JOB DESCRIPTION

JOB TITLE:	Director of Managed Care Operations	**STATUS:**	Exempt, Full Time
REPORTS TO:	Vice President, Operations		
DIRECT REPORTS:	Network Practice Support Managers, Corporate Coding Coordinators, Corporate Coding Coordinator Team Lead		

This job description is intended to be a general statement about this job and is not to be considered a detailed assignment. It may be modified to meet the needs of the organization.

JOB SUMMARY

Under the direction of the Vice President of Operations, this position is responsible for leading the managed care operations efforts to include the Network Practice Support Management and Coding teams. We are seeking a skilled and experienced professional to join our team as a Managed Care Operations Director at our Clinically Integrated Network (CIN) rooted in Federally Qualified Health Centers. The Managed Care Operations Director will play a crucial role in overseeing and managing the organization's managed care operations and contract administration, member provider and specialty network growth and management, Managed Service Organization (MSO) vendor accountability, coding and clinical documentation integrity audits, education, and engagement, and implementation of state and local managed care reform efforts. This leadership position requires a deep understanding of managed care principles, strong operational skills, and the ability to collaborate effectively with internal and external stakeholders.

ESSENTIAL JOB FUNCTIONS

- Contract Operational Oversight: Collaborate with the Director of Managed Care Contracting to ensure implementation and operations of managed care payer contracts based on contract terms and conditions. Partner with health center members to ensure network support related to operations, billing, and referral management.

- Health Center Support Team: Establish an onsite team of Network Practice Support Managers to provide member FQHC support for network initiatives, education, or process improvement efforts.

- Payer Relationship Management: Build and maintain strong relationships with payer partners, advocating for the organization's interests and fostering collaborative partnerships to drive operational and financial success.

- Provider Network Development and Management: Collaborate with member Health Centers and MSO to assess and expand the organization's provider network, ensuring optimal

network adequacy and appropriate geographic coverage to meet patient needs. Partner with MSO in the ongoing development and maintenance of the organization's provider network, including contracting, credentialing, quality, and ongoing network adequacy assessment. Foster positive relationships with providers on behalf of the network. Establish relationships with the specialists within the network to help drive change through performance improvement.

- MSO Partnership: Collaborate with the MSO and ensure high performance for the network on all duties outlined in the division of responsibility outlined in our vendor agreement. This could include claims processing, accurate and timely claims adjudication in accordance regulatory and payer requirements, and referral trends and utilization by payer and patient categories. Monitor performance metrics and collaborate with health centers, MSO, and internal teams to ensure continuous performance.

- Operational Performance Improvement Initiatives: Identify, design, implement, and maintain operational performance improvement efforts associated with both primary care capitation agreements and full professional risk agreements to ensure network advancement and utilization of industry best practices within the network, at health centers, and at specialty provider offices.

- Coding Compliance: Support the coding corporate coordinators in the process for quarterly coding audits and ensuring messaging and education to providers and health center staff. Collaborate with informatics to create robust reporting on coding compliance and to appropriate coding and compliance with key stakeholders and leadership in the network and within the health centers to drive continuous performance improvement.

- Utilization Management: Collaborate with the clinical quality team and MSO to monitor utilization in the network and develop strategies to ensure appropriate referrals from member health centers. Monitor utilization patterns, identify trends, and implement interventions to optimize patient care and outcomes.

- Quality Assurance: Collaborate with quality improvement and clinical teams to develop and implement quality assurance programs related to managed care operations. Monitor and evaluate the performance of providers and vendors, ensuring compliance with quality standards and contractual requirements.

- Vendor Management: Oversee relationships with third-party vendors supporting managed care operations, inclusive of the MSO. Partner to ensure smooth implementation across the network, adjusting to individual health center needs, and monitoring of performance and key metrics. Ensure vendor performance meets contractual obligations and service level agreements.

- Financial Analysis: Understand financial performance for value-based care agreements pertaining to managed care operations, including revenue, expenses, and cost containment initiatives. Identify opportunities for improvement and work collaboratively to implement strategies to enhance financial performance.

- Reporting and Communication: Prepare regular reports on managed care operations, including key performance indicators, financial metrics, and operational trends. Present findings to executive leadership, network workgroups and committees, the board of managers, and other stakeholders as required.

Other Required Skills/Abilities

- Leadership: Able to assume a role of authority as necessary; advocate new ideas, even when risk is involved; set an example for coworkers; delegate responsibility and empower associates to make decisions; provide constructive feedback to others. Must have excellent interpersonal, communication, written and presentation skills, and the ability to collaborate with leadership, providers, allied health and administrative staff and partner agency staff.

- Strategic Planning & Critical thinking: Able to strategically develop vision and action plans for new concepts within the network. Able to anticipate and manage current issues, exhibit critical thinking, and sound judgment, use reason, even when dealing with emotional topics, take action to resolve conflicts and problems. Able to review primary and secondary data, determine facts, identify trends and patterns, weigh options, offer solutions, make recommendations, and report data clearly, succulently, and objectively.

- Understanding of value-based care & payment reform: Deep understanding of value-based care and payment reform within the state of California to ensure strategic advancement of the network, members, and payer communities.

- Flexibility: Able to remain open-minded and change opinions based on data and/or new information; perform a wide variety of tasks and change focus quickly as demands change; manage transitions effectively from task to task; anticipate, plan for and adapt to varying patient / customer needs.

- Planning, prioritizing and goal setting: Able to prepare for emerging patient / customer needs; manage multiple projects; determine project urgency in a meaningful and practical way; use goals to guide actions and create detailed work plans and action plans; organize and schedule self, people, and tasks. Lead the transition of assigned project results to the operational process owners at the time of project closure, including developing a feasible plan to spread and sustain improvements.

- Compliance: Deep understanding of HIPAA. Carries-out responsibilities in keeping with applicable laws, regulations, and industry standards; alert to potential for internal problems and reports concerns appropriately.

- Performance improvement: Serves as content expert on improvement methodologies and imparts knowledge of improvement processes to team leaders and interdisciplinary team members.

- Industry Knowledge: Stay informed about emerging trends, regulations, and best practices in managed care, health insurance, and healthcare reimbursement. Proactively identify opportunities for innovation and strategic growth.

QUALIFICATIONS

EDUCATION/EXPERIENCE

- Bachelor's degree in Healthcare Administration, Business Administration, or a related field. A Master's degree is preferred.
- Minimum of 7 years of progressive experience in managed care operations, contract administration, and provider network management within a healthcare organization, preferably in an FQHC or similar setting.
- In-depth knowledge of managed care principles, payer contracting, claims processing, utilization management, and quality assurance.
- Strong understanding of healthcare regulations, compliance requirements, and accreditation standards related to managed care operations.
- Excellent analytical skills with the ability to interpret complex financial and operational data.
- Exceptional communication and interpersonal skills, with the ability to collaborate effectively with internal and external stakeholders.
- Proven leadership capabilities, including team management, conflict resolution, and decision-making skills.
- Proficiency in Tableau and Microsoft Office Suite preferred.

PHYSICAL REQUIREMENTS

- Ability to sit or stand for long periods of time.
- Ability to reach, bend and stoop.
- Physical ability to lift and carry up to 20 lbs.
- Office setting.
- Frequent, daily use of computer, telephone, copier, and FAX machines.
- Regular periods of high stress and long days
- Must be responsive to multiple deadlines.

HIPAA/COMPLIANCE

- Maintain privacy of all patient, employee and volunteer information and access such information only on as need to know basis for business purposes.
- Comply with all regulations regarding corporate integrity and security obligations. Report Unethical, fraudulent, or unlawful behavior or activity.