Medicaid Industry Jobs Hunter: 2/11/2019

Notebook:	Curator: Jobs		
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Tags:	5- Clay is Blessed with Work, jobs		
URL:	https://www.linkedin.com/jobs/view/community-health-worker-seattle-king-county-at-...		

consulting | training | free webinars

clay@mostlymedicaid.com | 919-727-9231

Medicaid Jobs Hunter

Feb 11, 2019

In this packet...

11. WellCare Health Plans Inc Market VP - Medicaid LOB Job in Houston, TX, United States
12. Medicaid Director - Healthplan

(1) Community Health Worker - Seattle / King County | Community Health Plan of Washington | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/community-health-worker-seattle-king-county-at-community-health-plan-of-washington-1114025390/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Community Health Worker - Seattle / King County

Company Name Community Health Plan of Washington Company Location Seattle, WA, US

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

Job Summary

The Community Health Worker serves as a liaison between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. They also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Essential Functions

Responsible for engaging prospective care management program participants who have been identified through data analysis and referral sources to likely benefit from care management program offerings.Conducts telephonic and face-to-face outreach and coordination of care activities for Apple Health Medicaid enrollees.Utilizes Internet databases, health record systems, and other resources to locate potential eligible Member contact informationAssists Care Managers in securing and identifying needed referrals to community and network medical, behavioral health and social assistance providers through telephonic and/or face to face outreachAssist care managers with contact for both medical and behavioral health providers to ensure coordination of aftercare and services from all higher levels of care.Provides follow up services via telephonic or face to face engagement with clients and service planning partners as needed to coordinate reminder calls, medication and medical appointments, upon request from the care management teamProvides community outreach services including home visits, assisting individuals with accessing transportation services, educating enrollees on healthy behaviors, and providing information on community resources.Provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills.Provides information to increase the enrollee's knowledge about his or her health conditions and improve adherence to prescribed treatment.Maintains the program community resource directory.Supports compliance with CHPW’s Apple Health Contract with the Health Care Authority for Fully Integrated Managed Care as related to care coordination requirements.Supports compliance with NCQA accreditation standards.Ensures that the Supervisor of Community Linkages is made aware of any potential risk management issues in a timely manner.Prepares for and participates in ongoing peer case staffing for all active cases on a regular basis.Provides oral and/or written status updates regarding client alerts, progress and needs to responsible Care Managers and providers, legal mandate, or other care plan affiliates as needed to assist the program and enrollees. Ensures case documentation is consistent with policies and procedures.Acts as an internal consultant to other departments for community linkage and peer support.This position requires traveling on behalf of the Company and working in the field at least 50% of the time. It is essential that a current driver’s license, proof of insurance and an acceptable driving record are maintained.Non-Exempt

- Reporting to work on time and for all scheduled shifts is essential to this position.Other duties as assigned. Essential functions listed are not necessarily exhaustive and may be revised by the employer, at its sole discretion.
- Qualifications**:

Education
High school diploma or equivalent required; Bachelor’s Degree preferred.
License, Certifications, and other Specialized Training
Certification as Peer Specialist may substitute for minimum experience and education requirements.

Experience

Three (3) years of job-related experience providing medical, mental health or substance abuse-focused services to individuals with chronic medical conditions and/or severe and persistent mental illness.Experience and familiarity with at-risk populations, communities of color and local resources for persons with behavioral and/or physical health needs.
Employment Eligibility
Complete and successfully pass a criminal background checkHas not been sanctioned or excluded from participation in federal or state healthcare programs by a federal or state law enforcement, regulatory, or licensing agency
Knowledge, Skills, and Abilities
Bilingual English/Spanish or another second language desired.Ability to demonstrate outgoing, empathetic and sincere interpersonal skills.Self-motivated team player with multitasking abilities.Excellent verbal and written communication skills.Excellent problem-solving skills.Comfortable in all socioeconomic environments.Proficient with Microsoft Word, Excel and Outlook.Experience using a health plan care management system or electronic medical record system.Works well with others in a collaborative and respectful manner.Able to multi-task, deal with complexity on a frequent basis.Performs all functions of the job accurately and in a timely manner.Able to work under pressure and time constraints.
SENSORY/PHYSICAL/MENTAL REQUI

Seniority Level

Entry level

Industry

- Information Technology & Services
- Business Supplies & Equipment
- Leisure, Travel & Tourism

Employment Type

Contract

Job Functions

- Other

(1) Senior Contract Manager | BMC HealthNet Plan/Well Sense Health Plan | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/senior-contract-manager-at-bmc-healthnet-plan-well-sense-health-plan-1113952081/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Senior Contract Manager

Company Name BMC HealthNet Plan/Well Sense Health Plan Company Location Township of Manchester, OK, US

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

SENIOR CONTRACT MANAGER
Apply
The Well Sense Health Plan Senior Regional Contract Manager is responsible for the development, implementation and management of a cost-effective New Hampshire provider network, maintaining complex and geographically diverse contracts. Serves as mentor to Regional Contract Manager, assisting in the development of network-wide strategies to improve efficiencies and access. Under the direction of the Director of Contracting & Provider Engagement, s/he performs all critical functions necessary to assess, develop, maintain and/or improve provider network adequacy and performance.

Key Functions/Responsibilities

- Interprets environmental (policy, contract, landscape, organizational) changes with contracting and provider impact. Guides internal response strategies.
- Gathers and analyzes data and other relevant intelligence in assessing provider network adequacy against required standards and business expectations;
- Identifies, assesses and develops strategies for improving provider and network cost, utilization and quality performance;
- Leads negotiations of financial and other contractual terms, including risk sharing terms;
- Ensures all contract terms and conditions comply with financial and legal requirements of Well Sense Health Plan and its regulatory entities (e.g., NH DHHS
- Develops and maintains business relationships with high-level representatives of key contracting hospitals, physicians and ancillary service providers;
- Participates in the development, implementation & continuous improvement of departmental policies, procedures, workflows, and tools as they relate to network development and provider contracting;
- Represents the department and organization supporting internal and external initiatives;
- Performs other duties as required to accomplish departmental and corporate goals & objectives;

Competencies, Skills, And Attributes

- 5-10 years experience, some in senior position. Medicaid managed care experience preferred;

- Interpersonal and leadership style necessary to serve as go-to resource for colleagues;
- Proven analytical skill in assessing and projecting financial, utilization and quality performance on an individual provider and network basis;
- In-depth knowledge and understanding of contract finance and provider reimbursement methodologies, including risk, shared savings, pay-for-performance and other financial incentive strategies;
- In-depth knowledge and understanding of current healthcare industry issues and trends, including national and state-level payment reform landscape and strategy (e.g., accountable care and patient centered medical home);
- Proven negotiation skills with hospitals, Integrated Delivery Networks, physicians and ancillary service providers;
- Proven skill in critical thinking and strategic planning and implementation;
- Knowledge of federal and state Medicare, Medicaid, and relevant guidelines, regulations and standards;
- Effective communication (verbal and written) and relationship building skills. Position will interact with internal and external executive teams;
- Expertise in Microsoft Office programs and industry-standard financial applications as appropriate.

Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status. BMC HealthNet? Plan/Well? Sense Plan participates in the E-Verify Program to electronically verify the employment eligibility of newly hired employees.

Employer's Job# 292716
Please visit job URL for more information about this opening and to view EOE statement.

(1) Behavioral Health Care Manager (Part Time 10 hours) - Robbinsville | Amerihealth

Inc | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/behavioral-health-care-manager-%28part-time-10-hours%29-robbinsville-at-amerihealth-inc-1115045063/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Behavioral Health Care Manager (Part Time 10 hours) - Robbinsville

Company Name Amerihealth Inc Company Location Robbinsville, NJ, US

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

Job Brief

responsible for the daily functions of the clinical department including triage of calls, care coordination and utilization management

Your career starts now. We're looking for the next generation of health care leaders.

At AmeriHealth Caritas, we're passionate about helping people get care, stay well and build healthy communities. As one of the nation's leaders in health care solutions, we offer our associates the opportunity to impact the lives of millions of people through our national footprint of products, services and award-winning programs. AmeriHealth Caritas is seeking talented, passionate individuals to join our team. Together we can build healthier communities. If you want to make a difference, we'd like to hear from you.

Headquartered in Philadelphia, AmeriHealth Caritas is a mission-driven organization with more than 30 years of experience. We deliver comprehensive,

outcomes-driven care to those who need it most. We offer integrated managed care products, pharmaceutical benefit management and specialty pharmacy services, behavioral health services, and other administrative services. Discover more about us at www.amerihealthcaritas.com.

As an individual contributor, the Behavioral Health Care Manager is responsible for the daily functions of the clinical department including triage of calls, care coordination and utilization management. The Care Manager makes timely intensity of service determinations or refers to higher level review when indicated. Provides linkage to community services as needed. Adheres to customer service level agreements and expected productivity measures. Adheres to documentation requirements. Identifies wide range of community resources to caller. Demonstrates respectful communication and excellent customer service. Adheres to recognized ethical standards. Completes all required trainings on time. Assists with projects as assigned.

Education/Experience

- Master's Degree.
- Graduate degree from an accredited educational program in Social Work, Clinical/Counseling Psychology, or Nursing.
- Licensed Clinical Social Worker or Licensed Professional Counselor or Licensed Marriage and Family Counselor Licensed Certified Drug and Alcohol Counselor, Certified Drug and Alcohol Counselor, Board Certified Behavior Analyst required.
- LCADC preferred
- Bilingual preferred.
- Independently licensed Behavioral Health professional or a BCBA preferred.
- Minimum three years post graduate clinical experience or equivalent combination of education and clinically related work experience. Minimum one year experience working with a managed care system.
- Minimum one year experience in Behavioral Health Service Delivery System. Knowledge base in Medicaid, Medicare and Commercial Managed Care Systems .
- Demonstrated knowledge of plan benefit information and managed care.
- PC Skills and Experience utilizing Microsoft Office, Outlook, Excel and PowerPoint.
- Ability to provide constructive feedback with a focus on improved quality.
- Ability to communicate in a positive/professional manner both orally and written.
- Ability to work independently, complete multiple tasks in the allotted timeframe.

- Strong problem solving skills and decision making skills.
- Ability to work effectively in a team environment.

(1) Claims Analyst IMedicaid - Bend | PacificSource Health Plans | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/claims-analyst-imedicaid-bend-at-pacificsource-health-plans-1112638161/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Claims Analyst IMedicaid - Bend

Company Name PacificSource Health Plans
Company Location Bend, OR, US

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

Overview

Position Overview: Responsible for processing Medicaid claims in a workflow environment. Accurately interpret benefit and policy provisions applicable to Medicaid enrollees. Review and resolve claim edits using multiple systems, processes and procedures. Maintain production and quality standards.

Responsibilities

Essential Responsibilities:

- Perform claims data entry tasks and accurately transfer data from claim images into Facets.
- Work in assigned workflow role to process Medicaid claims.
- Accurately interpret benefit and payment provisions applicable to Medicaid enrollees.
- Review and resolve claim and system edits using multiple systems, processes and procedures.
- Responsible for entering system Notes to record pertinent information involving a claim or member.
- Responsible for monitoring and working claims set-aside to ensure claims are released in a timely manner.
- Pursue answers to questions needed to process claim.
- Route to appropriate workflow queues to resolve setup issues.
- Process incoming Faxes and Mail tasks according to department procedure(s) as assigned.
- Document and report issues that affect claims processing or accuracy to claims leadership.

Supporting Responsibilities

- Meet department and company performance and attendance expectations.
- Follow the PacificSource privacy policy and HIPAA laws and regulations concerning confidentiality and security of protected health information.
- Regularly attend team meetings and daily team visual board huddle.
- Perform other duties as assigned.

Qualifications

Work Experience: One year medical or health insurance experience or equivalent health related education required. Experience working with QNXT, Facets, or other similar systems strongly preferred.

Education, Certificates, Licenses: High school diploma or equivalent required.

Knowledge: Ability to develop a thorough understanding of PacificSource Medicaid products, plan designs, provider/network relationships and health insurance terminology. Research skills and ability to evaluate claims in order to enter and process accurately. Preferred computer skills include keyboarding and 10-key proficiency, basic Microsoft Word and Excel. Ability to prioritize work and

perform under time constraints. Team player willing to collaborate and help others accomplish team objectives.

Competencies

Our Values

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

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

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

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

(1) Service Coordinator Associate LTSS, East (Philadelphia) | UPMC Health Plan | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/service-coordinator-associate-ltss%2C-east-%28philadelphia%29-at-upmc-health-plan-1115215735/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Service Coordinator Associate LTSS, East (Philadelphia)

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

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

Description

Community HealthChoices (CHC) is Pennsylvania's managed care long term services and supports (LTSS) program serving seniors and individuals with physical disabilities in the Commonwealth who are covered by Medicare and Medicaid.

This full-time, office -based position supports the Service Coordinator in coordinating care for Members. The Service Coordinator Associate builds a relationship with the Members, providing the Member with ongoing telephonic outreach and assistance with service coordination needs.

Responsibilities

- Assists in coordinating social services for Members including referrals to Community organizations as requested by Service Coordinator Utilizes information systems to build, research and enter Member information, as needed.
- Promotes communication, both internally and externally, to enhance effectiveness of service coordination services (e.g., health care providers, and health care team members respectively).
- Researches and assists in finding hard-to-find Members.
- Supports service coordination team in outreach to Members telephonically
- Supports the development and implementation of Member Care/Service Plans.
- Works in conjunction with the Service Coordinator to initiate, and revise Member Care Plans as needed.

Qualifications

High School Diploma required. One year of experience in Community or Public Health preferred Computer literacy in order to navigate through internal/external computer systems, including Excel and Microsoft Word. Familiarity with basic medical terminology and concepts used in Care Management Strong customer service skills to coordinate service delivery including attention to members, sensitivity to issues, proactive identification and resolution of issues to promote positive outcomes for members Ability to effectively participate in a multi-disciplinary team including internal and external participants Effective communication, telephonic and organizational skills.

(1) Manager, Claims & Contract Support Services | Home State Health Plan, Inc. | LinkedIn

Manager, Claims & Contract Support Services

Company Name Home State Health Plan, Inc. Company Location Chesterfield, MO, US

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

- Oversee the operation of the Contract Implementation Analyst and Claims Liaison teams
  Oversee the claims operation function, including contracting and configuration
  Monitor staff performance to identify any process or quality gaps and develop/implement business solutions to correct issues
  Provide management with necessary data to expedite resolution of claims issues and support in policy decisions related to claims operations
  Serve as the subject matter expert in resolution of claims and configuration issues
  Manage the health plan's workflow to assure timely, accurate submission and implementation of contracts
  Act as health plan interface on software product upgrades/implementations that affect contract implementation
  Promote change through establishment and sharing of best practices
  Interface with all organizational levels to mobilize commitment and ensure accurate configuration, contract implementation, and claims operations

Qualifications

Education/Experience: Bachelor’s degree in related field or equivalent experience. 5+ years of provider relations/services, provider contracting and/or claims administration experience in a managed care environment. Experience with Medicare and Medicaid claims and contracting preferred. Centene is an equal opportunity employer that is committed to diversity, and values the ways in which we are different. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, veteran status, or other characteristic protected by applicable law.

Seniority Level

Mid-Senior level

Industry

- Information Technology & Services
- Business Supplies & Equipment
- Consumer Services

Employment Type

Contract

Job Functions

- Finance
- Sales

(1) Entry Level Opportunity - Healthcare Credentialing | AmeriHealth Caritas | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/entry-level-opportunity-healthcare-credentialing-at-amerihealth-caritas-1092624907/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Entry Level Opportunity - Healthcare Credentialing

Company Name AmeriHealth Caritas
Company Location Philadelphia, US-PA

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

Entry Level Career Opportunity in Healthcare Support/Operations

Credentialing Technician

Do you have an interest in creating a career in Healthcare Support/Operations? Join a company where "Care is the Heart of our Work". Located at our Philadelphia HQ location near the Airport, we are currently seeking individuals to join our Credentialing team as a Credentialing Technician. The Credentialing Technician is responsible for the preparation of provider applications for the purposes of credentialing and recredentialing. This includes the retrieval of applications, review for completeness, and data entry into the Credentialing system for processing. In this role you will:
• Review applications for completeness and notify providers of missing information prior to discontinuing processing of application. • Accurately enter

provider data into the Credentialing system for complete applications within the established turnaround times. • Send approval letters to providers upon completion of the credentialing process. • Document completion of the recredentialing process in the system. • Monitors, responds to, and/or directs all requests from the Credentialing mailboxes. Responses may require both telephonic and written correspondence with internal and external clients. • May support other data entry needs of the department. Qualifications: For those individuals who have received a High School diploma we do require work experience following graduation Those candidates who have completed an Associates or Bachelors degree from an accredited college/university no experience is required You should have intermediate level technology skills, and be comfortable with applications such as Microsoft Office. You need to be a strong communicator, verbally and in your written communications skills. Strong organizational skills are required. You must have the ability to perform in a metrics-driven environment. See Job Description

Seniority Level

Entry level

Industry

- Hospital & Health Care
- Insurance

Employment Type

Full-time

Job Functions

- Administrative

Aetna Inc NC MCD VP, Medicaid Hlth Plan Job in Cary, NC

SourceURL: https://www.glassdoor.com/job-listing/nc-mcd-vp-medicaid-hlth-plan-aetna-JV_IC1138945_KO0,28_KE29,34.htm?jl=3113079995&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

NC MCD VP, Medicaid Hlth Plan

3.4 Aetna Inc – Cary, NC 1 day ago
Applied 2/11/19
Apply on Company Site

1 day ago

New

Get ahead of others. Apply now.

POSITION SUMMARY
This full-time position is the primary executive point person and day-to-day liaison with the State's regulator of Medicaid programs. The VP Medicaid Health Plan (CEO) is responsible for overall Medicaid health plan strategy, P&L;, operational performance and ensuring compliance with all state contract requirements. Provides executive leadership for local health plan operations and staff as well as coordinating with corporate shared services and other internal resources. Manages relationships and advocacy with regulators and external stakeholders. Must reside in North Carolina. Raleigh office location anticipated.
Fundamental Components:
Authority over the general administration and day-to-day business activities of the contract.
Accountable for plan P&L; to meet budget targets, drive cost improvement strategies and advocate for actuarially sound rates.

Ensure plan compliance with state regulatory and contract requirements.
Develop and manage key stakeholder relationships including regulators, legislators, provider associations, community based agencies and consumer advocates.
Lead innovative quality and performance improvement initiatives including accreditation, HEDIS, CAHPS and other clinical outcome measures, and state plan pay for performance programs.
Drive growth strategies including member outreach and retention activities, community and provider partnerships, and partner with business development to retain state contract and pursue new products.
Responsible for talent management and employee engagement for local plan leadership team and staff.
Support strong provider relationships that align incentives for high quality member clinical care with innovative value based purchasing strategies.
Maintain awareness of the regulatory, legislative and competitive landscape, partner with state government affairs and contracted lobbyists to advocate for policy positions supportive of the plan and its members.

BACKGROUND/EXPERIENCE desired:

Minimum of 10 years progressive management experience in managed care or health care related position. Demonstrated experience with all aspects of business development and financial management with a medical delivery and or managed care system(s). Effective technical skills regarding health plan administration, medical management concepts and underwriting. Demonstrated leadership experience including staff selection, hiring, coaching, mentoring and career development. Medicaid experience required. Demonstrated ability to represent organization and company in external meetings and/or healthcare venues. Exceptional time management and organization skills and the ability to work on multiple tasks, projects with tight deadlines. Exceptional communication skills, verbal, written and presentation. Proficiency with computer, keyboard navigation and MS Office Suite, Outlook, Word, and Excel. Experience managing budgets. Demonstrated ability to foster and build relationships, ability to influence and negotiate. Ability to work with people in such a manner as to build high morale and group commitment to goals and objective. Knowledge of community resources and provider networks. Experience working with diverse teams and populations. The minimum level of education desired for candidates in this position is a Bachelor's degree. Master's degree preferred.

EDUCATION

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

FUNCTIONAL EXPERIENCES

Functional - Leadership/Profit & Loss Accountability/More Than 10 Years

Functional - Leadership/Act as company spokesperson to external constituents/More Than 10 Years
Functional - Administration / Operations/Management: Functional - Network Management/Network market leadership/7-10 Years
Functional - Government Relations/State/7-10 Years

TECHNOLOGY EXPERIENCES

Technical - Desktop Tools/Microsoft Word/More Than 10 Years/End User
Technical - Desktop Tools/TE Microsoft Excel/More Than 10 Years/End User
Technical - Desktop Tools/Microsoft Outlook/More Than 10 Years/End User
Technical - Desktop Tools/Microsoft SharePoint/7-10 Years/End User

ADDITIONAL JOB INFORMATION

(1) Personal Care Clinical Manager / Medicaid Home | Professional Healthcare Resources | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/personal-care-clinical-manager-medicaid-home-at-professional-healthcare-resources-1113877607/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Personal Care Clinical Manager / Medicaid Home

Company Name Professional Healthcare Resources Company Location Washington, D.C., DC, US

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

Clinical Personal Care Manager Job Summary

Professional Healthcare Resources, a leader in Home Health, Hospice and Personal Care services in the Washington, DC and Baltimore, Maryland area, seeks a passionate and enthusiastic Clinical Manager/ Director of Nursing for the Personal Care Department to join our leadership team in Washington, DC.
The Clinical Manager is driving the business on the day to day basis and is responsible for the overall administration of processes and staff.
The position of the Personal Care Clinical Manager will have primary responsibility for managing and directing administrative and clinical staff and coordinating personal care aide care and services.
The successful candidate must by a Registered Nurse with a professional license in Washington, DC, or able to obtain one, have at least 3 years of management experience in the home health environment, and case management experience is highly desirable.

Compensation

IN OUR COMPANY YOU WILL FIND:

Diverse pay system and great earning potential
Holiday, weekend and on-call additional pay
Cell phone and mileage reimbursement
Advanced orientation and annual educational programs
Friendly, family oriented and caring working environment
Great benefits package which includes health, dental and vision care, PTO, company-paid life insurance and a 401K Plan

Seniority Level

Mid-Senior level

Industry

- Business Supplies & Equipment
- Consumer Services
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Health Care Provider

(1) Medicaid Director, Department of Health Care Policy & Financing | State of Colorado | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/medicaid-director-department-of-health-care-policy-financing-at-state-of-colorado-1113428953/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

(1) Medicaid Director, Department of Health Care Policy & Financing

Department Information

Make a difference-Join HCPF by improving health care access and outcomes for the people we serve while demonstrating stewardship of financial resources.

The Department of Health Care Policy and Financing (Department) offers a competitive benefits package to include the Public Employees Retirement Account (PERA), 401k/457, health/dental insurance options, 10 paid holidays, accrual of paid sick and vacation/annual time. The Department is also centrally located; offers affordable ECO passes; has a fitness center on-site; and a variety of discounts on services and products are available to state employees through the State of Colorado's Work-Life Employment Discount Program. The Department also encourages employees to take advantage of advanced education and offers reduced college tuition through CSU Global for their employees. This Department is a "Tobacco Free Workplace". http://www.colorado.gov/hcpf

Description of Job

What You'll be Doing

- Acts as the primary contact for the department with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) and is responsible for the Department's state and federal compliance.
- Attends CMS meetings and regional conference calls, state-based regional and national meetings with other Medicaid Directors to ensure awareness of changing policies.
- Keeps CMS informed of new Department initiatives or policy changes and seeks technical assistance from CMS to improve current programs or to acquire permission and approval to pursue new programs or waivers.
- Manage a multitude of relationships with different partners and stakeholders in order to leverage a complex system environment to bring services to beneficiaries and achieve quality outcomes.
- Leads Department staff, in developing and implementing medical assistance programs including Medicaid, the Children's Health Plan Plus program, and Home and Community Based Services for the older adult and people living with disabilities populations.
- Works with other areas of the Department to develop statistical, data and management information reports to analyze and evaluate the Triple Aim effectiveness and value outcome of all medical assistance programs.
- Acts as Office Director for the Department's Health Programs Office (> 100 staff) responsible for leading management in developing and ensuring staff success of running a health program.

- Reports program results to the Executive Director and makes related recommendations for improvement in policies and procedures that improve Triple Aim quality, member satisfaction and claim trend control.
- Works through the budgeting process to efficiently, thoughtfully and responsibly acquire and manage funds to operate the Medicaid and related medical assistance programs.
- Develops, approves, changes, and recommends program policies, rules and regulations and works with Department staff to develop provider rates.
- Develops communication materials with Department staff to effectively communicate all medical assistance programs and policy changes.
- Interacts with the federal government to develop and negotiate state plan amendments and waivers.
- Assures all medical assistance programs are compliant with State and Federal regulations.
- Recruits and hires qualified, dedicated and diverse staff that reflect the people of Colorado.
- Identifies new and existing staff training needs and works with Department staff to develop related training programs.
- Coordinate and partner closely with member advocate groups, counties, private sector providers, academic research and policy organizations, and publicly funded clinics and hospitals to achieve the Triple Aim and goals of the Department.
- Collaborates with the Executive Director and other senior leadership to represent and advocate for the Department and the Governor before key external stakeholders to include: The Legislature, tribal governments, statewide elected officials, constituent groups, local government, professional associations, businesses, labor organizations, interagency groups, Congress and federal agencies.

Minimum Qualifications

Minimum Qualifications, Substitutions, Conditions of Employment & Appeal Rights

Education And Experience

- Minimum of bachelor's degree in health-related field, management, business, or public administration.
- Master's degree in related field preferred.
- Experience in health care management with specific experience in Medicaid program leadership, public health program leadership.
- Experience in health insurance carrier leadership preferred.

- Experience in health regulations, law and/or program components.
- Knowledge of federal health care programs and related requirements.

This experience MUST be clearly explained in your employment history of the online application.

Substitutions

A combination of professional work experience in health care program management, which provided the same kind, amount and level of knowledge acquired in the required education, may be substituted on a year-for-year basis for the bachelor's degree. A master's degree from an accredited college or university in Public Health, Public Policy, Health Care Administration, or other closely related field may be substituted for the bachelor's degree and one year of general experience.

DEFINITION OF PROFESSIONAL EXPERIENCE: Work that involves exercising discretion, analytical skill, judgment, personal accountability, and responsibility for creating, developing, integrating, applying, and sharing an organized body of knowledge that characteristically is uniquely acquired through an intense education or training regimen at a recognized college or university; equivalent to the curriculum requirements for a bachelor's or higher degree with major study in or pertinent to the specialized field; and continuously studied to explore, extend, and use additional discoveries, interpretations, and application and to improve data, materials, equipment, applications and methods.

Preferred Qualifications

- Experience as a senior member of the leadership team of a medium to large organization in the health care field.
- Experience implementing a strategic plan at an executive leadership level for an organization or division and evaluating the success and impact of the associated initiatives.
- Experience identifying and interpreting data and information relative to market trends as well as program impact against objectives.
- Experience demonstrating effective communication and collaboration with stakeholders and executives to help achieve the strategic goals of an organization.
- Experience overseeing the day-to-day delivery of the programs and services of an organization including operations management, contract negotiation, policy development, strategic initiatives and implementation.

Special Qualifications

- Demonstrated Medicaid program acumen and senior leadership experience.
- Demonstrated ability to implement effective programs and policies that achieve the triple aim - improve patient health, increase patient satisfaction, and control costs.
- Experience as a senior leader in a health care organization, including the management of a large staff.
- Experience in public health, health care or health insurance including senior leadership responsibility for development of successful programs and policies.
- Experience with federal and state reimbursement regulations, health care delivery systems, modern managed care principles, working with government entities on a state and national level.
- Oversight of, and accountability for, the budgeting process for a large department and a significant budget.
- Experience analyzing state and federal statutory changes and rules and directing staff to implement changes affecting Medicaid operations and policy to ensure compliance with both state and federal regulations.

Highly Desirable Competencies

- Exceptional integrity, ethics and transparency.
- Significant fiscal responsibility in a complex organization managing budgets and budget policy alignment.
- Demonstrated ability to build a member-centered organization, acting as a strategic business partner while still performing a regulatory function with an emphasis on adding value through improved customer service.
- Progressive management experience in a private or non-profit health insurance program, government agency, or other related public, private, or non-profit health service organization.
- Extensive knowledge of federal and state medical programs, managed care operations and principles, alternate payment models, health care provider marketplace, state and federal health care reform law and policy.
- Extensive experience with provider, stakeholder, consumer, and client outreach and communication.
- Experience using performance metrics and data to achieve outcomes and attain goals and continuous improvement methods aimed at better outcomes.
- Knowledge of historical context of Colorado State health policy and evolution of federal law impacting low income populations, including Title XIX (Medicaid), Title XXI (CHIP), Title XVIII (Medicare), national health reform, and Colorado's Tribes.
- Experience in health equity, addressing systemic health disparities and collaborating with diverse, vulnerable and underrepresented populations with

a commitment to cultural competency that enables effective outcomes and working relationships in cross-cultural situations.
- Ability to respond thoughtfully to questions from the media, speak clearly, responsibly, and thoughtfully at public gatherings, and represent the Department and state government as directed by the Executive Director and as a representative of the Governor.
- Ability to participate in statewide planning efforts to improve the costs and quality of health care services to Coloradoans and determine what policies, programs, and budgets are needed to achieve department goals.
- Experience developing project plans for new initiatives and direct staff to implement projects on time, and on budget.
- Experience interacting with and influencing elected officials, legislative representatives, committees and/or other governmental entities as well as businesses, Tribes, community leaders and other stakeholders and partners.

Conditions of Employment

- All positions at HCPF are security sensitive positions and require individuals undergo a criminal record background check as a condition of employment.
- Significant statewide travel and occasional national travel to various national conventions is a regular part of this position and may involve weekend work and/or overnight and/or extended stays for conferences and meetings. Reliable transportation is necessary.
- Employees who have been disciplinarily terminated, resigned in lieu of disciplinary termination, or negotiated their termination from the State of Colorado must disclose this information on the application.

Appeal Rights

If you receive notice that you have been eliminated from consideration for the position, you may protest the action by filing an appeal with the State Personnel Board/State Personnel Director within 10 days from the date you receive notice of the elimination.

Also, if you wish to challenge the selection and comparative analysis process, you may file an appeal with the State Personnel Board/State Personnel Director within 10 days from the receipt of notice or knowledge of the action you are challenging.

Refer to Chapters 4 and 8 of the State Personnel Board Rules and Personnel Director's Administrative Procedures, 4 CCR 801, for more information about the

appeals process. The State Personnel Board Rules and Personnel Director's Administrative Procedures are available at www.colorado.gov/spb.

A standard appeal form is available at: www.colorado.gov/spb. If you appeal, your appeal must be submitted in writing on the official appeal form, signed by you or your representative, and received at the following address within 10 days of your receipt of notice or knowledge of the action: Colorado State Personnel Board/State Personnel Director, Attn: Appeals Processing, 1525 Sherman Street, 4th Floor, Denver, CO 80203. Fax: 303-866-5038. Phone: 303-866-3300. The ten-day deadline and these appeal procedures also apply to all charges of discrimination.

Supplemental Information

How to Apply (PLEASE READ CAREFULLY)

Applicants are encouraged to submit a resume and cover letter with their application. Please note that ONLY your State of Colorado job application will be reviewed during the initial screening; if you submit a resume and cover letter, they will be reviewed in later stages of the selection process. Therefore, it is paramount that you clearly describe all of your relevant experience on the application itself. Applications left blank or marked "SEE RESUME" will not be considered.

Your application will be reviewed against the minimum qualifications for the position. If your application demonstrates that you meet the minimum qualifications, you will be invited to the comparative analysis process, which is described below.

Comparative Analysis Process

The comparative analysis process will consist primarily of a review of applications against the minimum and preferred qualifications of this position. Applications will be reviewed in comparison to all others in the applicant pool in order to identify a top group of candidates who may be invited for a final interview. Depending on the size of the applicant pool, additional selection processes may be utilized to identify a top group of candidates. Applicants will be notified of their status via email.

Failure to submit properly completed documents by the closing date or when the required number of applications have been received, as specified in this announcement, will result in your application being rejected.

ADAAA Accommodations: Any person with a disability as defined by the ADA Amendments Act of 2008 (ADAAA) may be provided a reasonable accommodation upon request to enable the person to complete an employment assessment. To request an accommodation, please contact the person listed on this announcement by phone or email at least five business days before the assessment date to allow us to evaluate your request and prepare for the accommodation. You may be asked to provide additional information, including medical documentation, regarding functional limitations and type of accommodation needed. Please ensure that you have this information available well in advance of the assessment date.

~THE STATE OF COLORADO IS AN EQUAL OPPORTUNITY EMPLOYER~

Technical Help

If you experience difficulty in uploading or attaching documents to your online application, call NEOGOV technical support at 877-204-4442 anytime between 6:00 a.m.-6:00 p.m. (Pacific Time).

WellCare Health Plans Inc Market VP - Medicaid LOB Job in Houston, TX, United States

SourceURL: https://www.glassdoor.com/job-listing/market-vp-medicaid-lob-wellcare-health-plans-JV_IC1140171_KO0,22_KE23,44.htm?jl=3113104619&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid LOB Job in Houston, TX, United States

Market VP - Medicaid LOB

3.8 WellCare Health Plans Inc – Houston, TX 20 days ago

Applied 2/11/19
Apply on Company Site

20 days ago

Essential Functions:

- Key role supporting market on effective medical management, financial, compliance and quality through effective network contracting and long-term approach to successful partnerships with key providers. Matrix responsibility for overall success of the market.
- Provides day-to-day leadership for network development, provider relations, marketing and potentially sales
- Critical role in achieving business results within the assigned market
- Recognized as a senior member of WellCare s team in the market and responsible for establishing and maintaining key relationships with providers, hospitals, and community organizations.
- Oversees the development and maintenance of a viable provider network to ensure the health care needs of WellCare members. Develops and manages provider contracts and partnerships to achieve quality and cost management objectives. Works closely with providers to enhance relationships and maximize their ability to effectively manage the cost of medical delivery.
- Owns and manages special projects assigned by the health plan that may interface across multiple functional areas of WellCare, and liase with external stakeholders or consultants as needed.
- Recommendations carry considerable weight in budget decisions impacting their market.

- Provides leadership and direction to the management team to ensure the organization's strategic plan is translated into tactical goals and objectives that guarantee performance objectives are met or exceeded.
- Assists and leads where appropriate, with aspects of state and federal government relationships, including dealing with regulators, as necessary, to establish and continue effective working relationships. Ensures that all state and federal regulations are met.
- Performs other duties as assigned.

This position is contingent upon the bid award in the state of Texas to WellCare Health Plans, Inc.

Candidate Education:

- Required A Bachelor's Degree in a related field with 10 years of directly related experience with 5 years of previous management experience.
- Preferred A Master's Degree in a related field with 5 years of directly related experience with 3 to 5 years previous management experience
- Preferred or equivalent work experience

Candidate Experience:

- Required 10 years of experience in managing a P&L; in a health care environment; government programs and managed care experience
- Required 5 years of management experience

Candidate Skills:

- Advanced Ability to lead/manage others
- Advanced Ability to influence internal and external constituents
- Advanced Ability to analyze and interpret financial data in order to coordinate the preparation of financial records
- Advanced Ability to drive multiple projects
- Advanced Ability to lead/manage others in a matrixed environment
- Advanced Ability to represent the company with external constituents
- Advanced Demonstrated analytical skills
- Advanced Demonstrated interpersonal/verbal communication skills
- Advanced Demonstrated leadership skills
- Advanced Demonstrated negotiation skills
- Advanced Knowledge of healthcare delivery
- Advanced Other Extensive technical/functional expertise with strong management skills to coordinate broad function areas

Licenses and Certifications: Technical Skills:

- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft Outlook
- Required Intermediate Microsoft PowerPoint
- Required Intermediate Microsoft Word

(1) Medicaid Director - Healthplan | Konexus Group | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/medicaid-director-healthplan-at-konexus-group-1114818777/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

(1) Medicaid Director - Healthplan | Konexus Group | LinkedIn

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https://www.linkedin.com/jobs/view/medicaid-...

Medicaid Director - Healthplan Company Name Konexus Group Company Location Columbus, OH, US New Posted Date Posted 8 hours ago Number of applicants Be among the first 25 applicants Save Apply Apply to Medicaid Director - Healthplan on company website ** 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.