitored activities.
- Ø Actively participates in the development, implementation, and oversight of the department's activities; serves in an adjunct role for policy and procedure development and implementation.
- Ø Assists in the identification of issues which may adversely impact the attainment of department goals/initiatives (i.e., inpatient bed days per thousand, outpatient surgery utilization, etc.)
- Ø Collaborates with other departments to educate providers, vendors, and members regarding network providers/specialists benefits and utilization management policies and procedures.
- Ø Attends meetings with internal workgroups and external business parties.
- Ø Assists in the identification and triage of potential quality improvement issues. Responsible for assuring issues are reported to the Quality Improvement Department.
- Ø Responsible for compliance with State and Federal law regarding the handling of utilization management decisions and/or appeals. Ensures compliance with national accrediting body standards regarding utilization management decisions and/or grievances.
- Ø Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Ø Performs other duties as required.

### **JOB SPECIFICATIONS**

- Ø Registered nurse with active license in good standing in the state where job duties are performed.
- Ø Bachelor's degree or equivalent experience.
- Ø Previous (5-7 years) experience in utilization management.
- Ø Previous (3-5 years) clinical experience.
- Ø Previous (3-5 years) managerial experience.
- Ø Experience in program development preferred.

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## **COVENTRY HEALTH CARE JOB PROFILE**

( 4.1.6.15 PROVIDER CLAIMS EDUCATOR )

Last Updated: 12/08/08

<b>TITLE</b>	Manager, Provider System Information Administration	<b>JOB CODE</b>	555101
<b>JOB FUNCTION</b>	Operations – Provider Systems	<b>FLSA STATUS</b>	Exempt

### **GENERAL SUMMARY**

Oversees the day-to-day management of technical and non-technical staff responsible for analyzing, coding and building provider demographic and payment information and/or client provider network information into transactional systems and databases. Accountable for organizing, directing, and monitoring staff work assignments. Resolves issues and develops solutions as needed.

### **ESSENTIAL RESPONSIBILITIES**

- Ø Coordinates directly with heads of Health Plan network management and provider relations to design and implement new benefit programs, contracts, and fee schedules.
- Ø Manages all operational aspects of provider/client data processes and inventory management including data loads and updates, coding of contracts, fee schedules, implementation of provider demographics, pended claim analysis and issue resolution, and provider/client network setups or panels.
- Ø Manages all aspects of provider/client data analytics. Utilizes this information to drive business decisions.
- Ø Develops comprehensive business cases with cost, service, benefit dimensions of proposed provider/client systems information projects that are used at executive levels for funding and scope decisions.
- Ø Provides leadership in facilitating and conducting information gathering, structured documentation and presentation of findings to meet the needs of business partners.
- Ø Serves as a technical consultant regarding highly complex data interpretation requests to business partners regarding system capabilities and limitations.
- Ø Evaluates existing applications/products, and defines efficient, cost-effective solutions which support business processes and functional requirements.
- Ø Manages and leads cross-functional task forces to identify and document process requirements, work flow, information sources and distribution paths, and system specifications.
- Ø Offers system recommendations regarding benefits or claims processing when new products or new contracts are being initiated.
- Ø Investigates and confers with IT personnel when system inconsistencies occur and offers solutions and makes changes if necessary.
- Ø Resolves member, provider, and staff complaints, issues, and concerns. Serves as the focal point for all issues relative to the team's customers; fosters collaborative relationships with internal and external customers.
- Ø Builds and administers a business plan to meet or exceed goals.
- Ø Analyzes daily, weekly and monthly statistical reports and makes appropriate recommendations/forecasts. Provides accurate and pertinent data to Director/Vice President for use in strategic and tactical planning.
- Ø Provides leadership in developing, implementing, and maintaining departmental processes, identifying and resolving departmental issues, and directing, guiding and supporting the staff in the performance of their responsibilities.
- Ø Provides input into the development of the department budget. Manages the budget and controls expenses while meeting service requirements.
- Ø Recruits, develops, and motivates staff. Initiates and communicates a variety of personnel actions including employment, termination, performance reviews, salary reviews, and disciplinary actions.
- Ø Performs other duties as required.

### **JOB SPECIFICATIONS**

- Ø Bachelor's degree or equivalent experience.
- Ø Previous (7-10 years) experience in health care provider and/or client provider network data analysis and implementation; including experience managing projects.
- Ø Previous (1-3 years) supervisory or project lead experience required.
- Ø Demonstrated excellence in analysis, documentation, inventory management, and presentation tools required.
- Ø Excellent skills in critical thinking and analysis, meeting facilitation, verbal and written communications, and interpersonal interactions (e.g., partnering, conflict management, consulting, etc.).
- Ø Experience in the health care business and care delivery processes preferred.

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