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Medicaid Jobs Hunter

November 12, 2018

In this issue...

SourceURL: https://www.linkedin.com/jobs/view/healthcare-insurance-coordinator-at-fresenius-medical-care-north-america-957368268/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Healthcare Insurance Coordinator

Company Name Fresenius Medical Care North America Company Location

Birmingham, AL, US

Posted Date Posted 4 weeks ago Number of views 1 view

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Job description

Purpose And Scope

Explores, recommends, and coordinates the insurance and potential financial assistance options available to kidney dialysis patients in a specified geographic area, while maximizing revenue for the company. Supports FMCNA's mission, vision, core values and customer service philosophy. Adheres to the FMCNA Compliance Program, including following all regulatory and company policy requirements

Principal Duties And Responsibilities

Meets regularly with dialysis patients at the clinic(s) in the assigned region to educate and coordinate insurance options:

- Educates on the availability of alternative insurance options (i.e., Medicare, Medicaid, Medicare Supplement, State Renal programs and COBRA).
- Ensures patients have followed through with the application process.
- Obtains premium statements and signatures from patients.
- Discusses situation and options if employment status changes or other situations change.
- Completes and follows up with paperwork when claims are disputed for non-payment.
- Collects necessary documents to completed initial and annual indigent waivers.
- Discusses insurance options when insurance contracts are terminated.

Responsibilities involving Medicare and Medicaid include but are not limited to:

- Determining Medicare eligibility by meeting with the patients and contacting local Social Security offices to verify eligibility.
- Discussing the Medicare application with eligible patients and assisting with the application process.
- Acting as liaison between the patient and the local agents for Medicare terminations and re-in statements.

- Completing the annual open enrollment and Medicare reinstatement papers with the patients.
- Tracking 30-month coordinator period each month for those patients on employer Group Health Plans to ensure Medicare will be in place once coordination ends.
- Monitoring and verifying the Medicaid status of each patient on a monthly basis and determining the spend down amounts
- Works with patients to evaluate personal financial information and make determination for indigent program.
- Completes initial Indigent waiver applications.
- Tracks and completes annual indigent waiver applications.
- Monitors all patients' insurance information to ensure that it is updated and accurate for the Accounts Receivable Department.
- Addresses any identified anomalies or discrepancies, researches and answers questions as needed.
- Meets with patients receiving direct payments from insurance companies to ensure payment of dialysis treatments owed to Fresenius.
- Prepares, analyzes and reviews monthly reports to track work progress on caseloads; Analyzes patient reports from billing systems as an audit check to ensure the correct insurance information is entered into the billing system and that other changes are not overlooked. Researches and corrects any discrepancies identified.
- Provides QA team members with monthly information regarding the details of the patients' primary and secondary insurance status as well as documentation regarding the plans of actions currently in place on a monthly basis as required by QA processes
- Completes monthly audit exam to stay current on internal policies.
- May present on insurance and financial assistance options to patients as necessary.
- Assist with various projects as assigned by direct supervisor.
- Other duties as assigned.

Additional responsibilities may include focus on one or more departments or locations. See applicable addendum for department or location specific functions.

Physical Demands And Working Conditions

The physical demands and work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Day to day work includes desk and personal computer work

and interaction with patients and facility staff. The work environment is characteristic of a health care facility with air temperature control and moderate noise levels. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Extensive local travel to clinics in a specified geographic area; must have a valid Driver's License.

Education

- Bachelor's Degree required; Social Work or other Healthcare focus preferred.

Experience And Required Skills

- 2 – 5 years' related experience; healthcare industry preferred.
- Experience with Medicare, Social Security and Medicaid systems a plus.
- Past patient interaction a plus.
- Excellent written and communication skills.
- A strong customer service philosophy.
- Strong organizational and time management skills.
- Ability to work independently.
- Proficient with PCs and Microsoft Office applications.
- Valid Driver's License

EO/AA Employer: Minorities/Females/Veterans/Disability/Sexual Orientation/Gender Identity

Senior Government Health Plan/Managed Care Financial

Consultant

Apply Now

Marsh & McLennan Companies

Marsh & McLennan helps clients identify new opportunities by addressing the full range of risks, facilitating capital flows, and overcoming barriers to investment.

Company Profile

About This Job

Location

Save For Later

Description:

Mercer's Government Human Services Consulting (GHSC) practice focuses on the unique and challenging needs of the public health care sector, providing a wide array of consulting services to local, state, and federal government agencies

across the country. GHSC specializes in helping governments shape tomorrow's health programs. GHSC has been partnering with states and other stakeholder organizations for over 30 years to support health care programs for the low-income and most vulnerable populations in this country.

To accomplish these challenging and exciting tasks, GHSC brings together a team of highly-skilled and dedicated consultants, clinicians, actuaries, analysts, accountants and pharmacists across four offices in Phoenix, Minneapolis, Atlanta and Washington DC to ensure a coordinated approach to the administrative, clinical, operational, actuarial, and financial components of public-sponsored health care programs.

To learn more about Mercer's GHSC practice, please visit www.mercer-government.mercer.com.

The Senior Government Health Plan/Managed Care Financial Consultant will lead consulting work involving the review and analysis of Medicaid health plan reported performance. This role will also use expertise to provide the technical review of data, manage tasks and deadlines and is a resource for the client.

To fulfill this role, the Senior Government Health Plan/Managed Care Financial Consultant can expect to:

- Analyze and financial and other interpret reports submitted by Medicaid health plans
- Design procedures to validate operational performance metrics and accuracy of financial data and oversee the performance of those procedures
- Prepare analyses related to the financial and operational performance of Medicaid health plans
- Project manage multiple tasks on different projects simultaneously to include the following: design project work flow and assign project tasks to staff; manage the quality and timeliness of project deliverables
- Draft project communications and present results and analysts to clients and key stakeholders. During presentations, answer detailed and challenging questions
- Direct the work of employees in a team and/or coach/mentor others

Qualified candidates for a Government Health Care Financial Consultant position will have:

- BA/BS degree
- Minimum seven years of health plan/ managed care industry experience required

- Thorough understanding of general health care concepts, government health and welfare field preferred
- Strong critical thinking and analytical problem-solving skills
- Excellent interpersonal skills; strong oral and written communication skills
- Ability to prioritize and handle multiple tasks in a demanding work environment
- Ability to lead teams to deliver project objectives
- Ability to work independently and on a team
- Audit experience and/or health plan accounting experience preferred

Our client focus, integrity, expertise, and innovation are why clients choose Mercer. Employees choose Mercer for career growth, as well as the opportunity to assist clients in providing efficient and innovative ways to deliver vital health care services. Projects include helping clients navigate the Affordable Care Act, program design for innovative models of health care, analyzing health care costs and trends, and assessing quality incentives and strategies to improve overall managed care program effectiveness. Mercer's stimulating and learning-filled environment helps build strong relationships with colleagues and our clients.

Mercer is an equal opportunity employer. M/F/D/V.

COMPANY PROFILE:

Mercer is a global consulting leader in talent, health, retirement, and investments. Mercer helps clients around the world advance the health, wealth, and performance of their most vital asset - their people. Mercer's more than 22,000 employees are based in more than 40 countries, and we operate in more than 130 countries. Mercer is a wholly owned subsidiary of Marsh & McLennan Companies (NYSE: MMC), a global team of professional services companies offering clients advice and solutions in the areas of risk, strategy, and human capital.

Built on a history of industry leadership that began more than 70 years ago, Mercer helps organizations leverage the power of their people to achieve peak company performance. We work with clients today on current business issues: meeting the challenges of globalization, responding to emerging skill shortages and driving top-line revenue growth. We design strategies that link executive compensation to business goals, manage escalating benefit and pension costs while preserving employee engagement, and deliver on the expectations sought in mergers and acquisitions by successfully integrating diverse workforces. Working with chief executives and HR leaders, our consultants help leverage our clients' greatest resource - their employees.

Mercer GHSC is a specialty practice within Mercer's Health business. Mercer's Health business has the world's largest and most influential benefits brokerage and consulting capabilities. We strategize with clients of all sizes and industries to find benefits solutions that fit their needs. We provide the optimal combination of local-market knowledge and nationally driven best practices. Our innovations translate into superior benefits for clients and distinguish Mercer in the marketplace.

Mercer is in a unique position to help our clients achieve the extraordinary - and extraordinary results require extraordinary people. If you thrive on challenge, are passionate about ideas, love solving problems and truly enjoy connecting with people, we encourage you to explore the career opportunities available through Mercer. Our competitive programs, entrepreneurial spirit and team-oriented culture offer a richly rewarding and exciting environment where you can excel and achieve your professional goals.

To learn more about Mercer, visit us at www.mercer.com

Medicaid Health Systems Administrator 2

Company Name State of Ohio Company Location Franklin County, OH, US

Posted Date Posted 5 days ago Number of views 9 views

Be an early applicant

Job description

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

Office: Health Innovation & Quality

Bureau: Health Research & Quality

Working Title: Performance Improvement Administrator (PN 20047530)

Job Preview

The Ohio Department of Medicaid (ODM) is recruiting for an administrator to oversee its Performance Improvement Unit.

The Performance Improvement Administrator will manage one unit which is responsible for working with Medicaid's managed care plans (MCPs) to support ODM's Quality Strategy and population-based health approach for Medicaid. This includes developing strategies to work with MCPs utilizing quality improvement science methods to improve M P performance. The priority areas for this work in Medicaid are related to behavioral health, women's health, infant mortality, chronic conditions, value-based purchasing strategies and opiate reduction initiatives.

In this position, you will direct the development of data-driven improvement in conjunction with MCPs from a quality of care perspective, coordinating with other ODM bureaus and sections, as well as across State agencies and external entities. In addition, you will supervise one unit of programmatic management staff.

Job Description

Under general direction, plans, evaluates and directs one unit or multiple teams related to multiple statewide components of Medicaid health care delivery systems (e.g., health systems program policy analysis and development): oversees and directs the development and implementation of data-driven outcome improvement initiatives to improve the performance of Ohio Department of Medicaid (ODM) managed care programs; directs research, analysis and evaluation of evidence-based best practices and applies findings to the development of quality performance goals for each managed care program; provides strategic leadership and oversight to align other value-based purchasing efforts and ODM's population-based quality strategy with ODM's managed care programs and to achieve the quality and performance goals of ODM; gathers and brings into line, internal business perspectives to identify opportunity areas and capabilities across multiple data sources and systems to be used in establishing a multi-year roadmap to improve health outcomes of Ohio Medicaid consumers; proposes sequencing and prioritization of initiatives to close the gap between ODM's managed care programs' current status and established goals; directs development of analytical tools and data visualization techniques to identify gaps in care and best practives among managed care plans and providers; analyzes and interprets federal and state regulations, rules and laws to ensure program compliance; supervises assigned staff (e.g., establishes unit goals in conjunction with bureau, section goals; assigns work and provides direction; reviews work and provides feedback; establishes goals and monitors and evaluates performance: encourages staff development; makes recommendations for hire; approves/disapproves leave requests; recommends disciplinary action).

Coordinates program policies and procedures, project initiatives and/or proposed legislation with other agency representatives (e.g.,Office of Managed Care, Bureau of Health Plan Policy, Office of Information Technology Services, Office of Legal Counsel) and provides advice to higher level authorities; collaborates with multiple ODM bureaus and sections, as well as across State agencies, on performance improvement policy development; ensures alignment across managed care plans, providers and other community groups; directs and coordinates administration of rule development and revision process for outcome improvement-related rules; develops Medicaid outcomes initiatives; prepares budget proposals impacting across bureaus; develops and implements fiscal controls; providers consultative and technical assistance (e.g., interprets statutes, policies and procedures) for federal and sister-state agencies to ensure compliance; represents deputy director and/or on programmatic related uses, meetings and/or conferences; assists in long range strategic planning.

Represents agency in conferences, seminars, workshops and meetings; responds to sensitive inquiries and contacts from public, providers, government officials; prepares and oversees administrative reports and correspondence; operates personal computer and applicable software applications (e.g., Word, Excel, Access) to create, store, produce correspondence, reports and spreadsheets; prepares and delivers speeches and presentations; testifies at legislative or other public hearings; directs staff on work groups and attends and conducts training sessions.

Performs other related duties (e.g., conducts and attends staff meetings, attends meetings and seminars; travels to meeting sites; maintains records, logs and files).

Completion of graduate core program in business, management or public administration, public health, health administration, social or behavioral science or public finance; 24 mos. exp. in planning & administering health services program or health services project management (e.g., health care data analysis, health services contract management, health care market & financial expertise; health services program communication; health services budget development, HMO & hospital rate development, health services eligibility, health services data analysis).

Or 24 months experience as a Medicaid Health Systems Administrator 1, 65295.

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

- Or equivalent of Minimum Class Qualifications for Employment noted above.

Primary Location

United States of America-OHIO-Franklin County

Work Locations

Lazarus 5

Organization

Ohio Department of Medicaid

Classified Indicator

Classified

Bargaining Unit / Exempt

Exempt

Schedule

Full-time

Work Hours

8:00am - 5:00pm

Compensation

$33.96/hour

Unposting Date

Nov 25, 2018, 11:59:00 PM

Job Function

Health Administration

Seniority Level

Entry level

Industry

- Government Administration

Employment Type

Full-time

Job Functions

- Information Technology

SourceURL: https://www.linkedin.com/jobs/view/medicaid-compliance-dir-plan-ps14343-%E2%80%93-seattle-with-anthem-at-not-just-a-job-search-955946318/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Compliance Dir-Plan PS14343 – Seattle with Anthem

Company Name Not Just a Job Search
Company Location Seattle, WA, US

Posted Date Posted 4 days ago Number of views 1 view

Be an early applicant

Job description

The position listed below is not with Not Just a Job Search but with Anthem

Your Talent. Our Vision. At Anthem, Inc., it's a powerful combination, and the foundation upon which we're creating greater access to care for our members, greater value for our customers, and greater health for our communities. Join us and together we will drive the future of health care. This is an exceptional opportunity to do innovative work that means more to you and those we serve at one of America's leading health benefits companies and a Fortune Top 50 Company. Location: Seattle, WA office The Medicaid Compliance Director is responsible for implementing and maintaining the Medicaid Business Unit (MBU)

Compliance Program, incorporating the Office of Inspector General's Guidance on the essential components of an effective compliance program that serves, in part, to prevent and detect crime, to implement effective policies and procedures, to mitigate compliance risk, to establish an auditing and monitoring program and to uphold an ethical culture.Primary duties may include but are not limited to: Develops and implements an annual plan-specific compliance work plan to ensure the elements of an effective compliance program are appropriately in place at the plan-level and that the MBU compliance work plan is carried out locally, as appropriate. Participates as an active member of the health plan's leadership team, developing strong relationships with key leaders and engaging plan leadership in the compliance risk assessment process to identify and address compliance risks and failures and manage action plans designed to fully mitigate risk(s). Delivers compliance education sessions to address key issues. Monitors adherence to contractual obligations. Designs and implements a compliance communication strategy to keep senior management and other relevant associates informed of changes to the regulatory environment, as well as communicating about specific compliance program initiatives throughout the year. Requires BA/BS; 7+ years relevant experience compliance or audit, including 3 years of leadership/management experience; or any combination of education and experience, which would provide an equivalent background. Master's Degree preferred. Anthem, Inc. is ranked as one of America's Most Admired Companies among health insurers by Fortune magazine and is a 2018 DiversityInc magazine Top 50 Company for Diversity. To learn more about our company and apply, please visit us at careers.antheminc.com An Equal Opportunity Employer/Disability/Veteran Company Description:We recently changed our name from WellPoint to Anthem, Inc., the name people know us by best. As our companies continue to take a more active role in helping people access the right health care and programs, going by a name that people know and trust is important.

Anthem, Inc. is one of the nation's leading health benefits insurer and a Fortune Top 50 company. At Anthem, Inc., we are working to transform health care with trusted and caring solutions and meaningfully advance affordability and better health outcomes for our health plan members. Nearly 69 million people are served by our affiliated companies including more than 37 million enrolled in our family of health plans.

One in nine Americans receives coverage for their medical care through Anthem's affiliated plans.We offer a broad range of medical and specialty products.Bring your expertise to our innovative, achievement-driven culture, and you will discover lasting rewards and the opportunity to help drive the future of health care.

Anthem, Inc. is ranked as one of America s Most Admired Companies among health insurers by Fortune magazine and is a 2014 DiversityInc magazine Top 50 Company for Diversity. To learn more about our co Associated topics: business, care, cmo, donor, event, medical center, policy, presale, principle gift, regulatory

Insurance Reimbursement Lead – Medicaid & Government Billing – Maitland

Florida Hospital Maitland seeks to hire Insurance Reimbursement Lead who will embrace our mission to extend the healing ministry of Christ.

Facility Profile:

Established in 1908, Florida Hospital is one of the largest not-for-profit healthcare systems in the country, caring for more than a million patients each year. The Maitland Office Plaza houses our highly skilled teams that support our hospital system including Marketing, Patient Financial Services, Revenue Management, the Credit Union and Human Resources. The Trickel Building, a two-story office structure, creates an atmosphere of health and healing, with a healthy-style café and quaint chapel. The main lobby is filled with lush greenery and a light trickle of water, creating a holistic environment.

Department Profile:

Florida Hospital Patient Access/Guest Services – offers world class customer service and is the patient's first impression at our mission-centric organization. As patient advocacy ambassadors, the Maitland team strives for excellence in patient experience, patient safety, throughput, regulatory compliance and ensures financial stability across the system. Our team of highly engaged registration and concierge staff assist patients, providing them with knowledge on medical insurance benefits and options to take care of patient financial responsibility. We work hand in hand with multiple departments throughout the campus to give our patients a seamless experience. With a focus on fostering talent we provide a wide range of opportunities to learn new skills and grow professionally through individual development plans.

Work Hours/Shifts:

Monday – Friday; 8a – 5p

Job Summary:

The Insurance Reimbursement Lead is responsible for processing insurance and billing in a timely manner. Reviews assigned electronic claims and submission reports. Resolves and resubmits rejected claims appropriately as necessary. Processes daily and special reports, unlisted invoices and letters, error logs, stalled reports and aging. Performs outgoing calls to patients and insurance companies to obtain necessary information for accurate billing. Answers incoming calls from insurance companies requesting additional information and/or checking status of billings. Performs testing for system upgrades/changes. Provides quality assurance for like job functions when necessary. Adheres to Florida Hospital Corporate Compliance Plan and to all rules and regulations of all applicable local, state and federal agencies and accrediting bodies. Actively participates in outstanding customer service and accepts responsibility in maintaining relationships that are equally respectful to all.

Knowledge, Skills, Education, & Experience Required:

- Uses discretion when discussing employee/patient related issues that are confidential in nature

- Responsive to ever-changing matrix of business needs and acts accordingly
- Typing skills equal to 30 words per minute
- Proficiency in performance of basic math functions
- Communicates professionally and effectively in English, both verbally and in writing
- Proficiency in Microsoft Office products, such as, Word and Excel
- Strong analytical and research skills
- HCFA1500 formats relative to regulatory standards in claims (paper and/or electronic) processing
- Excellent knowledge of ICD, CPT, HCPS coding, and medical terminology
- Two years of experience in a Revenue Cycle department or a related field, such as, registration, finance, collections, customer service, medical, or contract management
- At least one year of experience in lines of business, such as, HMO, PPO, Medicare, Medicaid, etc
- High School diploma or GED (Preferred)

Licensure, Certification, or Registration Required:

- N/A

Job Responsibilities:

Demonstrates through behavior Florida Hospital's Core Values of Integrity, Compassion, Balance, Excellence, Stewardship and Teamwork as outlined in the organization's Performance Excellence Program

- Works with insurance payers to ensure proper reimbursement on patient accounts. When necessary, participates in conference calls, accounts receivable reporting, and compiles the issue report to expedite resolution of accounts. Examines contracts to ensure proper reimbursement, educates team of inconsistencies in processing, including disciplinary discussions, if necessary, and any changes to contract identified.
- Works follow up report daily, maintains established goal(s), and notifies Manager of issues preventing achievement of such goal(s). Follows up on daily correspondence (denials, underpayments, etc.) to appropriately work patient accounts. Assists Customer Service with patient concerns/questions to ensure prompt and accurate resolution is achieved. Produces written

correspondence to payers and patients regarding status of claim, requesting additional information, etc.
- Reviews previous account documentation and determines appropriate action(s) necessary to resolve each assigned account. Initiates next billing, follow-up and/or collection step(s), contacts patients, insurers or employers, as appropriate. Sends initial or secondary bills to insurance companies.
- Documents billing, follow-up and/or collection step(s) that are taken and all measures to resolve assigned accounts, including escalation to Manager if necessary. Processes administrative and medical appeals, refunds, reinstatements and rejections of insurance claims.
- Remains in consistent daily communication with team members, regarding new process education and disciplinary actions, and with Manager regarding all aspects of assigned projects. Effectively prioritizes work, identifies, and resolves complex concerns in a professional manner, and works in a team environment to achieve a common goal.
- Monitors and assists team members regularly, providing feedback, ensuring both goals and job requirements are met as assigned by Manager. Trains new staff, performs audits of work performed, and communicates progress to appropriate Manager. Provides continuing education to all team members on process and A/R requirements.
- When necessary, assists with coordinating, processing and posting of all payments (including cash and mail receipts) accurately within established department standards.
- Handles special projects and testing for system upgrades/changes as assigned by management. Provides quality assurance for like job functions when necessary. Makes recommendations by performing root cause analysis regarding any system-related problems to enhance efficiencies and savings to the department.
- Adheres to HIPAA regulations by verifying pertinent information to determine caller authorization level receiving information on account.

If you want to be a part of a team that is dedicated to delivering the highest quality in patient care, we invite you to explore the Insurance Reimbursement Lead opportunity with Florida Hospital Maitland and apply online today.

Job Keywords:

Insurance Reimbursement, Patient Financial Services, Maitland

State of Florida MEDICAL HEALTH CARE PROGRAM ANALYST Job in Tallahassee, FL

Requisition No: 47491

Agency: Agency for Health Care Administration

Working Title: MEDICAL HEALTH CARE PROGRAM ANALYST - 68064879

Position Number: 68064879

Salary: $1,574.93 / Bi-Weekly

Posting Closing Date: 11/18/2018

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

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

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

This position is responsible for contract management activities that include: coordinating program monitoring activities for Medicaid managed care plans; evaluating operations, providing technical assistance, and recommending compliance actions (e.g. corrective action plans, sanctions, liquidated damages, etc.) for managed care plans as it relates to areas of contract non-compliance; and performing analytical oversight to promote access to care, improve the quality of care and increase the efficiency and cost-effectiveness of the Medicaid program in relation to the managed care contracts.

AHCA offers an excellent array of benefits, including:

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

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

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

This position may require travel.

KNOWLEDGE, SKILLS, AND ABILITIES

- Knowledge of Florida Medicaid policies and procedures and managed health care;
- Knowledge of methods necessary for efficient research, data compilation, organization, and analysis;
- Ability to communicate effectively, both verbally and in writing;
- Ability to work cooperatively as a member of a team;
- Ability to understand and apply applicable statutes, rules, regulations, and contract management policies and procedures;
- Ability to plan, organize, and prioritize work assignments, ensuring proper completion of work assignments in a timely manner;
- Ability to develop reports and make recommendations;
- Ability to utilize problem-solving techniques;
- Ability to develop and implement various program monitoring protocols, procedures, methodologies, and techniques.
- Ability to travel with or without accommodations.

MINIMUM QUALIFICATION REQUIREMENTS

- One (1) year of professional work experience in auditing, investigating, or monitoring a program or service.

CONTACT: INDIYA WALKER 850-412-4011

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

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

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

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

requirements are available by clicking here. All documentation is due by the close of the vacancy announcement.

Nearest Major Market: Tallahassee

SourceURL: https://arizona.jobing.com/health-choice196/program-manager-arizona-medicaid-1-9867790?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Program Manager - Arizona Medicaid

at Health Choice

Job Description

The Program Manager - Arizona Medicaid conducts activities to achieve operational performance. Leads ongoing Medicaid program changes (contract, payment, and policy). Identification of required changes, communication to leaders, management of key deliverables - both internal and external. Review AHCCCS guidance and follow up with matrix partners for implementation of items as needed. Provide Medicaid expertise to team members. Meeting / presentation (internal and external) preparation. Participate in committees and workgroups as appropriate. Communicate and collaborate on key strategies.

Health Choice exists to improve the health and well-being of the individuals we serve through our health plans, integrated delivery systems and managed care solutions. We strive to recruit and retain only the finest health care professionals

with the highest levels of integrity, compassion and competency. If you are driven by your own personal commitment to these values and desire to work in a team-focused, collaborative and supportive environment - while still being valued for your individual strengths - Health Choice is the place for you.

Equal Opportunity Employer Minorities/Women/Veterans/Disabled

Qualifications

Qualifications:

Bachelor's degree, or higher, in health care, business administration, or related field required

Three (3) or more years of experience in program / project management

Intermediate experience in Microsoft Excel

Excellent writing skills

Presentation skills in Microsoft PowerPoint

Experience in AHCCCS required

Application Instructions

Please click on the link below to apply for this position. A new window will open and direct you to apply at our corporate careers page. We look forward to hearing from you!

Vice President Medicare/Medicaid Integration

3.7 Neighborhood Health Plan of RI – Smithfield, RI 4 days ago
Applied 11/12/18
Apply on Company Site

4 days ago

Overview

Strategically implement and lead Neighborhoods fully integrated Medicaid and Medicare (MME/LTSS) program/product. Represents Neighborhood with key advocates and constituents (and develops strategic relationships and identifies opportunities for strategic partnerships. Works closely with Compliance to ensure all contract/regulatory and reporting requirements are met. Responsible for development of strategies that ensure continued company growth in the MME/LTSS marketplace. Cultivates and maintains strong and effective relationships internally and externally, and specifically with Centers for Medicare and Medicaid Services (CMS) and Rhode Island Executive Office of Health and Human Service (EOHHS). Full accountability for the compliance, financial success, and quality measures of the product. Creates the strategy for the product and works collaboratively across the organizations in a matrixed environment to drive product results.

Responsibilities

Ensures Strategic Alliance

- Leads the formulation of company strategy and product model; leads the creation of product goals, policies, short and long range strategic planning activities
- Working closely with Business Development, builds a knowledge base of local, regional and national market trends, opportunities and threats, competitive intelligence, and product information

Manages Team Performance

- Strategically leads a unified product development process for MME by coordinating resources across product/market groups and functions (i.e. Medical Management, Compliance, Fiscal Ops, etc.)
- Management of professional level staff

Understands the Business

- Develops financial model in conjunction with Fiscal Operations regarding financial goals; creates annual operating plan
- Oversees rate analysis; assess adequacy and implications for administrative & medical budgets
- Maintains knowledge of state and federal regulatory environments
- Works closely with Compliance on interpretation and communication of regulatory and contractual requirements

Uses Influencing/Collaboration Skills Effectively

- Coordinates and collaborates with business leaders across the organization to insure proper implementation and resource allocation
- Cultivates relationship with CMS and EOHHS
- Serves as an effective Medicaid/Medicare expert and resource to Neighborhood's business units. Acts as lead for CMS and State agencies related to product line

Gets Results

- Develops and manages overall product budget based on utilization and financial data in support of product goals; Provides reporting to Senior Leadership in support of the financial health of the product
- Owns product department policies and procedures and provides guidance and feedback on compliance
- Accountable for internal business area compliance to regulatory and contract requirements/changes
- Provides guidance and oversight to execution of product line deliverables
- Provides reporting to organization in support of the financial health of the product
- Provides analysis of product performance and escalates issues to senior management
- Ensures compliance with all federal and state reporting requirements

Guides Innovation

- Oversees the implementation of new programs and operational processes to ensure resource optimization and compliance

- Analyzes best practices and plans for new product offerings
- Facilitates ongoing discussion on product improvement/enhancements and performance improvements
- Directs development of MME/LTSS policy/legislative strategies; provides ongoing oversight

Accountabilities:

- Revenue generation for product
- Performance against operational/financial targets
- Performance of quality measures State, Federal and member satisfaction
- Development of products that serve member needs within set cost and quality targets

Corporate Compliance Responsibility - As an essential function, responsible for complying with Neighborhood's Corporate Compliance Program, Standards of Business Conduct, applicable contracts, laws, rules and regulations, policies, and procedures as it applies to individual job duties, the department, and the Company. This position must exercise due diligence to prevent, detect, and report unlawful and/or unethical conduct by fellow co-workers, professional affiliates and/or agents.

Qualifications

- Experience in Medicare Advantage; detailed knowledge of Medicare Advantage regulations and CMS Health Management Plan Systems; Medicaid and/or LTSS experience
- 5-8 years' people management experience; experience leading across functions and/or matrixed teams
- 5 - 8 years' experience managing the financial component of a product line; P & L experience
- Excellent qualitative analysis skills
- Excellent collaborative skills and experience achieving results across an organization
- Experience in representing business opportunities with Senior Executives
- Experience in evaluating complex opportunities and providing organizational oversight to develop business solutions for such opportunities
- Proven ability to develop strong, lasting relationships that result in favorable business opportunities and alignment of public policy to support business needs
- Ability to build and maintain strong relationships/partnerships, both internally and externally
- Superior oral and written communications

- Master's Degree or significant experience related to position duties and requirements

Organizational Competencies:

- Judgement and Decision Making
- Gets Results
- Collaboration and Teamwork
- Business Awareness
- Customer Focus

Job Specific Competencies:

- Attention to Detail
- Creativity and Innovation
- Flexibility and Achieving Change
- Learning and Development
- Resilience
- Influencing and Negotiation
- Open Communication
- Relationship Building and Networking
- Respecting Others and Valuing Diversity
- Continuous Quality Improvement
- Organizational Savvy
- Planning and Organizing
- Problem Solving and Analysis
- Strategic Thinking and Alignment

Neighborhood is an Affirmative Action and Equal Opportunity Employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, gender, sexual orientation, national origin, genetic information, age, disability, veteran status or any other legally protected basis.

Neighborhood is committed to ensuring individuals with disabilities and/or those who have special needs participate in the workforce and are afforded equal opportunity to apply for jobs. If you would like to contact us regarding the accessibility of our Website or need assistance completing the application process, please contact us at recruiting@nhpri.org.

Neighborhood is an EOE M/F/D/V and an E-Verify Employer

Manager, Medicaid Case Management

Job description

It's Time For A Change...Your Future Evolves Here

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

Are we growing? Absolutely—70.3% in year-over-year revenue growth in 2017. Are we recognized? Definitely. We have been named one of "Becker's 150 Great Places to Work in Healthcare" in 2016 and 2017, and one of the "50 Great Places to Work" in 2017 by Washingtonian, and our CEO was number one on Glassdoor's 2015 Highest-Rated CEOs for Small and Medium Companies. If you're looking for a place where your work can be personally and professionally rewarding, don't just join a company with a mission. Join a mission with a company behind it.

Evolent Health is looking for a Manager, Medicaid Case Management to be a key member of our team. Reporting directly to the Managing Director of Clinical

Operations, this individual will play a critical role in executing Evolent Health's mission by monitoring clinical performance and ensuring adherence with the Plan's protocols, requirements and standards. Must have a Florida or Compact State Nursing License.

The **Manager, Medicaid Case Management** will serve as the liaison to the clinical operations and leadership with matrix responsibilities to the Plan's Compliance Director, Manager of Delegation Oversight, the Director of Quality Improvement and Director of Health Plan Operations. This position will successfully service, monitor and grow relationships with both internal and external business partners to implement ongoing clinical operations monitoring, resolve barriers, influence decision making and enable achievement of improved clinical quality outcomes and processes

What You'll Be Doing:

- Serve as a liaison between external business partners, internal team members and partner organization providing clinical leadership of SNP clinical requirements including utilization management (UM), care management (CM), quality improvement (QI), appeals and other requirements outlined in the Model of Care (MOC
- Provide guidance and support on clinical operations
- Partner with internal and external business partners to drive towards resolution of clinical operations-related issues with an emphasis on root cause analysis and resolution of problems
- Develop deep understanding of clinical system/platform capabilities, processes and procedures; identify and document limitations of business partners systems, tools and resources and provide recommendations to meet plan requirements
- Confirm that all benefit components, clinical protocols and administrative rules have been set up within the clinical payment system; monitor to ensure system and processes are aligned with the requirements as specified in the plan materials (i.e. MOC, evidence of coverage, summary of benefits, PBB)
- Regularly monitor and analyze clinical operations performance reports and data to inform decision-making, process design or improvement and program modification or implementation; take timely corrective action and follow-up to ensure positive outcomes
- Compile, review and analyze necessary clinical operations dashboards for management review; create and report operational tracking metrics and dashboards for monitoring clinical operations and performance

- Identify and advise UM, CM, QI, Medicare Operations and other operational leadership of trends, problems, and issues as well as recommended course of action; ensure timely communication; participate in the development and implementation of solutions
- Monitor adherence to the efficiency and service level goals including volume, processing, timeliness, accuracy and other metrics, internally and externally
- Compose, submit and track clinical system questions and configuration requests to correct identified systemic clinical operations issues
- Prioritize issues identified by business partners, internal team members and/or partner representatives and monitors progress in the resolution of the issues
- Coordinate the configuration, set up and/or modification of the clinical system/platform following business partner protocols
- Confirm that desk level procedures, processes, and policies for clinical operations have been finalized and are aligned with the plan requirements
- Coordinate corrective action plans with partner/client and business partner operations/administrator to resolve issues
- Support internal plan team members with the resolution of daily issues
- Support the clinical and quality leadership team efforts by developing solutions to improve effectiveness and identify continuous improvement opportunities and initiatives
- Work with other departments to identify and resolve problems leading to incorrect MOC requirements, UM, CM, QI and/or appeals-related processes
- Provides management assistance for activities specific to the DSNP case/care management program.
- Assist management in the identification and coordination of the necessary clinical operations and service training needs; monitor and implement educational and process interventions based on data, trends and identified opportunities.
- Serve on various committees and attends required meetings
- Perform other duties and projects as assigned

The Experience You Need (Required):

- Bachelor’s Degree or equivalent
- Must have a Florida or Compact State Nursing License.
- 3-5 years of experience within a health plan, managed care organization, third-party administrator, or other healthcare entity.
- At least 2 years experience in a clinical, quality or closely-related setting
- Prior supervisory or team lead experience

- A proven track record of success with both individual and collaborative problem-solving, showing demonstrable evidence of sound judgment and decision-making.
- Ability to work collaboratively across partner/organizations
- Experience with Medicare Advantage plans
- Exceptional organizational skills
- Exceptional communication skills
- Models leadership and takes initiative

Finishing Touches (Preferred):

- Master's Degree in healthcare, healthcare related discipline or business-related discipline
- 5 - 7 years of experience within a health plan, managed care organization, third-party administrator, or other healthcare entity.
- 3 - 5 years experience in a clinical, quality or closely-related setting
- Prior management experience
- Experience in clinical information system report design/development
- Project management experience or equivalent experience leading cross-functional teams to successful completion of projects Entrepreneurial mindset geared toward the creation, execution and continuous improvement of clinical health plan operations and implementations
- Excellent written and oral presentation skills
- Demonstrated exceptional active listening and communications skills

Evolent Health is an equal opportunity employer and considers all qualified applicants equally without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.

Actuarial Analyst - Medicare/Medicaid

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Get ahead of others. Apply now.

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*Rating Trends*Rating Trends

Glassdoor Estimated Salary

$62,000/ year

$54k

$71k

Provide actuarial services for PacificSource. Responsible for accurate and reliable actuarial activities. Ensure sound actuarial analysis of risk, resulting in the attainment of PacificSource's financial and enrollment goals. Work to increase enrollment and maintain a strong financial position. Provide documented input on decisions which impact the risk assumed through various current or proposed activities.

- Employ established formulas and guidelines for timely and accurate rating of existing and prospective insurance contracts. Analyze claims, enrollment, administrative expense, required reserves, trends, and other factors needed to determine appropriate revenue requirements for corporate financial forecasting and other activities.
- Review requirements for and identify information needed to accurately assess various elements of risk, cost, and utilization, and its financial impact upon PacificSource. Produce reports for use by Management and appropriate departments within PacificSource, such as Product Development, Health Services, Finance, etc.
- Make documented recommendations based on the analysis of information regarding methods to reduce costs.
- Provide support to Product Development and Sales by offering technical expertise regarding rating and benefit evaluation.
- Aid in rate filing process and other compliance activities required by various State and Federal law.

Supporting Responsibilities:

- Meet department and company performance and attendance expectations.
- Follow the PacificSource privacy policy and HIPAA laws and regulations concerning confidentiality and security of protected health information.
- Perform other duties as assigned.

Work Experience: Health or other actuarial experience is preferred, but recent graduate considered.

Education, Certificates, Licenses: Baccalaureate degree in mathematics, quantitative economics, or a related field required. Ability and interest in pursuing actuarial training with certification exams. Having passed a minimum of one actuarial exam is required. Advanced student/near-ASA is preferred but not required.

Knowledge: Data analysis, interpretation, and action recommendations related to rating strategies. Ability to identify problems, develop solutions and implement a chosen course of action. Requires excellent computer, oral and written communication skills and organization skills; ability to read, analyze and interpret documents and information; and ability to respond to common inquiries and effectively present information to a variety of groups.

Competencies

Our Values

- Adaptability
- Building Customer Loyalty
- Building Strategic Work Relationships
- Building Trust
- Continuous Improvement
- Work Standards
- Contributing to Team Success
- Planning and Organizing
- We are committed to doing the right thing.
- We are one team working toward a common goal.
- We are each responsible for our customers' experience.
- We practice open communication at all levels of the company to foster individual, team and company growth.
- We actively participate in efforts to improve our many communities-internally and externally.
- We encourage creativity, innovation, continuous improvement, and the pursuit of excellence.

Environment: Work inside in a general office setting with ergonomically configured equipment. Travel is required approximately 5% of the time.

Physical Requirements: Stoop and bend. Sit and/or stand for extended periods of time while performing core job functions. Repetitive motions to include typing, sorting and filing. Light lifting and carrying of files and business materials. Ability to read and comprehend both written and spoken English. Communicate clearly and effectively.

Disclaimer: This job description indicates the general nature and level of work performed by employees within this position and is subject to change. It is not designed to contain or be interpreted as a comprehensive list of all duties, responsibilities, and qualifications required of employees assigned to this position. Employment remains AT-WILL at all times.

PacificSource is an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to status as a protected veteran or a qualified individual with a disability, or other protected status, such as race, religion, color, national origin, sex, sexual orientation, gender identity or age.