

Attachment B.10.c  
Job Descriptions

## Job Descriptions

On the following pages, please find job descriptions for the following positions, which are not currently filled. The first column identifies the position title as referenced in the RFP, and the second column is the corresponding WellCare position title.

RFP Title	WellCare Title
Medical Director/CMO	Field Medical Director
Chief Financial Officer/CFO	Director, Finance
Compliance Officer	Compliance Liaison
Grievance System Manager	Supervisor, Appeals and Grievances
Business Continuity Planning and Emergency Coordinator	Regulatory Affairs Specialist
Quality Management Coordinator	Director, Quality
Performance/Quality Improvement Coordinator	QI Project Manager
Maternal Child Health/EPSTD Coordinator	QI Project Manager
Medical Management Coordinator	Director, Field Service Coordination
Provider Services Manager	Provider Relations Manager
Provider Claims Educator	Mgr, Field Provider Services
Case Management Administrator/Manager	Director, Field Service Coordination
Prior Authorization Staff	Prior Authorization Review Nurse
Concurrent Review Staff	Concurrent Review Nurse
Clerical and Support Staff	Administrative Assistant
Provider Services Staff	Provider Relations Rep
	Senior Provider Relations Rep
	Provider Operations Coordinator
	Senior Provider Operations Coordinator
Member Services Staff	Customer Service Rep
	Senior Customer Service Rep
Claims Processing Staff	Senior Claims Specialist
	Claims Specialist
	Claims Project Specialist
Encounter Processing Staff	Business System Analyst
Case Management Staff	Field Service Coordinator - RN
	Field Service Coordinator - SW
	Field Outreach Coordinator



**Human Resources  
Job Description Form**

Date: 12/1/09

Job Title: Medical Director-Field

Reports To (Title): Varies

Department Name: Varies

Location Name: Varies

**Section I - Job Summary**

**Please describe in 2-3 sentences a brief job summary:**

Works closely with matrix partners to manage utilization management and case management activities for all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Assists in the recruitment of participating providers, supports provider relations activities, monitors and actively manages performance of participating physicians and assists in the development and implementation of medical policy. Works in conjunction with the Senior Medical Director to attain quality management goals that meet or exceed quality standards as established by all external agencies. Participates in the identification and analysis of medical information from multiple sources in order to develop interventions to improve the quality of care and outcomes. Provides innovative solutions for key business drivers and leads efforts to improve upon these metrics.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Leads medical management and quality initiatives for assigned area to include utilization management through a matrix partnership, Quality Improvement & accreditation initiatives, Pharmacy utilization, quality and cost management of provider network, and program leadership for various corporate and local initiatives designed to improve member care and minimize unnecessary costs.
- Interprets medical policy for associates to facilitate the healthcare needs of plan members.
- Works closely with P&L owners to develop strategies to change member and provider behavior to improve quality of care, while also reducing medical costs.
- Works closely with and influences key business partners within a matrix organization faced with competing priorities.
- Makes recommendations (based on daily activities of evaluating members' care) about medical policy, clinical criteria and administrative process.
- Chairs medical policy, credentialing and related health plan committees.
- Works with the medical community to assist in the development and maintenance of a strong, quality network of providers.
- Supports provider relations and risk contracting through education, provider visits and problem resolution.
- Visits targeted providers for recruitment, as well as performing proactive provider visits as scheduled.
- Works with quality management and medical cost analysis staff to identify trends in treatment and outcomes by interpreting various data.
- Reviews provider and member complaints, assist in resolution, and make recommendations for changes.
- Utilizes clinical expertise to assist in the development of care improvement programs to improve health outcomes for the member population.
- Manages and develops direct reports who include directors and/or managers.
- Performs other duties as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: varies Indirect Reports: varies

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

**Section IV - Minimum Qualifications**

**Education:** A medical degree from an accredited medical school and board certification.

**Experience:** 7+ years experience and a strong working knowledge of managed healthcare. Experience and familiarity with government programs is preferred. Past experience with NCOA accreditation is preferred. Participation in hospital managed care or medical practice UM committees is desirable. Education, training or professional experience in medical or clinical practice.

**Licenses/Certifications:** Current license without restrictions in working state or the ability to obtain that license

**Special Skills (e.g. 2<sup>nd</sup> language):**

Demonstrated success implementing utilization tools/techniques  
Experience with physician behavior modification

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel, PowerPoint, Project and Outlook.

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section V – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section VI - Additional Requirements (if applicable)**

**Travel:** Varies

**Overtime:** %

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

**Date:** 3/30/04

**Job Title:** Dir, Finance

**Reports To (Title):** Varies

**Department Name:** Varies

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Position plans, provides resources and directs activities for state or enterprise-wide provider financial analysis. Provides analytics for strategic and operating decisions for product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Leads the contract modeling process.
- Manages the financial analysis of medical cost.
- Manages companywide capitation calculation and payment.
- Provides ad-hoc analysis for senior management.
- Manages and develops direct reports who include other management or supervisory personnel and/or exempt individual contributors.
- Develops strategies and maximizes efficiencies in the utilization of human and financial resources.
- Ensures corporate initiatives are implemented to achieve optimum results.
- Recommends changes in area(s) policy and procedure.
- Performs other duties as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: varies Indirect Reports: Varies

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

#### Section IV - Minimum Qualifications

**Education:** A Bachelor's Degree in Finance, Accounting or related field. An MBA preferred.

**Experience:** 7+ years experience in a corporate or regional finance setting. Substantial healthcare financial management experience. 3+ years of management experience.

**Licenses/Certifications:**

**Special Skills (e.g. 2<sup>nd</sup> language):**

In-depth knowledge of finance

Demonstrated leadership, people management and facilitative skills

Ability to retain confidentiality regarding privileged company information

Provide proactive approach and support to emerging business activities established to remain competitive in the marketplace.

Ability to work in a fast paced environment with changing priorities.

Ability to remain calm under pressure.

Ability to organize tasks and work environment

**Technical Skills/Requirements:** Advanced in Microsoft Office such as Excel, Project, Word, PowerPoint, Access and Outlook. Knowledge of database reporting tools to assist in preparing analysis

**Software Proficiency:**  Beginner  Intermediate  Advance

#### Section V – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

#### Section VI - Additional Requirements (if applicable)

**Travel:** varies%

**Overtime:** %

**Other Position Requirements:**



**Human Resources  
Job Description Form**

**Date:** 2/4/11

**Job Title:** Compliance Liaison

**Reports To (Title):** Compliance Regulatory Counsel

**Department Name:** Corporate Compliance

**Location Name:** Various states/markets

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Assists the Chief Compliance Officer to implement and monitor the policies, procedures, and practices designed to ensure compliance with the requirements set forth in the Corporate Integrity Agreement (CIA) and applicable Plan contracts with Medicare, Medicaid, ABD, Dual Eligible and Federal health care program requirements. Serves as a contact person for the Chief Compliance Officer for compliance activities at the applicable Plans/Markets. Acts as a local liaison for the various Corporate Compliance departments including Audit and Monitoring, Investigations, Information Security and HIPAA, Records Information Management, and Policies & Training.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Assists the Chief Compliance Officer to implement the policies, procedures, and practices designed to ensure compliance with the requirements set forth in the CIA and the Plan's contracts with Medicare, Medicaid, ABD, Dual Eligible and Federal health care program requirements for the applicable Plan.
- Assists the Chief Compliance Officer to monitor the day-to-day compliance activities at the applicable Plan
- Serves as a contact person for the Chief Compliance Officer for compliance activities at the applicable Plan. The Compliance Liaisons shall make periodic (at least semi-annual) written reports regarding compliance matters directly to the Chief Compliance Officer.
- Provides assistance and operational oversight of external audits including: risk assessment, external audit management, preparation and facilitation
- Local CAP/IAP Oversight
- Provides escalation path within the market for compliance related issues. Pull in the appropriate resources and support from Corporate Compliance as needed.
- Monitors and provides oversight of vendors as needed to ensure compliance
- Works as a liaison with the Compliance Special Investigation teams, including conducting investigations relative to agent Sales & Marketing and enrollment FWA cases and conducting interviews with potential beneficiaries, members, agents, providers, associates and/or downstream entities as required for investigatory purposes.
- Conducts and tracks on-site compliance trainings and updates to the field organization
- Acts as the local subject matter expert for HIPAA and responsible for local oversight of HIPAA requirements
- Acts as the local contact for the Records Information Management department. Assists in training and oversight as needed.
- Serves as the local internal information security consultant to the organization, documenting and implementing security policies and procedures in consultation with the Chief Privacy officer and Chief Compliance Officer.
- Monitors compliance with Information Security policies and procedures, referring problems to the appropriate department manager, data owner, HR, legal, IT or other as necessary.
- Assists Regulatory Affairs in monitoring state regulatory register and flagging new rules.
- Assists Regulatory Affairs in reporting as needed
- Assists Regulatory Affairs with projects at the local level as needed.
- Performs other projects and duties as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.

- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0 Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

**Section III - Minimum Qualifications**

**Education:** A Bachelor's Degree in a related field required. In lieu of a Bachelor's Degree, relevant 5 years experience will be considered. A Master's Degree in Business Administration, Public Health, or Healthcare Administration preferred.

**Experience:** 5+ years experience in business setting. Experience in Corporate compliance, regulatory affairs or state government preferred. Managed care experience preferred.

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Ability to manage multiple priorities and projects and meet deadlines

Excellent oral and written communication skills

Demonstrated experience developing and delivering training programs and making presentations to staff and providers.

Must exercise keen judgment in difficult situations, balancing the competing interests of corporate and regional offices in a matrix management system.

Ability to read, analyze, and interpret State and Federal laws, rules and regulations

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel, PowerPoint, Project and Outlook.

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section IV – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solution

**Section VI - Additional Requirements (if applicable)**

**Travel:** Varies

**Overtime:** %

**Other Position Requirements:**



**Human Resources  
Job Description Form**

Date: 01/01/09

Job Title: Supervisor, Appeals and Grievances

Reports To (Title): **Varies**

Department Name: **Varies**

Location Name: **Varies**

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Under the direction of the local leadership team, supervises a team in the day-to-day workflow processes of Appeals and Grievances functions across all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Monitors associate performance for timely and accurate processing of appeals and grievances, attendance, schedules, and other job related behavior. Ensures the collection, interpretation and safekeeping of all materials concerning each appeal and grievance.
- Reviews appeal and grievances management and error reports to ensure associate productivity, accuracy and timeliness. Gives subordinates regular feedback on performance and conducts counseling/corrective action procedures, up to and including separation, with manager and HR oversight when needed.
- Writes midyear and annual performance evaluations and reviews with associates.
- Completes new hire requisitions, conducts interviews and makes hiring decisions for associates in work group. Ensures comprehensive training for each new hire, including intensive period of supervision for first 90-120 days.
- Receives routine and ad hoc audit results from auditors and routinely delivers results to subordinates. Identifies & coordinates additional team member training needs based on associate performance.
- Answers internal and external customer questions, assists peers and Manager, Sr. Manager or Director with tasks. Serves as the first line contact for the company's problem resolution procedure for associates in his/her work group. Serves as liaison for escalated appeal issues identified by the Provider Relations team.
- Plays active role in creating, applying and utilizing accepted policies and procedures to review process and utilizes the parameters.
- Performs special duties as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: **varies** Indirect Reports: **varies**

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors

- Exempt level associates / Team Leaders
- Nonexempt level associates

#### Section IV - Minimum Qualifications

**Education:** High School Diploma required. Associate's degree preferred.

**Experience:** 4+ years directly related work experience in Appeals and Grievances. 1+ years of managed care. Previous supervisory/leading others preferred.

**Licenses/Certifications:** n/a

**Special Skills (e.g. 2<sup>nd</sup> language):**

Ability to effectively communicate, present information and respond to questions from clinical and non-clinical Appeals and Grievances staff, internal departments, providers and members.

Ability to write concise, grammatically correct notes and business correspondence.

Ability to review correspondence and system data to establish facts and draw valid conclusions consistent with applicable policy and procedures.

**Technical Skills/Requirements:**

Working knowledge of Microsoft Office Products including Outlook, Word and Excel.

Knowledge of or ability to learn and use personal computers and industry software including Paradigm, Sidewinder, and EMMA

**Software Proficiency:**  Beginner  Intermediate  Advanced

#### Section V – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

#### Section VI - Additional Requirements (if applicable)

**Travel:**  %

**Overtime:**  varies %

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

**Date:** 11/18/03

**Job Title:** Regulatory Affairs Specialist

**Reports To (Title):** Varies

**Department Name:** Varies

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Supports the Director of Regulatory Affairs in the management of WellCare Health Plans efforts to ensure compliance with the laws, regulations, and policies that govern its Medicare, Medicaid, ABD, Dual Eligible and commercial businesses.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Coordinates resources to ensure the ongoing effectiveness of the compliance program, which includes organizing and maintaining relevant files and preparing necessary reports on activities.
- Monitors compliance with laws, rules, and regulations, as well as Health Plan policy.
- Coordinates site visits for Federal and State regulators.
- Researches regulations, inform various departments of regulations, and assist as needed in developing procedures to comply, as well as draft responses to queries by regulatory agencies.
- Coordinates the filing of regulatory forms, reports, etc. Assists other departments in understanding and complying with regulatory requirements to include researching regulations, informing departments of regulations, and assisting as needed in developing procedures to comply with, and draft responses to queries by regulatory agencies.
- Tracks all issues referred to the Regulatory Affairs Department up to and including resolution.
- Represents the health plan at federal, state, and local government meetings.
- Communicates the importance of compliance and the compliance program to health plan staff, which includes promoting an increased awareness of the Corporate Ethics and Compliance Program, an understanding of new and existing compliance issues and related policies and procedures, and the importance of internal compliance audits.
- Develops and maintains productive relationships with all levels of management as well as regulators and other relevant external parties.
- Provides education and training about laws and regulations that affect operations.
- Works with different functional areas to implement mandates, regulations, and corrective action plans.
- Coordinates and oversees the emergency planning process. Works with corporate to put in best practice to ensures continuity of services for members.
- Performs special projects as assigned

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0

Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

**Section IV - Minimum Qualifications**

**Education:** A Bachelor's Degree in a related field. A Master's Degree in Business, Public Health, Health Care Administration a plus.

**Experience:** 5+ years experience in the health care industry. Familiarity with Medicare and Medicaid programs preferred. Previous state or federal managed care compliance experience a plus.

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Strong orientation to deadlines and details

Ability to exercise good judgment under pressure

Ability to manage a diverse and demanding workload

Ability to work well both independently and with others in a matrix environment

Ability to effectively present information and respond to inquiries from employees, regulatory agencies, and others, as necessary

Ability to read, analyzes, and interpret state and federal laws, rules and regulations

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel, PowerPoint, Project and Outlook.

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section V – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section VI - Additional Requirements (if applicable)**

**Travel:** varies%

**Overtime:** %

**Other Position Requirements:**



## Human Resources Job Description Form

**Date:** November 1, 2009

**Job Title:** Director, Field Quality Improvement

**Reports To (Title):** Sr. Director Quality

**Department Name:** Quality Improvement

**Location Name:** Varies

### Section I - Job Summary

Please describe in 2-3 sentences a brief job summary:

Plans, develops and directs the Quality Improvement functions for product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Provides leadership necessary to achieve national best practice performance levels in quality improvement while implementing evidence based medicine/practices. Ensures that the quality of healthcare services rendered meets or exceeds professionally recognized community standards. Interfaces with a diverse range of clinical and administrative professionals, resolves sometimes-complex policy and service issues within the group and directs data analytic and reporting activities that are prescribed by customers and regulators in a multi market environment. Ensures compliance with state, federal and accreditation requirements.

### Section II - Key Duties and Responsibilities

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Develops and implements quality improvement plan in accordance with the mission and strategic goals of the organization, federal and state laws and regulations, and accreditation standards.
- Establishes professional relationships with state, stakeholders and community agencies to facilitate quality process internally and externally.
- Develops and implements systems, policies, and procedures for the identification, collection, and analysis of performance measurement data.
- Analyzes, updates, and modifies standard operating procedures and processes to continually improve QI Department services/operations.
- Assists in strategizing and facilitating various committee structures and functions to best address the QI process and oversees Quality Committees.
- Oversight and interface internally and externally with pay for performance programs and initiatives
- Coordinates and completes all QI activities required to meet national accreditation and regulatory performance improvement initiatives.
- Supervises member outreach coordinators with overall responsibility for providing support for clinical quality initiatives and regulatory/contractual requirements. Support includes telephonic and in-person outreach to members who are identified as requiring outreach services. In addition, to provide assistance to clinical compliance staff with member education classes, quality management, and Health Promotion initiatives and performance data collection and recording.
- Collects and summarizes regional market performance data, identifies opportunities for improvement, and presents findings quarterly to the Performance Improvement Committee
- Develops strategies for special program participation and Quality Improvement. Develops systems for close coordination of QI related functions with departments whose activities are directly a part of the QI Program, including Credentialing.
- Supervises QI Specialists in the implementation of performance initiatives to drive HEDIS performance and contract compliance quality performance.
- Communicates new state, federal and third party regulations and requirements to the staff.
- Facilitates strategic and tactical planning for the quality improvement program, including needs assessments, evaluations, root cause analysis and interventions.
- Collaborates with Health Services, Operations, and Information Technology departments to ensure full integration of quality improvement reporting for contract and accreditation compliance
- Participates in site visit preparation and execution by regulatory and accreditation agencies (state agencies, URAC, NCOA, CMS, AAAHC, EQRO)
- Leads, facilitates, and advises internal quality improvement teams
- Actively participates on, or facilitates committees such as: Quality Improvement, Utilization Management, Patient Safety, and Risk Management
- Responsible for monitoring and evaluating staff performance.
- Performs other duties as assigned

### Section III - Scope

**Level of Supervision Received (choose one):**





## Human Resources Job Description Form

**Date:** November 1, 2009

**Job Title:** QI Project Manager

**Reports To (Title):** Dir, QI

**Department Name:** Quality Improvement

**Location Name:** Varies

### Section I - Job Summary

Please describe in 2-3 sentences a brief job summary:

Supports the development and implementation of quality improvement interventions and audits and assists in resolving deficiencies that impact plan compliance to regulatory and accreditation standards to product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Drives key quality improvement projects requiring the ability to work effectively in a matrix environment in order to receive needed data that reflects the overall health of the plan.

### Section II - Key Duties and Responsibilities

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Establishes and/or revises existing WellCare policies and procedures necessary for successful implementation of the Quality Improvement (QI) Program.
- Pursues methods to ensure receipt of relevant data, as required for accurate trending of various QI work plan metrics.
- Analyzes key plan metrics, such as top diagnoses, clinical procedures, and operational performance, to enable the development of sound and valid recommendations regarding and prioritization of clinical and service improvement initiatives.
- Works with QI Director to convene various QI committees and work groups, set agenda to drive desired meeting outcomes (based on contract and accreditation requirements), and ensure proper recording of committee activities.
- Acts as knowledge expert for continuous quality improvement activities, educating staff of other functional areas regarding the QI process and accreditation requirements.
- Performs various quality department functions and processes, such as quality of care complaint/adverse event review and assessment of medical record review results and recommend actions to address any identified improvement opportunities.
- Manages and monitors clinical quality studies to include receipt and analysis of trended data, assessment of national benchmarks as available, development of improvement recommendations (to include ROI and best practice interventions as appropriate), presentation to senior leadership, implementation of plan, and evaluation for desired result.
- Recommends strategies to improve member compliance to QI program activities, addressing methods to change knowledge, attitudes and behaviors, such as handbook content, newsletter articles, member outreach interventions, and member focus groups.
- Recommends methods to improve network provider compliance to health plan QI Program policies and procedures, including profiles/scorecards and efforts to increase provider compliance to practice guidelines, such as through medical record review.
- Fields annual member and provider satisfaction surveys, working with vendor to clarify results and present findings and recommendations to senior leadership.
- Assists with efforts to secure successful NCOA accreditation.
- Performs activities to comply with annual HEDIS data collection and analysis, preparing recommendations to increase rates as appropriate.
- Participate in site visit preparation and execution by various regulatory and accreditation agencies (DCH, DHR, CMS, EQRO).
- Monitors and tracks all state and federal quality improvement and reporting requirements.
- Supports efforts to submit monthly, quarterly, semi-annual, and annual regulatory required performance reports.
- Assists in developing short range plans for overall area activities.
- Develops and oversees the implementation of programs and strategies.
- In select states, leads efforts on EPSDT programs to measure outcomes and influence program changes.
- Acts in liaison capacity with other areas and business units.
- Makes recommendations on matters of policy in area of expertise.
- Performs other duties as assigned.

### Section III - Scope

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.





## Human Resources Job Description Form

**Date:** November 1, 2009

**Job Title:** QI Project Manager

**Reports To (Title):** Dir, QI

**Department Name:** Quality Improvement

**Location Name:** Varies

### Section I - Job Summary

Please describe in 2-3 sentences a brief job summary:

Supports the development and implementation of quality improvement interventions and audits and assists in resolving deficiencies that impact plan compliance to regulatory and accreditation standards to product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Drives key quality improvement projects requiring the ability to work effectively in a matrix environment in order to receive needed data that reflects the overall health of the plan.

### Section II - Key Duties and Responsibilities

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Establishes and/or revises existing WellCare policies and procedures necessary for successful implementation of the Quality Improvement (QI) Program.
- Pursues methods to ensure receipt of relevant data, as required for accurate trending of various QI work plan metrics.
- Analyzes key plan metrics, such as top diagnoses, clinical procedures, and operational performance, to enable the development of sound and valid recommendations regarding and prioritization of clinical and service improvement initiatives.
- Works with QI Director to convene various QI committees and work groups, set agenda to drive desired meeting outcomes (based on contract and accreditation requirements), and ensure proper recording of committee activities.
- Acts as knowledge expert for continuous quality improvement activities, educating staff of other functional areas regarding the QI process and accreditation requirements.
- Performs various quality department functions and processes, such as quality of care complaint/adverse event review and assessment of medical record review results and recommend actions to address any identified improvement opportunities.
- Manages and monitors clinical quality studies to include receipt and analysis of trended data, assessment of national benchmarks as available, development of improvement recommendations (to include ROI and best practice interventions as appropriate), presentation to senior leadership, implementation of plan, and evaluation for desired result.
- Recommends strategies to improve member compliance to QI program activities, addressing methods to change knowledge, attitudes and behaviors, such as handbook content, newsletter articles, member outreach interventions, and member focus groups.
- Recommends methods to improve network provider compliance to health plan QI Program policies and procedures, including profiles/scorecards and efforts to increase provider compliance to practice guidelines, such as through medical record review.
- Fields annual member and provider satisfaction surveys, working with vendor to clarify results and present findings and recommendations to senior leadership.
- Assists with efforts to secure successful NCOA accreditation.
- Performs activities to comply with annual HEDIS data collection and analysis, preparing recommendations to increase rates as appropriate.
- Participate in site visit preparation and execution by various regulatory and accreditation agencies (DCH, DHR, CMS, EQRO).
- Monitors and tracks all state and federal quality improvement and reporting requirements.
- Supports efforts to submit monthly, quarterly, semi-annual, and annual regulatory required performance reports.
- Assists in developing short range plans for overall area activities.
- Develops and oversees the implementation of programs and strategies.
- In select states, leads efforts on EPSDT programs to measure outcomes and influence program changes.
- Acts in liaison capacity with other areas and business units.
- Makes recommendations on matters of policy in area of expertise.
- Performs other duties as assigned.

### Section III - Scope

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.





## Human Resources Job Description Form

Date: 4/1/11

Job Title: Dir, Field Service Coordination

Reports To (Title): Medical Director

Department Name: Health Services

Location Name: Varies

### Section I - Job Summary

Please describe in 2-3 sentences a brief job summary:

Ensures the case management process of assessing, planning, implementation, coordination, monitoring, and evaluating services and outcomes is pursued to maximize the health of the member across all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Oversees the socio economic needs and services of selected member populations across the continuum of illness. Takes part in extensive community outreach to garner relationships with key stakeholder groups and organizations.

### Section II - Key Duties and Responsibilities

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Manages and develops direct reports who conduct both case management and social service functions within a member's care plan.
- Sets operational priorities and manages resources to operational goals and budgets.
- Proactively monitors appropriate metrics to drive up efficiency.
- Directs the case management process, providing advice when necessary of complex, controversial and/or unique administrative processes, medical procedures and payment guidelines.
- Establish, maintain and foster professional working relationships with all providers and community stakeholders.
- Partners & collaborates with other departments cross functionally regarding care and case management and/or Health Service initiatives.
- Manages & resolves e-mails and escalated phone issues in response to provider, staff and other department requests.
- Directs work assignments, measures results and initiates personnel actions as required.
- Participates in continuous quality improvement projects that involve case and social service components.
- Ensure timely and complete delivery of required regulatory reports.
- Serve on community advisory boards and task forces to address workforce and other long-term care challenges.
- Ensures compliance with all state and federal regulations and guidelines for all lines of business.
- Performs other duties as assigned.

### Section III - Scope

#### Level of Supervision Received (choose one):

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

#### Level of Supervision Exercised:

Total # Supervised: Direct Reports: varies Indirect Reports: varies

#### Level Supervised:

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

### Section III - Minimum Qualifications

**Education:** A Bachelor's Degree in Nursing, Health Administration or directly related field. Licensed Registered Nurse

**Experience:** 10+ years current case management experience and 5+ years managed care experience. At least 5+ years of supervisory/management experience.

**Licenses/Certifications:** Current state license (RN). Maintain required contact hours to fulfill regulatory requirements. CCM certification preferred

**Special Skills (e.g. 2<sup>nd</sup> language):**

Strong clinical knowledge of broad range of medical practice specialties

Demonstrates effective communication methods to assist in training and to relate effectively to upper management

Assists in evaluating process improvements

Demonstrates high level time management and priority setting

Advanced ability as a licensed professional to communicate on any level required to meet the demands of the position

Ability to lead and manage others in a metric driven environment

Ability to create, review and interpret treatment plans

Demonstrated negotiation skills

Demonstrated ability in problem solving and communication

Previous experience working with treatment teams to meet the healthcare needs of participants

Knowledge of community, state and federal laws and resources

Strong oral and written communication skills including the ability to effectively present information and respond to questions from families, members, and providers as well as the ability to relate effectively to upper management.

**Technical Skills/Requirements:** Proficient in Microsoft Office including Outlook, Word and Excel. Knowledge of or the ability to learn company approved software such as CRMS, Peradigm, InterQual, Sidewinder and other software in order to perform job duties.

**Software Proficiency:**  Beginner  Intermediate  Advanced

### Section IV – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

### Section V - Additional Requirements (if applicable)

**Travel:** %

**Overtime:** varies%

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

**Date:** 10/13/08

**Job Title:** Mgr., Provider Relations

**Reports To (Title):**

**Department Name:**

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Leads and develops a team of Provider Relations Reps and Provider Ops Coordinators who support product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Assists with prioritizing corporate functions and focuses on producing revenue for the corporation through the effective coaching and developing of Representatives to build relationships and manage the accounts of their Providers.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Leads and develops a team of Provider Relations Reps and Provider Ops Coordinators.
- Conducts car rides with Reps in the field to develop skills and behaviors, document progress and provide formative feedback through timely and consistent field trip reports.
- Conducts and directs provider contracting/negotiations and provider servicing.
- Performs data analysis and develops specific actions to manage medical cost trend.
- Assists in developing practices to assist risk partners in managing financial risk.
- Identifies areas to improve provider service levels.
- Educates/enhances relationships within the provider community.
- Assists in developing provider contracting and service.
- Strategizes for membership growth and retention.
- Special projects as assigned or directed.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: varies Indirect Reports: varies

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associate

### Section III - Minimum Qualifications

**Education:** A Bachelor's Degree preferred or equivalent directly related experience

**Experience:** 5+ years Provider Relations experience or similar background. 3+ years progressively responsible managerial experience. HMO/PPO background preferred.

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Demonstrated people management and facilitative skills

Strong functional and technical knowledge of healthcare delivery

Excellent interpersonal skills and demonstrated ability to influence internal and external constituents

Strong knowledge of CMS and state regulations.

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel and Outlook.

**Software Proficiency:**  Beginner  Intermediate  Advanced

### Section IV – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

### Section V - Additional Requirements (if applicable)

**Travel:** 75%

**Overtime:** varies%

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

**Date:** 8/23/10

**Job Title:** Mgr, Field Provider Services

**Reports To (Title):** Varies

**Department Name:** Varies

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Directs, supervises and provides leadership for the hospital component of the Provider Service Unit for product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Develops and executes the hospital services strategy to ensure superior customer service and issue management. Gathers and analyzes data associated with claim payment issues, identifies root cause analysis and drives process improvement opportunities with respect to health plan operations.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Oversees claims processing, provider contracts and contract configuration to the day-to-day escalated issues within the designated health plan.
- Manages process improvement initiatives, seeking root cause issues and developing appropriate corrective action plans. Develops and implements continuous improvement processes to reduce the occurrence of inaccurate claim payments.
- Serves as primary contact for Provider Relations for complex issues.
- Manages and develops direct reports. Directs work assignments, measures results and initiates personnel actions as required for assigned claims unit. Assists associates to resolve complex provider issues. Ensures timely response to escalated provider issues and resolution with root cause mindset.
- Establishes objectives, schedules, and cost data for the business of the function being managed.
- Ensures the delivery of superior customer services by providing timely and accurate resolution to claims related provider inquiries and complaints regarding claims processing.
- Recommends and implements changes to streamline departmental operations.
- Supports Divisional operations initiatives as assigned.
- Perform other duties as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 3      Indirect Reports:

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

### Section III - Minimum Qualifications

**Education:** A Bachelor's Degree preferably in a Health Administration, Business or related field required.

**Experience:** 5+ years experience with hospital, financial or managed care operations and Medicare/Medicaid billing and reimbursement practices. Experience with Managed Care. 1+ years of supervisory/managerial experience. Previous experience working directly with customers.

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Excellent communication, interpersonal skills and decision-making skills

Ability to work successfully in a team environment

Excellent analytical and problem solving skills

Excellent written communication

Solid presentation skills

Must be able to have a business presence in face of adversity with customers

Ability to work independently and support project / issue resolution

Ability to perform a multitude of tasks simultaneously in a fast-paced customer-centered organization

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel, PowerPoint, Visio and Outlook.

**Software Proficiency:**  Beginner  Intermediate  Advanced

### Section IV – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

### Section VI - Additional Requirements (if applicable)

**Travel:** %

**Overtime:** %

**Other Position Requirements:**



## Human Resources Job Description Form

Date: 4/1/11

Job Title: Dir, Field Service Coordination

Reports To (Title): Medical Director

Department Name: Health Services

Location Name: Varies

### Section I - Job Summary

Please describe in 2-3 sentences a brief job summary:

Ensures the case management process of assessing, planning, implementation, coordination, monitoring, and evaluating services and outcomes is pursued to maximize the health of the member across all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Oversees the socio economic needs and services of selected member populations across the continuum of illness. Takes part in extensive community outreach to garner relationships with key stakeholder groups and organizations.

### Section II - Key Duties and Responsibilities

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Manages and develops direct reports who conduct both case management and social service functions within a member's care plan.
- Sets operational priorities and manages resources to operational goals and budgets.
- Proactively monitors appropriate metrics to drive up efficiency.
- Directs the case management process, providing advice when necessary of complex, controversial and/or unique administrative processes, medical procedures and payment guidelines.
- Establish, maintain and foster professional working relationships with all providers and community stakeholders.
- Partners & collaborates with other departments cross functionally regarding care and case management and/or Health Service initiatives.
- Manages & resolves e-mails and escalated phone issues in response to provider, staff and other department requests.
- Directs work assignments, measures results and initiates personnel actions as required.
- Participates in continuous quality improvement projects that involve case and social service components.
- Ensure timely and complete delivery of required regulatory reports.
- Serve on community advisory boards and task forces to address workforce and other long-term care challenges.
- Ensures compliance with all state and federal regulations and guidelines for all lines of business.
- Performs other duties as assigned.

### Section III - Scope

#### Level of Supervision Received (choose one):

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

#### Level of Supervision Exercised:

Total # Supervised: Direct Reports: varies Indirect Reports: varies

#### Level Supervised:

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

### Section III - Minimum Qualifications

**Education:** A Bachelor's Degree in Nursing, Health Administration or directly related field. Licensed Registered Nurse

**Experience:** 10+ years current case management experience and 5+ years managed care experience. At least 5+ years of supervisory/management experience.

**Licenses/Certifications:** Current state license (RN). Maintain required contact hours to fulfill regulatory requirements. CCM certification preferred

**Special Skills (e.g. 2<sup>nd</sup> language):**

Strong clinical knowledge of broad range of medical practice specialties

Demonstrates effective communication methods to assist in training and to relate effectively to upper management

Assists in evaluating process improvements

Demonstrates high level time management and priority setting

Advanced ability as a licensed professional to communicate on any level required to meet the demands of the position

Ability to lead and manage others in a metric driven environment

Ability to create, review and interpret treatment plans

Demonstrated negotiation skills

Demonstrated ability in problem solving and communication

Previous experience working with treatment teams to meet the healthcare needs of participants

Knowledge of community, state and federal laws and resources

Strong oral and written communication skills including the ability to effectively present information and respond to questions from families, members, and providers as well as the ability to relate effectively to upper management.

**Technical Skills/Requirements:** Proficient in Microsoft Office including Outlook, Word and Excel. Knowledge of or the ability to learn company approved software such as CRMS, Peradigm, InterQual, Sidewinder and other software in order to perform job duties.

**Software Proficiency:**  Beginner  Intermediate  Advanced

### Section IV – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

### Section V - Additional Requirements (if applicable)

**Travel:** %

**Overtime:** varies%

**Other Position Requirements:**



**Human Resources  
Job Description Form**

**Date:** 10/28/2010

**Job Title:** Prior Authorization Review Nurse

**Reports To (Title):** Mgr, Prior Authorization

**Department Name:** HS/Care Mgmt

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Evaluates the pre-service authorization request received for scheduled inpatient admissions, ambulatory surgeries, outpatient services and out of network providers. Reviews medical records, uses clinical expertise and compares information to established guidelines and the members benefit plan for product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Works closely with departmental management staff to impact the treatment plan and identify treatment plan alternatives.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Utilizes Well Care designated criteria along with clinical knowledge to make authorization decisions and assist the Medical Director with review determinations.
- Evaluates all requests for service, to determine the Company's financial liability including the collection of information regarding subrogation and COB and entry in the Health Services system.
- Ensures accurate coding using CPT-4 and ICD-9 codes. Documents all information accurately.
- Initiates and continues direct communication with health care providers involved with the care of the member to obtain complete and accurate information.
- Adheres to all confidentiality requirements.
- Applies appropriate benefits information to determine if requested services are a covered benefit.
- Applies medical knowledge and experience to authorize pre-service requests.
- Arranges for transfer to in-network care when appropriate.
- Initiates process for Letter of Agreements for out of network provider requests that meet approval criteria.
- Identifies cases appropriate for case management and makes appropriate referrals.
- Identifies potential quality of care issues and refers to the Quality Department.
- Meets service standards for decision turn around times and written correspondence
- Performs special projects as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0 Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors

- Exempt level associates / Team Leaders
- Nonexempt level associates

**Section IV - Minimum Qualifications**

**Education:** Licensed Practical Nurse. A Bachelor's Degree in Health Services or nursing preferred.

**Experience:** 2-4 years clinical experience in an acute care facility. Managed care experience preferred. Previous experience working with treatment teams to meet the healthcare needs of participants. Knowledge of community, state and federal laws and resources.

**Licenses/Certifications:** Minimum of LPN licensure with current unrestricted license

**Special Skills (e.g. 2<sup>nd</sup> language):**

Ability to review and interpret treatment plans

Ability to define problems, collect and interpret data, establish facts, draw valid conclusions and process work to completion

**Technical Skills/Requirements:** Intermediate knowledge in Microsoft Office including Word, Excel and Outlook Express

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section V – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section VI - Additional Requirements (if applicable)**

**Travel:** \_\_\_\_\_ **Overtime:** \_\_\_\_\_ %  
**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

**Date:** 01/01/09

**Job Title:** Concurrent Review Nurse

**Reports To (Title):** Manager, Concurrent Review

**Department Name:** Utilization management

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Evaluates the inpatient treatment and clinical progress of members admitted to acute care facilities, skilled nursing facilities and inpatient rehabilitation facilities. Requests and reviews medical records, uses clinical experience and compares information to established guidelines and the members benefit plan for product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Anticipates and plans for the health care services required to facilitate a smooth transition of care when appropriate. Works closely with the departmental management to impact the treatment plan and identify treatment plan alternatives.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Conducts telephonic concurrent review for all assigned facilities. Communicates effectively with facility staff to gather clinical information through verbal and written communications, and provides timely and accurate responses to request information or provide authorization decisions.
- Utilizes InterQual criteria and WellCare clinical coverage criteria along with clinical experience to make authorization decisions. Identifies cases not meeting criteria and provides clinical information and rationale to the Medical Director for review and determination.
- Anticipates discharge planning early in acute admissions to prepare for appropriate outpatient level of care. Identifies post-acute care needs and authorizes appropriate services and/or providers to facilitate timely discharge or transfer to an alternate level of care.
- Interacts with Medical Directors using medical knowledge and clinical experience and evaluates plan of care to determine that patients are receiving the best care in the best setting. Applies medical knowledge to authorize outpatient services as an alternative to hospitalization when appropriate. Arranges for transfer to in-network care when appropriate.
- Updates clinical information in the electronic medical management record system with treatment plan, objectives, results and next steps. Documents all information accurately.
- Initiates and continues direct communication with health care providers involved with the care of the member, including the IPA or Hospitalist Group if applicable, to obtain complete and accurate information. Applies appropriate benefits information to determine if requested services are a covered benefit. Evaluates all requests for service to determine the Company's financial liability including the collection of information regarding subrogation and COB and performs data entry in the electronic medical management record system.
- Identifies cases appropriate for targeted programs including case and disease management and makes appropriate referrals. Works effectively with Case and Disease Managers to coordinate case transition when needed.
- Appropriately considers and applies regulatory requirements in the review process. Meets service standards for decision turn around times and written correspondence. Identifies potential quality of care issues and refers to the Quality Department. Adheres to all HIPAA and confidentiality requirements.
- Performs special projects as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0      Indirect Reports: 0

**Level Supervised:**

- Sr. Management/Directors
- Managers/Supervisors
- Exempt level associates/Team Leaders
- Nonexempt level associates

**Section IV - Minimum Qualifications**

**Education:** Licensed Practical Nurse required

**Experience:** 2-3 years clinical experience in an acute care facility. 2+ years of experience in a position demonstrating critical thinking skills managing patients within an inpatient environment using stated criteria. Managed care experience preferred.

**Licenses/Certifications:** Licensed Practical Nurse with current unrestricted license

**Special Skills (e.g. 2<sup>nd</sup> language):**

Ability to review and interpret treatment plans

Ability to collect and interpret data, establishes facts, draw valid conclusions and process work to completion

Previous experience working with treatment teams to meet the healthcare needs of participants

Knowledge of community, state and federal laws and resources

**Section V – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section VI - Additional Requirements (if applicable)**

**Travel:**

**Overtime:**      %

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

Date: 5/1/11

Job Title: Administrative Assistant

Reports To (Title): Varies

Department Name: Varies

Location Name: Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Provides administrative support to multiple Directors/Managers within a department or a Vice President with small people mgmt. scope who support product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Performs routine administrative functions such as drafting correspondence, scheduling appointments, organizing and maintaining paper/electronic documents, arranging travel, coordinating meetings, and greeting internal/external constituencies. May perform project work by conducting research, updating social media/websites and preparation of briefing charts and other presentation materials.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Manages a calendar for multiple Directors/Managers or Vice President. Schedules and cancels meetings and revises calendar(s) based on priority and important changes.
- Coordinates travel arrangements and prepares expense reports.
- Produces, formats and edits correspondence and documents.
- Creates and maintains necessary tracking/coordination of spreadsheets and administers department programs.
- Assists with the creation of presentation materials and briefing documents.
- Schedules department events, conference facilities, weekly/month department meetings, and plans and negotiates food and site locations where necessary.
- Takes meeting minutes.
- Organizes and distributes hard copy mail and email/phone distribution lists.
- Organizes and distributes department reports and/or materials.
- Receives and processes bill payments.
- Researches, prices and purchases office supplies.
- Oversees and manages department payroll.
- Performs special projects as assigned.

**Section III - Scope**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports:

Indirect Reports:

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

#### Section IV - Minimum Qualifications

**Education:** A high school diploma. An Associate's Degree in a related field preferred.

**Experience:** 1-2 years experience as an administrative assistant/office coordinator supporting an executive or a large department in a face paced and/or growing organization. Working knowledge of the healthcare industry preferred.

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Strong interpersonal and communication skills

Ability to interface with personnel at all levels

Ability to effectively manage/coordinate simultaneous projects; ability to be flexible and multi-task

Strong initiative and customer service focus

Strong organizational skills and the ability to meet strict deadlines

Demonstrated ability to deal with confidential information

Strong attention to detail

Solid knowledge of office management (answering phones, setting up files, record keeping etc)

Ability to work as part of team and with other administrative assistants

Strong typing skills

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel, PowerPoint, Visio and Outlook. Ability to type at least 50-60 words a minute. Proficient utilizing fax machines, copy machines, conference phones, audio/visual equipment etc.

**Software Proficiency:**  Beginner  Intermediate  Advanced

#### Section V – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

#### Section VI - Additional Requirements (if applicable)

**Travel:** None%

**Overtime:** varies%

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

Date: 10/13/08

Job Title: Provider Relations Rep

Reports To (Title): Mgr., Provider Relations

Department Name: Varies

Location Name: Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Manages physician networks by developing and maintaining relationships to drive business results within a specific geographic area. Provides service and education to network physicians/providers across all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Achieves company targets through implementation of Network Improvement plans.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Completes new provider orientation for all applicable product lines.
- Conducts site visits to service providers, resolve issues, educate staff/providers on policies, collect credentialing information, and review HEDIS information.
- Achieves call reach and frequency goals to establish consistent and strong relationship with provider offices.
- Provides oversight on inquiries and claims issues and follows up with providers to ensure problems have been resolved.
- Supports regional Network Improvement Plan targets by providing utilization reports, pharmacy profiles, ER contingencies, Frequent Flier Reports and other analytics available to improve /maintain regions.
- Identifies network gaps and completes contracts or works with Network Development.
- Understands and explains risk contracts.
- Strategizes for membership growth and retention.
- Provides oversight of delegated functions as applicable.
- Performs special projects as assigned or directed.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0      Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

#### Section IV - Minimum Qualifications

**Education:** Bachelor's degree preferred or equivalent directly related experience

**Experience:**

Minimum one (1) year experience in Medicaid/Medicare is preferred.  
Pharmacy, healthcare, provider or HMO/PPO background preferred.

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Excellent problem solving skills.  
Excellent oral and written communication skills.  
Must be organized and have excellent time management capabilities.  
Ability to analyze data to identify trends, and variance from goals.

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel, PowerPoint, Visio and Outlook.

**Software Proficiency:**  Beginner  Intermediate  Advanced

#### Section V – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

#### Section VI - Additional Requirements (if applicable)

**Travel:** varies

**Overtime:** %

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

Date: 10/13/08

Job Title: Sr. Provider Relations Rep

Reports To (Title): Mgr., Provider Relation

Department Name: Varies

Location Name: Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Manages physician network by developing and maintaining a specific geographic area. Provides service and education to network physicians/providers across all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Achieves company targets through the implementation of network improvement plans.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Completes new provider orientation for all applicable product lines.
- Conducts site visits to service providers, resolve issues, educate staff/providers on policies, collect credentialing information, and review HEDIS information.
- Achieves call reach and frequency goals to establish consistent and strong relationship with provider offices.
- Provides oversight on inquiries and claims issues and follows up with providers to ensure problems have been resolved.
- Supports regional Network Improvement Plan targets by providing utilization reports, pharmacy profiles, ER contingencies, Frequent Flier Reports and other analytics available to improve /maintain regions.
- Identifies network gaps and complete contracts or work with Network Development.
- Understands and explains risk contracts.
- Strategizes for membership growth and retention.
- Provides training, mentoring and guidance to new representatives.
- Special projects as assigned or directed.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0      Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

#### Section IV - Minimum Qualifications

**Education:** Bachelor's degree preferred or equivalent directly related experience

**Experience:** 3+ years Provider Relations experience or similar background. 1+ years' experience in Medicaid/Medicare. Pharmacy, healthcare, provider or HMO/PPO background preferred.

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Excellent influencing and negotiation skills.

Ability to explain complicated financial terms and utilization data to physicians/staff.

Excellent written, verbal and public speaking skills.

Advanced MS Word and Excel. Knowledge of CMS and state regulations.

Excellent written, verbal and public speaking skills.

Ability to understand, interpret and communicate all types of provider and regulatory contracts.

Strong knowledge of CMS and state regulations.

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel, PowerPoint, Visio and Outlook

**Software Proficiency:**  Beginner  Intermediate  Advanced

#### Section V – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

#### Section VI - Additional Requirements (if applicable)

**Travel:** varies

**Overtime:** %

**Other Position Requirements:**



**Human Resources  
Job Description Form**

**Date:** 10/13/08

**Job Title:** Provider Ops Coordinator

**Reports To (Title):** Varies

**Department Name:** Varies

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Supports the Provider Relations Field team to achieve department goals by servicing member across all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Answers incoming telephone inquiries from providers and assist with problem resolution of issues. Coordinates submission of provider to internal departments via contract maintenance forms.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Supports the Provider Relations Field Reps to resolve claims and payment issues.
- Answers incoming telephone inquiries from providers and assist with problem resolution of issues.
- Root cause analysis of operational and health services issues.
- Reviews and processes incoming and outgoing paperwork, including directory updates, provider credentialing applications, contract maintenance forms and other related forms.
- Tracks new contracts through sidewinder.
- Audits configuration loads on new contracts.
- Provides office, project management, provider recruitment and data analysis support.
- Special Projects as assigned or directed

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 5 Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

**Section IV - Minimum Qualifications**

**Education:** High school diploma. An Associate's Degree preferred

**Experience:** 1+ years experience in customer service or claims with exposure to problem resolution

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Excellent problem solving skills

Excellent oral and written communication skills

Must be organized and have excellent time management capabilities.

Ability to analyze data to identify trends, and variance from goals.

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel, PowerPoint, Visio and Outlook. Proficient utilizing fax machines, copy machines, conference phones, audio/visual equipment etc.

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section V – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section VI - Additional Requirements (if applicable)**

**Travel:**

**Overtime:** varies %

**Other Position Requirements:**



**Human Resources  
Job Description Form**

Date: 10/13/08

Job Title: Sr. Provider Ops Coordinator

Reports To (Title): Mgr., Provider Relation

Department Name: Varies

Location Name: Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Supports the Provider Relations Field Representative to achieve department goals. Answer incoming telephone inquiries from providers and assist with problem resolution of issues across all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Perform Excel data analysis. Process incoming mail. Coordinate submission of provider contract records to internal departments.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Supports the Provider Relations Field Representative to achieve department goals and resolve claims and payment issues.
- Answers incoming telephone inquiries from providers and assists with problem resolution of issues.
- Root cause analysis of operational and health services issues.
- Reviews and processes incoming and outgoing paperwork, including directory updates, provider credentialing applications, Contract Maintenance forms and other related forms.
- Tracks new contracts through sidewinder.
- Audits configuration loads on new contracts.
- Provides office, project management, provider recruitment and data analysis support.
- Special projects as assigned or directed.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised:      Direct Reports: varies      Indirect Reports: varies

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

**Section IV - Minimum Qualifications**

**Education:** Associate's degree preferred

**Experience:** 3+ years experience in customer service or claims with exposure to problem resolution

**Special Skills (e.g. 2<sup>nd</sup> language):**

Excellent problem solving skills.

Excellent oral and written communication skills.

Must be organized and have excellent time management capabilities.

Ability to analyze data to identify trends, and variance from goals.

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section V – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section VI - Additional Requirements (if applicable)**

**Travel:** %

**Overtime:** varies %

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

**Date:** 08/07/2007

**Job Title:** Customer Service Representative

**Reports To (Title):** Supv., Customer Service

**Department Name:** Customer Service

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Responds to member and provider inquiries (phone, written or walk in) across all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible regarding all aspects of WellCare business, including claims, in a professional, timely, accurate and caring manner while consistently meeting all guidelines.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Responds to member, provider and other inquiries via telephone, correspondence or lobby walk-in while meeting all corporate guidelines and performance standards.
- Demonstrates appropriate customer-care skills such as empathy, active listening, courtesy, politeness, helpfulness and other skills as identified.
- Records, investigates and resolves member complaints as detailed in the Grievance Procedure narrative.
- Assists in the education of new members and in the re-education of existing members regarding health plan procedures.
- Logs, tracks and appropriately documents all issues utilizing on-line systems and procedures, and in accordance with all applicable guidelines and requirements.
- Makes decisions that are consistent with the concept of a win-win-win for members, associates and WellCare.
- Demonstrates based behaviors such as initiative, accountability and value.
- Performs skills necessary to create a high-quality customer experience, as reflected through acceptable C-Sat scores, quality monitors and member feedback.
- Performs other duties as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0      Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

#### Section IV - Minimum Qualifications

**Education:** High School Diploma or directly related or equivalent work experience.

**Experience:**

6 months to 1 year practical work experience

Previous experience in a call center or customer service environment (preferred)

**Licenses/Certifications:** Customer service, quality or training certifications (preferred)

**Special Skills (e.g. 2<sup>nd</sup> language):**

Strong written and verbal communication skills and an ability to work with people from diverse backgrounds

Ability to multi-task, good organizational and time management skills

Ability to act on feedback provided by showing ownership of his or her own development

Ability to read, analyze, and interpret verbal and written instructions

Ability to write business correspondence

Ability to effectively present information and respond to questions from members

Ability to define problems, collect data, establish facts and draw valid conclusions

Seeks to build trust, respect and credibility with all partners through full, honest, consistent, and coordinated communication

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel, PowerPoint, Visio and Outlook.

**Software Proficiency:**  Beginner  Intermediate  Advanced

#### Section V – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

#### Section VI - Additional Requirements (if applicable)

**Travel:** %

**Overtime:** varies %

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

**Date:** 08/07/2007

**Job Title:** Customer Service Representative, Senior

**Reports To (Title):** Supv., Customer Service

**Department Name:** Operations/Customer Service

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Responds to member and provider inquiries (phone, written or walk in) regarding all aspects of WellCare business, including claims and pharmacy, in a professional, timely, accurate and caring manner while consistently meeting all guidelines to all of the member across all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Serves in a limited leadership capacity as a subject-matter-expert and mentor.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Responds to basic member, provider and other inquiries via telephone, correspondence or lobby walk-in while meeting all corporate guidelines and performance standards.
- Acts as a primary contact for escalated calls and/or escalated issues in which special care is required to enhance WellCare relationships with members and providers.
- Handles calls that require additional research and/or special handling including regulatory, congressional, trust, marketing, sales, executive office, Centers for Medicare and Medicare Services (CMS), etc.
- Investigates problems of an unusual nature in the area of responsibility. Presents proposed solutions in a clear and concise manner.
- Acts as a liaison between internal departments on data gathering and problem solving.
- Drives and supports WellCare initiatives at the team level by interacting with peers and other internal and external business partners while demonstrating a willingness to conform to WellCare policies and procedures.
- Demonstrates appropriate customer-care skills such as empathy, active listening, courtesy, politeness, helpfulness, and other skills as identified.
- Records, investigates and resolves customer complaints as detailed in the Grievance Procedure narrative.
- Assist in the education of new members and in the re-education of existing members regarding health plan procedures.
- Logs, tracks and follow-ups on all inquiries, utilizing on-line systems and procedures, according to the established guidelines.
- Demonstrates expertise within all assigned LOB's. Handles calls for multiple LOB's as assigned.
- Performs skills necessary to create a high-quality customer experience, as reflected through acceptable C-Sat scores, quality monitors and member feedback.
- Acts as a Subject Matter Expert (SME).
- Assists with other projects and duties as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: **0** Indirect Reports: **0**

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

**Section IV - Minimum Qualifications**

**Education:** High School Diploma or directly related or equivalent work experience.

**Experience:** 1-3 years experience within a call center or customer service environment. Experience within a health care company preferred

**Licenses/Certifications:** Customer service, quality, or training certifications (preferred)

**Special Skills (e.g. 2<sup>nd</sup> language):**

- Strong written and verbal communication skills and an ability to work with people from diverse backgrounds
- Ability to multi-task, good organizational and time management skills
- Ability to act on feedback provided by showing ownership of his or her own development
- Ability to read, analyze and interpret verbal and written instructions
- Ability to write business correspondence
- Ability to effectively present information and respond to questions from members
- Ability to define problems, collect data, establish facts and draw valid conclusions
- Seeks to build trust, respect and credibility with all partners through full, honest, consistent, and coordinated communication

**Technical Skills/Requirements:**

- Proficiency with Microsoft Outlook to easily and readily communicate with both internal and external contacts
- Proficiency with Word and/or Excel sufficient to easily and readily manipulate data

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section V – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section VI - Additional Requirements (if applicable)**

**Travel:** %

**Overtime:** varies %

**Other Position Requirements:**



**Human Resources  
Job Description Form**

Date: 11/1/2008

Job Title: Sr. Claims Specialist

Reports To (Title): Supv., Claims

Department Name: Operations - Claims

Location Name: Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Researches and processes institutional and/or professional claims for all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Serves as a mentor to less experienced associates and acts as a resource to resolve claims that are more complex.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Processes claim that pending for various hold reasons to assist in the final determination on claim disposition.
- Processes adjustments related to projects or correspondence.
- Researches post payment claims issues and takes necessary action to resolve issue.
- Completes new hire audits.
- Performs claims testing
- May complete some non-prod work
- Processes Provider Representative request emails
- Assists with special projects as assigned or directed.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised:            Direct Reports: 0            Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

**Section IV - Minimum Qualifications**

**Education:** High School diploma or equivalent

**Experience:**

If external candidate: 3+ years previous claims experience preferred in a healthcare organization.

If internal candidate: minimum 6 months as a Claims Specialist with experience in performing five or more key duties of senior position. Must also meet key performance metrics.

**Licenses/Certifications:** N/A

**Special Skills (e.g. 2<sup>nd</sup> language):**

Demonstrated organizational skills with the ability to prioritize, coordinate multiple tasks, and work independently.  
Display analytical and problem solving skills.  
Interpersonal skills required to work cooperatively and collaboratively with others.

**Technical Skills/Requirements:** Proficient in Microsoft Office such as Word, Excel, PowerPoint, Visio and Outlook.

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section V – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section VI - Additional Requirements (if applicable)**

**Travel:**

**Overtime:** varies

**Other Position Requirements:**



**Human Resources  
Job Description Form**

**Date:** 11/2008

**Job Title:** Claims Specialist

**Reports To (Title):** Supv., Claims

**Department Name:** Operations - Claims

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Researches and processes institutional and/or professional claims for all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Processes claims that pending for various hold reasons to assist in the final determination on claim disposition.
- Processes adjustments related to projects or correspondence.
- Researches post payment claims issues and takes necessary action for resolution
- Researches and processes all of the following work types:
  - Case Logs
  - Analyzers
  - Manuals
  - Hospital Audits
  - Appeals
  - Web Inquiries
- Assists with special projects as assigned or directed.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0      Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

#### Section IV - Minimum Qualifications

**Education:** High School diploma required or directly related or equivalent work experience.

**Experience:** 1 - 2 years previous claims or health insurance experience preferred

**Licenses/Certifications:**

**Special Skills (e.g. 2<sup>nd</sup> language):**

Demonstrated organizational skills with the ability to prioritize, coordinate multiple tasks, and work independently.  
Interpersonal skills required to work cooperatively and collaboratively with others.

**Technical Skills/Requirements:** Familiar with Microsoft Office such as Word, Excel, PowerPoint, Visio and Outlook

**Software Proficiency:**  Beginner  Intermediate  Advanced

#### Section V – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

#### Section VI - Additional Requirements (if applicable)

**Travel:**

**Overtime:** varies

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

Date: 11/1/2008

Job Title: Claims Project Specialist

Reports To (Title): Supv., Claims

Department Name: Operations - Claims

Location Name: Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Provides subject matter expertise to departmental and corporate projects across all product line including, but not limited to Medicaid, Medicare, ABD and Dual Eligible by analyzing and performing root cause analysis on all types of claims issues and adjustments, and serves as primary point of contact for interface between Claims and Configuration Departments.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Acts as Claims Department subject matter expert on departmental and corporate projects. Supports business definition and testing efforts, attends project meetings, maintains project plans and provides internal and external status reports.
- Works with management and associates to document current business and workflow processes and collaborates in identifying, defining and documenting process improvement options and alternatives.
- Researches complex claims issues and works with other departments to resolve. Serves as primary liaison to Configuration department on claims issues.
- Prepares detail and summary level reports including written interpretation of analytic results for senior management.
- Analyzes and trends claims issues, performs true root cause analysis and determines next steps for resolution and process improvement.
- Researches issues, compiles feedback and drafts corresponding business requirements documents and business decision documents as needed.
- Communicates changes in processes, project status and issue resolutions through email, memos, group presentations, and/or one on one meetings.
- Assist manager and director with projects and problem resolution as required.
- Runs and analyzes ad-hoc reports
- Performs special projects as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0

Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

#### Section IV - Minimum Qualifications

**Education:** A Bachelors level education or equivalent directly related experience.

**Experience:** 5+ years of practical work experience within a healthcare organization preferred. 3-4 years experience in claims processing with a solid understanding of internal company claims functions.

**Licenses/Certifications:**

**Special Skills (e.g. 2<sup>nd</sup> language):**

Strong functional knowledge and broad multifunctional knowledge of healthcare delivery.

Demonstrated organizational skills with the ability to prioritize, coordinate multiple tasks, and work independently. Strong analytical and problem solving skills.

Strong oral and written communication skills in order to present projects and issues to upper management who may pose challenging or difficult questions.

Interpersonal skills required to work cooperatively and collaboratively with others.

**Technical Skills/Requirements:**

Intermediate to Advanced knowledge of Microsoft Word, Excel, Project, and Visio.

Knowledge of Microsoft Access preferred. Intermediate to Advanced knowledge of Perot / Paradigm system.

Thorough knowledge of WellCare claims processing environment and procedures.

Knowledge of Legacy and Intelliclaim systems / processes preferred

**Software Proficiency:**  Beginner  Intermediate  Advanced

#### Section V – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

#### Section VI - Additional Requirements (if applicable)

**Travel:**

**Overtime:** varies

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

Date: 9/1/07

Job Title: Business Systems Analyst

Reports To (Title): Manager/Director, IT

Department Name: IT

Location Name: Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Acts as primary point of contact for interface between the business users and IS teams of the overall operations of the health plan product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Formulates and defines systems' scope and objectives through research and fact-finding, combined with a basic understanding of business systems. Conduct analyses of business and user needs, documenting requirements and revising existing logic, as necessary. Employees in this position should be experienced in full Software Development Life-Cycle (SDLC) and understand the business impact of applications and the information technology available to meet those needs.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Reviews programming requests and work with business users and technical staff to identify, gather, analyze, and document business system requirements.
- Articulates and present business analysis results clearly and concisely to programming staff.
- Develops requirements tractability matrix to be used in software development and QA testing.
- Works with business users to document current workflow processes and collaborate with users in identifying, defining, and documenting process improvement options and alternatives, as directed by business needs.
- Works with business users to define and document business rules.
- Identifies required information fields and develop data dictionary.
- Participates in systems development efforts.
- Participates in testing, acceptance testing and implementation of information systems, modules and subsystems.
- Provides user support during application software implementations.
- Participates in training users on application software.
- Participates in Application Group and business unit meetings.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0      Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

#### Section IV - Minimum Qualifications

**Education:** A Bachelor's Degree or equivalent experience

**Experience:** 3-5 years of business analysis experience required, 2-3 years full Software Development Life-Cycle experience, Health care experience preferred.

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Ability to read, analyzes, and interprets general business periodicals, professional journals or technical procedures.  
Ability to write reports, business correspondence and procedure manuals.  
Ability to effectively present information and respond to questions from managers, clients and customers.  
Ability to interpret a complex variety of technical instructions, and deal with several abstract and concrete variables.  
Ability to think logically in solving assigned problems and to present recommendations with clarity in written and graphic form.  
Strong verbal and written communications skills, with an ability to clearly articulate and explain business processes and concepts.  
Strong team-oriented interpersonal and communication skills and ability to work effectively in a cross-functional project team environment.  
Ability to define problems, collect data, establish facts, and draw valid conclusions.

**Technical Skills/Requirements:** Advanced working skills with MS Office including Word, Excel, PowerPoint, Access, Visio and Outlook.

**Software Proficiency:**  Beginner  Intermediate  Advanced

#### Section V – Critical Success Factors

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

#### Section VI - Additional Requirements (if applicable)

**Travel:**

**Overtime:** %

**Other Position Requirements:**



**Human Resources**  
**Job Description Form**

**Date:** 4/1/11

**Job Title:** Field Service Coordinator - RN

**Reports To (Title):** Mgr, Field Service Coordination

**Department Name:** Health Services

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Works with Care Coordination MVP Team members to assess, plan, implement, coordinate, monitor, and evaluate services and outcomes to maximize the health of the member across all product lines including, but not limited to Medicaid, Medicare, ABD, and Dual Eligible. Coordinates, monitors and ensures that appropriate and timely primary, acute and long-term care services are provided to members across the continuum of care. Promotes effective healthcare utilization, monitors health care resources and assumes a leadership role within the Interdisciplinary Care Team (ICT) to achieve optimal clinical and resource outcomes for member. Coordinates the care and services of selected member populations across the continuum of illness. Promotes effective utilization and monitors health care resources. Assumes a leadership role within the interdisciplinary team to achieve optimal clinical and resource outcomes. Works directly with the member in the field, i.e., inpatient bedside, member's home, provider's office, hospitals, etc. while collaborating with management to assess, plan, implement, coordinate, monitor and evaluate services and outcomes to maximize the health of the member.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Evaluates members for case management services and determines appropriate level of care coordination/ management services for member.
- Completes a comprehensive assessment and develops a care plan utilizing clinical expertise to evaluate the members need for alternative services.
- Acts as a primary case manager for members identified as Complex as defined by Case Management Program Description.
- Develops and monitors member's plan of care, to include progress toward meeting established goals and self-management activities.
- Interacts continuously with member, family, physician(s), and other providers utilizing clinical knowledge and expertise to determine medical history and current status. Assess the options for care including use of benefits and community resources to update the care plan.
- Supervises and/or acts as a resource for non-clinical staff (i.e., Service Coordinators and Field Social Workers).
- Act as liaison and member advocate between the member/family, physician and facilities/agencies.
- Maintains accurate records of case management activities in the Enterprise Medical Management Automation (EMMA) System using clinical guidelines.
- Coordinates community resources, with emphasis on medical, behavioral, and social services. Applies case management standards, maintains HIPAA standards and confidentiality of protected health information and reports critical incidents and information regarding quality of care issues.
- Ensures compliance with all state and federal regulations as well as corporate guidelines in day-to-day activities.
- Meets with clients in their homes, work-sites, physician's or hospital to provide management of services.
- Adapts to changes in policies, procedures, new techniques and additional responsibilities.
- Participates with other Case Managers and Medical Directors in regular or special meetings such as Clinical rounds.
- Perform other duties as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0 Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

**Section III - Minimum Qualifications**

**Education:** A Bachelor's Degree in Health Services or BSN or directly related equivalent work experience.

**Experience:** 2-4 years clinical acute care experience. Home health, physician's office or public health experiences a plus. At least 1-3 years current case management experience preferred. Managed care experience preferred. Understands the business and financial aspect of case mgmt in a managed care setting.

**Licenses/Certifications:** Current State RN licensure. Maintain required contact hours to fulfill regulatory requirements. CCM strongly preferred

**Special Skills (e.g. 2<sup>nd</sup> language):**

Bilingual skills a plus

Assists in evaluating process improvements

Ability to work independently, handle multiple assignments and prioritize workload

Demonstrates high level time management and priority setting

Communicates effectively in person and by phone

Ability to work independently in various environments

Advanced ability as a licensed professional to communicate on any level required to meet the demands of the position

Ability to create, review and interpret treatment plans

Understands the business and financial aspect of case mgmt in a managed care setting

**Technical Skills/Requirements:** Proficient in Microsoft Office including Excel, Word, PowerPoint, Access and Outlook Express. Knowledge of or the ability to learn company approved software such as CRMS, Paradigm, InterQual, Sidewinder and other software in order to perform job duties.

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section IV – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section V - Additional Requirements (if applicable)**

**Travel:** 50-70%

**Other Position Requirements:** Travel to inpatient bedside, member's home, provider's office, hospitals, etc required with dependable car. May spend up to 70% of time traveling with exposure to inclement weather and normal road hazards.





**Human Resources**  
**Job Description Form**

**Date:** 4/01/11

**Job Title:** Field Social Service Coordinator - SW

**Reports To (Title):** Mgr, Field Service Coordination

**Department Name:** Health Services

**Location Name:** Varies

**Section I - Job Summary**

Please describe in 2-3 sentences a brief job summary:

Coordinates the socio economic needs and service of selected member populations across the continuum of illness. Interviews, coordinates and plans activities to meet the psychosocial needs of members and their families across all product lines including, but not limited to Medicaid, Medicare, ABD and Dual Eligible. Provides support and/or intervention and assists members in understanding the implications and complexities of their current medical situation and/or overall personal care. Collaborates with the interdisciplinary team to achieve optimal resource outcomes. Works with management to assess, plan, implement, coordinate, monitor, and evaluate services and outcomes to maximize the health of the member. Conducts telephonic, mail and in-person outreach to members who are identified as requiring outreach services in support of clinical quality initiatives and regulatory/contractual requirements. Provides assistance to member to promote self management of healthcare.

**Section II - Key Duties and Responsibilities**

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Outreaches to members telephonically and/or in-person and coordinates members case management services. Prioritizes cases based on clinical intensity and acuity.
- Assists in the development and supports the member's care plan utilizing social service expertise to evaluate the members need for alternative services and third party support.
- Interacts continuously with members, family, physician(s), and other resources to determine appropriate behavioral action needed to address/support medical needs.
- Reviews benefits options, researches community resources, coordinates services, trains/creates behavioral routines and enables members to be active participants in their own healthcare. This includes providing the member information on community education classes and other resources related to healthcare.
- Acts as a liaison and member advocate between the member/family, physician and facilities/agencies.
- Maintains accurate records of case management activities in the Enterprise Medical Management Application (EMMA) and other proprietary IT applications using clinical guidelines.
- Coordinates community resources with member to promote self management and navigation of health systems. Provides information regarding benefits, regulations, laws and public entitlement programs as requested.
- Maintains HIPAA standards and ensures confidentiality of protected health information. Reports critical incidents and information regarding quality of care issues.
- Ensures compliance with all state and federal regulations and guidelines in day-to-day activities.
- Conducts telephonic, mail, and in person outreach to members, providers and community organizations to support Utilization Management, Case Management and/or Quality Improvement, regulatory & contractual metrics and requirements.
- Performs other duties as assigned.

**Section III - Scope**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0 Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

**Section III - Minimum Qualifications**

**Education:** A Bachelor's Degree in Social Work (BSW).

**Experience:** 2-4 years relevant social work experience. Experience in a managed care environment preferred.

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Ability to work independently, handle multiple assignments and prioritize workload  
 Communicates effectively in person and by phone  
 Advanced ability to communicate on any level required to meet the demands of the position.  
 Ability to create, review and interpret treatment plans

**Technical Skills/Requirements:**

Proficient in Microsoft Office including Outlook, Word and Excel.  
 Knowledge of or the ability to learn company approved software such as CRMS, Peradigm, InterQual, Sidewinder and other software in order to perform job duties.

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section IV – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section V - Additional Requirements (if applicable)**

**Travel:** 50-70%

**Overtime:** %

**Other Position Requirements:** Travel to inpatient bedside, member's home, provider's office, hospitals, etc required with dependable car. May spend up to 70% of time traveling with exposure to inclement weather and normal road hazards.



## Human Resources Job Description Form

**Date:** 4-28-2011

**Job Title:** Field Outreach Coordinator

**Reports To (Title):** Manager, Field Service  
Coordination

**Department Name:** Health Services

**Location Name:** Varies

### Section I - Job Summary

**Please describe in 2-3 sentences a brief job summary:**

Under the supervision of a clinician, assists in the clinical and socio-economic coordination and implementation of member's care to ensure that appropriate and timely primary, acute and long-term care services are provided to members with lower level acuity needs. Also, assists the interdisciplinary team by monitoring level 1 acuity care plans for compliance, and provides updates and status reports to assigned clinical Service Coordinator. Monitors and follows up on members seen in the Emergency Department and discharged on the same day. Conducts telephonic, mail and in-person outreach to members who are identified as requiring outreach services in support of clinical quality initiatives and regulatory/contractual requirements. Provides assistance to member to promote self management of healthcare.

### Section II - Key Duties and Responsibilities

List 4-6 key accountabilities (Be specific. Include level of independent judgment/discretion required)

- Manages a caseload and prioritizes case coordination services based on members' acuity.
- Provides telephone and/or in-person member outreach and follow-up to ensure members have seen their PCP and are completing their treatment plan or preventive care services as defined by the PCP.
- Monitors and follows up on members seen in the Emergency Department and discharged on the same day to ensure member has established an appointment with primary provider.
- Interacts continuously with members, family, physician(s), and other resources to determine appropriate behavioral action needed to address/support medical needs. Reviews benefits options, researches community resources, coordinates services, trains/creates behavioral routines and enables members to be active participants in their own healthcare.
- Acts as a liaison and member advocate between the member/family, physician and facilities/agencies.
- Maintains accurate records of case management activities in the Enterprise Medical Management Application (EMMA) and other proprietary IT applications using clinical guidelines.
- Coordinates community resources with emphasis on the development of natural support system. Coordinates benefits, regulations, laws and public entitlement programs.
- Maintains HIPAA standards and ensures confidentiality of protected health information. Reports critical incidents and information regarding quality of care issues.
- Ensures compliance with all state and federal regulations and guidelines in day-to-day activities.
- Conducts telephonic, mail, and in person outreach to members, providers and community organizations to support Utilization Management, Case Management and/or Quality Improvement, regulatory and contractual

metrics and requirements.

- Performs other duties as assigned.

### Section III - Scope

**Sales Revenue Responsibility:** \$N/A

**Total Membership Oversight:** N/A

**Peer Positions within the Company:**

**Level of Supervision Received (choose one):**

- Under immediate supervision, performs assigned tasks only as instructed, subject to regular check of performance.
- Under general supervision, proceeds alone on regular duties, referring questionable cases to supervisor.
- Plans and arranges own work, refers only unusual cases to supervisors or others.
- Functions independently within broad scope of established departmental policies/practices; generally refers specific problems to supervisor only where clarification of departmental operating policies/procedures may be required.
- Uses policies and general objectives with little functional guidance. Rarely refers specific cases to manager unless clarification or interpretation of organization policies is involved.
- Establishes personal standards of performance within broad framework of policy and objectives as set by Sr. Mgmt.

**Level of Supervision Exercised:**

Total # Supervised: Direct Reports: 0

Indirect Reports: 0

**Level Supervised:**

- Sr. Management / Directors
- Managers/Supervisors
- Exempt level associates / Team Leaders
- Nonexempt level associates

### Section IV - Minimum Qualifications

**Education:** A High School diploma or GED equivalent required.

**Experience:** 2+ years of medical office or other relevant health care experience. Experience in working with special populations, such as HIV/AIDS, developmental disabilities, medically fragile children, geriatrics, persons with neurotrauma, and younger adults with physical disabilities preferred. Managed care experience preferred.

**Licenses/Certifications:** None

**Special Skills (e.g. 2<sup>nd</sup> language):**

Ability to work independently, handles multiple assignments and prioritizes workload.

Communicates effectively in person and by phone.

Ability to review and interpret care plans.

Bi-lingual in English and Spanish preferred:

**Technical Skills/Requirements:** Proficient in Microsoft Office including Excel, Word and Outlook. Knowledge of data entry, documentation and report generation in any clinical system a plus. Knowledge of or the ability to learn company approved software such as CRMS, Paradigm, InterQual, Sidewinder and other software in order to perform job duties.

**Software Proficiency:**  Beginner  Intermediate  Advanced

**Section V – Critical Success Factors**

- Verbal Communication** – Able to clearly present information orally and/or influence others through oral presentation in positive or negative circumstances.
- Written Communication** – Able to write effectively and to extract information from written materials.
- Team Work** – Able to work with people in such a manner as to build up high morale and obtain group commitments to goals and objectives.
- Organization and Planning** – Able to organize or schedule people or tasks; to develop action plans leading to specific goals; and to plan effectively.
- Leadership** – Able to influence the actions and opinions of others in a desired direction; to exhibit judgment in leading others to profitable and rewarding objectives.
- Decision Making and Problem Solving** – Able to take action in solving problems while exhibiting judgment and a systematic approach to decision making; to identify the important dimensions of a problem, determine potential causes, obtain relevant information, and specify alternate solutions.

**Section VI - Additional Requirements (if applicable)**

**Travel:** 70%

**Overtime:** %

**Other Position Requirements:** Travel to inpatient bedside, member's home, provider's office, hospitals, etc required with dependable car. May spend up to 70% of time traveling with exposure to inclement weather and normal road hazards.

**TO BE COMPLETED BY HUMAN RESOURCES**

**Job Code:**

**FLSA:**

The intent of this job description is to describe the major duties and responsibilities performed by incumbents of this job. Incumbents may be required to perform additional job-related tasks other than those specifically presented in this description.

All duties and responsibilities identified in this job description are essential job functions and requirements which are subject to possible modification, consistent with applicable state and federal law, in order to reasonably accommodate individuals who are disabled.