Medicaid Industry Jobs Hunter: 1/21/2019

Notebook:	Curator: Jobs		
Created:	1/21/2019 10:57 AM	**Updated:**	1/21/2019 11:40 AM
Tags:	jobs		
URL:	https://www.linkedin.com/jobs/view/senior-finance-director%2C-medicaid-health-plan-at-valueoptim-1081057225/?utm_campaig...		

consulting | training | free webinars

clay@mostlymedicaid.com | 919-727-9231

Medicaid Jobs Hunter

Jan 21, 2019

In this packet...

Senior Finance Director, Medicaid Health Plan | ValueOptim | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/senior-finance-director%2C-medicaid-health-plan-at-valueoptim-1081057225/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Senior Finance Director, Medicaid Health Plan

Company Name ValueOptim Company Location Orlando, FL, US

New Posted Date Posted 4 hours ago Number of applicants Be among the first 25 applicants

Responsible for the management of financial results and operations for an assigned SBU. Areas of focus will vary based on assigned SBU and may include customer contracting, rate negotiations, product pricing, analysis of utilization and medical cost trends, new product development and implementation with customers. May also be responsible for the management of financial results for assigned customers, support of profitable sales growth and driving strategic initiatives. In the process, builds relationships with SBU leadership, enterprise financial operations and other functional leaders to drive performance. Develops and maintains external partnerships 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-year financial 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 financial support 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 financial reporting 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. General Job Information Title Senior Finance Director, Medicaid

- Orlando, FL Grade 31 Job Family Finance Group Country United States of America FLSA Status United States of America (Exempt) Recruiting Start Date 10/23/2018 Date Requisition Created 10/19/2018 Minimum Qualifications Education Bachelors (Required), Masters (Required) License and Certifications
- Required License and Certifications
- Preferred CPA
- Certified Public Accountant
- Enterprise Other Job Requirements Responsibilities Must be able to handle multiple priorities and meet tight deadlines. Must be detail oriented and have excellent analytical skills. Must have good communication skills, both written and verbal and experience with communication at an executive level. Must be able to interact with all levels of staff, including all senior management.8 years of progressive experience in financial operations within managed care, health care or insurance industries. 3 years in a managerial position interfacing with senior management.

Provider Relations Rep- NJ Medicaid Health Plan | Jobs @ TheJobNetwork | LinkedIn

Provider Relations Rep- NJ Medicaid Health Plan

Company Location Princeton, NJ, US

Posted Date Posted 2 days ago Number of applicants Be among the first 25 applicants

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.

Aetna is an Equal Opportunity, Affirmative Action Employer
PandoLogic. Keywords: Provider Relations Representative, Location: Princeton, NJ - 08542

Health Care Business Analyst(MEDICARE & MEDICAID) | Computer Consultants Llc | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/health-care-business-analyst-medicare-medicaid-at-computer-consultants-llc-1078434524/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Health Care Business Analyst(MEDICARE & MEDICAID)

Company Name Computer Consultants Llc
Company Location Olympia, WA, US

Posted Date Posted 2 days ago Number of applicants Be among the first 25 applicants

Job Description

CCI has a Client who is seeking a Candidate to develop a strategic roadmap to provide a holistic enterprise level “big picture” view and understanding to inform and guide the division’s efforts to support Agency and the clients its serves. The strategic roadmap will help outline the necessary steps to improve utilization of limited resources, increase the alignment of IT investments with Agency business drivers and goals, and enable organizational awareness and align work efforts towards meeting the desired strategic goals. Lastly, this strategic roadmap will positively influence Client’s long-term ability to conduct financial forecasting, planning, and alignment with funding opportunities.

The Contractor Will Provide Services In The Following Areas

Candidate will develop an Information Technology Strategic Plan for Enterprise Technology (ET) consisting within the following scope of work.

Collect and Review Agency Data

- Review the existing Agency strategic plan, study other current operational plans, organizational assets, business processes within the scope of this work request and other pertinent documentation such as regulatory requirements. Develop an understanding of current issues, priorities, goals, and objectives for Agency.
- Conduct a thorough analysis of the existing IT environment; infrastructure, services, staffing, applications, information security, and business systems.
- Conduct an assessment of ET needs.
- Conduct preliminary meetings with ET to identify requirements for strategic plan.
- Identify practical and relevant private and public-sector industry standards and strategies.
- Identify emerging technology needs, upgrades, major trends facing ET.
- Identify means and approaches to accommodate current and future technology requirements and trends.
- Initial scope is limited to ET, with potential to expand across Agency Administrations if agency needs dictate.

Project Administration

- Conduct project planning meetings with ET representatives responsible for the strategic plan. Project team members will be identified prior to kick-off meeting.
- Meet with key stakeholders at applicable work locations as identified during planning meetings.

Develop Recommendations

- Review meeting notes, observations, and additional documentation collected during site visits. Identify areas of opportunity. Collaborate with ET staff to establish priorities.

- Research and identify suitable best practices from comparable organizations to recommend maximally effective strategic planning processes.
- Provide recommendations for staff engagement and structure to achieve improved process for strategic planning that incorporates all plans.

Agency Review and Final Report

- Meet in person with ET management and the Enterprise Technology Steering Committee (ETSC) to go over preliminary findings.
- Prepare a final report incorporating Agency feedback from preliminary findings and report.
- Review final report with ET management and the ETSC to go over the final findings and recommendations for the best utilization of limited resources, how to increase the alignment of IT investments with DSHS business drivers and goals, and to align work efforts towards meeting strategic goals.

Final Process Implementation

- Lead strategic planning exercise to arrive at the 2019 – 2025 Strategic Plan.
- Draft Strategic Plan to review with ET management and the ETSC.
- Review final comments and develop written strategic plan

Qualifications

- Five (5) years' experience providing recommendations for strategic planning processes in health and human services organizations and state government.
- Five (5) years' experience providing strategic deliverables for large (5,000 or more employees) state or federal organizations in a federated environment.
- Five (5) years' experience facilitating and communication strategic planning objectives and methodologies with executives and partners.
- Five (5) years' experience with regulatory requirements such as IRS 1075, HIPAA, CJIS, and others.
- Five (5) years' experience dealing with Centers for MEDICARE and MEDICAID Services (CMS) standards and conditions.
- Experience working in health and human services organizations Desired
- Recognized ability to thoughtfully engage stakeholders Desired
- Experience developing strategic plans by integrating architectural models, artifacts and frameworks including but not limited to MITA, FEAF, TOGAF and NHSIA - Desired
- Experience in assessing staff and other types of plans and providing detailed recommendations that improve planning processes – Desired
- Please attach sample of work related to previous work-it might be in PDF format, Word document ,screenshots or link to work sample-REQUIRED TO CONSIDER YOUR PROFILE, ELSE IT WILL BE REJECTED

Additional Information

For immediate consideration, please send your resume to hire(at)cci-worldwide.com with "Health Care Business Analyst(MEDICARE & MEDICAID)(Job

ID:ITPS-1824-706)WA" as the subject line.

Director Medicaid Plan Marketing | ValueOptim | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/director-medicaid-plan-marketing-at-valueoptim-1080726022/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director Medicaid Plan Marketing

Company Name ValueOptim Company Location Eagan, MN, US

New Posted Date Posted 8 hours ago Number of applicants Be among the first 25 applicants

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. Required:

- Bachelor's Degree in Marketing, Business Administration or similar field.
- Years and Type of Experience: 10 years of sales, marketing or healthcare experience.
- 5 years of experience in a supervisory level.
- Proven track record of designing, developing and managing sales, marketing, and community relations functions. Knowledge of Protocols and Process Regulations. Preferred:
- Master's Degree in Business, Health Care Administration or a similar field.

Pharmacy Program Manager - Medicaid - SHCN

SourceURL: https://shcnjobs.steward.org/pharmacy-program-manager-medicaid-shcn/job/10293742?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Pharmacy Program Manager - Medicaid - SHCN

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

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!

Apply Online

Medicaid Eligibility Trainer in St Louis MO USA - HCA Health Care - 735281 | Recruit.net USA

SourceURL: https://www.recruit.net/job/trainer_st-louis_jobs/735281E2C0054B8F?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Eligibility Trainer in St Louis MO USA

Job Description

Description

Parallon believes that organizations that continuously learn and improve will thrive. That's why after more than a decade Parallon remains dedicated to helping hospitals and hospital systems operate knowledgeably, intelligently, effectively and efficiently in the rapidly evolving healthcare marketplace, today and in the future.

Now is the time to join our team of motivated and nurturing individuals working to assist patients with their Medicaid Eligibility screening and enrollment. Ideal candidates will have a steady work knowledge of medical terminology, practices and procedures, as well as laws, regulations, and guidelines. This position has the benefit of frequent travel to various states within the U.S. You should also share a passion for our purpose, **"To serve and enable those who care for and improve human life in their community."**

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

Parallon is now seeking a Full-Time Medicaid Eligibility Trainer.

You can also ***Like us on Facebook*** :
https://www.facebook.com/ParallonRCSJobs .

WHAT WE CAN OFFER YOU:

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

WHAT YOU WILL DO:
Responsible for developing and conducting training programs for the Medicaid Eligibility (ME) service line that provides staff with the knowledge and skills required to achieve desired levels of performance.
The position is a Work From Home (WFH) position with a minimum of 75% travel.

Essential Job Functions:

- Develop and maintain ME training program for each facility and state in scope for the assigned region / implementation team, adhering to the pre-established standard ME training curriculum. This includes researching and documenting applicable State Medicaid program(s) and guidelines, documenting center and facility-specific processes and procedures, and coordinating with Training Director and other ME trainers to maintain adherence to the standard curriculum across regions / implementation teams. It also includes converting State program guidelines, center/facility specific process documentation and technical systems documentation into training materials, following the standard ME curriculum. Curriculum covers implementation training for specific facilities, train-the-trainer training, ongoing new hire training, and ongoing refresher and just-in-time training for ME staff and first level leads.
- Develop an implementation training plan and schedule for each facility in the assigned region based on the implementation timeline, in full coordination with the Implementation Director during implementation phase. This includes coordinating all training logistics (classroom arrangements, training materials, etc.) and collaborating with the center / facility training point of contact for center / facility orientation and compliance training. It also includes assisting with systems access setup and testing related to implementations. After implementation, develop training schedule in coordination with Training Director, regional operations, and regional HR.
- D eliver training to new hires on-site at facility during implementation phase, coordinating with Implementation team. After implementation, deliver

training to center-based new hires within region, coordinating with Operations to deliver training to onsite facility-based new hires within region.
- Create and administer training evaluations and make recommendations to improve training effectiveness based on feedback. Create training certificates to recognize course completion.
- Use basic assessment, design, development, delivery and evaluation (ADDIE) method when designing and developing training programs. Determine length of training, delivery medium, materials and media used; visuals and other test/reinforcement aids based on class participants. Assist in designing Leap Frog training modules as needed. Keep a

Save Job

Contract and Network Development Specialist | Independent Care Health Plan | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/contract-and-network-development-specialist-at-independent-care-health-plan-1077508258/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Contract and Network Development Specialist

Company Name Independent Care Health Plan Company Location Milwaukee, WI, US

Posted Date Posted 3 days ago Number of applicants Be among the first 25 applicants

Job Description

The purpose of the **Network Development Contract Specialist (NDCS)** position is to develop and maintain a robust network of contracted providers to meet the needs for iCare membership and all lines of business. The NDCS proactively engages all levels of providers to achieve iCare goals and objectives, participates in the development of new provider networks, and successfully negotiates provider contracts favorable to iCare's business objectives. This position will effectively interact with providers, iCare department leaders, and iCare staff to assure contract compliance as well as clearly communicate with other iCare departments to assure that all applications properly reflect the contracted services and other negotiated contract terms.

This position effectively and efficiently develops and maintains a network of contracted providers to meet the needs for iCare membership and lines of business.

- Develops the iCare's provider network to best serve the needs of iCare enrollees.
- Works in collaboration with internal staff to complete and periodically update market analyses to determine network adequacy and identify network development needs.
- Participates in development of contracting strategy, including analysis of provider contracts, scope of provider services and provider profiles.
- Develops, in collaboration with iCare leadership and staff, strategies to engage providers around iCare goals for improvement in quality and service to members
- Participates in the assessment of the network development opportunities for new products, lines of business and expansion markets.
- Negotiates and prepares agreements and contracts for providers to achieve financial and non-financial goals according to iCare policy and limitations.
- Assists in the development of policy, procedures and protocols for provider data base setup and maintenance.
- Facilitates iCare credentialing process or credentialing delegation process
- Responds to requests from providers relative to contact concerns, problems and issues; conducts necessary research and analysis and responds verbally or by correspondence as appropriate.
- Interacts with other departments and seeks appropriate resolution to provider/contract issues. Advises internal staff on issues related to provider contracts and network.
- Delivers reports summarizing contracting and other activity periodically to management as requested
- Maintains compliance with all regulatory requirements.

Experience And Skills

- Broad knowledge of health care marketplace including hospital, physician and other long term care providers.

- Minimum of 5 years' experience in health insurance/managed care environment with knowledge of Medicaid and Medicare benefits and services and including provider contracting experience.
- Bachelor's degree in business administration, health care administration or related field, preferred.
- Excellent negotiation and problem-solving skills.
- Excellent oral and written communication skills; especially demonstrated telephone skills.
- Demonstrated knowledge of keyboard, Word, Excel, PowerPoint, email, and other office software applications.
- Must have own vehicle and valid driver's license for work-related travel.

Director, State Behavioral Health – Medicaid LOB with WellCare | Mid West Apply | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/director-state-behavioral-health-%E2%80%93-medicaid-lob-with-wellcare-at-mid-west-apply-1080518845/?trkInfo=searchKeywordString:Wellcare,searchLocationString:Houston%252C%2BTX,vertical:jobs,pageNum:0,position:20,MSRPsearchId:0b9004b1-4610-4857-ab36-2f24b9f44bc7&refId=0b9004b1-4610-4857-ab36-2f24b9f44bc7&trk=jobs_jserp_job_listing_text&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director, State Behavioral Health – Medicaid LOB with WellCare

Company Name Mid West Apply Company Location Houston, TX, US

New Posted Date Posted 10 hours ago Number of applicants Be among the first 25 applicants

The position listed below is not with Mid West Apply but with WellCare

Job Description - Director, State Behavioral Health - Medicaid LOB (1800916) Job Description Director, State Behavioral Health - Medicaid LOB-1800916 Headquartered in Tampa, Fla., WellCare Health Plans, Inc. (NYSE: WCG) focuses primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex medical needs primarily through Medicaid, Medicare Advantage and Medicare Prescription Drug Plans, as well as individuals in the Health Insurance Marketplace. WellCare serves approximately 5.5 million members nationwide as of September 30, 2018. WellCare is a Fortune 500 company that employs nearly 12,000 associates across ... Associated topics: agent, broker, guest, healthcare, inside sales, insurance agent, insurance sales agent, lead sales agent, sales associate, sell

Seniority Level

Director

Industry

- Insurance
- Financial Services
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Health Care Provider

Clinical Care Manager (RN) - Transition Coordinator - UPMC McKeesport | UPMC Health Plan | LinkedIn

Clinical Care Manager (RN) - Transition Coordinator - UPMC McKeesport

Company Name UPMC Health Plan
Company Location McKeesport, PA, US

Posted Date Posted 2 days ago Number of applicants Be among the first 25 applicants

Description

Do you have a strong interest in health insurance and care management? Are you interested in working onsite in a hospital setting, but want to work daylight hours? This opportunity may be a great fit for you! UPMC Health Plan is hiring a full-time Clinical Care Manager supporting our Medical Management group's onsite presence at UPMC McKeesport.

This position will work onsite at UPMC McKeesport Hospital I and will function as a transition coordinator for UPMC Health Plan Members receiving care at McKeesport.

The position will work standard daylight hours, Monday through Friday.

The Clinical Care Manager is responsible for care coordination and health education with identified Health Plan members through face to face collaboration with members and their caregivers and providers. The Care Manager identifies members medical, behavioral, and social needs and barriers to care, and develops a comprehensive care plan that assists members to close gaps in preventive care. In this role, you will address barriers to care, and support the members self-management of chronic illness based on clinical standards of care. Additionally, you will collaborate and facilitate care with other medical management staff, other departments, providers, community resources and caregivers to provide additional support.

Responsibilities

- Assist member with transition of care between health care facilities including sharing of clinical information and the plan of care.
- Conduct comprehensive face to face assessments that include the medical, behavioral, pharmacy, and social needs of the member. Review UPMC Health Plan data and documentation in the member electronic health records as appropriate and identify gaps in care based on clinical standards of care.
- Contact members with gaps in preventive health care services and assist them to schedule required screening or diagnostic tests with their providers. Assist member to schedule a follow up appointment after emergency room visits or hospitalizations.
- Document all activities in the Health Plan's care management tracking system following Health
- Plan standards and identify trends and opportunities for improvement based on information obtained from interaction with members and providers.
- Present or contribute to complex case reviews by the interdisciplinary team summarizing clinical and social history, healthcare resource utilization, case management interventions. Update the plan of care following review and communicate recommendations to the member and providers.
- Refer members to appropriate case management, health management, or lifestyle programs based on assessment data. Engage members in the Beating the Blues or other education or self management programs. Provide members with appropriate education materials or resources to enhance their knowledge and skills related to health or lifestyle management.
- Review member's current medication profile; identify issues related to medication adherence, and address with the member and providers as necessary. Refer member for Comprehensive Medication Review as appropriate.
- Successfully engage member to develop an individualized plan of care in collaboration with their primary care provider that promotes healthy lifestyles, closes gaps in care, and reduces unnecessary ER utilization and hospital readmissions. Coordinate and modify the care plan with member, caregivers, PCP, specialists, community resources, behavioral health contractor, and other health plan and system departments as appropriate.

Qualifications

- Minimum of 2 years of experience in a clinical and/or case management nursing required.
- BSN preferred
- Minimum 1 year of health insurance experience required.
- 1 year of experience in clinical, utilization management, home care, discharge planning, and/or case management preferred
- Excellent organizational skills
- High level of oral and written communication skills
- Computer proficiency required

Licensure, Certifications, and Clearances:

- Case management certification or approved clinical certification required (or must be obtained within 2 years of hire to remain in role)
- CPR required based on AHA standards that include both a didactic and skills demonstration component within 30 days of hire
- Act 33 Child Clearance with Renewal
- Act 34 Criminal Clearance with Renewal
- Act 73 FBI Clearance
- Automotive Insurance
- Driver's License
- Registered Nurse

AVP, Health Plan Operations Job in Jackson, MS at Molina Healthcare

SourceURL: https://www.ziprecruiter.com/c/Molina-Healthcare/Job/AVP,-Health-Plan-Operations/-in-Jackson,MS?ojob=791d8fd1910bfa43036e6ee7de476868&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

AVP, Health Plan Operations

Molina Healthcare Jackson, MS

Job Description *Job Summary* Molina Health Plan Operations jobs are responsible for the development and administration of State Health Plan's operational departments, programs and services, in alignment with Molina Healthcare's overall mission, core values, and strategic plan and in compliance with all relevant federal, state and local regulatory requirements. *Knowledge/Skills/Abilities* Under the leadership of the Plan President, this role directs and coordinates Health Plan Operations. Accountable for ensuring Health Plan Operating metrics consistently meet and/or exceed all compliance

requirements as well as key performance targets and associated service level agreements This position plans, organizes, staffs, and coordinates the operations of state Medicaid/CHIP, Medicare and Marketplace Health Plan operations. Works with staff and senior management to develop and implement improvements and oversight for non-clinical Health Plan operations. _Serves as the Senior Plan leader and liaison for MHI Service Operations, including:_Claims, Configuration Information Management, Enrollment, Contact Center Operations, IT, Provider Configuration Management, Program Integrity, Risk Adjustment, Provider Resolution Team, Provider Appeal and Grievances, Member Appeals and Grievances, and other departments as required. These MHI shared services operations that support the Health Plan will have dotted line responsibility and accountability to this position. Proactively develops, tracks, and reports to Plan leadership MHI Service Operations performance relative to Plan compliance requirements, key performance targets and/or associated service level agreements. Quickly escalates performance issues to the Plan President and Plan leadership along with clear action plans to mitigate. This role requires the identification and adoption of best practices from across the enterprise for Health Plan and MHI Service Operations; developing strategies and tactics in partnership with MHI Service Operations to mitigate any issues or performance levels not meeting established service levels and provides corporate oversight including the efficacy of vendor management. Serves as liaison with Enrollment and Contact Center Operation leaders to ensure full and consistent compliance with Health Plan state contract and regulatory requirements. Works collaboratively with corporate business owners to mitigate risk related to enrollment processes and call center performance. Directs analytical activities to identify trends and potential opportunities with those Corporate Operations functions that may impact the functionality of Health Plan Operations. Directly manages the Plan's benefit configuration, claim payment policies and the maintenance or modification of such, to support accurate and timely claims payment. In addition, manages the Plan's Provider Configuration/Information activities to ensure compliance with regulatory requirements and accurate claims and encounter submissions. Partners to support Plan encounter submissions to Regulators. Leads efforts through local Data/Business Analysts to audit provider contract loads and claims payments to ensure compliance with provider contract requirements. May directly manage the Project Management and Process Improvement teams and resources. May directly manage the Health Plan main reception desk at Plans discretion. Other operational duties as assigned by the Plan President. *Job Qualifications* *Required Education* Bachelor's Degree in Business, Health Services Administration or related field, or comparable experience. * * *Required Experience* 7-10 years' experience in Healthcare Administration, Health Plan Operations, Managed Care, and/or Provider Services. Experience managing/supervising employees. Demonstrated adaptability and flexibility to a rapidly moving business environment. Demonstrated experience with Medicaid and Managed Care. Experience working in Matrix environment. * * *Preferred Education* Master's Degree in Business, Health Administration or related field. * * *Preferred Experience* Experience with Medicaid and Medicare

managed care plans. /To all current Molina employees: If you are interested in applying for this position, please apply through the intranet job listing. Molina Healthcare offers a competitive benefits and compensation package. Molina Healthcare is an Equal Opportunity Employer (EOE) M/F/D/V./ **Job:** **Health Plans* **Organization:** **Health Plans* **Title:** *AVP, Health Plan Operations* **Location:** *MS-Jackson-ONEJACK* **Requisition ID:** *1900111*

Manager of Clinical Care Coordination (PA Medicaid) Job in Pittsburgh, PA at Highmark Health

SourceURL: https://www.ziprecruiter.com/c/Highmark-Health/Job/Manager-of-Clinical-Care-Coordination-(PA-Medicaid)/-in-Pittsburgh,PA?ojob=e96e74a84f16a84ba36ed2f15096e051&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Manager of Clinical Care Coordination (PA Medicaid)

Highmark Health Pittsburgh, PA

Company : Gateway Health Plan **Job Description :** **General Overview** : This job manages and coordinates the supervisory staff that has accountability for the case management, medical review, utilization review, quality management and/or health education team and programs. Monitors and evaluates the operational performance of overall departmental direction, leveraging analytics, regional market trends and utilization trends of members to set future direction and refine current state. Develops longer term plans that will improve utilization, quality and clinical outcomes based on market trends, legislative environment and company's mission, vision and direction. The incumbent is responsible for the leadership, performance management for supervisory staff as well as company and department objectives, supporting providers in a variety of health care

settings to appropriately identify members with chronic conditions and/or gaps in care that can be positively impacted related to quality and care costs. (note that health care settings could include, but not limited to, working in a physician's office, visiting physician practices on a routine basis, working within a hospital setting and/or assessing and coordinating member's care within the member's home). **Essential Job Functions** : + Perform management responsibilities including, but not limited to: involved in hiring and termination decisions, coaching and development, rewards and recognition, performance management and staff productivity. + Plan, organize, staff, direct and control the day-to-day operations of the department; develops and implements policies and programs as necessary; may have budgetary responsibility and authority. + Assist in the development of goal-setting and establishing future direction of the operations of a combined case management/utilization management team and assists with operations planning and efficiency. + Ensure overall compliance with applicable business process requirements, regulatory requirements and accreditation standards that support all lines of business. + Serve as key resource to both supervisory staff and external sources on complex issues, departmental direction and future planning. + Develop proposals to improve overall efficiency and managed care experience, utilization, quality and clinical outcomes. + Collaborate with supervisor staff and providers for insights to inform future direction and refinement of overall operations. + Collaborate with the appropriate cross-functional leadership and external entities to formulate new, innovative ideas to improve departmental performance, reduce costs while enhancing member experience. + Other duties as assigned or requested. **Minimum Qualifications** : + Current PA RN license and/or additional states as required **OR** current Social Work license + 4 years of any combination of clinical, case management and/or disease/condition management, provider operations and/or health insurance experience + 4 years of management experience + Clearances as required by specific practice or hospital, as applicable **Preferred Qualifications:** + Certification in Case Management (CCM) + BSN + Five years of any combination of clinical, utilization/case management and/or disease/condition management, provider operations and/or health insurance experience **Referral Bonus:** Level 2 **_Disclaimer:_** _The job description has been designed to indicate the general nature and essential duties and responsibilities of work performed by employees within this job title. It may not contain a comprehensive inventory of all duties, responsibilities, and qualifications required of employees to do this job._ **_Compliance Requirement:_** _This position adheres to the ethical and legal standards and behavioral expectations as set forth in the code of business conduct and company policies_ ---------- Highmark Health and its affiliates prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities, and prohibit discrimination against all individuals based on their race, color, religion, sex, national origin, sexual orientation/gender identity or any other category protected by applicable federal, state or local law. Highmark Health and its affiliates take affirmative action to employ and advance

in employment individuals without regard to race, color, religion, sex, national origin, sexual orientation/gender identity, protected veteran status or disability. EEO is The Law Equal Opportunity Employer Minorities/Women/ProtectedVeterans/Disabled/Sexual Orientation/Gender Identity (http://www1.eeoc.gov/employers/upload/eeoc_self_print_poster.pdf) We endeavor to make this site accessible to any and all users. If you would like to contact us regarding the accessibility of our website or need assistance completing the application process, please contact number below. For accommodation requests, please call HR Services at 844-242-HR4U or visit HR Services Online at HRServices@highmarkhealth.org

Pres Medicd Health Plan - CA Job in Woodland Hills, CA at Anthem, Inc

Pres Medicd Health Plan - CA

Anthem, Inc Woodland Hills, CA

Pres Medicd Health Plan - CA **New** **Location:** **Woodland Hills, California, United States** **Field:** Executive **Requisition #:** PS16496 **Post Date:** 9 hours ago ThePresident Medicaid Health Planwill have primary responsibility for the fiscal, operational, legislative, regulatory, and human resources objectives/agenda for assigned Medicaid health plan, part of the Medicaid Business Unit of Anthem, Inc.'s Government Business Division (GBD). This position is responsible for aligning strategy to achieve business goals and build a culture of accountability with people who are results driven, innovative and committed to excellence. This translates to the following specific responsibilities: 1.

Leadership - Must have experience and demonstrate the ability to perform successfully as a leader of: other leaders, teams and cross-functional groups. A successful incumbent will build the depth and operating environment that can achieve annual operating goals and support long-term growth for our business and our associates. Building strong, deep and highly functioning teams is a requirement. 2. **Achieve Annual Operating and business objectives** - Leader must be adept at managing P&L to include revenue, cost management, SG&A and forward-looking product growth opportunities. Plan leader should have actively led or participated in Cost Management, budget building and forecasting and successful premium rate management and renewals. Annual goals focus around: 3. Operating Gain 4. Growth 5. Cost of Care commitments 6. Revenue 7. Meeting or exceeding Quality and accreditation goals 8. **Experience and deep understanding of health plan operations to include:** 9. Health Services and Quality- Oversight and participation in medical management, including hospital census review, medical staffing, seasonality issues, detailed communications with the medical director and nurse leader and monthly accrual analysis. The incumbent should also have experience with Medicaid and/or CMS quality program management and Accreditation process. This should include a working knowledge of Population Health programs that are common to Managed Medicaid. 10. Product growth/Sales and Community Outreach- Oversight and participation in the development of growth strategies and retention initiatives for health plan. Oversee marketing and product growth strategies, business initiatives, school-based, faith-based, community-based and special needs initiatives. Experience in Complex Population administration, working with stakeholders and new program implementation and growth which may include one or more of the following: 11. LTSS - Long-term Services and Supports 12. BH - Program integration across populations and execution as part of overall plan operation. 13. FC - Children in Foster Care, Subsidized Adoptions or Guardianship 14. IDD - Individuals with Intellectual and developmental disabilities 15. Other complex populations as may apply 16. Provider Collaboration, Contracting and Service- Oversight and/or direct participation in relationships with key hospital, large physician practices/clinic and key ancillary providers such as dental and vision contractual relationships. Drive provider collaboration and engagement in the areas of service and Payment Innovation. Expect the incumbent would have that requisite network experience. 17. PlanOperations- Successful health plans have maintain a strong operating team with an ability to establish operating process, remediate service issues, implement new programs and support all areas of a health plan to accomplish established business goals. This includes: interfacing with Regional Operations Team, National Service Centers and Shared service operations. 18. **Strategic planning/competency** - Leader must be adept at the development of the health plan's business plan, quarterly reviews, and Business OperatingReviews and course corrections. Oversee resulting health plan budgeting and financials, including management of expenses, financial reports delivered to the State, capital budget planning and management. Incumbent must also possess strong strategic thinking and problem solving skills. 19. **Manage Customer and Regulatory Objectives** - The successful incumbent

will have a proven track record of developing and managing key State regulatory and legislative relationships and processes, including premium rates, covered populations, eligibility, benefit design, networks, administrative requirements, and new products. 1. Ensure plan maintains "preferred" position for our State customer- Responsible for establishing and leading an environment with the plan and senior leadership team that continually and effectively seeks to engage the state at multiple levels to meet and exceed service and performance goals while also driving innovation and trust. 2. Collaborate with GR (Government Relations) to achieve goals- Work in matrix model with GR officers to offer thought leadership in the political and legislative processes, and direction relative to contract negotiations with the state. Also aspire to create solutions for our state customers that achieve state and plan objectives that may also include new policy and product solutions. 3. Provide leadership to drive optimal consumer experiences- Work in matrix modelwith regional leaders and shared services partners to address and resolve claims, provider data, customer service needs and enhancements to meet and/or exceed customer service metrics. Also aspire to create solutions for our state customers that achieve state and plan objectives. 20. **Successfully support and operate within the broader organization's Business model** -Incumbent is required to work successfully in a matrix model business environment to include: 1. Work successfully across all lines of business- Market requires collaboration and teamwork with other GBD lines of business. 2. Work across matrix "shared service" business model- This includes Finance, Quality, Operations, Marketing, Health Care Management, HR, IT, Finance, Actuarial, Underwriting, Legal, compliance, Shared Services and National Service Centers. 3. Leverage Anthem Foundation- Strategic understanding of common interests among key constituents. 4. Successful internal and external communications- Liaison with corporate teams and external communications with the State, providers, members, community groups and the media. 21. **Compliance and Risk Management** - Ensure contract and HIPAA compliance, including securing and coordinating resources necessary for such compliance. Certify monthly and quarterly financial statements, encounter reporting, quality audits, HEDIS/EPSDT and other required regulatory reports. Oversight of risk management program, including fraud and abuse program compliance, and reporting responsibilities. Identify threats to financial assets, reputation, human resources and actively teach risk management to health plan leadership. 22. **Promote Anthem mission and culture** - Demonstrated success in building and leading successful teams with a culture that is committed to execution, collaboration, communication and a positive growth and learning environment for our associates. The application of regular coaching, timely performance management and active mentoring. Assess and develop bench strength and retain talent in accordance with Plan-level retention and development goals. Ensure Sarbanes-Oxley (SOX) compliance and meet other key manager goals and responsibilities as defined by annual Major Job Objectives (MJO). The incumbent must demonstrate the following abilities: + **Visionary Thinking** - Establish strategies that create or sustain competitive advantage. Think broadly and long-term, recognizing the impact of decisions and actions on the health plan and key stakeholders. + **Drive a Consumer-Focused

Culture** - Monitor program and service delivery to ensure that financial measures and quality standards are met. Continually reinforce a focus on quality throughout all program verticals (e.g., recognition of product development, implementation and product delivery efforts and programs that support the variety of member populations served). + **Drive an Innovative Culture** - Act quickly to seize opportunities for innovation and growth. Encourage others to champion need for effective problem solving, clearly communicating the rationale and urgency. + **Foster Teamwork and Collaboration** - Promote the importance of teamwork within, and across, large cross-functional groups. Ensure the sharing of information and best practices. + **Influence and negotiate** - Communicate a clear and compelling case for implementation of solutions, ideas and proposals. Build a broad base of support among key decision makers and influencers, using credibilit