Medicaid Industry Jobs Hunter: 1/14/2019

Notebook:	Curator: Jobs		
Created:	1/14/2019 6:17 AM	**Updated:**	1/14/2019 6:24 AM
Author:	Clay Farris		
Tags:	5- Clay is Blessed with Work, jobs		
URL:	https://www.ziprecruiter.com/c/Konexus-Group/Job/Medicaid-Director-Healthplan/-in-Columbus,OH?jobid=5cdc4e62-2cc83a26		

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Medicaid Jobs Hunter

Jan 14, 2019

In this packet...

Medicaid Director - Healthplan Job in Columbus, OH at Konexus Group

SourceURL: https://www.ziprecruiter.com/c/Konexus-Group/Job/Medicaid-Director-Healthplan/-in-Columbus,OH?jobid=5cdc4e62-2cc83a26
Author: Clay Farris

Medicaid Director - Healthplan

Columbus, OH

** Remote Opportunity **

We have a fulltime opportunity available for a Senior Director of Medicaid Strategy with a competitive and longstanding health plan. This is a work-from-home setup, and can be based anywhere in the country. This role will require 20-30% domestic travel with 1-2 weeks of notice per instance. Qualified applicants will have 8+ years of experience within Senior leadership / planning of a national health plan.

- Excellent salary and bonus potential + comprehensive benefits
- Ability to work from your home office
- Implement your vision to improve patient care for thousands!

Overview:
As the Senior Director, you will be the lead subject matter expert working directly with a national government health plan on the implementation of Medicaid initiatives and supporting the ongoing expansion in their markets. This individual will be the liaison between the product, regulatory, and account organizations.

Qualifications:

- Bachelor's Degree or higher required
- 8+ years' of management experience in managed care (primarily Medicaid), with knowledge of Medicare Advantage and Accountable Care Organizations
- Excellent interpersonal skills, thorough understanding of federal / state laws impacting health insurers and their delegated entities, including laws impacting utilization management, claims, and credentialing for governmental health plans (Medicare, Medicaid)
- Strong understanding of client management requirements and ability to bridge internal support with external requirements
- Ability to think strategically and analyze market trends and public policy essential
- Strong project management skills including ability to lead client requirements discussions
- Experience working in a matrix organization

Aetna Life Insurance Company Provider Relations Representative- NJ Medicaid Health Plan Job in Princeton, NJ

SourceURL: https://www.glassdoor.com/job-listing/provider-relations-representative-nj-medicaid-health-plan-aetna-life-insurance-company-JV_IC1127179_KO0,57_KE58,86.htm?jl=3084060659
Author: Clay Farris

Provider Relations Representative- NJ Medicaid Health Plan

– Princeton, NJ
Apply on Company Site
New
Get ahead of others. Apply now.
Aetna Better Health of New Jersey is hiring a Provider Relations Representative to join our growing Medicaid Health Plan!

Our **Provider Relations Representative** acts as the primary resource for assigned, high profile providers or groups (i.e. local, individual providers, small groups/systems) to establish, oversee, and maintain positive relationships by assisting with or responding to complex issues regarding policies and procedures, plan design, contract language, service, claims or compensation issues, and provider education needs.

Fundamental Components:

(*) Optimizes interactions with assigned providers and internal business partners to establish and maintain productive, professional relationships.
(*) Monitors service capabilities and collaborates cross-functionally to ensure that the needs of constituents are met and that escalated issues related but not limited to, claims payment, contract interpretation or parameters, and accuracy of provider contract or demographic information are resolved.
(*) Supports or assists with operational activities that may include, but are not limited to, database management, and contract coordination. Performs credentialing support activities as needed.
(*) Educates providers as needed to ensure compliance with contract policies and parameters, plan design, compensation process, technology, policies, and procedures.
(*) Meets with key providers periodically to ensure service levels are meeting expectations. Manages the development of agenda, validates materials, and facilitates external provider meetings.
(*) May collaborate cross-functionally on the implementation of large provider systems, to manage cost drivers and execute specific cost initiatives to support business objectives and to identify trends and enlist assistance in problem resolution.
(*) Conduct standard provider recruitment, contracting, or re-contracting activities and assist with more complex contracting and discussions as needed by business segment.

Background Experience Desired:

(*) 3+ years experience in servicing providers with exposure to benefits and/ or contract interpretation
(*) Working knowledge of health care networks, providers and contracting (NJ market will be preferred)
(*) 3-5 years experience with business segment specific policy, benefits, plan design and language
(*) Strong verbal and written communication, interpersonal, problem resolution and critical thinking skills

EDUCATION
The highest level of education desired for candidates in this position is a Bachelor's degree or equivalent experience.

ADDITIONAL JOB INFORMATION

Aetna is about more than just doing a job. This is our opportunity to re-shape healthcare for America and across the globe. We are developing solutions to improve the quality and affordability of healthcare. What we do will benefit generations to come.

We care about each other, our customers and our communities. We are inspired to make a difference, and we are committed to integrity and excellence.

Together we will empower people to live healthier lives.

Aetna is an equal opportunity & affirmative action employer. All qualified applicants will receive consideration for employment regardless of personal characteristics or status. We take affirmative action to recruit, select and develop women, people of color, veterans and individuals with disabilities.

We are a company built on excellence. We have a culture that values growth, achievement and diversity and a workplace where your voice can be heard.

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

Aetna takes our candidate's data privacy seriously. At no time will any Aetna recruiter or employee request any financial or personal information (Social Security Number, Credit card information for direct deposit, etc.) from you via e-mail. Any requests for information will be discussed prior and will be conducted through a secure website provided by the recruiter. Should you be asked for such information, please notify us immediately.

#LI-MR1
Aetna is an Equal Opportunity, Affirmative Action Employer

Senior Finance Director, Medicaid Health Plan - Miami, FL - Magellan Health Services | Ladders

SourceURL: https://www.theladders.com/job/senior-finance-director-medicaid-health-plan-magellan-health-services-miami-fl_38424893
Author: Clay Farris

Senior Finance Director, Medicaid Health Plan

Magellan Health Services

Miami, FL

Industry: Healthcare

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8 - 10 years

Posted Today

Job Description

The ideal candidate will have Medicaid health planexperience.

Responsible for the management offinancial results and operations for an assigned SBU. Areas of focus will vary based on assigned SBU and may include customercontracting, rate negotiations, product pricing, analysis ofutilization and medical cost trends, new product development and implementation with customers. May also beresponsible for the management offinancial results for assigned customers,support of profitable sales growth and drivingstrategic initiatives. In the process, builds relationships with SBU leadership, enterprisefinancial operations and other functional leaders to drive performance. Develops and maintains externalpartnerships with key customers, vendors and other constituents to influence the direction of the business.

- **Essential Functions**

  will vary based on assigned SBU.
- Analyzes monthly financial results, conducts periodic forecasts of current year profitability and develops the annual budget for all assigned customers.
- Participates in periodic meetings with internal stakeholders to discuss results and develop corrective action plans to mitigate risk and optimize profitability.
- Supports month end close process which includes reviewing journal entries, reconciliations and month end reports.
- Actively participates as a member of the SBU leadership team in the development and execution of both near-term and long-term business strategies.
- Performs financial modeling to support the 5-yearfinancial plan.
- Serves as the financial lead for specific strategic strategies including related investment/capital deployment requirements, cost/benefit analyses and evaluation of potential inorganic accelerants to each strategy.
- Leads financialsupport for all sales to assigned prospects.
- Leads bid qualification, pricing strategy, rate development, financial proposal terms and delivery to prospective target (including sales presentations).
- Develops financialreporting platform to enable deepen transparency of expense structure. Maintains cost transparency across entire SBU G&A cost structure.
- Partners with IT leadership team to enhance activity-based reporting.
- Monitors effective utilization of resources and recommends adjustments to cost structure.
- Assumes responsibility for the integrity and resolution of all balance sheet accounts associated assigned contracts managed including accounts receivable, funds withheld by customers, claims recoverables, etc.
- Supports underwriting efforts and financial aspects of proposals for RFPs.
- Manages select vendor contracts and payment reconciliations.
- Oversees FTE approvals and geographic changes within the financial system (i.e. cost centers).
- Provides support to both Account Management and Proposal team to aid in new business and account retention, if needed.
- Supports the finance team in evaluating customer-specific contractual reconciliations, renewals/rate openers and settlements of contingencies under each contract (eg. performance penalties/incentives), as needed. Identifies and communicates issues and cost drivers.
- Performs ad hoc financial analysis and special projects as requested by management.

R00000022322

Pharmacy Program Manager - Medicaid

SourceURL: https://www.linkedin.com/jobs/view/pharmacy-program-manager-medicaid-at-health-choice-1061259497
Author: Clay Farris

Pharmacy Program Manager - Medicaid

Hidden gem icon

Be one of the first 10 applicants.

Apply on company website
Apply on company website

Job description

Job Description

The Pharmacy Program Manager manages and conducts clinical and operational pharmacy processes for Steward Health Choice Medicaid plan members. The Pharmacy Program Manager maintains the plan Medicaid formularies, participates in the P&T Committee, reviews drug use criteria and protocols, and reviews requests for prescription drug services (prior authorizations). The Pharmacy Program Manager reviews complex member cases, participates in efforts to improve performance measures, works closely with the designated PBM to ensure pharmacy benefit is compliant with government regulations and requirements, and works with state officials and State Medicaid plan pharmacists.

Manage clinical pharmacy processes effectively and efficiently and serve as a subject matter expert for the State Medicaid pharmacy benefit to internal and external customers (Health Choice staff, State Medicaid officials, pharmacy directors, etc.). Conduct activities associated with clinical programs that promote clinically appropriate and safe medication use within Medicaid member and provider populations. Conduct pharmacy and medical drug prior authorization processes accurately, effectively, and efficiently.

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

Pharmacy degree from an accredited College of Pharmacy required; PharmD preferred

Pharmacy licensure in the state of Arizona or Utah, in good standing, required

Current state driver's license, reliable transportation, and current insurance coverage required

At least five (5) years of practice experience with a health plan pharmacy service, managed care environment, and / or retail pharmacy experience

At least two (2) years of practice experience in developing and applying clinical use drug criteria

Proficient in the principles and practices of managed care pharmacy

Broad based knowledge in a variety of pharmacy disciplines

Knowledge of Medicare and Medicaid regulations and guidelines regarding coverage determinations

Knowledge of peer-reviewed literature for production of PA Criteria Guidelines

Knowledge of drug options for the appropriate clinical management of member medical conditions

Industry

Health, Wellness and Fitness, Medical Practice, and Hospital & Health Care

Employment type

Full-time

Experience

Entry level

Job function

Project Management,Information Technology
See moreSee less

FCHP - Careers

SourceURL: https://jobs-fchp.icims.com/jobs/5453/medicaid-aco--clinical-program-manager/job?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic&mobile=false&width=460&height=500&bga=true&needsRedirect=false&jan1offset=-360&jun1offs
Author: Clay Farris

Medicaid ACO Clinical Program Manager

US-MA-Worcester — 1 month ago

Job ID 5453 **# Positions** 1 **Category**

Medicare Medicaid Programs

About Fallon Health:

Founded in 1977, Fallon Health is a leading health care services organization that supports the diverse and changing needs of those we serve. In addition to offering innovative health insurance solutions and a variety of Medicaid and Medicare products, we excel in creating unique health care programs and services that provide coordinated, integrated care for seniors and individuals with complex health needs. Fallon has consistently ranked among the nation's top health plans, and is the only health plan in Massachusetts to have been awarded "Excellent" Accreditation by the National Committee for Quality Assurance for its HMO, Medicare Advantage and Medicaid products. For more information, visit www.fallonhealth.org.

Brief summary of purpose:
The ACO Clinical Project Manager will develop, implement, and manage clinical-focused projects for the Medicaid ACO, both internally within FH and externally with our ACO partners, to manage cost of care and patient outcomes for the Medicaid ACO program. The ACO Clinical Project Manager works closely with the FH Medicaid ACO Medical Director, as well as the Fallon Health (FH) VP of Quality and Population Health and other members of the Medicaid ACO team, and ACO partners to manage and monitor specific clinical initiatives.

Responsibilities

Responsibilities:

- Plan, develop, implement, manage, and monitor specific Model of Care clinical projects for the Medicaid ACO programs aimed at reducing cost of care and improving patient outcomes
- Implement clinical program specific action plans, clinical work flows, strategies, and timelines
- Actively manage and coordinate clinical project activities with the Medicaid ACO Medical Director, Quality Director, and shared services (utilization management, behavioral health, and case management functions)
- Develop and sustain productive relationships with the FH ACO team
- Develop and sustain productive relationships with the ACO partners and Community Partners, including regular visits to provide clinical guidance, support for implementation of specific initiatives, and training

- Engage, educate, and support Medicaid ACO partners in appropriate and effective case management and utilization practices
- Collaborate with the FH Medicaid ACO Medical Director and ACO partners to develop, implement, and monitor behavioral health focused initiatives
- Apply expertise and serve as a resource to the FH and ACO teams on community supports, including LTSS and community/state supported behavioral health- and disability-related services
- Develop relationships with key contacts at state agencies including MassHealth, DDS and DMH
- Regularly gather and summarize relevant evidence-based literature and reports to guide Medicaid ACO Model of Care refinements
- Develop familiarity with the use of technology to advance the quality and efficient delivery of care
- Respond to clinical program specific inquiries and/or requests from the Medicaid ACO Medical Director
- Collaborate with the ACO Clinical and Operations teams to develop solutions to complex clinical care situations. Participate in interdisciplinary care team discussions at FH to improve operations and overall optimal member care
- Represent Fallon Health on externally facing work groups and work collaboratively with both internal and external teams comprising both clinical and non-clinical staff
- Strictly observe HIPAA regulations and the Fallon Health Policies regarding confidentiality of member information

Demonstrate the following areas of proficiency including, but not limited to:

- Ability to work with an interdisciplinary care team as a partner, demonstrating respect and value for all roles and serving as a positive contributor within job role scope and duties
- Robust knowledge of Medicaid programs and the needs of Medicaid populations
- Able to function independently to establish work plans and priorities
- Team player, dedicated to the company's mission and core values, with a track record demonstrating accountability for results
- Have expertise on the clinical and care management of

diverse low income populations

- Strong management and interpersonal skills and ability to guide projects and programs across organizations and with multiple stakeholders
- Have significant experience in leading multidisciplinary internal and external efforts
- Be an effective liaison with providers and state and community agencies
- Possess strong capability for on-the-ground-implementation
- Ability to establish credibility and communicate professionally with primary care providers and other medical and service providers about program level issues as well as individual member level clinical status and needs
- Be a strategic and analytic thinker
- Be able to make decisions in a complex, changing environment
- Basic facility with software systems including but not limited to Microsoft Office Products – Excel, Outlook, and Word

Qualifications

Education
Bachelors or advanced degree in nursing or health care related field. Masters degree preferred (Nursing, MBA, MPH, etc.) OR graduate of a social worker program with a Masters degree in social work or psychology.

License: Active licensure as a Registered Nurse (RN) in Massachusetts OR Licensed Clinical Social Worker (LCSW) OR Licensed Independent Clinical Social Worker (LICSW) in Massachusetts

Other: Satisfactory Criminal Offender Record Information (CORI) results

Experience

- A minimum of five years of experience in leading managed care, health care, or health policy programs focused on complex and vulnerable populations.
- Previous direct experience with MassHealth programs.
- Previous clinical program management experience requiring coordination across multiple stakeholders.
- Expertise in the provision of case management services for complex vulnerable populations

Search opportunities

All positions
All jobs in Mass.

Customer Service jobs
Information technology jobs
Medical jobs
Nursing jobs
Social worker jobs

with social and behavioral health needs preferred.

Resources (systems, etc.) used in performing role
Microsoft Office products including but not limited to: Excel, PowerPoint, Word, Outlook, Visio, reporting software such as Business Objects, Boxer Application, QNXT, TruCare, and other applications

Physical Requirements of Role
Physical health sufficient to meet the ergonomic standards and demands of the position and the ability to transport self to member, provider, facility sites and locations. Valid Driver's License and Clean Driving Record Required and a vehicle to be used for in-state travel.

The State of Florida MEDICAL/HEALTH CARE PROG ANALYST Jol

SourceURL: https://www.glassdoor.com/job-listing/medical-health-care-prog-analyst-the-state-of-florida-JV_IC1154378_KO0,32_KE33,53
Author: Clay Farris

MEDICAL/HEALTH CARE PROG ANALYST

The State of Florida
Applied 1/14/19
1 day ago
Get ahead of others. Apply now.
Requisition No: 52003

Agency: Agency for Health Care Administration

Working Title: MEDICAL/HEALTH CARE PROG ANALYST - 68064274

Position Number: 68064274

Salary: $1,574.93 - $3,084.18 / Bi-Weekly

Posting Closing Date: 01/17/2019

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

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

This position is located in the Bureau of Medicaid Policy. Medicaid Policy is responsible for the development, coordination, and implementation of Florida Medicaid program policies, including: all Medicaid federal authorities (e.g. the Florida State Plan, 1115 waivers and home and community based waivers), administrative rules, coverage policies, managed care plan contracts, bill analyses, drug utilization review boards, preferred drug lists, supplemental rebate contracts, and KidCare/Title 21.

Salary is negotiable and commensurate with experience.

The incumbent in this position is responsible for researching, developing, implementing, evaluating, and maintaining policies under the Florida Medicaid program.

Research

The incumbent shall:
Maintain up-to-date knowledge concerning all aspects of the Florida Medicaid program, including federal regulations, state statutes, administrative rules, and the Florida Medicaid State Plan
Maintain up-to-date knowledge of health care and relevant industry trends that may have an impact on Florida Medicaid or may inform policy development activities
Remain informed about the operations of the Medicaid fiscal agent, including Medicaid claims process, billing procedures, reimbursement methodologies, encounter submissions, and provider enrollment
Remain informed about Medicare policies, national Medicaid-related research and demonstration projects, Medicaid medical assistance program innovations for general and special populations, and alternative financing and service delivery systems models
Conduct research on assigned topics, including, but not limited to: performing a review of peer-reviewed research articles, federal and state laws, other reliable sources of evidence, the Medicaid State Plan, Agency communications, State Medicaid Director Letters, and vendor contracts.

Program Planning and Analysis

The incumbent shall:
Analyze health care/program related information (including alternative financing and reimbursement strategies) in order to determine the effect on the Florida Medicaid program and compliance with federal and state laws
Assist in the analysis and development of programmatic and fiscal impact statements based on proposed federal/state program or policy changes
Prepare reports of research findings, including synthesizing complex and/or large amounts of information into a useful format and presentation
Assist in the development of legislative budget requests and program proposals
Assist in the development of grant proposals
Assist in the completion of legislative reports, including collection of necessary data elements
Assist in the development and implementation of program designs, projects, and/or plans in order to meet bureau goals/priorities.

Policy Development

The incumbent shall:
Develop and maintain program policies and procedures under the Florida Medicaid program to ensure that programs operate in accordance with the goals and objectives of the Agency, state and federal laws, rules, regulations, and guidelines
Track and monitor the routing and approval of all policy documents to ensure timely completion and adherence to Agency established deadlines.

Communication

The incumbent shall:
Assist in the development of training and providing technical assistance to ensure consistency in service/program operation and conformity with goals and objectives of the Agency, state and federal laws, rules, regulations, and guidelines
Develop, coordinate, and implement statewide program training plans
Identify and document training needs
Design and evaluate training programs and materials
Conduct statewide and local trainings, as required
Provide technical assistance regarding service/program policies and procedures
Provide consultation through the accurate presentation of data and other service/program information
Participate on behalf of the Agency in local, state or national meetings, conferences, workshops, and seminars related to the Florida Medicaid program
Prepare presentations materials, as assigned

Contract Management

The incumbent shall:
Perform contract management activities in accordance with goals and objectives of the agency and state and federal laws, rules, regulations, and guidelines
Develop and execute provider contracts addressing standard contract documents, services to be provided, manner of service provision, method of payment, and special provisions
Process, inspect, review, and approve deliverables, and invoices for payment
Track and monitor provider expenditures
Maintain appropriate contract files and records
Carry out other necessary contract management activities

AHCA offers an excellent array of benefits, including:
Health insurance
Life insurance
Dental, vision and supplemental insurance
Retirement benefits
Vacation and sick leave
Paid holidays
Opportunities for career advancement
Tuition waiver for public college courses
Training opportunities

This position is located in the Bureau of Medicaid Policy. For more information about the Bureau of Medicaid Policy, 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

Ability to direct and coordinate the planning and implementation of operational and program reviews and program monitoring activities.
Ability to utilize problem-solving techniques.
Ability to understand and apply applicable rules, regulations, policies, and procedures pertaining to a health services program.
Ability to prioritize work load.
Ability to develop various reports.
Ability to design, develop, and implement research models.
Ability to manage a health services program.
Ability to assess budgetary needs.
Ability to collect and analyze financial data.
Ability to formulate policies and procedures.

Ability to plan, organize, and coordinate work activities.
Ability to communicate effectively.
Ability to establish and maintain effective working relationships with others.
Ability to travel with or without accommodations.

MINIMUM QUALIFICATIONS REQUIREMENTS

At least one year of experience implementing and/or managing complex projects
At least one year of experience in developing, managing, or monitoring health care related contracts
At least one year of experience serving as a leader or assistant on a major research project.
At least one year of professional writing experience (e.g., policy development, grant writing/submissions, rule promulgation, research publications, white paper, etc.)?
A bachelor's degree from a college or university is preferred and four years of professional clinical experience in behavioral health care, program planning, program research, program evaluation.
A master's degree from a college or university can substitute for one year of the required experience.
Professional or nonprofessional experience as described above can substitute on a year-for-year basis for the preferred college education.

CONTACT: DENESSA HATCHER 850-412-4195

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

Medicaid ACO Program Specialist - Needham

SourceURL: https://www.linkedin.com/jobs/view/medicaid-aco-program-specialist-needham-at-steward-health-care-1052150408
Author: Clay Farris

Medicaid ACO Program Specialist - Needham

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Job description

Position Purpose: The Medicaid ACO Program Specialist is responsible for supporting the implementation, operation, and improvement of the Medicaid ACO program.

- The Program Specialist plans and oversees multiple, inter-related, complex projects to drive performance improvements for Steward's Medicaid population and programs, under the direction of senior leadership. Creates, interprets, and disseminates information across multiple internal and external stakeholders.
- Coordinates with program leads and prepares financial opportunity and risk analyses to recommend initiatives to senior leadership.

Models and performs ad hoc analyses for the purpose of understanding the historical and future performance of initiatives.

- Monitors, interprets and reports on changes in performance, market trends, health care delivery systems and legislative initiatives which impact program efforts (e.g., EOHHS regulations, Massachusetts Health Care Reform, CMS rule-making).
- Provides support for the key Steward Medicaid Care Network (SMCN) leadership meetings, including SMCN Board and Operations Committee meetings. \
- Facilitates and operationalizes relationships with external organizations, including vendors, EOHHS, and large group practices.
- Other ad hoc duties as assigned

Education

- Bachelor's degree
- Master's degree beneficial

Years Of Experience

- Open to recent graduates of a Master's program

Work Related Experience

- Health Care industry experience preferred, especially Medicaid-related
- Experience working in a fast paced, matrixed organization

Specialized Knowledge

- Knowledge of Medicaid rules and regulations preferred
- Knowledge of healthcare programs & operations, including Accountable Care Organizations, preferred
- Microsoft office applications, advanced skills in Excel, PowerPoint, and Word

SDL2017

Industry

Information Technology and Services, Financial Services, and Hospital & Health Care

Employment type

Full-time

Experience

Entry level

Job function

Other
See moreSee less

Director of Business Development & Marketing - NY Medicaid Health Plan (52257BR) at Aetna

SourceURL: https://jobs.hireheroesusa.org/jobs/7396595-director-of-business-development-marketing-ny-medicaid-health-plan-52257br-at-aetna?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic
Author: Clay Farris

Director of Business Development & Marketing - NY Medicaid Health Plan (52257BR)

Aetna
New York, NY, 10176, USA Full Time

Req ID: 52257BR

Aetna Better Health of NY is hiring a Director of Business Development & Marketing to support our growing NY Health Plan.

Director of Business Development & Marketing: Responsible for developing and implementing marketing and business strategies to drive membership growth. Leads, develops and sets the strategy for multiple functions and units. Accountable for department's contribution to health plans membership growth and relationships with providers, business associates, the department of health and local community representatives.

Fundamental Components:

(*) Implements long-term and short-term strategic growth priorities

(*) Oversees marketing/membership growth, intake (enrollment), Medicaid recertification and community relations teams

(*) Develops workflows to ensure efficiencies within and across teams

(*) Works closely with Medical Management, Operations and Finance to execute membership growth-related strategies

(*) Builds and restores relationships with providers and business associates

(*) Engages community organizations and representatives

(*) Incorporates the use of technology in the execution of strategies

(*) Conducts regular analyses of the market to identify opportunities and anticipate challenges

(*) Implements marketing strategies and plans

(*) Analyzes and interprets internal, market and competitor information utilizing technology as appropriate; identifies underlying drivers of change and trends as base for future scenarios

(*) Provides information or recommendations regarding creation, change or abandonment of a place, a product, or a marketing program

(*) Creates frames of reference to evaluate relative attractiveness and risks of marketing opportunities and threats

(*) Provides analyses and/or recommendations regarding health plan marketing/membership growth priorities and resource allocations to geographic markets, market segments, products, or programs

(*) Stays current on health plans objectives and industry practices; identifies and anticipates industry trends

(*) Develops alternative courses of action and recommends strategic direction for marketing and membership growth

(*) Interacts with Senior Management (VPs and above) in effective dialogue

BACKGROUND/EXPERIENCE desired:

(*) 5+ years experience managing large teams.

(*) 3-7+ years of experience as SME

(*) Knowledge of value based payments

(*) Track record of building relationships

(*) Knowledge of NY Medicaid market (Managed Long-term Care a plus)

EDUCATION

The highest level of education desired for candidates in this position is a Bachelor's degree or equivalent experience.

FUNCTIONAL EXPERIENCES

Functional - General Management/Multi-functional management: < 25 employees/4-6 Years

Functional - Marketing/Strategy development/4-6 Years

Functional - Marketing/Competitive intelligence/4-6 Years

Functional - Marketing/Market Research/4-6 Years

ADDITIONAL JOB INFORMATION

Opportunity to lead membership growth and marketing strategy for a growing managed long-term care plan that is part of a large Fortune 50 company in the NY market.

Aetna is about more than just doing a job. This is our opportunity to re-shape healthcare for America and across the globe. We are developing solutions to improve the quality and affordability of healthcare. What we do will benefit generations to come.

We care about each other, our customers and our communities. We are inspired to make a difference, and we are committed to integrity and excellence.

Together we will empower people to live healthier lives.

Aetna is an equal opportunity & affirmative action employer. All qualified applicants will receive consideration for employment regardless of personal characteristics or status. We take affirmative action to recruit, select and develop women, people of color, veterans and individuals with disabilities.

We are a company built on excellence. We have a culture that values growth, achievement and diversity and a workplace where your voice can be heard.

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

Aetna takes our candidates's data privacy seriously. At no time will any Aetna recruiter or employee request any financial or personal information (Social Security Number, Credit card information for direct deposit, etc.) from you via e-mail. Any requests for information will be discussed prior and will be conducted through a secure website provided by the recruiter. Should you be asked for such information, please notify us immediately.

#LI-MR1

Job Function: Product & Marketing

Aetna is an Equal Opportunity/Affirmative Action employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, or protected Veterans status.

Director, Medicaid Challenges, Provider Solutions

SourceURL: https://www.linkedin.com/jobs/view/director-medicaid-challenges-provider-solutions-at-avia-1062030503
Author: Clay Farris

Director, Medicaid Challenges, Provider Solutions

Job description

The Director, Medicaid Challenges plays an important role in supporting the Medicaid Transformation Project for health systems and other health industry segments.

The Director, Medicaid Challenges is expected to serve a variety of areas of importance to our Members. You will be an integral part of the team by helping estimate and measure outsized impact and clearly communicating the value proposition of digital and operational solutions.

So Who is AVIA?

AVIA runs the nation’s leading network for health systems unlocking the power of digital technologies in everything they do. We guide a growing roster of over 40 health system Network Members—including major academic medical centers, large integrated delivery networks, and community hospitals—to create the efficient, effective health system their families and communities want, and their payers demand. And we are expanding into new Industry segments, such as Children’s Hospitals, Payors, and Provider-based Plans, with contracts already in place to market test expansion opportunities.

AVIA Network Members trust us to help them create and execute concrete plans to accelerate their future-readiness. Here’s how we do it:

- We relate their strategic challenges, plans and goals to Digital Capability Roadmaps.
- We identify digital solutions and companies that match key capabilities Members share the need to create or improve.
- We enable the group dynamic that leads to smarter investments in capabilities with thoughtful business cases and solution implementation plans.
- We help them build Innovation Capacity – the ability to govern and manage their own work better, implement technology-enabled capabilities, and operate digital assets--leading to a more automated delivery system, faster.
- We support successful implementations (the hardest part of making digital actually work), through the power of the network by curating best practices, facilitating user groups, providing tools to align stakeholders, and benchmarking results.
- We deliver our work on a proprietary platform that’s purpose-built for innovation teams to build and manage their enterprise-wide digital portfolios.
- We cross-pollinate, sharing learnings and outcomes among Members across the Network.

AVIA’s model creates a unique opportunity to frame “what good looks like” for an entirely new class of assets--digital solutions--and influence the next decade of investments being made by the most influential and iconic health systems.

Your Zone of Genius will be…

- Having had exposure to Medicaid Care Delivery
- Understanding the largest challenges and opportunities within Medicaid
- Experience working in operations within a health system or consulting firm, experience in a Children’s Hospital or with a payor as well is a bonus
- Designing and executing group engagements that simultaneously bring together multiple health systems through an organized process that produces a clear Capabilities roadmap, vetted digitally-enabled solutions, strong analytics and metrics, and support for successful implementation at scale…and you are able to manage multiple major bodies of work in this manner concurrently

- Creating a compelling point of view and clear direction for AVIA Members and the industry
- Building enduring relationships with Member stakeholders and solution companies
- Building a strong internal and external SME network to serve as credible foundation and critical reviewers of AVIA's work
- Volunteering and engaging your skills across the organization, jumping in and leading projects outside of your formal role to support timely business needs and expand your own skill set
- Exposure to behavioral health, social determinants and addiction/substance use is helpful

Minimum Qualifications:

- You hold a Bachelor's degree, Master's preferred, in a discipline related to business and/or healthcare (e.g., MBA, MPH, MHA) from a high-quality program' focus in areas such as technology or innovation a plus
- 8+ years (total work experience), in positions of increasing responsibility and impact
- You have experience with creating efficiencies in health systems via digital solutions.
- You possess deep experience in process improvement.
- You bring stellar analytical and critical thinking skills; you know how to break complex problems down into component parts, prioritize their value, and deliver concise, actionable products.
- You have knowledge of the current healthcare market with direct experience addressing health system challenges, particularly in digital health.
- You prioritize action over risk-aversion, MVP over perfection, and results over activity.
- You understand the digital solution world or have had meaningful exposure.
- You like managing multiple clients and projects concurrently, being efficient with your time, communicating to matrixed teams, accurately interpreting client's needs, and supporting repurposable standard work.
- You find ambiguity full of possibilities and it triggers a response to create, solve, own, guide, drive and stretch yourself and others.
- You possess excellent written/verbal communication; you are persuasive, motivating, and clear; your active listen skills set you apart.
- You take 100% accountability for your work, behavior, and how you show up to others
- You can travel up to 30% and Chicago based.

You're excited about AVIA and this opportunity because…

- You want to make an outsized investment of your time and talent in a growing company, and for that, be paid well, earn an ownership interest in the company via profit options, and enjoy great benefits.
- We are different. We are a successful, well-funded, fast-growing company that still prides itself on our start-up values…like agility and risk-taking and celebrating (big wins, our diversity, and simple pleasures, like National Chocolate Lovers Day). We have enough infrastructure that every day isn't a fire drill.
- We do work that matters—a lot—making exciting things happen in healthcare at a moment when exciting things really *need* to happen: creative destruction of failed systems and blossoming of more efficient alternatives that create better experiences and win-for-all outcomes.
- We are each allowed to be—expected to be! —creative daily.
- You've noticed—and appreciate—that we are genuinely committed to our Members and mission. It's not just lip service to build a company.
- You think we seem like cool, committed, smart people. And with all due humility, yes, we really are. Passionate, practical, high-achieving and results-oriented, we also love to laugh, spitball big ideas, celebrate shared success, and share funny, embarrassing stories about our family members.

We're excited about you because…

- We are parched for your Zone of Genius at this moment in our growth and development.
- You have a bias to action, prize results over activity, value speed to market, and strive for efficiency.
- You thrive in situations with big opportunity and limited direction. They bring out your best talents to create, solve, own, guide, drive and stretch yourself and others.
- You share our intense curiosity about the impact of technology on our world, and want to bring that lens to bear on making a significant positive difference. Even though your native language is systems and data, you understand that when it comes to health care, behind every trend line and data point is a real person, and n=1.

AVIA runs the nation's leading network for health systems seeking to innovate and transform through digital strategy. The AVIA Innovator Network brings together action-oriented health systems to solve pressing challenges that are ripe for digital innovation. Network members collaborate on strategic initiatives like consumer engagement and post-discharge success. With AVIA's rigorous process and the power of collaboration, members identify, deploy, and scale the best digital solutions to achieve financial and clinical impact. The result? Health systems accelerate their pace of transformation – moving faster with greater confidence. Learn more at aviahealthinnovation.com. Follow us on LinkedIn and Twitter.

Our company is an equal opportunity employer; applicants are considered for all roles without regard to race, color, religious creed, sex, national origin, citizenship status, age, physical or mental disability, sexual orientation, marital, parental, veteran or military status, unfavorable military discharge, or any other status protected by applicable federal, state or local law.

Informatics Lead Analyst - NJ Medicaid Health Plan (56036BR)

SourceURL: https://www.linkedin.com/jobs/view/informatics-lead-analyst-nj-medicaid-health-plan-56036br-at-aetna-a-cvs-health-company-1016697474
Author: Clay Farris

Informatics Lead Analyst - NJ Medicaid Health Plan (56036BR)

Hidden gem icon

Be one of the first 10 applicants.

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Apply on company website

Job description

Job Description

Aetna Better Health of New Jersey is hiring a Informatics Lead Analyst in our Princeton, NJ offices.

The **Informatics Lead Analyst** role will oversee the inbound and outbound data sources that service the health plan, working together with our corporate partners to put in place efficient and automated solutions. The position will also act as a Business Analyst, assisting to document plan processes that will lead to improved operational outcomes, and will support related regulatory reports

Fundamental Components

Document processes around inbound and outbound data transactions, building out tracking mechanisms to ensure that the plan is successfully receiving and sending data regularly. Work on higher level plan projects, that will require creating baseline understandings of current operational processes, identifying gaps, and creating solutions to correct gaps. Working with appropriate partners to put in place controls around data sources with goal to improve data integrity. Support plan regulatory reporting as needed.

BACKGROUND/EXPERIENCE Desired

Five or more years of health research, healthcare informatics, industry analytic experience. Demonstrated project management and/or team lead experience. Demonstrated extensive and diverse knowledge of health care data, metrics, systems and standards; demonstrated subject matter expert in multiple subject areas. Able to make sound decisions and recommendations to drive business solutions. Ability to communicate statistical and technical ideas and results to non-technical clients in written and verbal form. Health care analysis, health economics, or health services research experience. SQL programming abilities in data warehouse or big data analytics environment is a plus Strong collaboration and communication skills within and across teams. Strong problem solving skills and critical thinking ability. Understanding of relational databases, data systems and data warehouses. Strong reporting skills using Excel, Access, Word and/or PowerPoint. Strong understanding of customers strategies, information needs programs, processes and products. Experience in working in a data warehouse environment as well as the ability to work with large data sets from multiple data sources. Knowledge of other reporting platforms such as: Business Objects, Microsoft Access, web development technology, big data analytics, data mining, Visual Basic

EDUCATION
The highest level of education desired for candidates in this position is a Bachelor's degree or equivalent experience.

Functional Experiences

Functional - Information Management/Data acquisition, data management, programming and documentation/4-6 Years
Functional - Information Management/Business information analysis/1-3 Years
Functional - Claims/Reporting & special services/

Technology Experiences

Technical - EDI/EDI/1-3 Years/End User
Technical - Database/Microsoft SQL Server/1-3 Years/End User

Required Skills

Leadership/Driving a Culture of Compliance/FOUNDATION
Leadership/Collaborating for Results/FOUNDATION

Desired Skills

General Business/Maximizing Work Practices/FOUNDATION

Telework Specifications

1-2 days telework potential will be considered

Additional Job Information

Aetna is about more than just doing a job. This is our opportunity to re-shape healthcare for America and across the globe. We are developing solutions to improve the quality and affordability of healthcare. What we do will benefit generations to come.

We care about each other, our customers and our communities. We are inspired to make a difference, and we are committed to integrity and excellence.

Together we will empower people to live healthier lives.

Aetna is an equal opportunity & affirmative action employer. All qualified applicants will receive consideration for employment regardless of personal characteristics or status. We take affirmative action to recruit, select and develop women, people of color, veterans and individuals with disabilities.

We are a company built on excellence. We have a culture that values growth, achievement and diversity and a workplace where your voice can be heard.

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

Aetna takes our candidates's data privacy seriously. At no time will any Aetna recruiter or employee request any financial or personal information (Social Security Number, Credit card information for direct deposit, etc.) from you via e-mail. Any requests for information will be discussed prior and will be conducted through a secure website provided by the recruiter. Should you be asked for such information, please notify us immediately.

Req#
56036BR
Job Group
Health Care
EEO Statement
Aetna is an Equal Opportunity, Affirmative Action Employer
Primary Location
NJ-Princeton
Additional Locations
NJ-Princeton

Percent Of Travel Required

0 - 10%
Potential Telework Position
No
Full or Part Time
Full Time
Supervisory
No
Resource Group
2

Industry

Insurance, Financial Services, and Hospital & Health Care

Employment type

Full-time

Experience

Associate

Job function

Business Development,Sales
See moreSee less

Dir Medicaid Plan Marketing

SourceURL: https://www.linkedin.com/jobs/view/dir-medicaid-plan-marketing-at-thornton-tomasetti-1060387983
Author: Clay Farris

Dir Medicaid Plan Marketing

Job description

Your Talent. Our Vision. At **Anthem, Inc.,** the Government Business Division is focused on serving Medicaid, Medicare and uninsured individuals. Our commitment and focus on government health programs is the foundation upon which we're creating better care for our members, greater value for our customers and better health for our communities. Join us and together we will **drive the future of health care.**

Join one of the fastest growing businesses in a company with the largest and most successful Medicaid business in the nation. The associate in this position will be supporting members enrolled in the **Iowa and Minnesota** Medicaid Program.

This position can be located in Des Moines, IA and/or Eagan, MN

As a member of our Central Region Marketing Leadership team, the Director, Medicaid Marketing will be accountable for executing marketing strategies in a multi-state **(Iowa and Minnesota)** Medicaid Health Plans environment. This leader will work in conjunction with other Medicaid Health Plans, key business partners, and key corporate staff all to enhance national corporate branding efforts. This position will also develop objectives, policies and programs for marketing activities that directs and coordinates the efforts of marketing associates toward the accomplishment of corporate and key partnership objectives.

Primary duties may include, but are not limited to

- Coordinates with key partner marketing leadership to ensure alignment of strategy and tactics.
- Strategically plans and executes strategies, outreach and education activities for products to extend and increase membership growth and marketing.
- Executes and leads a team on short and long-term strategic directives for the corporation, plans campaigns and programs to meet goals; reviews department performance in relation to established goals, implementing changes to effect improvement or react to a change in the organization or industry.
- Researches and evaluates trends related to membership growth patterns.
- Develops, recommends and presents short and long-term outreach strategies; develop projections of estimated usage and cost benefits of services.
- Maintains and constantly improves the corporation's competitive position and ensures maximum productivity within budget guidelines.
- Prepares presentations regarding marketing and outreach programs for senior management groups.
- Develops and maintains favorable relationships with key decision-makers and influencers in the community.
- Develops and recommends department operating budgets; reviews and revises financial reports, and prepares departmental statistics.
- Directs and coordinates activities of the marketing operation in accomplishing corporate outreach activities, and periodically evaluates and reports results.
- Ensure compliance with state and municipal laws, rules, and guidelines for marketing and outreach; organizes and directs training and orientation for all associates.
- Develops, approves and/or secures approval of objectives, policies and programs for corporate marketing activities, and evaluates and reports results.
- Directs outreach planning and activities, which includes maintaining favorable relations with members, analysis of competitive products and outreach techniques, consumer research, marketing legislation, outreach budget and goals.
- Makes recommendations to appropriate functions to achieve product modifications or improvements derived from market research, technical service work or Marketing feedback.
- Identifies and implements activities/services that promote member attendance and participation, member retention and growth, member health education and promotion.
- Develops education materials which address the cultural and educational diversity of membership.
- In partnership with Marketing Communications, responsible for identifying appropriate media opportunities and developing media relationships to assist in developing brand recognition.
- Participates in appropriate Board(s) and or committee(s) which will assist in the development of brand recognition.
- Other duties as requested or assigned.

StartWire

SourceURL: https://www2.startwire.com/jobs/louisville-ky/market-medical-director-passport-health-plan-48509176?source=seo&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic
Author: Clay Farris

StartWire

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.

Are we growing? Absolutely—56.7% in year-over-year revenue growth in 2016. 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.

Passport Health Plan is a Louisville, KY based not-for-profit health plan with Medicaid and Medicare Advantage lives. Evolent Health is a delegated partner in CM, UM, quality, and other clinical and business functions. The Market Medical Director is a senior physician member of the Evolent clinical leadership team serving in a Passport Health Plan facing role collaborating with the Passport Health Plan CMO and Passport-Evolent joint leadership teams. As a leader of the clinical team, you will have the opportunity to make a profound impact on the lives of our statewide Kentucky members in partnership with the network hospitals, physicians and providers.

The primary role is to partner with the Passport Chief Medical Officer and the clinical team responsible for developing and executing strategies that both improves the quality of health care delivered to our members and improves cost and efficiency. Together with the CMO, the Market Medical Director will be responsible for leading clinical operations functions including utilization management, care management, population health, medical economics, quality, and pharmacy management. They will be responsible for supporting clinical operations, physician engagement strategies, and for managing total cost of care.

Key focus areas include:

* Leading clinical strategy development and implementation

* Leading clinical innovation including improved alignment of clinical programs that benefit members, e.g. behavioral health and social determinants

* Managing the medical economics process

* Leading the physician/provider network engagement strategy including alternative incentive and payment models

* Strategic partner with Passport ELT to accomplish and/or exceed State goals and requirements

* Advancing physician/provider network depth and increasing member acquisition

The Market Medical Director will have the added strength of working with the clinical, financial, analytics, and operations of Evolent Health to support the local health plan needs and functions.

Reporting Relationship

The Market Medical Director will report directly to the Evolent Medicaid Medical Executive and have a matrix reporting relationship to the Passport CMO and the Evolent Market President at Passport.

Responsibilities

Physician and provider relationship management

* Leading change with physicians and other providers to improve the quality and efficiency of care in the network and integrate these providers into our clinical initiatives, including creating and maintaining a system that gives performance feedback on these initiatives

* Visits network facilities on a regular basis, identifies key issues facing leaders and works collaboratively with leadership to accomplish mutually agreed upon goals

* Participates in the development of physician incentives, value based contracting arrangements, pay for performance and targeted network improvement programs

* Partners with Analytics to provide meaningful and actionable information to physicians

* Lead and support activities related to communications, physician/provider engagement, and programming including outward facing membership growth and organizational visibility and success

* Participates in Physician/Practice meetings to promote education and alignment with the clinical and medical economics initiatives of the plan

Population health

* Provides clinical leadership and development for population health programs and medical management

* Assists in assuring appropriate health care delivery for the assigned membership and managing the medical economics and efficiency associated with the assigned population

* Promotion of managed care systems using evidence-based medicine to educate and facilitate best practices with care management staff and network physicians/providers

Utilization Management

* Responsible for executing and maintaining Evolent Health's benchmarked Utilization/Cost Management Program and relevant Quality Improvement Programs

* Participates as needed as part of Evolent Health's UM Medical Director team to assure quality of care in all aspects of medical utilization and to assure that utilization is appropriate to meet the needs of the members and falls within recognized standards of efficiency

* Participate in the Appeals and Grievance process, as necessary, to assure timely and accurate responses to members

* Supports and leads, as needed, operational performance to develop and implement the health plan's clinical guidelines and protocols that can be utilized through the quality improvement, utilization management, and case management processes to positively impact the delivery of care.

* Collaborates as needed with risk management, claim adjudication, pharmacy utilization management, catastrophic case review, outreach programs, HEDIS reporting, site visit review coordination, triage, provider orientation, and others

Quality of care and service delivery

* Provides guidance and interpretation on issues of medical appropriateness, benefit application as appropriate, level of care necessary to include out-of-network care

* Evaluates and ensures systems and processes to assist physicians/providers with adherence to evidence based protocols

* Assures compliance related to Federal (e.g., CMS), State (e.g., Insurance commission) and local rules and regulations

* Identifies and implements other strategies that insure quality care, access to care, and the financial success of the Company

Qualifications

Required:

* Graduate of an accredited medical school. M.D. or D.O.

* Active physician license without any restrictions

* 3-5+ years of clinical practice in a primary care setting preferred and progressively responsible medical administrative experience

* Board certification in ABMS recognized specialty

* 3-5+ years of managed care or population health experience

Preferred:

* Proven ability in medical leadership position possessing clinical credibility with peers and the ability to be a team player and team builder

* MBA or a Master's Degree in healthcare or other related fields of study

* Experience with Medicaid population health management strategies and implementation

* Excellent interpersonal, verbal, and written communication skills

* Ability to navigate in a corporate matrix environment

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