Medicaid Industry Jobs Hunter 10.28.19

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Medicaid Jobs Hunter

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Director, Medicaid Care Management | AdvantageCare Physicians

https://www.linkedin.com/company/advantagecare-physicians/jobs/

Director, Medicaid Care Management

AdvantageCare PhysiciansNew York City, NY, US

Oversee a team of care coordinators and outreach workers responsible for person-centered care planning, addressing social determinants of health, and improving access to care. Develop, implement and monitor care coordination programs and processes, and quality improvement initiatives specifically designed to improve Medicaid member engagement, access to care, CHAPS scores, and overall quality performance. Develop and implement strategies designed to improve PDPQI performance. In collaboration with the Quality team, develop rewards and incentive programs for Medicaid members. Develop dashboards to evaluate and monitor performance and outcomes achieved by the care coordinators. Collaborate with the Director of Medicaid Strategy to implement innovations around social determinants of health. Ensure that Care Coordinators are implementing EmblemHealth Health plan policies, procedures and all regulatory mandates, consistent with EmblemHealth Plan's mission, vision, purpose and value statement in collaboration with departments across the enterprise. Report on program metrics, collecting all data needed.

Responsibilities

- Ensure all Medicaid members care is coordinated for all physical and mental health diagnoses, including communicating referrals to medical providers, behavioral health providers, and community-based referrals.
- Direct the day-to-day operation and performance of the Care Coordination unit.
- Effectively communicate with and guide the Care Coordinators to accomplish the Medicaid program's goals and objectives and facilitates clinical insight on Medicaid operational and member issues.
- Educate and work collaboratively with community partners, i.e. Health Homes, on member referrals, engagement and case conferencing
- Provide comprehensive outreach program planning with follow-through to members and an on as-needed, ongoing basis.
- Work collaboratively with enrollment and retention to ensure care coordinators assist in member recertification and retention.
- Develop and manage a plan of care program that ensures the health of all Medicaid members, including field-based outreach and visits, telephonic outreach to members, telephonic outreach to providers and community-based organizations, connections to health home services, and regulatory reporting.
- Design and implement Care Coordination and quality initiatives reporting requirements required by NYS DOH, OMH, OASAS.
- Working with LDSS, identify Medicaid members, develop their plans of care and update local government agencies in routine care conferences through discharge planning.
- Maintain contract obligations for all aspects of care to Medicaid members.
- Develop a dashboard with quality measures tracking Care

Coordination to oversee PDI/PQI requirements to support organizational deliverables.

- Deliver disease management coordination and support to Medicaid members, including managing the coordination of treatment and services among providers and community groups and services.
- Grow Medicaid membership at EmblemHealth, and in doing so meet expectations by each member to receive treatment and support-including medication.
- Develop optimal workflows with each business area within EmblemHealth to meet compliance with the Medicaid contract.
- Direct and manage treatment and services across EmblemHealth departments to align treatment best practices.
- Develop and report results across the enterprise for Key Performance Indicators describing care coordination for Medicaid patients.
- Provide education to community-based organizations on large scale trends by disease category affecting members.
- Provide education to community-based organizations on specific diseases on a case by case basis.
- Direct strategy and initiatives to engage the Medicaid population, ensuring that Care Coordinators meet all requirements for annual visits with providers.
- Design a member-incentive program with leaders of the Quality Management department.
- Develop survey methodologies to gain data directly from members and evaluate the effectiveness of EmblemHealth's care coordination of Medicaid population health.
- Address findings of surveys across departments in EmblemHealth to improve services and ensure health issues are fully addressed.
- Collaborate with LDSS and VFCA's and ensure liaisons are ensuring access to care and community partners for the medically fragile and

foster care children.
- Manage committee meetings across all operational groups to inform the business areas on what they are doing and to improve interdepartmental cross-functional ability.
- Lead and build effective, tight clinical relationships across the enterprise to ensure consistent delivery of services and resolution of obstacles and issues.

Qualifications

- Bachelor's Degree in healthcare, business, finance, mathematics, engineering, applied stats/economic or any other related analytical fields; Master's preferred
- RN preferred
- Minimum 10 years' experience in the healthcare or managed care industry, or related field required
- Minimum 3 - 5 years' experience managing staff/processes in Medicaid function or related required
- Industry level proficiency in all applicable Medicaid-related areas, including HEDIS/QARR/CAHPS, CMS Star Ratings, and Accreditation process required
- Thorough knowledge of State and/or Federal program operations and regulations required
- Experience managing performance and processes to improve performance required
- Excellent communication skills, written and verbal required
- Proven ability to establish and maintain relationships of trust with department staff and management required
- Proficient handling data, analytics, metrics; ability to interpret data and develop cohesive findings and summaries for senior management required
- Proficient in Microsoft Office (Word, PowerPoint, Excel, Access)

required

Additional Information

- Requisition ID: 1919K

NaviCare Account Manager Sales Rep. Fallon Health | Fallon Health

Source URL: https://www.linkedin.com/jobs/view/navicare-account-manager-sales-rep-fallon-health-at-fallon-health-1578061203/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

NaviCare Account Manager Sales Rep. Fallon Health

Fallon Health Worcester, MA, US

NaviCare Account Manager Sales Rep. Fallon HealthUS-MA-WorcesterJob ID: 5760Type: Full Time# of Openings: 1Category:

SalesFallon Health - Corp HQOverviewAbout 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 accredited by the National Committee for Quality Assurance for its HMO, Medicare Advantage and Medicaid products. For more information, visit About NaviCare:Fallon Health is a leader in providing senior care solutions such as NaviCare, a Medicare Advantage Special Needs Plan and Senior Care Options program. Navicare integrates care for adults age 65 and older who are dually eligible for both Medicare and MassHealth Standard. A personalized primary care team manages and coordinates the NaviCare member?s health care by working with each member, the member?s family and health care providers to ensure the best possible outcomes. Position Overview:Fallon Health?s NaviCare product is already a thriving and successful Medicare and MassHealth Standard offering with services throughout the state. This is a fantastic opportunity for a sales professional already specializing in Medicaid, Medicare or Insurance Product sales that?s looking to make a rewarding impact on helping Fallon build a membership base in a new region. What may make this even more attractive for the right individual is you can be based remote out of your home office! This of course takes a unique disciplined sales professional who thrives on autonomy and independence but we will provide plenty of support and occasional trips to the corporate office in Worcester. Come help

us grow and become a rock star opening a new territory.
Responsibilities

- Relationship BuildingCreates productive and collaborative relationships with internal and external referral sources in order to obtain qualified referrals and enrollments for the NaviCare program.Participates in community outreach activities, such as senior fairs, community events, and elder services professional association events.Presents the NaviCare program to groups who are likely prospects, caregivers and community referral sources.Develops and implements their own Territory Development Plan, and carries out activities to penetrate accounts listed on the plan
- Secure ApplicationsGenerates sufficient NaviCare enrollment applications to meet monthly enrollment goals.Explains the NaviCare program clearly and consistently to prospects and their families to ensure that prospects enroll with a solid understanding of the program and will remain members. Meets with NaviCare prospects in their homes.Tracking & ReportingDocuments all sales activities in the department?s CRM application in a timely manner.Meets weekly sales activity deliverables consistently, and tracks these in the CRM and their Outlook calendar.Maintains records of NaviCare applications and documentation related to scope of appointments.AssessmentRegularly reviews effectiveness of efforts against goals. Provides market intelligence to the NaviCare/SE Manager and the Marketing director so that adjustments can be made to tactical plansManages their own professional development by seeking advice, training, and coaching from their colleagues, manager, and the Director of Outreach.
- Regulatory GuidelinesOperates within the marketing and

outreach guidelines and regulations provided by CMS and EOHHS..Retains Scope of Appointment and other Enrollment Records.Submits information on NaviCare prospect events to Outreach Support in a timely manner, for CMS submission.When in doubt, asks questions pertaining to compliance or privacy regulations. QualificationsEducation, Licenses, certification and experience requirements:Education: BS or BA degree and/or comparable experienceLicense: Massachusetts Driver?s LicenseCertification: Experience: 3 years of sales experience in healthcare or group insurance strongly preferred.Must have proven experience working in a customer facing role focused on sales, lead generation in a high paced customer service or sales environment.Knowledge of Medicare, Medicaid and insurance products is desirable.Knowledge of customer service, sales, outreach and marketing principles and practices.Possession of a valid Mass. driver?s license and a vehicle to be used for marketing activities and home visits. JT18 PI114415340

Medicaid Eligibility Advocate in Odessa, TX - HCA Healthcare

Source URL: https://careers.hcahealthcare.com/jobs/4728720-medicaid-eligibility-advocate?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Eligibility Advocate

Odessa, TX, United States

Description

SHIFT: Days (rotating weekends)

SCHEDULE: Full-time
Do you have exceptional customer service and the ability to plan organize and exercise sound judgment? Do you demonstrate communication, problem solving and case management skills and the ability to act/decide accordingly? Now is the time to join our team of **motivated** and nurturing individuals working to assist patients with their Medicaid Eligibility screening and enrollment. Ideal candidates will have a steady work knowledge of medical terminology, practices and procedures, as well as laws, regulations, and guidelines. You should also share a passion for our purpose, **"To serve and enable those who care for and improve human life in their community."**

Does this sound like you? If so, APPLY TODAY. See what makes us a **fabulous place to work!**

WHAT WE CAN OFFER YOU:

- We offer you an excellent total compensation package, including competitive salary, excellent benefit package and growth

opportunities. We believe deeply in our team and your ability to do excellent work with us.
- Your benefits package allows you to select the options that best meet the needs of you and your family. Benefits include 401k, paid time off medical, dental, flex spending, life, disability, tuition reimbursement, employee discount program, employee stock purchase program and student loan repayment.

WHAT YOU WILL DO:

- Responsible for conducting eligibility screenings, assessment of patient financial requirements, and counseling patients on insurance benefits and co-payments.
- Serve as a liaison between the patient, hospital, and governmental agencies; and you will be actively involved in all areas of case management.
- Screen and evaluate patients for existing insurance coverage, federal and state assistance programs, or hospital charity application.
- Re-verify benefits and obtains authorization and/or referral after treatment plan has been discussed, prior to initiation of treatment.
- Ensures appropriate signatures are obtained on all necessary forms.
- Obtain legal relevant medical evidence, physician statements and all other documentation required for eligibility determination, and complete and file applications.
- Initiate and maintain proper follow-up with the patient and government agency caseworkers to ensure timely processing and completion of all mandated applications and accompanying documentation.
- Document progress notes to the patient's file and the hospital computer system.
- Participate in ongoing, comprehensive training programs as

required.
- Required to make field visits as necessary.

Qualifications

- College degree preferred or high school diploma (equivalent).
- Minimum three years of hospital/medical business office experience with insurance procedures and patient interaction
- Understanding of patient confidentiality to protect the patient and the clinic/corporation.
- Ability to collect, synthesize and research complex or diverse information.
- Must be bilingual in Spanish.
- Must have flexible schedules, including weekends.

ABOUT US

Parallon is an **industry leader** in revenue cycle services. We partner with over 650 hospitals and 2,400 physician practices nation-wide. Our parent company, HCA Healthcare has been consistently named a **World's Most Ethical Company** by Ethisphere and is ranked in the Fortune 100. We are dedicated to ensuring our patients have the best experience even after they leave our facilities.

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

Project Manager (Remote - Medicaid Healthplan Operations) | Molina Healthcare

Source URL: https://www.linkedin.com/jobs/view/project-manager-remote-medicaid-healthplan-operations-at-molina-healthcare-1538129322/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Project Manager (Remote - Medicaid Healthplan Operations)

Molina Healthcare Greater New York City Area

Molina Healthcare of NY is hiring a Project Manager to oversee their Medicaid Healthcare Operations projects.

- Candidate with prior experience in Medicaid Managed Care are highly desirable.
- Candidates with Project Management Certification are highly desirable.

- Experience working with Enterprise Projects and a Matrix environment is highly desirable.
- Demonstrated experience with Process Improvement projects.
- Capacity to work on multiple projects at the same time, excellent communication skills and MS Office experience are highly desirable.

Job Summary:
Plans and directs schedules as well as project budgets. Monitors the project from inception through delivery. May engage and oversee the work of external vendors. Assigns, directs and monitors system analysis and program staff. These positions' primary focus is project/program management, rather than the application of expertise in a specialized functional field of knowledge although they may have technical team members.

Knowledge/Skills/Abilities:
• Manages all aspects of assigned projects throughout the project lifecycle including project scope, schedule, resources, quality, costs and change.
• Develops and maintains detailed project plan to include milestones, tasks, and target/actual dates of completion.
• Revises project plans as appropriate to meet changing needs and requirements.
• Prepares and submits project status reports to management.
• Schedules and conducts project meetings to include logistics, agendas, and meeting minutes.

Required Education:
Associate's Degree or equivalent combination of education and experience

Required Experience:
3-5 years

Preferred Education:
Bachelor's Degree or equivalent combination of education and experience

Preferred Experience:
5-7 years

Preferred License, Certification, Association
PMP or Six Sigma Green Belt certification

Skills

Analytical Skills
Medicaid
Medicaid Managed Care
Managed Care
Program Management
Project Management
Process Improvement
Communication
Project Plans
Process Improvement Projects

Level of education

Associate's Degree

Job Details

Seniority Level

Mid-Senior level

Industry

- Hospital & Health Care
- Non-profit Organization Management
- Insurance

Employment Type

Full-time

Job Functions

- Project Management
- Management
- Health Care Provider

Support Specialist - Medicaid | Moda Health

Source URL: https://www.linkedin.com/jobs/view/support-specialist-medicaid-at-moda-health-1574988682/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Support Specialist - Medicaid

Moda Health Portland, OR, US

Support Specialist - Medicaid

Job Title
Support Specialist - Medicaid
Duration
Open Until Filled
Location
Portland,
OR
97204
Other Location
Job Class: P10/108.0

Description

Let’s do great things, together Founded in Oregon in 1955, Moda is proud to be a company of real people committed to quality. Today, like then, we’re focused on building a better future for healthcare. That starts by offering outstanding coverage to our members, compassionate support to our community and comprehensive benefits to our employees. It keeps going by connecting with neighbors to create healthy spaces and places, together.Moda Health is seeking a Medicaid Services Support Specialist. This position will provide ongoing assistance to team by working with internal and external customers in the Eastern Oregon Coordinated Care Organization (EOCCO) network to problem solve issues with claims, customer service and member access. Support the Encounter Data process and other functions of the Medicaid Services department. Responsible for various weekly/monthly routine tasks and reports.Are you ready to be a betterist? If you’re ready to make a difference that matters, we want to hear from you. Because it’s time to discover what’s possible. Together, we can be more. We can be better. Moda Health seeks to allow equal employment opportunities for all qualified persons without regard to race, religion, color, age, sex, sexual orientation, national origin, marital status, disability, veteran status or any other status protected by law.

Required Skills

- College degree in Public Health or equivalent work experience.
- 2 – 4 years claims, customer service, provider relations, billing and eligibility and/or benefit programming background preferred. Working knowledge of the Oregon Health Plan (OHP) encouraged.
- PC proficiency with Microsoft Office applications.
- Knowledge and understanding of Medicaid program mandates and administrative policies preferred.
- Ability to read and interpret written materials into practical application.

- Ability to communicate with technical and non-technical individuals both internally and externally on CCO contract and administrative rule changes.
- Good analytical, problem solving, organizational and detail orientation skills.
- Strong verbal, written, and interpersonal communication skills. Must be able to communicate with internal and external contacts in an effectively.
- Ability to meet deadlines and work well under pressure; work with frequent interruptions and shifting priorities in a complex and rapidly changing environment.
- Ability to come in to work on time and on a daily basis.
- Maintain confidentiality and project a professional business image.

Clinical Operations Manager - Behavioral Health | CareOregon

Source URL: https://www.linkedin.com/jobs/view/clinical-operations-mgr-behavioral-health-at-careoregon-1535849955/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Clinical Operations Manager

Position Title: Behavioral Health Clinical Operations Manager

Department: Clinical Operations

Title of Manager: Director, Clinical Operations

Supervises: Utilization Management Team Supervisor

Exemption Status: Exempt

Requisition: 13216

General Statement of Duties

This position is responsible for managing the organization's utilization management team. Areas of oversight include prior authorizations, referrals, concurrent review for Behavioral Health Services. This includes the development and implementation of program standards and procedures, monitoring program impact, and ensuring effectiveness and integrity. This position works closely with other managers across the organization to ensure collaboration, integration and support of organizational activities and goals.

Essential Position Functions

Operational Management

- Provide operational and clinical leadership.
- Develop and implement utilization programs and services to ensure the use of CareOregon resources meet medical appropriateness and least costly alternative criteria; this entails oversight of multi-

million dollar costs of services.

- Work collaboratively with department leaders to oversee program standards and procedures and to monitor program impact and effectiveness on the health, experience, and cost of care for the membership.
- Lead team in setting and fulfilling established goals and objectives.
- Ensure policies and procedures meet CareOregon/Division of Medical Assistance Program (DMAP) contracting requirements and the Centers for Medicare and Medicaid (CMS) requirements.
- Ensure program compliance with DMAP, CMS, and other relevant regulatory bodies that oversee health plan operations.
- Ensure integration of work between program functional areas; promote effective communications within CareOregon and between external partners, providers and members.
- Consult with Behvioral Health Medical Director(s) as appropriate for input on complex clinical cases and benefit management policies.
- Act as a technical and operational resource to program supervisors.
- Ensure unit work is performed in coordination with other relevant CareOregon departments; service as a liaison and collaborator with multiple teams including provider customer service, claims, appeals and grievances, population health, information systems, and others.
- Keep current on standards for health plan operations related to utilization and case management.
- Perform on-going analysis of data and information, looking for opportunities for improvement in appropriate utilization of resources.
- Frequently communicate with providers and partners to problem solve issues and improve workflows.
- Monitor outlier utilization and communicate with Finance department and reinsurer to ensure compliance with contracted reporting expectations.

- Collaborate with IS on system performance, improvement and functionability to maximize performance of multiple technology platforms and products, and to provide reporting to internal and external stakeholders.

Program Development, Improvement, and Evaluation

- Collaborate with Behavioral Health department leadership on updates to clinical policies and procedures, and benefit management policies.
- Assist in regularly developing programmatic guidelines, and ensure these guidelines are followed.
- Identify opportunities for improvement and participate in their development and implementation, including process improvement initiatives.
- Develop, utilize and regularly monitor measures/metrics to improve the program's effectiveness and efficiency of work processes.
- Create a unit environment that encourages professionalism and teamwork and uses progressive problem solving to meet expectations.

Management and Leadership

- Train, supervise and evaluate performance of assigned staff.
- Provide staff with the training, mentoring and resources necessary to carry out their work.
- Ensure adherence to department and organizational standards, policies and procedures.
- Ensure performance goals, expectations and standards are clearly understood by supervised staff.
- Evaluate employees' performance on an ongoing basis and take appropriate corrective action if needed.
- Perform human resource functions in collaboration with Human

Resources.

- Represent CareOregon at community stakeholder and coalition-building meetings.
- Act as a role model to departmental staff for professional behavior and appropriate work ethic.

Knowledge, Skills and Abilities Required

- Advanced knowledge of managed care concepts and principles
- Advanced knowledge of health plan regulatory requirements for Medicaid and Medicare managed care plans
- Advanced knowledge of basic health plan operations
- Advanced knowledge of utilization management concepts, principles and practices
- Advanced knowledge of care coordination and case management concepts, principles and practices
- Knowledge of principles of organizational change and ability to act as a change agent
- Knowledge of disease management and health promotion principles and processes
- Excellent time management and organizational skills
- Excellent reading, oral and written communication skills
- Excellent problem solving and decision making skills
- Excellent interpersonal skills
- Ability to effectively collaborate with the department's medical directors, leadership and staff, and other stakeholders/customers
- Ability to work well under pressure in a complex and rapidly changing environment
- Ability to work in an environment with diverse individuals and groups
- Ability to negotiate skillfully and to build consensus
- Ability to manage staff, including mentoring staff growth

- Ability to oversee services involving substantial costs
- Ability to supportand comply with organizational policies, procedures and guidelines
- Ability to use basic computer programs commonly used for health plan operations
- Ability to implement projects and to train staff to new processes and procedures
- Ability to develop and implement procedures and program standards
- Ability to manage multiple tasks, complex projects, and to delegate as deemed appropriate
- Ability to work as an effective team member and leader in a complex and fast-paced environment

Cognitive And Other Skills And Abilities

Ability to focus on and comprehend information, learn new skills and abilities, assess a situation and seek or determine appropriate resolution, accept managerial direction and feedback, and tolerate and manage stress.

Required

Education and/or Experience

- Master's degree in health care related field
- Minimum 5 y ea r s' experience in a health care setting, including a minimum of:
- 2 years' experience in a Medicare and/or Medicaid health plan setting

- 2 years’ experience in quality, compliance, and/or operations work
- Minimum 2 years’ experience in a supervisory or leadership role

Preferred

- Work experience in a behavioral health system of care and/or administering Medicaid/Medicare behavioral health benefits
- Management or supervisory experience in managed care
- Licensure (LPC, LCSW, LMFT)
- Process improvement and project management experience
- Health Plan experience, including detailed knowledge of the Oregon Health Plan (OHP) benefit and the Division of Medical Assistance Programs (DMAP) and the Centers for Medicare and Medicaid Services (CMS) rules and regulations
- Experience with NCQA Accreditation, certification in Utilization Management (CPUM), Health Care Management (CPHM), Managed Care Nurse (CMCN) or Case Management (CCM)

Working Conditions

- Environment: This position’s primary responsibilities typically take place in the following environment(s) (check all that apply on a regular basis):

☒ Inside/office ☐ Clinics/health facilities ☐ Member homes

☐ Other___________________________________

- Travel: This position may include occasional required or optional travel outside of the workplace, in which the employee’s personal vehicle, local transit, or other means of transportation may be used.
- Equipment: General office equipment
- Hazards: n/a

Equal opportunity employer. This company considers all candidates regardless of race, color, religion, sex, sexual orientation, gender identity, national origin, disability or veteran status.

Veterans welcome to apply

VP- Medicaid Programs | Henry Ford Health System

Source URL: https://www.linkedin.com/jobs/view/vp-medicaid-programs-at-henry-ford-health-system-1575064002/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

VP- Medicaid Programs

Henry Ford Health System Troy, MI, US

General Summary

The Vice President of Medicaid Programs is responsible for
the strategic direction and business operations for the managed
Medicaid
divisions of Health Alliance Plan, part of the Henry Ford Health System.
This
position provides the vision and leadership to enable profitability,
growth and
stability of the Medicaid lines of business including Special Needs Plans
(D-SNP) and manages key regulatory relationships in order to address
issues
including premium rates, eligibility, membership assignment, program
changes,
and contractual requirements.
With a team of product specific direct reports and many
matrix relationships, the Vice President will collaborate with matrix
leaders
in marketing, government relationships, operations, medical
management, network
contracting and performance management, risk adjustment and
compliance, the
Vice President will drive membership growth, community outreach and
manage the
medical loss ratio and achieve the highest levels of quality and member
satisfaction. This position's direct reports include two - four leaders
(Managers and/or Directors) and provides oversight of 20+ indirect
reports.
The successful candidate will bring past experience and understanding
of working in the health insurance industry, specifically in government
programs that are role models of success. S/he will also have
demonstrated applying

sound and replicable business solutions to address the changing focus of healthcare
to a more consumer-oriented, risk-based model that incorporates social determinants of health. This position calls for the talents and experience of a
respected and dynamic leader who will establish credibility with members,
providers, executives and employees. S/he
will have an excellent reputation with state MMP leadership gained through
proven success within the healthcare industry.
This is a wonderful opportunity to grow HAP's Medicaid business from its current state to one that is significantly larger. HAP is part of the Henry Ford Health System, one
of the largest delivery systems in Michigan.
PRINCIPAL DUTIES

And Responsibilities

Business Development
and Strategy

- Develop and oversee implementation of annual and

multi-year business plans.

- Collaborate with HAP Senior Vice President and

Chief Business Development and Marketing Officer to define develop innovative
and differentiated program offerings to support growth, earnings and further

the Henry Ford Health System mission.

- Collaborate with HFHS Senior Vice President and

Chief Strategy Officer to establish customer experience strategy across all
Medicaid and Commercial Individual programs and with accountable leader within
Henry Ford Provider System to drive medical cost control and growth targets.

- Establish the business objectives for critical

functions that impact business performance (including functions such as
contracting, population health, provider performance management, operations,
risk adjustment and medical cost management). Work with matrixed business
leaders in these functions as they develop strategies to execute on these
defined business objectives.

- Establish business objectives for membership

growth, including acquisition and retention objectives. Integrate strategies
that increase membership through alternative sources, outreach, education
activities and strategic provider and 2 of 4 community relationships. Develop
and execute value propositions, market positioning and voice to consumers,
community leaders and affinity partners.

- Assess changes in the external environment

including state and federal government, identify implications and develop plans
to address.
- Remain alert to trends and federal and state

policies and new opportunities to support government sponsored products such as
ACA Exchange business.
- Collaborate with VP of Strategy and Business

Delivery to support strategy development and monitoring, and delivery of
technical solutions to support Medicaid programs.
- Provide input to function leaders on issues

impacting business success including medical cost innovation, quality, operations, member experience and government affairs.
- Identify local alliances and relationships,

including key decision-makers and influencers in the community. Develop, maintain
and leverage relationships with key external stakeholders in target markets.
Distribution and Measures Management
- Lead and oversee measures management for

Medicaid products in all markets.
- Ensure Medicaid strategic plans are translated

into tactical goals, objectives and lead measures that guarantee performance
measures are met or exceeded.

- Partner with executive shared services teams to

ensure that enterprise-wide quality, operational, financial and leadership
expectations are met.

- Partner with Medicare Product Manager to ensure

Medicaid priorities are clear and execution occurs in line with expectations in
those matrixed markets.

- Collaborate with cross functional leaders to

identify and implement opportunities for improved business performance.
Operational Management

- Lead, direct and oversee operational management

for Medicaid products in all markets.

- Ensure Medicaid strategic plans and customer

experience strategy are translated into tactical goals, objectives and lead
measures that guarantee operational objectives are met or exceeded.

- Collaborate with cross functional leaders to

identify and implement opportunities for improving operational performance.

- Develop and lead a Medicaid vendor and/or

partner strategy to support all operational functions of Medicaid Programs that
meets or exceeds operational management goals, objectives and lead measures.

- Collaborate with vendor management team(s) to

ensure acquisition of services required to support vendor strategy and ongoing
relationship management, including adherence to all business and administrative
regulations.

- Collaborate with Director of Compliance,

Government Programs and Medicaid Compliance Officer, to ensure compliance with
all business, administrative and relevant federal, State and local regulations.
Financial Management

- Lead financial performance P & L

accountability of all Medicaid plans to meet membership, earnings and quality
targets. Take appropriate actions to increase revenue, leverage resources,
manage and/or minimize expenses and drive medical expense initiatives.

- Partner with HFHS and HAP Finance leaders to

develop the annual fiscal operating budget to ensure financial goals and supporting operational objectives are met.

- Provide executive profit and loss (P&L)

leadership, direction and operational oversight.

- Accountable for successful deployment of the

budget to deliver required growth in membership, manage medical loss ratio and
achieve quality and member satisfaction goals.

- Collaborate with a matrixed cross-functional

team to identify opportunities to improve performance and develop plans to
drive growth, manage medical cost and utilization and improve quality.

- Perform other related duties as assigned.

Required

EDUCATION/EXPERIENCE

- Bachelor's Degree required in related field
- Master's
  Degree preferred.
  - Minimum of ten (10) years of progressively

  responsible management experience in managed care insurance, finance, government, health care setting or related field.
  - Minimum of five (5) years of business unit

  leadership with P&L responsibility and a proven ability to drive membership growth and profitability.
  - Experience in Medicaid managed care.
  - Experience in at least one of the following:

  market strategy, network management, risk adjustment, Medicaid

compliance or medical cost management.

- Strong leadership skills, with experience in

driving organizational alignment and change.

- Experience in strategic management and execution

of Medicaid strategy. Must meet or exceed core customer service responsibilities, standards and behaviors as outlined in the HFHS' Customer Service Policy and

Summarized Below

- Communication ?Ownership ?Understanding ?Motivation
- Sensitivity ?Excellence ?Teamwork ?Respect

Must practice the customer skills as provided through on-going training and in-services. Must possess the following personal

Qualities

- Be self-directed
- Be flexible and committed to the team concept
- Demonstrate teamwork, initiative and willingness

to learn

- Be open to new learning experiences
- Accepts and respects diversity without judgment
- Demonstrates customer service values

Overview

Henry Ford Health System, one of the largest and most comprehensive integrated U.S. health care systems, is a national leader in clinical care, research and education. The system includes

the 1,200-member Henry Ford Medical Group, five hospitals, Health Alliance Plan (a health insurance and wellness company), Henry Ford Physician Network, a 150-site ambulatory network and many other health-related entities throughout southeast Michigan, providing a full continuum of care. In 2015, Henry Ford provided $299 million in uncompensated care. The health system also is a major economic driver in Michigan and employs more than 24,600 employees. Henry Ford is a 2011Malcolm Baldrige National Quality Award recipient. The health system is led by President and CEO Wright Lassiter III. To learn more, visitHenryFord.com.

Benefits

Whether it's offering a new medical option, helping you make healthier lifestyle choices or making the employee enrollment selection experience easier, it's all about choice. Henry Ford Health System has a new approach for its employee benefits program - My Choice Rewards. My Choice Rewards is a program as diverse as the people it serves. There are dozens of options for all of our employees including compensation, benefits, work/life balance and learning - options that enhance your career and add value to your personal life. As an employee you are provided access to Retirement Programs, an Employee Assistance Program (Henry Ford Enhanced), Tuition Reimbursement, Paid Time Off, Employee Health and Wellness, and a whole host of other benefits and services. Employee's classified as contingent status are not eligible for benefits. Equal Employment Opportunity/Affirmative Action Employer Equal Employment Opportunity / Affirmative Action Employer Henry Ford Health System is committed to the hiring, advancement and fair treatment of all individuals without regard to race, color, creed, religion, age, sex, national origin, disability, veteran status, size, height, weight, marital status, family status,

gender identity, sexual orientation, and genetic information, or any other protected status in accordance with applicable federal and state laws.

Prior Authorization/Utilization Review Nurse - Job at Independent Care Health Plan (iCare)

Source URL: https://www.milwaukeejobs.com/job/detail/39397132/Prior-Authorization-Utilization-Review-Nurse?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Prior Authorization/Utilization Review Nurse

Job Description:

This professional position reviews the clinical appropriateness of prior authorization (PA) requests and ensures that all benefits authorized meet medical necessity and other Medicare and/or Medicaid criteria if applicable to promote cost-effective delivery of health care services. Works with the Chief Medical Officer (CMO)/Medical Director to review

PA requests, and ensures appropriate information sharing takes place between the PA Department and Care Management and/or other Departments to facilitate proper care management activities.

1. Review PA requests for home health services, durable medical equipment, outpatient therapies, skilled nursing facility therapies, and all outpatient procedures pursuant to applicable Medicare and Medicaid criteria, *i*Care guidelines, and PA Department policies and procedures.
2. Provide complete and accurate documentation specifying the rational for approval, or for forwarding to the CMO/Medical Director for further review.
3. Create reduction/denial letters based on the CMO/Medical Director's review and applicable guidelines.
4. Maintain a thorough understanding of Medicare and Medicaid guidelines and stay abreast of updates and changes.
5. Work in collaboration with the PA staff to ensure timely and efficient completion of all workflows within the Department.
6. Fully participate in *i*Care's Compliance Program, including compliance with *i*Care's Code of Conduct, policies and procedures, and all applicable Privacy and Security laws.

DOM-Medicaid Program Nurse III

Source URL: https://www.governmentjobs.com/jobs/2612186-0/dom-medicaid-program-nurse-iii?

utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

DOM-Medicaid Program Nurse III

Characteristics of Work
The DOM-Medicaid Program Nurse III practices professional nursing under the direct or indirect supervision of the Medicaid-Program Nurse Director or the DOM-Medicaid Nurse Bureau Director. The work includes case finding, health teaching, health counseling, assessment, and evaluation of providers of services and related sites to ensure compliance with Medicaid Provider agreements, development, and review of Medicaid policies. Other duties include analyzing findings and recommending plans for correction to the providers. The incumbent may provide technical and programmatic guidance to nurses in the DOM-Medicaid Nurse I and DOM-Medicaid Nurse II classifications.
Examples of Work
Examples of work performed in this classification include, but are not limited to, the following:

Reviews and studies federal and state laws, rules, and regulations governing agency's compliance.

Interprets and explains Medicaid regulations and guidelines to providers, beneficiaries, families, and other groups.

Conducts workshops and/or on-site training to providers of service in order to improve skills and knowledge of Medicaid rules and regulations.

Reviews and analyzes trends pertinent to delivery of services to Medicaid beneficiaries.

Develops and recommends new and revised policies, procedures, plans, and strategies to respond to changes in program needs, objectives, and priorities and to improve the effectiveness of services.

Provides assistance in developing and implementing policy and procedures for detecting fraud and abuse of program services, mis-utilization of services by providers and beneficiaries, and utilization reviews.

Reviews and audits records, charts, and reports to determine if correct and appropriate services were given.

Monitors and evaluates providers of service and related provider sites to beneficiaries in the Medicaid program.

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 Master's Degree in Nursing;

AND

Experience:

Five (5) years of experience in nursing as a Registered Nurse/Nurse Practitioner and licensure as required below;

OR

Education:

Graduation from a state approved Nurse Practitioner program with credentials (certification);*

AND

Experience:

Five (5) years of experience in nursing as a Registered Nurse/Nurse Practitioner and licensure as required below;

OR

<u>Education</u>:

A Bachelor's Degree from an accredited four-year college or university in nursing;

AND

<u>Experience</u>:

Six (6) years of experience in nursing as a Registered Nurse/Nurse Practitioner and licensure as required below;

OR

<u>Education</u>:

A three-year diploma in nursing or a two-year Associate's Degree in nursing, and licensure as required below;

AND

<u>Experience</u>:

Seven (7) years of experience in nursing as a Registered Nurse/Nurse Practitioner and licensure as required below;

OR

<u>Experience:</u>

One (1) year as a DOM-Medicaid Program Nurse II, or three (3) years as a DOM-Medicaid Program Nurse I, and licensure as required below.

Certification/Licensure Requirements:

Must have a valid license to practice as a Registered Nurse and/or Nurse Practitioner in the State of Mississippi.

*Must possess approved certificate in area of practice.

Documentation Required:

Applicant must attach a valid copy of his/her license to practice as a Registered Nurse and/or Nurse Practitioner in the State of Mississippi.

INTERVIEW REQUIREMENTS:
Any candidate who is called to an agency for an interview must notify the interviewing agency in writing of any reasonable accommodation needed prior to the date of the interview.

Pharmacy Director (NC Medicaid)

Source URL: https://www.governmentjobs.com/jobs/2608549-0/pharmacy-director-nc-medicaid?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Pharmacy Director (NC Medicaid)

****This position is exempt from the State Human Resources Act****

Position Summary

The Pharmacy Director provides oversight and management to the Medicaid Direct (Fee-for-Service) Pharmacy Benefit Management and the Managed Care Pharmacy Benefit. This position will also manage and oversee additional Medicaid Program Services (Pharmacy, Durable Medical Equipment and Supplies and Prosthetics and Orthotics, Specialized Therapies, Independent Practitioners and Local Education Agencies).

Job Specific Responsibilities

- Direct the prescription drug and medical drug benefits for the NC Medicaid Direct, in compliance with both Federal and State regulations to meet the goals, objectives and priorities of the Department and the Division.
- Provide oversight of the prescription drug and medical drug benefit offered by the managed care health plans
- Provide direction and oversight to departmental and division staff and multi-disciplinary project teams, with the oversight of the managed care prescription drug and medical drug benefit for each of the managed care health plans

- Identify clinical and financial initiatives and necessary modifications to current programs and processes intended to produce positive clinical and financial outcomes; trend and direct the implementation and operational oversight of these initiatives and modifications into the managed care pharmacy benefit design
- Lead in the assessment of value-based pharmacy programs and alternative payment models to continually enhance the performance of associated clinical and financial performance metrics (e.g. medication adherence, pharmacy provider network access, PMPM, etc.).
- Direct and oversee the development and ongoing process to maintain the NC Medicaid and NCHC Preferred Drug List (PDL).
- Direct and support analysis of program initiatives including drug rebate programs for the pharmacy and medical drug benefit.
- Develop and implement fee-for-service program components.
- Authorize payment system controls to ensure services are properly reimbursed and ensure the Medicaid claims system reflects policy guidelines and appropriate change control requests are initiated, implemented and monitored.
- Work with prepaid health plans' pharmacy benefit managers, external vendors, and stakeholders to align program goals and benefit execution.
- Work on the pharmacy benefit design and requirements in any division or departmental procurements.
- Monitor and evaluate progression of goals and objectives
- Coordinate activities and external communications to ensure program compliance with Federal and State requirements.
- Maintain liaison and good relations with State and Federal partners
- Ensure program clinical coverage policies are developed and aligned with the requirements of State law and Federal regulations.
- Oversee the coordination of all activities with State agencies;

appropriate clinical/professional organizations; and various stakeholders.
- Ensure program contracts reflect performance-based concepts and are appropriately administered

Salary Grade: GN22

Position #:   60042665

Salaries are determined based on education, experience, equity and budget

The North Carolina Medicaid and NC Health Choice programs (NC Medicaid), managed by the Division of Health Benefits (DHB), helps North Carolinians improve their health and well-being by providing access to services and supports for low-income parents, children, seniors, people with intellectual / developmental disabilities, behavioral health needs or substance use disorders. With a budget of more than $14 billion per fiscal year, Medicaid ensures that 69,000 enrolled providers are reimbursed for delivering covered services to more than two million beneficiaries.

On Sept. 23, 2015, the North Carolina General Assembly passed Session Law 2015-245, as amended, directing NCDHHS and DHB to lead the transformation of the Medicaid and NC Health Choice programs from a predominantly fee-for-service delivery system to managed care