Medicaid Industry Jobs Hunter: 11/18/2019

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Medicaid Jobs Hunter

In this packet….

Behavioral Health Utilization Manager/ RN

Behavioral Health Utilization Manager/ RN

Job Description

	About Us
	Community Health Choice, Inc. (Community) is a non-profit managed care organization (MCO), licensed by the Texas Department of Insurance. Through its network of more than 10,000 providers and 94 hospitals, Community serves over 400,000 Members with the following programs: • Medicaid State of Texas Access Reform (STAR) program for low-income children and pregnant women

	• Children’s Health Insurance Program (CHIP) for the children of low-income parents, which includes CHIP Perinatal benefits for unborn children of pregnant women who do not qualify for Medicaid STAR • Health Insurance Marketplace Plans that offer individual health coverage that includes preventive care, emergency services, prescription drugs, and hospitalization available to all, regardless of pre-existing conditions. Improving Members' experiences is at the heart of every Community position. We strive every day to make sure that our Members have access to the high-quality health care they need and deserve. Community is accredited by URAC for its health plan operations. We offer care management programs for asthma, diabetes, and high-risk pregnancy. An affiliate of the Harris Health System (Harris Health), Community is financially self-sufficient and receives no financial support from Harris Health or from Harris County taxpayers.
	Job Profile
	Behavioral Health Utilization Manager will perform concurrent and discharge reviews on assigned patients. Applies approved criteria for justification of admission and continued stay in the appropriate level of care. Notifies Medical Director regarding the review of medical records submitted by providers for peer to peer reviews. Utilizes nationally recognized evidenced based clinical criteria, approved medical guidelines, and company policies. Provides timely responses of the outcome to the provider based on State policy. Assists in the ongoing development and maintenance of a database for tracking, trending and reporting of cases. QUALIFICATIONS: • Bachelor's degree in Nursing, preferred. • Current state Registered Nurse License. • Two (2) years experience in an acute psychiatric care setting. • Two (2) years experience in utilization and appeal review in a managed care environment with Medicaid and Medicare members. OTHER SKILLS:

	• MS Word, MS Excel, Outlook • Above Average Verbal (Heavy Public Contact) • Writing /Composing Yes (Correspondence / Reports) • Analytical • Medical Terminology • Research • Able to work independently under general instructions and working within a team environment, Able to apply the appeal and medical necessity criteria and use critical thinking
	Benefits and EEOC
	Community employees' benefits are provided by Harris Health. These benefits are designed to provide you with flexibility and choices in meeting your specific needs. Community is an Equal Opportunity Employer.
	Job Category
	All Jobs

Job Reference #: 147858

Clinical Claims Review Nurse | WellCare Health Plans

Source URL: https://www.linkedin.com/jobs/view/clinical-claims-review-nurse-at-wellcare-health-plans-1609777235/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Clinical Claims Review Nurse

WellCare Health Plans | Tampa, FL, US

Position reviews and audits clinical information (post service, prepayment medical claims) to determine appropriateness of charges in accordance with contracted payor terms, standards of care and Medicare/Medicaid requirements. Works with internal and external partners (physicians, members, payors and other healthcare providers) in support of appropriate utilization and timely reimbursement of healthcare services.

Reports to: Supv, Clinical Appeals

Department: PHS-Retro Review
Location: Tampa, FL 33634
Pay Level: L09

Essential Functions

- Evaluates medical claims and/or medical records by applying clinical expertise to assess appropriateness of service provided, length of stay and level of care. Identifies and refers all cases not meeting medical necessity criteria and guidelines to appropriate decision maker for review.
- Reviews claims at the post service, prepayment level and identifies and reports discrepancies, including quality of care issues.
- Evaluates and intervenes as needed for level of care, denial and compliance issues.
- Assists with Complex Claim review; requires decision making pertinent to clinical experience.
- Documents clinical review summaries, bill audit findings and audit details in the system.
- Provides supporting documentation for denial and modification of payment decisions.
- Reviews readmission claims for appropriate DRG coding and medical necessity.

Candidate Education

- Associate's Degree in Nursing or equivalent work experience in a health care related field is Required

Candidate Experience

- 3 years of experience in general nursing with the preference in critical care/ER/surgical setting is Required
- 1+ year of experience in Medical Claims Review (1 of the 3 years of experience must be in medical claims review) is Required

Candidate Skills

- Ability to identify basic problems and procedural irregularities, collect data, establish facts, and draw valid conclusions
- Ability to work as part of a team
- Ability to work in a fast paced environment with changing priorities
- Ability to work independently
- Demonstrated analytical skills
- Demonstrated problem solving skills
- Demonstrated written communication skills
- Knowledge of medical terminology and/or experience with CPT and ICD-10 coding
- Other Knowledge of Milliman or InterQual guidelines

Licenses And Certifications

A license in one of the following is required:

- Required Other One of the following licenses is required: LPN, RN

Technical Skills

- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft Outlook
- Required Intermediate Microsoft Word
- Preferred Intermediate Healthcare Management Systems (Generic)

RN Care Manager, Select Health | Visiting Nurse Service of New York

Source URL: https://www.linkedin.com/jobs/view/rn-care-manager-select-health-at-visiting-nurse-service-of-new-york-1593999119/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

RN Care Manager, Select Health

Visiting Nurse Service of New York Brooklyn, NY, US

Overview

The RN Care Manager improves clinical and cost-effective outcomes by reducing hospital admission and emergency department visits for members enrolled in VNSNY CHOICE Medicare and Medicaid, through on-going member education, care coordination and collaboration with providers of care. Provides telephonic case management to members, balancing clinical, social, and environmental concerns. Ensures services provided are in compliance with VNSNY CHOICE Medicare and Medicaid policies and procedures, as well as applicable state and federal regulations.

Responsibilities

- Assesses, plans, facilitates and advocates for options and services to effectively manage an individual's health needs. Leads the care coordination for complex clinical cases. Promotes quality and cost-effective outcomes at all times.
- Collaborates with physician and other healthcare professionals in managing coordination of care decisions related to case management and services provided to member enrolled in VNSNY CHOICE Medicare and Medicaid.
- Provides input and recommendations for design and development of, processes and procedures for effective member case management, efficient department operations, and excellent customer service.
- Provides analysis of initial health evaluation and comprehensive assessment of the member/family psychosocial status and case management needs.Participates in the development, coordination and implementation of the care plan to address specific needs of the member/family including thorough transitions between settings of care.
- Reviews covered and coordinated services in accordance with established plan benefits, application of evidenced based medical criteria, and regulatory requirements to ensure appropriate authorization of services and execution of the plan's fiduciary responsibilities.

Qualifications

- License and current registration to practice as a registered professional nurse in New York State required. Certified Case Manager Certification preferred.
- Associate Degree in Nursing required. Bachelor's or Master's Degree in Nursing preferred.
- Minimum of two years of case management experience assessing needs, coordinating/collaborating services and referrals required.

- Case management experience in a managed care organization or health plan preferred. Excellent organizational and time management skills, interpersonal skills, verbal and written communication skills required.
- Working knowledge of Microsoft Excel, Power-Point, and Word required.
- Knowledge of Medicare/Medicaid and/or commercial regulations preferred..
- Knowledge of Milliman criteria (MCG) preferred

Medicaid Program Director | Avalon Executive Search, LLC

Source URL: https://www.linkedin.com/jobs/view/medicaid-program-director-at-avalon-executive-search-llc-1557901785/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Program Director

Avalon Executive Search, LLC
Salem, Oregon, United States

We are working with an award-winning health plan to find them a Medicaid Program Director to work closely with providers, community partners, and other stakeholders to develop and lead community based health programs.

Qualifications

· Strong experience in an operational area within a health plan such as community

health, strategic planning, business development, quality improvement,

strategic relationship development etc.

· Strategic management experience within Government Programs, specifically Medicaid

preferred.

· Strong written, verbal and collaboration skills

How you match
See how your LinkedIn profile matches the job poster's preferences.

Criteria provided by job poster

Skills

Match
Business
Match
Quality Improvement
Match
Management
Match
Medicaid
Match
Business Development
Match
Strategic Planning
Match
Business Strategy
No match
Government Programs
No match
Relationship Development
No match
Programme Directors

Contact the job poster

Jodie Temmerman 2nd

Nationwide Managed Care Executive Recruiter at Avalon Executive Search

Project Coordinator, Medicaid Administration - SelectHealth Job In Utah,

Source URL: https://www.homecarecareers.com/career/1186794/Project-Coordinator-Medicaid-Administration-Selecthealth-Utah?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Project Coordinator, Medicaid Administration - SelectHealth

Job Ref No: 241321

About Us

Being a part of Intermountain Healthcare means joining a world-class team of over 37,500 employees and caregivers while embarking on a career filled with opportunities, strength, innovation, and fulfillment. Our mission is: Helping people live the healthiest lives possible.

Our patients deserve the best in healthcare, and we deliver.

To find out more about us, head to our career site here .

Job Description

The Medicaid Project Coordinator provides project support to the Medicaid Administration team at SelectHealth to ensure timeliness and effectiveness in completion of needed projects. This Project Coordinator will be expected to become a subject matter expert in Medicaid policy, processes, and benefits and in turn will be a resource to, and may train, other SelectHealth departments on said areas. Additionally, the Project Coordinator could represent SelectHealth Medicaid in external settings, such as Utah State Department of Health meetings, advocacy groups, etc. This position also has the potential to manage external vendor contracts, including the initial contracting process and ongoing relationship management.

Essential Job Duties

1. Defines, develops and executes project planning deliverables including work plans and schedules for medium, multiple scope

projects. Identifies needed resources and defines roles and responsibilities for assigned projects. Arranges for assignment of key project participants. May participate as a team member as needed.
2. Develops comprehensive business cases and scope documents for complex projects. Writes project business proposals. Assists team members with business case and business proposal development.
3. Analyzes data to validate client and functional requirements. Ensures that client and functional requirements are being met on assigned projects. Determines impact on existing processes and communicates to project sponsor.
4. Conducts analysis and defines efficient, cost effective solutions that support business and functional requirements. Coordinates project risk assessment and response planning. Communicates risk to sponsors and develops and executes mitigation strategies, with guidance as needed. Develops and performs quality assurance plans, reviews assigned projects.
5. Documents project deliverables, scope and content for assigned projects. Prepares and provides reports on task and deliverable completion. Develops and executes project communication plans. As needed, prepares presentations on findings to inform and suggests recommendations.

Posting Specifics

- Entry Rate: $24.80/hour, but based on applicable project experience
- Benefits Eligible: Yes
- Shift Details: Full-time, Exempt
- Department: Medicaid Administration - SelectHealth (Murray, Utah)

Minimum Requirements

- Bachelor's degree or four years applicable department operations or project management experience such as managing a medium sized team, or multiple scope projects. Degree must be obtained through an accredited institution, which will be verified.
- Two years project related work experience.
- Demonstrated advanced level experience with computer system applications including spreadsheet, word processing and database applications.
- Demonstrated analytical, organizational and communication skills.

Physical Requirements

- Manual Dexterity

Preferred Requirements

- Experience with Medicaid, preferably within a health plan environment.
- Experience in a health insurance or health care setting, including experience as a member of team managing medium sized or

multiple scope projects.

Behavioral Health Care Coordinator

Source URL: https://jobs.harrishealth.org/behavioral-health-care-coordinator/job/11340702?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Behavioral Health Care Coordinator

Community Health Choice, Inc.

		About Us
		Community Health Choice, Inc. (Community) is a non-profit managed care organization (MCO), licensed by the Texas Department of Insurance. Through its network of more than 10,000 providers and 94 hospitals, Community serves over 400,000 Members with the following programs: • Medicaid State of Texas Access Reform (STAR) program for low-income children and pregnant women • Children's Health Insurance Program (CHIP) for the children of low-income parents, which includes CHIP Perinatal benefits for unborn children of pregnant women who do not qualify for Medicaid STAR • Health Insurance Marketplace Plans that offer individual health coverage that includes preventive care, emergency services, prescription drugs, and hospitalization available to all, regardless of pre-existing conditions. Improving Members' experiences is at the heart of every Community position. We strive every day to

		make sure that our Members have access to the high-quality health care they need and deserve. Community is accredited by URAC for its health plan operations. We offer care management programs for asthma, diabetes, and high-risk pregnancy. An affiliate of the Harris Health System (Harris Health), Community is financially self-sufficient and receives no financial support from Harris Health or from Harris County taxpayers.
		Job Profile
		Provides telephonic services to Members and their families for purposes of, identifying members with behavioral healthcare needs and provide available resource assistance. Works with the Member or the Member's legal representative to develop a service plan. Monitors Member's behavioral healthcare needs as per HHS guidelines. Assists with outreach to Members recently discharged from inpatient level of care for post discharge assistance with a goal to contact members who may be at risk of follow up shortly after an inpatient Behavioral Health admission. Makes SSI referrals to outside vendor and follow up on the eligibility process with financial and eligibility departments according to established guidelines. Works closely with case managers, team leads and Manager of Behavioral Health to coordinate care for Members with a behavioral health diagnosis. Outreach Members for special projects to assist with quality initiatives. QUALIFICATIONS: • Bachelor's Degree in Sociology, Social Work, or Psychology preferred • Three (3) years experience in a healthcare setting such as medical clinic, hospital, and managed care facility Communication Skills: Above Average Verbal (Heavy Public Contact) Writing /Composing Yes (Correspondence / Reports) MS Word MS Excel MS Office products, filing, telephone skills, working independently. Bilingual (English/Spanish) preferred
		Benefits and EEOC
		Community employees’ benefits are provided by Harris Health. These benefits are designed to provide you with flexibility and choices in meeting your specific needs.

		Community is an Equal Opportunity Employer.
		Job Category
		CHC Clinical

Apply Online

Executive Assistant to C-Suite - Health Care Insurance and Services | Fallon Health

Source URL: https://www.linkedin.com/jobs/view/executive-assistant-to-c-suite-health-care-insurance-and-services%21-at-fallon-health-1614055620/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Executive Assistant to C-Suite - Health Care Insurance and Services

Fallon Health | Worcester, MA, US

Executive Assistant to C-Suite - Health Care Insurance and Services! US-MA-Worcester Job ID: 5811 Type: Full Time # of Openings: 1 Category: Administrative/Clerical Fallon Health - Corp HQ 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 nation'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. This Executive Assistant position will support C-level executives and will be responsible for performing a number of administrative duties. The ideal candidate is highly self-motivated, professional and capable of managing their work load and prioritizing tasks in a fast-paced corporate environment. The ideal candidate must possess:

- Excellent organizational and multitasking skills.
- High level of integrity with a service oriented mindset.
- Attention to detail with a keen eye for quality output.
- Must be able to meet deadlines in a fast-paced quickly changing environment.
- Exhibit grace under pressure.
- A proactive approach to problem-solving with strong decision-making skills.
- Professional level verbal and written communication skills.
- Experienced in exercising discretion and confidentiality with sensitive company information.
- Collaborates and builds relationships with executives, peers and other essential staff. Responsibilities
- Completes a broad variety of administrative tasks for C-level executives.
- Manages extremely active calendars.
- Proactive thinker who actively anticipates and proposes solutions.
- Arranges detailed travel plans, itineraries and agendas; compiling documents for travel-related meetings.
- Manages a variety of special projects, some of which may have organizational impact.
- Participates in select meetings; accurately drafts minutes in a timely fashion, where appropriate.
- Screens calls/emails and attempts to resolve matters directly.
- Performs timely assignment/deliverable follow-ups with executive's, direct reports and staff
- Responsible for packaging Board of Directors' committee related materials.
- Maintains vacation schedules for all executive's direct reports.
- Event Planning.
- Compose and prepare emails/correspondence that is sometimes confidential.
- Provide budget & expense management tracking & reporting.
- Supports a variety of special projects often requiring coordination with department leaders.
- Collaborates closely with the Executive Assistant team, exchanging ideas and efficiencies as well as providing coverage as required.
- Ensures established office procedures and administrative policies are followed.

- Performs a full range of routine administrative support: mail, electronic/paper filing, expense reports, purchase requisitions, office supplies, faxes, etc. Qualifications
- 5+ years professional administrative experience supporting C-level executives.
- Advanced proficiancy with MS Office Suite and exposure to other systems such as Sharepoint, Oracle and Adobe products.
- Legal and/or HMO experience strongly preferred
- Open to learning various other applications when needed, as company standards evolve.
- Bachelors or Associates Degree preferred. PM16

Medicaid Eligibility Specialist | Alltran

Source URL: https://www.linkedin.com/jobs/view/medicaid-eligibility-specialist-at-alltran-1614171833/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Eligibility Specialist

Alltran | Manchester, NH, US

Alltran is Seeking a **Medicaid Eligibility Specialist** in **Manchester, NH**

Healthcare/Patient Services Professionals - Apply Today

The Medicaid Eligibility Specialist will screen uninsured or underinsured patients for potential program eligibility for Medicaid and other available funding sources. This individual will assist the patient in gathering additional documentation. The Medicaid Eligibility Specialist will coordinate working with local Department of Social Services offices and/or other state government offices, in an effort to determine program eligibility.

Responsibilities

- Conduct financial fact-finding interviews with patients who are seeking Medicaid benefits.
- Complete Medicaid and other applicable applications/releases.
- Monitor all applicants who are eligible for Medicaid or other financial assistance or coverage plans, as required.
- Enter clear and concise notes in the required patient accounting systems.
- Ensure all supporting documents, including applications and receipts, are obtained and filed timely.
- Successfully help coordinate and manage the portfolio of Medicaid applicants.
- Adhere to all relevant regulations related to our involvement with Federal, State and local government programs as well as Alltran and our clients' compliance programs.

Requirements

- 1+ year(s) of Customer Service, Social Services or Hospital setting experience
- Customer Service skills
- Computer proficiency
- Working knowledge and understanding of the Medicaid application process
- Experience working in a hospital environment
- Strong verbal and written communication skills
- Dependable transportation to do field work (when required)
- College degree preferred; related experience may be substituted in lieu of a degree

Disclaimer

This position description is not intended, and should not be construed, to be an exhaustive list of all responsibilities, skills, efforts or working conditions associated with the job. It is intended to be an accurate reflection of those principle job elements essential to the job.

Alltran provides Equal Employment Opportunities (EEO) to all employees and applicants for employment. Alltran does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity, national origin, age, physical or mental disability, marital status, genetic information, or any other characteristic protected by federal, state, or local law, ordinance, or regulation.

Alltran is more than just a new name. It's a whole new way of doing business. We have united industry leading organizations with over 100 years of combined experience across the Revenue Cycle and Accounts Receivable Management spectrum. Alltran offers competitive

compensation, full health benefits, 401(k), and paid vacation/holidays.

Clinical RN Manager/ Personal Care Medicaid Home Health | Professional Healthcare Resources

Source URL: https://www.linkedin.com/jobs/view/clinical-rn-manager-personal-care-medicaid-home-health-at-professional-healthcare-resources-1612011324/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Clinical RN Manager/ Personal Care Medicaid Home Health

Professional Healthcare Resources
Washington, DC, US

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 Nurs ing for the Personal Care Departmen** t 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.

Position Summary

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

Director Finance (Medicaid and Provider Contracting experience) Job in Washington, DC at AmeriHealth Caritas

Source URL: https://www.ziprecruiter.com/c/AmeriHealth-Caritas/Job/Director-Finance-(Medicaid-and-Provider-Contracting-experience)/-in-Washington,DC?jid=DO01a27705c0995d0a1d9a44c3c8c594e6&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director Finance (Medicaid and Provider Contracting experience)

AmeriHealth Caritas Washington, DC

Posted: November 16, 2019
Full-Time
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. The Director of Finance is responsible for the oversight of all financial activities including but not limited to financial statements, active participation in the annual budget process and reconciliation of operational staff.

The director is a critical member of management who provides membership, financial results and support during the budgeting process and provides support to the Executive Director and President. The director develops and supports partnerships with Plan Oversight, other departments including; Account Management, Informatics, Member Services, and corporate accounting. The Director is responsible for managing and supporting a team of finance professionals.

The director is required to interface with all levels of management and outside vendors in order to resolve funding issues, accounts receivable balances and any finance related issues. The director also provides ongoing direct support to cost center managers regarding staffing and around G&A Expenses. Responsibilities: The Director of Finance is responsible for the oversight of all financial activities including but not limited to financial statements, active participation in the annual budget process and reconciliation of operational staff.

The director is a critical member of management who provides membership, financial results and support during the budgeting process and provides support to the Executive Director and President. The director develops and supports partnerships with Plan Oversight, other departments including; Account Management, Informatics, Member Services, and corporate accounting. The Director is responsible for managing and supporting a team of finance professionals.

The director is required to interface with all levels of management and outside vendors in order to resolve funding issues, accounts receivable balances and any finance related issues. The director also provides

ongoing direct support to cost center managers regarding staffing and around G&A Expenses. Financial Management Oversee key financial aspects of operational activities (Revenue, Expenses, Management Fee & Intercompany) Ensure accurate and timely processing of cash receipts (accounts receivable & network administration fees) Directs the individual and consolidated reporting of results for cost centers.

Develop budget projections (forecasts, reforecast) and monitors performance monthly. Maintain and review Operating Revenue models and strategic planning needs. Provide financial oversight to ensure contract compliance.

Ensure accurate and timely invoicing of clients where appropriate. Provide financial compliance and oversight for contracts between and outside vendors. Act as a liaison with internal and external business partners on all financial matters.

Resolving contractual billing conflicts, and ensuring accuracy . Review and provide approval for claims processor payment and dispute costs as necessary. Manage the daily activities of the Finance Administration staff.

Act as a liaison with internal and external business partners. Develop and maintain a process to provide reliable critical metrics to management. Hire, train, coach and evaluate performance of direct reports.

Education/Experience: Required: Bachelor's Degree required. Master's Degree preferred Required: 5-10 years proven people leadership, Finance/Accounting experience Required: Experience working in a cross-functional matrix organization Required: Managed Care and Provider Contracting acumen Highly Preferred: Finance consulting exposure

AmeriHealth Caritas

Address

Washington, DC

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