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Medicaid Jobs Hunter

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Johnston County Income Maintenance Caseworker III- Long Term Care Medicaid Job in NC

SourceURL: https://www.glassdoor.com/job-listing/income-maintenance-caseworker-iii-long-term-care-medicaid-johnston-county-JV_IC1138963_KO0,57_KE58,73.htm?jl=3277694415

Income Maintenance Caseworker III- Long Term Care Medicaid

The Johnston County Department of Social Services has an immediate opening for Income Maintenance Caseworker III Long Term Care worker in the Adult Medicaid Unit.

Preference will be given to individuals who have experience in determining eligibility for Long Term Care Medicaid.

Johnston County DSS in-house applicants must apply online to be considered.

Duties and Responsibilities

The primary purpose of this Income Maintenance Caseworker's position is to interview and determine, re-determine applicant's and recipient's eligibility for Medicaid in Long Term Care (LTC). This position takes and processes applications for LTC and SA and backup PLA Medicaid. This position also completes re-certifications for LTC and SA ongoing recipients and completes program changes as they are received all while utilizing the NC FAST system to manage the applications and caseload. This position is in the Adult Medicaid Unit which is one of seven units in the Income Maintenance Section. Filing and mail preparation for the caseload assigned is part of the responsibility for this position.

Knowledge, Skills and Abilities

Must have general knowledge of all Income Maintenance programs. Considerable knowledge of all agency and community programs and services which could affect the client/applicant. Good mathematical reasoning and computational skills. Ability to read, analyze, and interpret a variety of regulations, policies and procedures of varying complexity. Ability to work independently and prioritize work. Ability to instruct and evaluate the work of lower level employees. Ability to train employees in new and existing rules, regulations, policies and procedures. Ability to perform caseworker functions under and within structured time frames. Willingness to attend meetings as necessary. Some meetings will require overnight travel.

Desired Education and Experience

Two years of experience as an Income Maintenance Caseworker; or an equivalent combination of training and experience.

Preference will be given to individuals who have experience in determining eligibility for Long Term Care Medicaid.

Group Health Insurance

Johnston County provides full time and part time permanent employees working 20 plus hours per week with Health Insurance coverage with Aetna. Premiums will be pro-rated based on the number of hours worked. Aetna offers a Core Plan and Plus Plan with in-network and out-of-network benefits. The monthly premiums are as follows:

Core Plan

- Full time employee coverage for the Core Plan is paid at 100% by the County.
- Employee plus 1 child, $215
- Employee plus 2+ children, $425

- Employee plus spouse, $510
- Employee plus family coverage, $570

Plus Plan

Employees can elect to upgrade to the Plus Plan which also offers in-network and out-of-network benefits with lower deductibles and co-payments than the Core Plan.

- Employee coverage for the Plus Plan is $70 per month.
- Employee plus one child, $305
- Employee plus 2+ children, $540
- Employee plus spouse, $640
- Employee plus family coverage, $740

Health insurance becomes effective for employees the first day of the month following the 30th day of employment.

Group Dental Insurance

Johnston County provides full time and part time permanent employees working 20 plus hours per week the option to purchase Dental Insurance from MetLife. Two options are available to employees.

The first option, called the Low Plan, allows you to have dental services performed by a dentist of your choosing. Services performed under this plan are paid in accordance with usual, customary and reasonable rates at lower percentages than on the High Plan. The monthly premiums for this plan are as follows:

- Employee only $31.25
- Employee plus spouse $55.85
- Employee plus 1 child $55.85
- Employee plus 2+ children $75.01
- Family $87.12

The second option, or High Plan, also allows that your dental services be performed by a dentist of your choosing. Services performed under this plan are paid in accordance with usual, customary and reasonable rates at higher percentages than on the Low Plan. The monthly premiums are as follows:

- Employee only $45.53
- Employee plus 1 child $88.53
- Employee plus spouse $88.53
- Employee plus 2+ children $126.41
- Family $155.95

Dental Insurance becomes effective for employees the first day of the month following the 30th day of employment.

Group Life Insurance

Johnston County provides term Life Insurance through Reliance Standard Life for full time and part time permanent employees working 20 or more hours per week. Life insurance is paid for you by Johnston County and pays your beneficiary one time your annual salary not to exceed $200,000 in the event of your death. Accidental death and dismemberment coverage is also provided. You can purchase optional dependent coverage at a rate of $0.70 cents per month for coverage on an unlimited eligible number of dependents. Optional dependent coverage provides $2,500 to you in the event of the death of a spouse or child 6 months to age 19 or age 25 if a full time student. Life Insurance becomes effective the first day of the month following 30 days of employment. Voluntary supplemental term life insurance coverage for you, your spouse or your

dependent children is also available through Reliance Standard Life - please see the Human Resources Department for more details.

Short Term Disability Insurance

Johnston County provides active full time permanent employees working 30 plus hours per week the option to purchase Short Term Disability Insurance through UNUM. Short Term Disability Insurance covers 60% of employee's weekly salary with a maximum of $600 per week in the event of a non-work related injury or illness for up to 52 weeks. Benefit begins after 30 days. If elected during initial enrollment, pre-existing conditions are waived. If you choose to enroll at a time other than initial enrollment, then you must complete an Evidence of Insurability in which pre-existing conditions are no longer excluded. Short Term Disability is available at a monthly cost of $0.79 per $10.00 of weekly benefit.

125 Flexible Benefit Plan

Pre-tax deductions for Medical, Dental and Dependent Care costs. Employees are eligible to participate in Dependent Day Care and Health/Dental Reimbursement accounts effective the first day of the month following the 30th day of employment.

401(k) and 457(b)

Johnston County provides full time and part time permanent employees working 20 plus hours per week with a 401(k) Supplemental Retirement Income Plan through Prudential Retirement Services. The county will match up to 5% of the employee's annual salary to the 401(k), following a one-year waiting period for non-sworn employees hired on July 1, 2007 or later. Vesting is immediate. Employees can make monthly voluntary pre-tax and/or after-tax contributions to the 401(k) immediately upon hire with no waiting period.

In addition, Johnston County provides full time and part time permanent employees working 20 plus hours per week with a voluntary 457(b) Deferred Compensation Plan through Prudential Retirement Services. With this plan, you can defer part of your income for retirement by contributing pre-tax and/or after-tax dollars.

The maximum annual contribution for both plans is $18,500 ($24,500 with age 50 or older) for calendar year 2017. Both plans offer a choice of investment options ranging from conservative to aggressive, loan provisions and unmatched personal service.

NC Local Governmental Employee's Retirement System

As a local government employee, you are required to participate in the North Carolina State Government Retirement System which acts much like a 401(k). You will be automatically enrolled at date of hire and will contribute a mandatory pre-tax 6% of your monthly income into the plan. The employer shares in the cost of retirement benefits. The benefits received at retirement are based on your salary, age and years of service. You are vested after 5 years of creditable service.

The Retirement System also includes a Life Insurance Plan or Death Benefit which is paid by the county. Your named beneficiary receives a single lump sum payment equal to highest 12 months salary in a row during 24 months prior to death and can be no less than $25,000 but no more than $50,000. Your named beneficiary is only eligible for the Death Benefit if you completed one year of employment and were a contributing member to the system for one year.

Holidays

The policy of the county is to follow the holiday schedule as published by the State of North Carolina each year. The following holidays are observed: New Year's Day, Martin Luther King, Jr. Day, Good Friday, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving Day and the day after and three (3) days at Christmas.

Vacation

Each full and part-time permanent employee of the County shall earn vacation at the following schedule, prorated by the regular number of hours in the workweek:
Year of Service:

Days Accrued Per Year:
0 - 4

12
5 - 9

15
10- 14

18
15 plus

20
Service with other governmental units under the NC Retirement Systems may be applied only if the service is continuous from the immediately preceding unit of government. Employees shall be allowed to take accumulated vacation leave after six (6) months of service. Vacation leave may be accumulated without any applicable maximum until December 31 of each year. Effective the last payroll in the calendar year, any employee with more than 30 days of accumulated leave shall have the excess accumulation transferred to sick leave so that only 30 days are carried forward to January 1 of the next calendar year.

Sick Leave

Sick leave shall accrue at a rate of one day per month of service or twelve days per year. Sick leave for full and part-time permanent employees working other than the basic work schedule shall be prorated by the regular number of hours in the workweek. Sick leave will be cumulative for an indefinite period of time and may be converted upon retirement for service credit. New employees with continuous employment from another unit of government under the NC Retirement System may transfer sick leave after successfully completing their probationary period.

Tuition Assistance Program

Full-time permanent employees who have completed initial probation may apply for tuition reimbursement for courses taken on their own time, which will improve their skills for their current job or prepare them for promotional opportunities within the County service. Tuition, registration, and fees are eligible expenses. Employees may be reimbursed up to $500 per fiscal year upon satisfactory course completion. Requests must be approved and are subject to availability of funds.

Miscellaneous

Mileage reimbursement, membership in the State Employee's Credit Union, and various sick & accident insurance policies through Colonial and American Family Life are also available.
01
Do you have experience working in NC FAST?

- Yes
- No

02

Do you have experience as a Long Term Care caseworker in a DSS?

- Yes
- No

03
Do you have experience as an Adult Medicaid caseworker in a DSS?

- Yes
- No

* Required Question

Iowa Department of Administrative Services hiring Medicaid Program Manager in Des Moines, IA, US

SourceURL: https://www.linkedin.com/jobs/view/medicaid-program-manager-at-iowa-department-of-administrative-services-1351246448

Medicaid Program Manager

Salary
$55,182.40 - $85,633.59 Annually
Location
Des Moines - 50309 - Polk County, IA
Job Type
Full-time
Agency
401 Dept of Human Services - Central Office
Job Number
19-02870
Closing
7/4/2019 11:59 PM Central
LinkedIn Tag
Point of Contact
Alisa Horn - ahorn@dhs.state.ia.us

- Description
- Benefits
- Questions

Job Description

Only applicants who meet the Minimum Qualification Requirements and meet all selective requirements (listed below) will be placed on the eligible list.
The Department of Human Services - Central Office is looking to fill a Management Analyst 3 position to assist the state as a Medicaid Program Manager.
The Iowa Medicaid Enterprise (IME) establishes the state Medical and Long Term Care Services and Supports programs and policies defining covered services, qualifications for eligible

providers and establishing reimbursement standards. The IME Policy Analyst (MA3) positions continuously conduct analysis of complex managed care and fee for service plans to ensure adherence to contractual provisions and to evaluate performance outcomes. These positions analyze, develop and update IME policies and procedures based on contractual changes based driven by state or federal requirements. These positions monitor the implementation of policy to ensure providers meet established contractual scope of services such as payment processing, satisfaction of delineated deliverables for Managed Care and Fee for Service (FFS).
Data Analysts exercise considerable independent judgement to adapt and manage payment reimbursement guidelines for general and specific situations. The role requires continual analysis of data to assess contractual compliance for MCO, and to formulate solutions for DHS leadership to discern, discuss and approve. This role would effectively communicate procedural or contractual changes to both internal and external parties, and establish the tools to monitor and evaluate compliance. An important aspect of the role is to actively engage the IME Medicaid Management Information Systems (MMIS) group to design, test, and implement systems to obtain requisite data or for the design of systematic changes to meet programmatic needs.
These positions collaborate with the Centers for Medicare and Medicaid Services (CMS), Legislators, constituency groups, health care providers, Medicaid members and the Attorney General's office in order to prepare and present programmatic policy to internal and external audiences inclusive of the Council on Human Services, providers, consumer advocates, legislative committees, and state and national work groups. The Analysts draft language for changes to the Code of Iowa, promulgate changes to the Iowa Administrative Code, participate in the preparation and submission of state plan amendments (SPA) for CMS, authoring provider manuals and informational communications.
Successful candidates will have critical thinking/analysis skills and the ability to strategically apply quality improvement techniques within policy development inclusive of IT system structure supports. Preference will be given to those candidates with experience in the application of medical coding procedures and reimbursement.
Applicants may attach a resume/cover letter to the online application.
Selectives
292 Hospital/Health Care Statistics and Reimbursement
6 months' experience, 12 semester hours, or a combination of both in health care industry technology and standards with emphasis on health care insurance, payment systems, and health care data processing requirements.

Minimum Qualification Requirements

Applicants must meet at least one of the following minimum requirements to qualify for positions in this job classification:

- Graduation from an accredited four-year college or university with a degree in business or public administration, management information systems, industrial management, or statistics, and experience equal to three years of full-time work in management analysis or project management.
- Seven years of full-time work experience in management analysis or project management.
- A combination of a total of seven years of education and full-time experience (as described in number one), where thirty semester hours of accredited college or university course work equals one year of full-time experience.
- Current, continuous experience in the state executive branch that includes two years of full-time work as a Management Analyst 2 or two and a half years as a Management Analyst 1.

For additional information, please click on thislink to view the job description.
Join Us!
Whether it's caring for those in need, making highways safer, or improving agriculture production, the work that we do matters to the people of Iowa.
We take our responsibilities and the public trust very seriously. We are committed to delivering the services that matter most to the people of Iowa. If you have the skills, the commitment and

the desire to make a difference, then we invite you to explore the career opportunities available with the State of Iowa.
CareerChoices
State government is one of the largest employers in Iowa, and also one of the most diverse. From state trooper to nurse to engineer, the state offers a wide variety of career opportunities.

Benefits

The state offers paid vacation, sick time and holidays, a defined benefit retirement plan, health, dental, vision, and long-term disability insurance along with flexible spending accounts. For more information, please visit the executive branch employee benefits website.
The State of Iowa is committed to providing an outstanding employment experience. Check out thisBenefits Beyond the Paycheck brochure.
01
Do you understand that the answers to all of the following questions must be truthful, honest, and accurate to the best of your ability?
Please read all questions and answers thoroughly and make sure you understand them completely. Ensure the answers to your questions match the information filled out on your application and the attachments you have uploaded. If the answers to your questions are inconsistent with your application information or uploaded attachments, you will be given zero points for the question.
Knowingly misrepresenting the facts when submitting any information related to an application, examination, certification, appeal, or any other facet of the selection process will result in your disqualification from this application and future employment with the state of Iowa.

- Yes - I understand and agree.
- No

02
Have you graduated from an accredited college or university with a Bachelor's degree in business or public administration, management information systems, industrial management, or statistics? IF YES - How many years do you have of full-time work in management analysis or project management?

- No experience in the identified areas
- Less than one year of experience in the identified areas
- One year to less than two years of experience in the identified areas
- Two years to less than three years of experience in the identified areas
- Three or more years of experience in the identified areas
- Not applicable

03
How many years of full-time work experience do you have in management analysis or project management?

- No experience in the identified areas
- Less than two year of experience in the identified areas
- Two years to less than three years of experience in the identified areas
- Three years to less than four years of experience in the identified areas
- Four years to less than five years of experience in the identified areas
- Five years to less than six years of experience in the identified areas
- Six years to less than seven years of experience in the identified areas
- Seven or more years of experience in the identified areas
- Not applicable

04
How many years do you have of COMBINED post high school education in business or public administration, management information systems, industrial management, or statistics AND full-

time work in management analysis or project management. 30 semester hours of the specified education may be substituted for each year of the required experience.

- Less than two years of the combined specified education and experience
- Two years to less than three years of the combined specified education and experience
- Three years to less than four years of the combined specified education and experience
- Four years to less than five years of the combined specified education and experience
- Five years to less than six years of the combined specified education and experience
- Six years to less than seven years of the combined specified education and experience
- Seven or more years of the combined specified education and experience
- Not applicable

05
If you are a CURRENT employee for the State of Iowa (executive branch) how many years of full-time experience as a Management Analyst 2 do you have?

- No Experience as a Management Analyst 2
- Less than one year of experience as a Management Analyst 2
- One year to less than two years of work experience as a Management Analyst 2
- Two or more years of work experience as a Management Analyst 2
- Not applicable – I am not a State Employee

06
If you are a CURRENT employee for the State of Iowa (executive branch) how many years of full-time experience as a Management Analyst 1 do you have?

- No Experience as a Management Analyst 1
- Less than 12 months of experience as a Management Analyst 1
- 12 months to less than 18 months of work experience as a Management Analyst 1
- 18 months to less than 24months of work experience as a Management Analyst 1
- 24 months to less than 30 months of work experience as a Management Analyst 1
- 30 months or more of work experience as a Management Analyst 1
- Not applicable – I am not a State Employee

07
Does your application demonstrate that you have 6 months' experience, 12 semester hours, or a combination of both in health care industry technology and standards with emphasis on health care insurance, payment systems, and health care data processing requirements?

- Yes - My current application and/or attached documentation clearly addresses this requirement
- No - I do not currently meet this requirement

Required Question
Agency
State of Iowa
Website
owa.gov/
Apply

Humana hiring Behavioral Health Medical Director - Louisiana Medicaid in Metairie, LA, US

SourceURL: https://www.linkedin.com/jobs/view/behavioral-health-medical-director-louisiana-medicaid-at-humana-1160728895

Description

The Medical Director relies on medical background and reviews health claims. The Medical Director work assignments involve moderately complex to complex issues where the analysis of situations or data requires an in-depth evaluation of variable factors.

Responsibilities

Humana's Louisiana Medicaid BH Medical Director will oversee our behavioral health (BH) clinical program for Louisiana Medicaid plan members. They will collaborate closely with the Chief Medical Officer (CMO) to integrate the day-to-day administration and strategic management of behavioral and physical health services, including utilization management (UM), quality improvement, and value-based payment programs. The BH Medical Director will be based in Louisiana and will also lead the development of new products and services in Humana's Medicaid BH delivery model.

Essential Functions And Responsibilities

- Lead major clinical and quality management components of Humana's BH services
- Provide clinical case management consultations and clinical guidance for contracted primary care physicians (PCPs) treating BH-related concerns not requiring referral to BH specialists
- Develop comprehensive care programs for the management of youth and adult BH concerns typically treated by PCPs (such as ADHD and depression)
- Oversee, monitor and assist with effective implementation of the Quality Management (QM) program; accountable for overall continuous improvement of BH services and programs
- Oversee, monitor, and assist with the management of psychopharmacology pharmacy benefits manager (PBM) activities, including the establishment of prior authorization, clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrollees under age 18
- Work closely with the UM of services and associated appeals related to children and youth and adults with mental illness and/or substance use disorders (SUD)
- Develop targeted education and training for Humana PCPs to screen for mental health and SUD using evidence-based tools (e.g. AUDIT-C, PHQ-9, and GAD-7), perform diagnostic assessments, provide counseling and prescribe pharmacotherapy when indicated, and build collaborative care models in their practices
- Lead BH policy development in Louisiana, driving implementation, oversight, and accountability for both Humana internal and external stakeholders
- Adhere to and comply with federal and state laws and programmatic requirements
- Collaborate with provider relations personnel to ensure high-quality and appropriate care delivered through the BH provider network
- Establish and maintain relationships with providers, advocates, and other key Louisiana stakeholders by maintaining open and ongoing communications; represent Humana at public forums and engagement opportunities
- Maintain compliance with BH-related contract requirements and attend oversight committee meetings to ensure appropriate procedures are adhered to within Humana and within care delivery
- Collaborate closely with corporate and local population health teams in developing programs and strategies to address BH needs at a population health level
- Share responsibility for the management of the BH services delivery system with the BH Coordinator and Addictionologist/Addiction Services Manager
- Serve as co-chairperson of Humana's Louisiana Quality Improvement Committee

Required Education, Certification, & Experience Qualifications

- Physician with a current, unencumbered Louisiana-license as a physician
- Board-certified in psychiatry
- At least three (3) years of training in a medical specialty
- Knowledge of the managed care industry
- Possess analysis and interpretation skills with prior experience leading teams focusing on quality management, UM, discharge planning and/or home health or rehab

Preferred Experience Qualifications

- Five (5) years or more clinical experience working in BH
- Familiarity with Louisiana-based BH organizations
- Medicaid Managed Care clinical or behavioral health leadership experience

Scheduled Weekly Hours
40

State of Ohio Jobs hiring Medicaid Health Systems Administrator 2 in Columbus, OH, US

SourceURL: https://www.linkedin.com/jobs/view/medicaid-health-systems-administrator-2-at-state-of-ohio-jobs-1349368736

- Primary Location**: United States of America-OHIO-Franklin County
- Work Locations**: Lazarus 4 50 West Town Street Columbus 43215
- Organization**: Ohio Department of Medicaid
- Classified Indicator**: Classified
- Bargaining Unit / Exempt**: Exempt
- Schedule**: Full-time
- Work Hours**: 8am -5pm
- Compensation**: $34.89/hour
- Unposting Date**: Jul 8, 2019, 10:59:00 PM
- Job Function**: Health Administration
- Agency Contact Name**: ODM Human Resources
- Agency Contact Information**: HumanResources@medicaid.ohio.gov
  Medicaid Health Systems Administrator 2
  (190003M2)
  Job Duties
    - _
  Unless required by legislation or union contract, starting salary will be set at step 1 of the pay range._**
  Office: Operations
  Bureau: MITS & System Operations
  Working Title: UAT Test Manager (PN 20097618)

  Job Preview

The Ohio Department of Medicaid (ODM) delivers health care coverage to more than 3 million residents of Ohio on a daily basis. The User Acceptance Testing (UAT) unit is a high performing, fast-paced unit where multi-tasking, critical thinking, and problem solving skills are critical to success.
The User Acceptance Testing (UAT) Test Manager will manage the daily testing efforts for releases and will include capacity and staffing planning for all Releases for Ohio Benefits (OB), Medicaid Information Technology System (MITS) and other Ohio Medicaid Enterprise System (OMES) modules.

- Job Description**:

Under general direction, plans, evaluates and directs activities of one unit or multiple teams related to multiple statewide components of Medicaid health care delivery systems (e.g., health systems data collection systems and Medicaid information and data support): plans, manages and evaluates the development and implementation of strategic goals and objectives for Medicaid health systems data collection and delivery systems functions/changes in Medicaid Information Technology System (MITS) including [e.g., Business intelligence AnalyticReporting (BIAR), Management Account Reporting (MAR), Surveillance and Utilization Review (SUR), Buy-In Data Maintenance, Claims, Drug Rebate, Electronic Data Interchange (EDI), Electronic Document Management System (EDMS), Early and Periodic Screening Diagnosis and Treatment Program (EPSDT), Financial, Provider, Managed Care, Pharmacy, Prior Authorization, Recipient, Reference, RetroDUR, Security, Web Portal and other system changes]; Ohio Benefits including [e.g., Interactive Voice Recording (IVR), Electronic Document Management Systems (EDMS), Accenture Benefit Management System (ABMS), Presumptive Eligibility (PE) Portal, Self Service Portal (SSP), Business Intelligence (BI) Portal, Interfaces, Master Client Index (MCI), Audits (including Security), Notice of Adverse Actions (NOAs), Forms, Rules Engine]; and future Ohio Medicaid Enterprise Solution (OMES) Modules; directs and oversees analysis of health care delivery and practice patterns for quality assurance and proper system interfaces. Supervises assigned staff (e.g., establishes goals and monitors and evaluates performance; reviews works and provides feedback; encourages staff development; assigns work and provides direction; approves/disapproves leave requests; makes recommendations for hire; recommends disciplinary action).
Acts as liaison with agency staff (e.g., Offices of Policy, Fiscal, Long Term Care, Eligibility, Claims, Managed Care, Provider Network Services, Information Technology Services) and/or sister agencies (e.g., Departments of Health, Aging, Mental Health and Addiction Services, Developmental Disabilities and Job and Family Services) providers, advocates, beneficiaries and/or consumers to ensure health services delivery systems policies meet consumers' needs and are cost effective; assists ODM bureaus in developing reform initiatives; develops system interface recommendations based on quality assurance findings; assists in capacity planning for Medicaid Information Technology Systems (MITS) releases, Ohio Benefits Releases and OMES Releases; develops risk mitigation strategies; assists in implementation planning and deployment; assists high level management in developing new and/or revised Medicaid programs; prepares &/or directs preparation of correspondence, reports, records, analysis & quality assessments; responds to sensitive inquiries and contracts from consumers, providers and government officials; operates personal computer & applicable software applications to create, store, retrieve correspondence, reports & spreadsheets.
Advises deputy director/director regarding various issues and problems (e.g., timely and accurate delivery of health information); testifies at legislative or public hearings and /or administrative appeals; originates correspondence; prepares and delivers speeches and presentations; develops and/or assists in development and/or review of budget proposals or federal requests for enhanced federal financial participation.

- **Seniority level**

  Entry level

- **Employment type**

Full-time

- **Job function**

  Information Technology

- **Industries**

  Information Technology and Services

Manager, Actuarial Services (Medicaid)

SourceURL: https://www.resume-library.com/job/view/23060038/manager-actuarial-services-medicaid

Description:
Position Purpose: Conduct analysis, pricing and risk assessment to estimate financial outcomes. Provide expertise and technical support in matters related to the successful and financially sounds operations of the company's health plan businesses.
* Apply knowledge of mathematics, probability, statistics, principles of finance and business to calculate financial outcomes.
* Negotiate capitation rates with State agencies
* Oversee health plan experience, identify trends and recommend improvements
* Research and identify new business opportunities
* Work with Health Plans to ensure soundness of capitation rates
* Work with State agencies to assess impact of program/policy changes

Job ref: 724d7734891dc11

Job type: Permanent

Job ID: 23060038

Apply now

State of Missouri hiring Medicaid Specialist in Jefferson City, MO, US

SourceURL: https://www.linkedin.com/jobs/view/medicaid-specialist-at-state-of-missouri-1347910032

Job Description:

This is advanced technical and specialized work in the evaluation and operation of the Medicaid program. This position is with Missouri Medicaid Audit and Compliance (MMAC). The Provider Review Section monitors MO HealthNet program compliance by MO HealthNet providers and participants. The Provider Review Section conducts post-payment reviews of MO HealthNet claims to assure that appro
priate payments were made and that providers are billing and providing services in accordance with federal and state regulations and MO HealthNet requirements.
Employees in this position are responsible for reviewing and understanding MO HealthNet policies and procedures in assigned programs which is currently the Behavioral Health Program; detecting program abuse and misutilization, including MO HealthNet eligibility issues; making determinations on what enforcement activities to pursue, such as, education, demand of repayment and/or prepayment review. Other duties include the selection of claim samples, review of medical record documentation, evaluation of findings, and preparation of written reports. Specialist must also be able to explain the review process and results, and testify to the Administrative Hearings Commission, as required. Other duties include monitoring corrective action plans, recovery of identified overpayments and providing assistance to Unit Supervisor or other designated management or executive staff. Duties may also require the coordination and review of special projects, the development and management of tracking files, and coordinating efforts between other MHD units or other agencies. You will also be required to present at the MO HealthNet workshops for your program(s) on behalf of MMAC.
Work is performed with independence and initiative. General supervision is received from unit supervisor, management, and executive staff.

Knowledge, Skills, And Abilities

ESSENTIAL SKILLS: Knowledge of MO HealthNet claims processing, MO HealthNet programs, state and federal regulations, on-line reference files and reporting systems. Knowledge of various computer software packages such as Word and Excel and the FADS system is preferred. CPT, HCPCS, and ICD-10 coding knowledge is helpful.
WORKING CONDITIONS: Work in this position will be primarily in an office setting, although there will be travel and provider visits required. Equipment used in the position may include the following: computer, scanner, and printer; telephone; copier; fax machine; calculator; and various reference books, manuals, and computer reports.
INTERPERSONAL SKILLS REQUIRED: Due to the nature of responsibilities associated with this position, good verbal and written communication skills are required. This position may be required to speak with providers and may also the need to confer with medical or professional consultants, representatives of federal and state agencies, the MO HealthNet fiscal agent, professional organizations and others to provide instruction, obtain advice, coordinate policies and procedures, and resolve problems.
HOURS, SHIFT and OTHER SCHEDULING DETAILS: The hours for this position will be from 8:00 am - 5:00 pm, Monday through Friday, with one hour for lunch. Travel will be required statewide. Provider visits may require days exceeding the normal 8 hours or overnight stays, the length and frequency may vary based on the geographical area, the size of the claim review and the current MMAC travel policies.

Qualifications

Two or more years of experience as a Medicaid Technician, Medicaid Pharmaceutical Technician, or Correspondence and Information Specialist I within a Medicaid Program with the Missouri Department of Social Services; and possession of a high school diploma or proof of high school equivalency. OR A Bachelor's degree from an accredited college or university with a minimum of 15 earned credit hours in one or a combination of the following: Public, Business, or Health Care Administration; Nursing; Health Sciences; Medical Technology; Social Work; Finance; Accounting; or a closely related field; and, Two or more years of professional or technical experience in one or more of the following fields: health care provider relations; medical insurance claims processing; Medicaid Program regulations, operations, or activities; health care regulations development/enforcement; statistical or fiscal record keeping and/or analysis; or closely related

work. (24 earned graduate credit hours from an accredited college or university in the specified areas may substitute for one year of the required experience.) (Additional qualifying experience may substitute on a year-for-year basis for deficiencies in the required education.) OR A Bachelor's degree from an accredited college or university with a minimum of 15 earned credit hours in one or a combination of the following: Public, Business, or Health Care Administration; Nursing; Health Sciences; Medical Technology; Social Work; Finance; Accounting; or a closely related field; and, Two or more years of professional supervisory or consultative experience in financial eligibility assessment. (24 earned graduate credit hours from an accredited college or university in the specified areas may substitute for one year of the required experience.) (Additional qualifying experience may substitute on a year-for-year basis for deficiencies in the required education.)

Job Posting Number

17596

Opening Date

6/18/2019

Closing Date

7/2/2019

Number Of Vacancies

1

Agency

Social Services

Location:

County

COLE

City

Jefferson City

State

MO

Zip Code

65109

Job Type

Full-Time

Shift

Day

Salary Range

$37,624.08 - $39,004.08 Annual

Job Posting Number

17596

- **Seniority level**

  Associate

- **Employment type**

  Full-time

- **Job function**

  Other

- **Industries**

  Nonprofit Organization ManagementGovernment AdministrationHospital & Health Care

State of Florida hiring MEDICAL/HEALTH CARE PROG ANALYST in Tallahassee, FL, US

SourceURL: https://www.linkedin.com/jobs/view/68064849-medical-health-care-prog-analyst-at-state-of-florida-1351166857

Requisition No: 62121

Agency: Agency for Health Care Administration

Working Title: 68064849 - MEDICAL/HEALTH CARE PROG ANALYST

Position Number: 68064849

Salary: $1,574.93 / Bi-Weekly

Posting Closing Date: 07/03/2019

This is an exciting opportunity to help shape the quality of health care in Florida. The Agency for Health Care Administration (AHCA) is the State of Florida agency responsible for oversight of the Medicaid program. The Medicaid program provides low-income families and individuals with access to health care. If you have a desire to use your talent and skills at an organization that provides critical services to millions of individuals and families across the state, AHCA invites you to apply to become an essential member of our team. As one of Florida's leading state agencies, AHCA's diverse workforce community of more than 1,400 employees is proud of its efforts to serve the people of Florida.

We are seeking to hire a Medical Health Care Program Analyst who desires to work to enhance the delivery of health care services through the Florida Medicaid Program. This position requires a candidate who is creative, flexible, innovative, and who will thrive in a fast-paced, team based work environment.

This position is located in the Bureau of Medicaid Plan Management Operations (PMO). PMO is responsible for the primary oversight of Medicaid's managed care programs, with a focus on the Statewide Medicaid Managed Care (SMMC) program. The bureau's primary responsibility is ensuring that the managed care plans meet Medicaid contractual requirements, including the timely provision of medically needed services and provider payment for such services.

This position is responsible for analyzing, developing, implementing and monitoring managed care plan contract services. This work consists of conducting studies and evaluations, conducting work simplifications and measurement studies, providing technical assistance and developing operations and procedures to assist the Agency in operating more efficiently and effectively (which may include program analysis, management consulting, and examination development). This position serves as a Contract Manager and the lead point of contact for assigned Medicaid managed care plan contract(s).

The incumbent in this position maintains up-to-date knowledge concerning the Florida Medicaid program by researching and analyzing pertinent federal regulations, state statutes, administrative rules, Florida Medicaid State Plan, federal managed care waivers, and Medicaid policies. The incumbent remains informed about regulations of the Agency for Health Care Administration, managed care contracts, as well as Medicaid systems and technology, and Medicaid-related activities of the Agency. The incumbent maintains knowledge about Agency operating procedures and processes.

The incumbent conducts strategic program planning activities in order to promote access to care, improve the quality of care and increase the efficiency and cost-effectiveness of the Medicaid program related to the managed care programs and contracts.

The incumbent's Agency contract manager duties include, but may not be limited to, maintaining active Agency and state of Florida contract manager certification, adhering to established Agency procurement policies and procedures, participating in the competitive and non-competitive procurement and development of assigned contracts, overseeing the day-to-day administrative, programmatic, and financial operations of assigned contracts, maintaining appropriate and up-to-date contract files, and serving as liaison with assigned contract vendor(s).

The incumbent plans, organizes and coordinates the program monitoring activities for Medicaid managed care plans, including oversight analysis to identify managed care plan compliance issues and problems. The incumbent provides guidance and counsel to Plan Management leadership and their staff by analyzing results and findings and developing compliance actions as prescribed in the managed care contract (e.g., corrective action plans, sanctions, liquidated damages, etc.) and completing follow-up investigation to ensure compliance with the managed care plan contract and Medicaid policies and procedures.

The incumbent conducts program training and provides technical assistance related to Medicaid managed care contracts, in order to ensure consistency in program operation and conformity with goals and objectives of the Agency and state and federal laws, rules, regulations and guidelines.

The incumbent leads and coordinates meetings within the Agency, between the Agency and other state agencies, with contacts from the assigned Medicaid contract(s), and with other organizations for the purpose of presenting and evaluating Medicaid programs and contracted Medicaid medical assistance services. The incumbent participates in meetings, conferences and workshops on federal and state health care related programs and managed care programs. The incumbent prepares and delivers speeches and presents programs to provider groups, provider associations, and other local, state and national associations and organizations. The incumbent

represents Medicaid on health care related committees, task forces, and special projects as assigned.

The incumbent in this position may be required to analyze proposed state and federal legislation, rules, regulations and policies to determine the impact on Medicaid including: conducting bill analyses, analyzing federal and state legislation, drafting Legislative Budget Requests, drafting managed care legislation, developing presentation materials, and responding to Legislative requests for information. The incumbent assists in the completion of legislative reports as required.

AHCA Offers An Excellent Array Of Benefits, Including

- Health insurance
- Life insurance
- Dental, vision and supplemental insurance
- Retirement benefits
- Vacation and sick leave
- Paid holidays
- Opportunities for career advancement
- Tuition waiver for public college courses
- Training opportunities

This position may require travel.

For more information about the Bureau of Plan Management Operations, please visit our website at http://ahca.myflorida.com/Medicaid/index.shtml.

Join us at the Agency for Health Care Administration in fulfilling our mission to provide "Better Health Care for all Floridians".

Knowledge, Skills, And Abilities

- Knowledge of the Medicaid Program and Managed Care.
- Knowledge of the methods of data collection and analysis.
- Ability to develop tracking systems, maintain accurate information within tracking systems, and coordinate the gathering of information from various sources.
- Ability to organize data into logical formats for presentation in reports, documents and other written materials.
- Ability to conduct fact-finding research.
- Ability to work independently.
- Ability to understand and apply applicable rules, regulations, policies and procedures relating to plan management activities.
- Ability to plan, organize, coordinate and complete work assignments.
- Ability to communicate effectively.
- Ability to establish and maintain effective working relationships with others.
- Ability to work with Microsoft Suite; proficient in Microsoft Word, Excel, Outlook and Internet Explorer.
- Ability to travel with or without accommodations.

Minimum Qualification Requirements

- At least one (1) year of work experience in Medicaid.
- At least one (1) year of experience working with contract-related activities (e.g. monitoring receipt of deliverables, compliance, and provision of technical assistance)
- At least one (1) year of experience analyzing data.

Licensure, Certification, Or Registration Requirements

N/A

CONTACT: SARAH M. JAMES 850-412-4032

The State of Florida is an Equal Opportunity Employer/Affirmative Action Employer, and does not tolerate discrimination or violence in the workplace.

Candidates requiring a reasonable accommodation, as defined by the Americans with Disabilities Act, must notify the agency hiring authority and/or People First Service Center (1-866-663-4735). Notification to the hiring authority must be made in advance to allow sufficient time to provide the accommodation.

The State of Florida supports a Drug-Free workplace. All employees are subject to reasonable suspicion drug testing in accordance with Section 112.0455, F.S., Drug-Free Workplace Act.

VETERANS' PREFERENCE. Pursuant to Chapter 295, Florida Statutes, candidates eligible for Veterans' Preference will receive preference in employment for Career Service vacancies and are encouraged to apply. Candidates claiming Veterans' Preference must attach supporting documentation with each submission that includes character of service (for example, DD Form 214 Member Copy #4) along with any other documentation as required by Rule 55A-7, Florida Administrative Code. Veterans' Preference documentation requirements are available by clicking here. All documentation is due by the close of the vacancy announcement.

Medicaid / Managed Care Billing Coordinator in Lombard, IL, US

SourceURL: https://www.linkedin.com/jobs/view/medicaid-managed-care-billing-coordinator-at-jobs-%40-thejobnetwork-1351771473

Teamwork is what were all about at Lexington Health Care, working together to achieve positive patient outcomes. We realize that when you collaborate, great things are possible; for your patients, and for your career. Lexington proudly employs more than 2,500 employees allowing us to provide an immeasurable value to the communities we serve. So much of who we are comes from being an organization dedicated to the highest attainable quality of care available today. In an industry filled with rapid change and growth, our commitment to family values will never change. As a family owned organization, we have always maintained a unique perspective. Our reputation as a leading health care employer is unmatched. Come see for yourself why its so fulfilling to be a part of Lexington!

- The Medicaid/Managed Care Billing Coordinator is responsible for submitting and follow up on all Medicaid, Commercial, and third party payers as assigned
- Submits all claims for Medicaid, Commercial, and Managed Care and third party payers for the Lexington Health Network as assigned.
- Completes all rejections errors/edits at time of claim submission.
- Attends all Quad checks when requested.
- Researches and analyzes denial data; identifies, analyzes, and researches frequent root causes of denials and develops plans for resolution of denials
- Contact insurance carriers through website, email or telephone to resolve outstanding accounts
- Analyze and resolve moderately complex insurance denials including coding review to prevent errors within appeals process
- Prioritizes activities to work overturns in a timely manner to alleviate untimely filings

- Uses reports that categorize denials to work to overturn denials
- Identifies and pursues opportunities for improvements in denial performance
- Manage correspondences and any ADR requests as defined within department workflow procedure to ensure timeless and accuracy of response; works with all outside vendors, medical records, and clinical reimbursement team for all clinical review and information pertaining to ADR
- Assist with all chart audits and maintain documentation
- Researches, responds, and documents insurer and patient correspondence/inquiry notes regarding coverage, benefits, and reimbursement on all insurance accounts
- Researches rejections included in EOBs for resolution and files appropriately
- Makes management aware of any issues or changes in the billing system, insurance carriers, and/or networks
- Maintain internal logs (Excel format)
- Other duties as assigned
- Assist with Month End Close Processes
- Maintain internal logs (Excel format)
- Other duties as assigned
- High school diploma or GED required
- At Least one-year experience in long-term care or hospital AR department.
- Experience and knowledge of Medicare, Medicaid, Managed care, and other third party payers
- Excellent communication skills and ability to effectively communicate with insurance carriers/staff/management and other agencies for completion of tasks and assignments.
- Ability to handle and prioritize work in a fast-paced environment.
- Ability to manage own schedule for accurate and timely completion of multiple tasks and assignments.
- Must be organized, detail oriented with problem solving and analytical skills.
- Basic computer skills including Microsoft word, Excel, Outlook and web-based programs.

Physical Requirements

- Must have the ability to sit, stand, walk, stoop and reach, and to use hands to manipulate the computer, writing, calculation or other instruments to carry out responsibilities of the position.
- Must be able to lift objects up to 20 pounds.
- Must have adequate vision to perform essential job functions.

We offer a professional work environment, growth and advancement, training, Competitive compensation and a benefits package including a comprehensive Medical, dental, and vision plan, voluntary benefits, Credit Union, 401(k) savings plan with company match, holiday pay and paid time off.

Lexington Health Network provides equal employment opportunities to all employees and applicants for employment and prohibits discrimination and harassment of any type without regard to race, color, religion, age, sex, national origin, disability status, genetics, protected veteran status, sexual orientation, gender identity or expression, or any other characteristic protected by federal, state or local laws.

iCIMS Requisition ID: 2019-4810

Street: 665 W. North Avenue

Work Schedule: Days
PandoLogic. Keywords: Managed Care Coordinator, Location: Lombard, IL - 60148

Market Medical Director, Vivida Health Plan in Alturas, FL, US

SourceURL: https://www.linkedin.com/jobs/view/market-medical-director-vivida-health-plan-at-jobs-%40-thejobnetwork-1351498354

Evolent Health is looking for the Health Plan Market Medical Director of Vivida Health Plan, a new Florida Medicaid provider sponsored network (PSN) health plan, who is committed to removing barriers to care and keeping Floridians healthy in Region 8.

Evolent Health has a bold mission to change the health of the nation by changing the way health care is delivered. Our pursuit of this mission is the driving force that brings us to work each day. We believe in embracing new ideas, challenging ourselves and failing forward. We respect and celebrate individual talents and team wins. We have fun while working hard and Evolenteers often make a difference in everything from scrubs to jeans.

We have been named one of Beckers 150 Great Places to Work in Healthcare in 2017, and one of the 50 Great Places to Work in 2017 by Washingtonian. If youre looking for a place where your work can be personally and professionally rewarding, dont just join a company with a mission. Join a mission with a company behind it.

Overview

The Market Medical Director (MMD) is a key member of the Vivida Health Plan Senior Leadership Team. The selected candidate will act as the clinical thought leader responsible for developing and executing strategies that both improves the quality of health care delivered to our members and improves cost and efficiency. The MMD will be directly responsible for managing an integrated clinical operation that includes utilization management, care management, population health, quality and pharmacy management. The MMD will be responsible for all the clinical operations, and for establishing and maintaining clinical and medical policies that conform to optimal clinical practice standards. As a collaborative member of a team of nurses, clinicians, physicians, pharmacists, quality improvement, and other health plan leaders, the Market Medical Director will have the opportunity to make a profound impact on the lives of our members.

As a Provider Sponsored Network (PSN) health plan, critical functions of the role include engaging the physician network, organizing physician-led clinical governance and culture, and providing medical direction on all provider network issues. The MMD will have responsibility for managing total cost of care using a collaborative, multi-disciplinary approach, including using value based payment programs aligning to provider network clinical activities and outcomes and managing operational aspects of all clinical programs.

The Health Plan leadership team, including the MMD, will have the added strength of working with the clinical, financial, analytics, and operational services of both Evolent Health and the primary provider PSN entity, Lee Health, to support the local health plan needs and functions. Evolent Health is the primary operating partner supporting almost all clinical and health plan operations for Vivida Health.

Vivida Health is the only Provider Sponsored Network (PSN) health plan in Floridas managed Medicaid Managed Medical Assistance (MMA) program in Region 8 that includes Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota counties. Vivida Health headquarters and main office is in Fort Myers, Florida.

Reporting Relationship

The Health Plan Market Medical Director (MMD) will report directly to the Evolent Health Associate CMO but will set priorities and direction with the Lee Health VP Clinical Strategy and Population Health who is also the Vivida Health CMO. The Vivida Health Market Medical Director will be 100% dedicated to Vivida Health.

Responsibilities

Physician and provider relationship management

- Responsible leading change with physicians and other providers to improve the quality and efficiency of care in the network and integrate these providers into our clinical initiatives, including creating and maintaining a system that gives continuous feedback on these initiatives
- Visits network facilities on a regular basis, identifies key issues facing leaders and works collaboratively with leadership to accomplish mutually agreed upon goals
- Participates in the development of physician incentives, value based contracting arrangements, pay for performance and targeted network improvement programs
- Partners with Evolent Health analytics to provide meaningful and actionable information to physicians
- Lead and support activities related to communications, physician/provider engagement, and programming including outward facing membership growth and organizational visibility and success

Population Health collaborative care management leadership

- Provides clinical leadership and development for population health programs or functional areas within Medical Management
- Serves as a lead physician on the medical management team working closely with clinical and market leadership, in addition to providing direction for program development of the Medicaid line of business (LOB)
- Serves as the chairperson for the Physician Advisory Committee (PAC) and other physician-led committees
- Assists in assuring appropriate health care delivery for the assigned membership and managing the medical costs associated with the assigned population
- Promotion of managed care systems using evidence-based medicine to educate and facilitate best practices with care management staff and medical physicians/providers
- Participates in Physician/Practice Meetings

Utilization Management

- Responsible for executing and maintaining Evolent Healths benchmarked Utilization/Cost Management Program and relevant Clinical Quality Improvement Programs
- Participates as needed as part of Evolent Healths national UM Medical Director team to assure quality of care in all aspects of medical utilization and to assure that utilization is appropriate to meet the needs of the members and falls within recognized standards of efficiency
- Participate in the Appeals and Grievance process, as necessary, to assure timely and accurate responses to members
- Supports and leads, as needed, operational performance to develop and implement the health plans clinical guidelines and protocols that can be utilized through the quality improvement, utilization management, and case management processes to positively impact the delivery of care.
- Collaborates as needed with risk management, claim adjudication, pharmacy utilization management, catastrophic case review, outreach programs, HEDIS reporting, site visit review coordination, triage, provider orientation, and others

Quality of care and service delivery

- Provides guidance and interpretation on issues of medical appropriateness, benefit application as appropriate, level of care necessary to include out-of-network care
- Evaluates and ensures systems and processes to assist physicians/providers with adherence to evidence based protocols
- Assures compliance related to Federal (e.g., CMS), State (e.g., Insurance commission) and local rules and regulations
- Works closely with community provider leaders to ensure accurate understanding of the Companys mission and goals and quick response to any provider issues and questions regarding Company performance and progress
- Identifies and implements other strategies that insure quality care, access to care, and the financial success of the Company

Required

Qualifications

- Graduate of an accredited medical school. M.D. or D.O.
- Active physician license without any restrictions
- 3-5 years of clinical practice in a primary care setting preferred and progressively responsible medical administrative experience
- Board certification in ABMS recognized specialty
- 3-5 years of managed care or population health experience

Preferred

- Proven ability in medical leadership position possessing clinical credibility with peers and the ability to be a team player and team builder
- MBA or a Master's Degree in healthcare or other related fields of study
- Experience with population health management strategies and implementation
- Excellent interpersonal, verbal, and written communication skills
- Ability to navigate in a corporate matrix environment

Evolent Health is an Equal Opportunity/Affirmative Action Employer
PandoLogic. Keywords: Medical Director, Location: Alturas, FL - 33820

VP, Medicaid Chief Medical Officer in Atlanta, GA, US

SourceURL: https://www.linkedin.com/jobs/view/vp-medicaid-chief-medical-officer-at-jobs-%40-thejobnetwork-1351743212

VP, Medicaid Chief Medical Officer

Atlanta, GA, US

Be among the first 25 applicants

[Apply on company website]
Req ID: 60448BR

Job Description

Aetna's Medicaid Chief Medical Officer (CMO) plays a strategic lead role, with a balance of internal and external-facing activities that support a shift to a higher-touch, patient-centric focus. In collaboration with various Medicaid leaders in personalized health, health care quality and equity and across all the State Medicaid health plans, the Medicaid CMO will develop, implement, support, and promote population health strategies, tactics, policies, and programs that drive the delivery of high value healthcare to establish a sustainable competitive business advantage for Aetna Medicaid. These strategies, policies, and programs are comprised of care management, utilization management, quality improvement, network management as well as clinical coverage protocol.

Fundamental Components Included But Are Not Limited To

The Medicaid CMO will develop a clear and compelling vision and strategy and ensure enterprise strategies are aligned with emerging customer and market needs. S/He will identify critical goals and success factors for the Medicaid business and help guide the Aetna Medicaid clinical strategy in order to improve health at a lower cost. S/He has a proven ability to leverage understanding of the emerging health care environment to create the platform for change and to meet demands for evolving health management solutions.

The Medicaid CMO oversees Medicaid medical management and clinical strategy for all health plans owned and administered by Aetna Medicaid. Works with Medicaid teams and Enterprise partners to support profitable growth of health plan markets and build strategies to support the needs of members on their health journey.

Responsible for Aetna Medicaid medical policies that ensure the appropriate and most cost-effective medical care is received and responsible to lead the medical management staff responsible for recommending changes and enhancements to current managed care, review guidelines, and clinical criteria based on extensive knowledge of health care delivery systems, utilization methods, reimbursement methods, and treatment protocols.

Uses expertise in Case Management and Disease Management to collaborate with all stakeholders both at the shared services and State health plan levels, understanding the guidelines/basics (how to access), the requirements, opportunities to shape the scope of the Medical roles within Aetna Medicaid. Have oversight of the design, development and deployment of Care Models across all Aetna Medicaid and products. Acts as a subject matter expert to fellow team members in clinical design of Care Model programs and ability to shape specialized care planning strategies for medically complex patients to improve care outcomes.

Ability to analyze data (e.g., medical cost trends) and articulate trend and solutions to internal and external stakeholders. Ability to consult with Aetna Medicaid Medical staff to manage complex cases and client relationships with plan sponsors. Derive insights from analytics to provide better care and deliver services more efficiently. Provide medical consultation to analytics and technology-based teams to steer effectiveness of analytics applications and platforms.

Have an end-to-end Aetna Medicaid Market Understanding with strong business acumen. Understands and is proficient articulating products, financial impacts and market demands. Consultant and supplier of actionable information. Expertise in market/state DOL regulations delivering HEDIS/STARS consultation. Thought leader and is an externally facing brand ambassador; inform and influence all constituents (e.g. providers, broker/consultants, employers, state and federal government regulators). Collaborate with and provide strategic clinical direction to Care Management, Utilization Management, Network and Provider Relations to support the effective execution of medical services programs by the clinical teams that are provider and member facing.

Builds and fosters the relationships and partners with the external community, enterprise CMO and segments to engage providers in a pro-active approach to population health. Using data

analytics to inform and influence population health to drive behavior change and expand Aetna Medicaid s medical management programs to address specific member conditions across the continuum of care

The Medicaid CMO has a constant focus across the enterprise on what will achieve the best result for the entire company rather than just their own unit or function. Is adept at negotiation and conflict resolution, demonstrating the ability to influence others, win support on critical issues, and reach consensus when appropriate.

Qualifications Requirements And Preferences

Background in Medicaid is highly desired.

MD Board Certification is required.

Location: Open to location; Phoenix AZ would be preferred.

Benefit Eligibility

Benefit eligibility may vary by position. Click here to review the benefits associated with this position.

Job Function: Management

Aetna is an Equal Opportunity/Affirmative Action employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, or protected Veterans status.
PandoLogic. Keywords: Chief Medical Officer, Location: Atlanta, GA - 30332