JBM Recruitment

Director of Value Based Payer Contracting

CLIENT OVERVIEW

This Chicagoland based client is a clinically integrated network of physicians and hospitals working together to improve health through high quality, efficient health services covering the spectrum of patient care from wellness, prevention and health promotion, to disease management and complex care management. Our network includes four hospitals and over 1900 professional providers.

POSITION SUMMARY

The Director Value Based Payer Contracting has responsibility for negotiating and managing value based care (VBC) contracts on behalf of Participating Physician practices and Participating Hospitals (Members) with third party payers, including but not limited to Commercial payers, Medicare Advantage payers and Medicaid managed care payers. This position shall also coordinate and manage any VBC contract terms with governmental payers including CMS. Responsibility includes management of all VBC arrangements including the internal Clinical Integration Program (CIP) with third party payers, Pay-for-Performance agreements and risk based agreements including ACO, shared savings/shared risk, capitation, global bundled pricing and % of premium contracts. In coordination with the Director FFS Payer Contracting, this position is responsible for managing and facilitating the relationships with third party payers including Joint Operating Committees (JOCs). This position shall also assist in Member education and internal program management of VBC agreements. This position is pivotal to capturing and retaining business for our Members and growing and maximizing financial performance. The person in this postion must xemplify the organization mission, vision and values and acts in accordance with policies and procedures.

ESSENTIAL DUTIES

1. Negotiate and manage all value based care (VBC) contracts with third party payers in consultation with internal business and support departments (Clinical, Analytics, HIT, Payer Relations, Legal, Finance).
2. Supervise and manage Payer Contracting Managers in conjunction with the Director FFS Payer Contracting.
3. Working jointly with the Director FFS Payer Contracting, maintain and manage high level third party payer relationships and coordination of all payer specific contract negotiations.
4. Under the direction of the VP Payer Contracting, evaluate and initiate new VBC contract opportunities, business models and payers relationships.

5. Negotiate VBC financial risk terms working in conjunction with Analytics and actuary, when needed, to develop financial risk models to analyze payer VBC proposals including ACO, shared savings/shared risk, capitation, global bundled pricing and % of premium contracts. Assess risk exposure, potential upside and downside opportunities and coordinate feedback from Member CFOs and finance staff.
6. Coordinate feedback and approval of VBC contracts including VBC financial risks and rewards from Rush Health governing bodies.
7. Negotiate VBC contract language and performance terms in consultation with Rush Health business and support departments (Clinical, Analytics, HIT, Payer Relations, Legal, Finance). This includes legal, compliance, quality measures, reporting and data exchange requirements. Coordination through VBC Workgroup.
8. Facilitate internal VBC Workgroup that shall monitor, analyze and manage VBC contract performance, requirements and reconciliation. Coordinate work product in coordination with Rush Health business and support departments (Clinical, Analytics, HIT, Payer Relations, Legal, Finance). Initiate renegotiates as warranted.
9. Monitor, track and communicate VBC market trends including local and national commercial and governmental payer VBC innovations and initiatives and assist in development of annual VBC strategic plan under the direction of the VP, Payer Contracting and Rush Health senior leadership.
10. Coordinate and manage VBC program initiatives and contract terms with governmental payers including CMS and programs such as MSSP, BPCI.
11. In collaboration with the Rush Health CMO, negotiate and manage the CIP/P4P quality and efficiency terms in third party payer contracts both Rush Health CIP programs and Payer specific programs. Coordinate the annual payer incentive reconciliation process.
12. Lead implementation and coordination of new VBC contracts including governance, communication, education, business operations, HIT, care delivery, analytics and reporting in collaboration with Rush Health business and support departments.
13. Establish, facilitate and participate in Payer VBC joint operating committee (JOC) meetings.
14. Work closely with Rush Health business and support departments (Clinical, Analytics, HIT, Payer Relations, Legal, Finance) to

develop, communicate and disseminate orientation and educational materials to inform and educate Members regarding VBC contract and performance terms, reporting tools and resources and market trends.

15. Develop and maintain VBC contract summaries including performance targets and measures matrix, timelines, contract requirements and deadlines.
16. Serve as the liaison for Rush Health business and support departments to initiate and manage VBC communications including questions and operational requirements with third party payers.
17. In coordination with Payer Relations and the Payer Contracting Managers, monitor and manage VBC payer compliance issues including rosters, assignment, reports, delivery dates, fees, audits.
18. Monitor and analyze changes in payer VBC programs and policies that may affect contract performance and initiate negotiations as warranted.
19. Working with Payer Contracting Managers, coordinate any credentialing or request for information (RFI's) requirements for new VBC initiatives.
20. Participate in and report to various governing bodies including the Rush Health Finance and Contract committees; provide support for these meetings and assist with VBC contract material preparation and presentation.
21. Staff Committees as assigned
22. Other duties and responsibilities as assigned

REQUIREMENTS

- Master's degree in Health Care Administration or Business required.
- At least ten (10) years' experience in a managed care environment with direct payer contracting experience in a multi-facility health system, large academic medical center or insurer environment.
- Direct experience negotiating and managing value based care risk contracts.
- Strong financial knowledge base related to all managed care reimbursement methodologies including the various fee-for-service structures and risk based structures such as capitation, shared savings and global payments.
- Management experience required

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QUALIFICATIONS

- Strong knowledge base of population health management activities and value based care delivery models.
- Experience with governmental programs related to Medicare, Medicaid and Medicare Advantage highly desirable.
- Ability to think strategically.
- Strong written and verbal communication skills.
- Strong analytical and financial skills.
- Strong attention to detail and well organized.
- Adapts well to rapid change and multiple, demanding priorities.
- Focuses on team success and promotes collaboration efforts with others.
- Excellent time and project management skills.
- Ability to network internally and externally to build relationships, facilitate discussion and resolution.
- Microsoft Office Suite advanced proficiency, particularly MS Excel and PowerPoint.