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Medicaid Jobs Hunter

In this packet....

Independent Care Health Plan Medicare Benefits Consultant in Green Bay, WI, US

SourceURL: https://www.linkedin.com/jobs/view/medicare-benefits-consultant-at-independent-care-health-plan-1295774368

Medicare Benefits Consultant

Green Bay, WI, US

0 applicants

Job Description

The Medicare Benefits Consultant is responsible for growing Medicare Advantage enrollment volume by targeting low-income and disabled Medicare beneficiaries that reside in the Independent Care Health Plan service area. The Medicare Benefits Consultant's primary area of focus is on achievement of the membership goals outlined in the annual operating plan. The Medicare Benefits Consultant conducts all sales and marketing activities in an ethical and responsible manner and complies with all CMS and other applicable laws and regulatory guidelines.

Essential Duties And Responsibilities

- markets products that are designed for the low-income and disabled Medicare population
- hosts group seminars
- conducts one-on-one sales meetings and house calls
- spends time in the field working with key providers, local government agencies, community leaders, community-based organizations, and others serving the low-income and disabled Medicare population
- attends community events and health fairs to promote product education and awareness
- enters leads and applicant information into a database
- supports and demonstrates a customer service commitment to internal and external customers
- understands how applicable laws, regulations, policies, and procedures impact specific job responsibilities and functions; demonstrates actions to reasonably prevent, detect, and report unethical and unlawful business practices
- is fiscally responsible and is in accordance with department policies and procedures regarding business practice
- will require frequent travel within Northeast counties of Wisconsin and to the home office in Milwaukee, WI

Experience And Skills

- minimum two-year Associates Degree in related field or equivalent in experience
- two to four years outside sales experience preferred with a proven track record selling Medicare Advantage, Medicare Supplement or related products
- valid Wisconsin Accident and Disability insurance license
- knowledge of health insurance sales and marketing processes and operational principals with Medicare product experience
- cultural sensitivity and sensitivity to the low-income and disabled Medicare population
- ability to work independently under general instructions and with a team
- a car, a valid WI driver's license and automobile insurance are required for territory travel
- excellent oral communication skills
- proficiency with computer software packages including Word, Excel, Power Point, Internet Applications, and Outlook
- prior experience making group presentations is desirable
- bilingual capabilities in Spanish are desirable

- must be available for training in the Milwaukee, WI office for an extended period of time upon hire

State of Florida 68064589 - CHIEF OF MEDICAID QUALITY Job in Tallahassee, FL

SourceURL: https://www.glassdoor.com/job-listing/68064589-chief-of-medicaid-quality-state-of-florida-JV_IC1154378_KO0,34_KE35,51.htm?jl=3246368509

68064589 - CHIEF OF MEDICAID QUALITY

State of Florida
Applied 5/28/19
Today
Get ahead of others. Apply now.
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Job
Rating
Reviews
Requisition No: 62983

Agency: Agency for Health Care Administration

Working Title: 68064589 - CHIEF OF MEDICAID QUALITY

Position Number: 68064589

Salary: $3,615.39 / Bi-Weekly

Posting Closing Date: 05/30/2019

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

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

This position is located in the Bureau of Medicaid Quality. Medicaid Quality provides data-driven, focused and systematic feedback on the quality of Florida's Medicaid program to federal and state agencies, Medicaid recipients, Medicaid managed care plans, and providers. The Bureau of

Medicaid Quality has a strong focus on providing more comprehensive care, improving health outcomes, and reducing costs.

This position is responsible for working independently to provide managerial work planning, supervising, and coordinating programmatic activities for the Bureau of Medicaid Quality. Job duties include planning, directing, organizing, and maintaining all aspects of the Bureau; directly managing highly trained professionals with varied professional and clinical backgrounds; supporting the design of innovative quality enhancement initiatives in coordination with outside agencies and stakeholders to create system-wide improvements in outcomes; overseeing coordination and review of utilization management contracting and quality assurance monitoring and review of specific Medicaid services that are paid outside of managed care; overseeing the Florida Medicaid Comprehensive Quality Strategy, developing and implementing policy for quality and performance standards for Medicaid managed care plans; oversight of contracts for federally required and other program evaluations; and overseeing all clinical/compliance activities related to Medicaid managed care clinical programs.

Primary responsibilities of this position include coordinating and supervising activities of staff in the Bureau of Medicaid Quality to ensure continuing operations, compliance with state and federal mandates, and maximizing productivity and efficiency.

AHCA offers an excellent array of benefits, including:

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

This position may require travel.

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

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

KNOWLEDGE, SKILLS, AND ABILITIES

- Ability to direct and oversee complex quality research, financial and fiscal analysis
- Ability to interpret Medicaid claims data analysis for policy direction
- Ability to maintain a positive and innovative work environment to maximize the use of staff skills and experience for service quality monitoring and improvement
- Strong written and oral communications skills
- Ability to interpret and present highly technical information in a useful format for high level policy discussion
- Knowledge of various methods of consumer research regarding perceptions of service quality, including written or web-based surveys, interviews, telephone surveys, and focus groups, as well as complex research and analyses.
- Knowledge of/experience with large-scale staffing transitions and reorganization to adapt to structural work environment changes impacting Agency operations
- Ability to develop and oversee complex vendor contracts.
- Ability to travel with or without accommodations.

CONTACT:SHEVAUN HARRIS 850-412-4264

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

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

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

IlliniCare Health hiring Provider Network Specialist II in Chicago, IL, US

SourceURL: https://www.linkedin.com/jobs/view/provider-network-specialist-ii-at-illinicare-health-1294702305

Provider Network Specialist II

IlliniCare Health Chicago, IL, US

Description

Position Purpose: Perform health plan provider orientations and conduct ongoing educational outreach with a focus on improving quality and financial outcomes within the provider network. Act as liaison between providers and the health plan to enhance the business relationship. Conduct initial provider orientations as well as ongoing educational outreach

Educate providers regarding policies and procedures related to referrals, claims submission, credentialing documentation, web site education, Electronic Health Records, Health Information Exchange, and Electronic Data Interface

Enhance account relationships by investigating, documenting and resolving provider matters and effectively handling and responding to account changes and correspondence.

Engage providers and educate them on Patient Centered Medical Home initiatives

Perform detailed HBR (Health Benefits Ratio) analyses, Health Information data Information Set (HEDIS) analyses, and create reports for provider Review provider performance by both quantitative metrics and qualitative factors

Create and communicate milestone documents, dashboards and success or improvement metrics

Act as a liaison between the provider and the health plan ensuring a coordinated effort in improving financial and quality performance

Provide information and status updates for providers regarding incentive agreements

Conduct site visits when required

Perform other contracting duties as requested, including but not limited to recommending changes to pricing subsystems, submitting changes to provider related database information and assisting in the completion of special projects

Ability to travel

Qualifications

Education/Experience:

Bachelor's degree in related field or equivalent experience. 2+ years of combined managed healthcare and provider reimbursement experience. Advanced knowledge of Microsoft Excel. Clinical or health information management (HIM) experience preferred. Claims processing and/or managed care experience preferred.
Licenses/Certifications: Current state driver's license.
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.

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- **Seniority level**

  Entry level

- **Employment type**

  Full-time

- **Job function**

  Information Technology

- **Industries**

  Nonprofit Organization ManagementInsuranceHospital & Health Care

Analytica International State Medicaid Program Director in Baltimore, MD, US

SourceURL: https://www.linkedin.com/jobs/view/state-medicaid-program-director-at-analytica-international-1294773025

State Medicaid Program Director

Baltimore, MD, US

1 applicants

ANALYTICA is seeking a State Medicaid Program Integrity Director/SME to provide oversight support on a Medicaid program integrity audit/review program covering 30+ states. The Program Director shall have deep programmatic and program integrity understanding and knowledge around (1) program integrity monitoring; (2) federal oversight of state Medicaid managed care programs and technical assistance to support improvements; and (3) comprehensive fraud risk assessment methodologies and practices.

Primary Responsibilities May Include

- Act as the client point of contact for day to day projects, activities may include leading customer interaction, managing progress communications, resolving any potential issues, mitigating risks, develop, organize, and manage risks, action items, change control, and communication plans
- May be tasked to oversee a range of project sizes, from small to mid-scale project delivery (ranging from 1 - 30 FTEs), leading cross-functional technical teams to deliver projects within the constraints of quality, scope, schedule, and budget
- Engage functional corporate support teams (such as staffing, finance, etc.) to ensure projects are exceeding requirements and are delivered at an exceptional service level, on time and on budget.
- Participate in federal capture activities, such as proposal development, opportunity identification, and client meetings
- Facilitate team's work by leveraging understanding of stakeholders when interfacing with CMS, state, or other stakeholders as needed, such as to remove potential roadblocks
- Provide unique and valuable insights and help resolve protocol issues through extensive domain knowledge and a keen understanding of CMS Program Integrity broader goals, needs, and constraints.
- Ability to enable and harness team's skills and talents to successfully accomplish PI reviews
- Capabilities to conduct desk reviews on State program integrity activities related to the Opioid crisis
- Experience working with managed care, beneficiary eligibility, and opioids, as well as a broad range of Medicaid topics that may be prioritized in future review activities
- Extensive program management skills to manage resources and ensure staff are effectively utilized across multiple, sometimes overlapping focused reviews across various states

Qualifications

- 5+ years in a Director role at both state-level and federal-level Program Integrity offices or initiatives
- 7+ years in management capacity or with Project Management experience where responsible for managing complex systems and workflows
- Bachelor's degree from an accredited institution
- Ability to extract meaning from complex information
- Strong Medicaid program and policy background with experience at the federal and/or state level
- Strong Medicaid program integrity background with oversight experience at the federal and/or state level
- Extensive Medicaid program integrity subject-matter and analytics expertise, ideally including managed care program integrity or oversight experience
- Ability to work in a fast-paced, small business environment that may entail cross functional support and late nights or weekends when required
- Solution-oriented work style with a focus on results and willingness to deliver

- Expertise in conducting oversight activities of states and performing risk assessments of government programs
- Experience around principles for identifying Medicaid vulnerabilities and mitigating improper payments and waste, fraud, and abuse
- Experience working with managed care, beneficiary eligibility, and opioids, as well as a broad range of Medicaid topics

About : Analytica is a leading consulting and information technology solutions provider to public sector organizations supporting health, civilian, and national security missions. Founded in 2009 and headquartered in Washington D.C., the company is an established and that has been recognized by *Inc. Magazine* each of the past three years as one of the 250 fastest-growing companies in the U.S. Analytica specializes in providing software and systems engineering, information management, analytics & visualization, agile project management, and management consulting services. The company is appraised by the Software Engineering Institute (SEI) at and is an provider.

Physicians Health Partners hiring Senior Member Support Specialist (Medicaid) in Colorado Springs, CO, US

SourceURL: https://www.linkedin.com/jobs/view/senior-member-support-specialist-medicaid-at-physicians-health-partners-1295126147

Physicians Health Partners hiring Senior Member Support Specialist (Medicaid) in Colorado Springs, CO, US

This position will be based out of our Colorado Springs office. 50% travel within the counties El Paso, Park, and Teller.

Position Summary: The Senior Member Support Specialist will be responsible for the following: a) outreach and follow up related to CCHA's KPI initiatives; b) triaging care coordination referrals to the appropriate level of integrated care, including physical and/or behavioral health; c) conducting telephonic and in-person or field-based care coordination or system navigation for members with physical and behavioral health needs; d) liaising between members and their primary care providers and/or behavioral health providers for streamlined care coordination, appointment scheduling, follow up, and member advocacy; e) coordinating between local service organizations and/or medical facilities in which the Senior Member Support Specialist might be based; f) initiating and completing care plans for physical and behavioral health, member identified goals and communicating care plan progress to primary care providers and behavioral health providers; and g) conducting in-person screenings at facilities in which the Senior Member Support Specialist might be embedded.

COMPETENCIES/Role-Specific Functions

COMMUNICATION

Communicates well both verbally and in writing, creates accurate and punctual reports, delivers presentations, shares information and ideas with others, has good listening skills.

- Provides feedback and recommendations to manager regarding KPI outreach and other initiatives
- Promotes communication among team to identify and streamline roles and responsibilities
- Participates in meetings and presents information as needed
- Effectively communicates both verbally and written with clients, members, and care management team
- Reliably consumes instructions from Manager and asks clarifying questions
- Reports on outcomes related to KPI outreach and other initiatives
- Communicates professionally with providers, physicians, and other healthcare professionals

PROBLEM SOLVING

Breaks down problems into smaller components, understands underlying issues, can simplify and process complex issues, understands the difference between critical details and unimportant facts.

- Accurately coordinates referrals to other team members by: a) assessing for level of urgency and level of risk; b) reviewing, documenting, and determining appropriate level of care; and c) creating appropriate case requests
- Implements appropriate intervention(s) in a timely manner to assure problem prevention and resolution
- Identifies, develops, and utilizes community resources appropriately
- Uses motivational interviewing to achieve desired outcomes for the member
- Effectively navigates systems in order to obtain information needed for specialized projects

MENTORING/TRAINING

Acting as subject matter expert for the team and the 'go to' person for questions and answers. Delivering formal and informal training on day to day objectives within the team.

- Provides feedback on co-location and/or case activity to supervisor and assists in development of action plans
- Assists in new-hire training and onboarding
- Assists in on-going education of program or co-location changes to Member Support Specialist
- Delivers training, when appropriate

PROJECT MANAGEMENT

Establishes project goals, milestones, and procedures, defines roles and responsibilities, acquires project resources, coordinates projects throughout company, monitors project progress, manages multiple projects.

- Tracks and reports results of outreach projects and co-location activities
- Monthly and ad-hoc reporting duties as assigned
- Single Point of Contact for co-location

CUSTOMER FOCUS

Builds customer confidence, is committed to increasing customer satisfaction, sets achievable customer expectations, assumes responsibility for solving customer problems, ensures commitments to customers are met, solicits opinions and ideas from customers, responds to customers.

- Has working knowledge of local community programs, government and social agencies, and conveys that knowledge to team members when appropriate
- Develops strong telephonic relationships with members to include handling escalated members and/or members with high acuity and high intensity needs
- Advocates on behalf of members with providers, specialists and community agencies
- Follows up with high acuity and high intensity members to ensure their needs are met

JOB KNOWLEDGE

Understands duties and responsibilities, has necessary job knowledge, has necessary technical skills, understands company mission/values, keeps job knowledge current, is in command of critical issues.

- Acts as the subject matter expert for KPI initiatives to assure best practices in outreach and communication
- Understands and effectively utilizes "specialized" resources
- Understands integrated care coordination program requirements
- Maintains confidentiality and ensures compliance with HIPAA regulations
- Other duties as assigned

Qualifications (Education/Experience/Knowledge/Skills/Abilities)

- High school diploma or GED required.
- Bachelor's degree, and/or experience in a Social work, or Behavioral Health realted field, Licensed Practical Nurse, or certified Medical Assistant preferred.
- Minimum one to two years in a healthcare setting.
- Minimum one to two years of customer service phone experience preferred.
- Advanced computer skills utilizing Microsoft Excel, Word and Outlook.
- Possess excellent customer service skills and ability to effectively interact with PHP personnel, medical and facility staff, other healthcare professionals and the general public.
- Precise and detail oriented in managing, editing and communicating information through spreadsheets and computer systems.
- Ability to work effectively and communicate with other teams and personnel within the PHP organization.
- Skilled in conflict management, problem prevention and resolution.
- Knowledge of medical terminology.
- Able to accept and work with diverse populations and provide culturally sensitive education and assistance to patients/families.
- Available to begin workday as early as 8 am.
- Home office that is HIPAA compliant for all remote or telecommuting positions as outlined by the company policies and procedures.

Physical Demands The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this Job, the employee is regularly required to sit; use hands to finger, handle, or feel and talk or hear. The employee is frequently required to stand; walk; reach with hands and arms and stoop, kneel, crouch, or crawl. The employee is occasionally required to climb or balance. The employee must regularly lift and/or move up to 25 pounds. Specific vision abilities required by this job include close vision and ability to adjust focus.

Work Environment The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. The noise level in the work environment is usually moderate.

IlliniCare Health hiring Community Health Services Representative I in Carbondale, IL, US

SourceURL: https://www.linkedin.com/jobs/view/community-health-services-representative-i-at-illinicare-health-1294701486

Community Health Services Representative I

Carbondale, IL, US

0 applicants

Community Health Services Representative I
Carbondale, IllinoisApply Now**Job ID** 1140989**Category** Health Insurance Operations**Organization** IlliniCare Health Plan**Schedule** Full-time

Description

Position Purpose: Responsible for delivering of a range of activities for individuals who are enrolled in the health plan for Medicaid or and Medicare in order to impact individual health outcomes and provide assistance to the clinical team of nurses and social workers. Activities include, but are not limited to outreach, community education, informal guidance and member support.
Educate, coach and support members to understand disease prevention and achieve good health outcomes, including diabetes, high blood pressure, mental health, substance use, etc.
Participate in coordination and resolution of medical and non-medical needs, including appointment tracking, documentation of member information, referrals and follow up, facilitating transportation to services, etc.
Participate in meetings with external providers and community organizations to build partnerships for our members to be able to leverage member care services. Provide key information to providers for improving members care based on member's home environment and communities.
Conduct non-clinical general health assessments in order to refer members to appropriate services, resolve concerns on member's behalf, and gather information for medical providers and staff working within the organization.
Conduct non-medical assessments such as home safety, assessment of the community/environment resources, transportation, employment, and others to be able to refer to appropriate services, resolve concerns on member's behalf, and gather information for medical providers in staff working within our organization.
Coordinate and implement community events such as baby showers, health fairs, and other health education events.
Conduct telephonic and in-person outreach to locate individuals and families in the community who are hard to reach.
Work with other community health workers internally and externally to share best practices, strengthen education and outreach.
Participate in large scale community assessments including resource mapping, community surveys, and community meetings to discuss findings and resolutions to key member concerns.
Make frequent visits to individual homes and community organizations.

Qualifications

Education/Experience: High school diploma or equivalent. 2+ years of community health, social work, social services, community advocacy, community outreach, member services, or education, experience. Understanding of the community in designated region through shared experiences or strong desire to help people in vulnerable communities. Bilingual skills preferred.

Licenses/Certifications: Valid driver's license and proof of insurance. Community Health Worker Training/Certification must be successfully completed within 15 weeks of hire date.
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.
Apply Now

- **Seniority level**

  Entry level

- **Employment type**

  Full-time

- **Job function**

  Customer ServiceInformation Technology

- **Industries**

  Nonprofit Organization ManagementInsuranceHospital & Health Care

Fallon Health hiring Registered Nurse Case Manager in Berkshire, MA, US

SourceURL: https://www.linkedin.com/jobs/view/registered-nurse-case-manager-at-fallon-health-1287015922

RN Case Manager - ACO - Berkshire County - New Role - Growing Healthcare Organization

Location US-MA-Berkshire

Job ID
5598

Positions
1

Category
Nursing

Overview

About Fallon Health

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

Brief Summary Of Purpose

This role is responsible for the Berkshire County area and will act as the Liaison between Fallon Health the ACO and our member, you need to be very flexible and a relationship builder.

The ACO Liaison Nurse Case Manager (NCM) works closely with Fallon Healthrsquo;s ACO and Community Partners at their sites to support, educate,

develop and maintain positive relationships with members, caregivers, medical professionals in the communities we serve. Through the building of

long term relationships, the Liaison will facilitate communication and care coordination between all ACO Partners, thus improving quality of care and access to services for Fallon ACO members. The Liaison NCM will work in collaboration with the ACOs and Community Partners to support the members in a role that may include completing in-home/facility face to face visits with members and/or providers. Responsibilities include: telephonically assessing a Memberrsquo;s clinical/functional status to identify ongoing special conditions and providing education. Develops and implements a coordinated plan in collaboration with the member, ACO, Community Partners and Primary Care Provider and/or specialist and other community partners to ensure quality outcomes in a cost effective way. Facilitates referrals to Clinical Integration RN team for further member follow-up and/or follow-up with the Care Teams at the ACO and/or Community Partners. Works collaboratively with other members of the Clinical Integration Team.

Responsibilities

Provider Partnerships and Collaboration

- Partners with Outreach/Provider Relations/Clinical Integration Team Clinical Leadership Team to attend and contributes to Model of Care trainings/orientations with providers and/or vendors explaining the various roles of the clinical team in coordination of memberrsquo;s care
- Embeds/Attends and contributes to Model of Care trainings/orientations with providers and/or vendors explaining the various roles of the clinical team in coordination of memberrsquo;s care
- Performs and lead in-person member care plan review with providers including but not limited to Primary Care Providers, Aging Service Access Point Providers, Long Term Services and Support Providers, Behavioral Health Providers, Long Term Care Facility Providers, and/or any other Provider/Member/Authorized Representatives to ensure effective communication and collaboration between all involved
- Partners with interdepartmental teams (including but not limited to: Utilization Management, Appeals and Grievance, Clinical Integration Team Operations, Provider Relations, Pharmacy, Behavioral Health Leadership) within Fallon Health to ensure provider/member satisfaction is maintained while articulating issues to help to facilitate problem/issue resolution

Regulatory Requirements ndash; Actions and Oversight

- Works collaboratively with the Manager to ensure program regulatory deadlines are met
- Completes Program Assessments, Minimum Data Set Home Care (MDS HC) Assessments, Transition of Care Assessments, and Care Plans in the Centralized Enrollee Record and Virtual Gateway according to Regulatory Requirements and Program policies and processes
- Knowledge of and compliance with HEDIS and Medicare 5 Star measure processes, performing member education, outreach, and actions in conjunction with the Navigator

Member Assessment, Education, and Advocacy

- Conducts in home face to face visits for Complex Members utilizing a variety of interviewing techniques, including motivational
- interviewing, and employs culturally sensitive strategies to assess a Members clinical/functional status to identify ongoing special conditions
- Develops and implements an individualized, coordinated care plan, in collaboration with the member and Primary Care Physician and/or specialist, to ensure a cost effective, quality outcome, focused in the ambulatory setting
- Performs medication reconciliations
- Performs Care Transitions Assessments ndash; per Program Processes
- Utilizing clinical judgment and nursing assessment skills, completes the Program Assessment Tools
- Maintains up to date knowledge of Program benefits, Plan Evidence of Coverage details, and department policies and processes and follows policies and processes as outlined to be able to provide education to members and providers; performing a member advocacy and education role including but not limited to member rights
- Serves as an advocate for members to ensure they receive Fallon Health benefits as appropriate and if member needs are identified but not covered by Fallon Health, works with community agencies to facilitate access to programs such as community transportation, food programs, and other services available through senior centers and other external partners
- Follows department and regulatory standards to authorize and coordinate healthcare services ensuring timeliness in compliance with documented care plan goals and objectives
- Assesses the Memberrsquo;s knowledge about the management of current disease processes and medication regimen, provides teaching to increase Member/caregiver knowledge, and works with the members to assist with learning how to self-manage his or her health needs, social needs or behavioral health needs
- Collaborates with appropriate team members to ensure health education/disease management information is provided as identified
- Collaborates with the interdisciplinary team in identifying and addressing high risk members
- Educate members on preventative screenings and other health care procedures such

Qualifications

Graduate from an accrdited school of nursing mandatory and a Bachelors or Advanced degree in nursing or a health care related field preferred.

Active, unrestricted license as a Registered Nurse in Massachusetts; current Driverrsquo;s license and a vehicle to be used for home visits

Certification in Case Management strongly desired

- 4+ years of clinical experience as a Registered Nurse managing chronically ill members or experience in a coordinated care program required
- 2+ years as a Nurse Case Manager with experience teaching and mentoring team members. A willingness to perform unanticipated projects as requested and perform responsibilities as required.
- Home Health Care experience preferred

- Familiar with NCQA case management preferred
- Experience working face to face with members and providers required
- Experience with telephonic interviewing skills and working with a diverse population, that may also be Non-English speaking, required

WellCare Health Plans hiring State President - Ohio in Columbus, OH, US

SourceURL: https://www.linkedin.com/jobs/view/state-president-ohio-at-wellcare-health-plans-1088616272

State President - Ohio

Columbus, OH, US

9 applicants

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

Responsible for the overall operations of the health plan, including strategic direction, administration of all existing programs and development of new programs to ensure goals and objectives are met or exceeded. Working closely with the Division President and WellCare's executive leadership team, leads and directs overall operations including: provider contracting and relations, sales and marketing, medical management, regulatory compliance, government relations and finance, as well as interfacing with corporate office operations. May serve as the representative of the health plan to government entities and other external agencies. Ensures compliance with all relevant state and federal regulatory agencies, contracts and regulations.

Reports to: SVP, Division President

Dept.: Exec - State

Location: Ohio

Essential Functions

- Leads and directs the day to day operations of the health plan. This includes providing 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.
- Sets the tone from the top that compliance with all regulations and contract adherence is critical to WellCare success.
- Directs and manages the organization's financial performance. Takes appropriate actions to increase revenue, leverage resources, manage and/or minimize expenses.
- Directs the development of annual budgets and presents the budgets for approval.
- Assists and leads where appropriate, with aspects of state and federal government relationships, including working with regulators, as necessary, to establish and continue effective working relationships. Ensures that all state and federal regulations are met.

- Oversees the development and maintenance of a viable provider network to ensure the health care needs of WellCare members are met. Develops or 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.
- Oversees the development, implementation and continuous evaluation of the utilization and quality management program for medical services delivered by contracted health care providers.
- Oversees the development and implementation of short and long term sales and marketing plans.
- Leads organizational development activities that develop and foster strong working relationships among the members of the management team. Builds and promotes the culture of the plan to be consistent with the values established by the corporate office.
- Establishes formal and informal mechanisms to promote and maintain credibility, competence, and a positive corporate image by exhibiting strong communication to the corporate office, providers, members and committees.
- Develops new models and processes to meet future business needs
- Provides problem analysis and problem resolution at both a strategic and functional level
- Recommends and leads improvement processes and initiatives
- Performs other related duties as assigned by management

Additional Responsibilities:

Candidate Education

- Required A Bachelor's Degree in business administration, finance, healthcare administration or a related field
- Required or equivalent work experience directly related to the level, scope and primary duties of the roles and responsibilities of the position
- Preferred A Master's Degree in a related field

Candidate Experience:

- Required 5 years of experience in senior management with profit and loss accountability for a managed care organization

Candidate Skills:

- Advanced Demonstrated leadership skills
- Intermediate Demonstrated ability to deal with confidential information
- Intermediate Demonstrated written communication skills
- Intermediate Demonstrated interpersonal/verbal communication skills
- Advanced Demonstrated organizational skills
- Intermediate Ability to work in a fast paced environment with changing priorities
- Intermediate Demonstrated problem solving skills
- Intermediate Other Ability to remain calm under pressure
- Intermediate Other Provides proactive approach and support to emerging business activities established to remain competitive in the marketplace
- Intermediate Other Proven ability to affect change and meet business goals, monitor progress and take corrective actions when necessary
- Intermediate Other Disciplined, hands on and process oriented leader who is not afraid of digging into details when necessary
- Intermediate Other A "failure is not an option" mentality and demonstrated proactive management style
- Intermediate Other Strong business acumen, intelligence and capacity. Thinks strategically and implements tactically
- Intermediate Other Ability to think creatively and out of the box
- Intermediate Other Comprehensive knowledge of delivery system operations, provider contracting, strategic planning and overall service delivery

Technical Skills

- Required Intermediate Microsoft Word
- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft PowerPoint
- Required Intermediate Microsoft Outlook
- Required Intermediate Other Knowledge of and/or ability to utilize COGNOS for budgetary decisions or review

About Us

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 the country and was ranked a "World's Most Admired Company" in 2018 by Fortune magazine. For more information about WellCare, please visit the company's website at www.wellcare.com. EOE: All qualified applicants shall receive consideration for employment without regard to race, color, religion, creed, age, sex, pregnancy, veteran status, marital status, sexual orientation, gender identity or expression, national origin, ancestry, disability, genetic information, childbirth or related medical condition or other legally protected basis protected by applicable federal or state law except where a bona fide occupational qualification applies. Comprehensive Health Management, Inc. is an equal opportunity employer, M/F/D/V/SO.

Molina Healthcare hiring Sr Program Specialist, Medicare in Long Beach, CA, US

SourceURL: https://www.linkedin.com/jobs/view/sr-program-specialist-medicare-at-molina-healthcare-1291052224

Sr Program Specialist, Medicare

Long Beach, CA, US

0 applicants

Job Description

Description

Job Summary

Responsible for the management of the benefits, operations, communication, reporting, and data exchange of the Medicare/MMP product in support of strategic and corporate business objectives. Manage for all Medicare lines of business the annual Medicare and Medicare-Medicaid Plan Applications and Plan Benefit Package design, as well as provide centralized year-round support in Medicare for the development and editing of core beneficiary communications,

to include the Medicare Summary of Benefits and Annual Notice of Change/Evidence of Coverage for print and online distribution via the iCat authoring process, ensuring compliance with CMS guidelines. Support Medicare and MMP line of business for upcoming contract year business readiness. This position also needs to assist in the development, implementation, and maintenance of annual timelines/work plans to ensure timely and successful project completion including adhoc projects and submissions as assigned by the Director of Medicare Programs.

Knowledge/Skills/Abilities

- Initiate projects by documenting the project scope including goals, objectives, milestones, deliverables and obtaining approval of the project sponsor.
- Plan projects by creating process improvement workflows, project presentations, work plans, establishing due dates, and assigning task responsibilities.
- Guides project efforts by leading work teams and utilizing effective project management tools to achieve desired project results.
- Monitor and control projects by measuring progress according to plan and making course corrections as needed to keep the project on track.
- Provide interim reports and keeping the project sponsor and stakeholders informed of progress and risks.
- Serves in an internal consultant capacity and possesses ability to rapidly learn, assess, and implement projects.
- Develop and distribute internal communications.
- Spearhead submission of Medicare and MMP Applications, annual Medicare Bid and PBP, ANOC/EOC, and Summary of Benefits working closely with a variety of internal and external partners. Responsible for staying up to date with the latest communications and guidance provided by CMS as it relates to applicable projects.
- Coordinate cross-departmental informational updates – focusing on team work, information flow and support data to promote cross-training and unified team direction.
- Annual implementation and roll out of business expansion for Medicare/MMP line of business.
- SQL queries
- Eligibility Extract analysis (834 file)
- BRD development/Multiple third party applications that contain Molina member data (examples, case management, MTM)**Job Qualifications**

Required Education

Job Qualifications

Bachelor's degree in Healthcare Admin, Marketing, Communications, English

Required Experience

- 5+ years in healthcare process design and development, business analysis, compliance, project management or related experience.
- Requires a minimum 2 years experience in Medicare and/or healthcare and
- 1 year experience in project management.
- 1-2 years of experience in Information Technology, database Content Management Systems environments.

Preferred Experience

3-5 years in project coordination, project management, business analysis, compliance.

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.

To learn more about Molina Healthcare Careers, follow us on LinkedIn , Twitter & Facebook . You can also visit Molina Cares to view interactive tutorials on resume & cover letter writing, interviewing and more!

Primary Location

US-CA-Long Beach-LB6TH

Job

Exchange and Duals

Organization

Corporate

- **Seniority level**

  Associate

- **Employment type**

  Full-time

- **Job function**

  Project ManagementInformation Technology

- **Industries**

  Hospital & Health Care

Medical Director (Aetna Better Health of Maryland) in Linthicum, Maryland, United States

SourceURL: https://aetna.jobs/linthicum-md/medical-director-aetna-better-health-of-maryland/cb30d49cb98d417f894867399957d111/job/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Req ID: 60290BR

Position Summary:

Aetna Better Health of Maryland (Aetna Medicaid Plan)is looking for a Medical Director to join our team. The Medical Director will provide oversight for medical policy implementation and participate in the development, implementation, and evaluation of clinical/medical programs.

This position is an opportunity to get in near the beginning of a new and rapidly growing Medicaid Managed Care Health Plan. We are looking for a high-energy clinician leader to work with the Chief Medical Officer to provide support to the Care Management, Utilization Management Community Development and Quality team departments dedicated to caring for our growing membership.

Are you ready to join a company that is changing the face of health care across the nation? Aetna Better Health of Maryland is looking for people like you who value excellence, integrity, caring and innovation. As an employee, you'll join a team dedicated to improving the lives of Maryland Health Choice members. Our vision incorporates community-based health care that addresses the Social Determinants of Health. We value diversity. Align your career goals with Aetna Better Health of Maryland and we will support you all the way.

In this role you will:

Reinforce clinical philosophy, programs, policies and procedures

Perform daily review of individual cases from concurrent review and prior authorization processes, including denial decisions for cases that do not meet established criteria.

Provide medical review and support for case management and care coordination staff to ensure optimal care is rendered to our members according to the terms of the benefit members receive.
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Identify opportunities to implement best practice approaches and introduce innovations to better improve outcomes.

Assess Developmental needs and collaborate with others to identify and implement action plans that support the development of high performing teams.

Consistently demonstrate the ability to serve as a model change agent and lead change efforts.

Be responsible for maintaining compliance with policies and procedures and implements them at the employee level.

Ability to evaluate and interpret data, identify areas of improvement, and focuses on interventions to improve outcomes.

Function in a variety of external facing roles including member education, providers visits and interfacing with community partners

Background /Experience:

2-3 years of experience in Health Care Delivery System e.g., Clinical Practice and Health Care Industry.

Previous managed care experience with an insurer / payer highly preferred but not required

Education:

The highest level of education desired for candidates in this position is an MD or DO.

License and Certifications:

M.D. or D.O., Board Certification in a recognized specialty including post-graduate direct patient care experience.

Active and current state medical license without encumbrances

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.

Job Function: Health Care

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