Medicaid Industry Jobs Hunter 03/09/20

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Medicaid Jobs Hunter

In this packet….

Program Director/Program Manager | Healogics, Inc.

Program Director/Program Manager

Description

Healogics is hiring for a Program Director to join our Wound Care Center team in Van Nuys, CA

Schedule: Full Time Monday-Friday, Standard Daytime Business Hours

Job Summary

The Program Director or Program Manager is responsible for the management and the strategic growth of the Wound Care Program for the assigned area of responsibility. This position is responsible for the complete oversight of the Wound Care Center, to include the following functions: day-to-day center operations, staff management, financial management, quality/performance improvement, and community education. The Program Director/Program Manager is also responsible for maintaining collaborative and consultative client relationships within and outside the hospital organization and for creating effective working relationships between Healogics and the hospital.

All Healogics employees must perform their job responsibilities according to all Healogics policies, Hospital policies, as well as to accrediting organizations, federal and state regulation, and to the Centers for Medicare and Medicaid Services (CMS) guidelines, as applicable.

Essential Functions/Responsibilities: (Percentage times shown in parenthesis next to each function)

- Manages the Center's Operations (20%):
  - Oversees the day-to-day management of outpatient clinic(s) and other wound continuum programs, as applicable.
  - Continuously assesses current clinic flows, processes and procedures, identifies areas of improvement, and develops and implements best practices and appropriate changes to improve outcomes, using the company's resources.
  - Works with hospital and company personnel to ensure availability of adequate resources, supplies, equipment and services.
  - Facilitates the flow of information and maximizes effective communication throughout the program.
  - Prioritizes responsibilities and directs the work of the Center's clinical staff and non- clinical staff.
  - Collaborates with other health care providers, Wound Care Center Providers, and Medical Director regarding clinic and patient needs.

- Manages direct reports in conjunction with the company and hospital HR departments. This includes interviewing, hiring, motivating, coaching, counselling, establishing performance expectations, and conducting performance reviews. (5%)
- Performs Financial Management (10%):
  - Manages and coordinates all aspects of the revenue cycle for Healogics and for the hospital partner, as appropriate.
  - Stays current with reimbursement changes, providing physician and staff updates and education as needed.
  - Reviews key financial reports, identifies key indicator trends and develops plans to implement best practices to ensure fiscal responsibility.
  - Tracks and reports all ancillary revenues generated by the program.
  - Manages costs through appropriate utilization and management

of labor and supply.
    - Works with Healogics support team to complete financial reviews and presents results to hospital leadership.

- Manages Community Education/Marketing functions (40%)
    - Works directly with the hospital and Healogics marketing departments to ensure that the wound care program has established strategic marketing plans and works with the same group and the hospital physician liaison to plan, coordinate, and execute activities directed toward increasing patient referrals to the wound care center(s).
    - Works collaboratively, as part of a multi-functional team, to best determine key target referral sources, and develops a systematic approach to build those customer relationships and increase wound care center referrals.
    - Maintains, monitors and updates the list of Physician Practice(s) within a given radius of the hospital on an ongoing basis.
    - Visits Physician Practices and interacts with key physicians to provide awareness of the Wound Care Center program, using educational marketing materials. Also documents all physician office interactions, as well as the visits with the Physician Practices in the Healogics Customer Relationship Management (CRM) system.
    - Communicates on a regular basis with the (C)DO and/or (C)VPO and the hospital executive sponsor regarding goals, targets, and other relevant referral development information, as needed.

- Manages Quality/Performance Improvement functions (10%):
    - Implements and manages a continuous Wound Care Center Performance Improvement Program (PIP) and strives to meet Wound Care Center quality indicators. Ensures program is integrated into the partner hospital's PIP program.
    - Participates in hospital committees as appropriate and ensures

timely and accurate documentation in the patient record and outcomes database.
    - Monitors patient, referring physician and customer satisfaction.
    - Ensures that Patient Safety Guidelines are followed, that Healogics employees complete annual compliance requirements, and creates an environment that promotes the escalation of compliance concerns as appropriate.

- Manages Relationships (15%):
    - Maintains excellent relationship with hospital client and continuously seeks to understand needs, confirm goal alignment and demonstrate value proposition. Identifies the hospital strategic goals and objectives and manages the program to achieve those goals, while remaining compliant with all Healogics operations standards. Works effectively and seamlessly at all levels within the partner hospital. Participates in hospital department/management meetings and actively participates in Hospital communication activities.
    - Builds and develops effective working relationships with panel physicians, clinical and support staff. Encourages all program staff to provide excellent customer service to members of other hospital departments.
    - Meets regularly with leadership including hospital and area management.
    - Performs other duties as required.

Required Education, Experience And Credentials

- Bachelor's degree in Business Administration, Healthcare Administration, Nursing or related field preferred and Five (5) or more years of marketing/community education in the healthcare industry or clinical operations experience, with increasing levels of responsibility
- OR Associate's degree in Business Administration, Healthcare

Administration, Nursing or related field preferred and seven (7) or more years of marketing/community education in the healthcare industry or clinical operations experience, with increasing levels of responsibility to include management
- Management experience preferred

Required Knowledge, Skills And Abilities

- Demonstrated knowledge of regulatory/accrediting requirements for healthcare organizations
- Proficient in Microsoft Office Suite (Word, Excel, Outlook and PowerPoint)
- Strong interpersonal, verbal and written communication skills, to include group presentation skills
- Strong analytical and quantitative skills
- Strong customer service and follow-up skills
- Strong organization, time management skills and ability to multi-task in a fast-paced environment
- Leadership and teaching skills
- Strong relationship building and influential skills
- Strong team building and motivational skills
- Ability to work with Healogics and hospital management.
- Budget and strategic planning skills
- Ability to travel overnight

The Program Director is ultimately accountable for achieving program metrics, demonstrating the value proposition to the customer and contract retention.

Healogics is the nation’s largest healthcare provider for wound care services and offers our consulting services to nearly 800 hospitals throughout the United States. If you would like to join a specialized team dedicated to wound healing and committed to sharing our

expertise, apply today.

Client Account VP, Health Plans | American Well

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Client Account VP, Health Plans

Company Description

Amwell is a leading telehealth platform in the United States and globally, connecting and enabling providers, insurers, patients, and innovators to deliver greater access to more affordable, higher quality care. Amwell believes that digital care delivery will transform healthcare. We offer a single, comprehensive platform to support all telehealth needs from urgent to acute and post-acute care, as well as chronic care management and healthy living. With over a decade of experience, Amwell powers telehealth solutions for over 240 health systems comprised of 2,000 hospitals and 55 health plan partners with over 36,000 employers, covering over 150 million lives.

Brief Overview

The Client Account VP will play a critical role in the success of Amwell's relationship with one very large assigned client. The Client Account VP will be assigned to this client, managing and overseeing all facets of the client's experience. Success will be measured by creating new value for the client using Amwell's products and services through health plan cost of care savings, new revenue, or strategic differentiation in their markets. The Client Account VP success will be measured in new business opportunity development, revenue growth, client satisfaction, optimizing telehealth enrollments and utilization, and the overall deep engagement and financial performance of the client. While managing a high-performing strategic client, the on-going focus of the role will be to strengthen and broaden relationships within each of the P&L and functional areas including commercial, government business, digital strategy and provider strategies, product and clinical, at all levels, including senior and executive level leadership to maximize value.i

The role requires extensive knowledge of 1) task management around product and services deliverables, 2) execution beyond initial launch of new programs and innovations, 3) account planning and understanding of client's objectives; 4) identification of new revenue opportunities, 5) product demonstrations and explanation of features and functionality, and 6) internally interfacing and coordinating with business leadership and project, marketing, clinical and product resources to support the client.

Working directly for the President and GM of the Clinical Programs division and executive sponsor of the strategic account, the Client Account VP will be tasked to seamlessly interface and gain the trust of

the client at all levels, and lead the internal Amwell client account and internal functions team through implementations, launch, marketing, campaigns, re-selling to client's employer accounts, and expansion of the existing relationship.

Frequent interaction with the Amwell executive sponsor and other Amwell leads to keep the entire team apprised of client strategies, goals, objectives, and tactical developments is essential. This key position will be focused on client satisfaction, retention, and revenue growth.

Core Responsibilities

While tactically managing the needs of the client on a day to day basis, the Client Account VP will strategize with client account leadership and project/program leads. This will require an understanding of the client's expectations, objectives, initiatives, and opportunities for growth. Additional responsibilities include:

- Up-sell and grow the account as well as accurately forecast respective opportunities in Sales Force.com based upon realistic assessments.
- Collaborate with internal and external teams to develop strategic and tactical plans to achieve desired annual revenue and growth targets.
- Support and have an understanding of the client's member populations, including Commercial, Medicaid, and Medicare recipients.
- Nurture the strategic client to ensure success, satisfaction, and retention.
- Lead presentations and site visits
- Understand Amwell's key differentiators, product strategy, product

features and functionality, and their applicability to the client's implementation.
- Oversee the senior director and sales/account team to work with client employer teams to effectively sell, deploy and implement telehealth at individual employer accounts, including delivering product demonstrations, presentations, review of best practices, and sharing client success stories.
- Demonstrate a clear understanding of the sales process and product and service value propositions.
- Maintain professional internal and external relationships that reflect the core values of Amwell.
- Stay current on changing and evolving telehealth landscape, regulations, and related health plan/payer trends.

Qualifications

- 8-10 years of minimum experience and background working specially with health plan organizations.
- Proven track record successfully selling enterprise technology solutions to health plan executives.
- Deep knowledge of the payer/health plan space, including reimbursement, health care services delivery, employer and population health and wellness programs, employee benefits.
- Excellent written and presentation skills, including responding to RFIs and RFPs.
- Skilled relationship developer.
- Strong planning and organization skills.
- Background in product, marketing, and/or professional services beneficial.
- Must be comfortable dealing with and managing in an extremely fluid, fast-paced environment.
- BS Degree required. MBA preferred
- Previous consulting experience is considered valuable
- Experience selling products and/or services to health plan

executives

Additional Information

Your Team

Should you join Amwell and the Clinical Services team, you can expect:

The Clinical Services team is a fast growing, fast paced clinical services team who works directly with onboarding clinicians to offer flexible physician jobs that connect patients through live, video visits. Care is delivered utilizing the AmWell system, as well as client-branded systems in which you will play a key role in supporting.

The Online Care Group offers care in all 50 states and provides Urgent Care, Behavioral Health, Nutrition and Lactation services to the general public, as well as multiple employer groups and health plans.

Online Care allows patients and consumers to connect with physicians immediately, through an innovative Telemedicine Platform. Whether a patient has the flu or a general health question, they can access the professional help of our Online Care Group providers from the comfort of their home or office. We use the most advanced Web-based technologies and telephony to remove traditional barriers to healthcare access, including insurance coverage, geography, mobility and time constraints.

In addition to New Clinical Programs, the Clinical Services team is comprised of 4 key areas: Provider Onboarding, Provider Operations, Network Operations, and Clinical Quality. We all work together to

develop innovative new clinical programs, help find the best doctors to work on the platform, support their technology needs, and build relationships to make the provider and patient experience unique and successful.

Working at Amwell

We strive to make the hard work of healthcare look easy. In order to make this a reality, we look for people with a fast-paced, mission-driven mentality. We're a go-getter culture that prides itself on quality, efficiency, smarts, initiative, creative thinking, and a strong work ethic. Our corporate headquarters are located in downtown Boston at 75 State Street –in the heart of the city. In addition to the opportunity to build the future of healthcare technology and a great location, we offer:

- Unlimited Paid Time Off
- 401K match
- Competitive health, dental and vision insurance plans
- Pre-tax commuter benefits
- On-site gym – free to use and open 24/7
- Prime office space with roof deck access and views overlooking all of Boston
- Café lounge stocked with a wide range of complimentary snacks, coffee and other beverages.

Director, Market Leadership | Humana

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Director, Market Leadership

Description

This role is uniquely positioned to influence health care leaders and other stakeholders to think differently about health and wellness. Enthusiasm for improving the health care system and prior community leadership experience within health-related foundations, associations, and charitable entities is strongly desired.

The successful candidate will possess broad managed care leadership experience and significant Medicare Advantage experience from the payer side. He/she will have current or recent experience in the market with a strong track record of building provider relationships and expanding business opportunities. Prior business “ownership” and operating experience within a health care provider entity will be advantageous to this role.

A current perspective regarding Health Care Reform initiatives and their impact on payer/provider business models is required, as is the ability to effectively articulate a strategy or value proposition to professionals across the continuum of health care business entities.

Responsibilities

- Establish and maintain an executive leadership presence in key metropolitan markets within the markets, developing business relationships with customers and decision-makers in provider and community settings.
- Represent Humana as a progressive thought leader on Health Care Reform initiatives and our approach to improving our health care system. Drive and support initiatives to position Humana as a leader in helping people achieve lifelong well-being and align this objective with business strategies supporting product development, agent attraction, and provider engagement.
- Work closely with the Regional President to develop membership and financial performance goals for multiple markets, assessing which specific strategies and tools will be most effective.
- As a key contributor to business strategy, develop trust and credibility with cross-functional leadership teams. Collaborate with National Contracting, Medical Management, MarketPoint (Medicare sales distribution), Market Operations, Commercial Sales/Operations, and other core functions to develop and execute on strategies specific to defined markets.
- Align with the Provider Development/Engagement team to foster strategic provider relationships, with sensitivity to potential joint venture, acquisition and/or other innovative partnership opportunities.
- Create innovative partnership opportunities which increase shared reward opportunities with providers; develop tactics which integrate Humana's health and well-being strategies and commitments into provider orientation and ongoing communication

Required Qualifications

- Bachelor's degree in related field
- 8 plus years successful business leadership experience in managed care insurance, finance, health and wellness, with 5 or more years as

the executive leader of a business development, network development or provider relations function
- Comprehensive knowledge of health plan finance and the compensation arrangements between health plans and providers, including the financial viability of complex provider contracts
- Familiarity with/exposure to Medicare managed care experience is essential
- Experience building and managing relationships with a wide variety of providers
- Prior operational leadership experience in finance, health services, and/or medical management; ability to partner across functions to create and deploy win/win strategies
- Competencies such as big-picture visualization, critical thinking and sequencing, (i.e., the ability to envision the product of complex business goals and work backwards to ensure all of the requisite steps and details are covered for successful achievement)

Preferred Qualifications

- Master's degree in related field
- Medicaid and Dual-Eligible experience is desired

Additional Information

Scheduled Weekly Hours

40

Associate Manager, Healthcare Compliance | Lyft

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Associate Manager, Healthcare Compliance

Company Name Lyft Company Location San Francisco, CA, US

Posted DatePosted 1 day agoNumber of applicants Be among the first 25 applicants

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At Lyft, our mission is to improve people's lives with the world's best transportation. To do this, we start with our own community by creating an open, inclusive, and diverse organization.

Lyft is hiring for its growing Compliance Team. If you want to help Lyft

change the transportation industry and enjoy finding creative solutions to complex problems, this team is for you!

As the Associate Manager for Healthcare Compliance, you will engage in a variety of healthcare compliance related projects including working with cross-functional teams to assess compliance risks and deliver solutions. The role requires an understanding of healthcare compliance requirements including HIPAA privacy, Medicare and Medicaid regulations, healthcare fraud/waste/abuse prevention, regulatory audits and inquiries. In this role, you will report to Lyft's Director of Healthcare Compliance.

Responsibilities

- Work with internal business partners to identify compliance gaps and devise remediation plans
- Manage healthcare compliance education programs for internal business partners
- Interface with background and exclusion screening teams to ensure requirements for healthcare workforce and vendors are met
- Participate in investigations of reported non-compliance related to healthcare
- Play a supporting role in healthcare audits and inquiries
- Recommend improvements to processes and controls and help stakeholders address risks identified
- Stay current on changing federal and state regulations impacting healthcare business operations

Experience

- Bachelor's degree with 5+ years experience in a healthcare

compliance role
- Healthcare Compliance training or certification preferred (i.e. CHC, CHPC)
- Experience in managing projects related to healthcare compliance such as audit responses, regulatory inquiry responses, compliance training, compliance regulatory implementations, and drafting policies and procedures
- Ability to lead teams or projects to accomplish compliance objectives
- Willingness to learn, collaborate, build relationships, and demonstrate flexibility to respond to evolving business needs and strategy

Benefits

- Great medical, dental, and vision insurance options
- In addition to 11 observed holidays, salaried team members have unlimited paid time off, hourly team members have 15 days paid time off
- 401(k) plan to help save for your future
- 18 weeks of paid parental leave. Biological, adoptive, and foster parents are all eligible
- Monthly commuter subsidy to cover your transit to work
- 20% off all Lyft rides

Lyft is an Equal Employment Opportunity employer that proudly pursues and hires a diverse workforce. Lyft does not make hiring or employment decisions on the basis of race, color, religion or religious belief, ethnic or national origin, nationality, sex, gender, gender-identity, sexual orientation, disability, age, military or veteran status, or any other basis protected by applicable local, state, or federal laws or prohibited by Company policy. Lyft also strives for a healthy and safe workplace and strictly prohibits harassment of any kind. Pursuant to the San Francisco Fair Chance

Ordinance and other similar state laws and local ordinances, and its internal policy, Lyft will also consider for employment qualified applicants with arrest and conviction records.

Director Of Operations Integrated Care For Kids Program | Ann & Robert H. Lurie Children's Hospital of Chicago

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Director Of Operations Integrated Care For Kids Program

Company Name Ann & Robert H. Lurie Children's Hospital of

Chicago Company Location
Evergreen Park, IL, US

Posted DatePosted 1 day agoNumber of applicants Be among the first 25 applicants

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The Director of Operations provides operational, financial, strategic and human resource leadership to Lurie Children's Integrated Care for Kids (InCK) program funded through a Centers for Medicare and Medicaid Innovations grant. Plans, coordinates, communicates and evaluates systems and processes that support the InCK program. Builds and maintains strong, collaborative working relationships within Lurie Childrens Hospital and the participating community organizations. Develops and refines strong collaborative relationships with providers, vendors and community organizations leading to improvements in patient outcomes, network satisfaction, reduced medical costs, and achieving quality targets. Facilitates strategic discussions, builds consensus, and drives decision making among cross-functional teams, departments, community organizations and key stakeholders. Collaborates with the Executive Committee to achieve InCK program quality goals and grant requirements. The ideal candidate will have exstensive and proven record of managing programs working with communities of color.
Responsibilities

- Hires and manages InCK staff.

- Oversees network contracting and relationships. Develops a strategy to recruit and retain community organizations and medical providers to participate in the InCK network. Acts as the community-facing leader for all issues and concerns from the network and manages the network liaisons.
- Actively manages InCK vendor partnerships and subcontracting. Meets regularly with Service Integration Coordinator vendor and reviews performance reports to ensure high levels of performance and assist with the resolution of problems and issues as they arise in a timely manner.
- Working through the network liaisons, manages aggregation of clinical and social data and ongoing maintenance of data feeds across the network. Assists the data aggregation vendor and community organizations and practices with establishing the data feeds necessary for the quality improvement and reporting requirements of the InCK program.
- Accounts for the financial management of the InCK grant. Plans and monitors all budgets/contracts/funds. Ensures financial templates are up-to-date and accurate for all personnel assigned to work on the grant. Reports financial status to Executive Director, Financial Director, Executive Committee and the Partnership Council.
- Working with the Medical Director, Behavioral Health Director and the Clinical Quality Committee and through the network liaisons, oversees the implementation of quality improvement initiatives within the InCK network.
- Working with the Executive Director, produces quarterly and annual reports regarding the performance of the InCK program to be submitted to CMS at regularly scheduled intervals.
- Supports functions of the Partnership Council and its committees, including assisting the Executive Director in preparing for meetings. Attends and staffs meetings.
- Acts as a project leader for assigned projects including all

marketing and communications of the InCK program.

- Collaborates with InCK Executive Director, Executive Committee, Healthy Communities leadership and the Foundation Liaison to identify opportunities and seek, steward and manage existing and new funding for the growth and enhancement of InCK initiatives.
- Cultivates collaborative internal and external relationships to enhance the presence and growth of the InCK program and network.
- Assumes other responsibilities as assigned. Qualifications
- Masters degree in business, Public Health, Health Administration, a related field or commensorate work experience required.
- Minimum of 5 years prior health care and/or community organization experience required.
- Strong financial and grants management experience.
- Demonstrated strong verbal and written communication skills.
- Proven ability to analyze issues and formulate and implement action plans.
- Must be self-directed, with in-depth understanding of the organizational and InCK goals.
- Demonstrated strong leadership skills. Ability to lead in a collaborative and facilitative style.
- Must possess discretion and sound judgment.
- Demonstrated ability to juggle multiple projects and work with a sense of urgency when necessary.
- Local travel required.

Manager, Care Coordination | Main Line Health

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(99+) Manager, Care Coordination

Job Description

Main Line Health is suburban Philadelphia's most comprehensive health care resource with over 11,000 employees, offering a full range of medical, surgical, obstetric, pediatric, psychiatric and emergency services. Composed of five hospitals, a medical research institute, physician practices and other specialized facilities and services. Recognized as a Magnet system Main Line Health is committed to the highest standards of patient care, education and research.

Bryn Mawr Hospital is a 319-bed not-for-profit acute care hospital, located in the heart of the Bryn Mawr community and easily accessible from all areas of the Philadelphia and the western suburbs. For more than 100 years, Bryn Mawr Hospital has provided quality compassionate care to our patients. We have made it our mission to provide patients with a superior patient experience. This translates to the consistent delivery of safe, high quality clinical care in the absence of preventable

harm. Today, the Hospital continues its leadership as a sophisticated community hospital offering advanced medical technology and access to the most qualified medical staff in the region.

Why Work at Bryn Mawr Hospital?

The *Philadelphia Business Journal* named Bryn Mawr Hospital one of the top ten "Best Places to Work" in the Delaware Valley. We also rank among Modern Healthcare 's top 100 places in the nation to work in healthcare. The hospital has been named among *U.S. News & World Report's* Best Hospitals for the Philadelphia metro area and has been nationally recognized by Press Ganey, Truven Analytics, and The Joint Commission for its high quality patient care. The Hospital has received Magnet® designation by the American Nurses Credentialing Center (ANCC), the nation's highest award for recognizing excellence in nursing care.

We are committed to providing exceptional care with empathy and compassion for people at all stages in life. Our Diversity, Respect and Inclusion Initiative celebrates our differences and our similarities. Ultimately, we want everyone to feel respected for who they are.

Turn your job into a career by joining Main Line Health!

Job Title: Manager, Care Coordination – Bryn Mawr Hospital

Job Summary

The Care Coordination Manager will manage the operations of the site-specific Care Coordination Department both functionally and administratively. The Care Coordination Site Manager will demonstrate the knowledge and skills necessary to be accountable for the responsibilities of RN Care Coordination and Social Work activities. The Care Coordination Site Manager will facilitate communication between the Care Coordination Department and other departments/members who encompass the multidisciplinary team.

Primary Functions

Essential Accountabilities:

Ensures Quality Care Coordination

- Responsible for oversight for day to day Care Coordination responsibilities for RN and Social Work Care Coordination Services, Coordination at designated facility.
- Participates with the RN Care Coordination and SW Care Coordination and staff in the development and implementation of standards for the department.
- Monitors and directs staff in developing and implementing effective plans for coordinating the care of patients - assuring individualized plans and the utilization of clinical pathways when appropriate.
- Acts as a resource for RN and SW Care Coordination staff.

- Coordinates and facilitates timely completion of outlier reports. Encourage staff to report potential outliers to the Care Coordination Site Manager, Social Work Supervisor, and/or Financial Services.
- Works with Senior Leadership regarding Care Coordination data that is shared with them on a regular basis.
- The operation of Care Coordination, Emergency Care Coordination, and Social Work Services seven days per week, including after hours on-call coverage and holiday coverage.
- Assures communication in Care Coordination Services by conducting monthly staff meetings and maintaining minutes.
- Demonstrates the ability to relate to all age groups and is knowledgeable of age specific developmental tasks/challenges and issues related to each group (i.e. neonates, pediatrics, adult-geriatric). Is aware of resources to assist such patients.

Coordinates Appropriate Staffing

- Responsible for delegation of assignments and appropriate aspects of Care Coordination to members of the Care Coordination teams. Monitors workflow and assists in equitable distribution and coverage of assignments.
- Approves and monitors requested time off as per departmental policy, utilizing part-time and per diem coverage.
- Maintains accurate time schedules and posts on-call schedule at least one week prior to start of new schedule period.
- Interviews and appoints applicants for staffing positions within the department with the System Director.

Plans and Monitors Development of Staff

- Orient new employees to the department as to Policy and Procedures for Care Coordination Services, assign with preceptors, and evaluate readiness for accepted position.

- Develop staff by identifying learning needs and providing support for their development.
- Identifies potential disciplinary problems in conjunction of Social Work Supervisor (if present) (performance, attendance, punctuality) and addresses with staff on a timely basis. Formulates interventions with the System Director to improve behavior and foster growth.
- Develops and maintains a system for auditing performance expectations and meeting Departmental Goals.

Plans for and Monitors the Financial Operations of the Site

- Participates in the preparation of the annual operational, capital and personnel budgets for the site and coordinates with Social Work Supervisor (if present)..
- Monitors, evaluates and controls appropriate utilization of budgeted FTE's and operational expenses.
- Work within budgetary constraints.
- Works with Finance Director to justify any variances to the established budgetary parameters.

ORGANIZATIONAL/DELEGATIONAL

- Hold assigned staff accountable for:
- Complying with hospital policies and procedures
- Documenting information consistent within established guidelines
- Communicating information consistent with established guidelines
- Identifying staff learning needs
- Completing assignments
- Hospital Code of Conduct guidelines
- Participates and supports Quality Improvement programs within the department.
- Evaluates and supports changes, updates and needs for Policies and Procedures within the department.

- Acts as member of various Steering Committees where/when assigned.
- Assigns Department staff to specific committees and ancillary task force groups when requested by Senior Leadership.
- Reviews LOS and plan of care issues with the Physician and participates in understanding of denials and delays for process improvement.
- Demonstrates awareness of cost containment by implementing standards and changes to support cost containment.
- Supports Reviewer maintenance and user assignments in Clinical Data entry system.
- Monitors applications for documentation of correct disposition. Coordinates staff education and updating of new codes by HIM
- Monitors effectiveness of Web-based program for clinical entry and Discharge Planning.

Education

QUALIFICATIONS

- Graduate of an accredited School of Nursing, Bachelor's degree or in progress required, MSN preferred ***OR*** graduate of an accredited school of Social Work; Master's degree required

Licensures & Certifications

- Current licensure in the Commonwealth of PA as a Registered Nurse or Social Worker.
- Care Coordination certification preferred or active pursuance.
- Certified Professional Utilization Review certification preferred or active pursuance.
- Certification preferred or active pursuance in Documentation and

Compliance.

Experience

- Minimum of 2 years direct medical Care Coordination experience.
- Ability to orient, motivate, train and act as resource person for the team by utilizing excellent communication and organizational skills acquired through education and/or experience.
- Previous nursing or social work experience to include: med/surg and home health/discharge planning, or utilization review or other appropriate health related field.
- Working knowledge of insurance including but not limited to Medicare, Medicaid, and Managed Care.

We offer competitive compensation and outstanding comprehensive benefits including tuition reimbursement, 403B matching savings plan, a pension plan, and a generous paid time off program. To be considered, please apply online with your resume at https://www.mainlinehealth.org/careers Enter Job ID 51801 in Keyword search box.

Applicants must certify that they have not used tobacco products or nicotine in any form in the 90-days prior to submitting an application to Main Line Health. This will be verified during pre-employment testing. We are an Equal Opportunity Employer. Please, no agency calls.

Primary Location

United States-Pennsylvania-BrynMawr

Work Locations

Bryn Mawr Hospital

Job

Management

Organization

B04019-Care Management

Schedule

Full-time

Shift

Day Job

Employee Status

Regular

Job Posting

Mar 10, 2020, 12:09:18 PM

Shift Details

1

Policy Analyst, Health | American Academy of Actuaries

Policy Analyst, Health

Company Name American Academy of Actuaries Company Location Washington, D.C., DC, US

NewPosted DatePosted 20 hours agoNumber of applicants Be among the first 25 applicants

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The Health Policy Analyst Will

The American Academy of Actuaries (Academy) is seeking a public policy analyst to oversee a portfolio of issues related to health insurance at the federal, state, and international levels.

- Act as the lead staff representative interacting with public policymakers on issues of key concern to the Academy in the area of private health insurance, Medicare, Medicaid and other public and private health programs/systems.
- Build relationships with policymakers and regulators to expand the

Academy's role in health insurance policy issues.
- Develop and maintain relationships with key stakeholders, congressional and administration offices, relevant congressional committees of jurisdiction, and the National Association of Insurance Commissioners (NAIC).
- Monitor and facilitate Academy interactions with agencies such as the Center for Medicare and Medicaid Services (CMS), Center for Consumer Information and Oversight (CCIIO), Congressional Budget Office, and Government Accountability Office.
- Proactively identify initiatives to increase the effectiveness of the Academy's health insurance public policy efforts.
- Working with Academy volunteers and staff, assist in the development of Health Practice Council statements, comment letters, issue briefs, and other public policy content.
- Develop webinars and briefings for internal as well as external audiences on relevant Academy health policy work.

PandoLogic. Keywords: Healthcare Policy Analyst, Location: Washington, DC - 20036

Seniority Level

Associate

Industry

- Non-profit Organization Management
- Insurance
- Financial Services

Employment Type

Full-time

Job Functions

- Other

Dental Consultant/Healthcare | DXC Technology

Source URL: https://www.linkedin.com/jobs/view/1775982693/?alternateChannel=search&refId=66c2c44b-b78b-4910-9911-c24439919a4e&trk=flagship3_search_srp_jobs

Dental Consultant/Healthcare

Company Name DXC Technology
Company Location Madison, WI, US

NewPosted DatePosted 12 hours agoNumber of applicants Be among

the first 25 applicants

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Job Description

DXC Technology (NYSE: DXC) is the world's leading independent, end-to-end IT services company, helping clients harness the power of innovation to thrive on change. Created by the merger of CSC and the Enterprise Services business of Hewlett Packard Enterprise, DXC Technology serves nearly 6,000 private and public sector clients across 70 countries. The company's technology independence, global talent and extensive partner alliance combine to deliver powerful next-generation IT services and solutions. DXC Technology is recognized among the best corporate citizens globally. For more information, visit www.dxc.technology.

The Dental Consultant will review Medicaid Prior Authorizations based on medical necessity in accordance with State policy guidelines, provide guidance and support for Medicaid Providers when appropriate, and act as a clinical SME (or liaison) for internal DXC entities. Note: This is **not** a patient facing position.

Primary Job Responsibilities

- Adjudicating dental prior authorizations based on medical necessity and eligibility, in accordance with State policy guidelines and accepted dental practices.
- Reviewing and evaluating prior authorization submissions utilizing multiple computer systems, and when appropriate seeking additional information or clarification from requesting Provider
- Entering prior authorization outcome into the Medicaid Management Information System (MMIS) for processing.
- Participation in monthly meetings which include DXC leadership, operational staff support, clinical peers and State stakeholders.
- Providing assistance and education to the provider community related to specific prior authorization submissions, when applicable.
- Offering analysis and recommendations to DXC and State leadership on methods and potential process improvements related to the administration and application of the dental program.
- Review communications to providers and members on new/revised policies.
- Working onsite in Madison, WI

Qualifications

- Current license to practice dentistry in the state of WI (or license from another state and ability to obtain WI license prior to position start date).
- Knowledge of and/or experience working with the Wisconsin Medicaid program (or other state's Medicaid programs)
- Excellent interpersonal, oral, and written communication skills.
- Ability to meet deadlines and manage priorities with minimal direct supervision.
- Experience working with various partners or team members toward shared goals.
- Ability to communicate effectively and interpret policies and procedures.

- This is a part time position working 25 hours per week, onsite at the Madison, WI location

Vice President of Medicare / Medicaid Claims job with Capstone Search Group

Source URL: https://www.orlandojobs.com/job/6430947/vice-president-of-medicare-medicaid-claims/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Vice President of Medicare / Medicaid Claims

About the Role

This is an exceptional opportunity to do innovative work at one of America's leading health benefits companies and a Fortune Top 50 Company. Responsible for developing the claims payment and adjustment strategy in Government Business Division Claim Operations.

Duties & Responsibilities

- Leads multiple claims processing units & executes strategies to

deliver industry leading service results
- Improves processes and partners across lines of business to develop consistency and share best practices
- Drives results to improve provider satisfaction
- Builds strong partnerships with Plan Presidents
- Leads systems consolidation efforts, compliance requirements, and monitors state/federal regulations
- Hires, trains, coaches, counsels, and evaluates performance of direct reports

Skills & Experience

- Health Insurance / Payer at larger competitors
- Government – Medicaid and/or Medicare
- Transaction Operations, Claims Leadership Depth and Breadth
- Oversight of vendor relationships and operations transition experience
- 10 + years of management experience in claims that includes adjustments in managed care
- MBA preferred
- Focused on metric driven results, identifies and analyzes problems using facts and data to leverage resources available and solve problems creatively

DSHS OOS Integrated Systems Program Manager | Dept. of Social and Health

Services - State of Washington |

Source URL: http://agency.governmentjobs.com/washington/job_bulletin.cfm?jobID=2738529&sharedWindow=0

Job Bulletin

OPENING DATE: 03/06/20 **CLOSING DATE:** 03/26/20 11:59 PM
DESCRIPTION:

Are you driven by the ability to operate as a decision catalyst? Joining our team as the Integrated Systems Program Director, you'll have a unique opportunity to impact the services provided within the Department of Social and Health Services as well as influence five other Washington State agencies in creating system synergy and modernizing business processes.

Serving as the lead program director of the Health and Human Services Coalition (HHS) in implementing program operations for DSHS and the coalition partners, this is a high-visibility role supporting the critical need for an integrated eligibility platform to better serve Washingtonians. With the evolving capacity of this job, you'll enjoy the ability to utilize strategic vision, initiative, and process improvement to establish a precedence for the integrated approach.

You'll be providing technical and organizational leadership in the areas of:

- Business plan and strategies to support an integrated eligibility

platform for use by coalition agencies.
- Modular approach to implementing technology systems.
- Identification of HHS Coalition plans which have an impact on coalition partners.
- Organizational change management as it relates to initiatives involving multiple agencies.
- Lean/Continuous Process Improvement as a component of business process re-engineering of impacted programs.
- Devising and implementing communications, marketing, and customer relations of assigned initiatives.
- Collaborate with multiple agencies and executives.
- Electronic Health Record completion.

What we're looking for:

- Demonstrated expertise in organizational change and effectively guiding and influencing people to accomplishing outcomes.
- Excellent negotiation skills and the ability to navigate multiple viewpoints in order to set the scope and outcomes of business portfolio management work.
- Ability to create original concepts and theories across a variety of projects and to think creatively and beyond normal constraints, including across functional and organizational boundaries inside and outside of the enterprise.
- Strength in organizational management initiatives that show evidence of innovative outcomes and related business cased for the overall enterprise.
- Advanced skill in consulting and facilitating concepts among a variety of stakeholders and executives.
- Ability to influence decisions by developing and presenting information to the most senior levels of the HHSC executive level, legislature and governing bodies in both federal and state entities.
- Understanding of federal or state government in a general sense along with laws, policies and governance which impact social and

health services.

Who should apply:

- Professionals with a Master's degree in organization development, applied behavioral sciences, business administration or a related field.
- A minimum of 8 years of experience in organizational change management, strategic planning, process improvement, performance measurement, project management or portfolio management.
- Experience leading multi-disciplinary teams and facilitating discussion on complex multi-system-issues.
- 5 years of experience in project leadership over projects costing 10 million or more.

Interested? Include the following with your application:

- Current resume
- Cover Letter that addresses your demonstrated experience and education as it relates to the points listed above in 'Who Should Apply.'

Questions about this opportunity? Please email Lindsey White at Lindsey.white@dshs.wa.gov or call (360) 890-5962 and reference job 02375