Medicaid Industry Jobs Hunter: 10/14/2019

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Medicaid Jobs Hunter

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Medicaid Program / Healthcare Policy Analyst -Austin | Chandra Technologies, Inc

Medicaid Program / Healthcare Policy Analyst - Austin

Chandra Technologies, Inc | Austin, TX, US

Please apply for this position by sending your resume to: Email: apply AT chandratech DOT com SUBJECT: Applying for Medicaid Program / Healthcare Policy Analyst Austin, TX Hourly Rate: $70 W2; $81 CTC/1099 (Please be advised that this posted CTC rate is applicable only for consultant who are senior level and exceeds the required experience and or having State Govt exp) Job Description: Medicaid/CHIP Services is seeking to hire a contract employee to conduct project lead activities. The Project Lead II would provide operational and administrative support to the Medicaid Electronic Health Record (EHR) Incentive/ Promoting Interoperability (PI) Program. The Program provides financial incentives to eligible providers and hospitals for the adoption and utilization of certified EHR technology (CEHRT). The general responsibilities of the Project Lead II would include assisting in tracking provider post payment audits, appeals and maintaining documentation of their status, communicating with appealing providers on required deliverables, deadlines and other appeal related information as needed, reviewing and researching

provider audit files, associated federal regulations and supporting case documentation, assisting in developing HHSC appeal memoranda, working closely with HHSC Legal and contracted audit vendor, assisting in communicating and coordinating duties of the HHSC Audit Ad Hoc Review Panel, interacting with key stakeholders by attending meetings, resolving unique and difficult appeal issues, demonstrating effective communication solutions, assisting in the development of written and online program information for providers, HHSC leadership and the general public and developing other information and/or outreach materials as needed. The Project Lead II will work closely with the Program Manager and Senior Policy Advisor of the EHR Incentive/PI Program to ensure support of any other operational or administrative duties related to the Program. The ability to rely on limited experience and judgment to plan and accomplish goals as well as utilizing a moderate degree of creativity and latitude is necessary. Because of the nature of the information in the projects that will be implemented, all entities must sign a Data Use Agreement (DUA) as a condition of employment. Face-to-face interview is required. Required Skills: BS or equivalent with 5 years of experience in leading projects and/or programs preferably in the area of Health Information Technology (HIT). (5 years) Medicaid program and/or Healthcare legal/ policy knowledge and experience. (5 years) Strong computer skills with tools such as Word, Excel, PowerPoint, Office, etc. (5 years) Strong organizational and communication skills (both verbal and written). (5 years) Demonstrated ability to adapt to changing requirements and priorities. (5 years) Strong client service/consulting and organizational skills with the ability to multi-task. (5 years) Preferred Skills: PMP or other professional Project Management certification Electronic health records or EHR/PI Program experience Medicaid Program / Healthcare Policy Analyst BS or Equivalent, Project Management, Medicaid Program Experience, Health Information Technology (HIT), Client

Service, Project Management Certification (PMP, etc.), Electronic Health Records, EHR/PI Program Higher Competitive Rates will be considered for consultants with advanced skill set Corp to Corp Resumes are welcome Consultants may need a criminal background check - provided by Dice

Seniority Level

Associate

Industry

- Information Technology & Services
- Computer Software
- Financial Services

Employment Type

Full-time

Job Functions

- Other

Market Medical Director, Vivida Health Plan | The Job Network

Source URL: https://www.linkedin.com/jobs/view/market-medical-director-vivida-health-plan-at-the-job-network-1555188168/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Market Medical Director, Vivida Health Plan

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

Medicaid Health Systems Administrator 1 | Ohio Department of Medicaid

Source URL: https://www.linkedin.com/jobs/view/medicaid-health-systems-administrator-1-at-ohio-department-of-medicaid-1551925693/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Health Systems Administrator 1

Ohio Department of Medicaid

| Franklin County, OH, US

UNLESS REQUIRED BY LEGISLATION OR UNION CONTRACT, STARTING SALARY WILL BE SET AT STEP 1 OF THE PAY RANGE.

Office: Health Innovation & Quality

Bureau: Clinical Operations

Working Title: Care Coordination Manager (PN 20093474)

Job Preview

As the Care Coordination Manager in the Bureau of Clinical Operations, Ohio Department of Medicaid (ODM), you will assess and monitor care management services provided by ODM's contracted health care providers Managed Care Plans (MCPs). You will assist in the development of innovative program initiatives designed to improve access to health services for special populations (i.e. individuals with chronic conditions, the elderly and disabled populations, children with special health care needs, high risk pregnant women).

In this position, you will assist with the coordination of policy and program planning by researching care management delivery systems within a population health model and providing feedback on findings. In addition, you will review, analyze, and interpret data and reports and provide recommendations for follow up activities related to MCP care management performance. You will work collaboratively with internal and external stakeholders across a variety of departments, levels, state agencies, and MCPs to improve care management services for the individuals served by ODM.

Job Duties

Under general direction, serves as agency manager of Medicaid program(s) &/or initiatives to oversee & evaluate one statewide component of Medicaid health care delivery systems (e.g., health

systems access): ensures access to quality health care services through care coordination strategies for Medicaid Managed Care populations (e.g., high risk pregnant women; children with special health care needs; Comprehensive Primary Care) enrolled in Medicaid programs; develops and establishes health care quality improvement strategies to improve the health, welfare, and safety of Managed Care populations enrolled in Medicaid programs with a focus on improving the effectiveness of a coordinated approach to service delivery; analyzes and interprets federal and state regulations, rules and laws, and related policy documents; formulates policy for access to quality health care services for special populations and recommends legislative changes.

Coordinates development of policies, procedures and/or rules; directs and prepares new state rules and coordinates program planning; assists higher-level administrators and/or direct supervisor in development and/or coordination of strategies to remove barriers to care and accessing Medicaid services; assists supervisor in providing strategic oversight of policies and procedures governing core delivery system management functions (e.g., monitoring and evaluation systems); conducts needs assessments; directs data analysis (e.g., analysis data collected from consumer surveys); and/or conducts and/or directs quality assurance reviews of contracted Medicaid managed care plans or Medicaid Waiver programs.

Develops and evaluates administrative reports and recommendations (e.g., program evaluation and improvement); responds to sensitive inquiries and contacts from the public, providers and government officials; originates correspondence; acts as liaison with community and other state and federal agencies; advises direct supervisor and/or higher-level administrators regarding issues and concerns. Acts as

back-up to other Care Coordination managers within the unit (e.g., workload, vacation, vacancies).

Performs other related duties (e.g., attends and participates in staff meetings and meetings, attends training sessions and seminars; travels to meetings, training and seminar sites; maintains records, logs and files).

Completion of graduate core program in business, management or public administration, public health, health administration, social or behavioral science or public finance; 12 mos. exp. in the delivery of a health services program or health services project management (e.g., health care data analysis, health services contract management, health care market & financial expertise; health services program communication; health services budget development, HMO & hospital rate development, health services eligibility, health services data base analysis).

- Or 12 months experience has Medicaid Health Systems Specialist, 65293.

Note: education & experience is to be commensurate with approved position description on file.

- Or equivalent of Minimum Class Qualifications for Employment noted above

Primary Location

United States of America-OHIO-Franklin County

Work Locations

Lazarus 5

Organization

Ohio Department of Medicaid

Classified Indicator

Classified

Bargaining Unit / Exempt

Exempt

Schedule

Full-time

Work Hours

8:00 AM to 5:00 PM

Compensation

$31.76/hour

Unposting Date

Oct 21, 2019, 10:59:00 PM

Job Function

Health Administration

Agency Contact Name

ODM Human Resources

Agency Contact Information

HumanResources@medicaid.ohio.gov

Seniority Level

Entry level

Industry

- Government Administration

Employment Type

Full-time

Job Functions

- Information Technology

Director, Consumer Experience & Strategy - Health Plan Products & Services - Great New R -Worcester | Fallon Health

Source URL: https://www.linkedin.com/jobs/view/director-consumer-experience-strategy-health-plan-products-and-services-great-new-r-worcester-at-fallon-health-1555018316/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director, Consumer Experience & Strategy - Health Plan Products &

Services - Great New R - Worcester

Fallon Health | Worcester, MA, US

DIRECTOR, CONSUMER EXPERIENCE & STRATEGY

- HEALTH PLAN PRODUCTS AND SERVICES
- GREAT NEW ROLE! US-MA-Worcester Job ID: 5742 Type: Full Time # of Openings: 1 Category: Data Management/Reporting Fallon Health
- Corp HQ Overview THE OPPORTUNITY: This is a fantastic new leadership opportunity for the right person who has been instrumental in transforming the consumer and customer experience across an organization. Health Care has become a very consumer driven industry and there are a great deal of quantified metrics and benchmarks that are measured and monitored that directly correlate to our success. We're looking for a dynamic leader and change agent who can take this business critical function to the next level. More details follow below and we would love to hear from you if you have enjoyed success in this capacity, even if we start out with an exploratory and confidential conversation. ABOUT FALLON HEALTH: Founded in 1977, Fallon Health is a leading health care services organization that supports the diverse and changing needs of those we serve. In addition to offering innovative health insurance solutions and a variety of

Medicaid and Medicare products, we excel in creating unique health care programs and services that provide coordinated, integrated care for seniors and individuals with complex health needs. Fallon has consistently ranked among the nation's top health plans, and is the only health plan in Massachusetts to have been awarded "Excellent" Accreditation by the National Committee for Quality Assurance for its HMO, Medicare Advantage and Medicaid products. For more information, visit www.fallonhealth.org. SUMMARY: The Director of Consumer Experience is accountable for the definition, development and deployment of a new Consumer Experience strategy, in collaboration with other Fallon stakeholders, that allows Fallon to transform from an ad hoc/reactive approach to a strategic, deliberate and proactive approach with clear outcomes pertaining to customer satisfaction, growth and retention. He/she is responsible for assessing and, where needed, refocuses current work being done through the Service Excellence Committee structure to fall under new strategy. Ensure new strategy captures work to be done to support CMS star ratings initiative, digital strategy, NCQA standards, cultural competency, etc., and supports the maximization of portal/CRM/marketing automation investments. Responsibilities Establish and Execute Consumer Experience Roadmap (55%)

- Set an inspirational vision for the organization, working closely with the VOOM team, Service Advisory and others to continuously improve Consumer experience metrics and reporting. Establish clear objectives, goals and milestones for the customer experience strategy.
- Understands the drivers of Consumer Experience performance and drive actions to improve FH's score with a specific focus on CAHPS

- Design a multi-year roadmap to redefine Consumer experience framework and help the company strengthen customer experience management capabilities.
- Champion a customer experience culture using a common language and definitions at all levels and providing executive visibility around key customer experience metrics.
- Maintain and ultimately enhance survey processes that create customer experience metric results (currently member experience and provider satisfaction) and define actions to improve over time.
- Produces and monitors dashboards, trends and surveillance reports for Sr. Management and department leaders and teams. Includes CAHPS, internal monitoring and other sources as appropriate
- Develops action plans and interventions specifically designed to improve CAHPS performance. Includes successful execution and management working with cross functional teams to implement.
- Provide a fresh perspective on customer process work and recommendations on cross-functional updates to improve customer engagement programs and activities.
- Work closely with key cross-functional stakeholders and leaders across the organization to drive required changes to improve customer experience.
- Provide quarterly analysis and recommendations to the executive team on enhancements to customer experience.
- Drive execution of identified activities to improve consumer experience. Includes defined success criteria, meeting goals and active monitoring to determine if goals are achieved.
- Review industry trends routinely for new reporting, analysis and opportunities
- Improve Consumer Experience performance based on defined

internal goals

- Keep abreast of relevant regulatory (pending and potential) updates. Identify and plan for potential impact to consumer experience Corporate Leadership (15%)
- Establish and maintain relationships with senior leaders and business partners, ensuring alignment with strategic priorities.
- Provide key metrics/reporting to leadership for Consumer Experience Performance
- Advocate and demonstrate value for Consumer Experience initiatives to Fallon Health management teams
- Share trends from data collection to areas to identify opportunities for improvements
- Build collaborative relationships across the organization and with FH customers and business partners
- Represent FH on external workgroups focused on consumer experience
- Participate in various Fallon Health workgroups/committees to advocate for Consumer Experience initiatives and recommendations for improvements Contribute to achievement of Fallon Health financial goals (15%)
- Ensure customer priorities are considered in planning and budgeting processes.
- Responsible for adherence to the approved budget and developing the business case for any variances. Resource Development (15%)
- Foster development of Fallon Health staff to support the needs of our members for optimal consumer experience via Training, workforce development etc.
- Initiate actions to foster organizational development and change management activities to ensure high performing work teams.
- Provide guidance and leadership to colleagues and indirect reports to ensure effective team environments through efficient

leadership, motivational and organizational methods.

- Ensure adherence to established HR practices and protocols, champion teamwork and mutual respect and maintain the highest level of professionalism.
- Build collaborative relationships across the organization and with Fallon Health customers and business partners Qualifications
- 5+ years in customer experience transformation work and Voice of the Customer/Customer Advocacy Programs; health care a plus
- Ability to see from the customer point of view and championing that view across the company
- Proven track record for driving significant change/business transformation
- Experience building trusting relationships and influencing others (incl. executive audiences)
- Excellent planning skills through devising plans and strategies to move projects and the organization forward to enhance our consumer experience ratings.
- Consumer experience design and development preferred (including in the digital space)
- Results- and outcome-oriented program management experience
- Ability to shift from developing high level strategies to effective execution, influencing at every level, and driving decisions through appropriate collaboration
- Effective communicator, able to convey complex ideas in a clear, concise manner both verbally and in writing; comfortable in business and technical discussions
- Demonstrated effectiveness bridging technology & business perspectives to collaboratively achieve shared project objectives
- Knowledge of Medicare, Medicaid and Commercial regulations, legislation and laws, auditing reports and system functions preferred

- Advanced skills in analytics and problem solving PM16

MEQC Health Program Manager | State of Utah

Source URL: https://www.linkedin.com/jobs/view/meqc-health-program-manager-at-state-of-utah-1554364203/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

MEQC Health Program Manager

State of Utah | Salt Lake City, UT, US

Description

Manages the Medicaid Eligibility Quality Control (MEQC)

Program and Team. Supervises a team of MEQC auditors that apply Medicaid and Children's Health Insurance Program (CHIP) policy and procedures to monitor eligibility determinations and assess claims processing expenditures. Reviews federal MEQC regulations and communicates/coordinates with our federal partner, CMS (Centers for Medicare and Medicaid Services), to ensure each project meets the federal requirements and objectives. Develops, evaluates, and reviews plans and criteria for various MEQC projects.

Compiles and analyzes a vast amount of data to track error trends, identify problematic eligibility areas, using Excel formulas, graphs, and pivot tables. Provide consultant and expertise to upper management on audits and correction action plans. Recommends and advocates changes to existing state policies, procedures, and system processes based on audit findings. Coordinates and assigns projects to staff. Establishes work schedules and work priorities. Hires, determines workloads, delegates assignments, trains, monitors and evaluates performances, and initiates corrective actions as necessary for subordinate personnel.

- Management or supervisory experience.
- Medicaid and CHIP eligibility policy knowledge.
- Knowledge of the eREP eligibility system.

Why work for the Utah Department of Health? In addition to the rich the State of Utah offers, the department offers:

- UTA Eco Pass, free of charge
- On-site fitness center, for a minimal membership fee
- On-site day care center with First Steps Day Care - contact for rates and availability, 801-538-6996

For more information on the Utah Department of Health, please click

If offered this position, your employment will be contingent upon passing a background check and review. There will be no cost to you for this check. This check will include fingerprinting, which will be available at various UDOH locations for your convenience. Fingerprinting will be completed prior to your first day of employment . You may review the policy by clicking

Example Of Duties

- Plan and implement CMS and MEQC projects.
- Write detailed audit report.
- Coordinates with bureau management, policy specialists, Department of Workforce Services management and program specialists regarding project objectives, case findings and case corrections.
- Monitor state corrective action plans (CAPs) submitted by DWS and DOH policy.
- Ensures compliance with applicable federal and/or state laws, regulations, and/or agency rules, standards and guidelines, etc.
- Ability to read, interpret and apply laws, rules, regulations, policies and/or procedures.
- Communicates information and ideas clearly, and concisely, in discussions and in writing.
- Supervises subordinate personnel including: hiring, determining workload and delegating assignments, training, monitoring and evaluating performance, and initiating corrective or disciplinary actions.

Supplemental Information

- Risks found in the typical office setting, which is adequately lighted, heated and ventilated, e.g., safe use of office equipment, avoiding trips and falls, observing fire regulations, etc.
- Typically, the employee may sit comfortably to perform the work; however, there may be some walking; standing; bending; carrying light items; driving an automobile, etc. Special physical demands are not required to perform the work.

This position is eligible for a full benefits package including medical, dental, life, and long-term disability insurance, a retirement plan, plus paid leave to include annual, sick, and holiday pay. The State requires employees to receive their pay through direct deposit. If selected, you will receive more information about these benefit options and enrollment information through our onboarding process and during your first week or two on the job.

In-Patient Concurrent Review Nurse I or II (RN) REMOTE - WA State Medicaid (PS28851) in Cerritos, California, United

States

Source URL: https://antheminc-healthinsurance.jobs/cerritos-ca/in-patient-concurrent-review-nurse-l-or-ll-rn-remote-wa-state-medicaid-ps28851/C500F96121C34209AE43D4327619A365/job/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Anthem In-Patient Concurrent Review Nurse l or ll (RN) REMOTE - WA State Medicaid (PS28851) in Cerritos, California

In-Patient Concurrent Review Nurse l or ll (RN) REMOTE - WA State Medicaid (PS28851)

Location:United States

New

Requisition #: PS28851

*Your Talent. Our Vision.***At Anthem, Inc.,** it’s a powerful combination, and the foundation upon which we’re creating greater access to care for our members, greater value for our customers, and greater health for our communities. Join us and together we will **drive the future of health care** .

This is an exceptional opportunity to do innovative work that means more to you and those we serve at one of America's leading health benefits companies and a Fortune Top 50 Company.

Note: These positions may be filled at the Level l or ll depending on skills and experience.

Location: This position will allow you to work from home. Washington State preferred.

Required Work Hours: Pacific Coast Time Zone - 8am - 5pm, Monday - Friday.

The **Nurse Medical Management I / ll** is responsible to collaborate with healthcare providers and members to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources. Ensures medically appropriate, high quality, cost effective care through assessing the medical necessity of inpatient admissions, outpatient services, focused surgical and diagnostic procedures, out of network services, and appropriateness of treatment setting by utilizing the applicable medical policy and industry standards, accurately interpreting benefits and managed care products, and steering members to appropriate providers, programs or community resources. Works with medical directors in interpreting appropriateness of care. Primary duties may include, but are not limited to:

- Conducts pre-certification, continued stay review, care coordination, or discharge planning for appropriateness of treatment setting reviews to ensure compliance with applicable criteria, medical policy, and member eligibility, benefits, and contracts.
- Ensures member access to medical necessary, quality healthcare in a

cost effective setting according to contract.

- Consult with clinical reviewers and/or medical directors to ensure medically appropriate, high quality, cost effective care throughout the medical management process.
- Collaborates with providers to assess members' needs for early identification of and proactive planning for discharge planning.
- Facilitates member care transition through the healthcare continuum and refers treatment plans/plan of care to clinical reviewers as required and does not issue non-certifications.
- Facilitates accreditation by knowing, understanding, correctly interpreting, and accurately applying accrediting and regulatory requirements and standards.

Qualifications - External

The **Nurse Medical Management I and ll** requires:

- Current, active unrestricted Washington State RN license and a current unrestricted RN license in the state where you reside.
- Minimum 2 years (3 – 5 years for the Level ll) acute care clinical experience
- Strong oral, written and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills

Preferred:

- Utilization Management experience strongly preferred
- MCG or Interqual experience strongly preferred
- Managed care

Anthem, Inc. is ranked as one of America's Most Admired Companies among health insurers by Fortune magazine and is a 2018 DiversityInc magazine Top 50 Company for Diversity. To learn more about our

company and apply, please visit us at careers.antheminc.com.An Equal Opportunity Employer/Disability/Veteran.

Apply Now

Outreach Representative, CareConnections Long Beach, CA | Molina Healthcare

Source URL: https://www.linkedin.com/jobs/view/outreach-representative-careconnections-long-beach-ca-at-molina-healthcare-1518255468/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Outreach Representative, CareConnections (Long Beach, CA)

Molina Healthcare has always been a special place to work. Founded by Dr. C. David Molina 35 years ago, the company has grown over the past few decades from a single clinic to health plans serving fifteen states. During the time of expansion we have never lost sight of the mission

that defines us; to serve the most financially vulnerable members of our society with dignity and respect. Our goal is to ensure “that everyone has access to quality healthcare.”

CareConnections, our national team of Nurse Practitioners, provides in home health services for Medicare, Marketplace, and Medicaid recipients. Through our program we are able to meet our patients where they live and conduct health assessments in the privacy and comfort of their home.

By utilizing Epic, our customized electronic health record, we are able to provide our patients with a thorough and comprehensive health care experience. We use technology to strategically schedule visits with the aim of maximizing patient care time while decreasing the time spent driving from home to home. Visits vary from preventive care for diabetics, to post-partum assessments, and annual comprehensive exams to make sure our health plans receive a complete and accurate picture of our patients’ health conditions and needs.

The Outreach Representative is responsible for calling our Molina members to schedule appointments in the patient home. The Outreach Representative explains the purpose of the visit, the services provided and answers any questions the patient may have so that they feel safe and comfortable with our Nurse Practitioners in their homes.

We are looking for Outreach Representatives who are committed to caring for those who are often overlooked and underserved in our society. As the next generation of delivery models unfold, this is an opportunity to join a progressive organization that has never lost sight

of the mission of meeting the medical, psychological and social needs of each patient. As a result, this strengthens the communities we serve and delivers superior outcomes.

ABOUT US: Molina Healthcare, a FORTUNE 500, managed care organization, arranges for the delivery of health care services and offers health information management solutions to nearly five million individuals and families who receive their care through Medicaid, Medicare and other government-funded programs in fifteen states.

As An Outreach Representative You Will

- Make large amounts of outbound calls to schedule appointments with our Molina members daily
- Engage patients in their care by identifying their needs, providing any clarifying information they need and securing their appointments
- Accurately document each call and appointment, including verifying patient address, phone number, etc.
- Remain member focused and adaptable to cultural and community sensitivities
- Conduct research to find the appropriate patient demographic information
- Meet personal and team qualitative and quantitative targets
- Answer email inquiries within 3-5 minutes of receipt
- Communicate to Outreach Lead in a timely fashion any concerns with scheduling and/or targets

Ideal Candidates Have

- A passion to serve the underserved
- Bilingual or multi-lingual communication skills

- Epic EHR experience
- Previous experience working with Medicaid, Marketplace and Medicare populations
- The ability to multi-task and manage time effectively
- General competency with basic business applications such as Microsoft Outlook, Excel, Word, etc.

You Will Love This Job If

- You are a new graduate looking for a fulfilling entry into the world of healthcare
- You are tech savvy and want to learn more about Health Information Technology
- You want to be mentored and developed to help you advance your career
- You love a strong team environment and value light-hearted, but hard working, approach

WHAT'S IN IT FOR YOU?

- Competitive financial compensation including generous health insurance benefits
- Continuous learning environment that includes tuition reimbursement
- Walking the talk: Molina's commitment to community includes 16 hours of paid volunteer time off!
- Generous retirement program
- Employee Stock Purchase Program

We are an equal opportunity employer and value diversity at Molina Healthcare. We do not discriminate on the basis of race, religion, color, national origin, gender, sexual orientation, age, martial status, veteran status, or disability status.

Qualifications

Job Qualifications

Required Education

HS Diploma or equivalent combination of education and experience

Required Experience

0-1 year

Preferred Education

Associate's Degree or equivalent combination of education and experience

Preferred Experience

1-3 years

To all current Molina employees: If you are interested in applying for this position, please apply through the intranet job listing.

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Medicaid Clinical Pharmacy Lead | Humana | LinkedIn

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Medicaid Clinical Pharmacy Lead

Humana | Metairie, LA, US

Description

The Clinical Pharmacy Lead will be responsible for the operations of all pharmacy related activities for our Louisiana Medicaid contract. They will leverage a broad understanding of managed care and Pharmacy Benefit Management (PBM) to develop and implement strategies and programs to drive trend and improve health outcomes. The Clinical Pharmacy Lead will monitor the drug development pipeline, and medical literature, while providing clinical support for internal stakeholders. This position will be based in Louisiana, report to Humana's National Medicaid Channel Development Lead, and coordinate day-to-day pharmacy operations directly with the plan Chief Executive Officer (CEO), Chief Medical Officer (CMO), and Behavior Health (BH) Medical Director.

Responsibilities

The Clinical Pharmacy Lead monitors drug development pipeline, and medical literature, while providing clinical support for internal and external stakeholders. Utilizes broad understanding of managed care and PBM knowledge to develop, and/or implement strategies and programs to mitigate cost trend and improve health outcomes. The Clinical Pharmacy Lead works on problems of diverse scope and complexity ranging from moderate to substantial.

Responsibilities

This role supports the Humana Medicaid Health plan for all pharmacy activities. The Pharmacy Lead develops corporate communications to be shared with senior leadership, supports trend management by conducting analysis of drug spend, utilization, and/or approval

scenarios, advises executives to develop functional strategies on matters of significance, and uses independent judgement requiring analysis of variable factors and determining the best course of action.

You will have the opportunity to work with state and corporate Medicaid teams and positively influence members' health through plan benefit design, identifying and driving provider quality initiatives, and educating internal and external customers using your clinical acumen.

- Primary focus of position is the pharmacy subject matter expert, supporting internal partners (Humana state Medicaid Health Plans) and external partners (State Medicaid Agencies and contracted provider systems).
- Providing full service account management for the Humana Senior Products Medicaid division for all pharmacy-related needs
- Providing financial and utilization analysis related to pharmacy trends and collaborating with Market leadership on managing and understanding drivers of pharmacy utilization and spend
- Create and develop strategic initiatives around pharmacy to help the markets and the plan achieve operational targets and goals
- Participate representing Humana Pharmacy in Medicaid trend committees and relevant operational meetings
- Monitoring potential impacts from federal and state regulatory agencies for pharmacy program impacts and working with business partners in developing implementation strategies
- Providing expertise for annual pharmacy benefit planning and readiness activities
- Creating a high level of engagement with the respective senior products leadership team for each state or Medicaid product
- Engaging senior products leadership with Humana Pharmacy Solutions (HPS) programs and leading the pull-through of HPS initiatives aligned with Medicaid programs

- Participating in state association and agency relevant operational meetings
- Provide clinical support to providers through operational and executive meetings including analysis of key performance metrics to identify opportunities for improving quality and lowering costs
- Create high level of engagement with the respective market leadership/ provider groups/ and state agency personnel
- Identifying the new program and industry best practices that could be considered as part of trends and best practices
- Work with internal stakeholders to define appropriate messaging, strategy, and data analysis for internal Humana Inc. markets, and external provider systems
- Provide expertise and support to internal Humana Inc. markets and external provider systems related to pharmacy quality measures Approximately 10-20% overnight travel required.

Required Qualifications

- Active Louisiana Board of Pharmacy license, and in good standing
- Bachelor of Science degree in Pharmacy from a college accredited by the American Council on Pharmaceutical Education (ACPE).
- Minimum five (5) years of experience as a pharmacist practicing in a retail setting with managerial experience
- Minimum three (3) years of experience in managed care
- Knowledge of pharmacy practice and the cost drivers of pharmacy
- Familiarity with Pharmacy utilization, spend and trend financials
- Successful track record in facilitating and consulting across teams and managing projects
- Ability to work independently under general instructions and with a team
- Ability to develop cross functional relationships across multiple operational departments

- Excellent communication skills, both oral and written
- Proficiency in Microsoft Applications including Word, Excel, & Power Point

Preferred Qualifications

- PharmD degree
- Medicaid and/or Medicare experience
- Advanced Microsoft Excel skills
- Proficiency with Microsoft Access & Microsoft Project
- Experience with pharmacy benefits and health benefits management

Scheduled Weekly Hours

40

Scheduled Weekly Hours

40

Performance Monitoring Specialist, Clinical at WellCare

Source URL: https://jobs.wellcare.com/search/jobdetails/performance-monitoring-

specialist-clinical/fcb73aac-fb2a-41df-b6b3-51a752ad541b?
utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Performance Monitoring Specialist, Clinical at WellCare

Report To: Director, Quality Improvement

Department: PHS-NC Corp

Location: 8735 Henderson Road, Tampa, FL 33634

Conducts Utilization Management (Medical, Behavioral Health, Prior Auth, and Appeals) case documentation review for adherence to contract requirements and UM standards.

- Participates in the development and ongoing review of clinical review tool to ensure that clinical elements accurately capture adherence with required contract requirements and UM performance standards.
- Reviews Utilization Management program descriptions, policies and procedures, step actions, and training materials as well as State Contracts when needed to evaluate alignment of review tool elements, departmental processes, staff training, and contractual/departmental standards.
- Utilizes clinical knowledge and experience to evaluate documentation of medical necessity criteria, clinical needs and interventions in meeting UM standards and contract requirements.
- Participates in meetings with Utilization Management and others to discuss review findings, areas of opportunity and recommendations

for improvement.
- Appropriately escalates areas of concern identified during clinical file reviews.
- Participates as needed with preparation for State, CMS, and NCQA audits by collecting and /or reviewing clinical areas of relevance.
- Meets established productivity and IRR standards for file reviews.
- Follows departmental guidelines and processes.
- Other duties as assigned.

Candidate Education:

- Required A Bachelor's Degree in Nursing, Clinical Social Work/Counseling
- Required Other or Associate Degreed RN with 3 years of clinical experience

Candidate Experience:

- Required 3 years of experience in a clinical environment (inpatient or outpatient)
- Required 1 year of experience in Managed Care (UM, BH, CM)
- Preferred Other Familiarity with Medicare and Medicaid programs

Candidate Skills:

- Intermediate Ability to effectively present information and respond to questions from peers and management
- Intermediate Ability to identify basic problems and procedural irregularities, collect data, establish facts, and draw valid conclusions
- Intermediate Demonstrated time management and priority setting skills
- Intermediate Demonstrated written communication skills
- Intermediate Demonstrated interpersonal/verbal communication

skills
- Intermediate Ability to create, review and interpret treatment plans
- Intermediate Other Ability to read and interpret state and federal laws and regulations in relation to organization clinical documentation
- Intermediate Other Ability to assess clinical documentation in relation to audit standards and make recommendations for improvement based on findings
- Advanced Ability to work as part of a team

Licenses and Certifications:

A license in one of the following is required:
- Other A license in one of the following is required
- Required Licensed Registered Nurse (RN)
- Required Licensed Clinical Social Worker (LCSW)
- Required Licensed Mental Health Counselor (LMHC)
- Required Licensed Marital and Family Therapist (LMFT)
- Preferred Certified Case Manager (CCM)

Technical Skills:
- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft Outlook
- Required Intermediate Microsoft Word
- Preferred Intermediate Healthcare Management Systems (Generic)

Languages:
About us

Headquartered in Tampa, Fla., WellCare Health Plans, Inc. (NYSE: WCG) focuses primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex

medical needs primarily through Medicaid, Medicare Advantage and Medicare Prescription Drug Plans, as well as individuals in the Health Insurance Marketplace. WellCare serves approximately 5.5 million members nationwide as of September 30, 2018. WellCare is a Fortune 500 company that employs nearly 12,000 associates across the country and was ranked a "World's Most Admired Company" in 2018 by Fortune magazine. For more information about WellCare, please visit the company's website at www.wellcare.com. EOE: All qualified applicants shall receive consideration for employment without regard to race, color, religion, creed, age, sex, pregnancy, veteran status, marital status, sexual orientation, gender identity or expression, national origin, ancestry, disability, genetic information, childbirth or related medical condition or other legally protected basis protected by applicable federal or state law except where a bona fide occupational qualification applies. Comprehensive Health Management, Inc. is an equal opportunity employer, M/F/D/V/SO.

Apply

Medicaid Specialist I

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Medicaid Specialist I

Characteristics of Work
This is investigative work involving the interpretation of policy to determine Medicaid eligibility for families and children and aged, blind, and disabled individuals. The incumbent makes the initial and continuing determinations of eligibility for Medicaid recipients who live in private and institutional settings. Limited supervision is received from administrative supervisors who oversee a regional office or Central Enrollment Office.
Examples of Work
Examples of work performed in this classification include, but are not limited to, the following:

Assumes responsibility for a Medicaid eligibility determination caseload for a designated territory within a region.

Investigates and verifies accuracy of information provided by recipients under the Medicaid programs to determine compliance with State and Federal laws, rules, and regulations.

Determines an applicant's eligibility for institutional care based on State and Federal guidelines and verifies the accuracy of information listed on the applicants' applications.

Maintains effective public relations with medical facilities and federal, state, county, and city agencies within assigned territory.

Verifies accuracy of information listed on applicants' applications including income, bank accounts, and any other assets.

Makes determination of an applicant's eligibility based upon established criteria.

Visits contact centers and medical facilities; assists other regional offices on an as-needed basis.

Performs related or similar duties as required or assigned.
Minimum Qualifications
These minimum qualifications have been agreed upon by Subject Matter Experts (SMEs) in this job class and are based upon a job analysis and the essential functions. However, if a candidate believes he/she is qualified for the job although he/she does not have the minimum qualifications set forth below, he/she may request special consideration through substitution of related education and experience, demonstrating the ability to perform the essential functions of the position. Any request to substitute related education or experience for minimum qualifications must be addressed to the Mississippi State Personnel Board in writing, identifying the related education and experience which demonstrates the candidate's ability to perform all essential functions of the position.

EXPERIENCE/EDUCATIONAL REQUIREMENTS:

Education:

A Bachelor's Degree from an accredited four-year college or university.

OR

Education:

An Associate's Degree or completion of sixty (60) semester hours from an accredited college or university;

AND

Experience:

Two (2) years of experience related to the described duties.

Substitution Statement:

Above an Associate's Degree or completion of sixty semester hours from an accredited college or university, related education and related experience may be substituted on an equal basis.

Essential Functions

Additional essential functions may be identified and included by the hiring agency. The essential functions include, but are not limited to, the following:

1. Maintains caseload for Medicaid eligibility.

2. Maintains good public relations and customer service.

3. Collects eligibility data information.

4. Visits Medicaid contact centers and/or long-term care facilities.