Medicaid Industry Jobs Hunter 11.04.19

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Medicaid Jobs Hunter

In this packet….

Finance Director-Government Business Division (Western NY Medicaid Alliance)-PS26744 | The Job Network

Finance Director-Government Business Division (Western NY Medicaid Alliance)-PS26744

The Job Network Buffalo, NY, US

Your Talent. Our Vision. At Anthem, Inc., it's a
powerful combination, and the foundation upon which we're creating
greater
access to care for our members, greater value for our customers, and
greater
health for our communities. Join us and together we will drive the

future of health care.This is an exceptional opportunity to do innovative work that
means more to you and those we serve at one of America's leading health
benefits companies and a Fortune Top 50 Company.This position must be onsite in the
Buffalo, NY OfficeResponsible for
financial leadership, decision support, and strategic consultation to the Western New York Medicaid Health
Plan, Blue Alliance leadership team.
Directs health plan financial analysis, cost of care analytics, trend analysis,
financial reporting, financial operations, and cost and budget management and
allocation, which may include specialty products and/or provider contracting
arrangements that carry financial risk to the plan P&L. Serves as legislative consultant with state partners on financial/reimbursement policy
and payment mechanisms.Primary duties may
include, but are not limited to:Directs market leadership for P&L and SG&A budget; operates as a financial liaison to state
partners; Leads rates management and negotiation
including reserve development and analytics; and leads the Medical Cost
Trend identification and mitigation process. Maintains trends that are appropriate
given premium reimbursement. Reviews, analyzes, reports, and presents financial results. Provides decision support for business unit President and senior management teams' operational and business goals. Directs health plan preparation of
overall budget, forecast, and cost allocation processes. Achieves Medical Cost and MLR targets
set in plans and forecasts; may ensure that provider network contracting
efforts obtain the best possible financial arrangements; may own the setting of and achievement of Cost of Care targets; and achieves operating
gain targets set in budgets and forecasts. Directs Health Plan preparation of
annual operating/capital budget and quarterly forecasts to provide senior
leadership with tools necessary to maximize investment of resources. Directs interface with regulatory and
audit personnel and technical consultants as required to ensure fiscal accountability.Requires a BS/BA in Finance, Business Administration, or Accounting; 8-10 years of progressive financial experience in

accounting,
financial reporting, business analysis, budgeting, forecasting, and strategic
and tactical planning within a health insurance/managed care environment;
experience with complex business environments including multiple entity and
highly regulated situations; 5 years management experience; or any combination
of education and experience, which would provide an equivalent background.; MBA

Preferred. Significant Experience Working With Shared Savings

arrangements is strongly preferred. Managed care experience preferred.AnEqualOpportunityEmployer/Disability/VeteranPandoLogic.
Keywords: Finance Manager, Location: Buffalo, NY - 14208

Director, Health Plan Sales | Ethos Search

Source URL: https://www.linkedin.com/jobs/view/director-health-plan-sales-at-ethos-search-1592141895/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director, Health Plan Sales

Ethos Search Gainesville, GA, US

Brief Overview

The Sales Director will play a critical role in the Health Plan Solutions organization. Specifically, identifying and closing new health plan logo opportunities, with an assigned territory in the west coast. The Sales Director will be responsible for all facets of the sales cycle and delivering on quarterly revenue targets. The position requires a high-

energy, healthcare savvy, well-rounded sales leader who has a proven sales track record.

A strong background in healthcare, sales, and the health plan/payer market, is critical. The highly consultative position requires a polished individual who can articulate vision, convincing present value, and has healthcare industry depth and breadth. Experience with demonstrating value, ROI and differentiators, member and employer engagement, Medicare and Medicaid populations, provider network relations, and taking new solutions to market are essential in order to work alongside prospective clients in their acquisition and deployment of telehealth.

Along with identifying and developing new sales opportunities, the selected Sales Director will have a deep understanding in operating/contributing to a high-performance sales and account team including: lead generation and qualification, pipeline and opportunity management, proposal and presentation best practices, and managing overall opportunities from qualification to close. A proven track record in growing revenue, working collaboratively with internal business partners, and successfully driving results on a quarterly basis is essential.

Core Responsibilities

- Deep experience with forecasting/pipeline management (process and methodology to accurately forecast), preferably with SalesForce.com
- Excellent communicator — with strong interpersonal, C-Suite presentations, written and communication skills, to both clinical and business stakeholders
- Ability to develop and manage multi-million-dollar sales opportunities
- Ability to communicate business & outcome value of technology solutions
- Ability to develop the west coast territory with specific opportunities that may include large regional and national health plans, large TPAs, disease/care management and behavioral health organizations, Medicare and Medicaid plans, and similar healthcare companies that deliver healthcare services to members, employers and/or consumers

Qualifications

- BS/BA in business, healthcare, computer science or equivalent, advance degree a bonus
- Specific understanding of the payer and provider market and related healthcare landscape
- 5+ years' experience selling enterprise technology solutions to

health plan organizations
- Specific experience with telemedicine and telehealth products a bonus
- Documented track record of selling large, enterprise-wide, complex technology deals
- Documented record of meeting and exceeding multi-million dollar annual quota
- Approximately 35% overnight travel required; position is west coast based

Contracting Officer Representative | Centers for Medicare & Medicaid Services

Source URL: https://www.linkedin.com/jobs/view/contracting-officer-representative-at-centers-for-medicare-medicaid-services-1540469552/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Contracting Officer Representative

Centers for Medicare & Medicaid Services Baltimore, Maryland

The Center for Medicare and Medicaid Innovation (CMMI) is seeking a **Contracting Officer Representative** to serve in our Woodlawn office. CMMI was established for testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits.

As a Contracting Officer Representative, you will implement models that test new ways for CMS to pay for care, measure quality, and

collaborate with the healthcare industry.

Responsibilities

- Evaluates contract performance to ensure that products or services comply with contractual requirements and authorizes payment to vendors.
- Plans and conduct contract price/cost analyses of a variety of pre-award and/or post-award procurement actions.
- Design and develop measures, charts, graphs and management reports that support the status reporting and action planning required to monitor and achieve the strategic plan.
- Provides technical advice and support in the division of procurement, functional administration and oversight of all center and enterprise wide contract vehicles.
- Develops implementation plans with milestones, timetables, audit trails, and evaluation procedures.

*****This position is only open for Federal employees and those of whom qualify for one of the special hiring authorities listed on the announcement*****

Please submit your complete application package **no later than 11:59 pm on 11/12!!**

Pharmacy Director (NC Medicaid) | NC Department of Health and Human Services

Source URL: https://www.linkedin.com/jobs/view/pharmacy-director-nc-medicaid-at-nc-department-of-health-and-human-services-1591966968/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Pharmacy Director (NC Medicaid)

NC Department of Health and Human

Services North Carolina, NC, US

This position is exempt from the State Human Resources Act

Position Summary
The Pharmacy Director provides oversight and management to the Medicaid Direct (Fee-for-Service) Pharmacy Benefit Management and the Managed Care Pharmacy Benefit. This position will also manage and oversee additional Medicaid Program Services (Pharmacy, Durable Medical Equipment and Supplies and Prosthetics and Orthotics, Specialized Therapies, Independent Practitioners and Local Education Agencies).

Job Specific Responsibilities Direct the prescription drug and medical drug benefits for the NC Medicaid Direct, in compliance with both Federal and State regulations to meet the goals, objectives and priorities of the Department and the Division.
Provide oversight of the prescription drug and medical drug benefit offered by the managed care health plans
Provide direction and oversight to departmental and division staff and multi-disciplinary project teams, with the oversight of the managed care prescription drug and medical drug benefit for each of the managed care health plans
Identify clinical and financial initiatives and necessary modifications to current programs and processes intended to produce positive clinical and financial outcomes; trend and direct the implementation and operational oversight of these initiatives and modifications into the managed care pharmacy benefit design
Lead in the assessment of value-based pharmacy programs and alternative payment models to continually enhance the performance of associated clinical and financial performance metrics (e.g. medication adherence, pharmacy provider network access, PMPM, etc.).
Direct and oversee the development and ongoing process to maintain the NC Medicaid and NCHC Preferred Drug List (PDL).
Direct and support analysis of program initiatives including drug rebate programs for the pharmacy and medical drug benefit.
Develop and implement fee-for-service program components.
Authorize payment system controls to ensure services are properly reimbursed and ensure the Medicaid claims system reflects policy guidelines and appropriate change control requests are initiated, implemented and monitored.
Work with prepaid health plans' pharmacy benefit managers, external vendors, and stakeholders to align program goals and benefit execution.
Work on the pharmacy benefit design and requirements in any division or departmental procurements.
Monitor and evaluate progression of goals and objectives

Coordinate activities and external communications to ensure program compliance with Federal and State requirements.
Maintain liaison and good relations with State and Federal partners
Ensure program clinical coverage policies are developed and aligned with the requirements of State law and Federal regulations.
Oversee the coordination of all activities with State agencies; appropriate clinical/professional organizations; and various stakeholders.
Ensure program contracts reflect performance-based concepts and are appropriately administered

Salary Grade: GN22
Position #: 60042665
Salaries are determined based on education, experience, equity and budget

The North Carolina Medicaid and NC Health Choice programs (NC Medicaid), managed by the Division of Health Benefits (DHB), helps North Carolinians improve their health and well-being by providing access to services and supports for low-income parents, children, seniors, people with intellectual / developmental disabilities, behavioral health needs or substance use disorders. With a budget of more than $14 billion per fiscal year, Medicaid ensures that 69,000 enrolled providers are reimbursed for delivering covered services to more than two million beneficiaries.
On Sept. 23, 2015, the North Carolina General Assembly passed Session Law 2015-245, as amended, directing NCDHHS and DHB to lead the transformation of the Medicaid and NC Health Choice programs from a predominantly fee-for-service delivery system to managed care
Knowledge, Skills and Abilities / Competencies
To receive credit for all of your work history and credentials, you must list the information on the application form. Any information listed under the text

Qualified Applicants Must Document On The Application That They Possess All Of The Following

resume section or on an attachment will not be considered for qualifying credit.

Proven management skills to develop, implement, operate, evaluate and revise operations
Working knowledge of the pharmacy benefit management and various pharmacy providers, payment mechanisms, and regulations
Working knowledge and understanding of the principles and practices

of public, business, contract and financial management
Demonstrated ability to understand complex regulatory requirements and proposals
Proven ability to select, train and supervise employees
Demonstrated analytical skills for evaluating the coverage and effectiveness of policies and procedures
Proven ability to communicate and present effectively with key stakeholders
Proven ability to establish and maintain effective working relationships with various stakeholders
Demonstrated ability to exercise appropriate judgment in evaluating complex program and medical policy issues

Management prefers Candidate with MBA or Pharm D and 5 years of professional experience in Health Care Administration, including 2 years in management
Experience with Medicare/Medicaid

Must be able to obtain a pharmacy license in North Carolina (If not currently licensed to practice medicine in the State of North Carolina)

Minimum Education And Experience Requirements

Licensed to practice pharmacy in the State of North Carolina and two years of experience as a licensed Pharmacist.

Degrees must be from appropriately accredited colleges or universities.
Supplemental and Contact Information
The North Carolina Department of Health and Human Services is an Equal Opportunity Employer.

Pre-Employment criminal background checks are required for all positions with the Division of Health Benefits.

Due to the volume of applications received, we are unable to provide information regarding the status of your application over the phone. To check the status of your application, please log in to your account. You will either receive a call to schedule an interview or an email notifying you when the job has been filled.

For technical issues with your application, please call the NeoGov Help Line at click apply. Applicants will be communicated with via email only for updates on the status of their application. If there are any questions

about this posting other than your application status, please contact HR at click apply.

Seniority Level

Director

Industry

- Non-profit Organization Management
- Health, Wellness & Fitness
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Health Care Provider

RN Utilization Management Nurse - Medicaid - London Kentucky job in Wheatcroft at Humana

Source URL: https://lensa.com/rn-utilization-management-nurse-medicaid-london-kentucky-jobs/wheatcroft/jd/82a9450b05eacd780983db4fc976bb99?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

RN Utilization Management Nurse - Medicaid - London Kentucky job

Humana Wheatcroft, KY

Company Description

Humana Inc. is a for-profit American health insurance company based in Louisville, Kentucky. As of 2014 Humana has had over 13 million customers in the U.S.,not in citation given reported a 2013 revenue of US$41.3 billion, and has had 51,600 employees. In 2013, the company ranked 73 on the Fortune 500 list, which made it the highest ranked (by revenues) company based in Kentucky. It has been the third largest health insurance in the nation.The U.S. Dept. of Health and Human Services investigated Humana in 2009 for sending flyers to Medicare recipients that the AARP characterized as deceptive. The company's managed care model has also been criticized for ethical lapses and limitations.

Job Description

Description

The Utilization Management Nurse 2 utilizes clinical nursing skills to support the coordination, documentation and communication of medical services and/or benefit administration determinations for Humana’s Kentucky Medicaid Plan. The Utilization Management Nurse 2 work assignments are varied and frequently require interpretation and independent determination of the appropriate courses of action.

Responsibilities

The Utilization Management Nurse 2 uses clinical knowledge, communication skills, and independent critical thinking skills towards interpreting criteria, policies, and procedures to provide the best and most appropriate treatment, care or services for members. Coordinates and communicates with providers, members, or other parties to facilitate optimal care and treatment. Understands department, segment, and organizational strategy and operating objectives, including their linkages to related areas. Makes decisions regarding own work methods, occasionally in ambiguous situations, and requires minimal direction and receives guidance where needed. Follows established guidelines/procedures.

Required Qualifications

Licensed Registered Nurse (RN) in the state of Kentucky with

no disciplinary action and ability to hold licenses in multiple states without restriction.

2+ Progressive clinical experience preferably in an acute care, skilled or rehabilitation clinical setting

Strong Proficiency with MS Office Suite to include Word, Excel, Power Point,

2+ years Technical experience aptitude to troubleshoot and resolve system platform and connectivity problems

Experience with the development and implementation of policies and procedures

Ability to work independently under general instructions and with a team

Additional Requirements:

Hours: Typically an 8 hours shift Monday-Friday between 8:00 AM and 5:00 PM Central Time with rotating on-call coverage and oversight during weekends and holidays.

Primary Location: Louisville Kentucky Additional Locations: Covington, Lexington, Bowling Green, London, Pikeville

Travel: This role is an agile workstyle with a combination telephonic in an office and may anticipate visiting onsite facilities depending on the supported region. Travel may be required up to 3 days a week depending on location.

Transportation and Insurance Requirements: Valid driver’s license, car insurance, and access to an automobile. This role is a part of Humana’s Driver Safety program and therefore requires an individual to have a valid state driver’s license and proof of personal vehicle liability insurance with at least 100,000/300,000/100,000 limits.

Tuberculosis Screening: In the event that this role is requires facility visits or is patient facing within your region, you will be required to screen for TB as part of Humana's Tuberculosis (TB) screening program.

Work Style: This position is a combination office and remote/agile work based environment and will require the following:

- Must ensure absolute and continuous privacy while you

work within a home office or other remote location.
- Must have accessibility to hardwired high speed internet with minimum speeds of 10Mx1M for a home office (Wireless and Satellite are prohibited)

Preferred Qualifications

Bachelor's Degree

1+ year in-hospital Utilization Management experience

MCG experience

1+ year Care Management experience in an acute care, skilled or Rehabilitation clinical setting

Certified Case Manager, CCM

Health Plan experience

Medicaid experience

Call center or triage experience

Ability to work in multiple states without restriction

Bilingual is a plus - Language Proficiency Assessment will be performed to test fluency in reading, writing and speaking in both languages before placing on a dedicate line to service our members.

Additional Information:

Interview Format

As part of our hiring process for this opportunity, we will be using an exciting interviewing technology called Montage Voice to enhance our hiring and decision-making ability. Montage Voice allows us to quickly connect and gain valuable information from you pertaining to your relevant skills and experience at a time that is best for your schedule.

If you are selected for a first round interview, you will receive an email correspondence (please be sure to check your spam or junk folders often to ensure communication isn’t missed) inviting you to participate in a Montage Voice interview. In this interview, you will listen to a set of interview questions over your phone and you will provide recorded responses to each question. You should anticipate this interview to take

about 15 to 30 minutes. Your recorded interview will be reviewed and you will subsequently be informed if you will be moving forward to next round of interviews.

Scheduled Weekly Hours

40

About Us

Mission: At Humana, our cultural foundation is aligned to helping members achieve their best health by delivering personalized, simplified, whole-person healthcare experiences. Recognizing healthcare needs continue to evolve for each person, for each family and for each community, Humana continuously creates innovative solutions and resources that help people live their healthiest lives on their terms –when and where they need it. Our employees are at the heart of making this happen and that's why we are dedicated to building an organization of dynamic talent whose experience and passion center on putting the customer first.

Equal Opportunity Employer

It is our policy to recruit, hire, train, and promote people without regard to race, color, religion, sex, national origin, age, sexual orientation, gender identity or expression, disability, or veteran status, except where age, sex, or physical status is a bona fide occupational qualification. View the EEO is the Law poster.

If you are an individual with a disability and require a reasonable accommodation to complete any part of the application process, or are limited in the ability or unable to access or use this online application process and need an alternative method for applying, you may contact mailbox*tas*recruit@humana.com for assistance.

Humana Safety and Security

Humana will never ask, nor require a candidate provide money for work equipment and network access during the application process. If you become aware of any instances where you as a candidate are asked to provide information and do not believe it is a legitimate request from Humana or affiliate, please contact mailbox*tas*recruit@humana.com to validate the request.

Reg. Nurse, Vice President, Medical Management - Medicaid Division Job in Little Rock, AR at Zentech Consulting

Reg. Nurse, Vice President, Medical Management - Medicaid Division

Zentech Consulting- S Little Rock, AR

Posted: 21 hours ago
$140,000 to $165,000 Annually
Full-Time
Benefits: Vision, Medical, 401k, Dental
Job description

Position Purpose: Perform duties to direct and coordinate the medical management, quality improvement and credentialing functions for the assigned health plan based on, and in support of the company's strategic plan; establishing the strategic vision and attendant policies and procedures.

- Direct and coordinate activities of department and aid the chief officer of the health plan and appropriate corporate staff in formulating and administering organizational and departmental policies.
- Review analyses of activities, costs, operations and forecast data to determine department progress toward stated goals and objectives.
- Serve as a member of management committees on special studies.
- Administer and ensure compliance with National Committee on Quality Assurance (NCQA) and/or Joint Commission on Accreditation of Healthcare Organization (JACHO) standards as determined for accreditation of the health plan.
- Participate in, attend and plan/coordinate staff, departmental,

committee, sub-committee, community, State and other activities, meetings and seminars.
- Participate in provider education and contracting, as necessary.

Qualifications:

Education/Experience:

- Bachelor's degree in Nursing, related field or equivalent experience.
- 10+ years of clinical nursing, quality improvement, and management experience in a managed care setting.
- Thorough knowledge of a specialized or technical field such as clinical nursing, managed care, and healthcare administration
- Thorough skills knowledge of quality improvement practices.
- Working knowledge of medical information systems, medical claims payment process, medical terminology and coding, case management practices, managed care, and Medicaid programs.
- Familiarity of National Committee on Quality Assurance (NCQA) accreditation process and standards.
- Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff.

License/Certification: Current state nursing license.

This position will oversee our Medicaid division and be based in our Little Rock, AR office full-time. Remote/Telecommute is not available.

Employee Status:

Regular

Job Level:

Field VP

Job Type:

Regular

Nurse Medical Management I - Medicaid HCMS in Cordova,

Tennessee, United States

Source URL: https://antheminc.jobs/cordova-tn/nurse-medical-management-i-medicaid-hcms/afcc92cf9e954350aeb92693424a3466/job/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Anthem Nurse Medical Management I - Medicaid HCMS in Cordova, Tennessee

Nurse Medical Management I - Medicaid HCMS

Location:United States

Requisition #: PS29019

Post Date: Oct 21, 2019

Your Talent. Our Vision. **At Amerigroup** , a proud member of the Anthem, Inc. family of companies focused on serving Medicaid, Medicare and uninsured individuals, it's a powerful combination. It's the foundation upon which we're creating greater access to care for our members, greater value for our customers and greater health for our communities. Join us and together we will **drive the future of health care** .

This is an exceptional opportunity to do innovative work that means more to you and those we serve.

The Nurse, Medical Management is responsible for collaborating with external and internal healthcare providers to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources in the in-patient setting.

Primary duties may include, but are not limited to:

- Ensures medically appropriate, high quality, cost effective care through assessing the medical necessity of inpatient admissions, elective surgicalprocedures, and out of network services by evaluating the appropriateness of the treatment setting by utilizing the applicable medical policy and industry standards, accurately interpreting benefits and managed care products, and steering members to the appropriate providers and level of care, as well asprograms or community resources needed at discharge.Applies clinical knowledge to work with facilities and providers for care

coordination.

- Works with medical directors in interpreting appropriateness of care and accurate claims payment.
- Conducts **the review of initial & concurrent authorization requests; retro reviews; elective procedures/in-patient stay reviews; coordination of care and discharge planning in collaboration with the acute carefacility Case Management staff, as well as the internal Home Health & Sub-Acute Teams.**
- Ensures member access to medical necessary, quality healthcare in a cost effective setting according to contract.
- Routes and/or pends cases requiring second level review to the Health Plan Medical Directorto ensure medically appropriate, high quality, cost effective care throughout the medical management process.
- **Communicates determinations to acute care facility and c** ollaborates with providers to assess members' needs for early identification of and proactive planning for discharge.
- Facilitates member care transition through the healthcare continuum and refers treatment plans/plan of care to clinical reviewers as required and does not issue non-certifications.
- Facilitates accreditation by knowing, understanding, correctly interpreting, and accurately applying accrediting and regulatory requirements and standards.
- **Supports local and corporate cost of care initiatives.**

Qualifications

- Requires 2 years of acute care clinical experience; or any combination of education and experience, which would provide an equivalent background.
- Current unrestricted RN license in Tennessee is required. AS/BS in nursing preferred.
- Prior Utilization Management, Case Management or managed care experience preferred

EOE.M/F/Disability/Veteran

Apply Now

Operations Support Specialist at WellCare

Operations Support Specialist at WellCare

Serves as a department SME for a wide range of tasks and special functions to include vendor support, training, quality reviews, new business implementations, reporting analytics, process improvement, etc.

Reports To: Manager, Operations

Department: Acquisition Related Aetna

Location: Tampa , FL

Level: 15

Essential Functions:

- Serves as liaison between department and business partners, both internal and external.
- Plan, manage, monitor, perform UAT and complete key improvement projects in an accurate and timely manner.
- Identifies, evaluates, recommends and implements data-driven process improvement initiatives.
- Provide support on tasks and special functions such as vendor oversight, contracting, inventory monitoring, reporting, new business implementations, quality reviews, root cause analysis, training, operational processes, etc.
- Maintains/ Creates resources applicable to assigned area, such as timely updates to training, announcements, step actions, reference call tools, FAQs etc.
- Represents team in cross functional environment and collaborates with leadership to implement new processes.
- Partners with WellCare vendors supporting operations. Supports and assists all LOB's with specific focus on Health Services, Pharmacy, Medicaid, Exchanges, Medicare and PDP, etc.
- Investigates problems of a moderately complex nature and provide findings, impact, remediation and preventative actions in a clear and concise manner.
- Analyzes data and reports to identify trends, operational issues, financial impact of implemented initiatives, etc. May need to run existing SQL queries to generate data into Excel to conduct research

and analysis.
- Other duties as assigned.

Candidate Education:

- Required A High School or GED
- Preferred A Bachelor's Degree in a related field

Candidate Experience:

- Required 3 years of experience in a related field based on assigned area
- Preferred Other Previous experience in a customer service environment and health insurance

Candidate Skills:

- Intermediate Demonstrated analytical skills
- Intermediate Demonstrated written communication skills
- Intermediate Demonstrated interpersonal/verbal communication skills
- Beginner Ability to communicate and make recommendations to upper management
- Intermediate Other Strong understanding of managed care and its place in the health care industry
- Intermediate Other Understanding of interdependencies on other business units such as Health Services, Provider Relations, Sales, Vendors, Claims
- Beginner Other Demonstrate ability to implement process improvements

Licenses and Certifications:

A license in one of the following is required:

Technical Skills:

- Required Intermediate Microsoft Outlook
- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft Word
- Preferred Intermediate Microsoft PowerPoint
- Preferred Intermediate Microsoft Visio
- Preferred Intermediate Xcelys

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.

Apply

Adult Medicaid Trainer - Human Services Program Specialist | Wake County

Source URL: https://www.linkedin.com/jobs/view/adult-medicaid-trainer-human-services-program-specialist-at-wake-county-1592957845/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Human Services Program Specialist

What You'll Be Doing

The purpose of the Adult Medicaid Trainer - Human Services Program Specialist is to design, develop and provide training to new hires and seasoned staff within Economic Services (ES). This position's primary focus is Adult Medicaid (AMA) with other program focus based on departmental need. The Staff Trainer reports directly to the Program and Staff Development (PSD) Supervisor. The goal of the Staff Trainer and PSD is to create a "High Performing Work Team." We are currently seeking a Human Services professional to become part of this team.

Essential functions;

- Ensure that consistent, high quality training curriculum is developed and implemented
- Participate in the analysis, design, development, and facilitation of training efforts and integrates best practices
- Focus on assigned FNS, Medicaid, Child Care Subsidy, or Work First training programs that will increase the performance of individuals and various departments/units served
- Develop and implement organizational development services
- Coordinate programming for professional development
- Evaluate and report on program effectiveness

NOTE: Wake County Human Services employees are required to be in their current role for a minimum of one (1) year to be eligible to apply for another Human Services position. Upon acceptance of employment you acknowledge that (i) you will rescind your application for any other positions within Wake County Human Services, (ii) after accepting your position with Wake County Human Services you must remain in your role for one (1) year before you are eligible to apply for another position within Wake County Human Services, (iii) if you work in the Health Clinics and Public Health Division, influenza immunization is a condition of initial and continued employment, subject to compliance with federal law, (iv) actively supports and participates in department emergency preparedness and response activities, which may include temporary changes in responsibilities and working hours.

About Our Team

Wake County Human Services is the consolidation of programs and services that include social services, public health, job search assistance, child support, and transportation. Our mission is, in partnership with the community, will facilitate full access to high quality and effective health and human services for Wake County residents. In addition to our numerous standard programs, Wake County Human Services (WCHS) is engaged in a number of Special Initiatives that are impacting services and programs throughout our entire agency. Whether legislated down from the changing regulations on the Federal or State level or bubbling up from the entrepreneurial spirit of our staff, you can always look forward to Wake County Human Services implementing new and exciting enhancements to our services and programs.

The Basics (Required Education And Experience)

Bachelor's degree in Human Services, Health or related field and three years of experience related to the area of employment. A valid driver's license and a "safe" driving record may be required. Equivalent education and experience combination accepted.

Beyond The Basics (Preferred Education And Experience)

- Two years or more of current experience providing case management and income eligibility determination in a State or County Economic Services program unit, such as, Adult Medicaid, which encompasses CAP, SA, LTC and PLA
- Experience in providing program policy training within a North Carolina State or County Economic Services programs
- Experience working with NCFAST and Onbase
- Experience with designing online training and videos

How Will We Know You're 'The One'?

- Knowledge of North Carolina and Federal Economic Benefit policies for Adult Medicaid Programs
- Well versed in Adult Learning principles
- Ability to facilitate training classes and make learning fun and engaging
- Advanced working knowledge of NCFAST including ability to navigate and troubleshoot user errors
- Demonstrates confidence, a self-starter, being proactive and taking initiative to get the job done
- Open communication style and promotes accountability for ensuring that the transfer of learning occurs
- Excellent interpersonal skills; creates a climate that will foster effectiveness, while training
- Ability to develop and maintain effective relationships with others in order to encourage and support communication and teamwork
- Ability to create training material using a variety of tools
- Ability to be flexible
- Results driven attitude with experience operating in a fast-paced outcome-oriented environment
- Excellent written and verbal communication skills including ability to plan and deliver effective presentations and training information

About This Position

Location: Human Services Center Swinburne 220 Swinburne Street, Raleigh, NC 27680

Employment Type: Regular

Work Schedule: Mon - Fri 8:00 am - 5:00 pm

Hiring Range: $21.00 - $23.00

Posting Closing Date: 7:00 pm on 11/13/2019

What Makes Wake Great

Home to the State Capital, Wake County is one of the fastest growing areas in the nation and the second-most populous county in the state, with approximately 1,000,000 residents. The County has received national and international rankings and accolades from publications such as Money, Fortune, and Time magazines as being one of the best places to live, work and play. The central location of the County allows for a short drive to the spectacular mountains or coast. Wake County Government is governed by a seven-member Board of Commissioners, who are elected at-large to serve four-year terms. Wake County Government has a general operating budget of $1.3 billion, employs approximately 4,200 employees, experiences minimal turnover, and is an award-winning leader in wellness and technology initiatives; such as offering employees and covered spouses free access to the Employee Health Center. Wake County Government offers a wide range of training and development opportunities, a stable career in public service with a balance of work and family life, flexible work schedules and a competitive salary and benefits package.

Our company provides equal employment opportunities (EEO) to all employees and applicants for employment without regard to race, color, religion, sex, national origin, age, disability or genetics.

Position may require a background check that may include: criminal, credit, motor vehicle, education, and sexual offender registry or others based on job requirements. Unless required by state law, a record of conviction will not automatically exclude you from consideration for employment. Wake County Government is an Equal Opportunity Employer.

President Medicaid Health Plan - FL PS30076 in Plantation, Florida, United States

Anthem, Inc President Medicaid Health Plan - FL PS30076 in Plantation, Florida

President Medicaid Health Plan - FL PS30076

Location:Florida, United States

New

Requisition #: PS30076

Post Date: 5 hours ago

The President Medicaid Health Plan will have primary responsibility for the fiscal, operational, legislative, regulatory, and human resources objectives/agenda for assigned Medicaid health plan, part of the Medicaid Business Unit of Anthem, Inc.'s Government Business Division (GBD). This position is responsible for aligning strategy to achieve business goals and build a culture of accountability with people who are results driven, innovative and committed to excellence. This translates to the following specific responsibilities:

Leadership – Must have experience and demonstrate the ability to perform successfully as a leader of: other leaders, teams and cross-functional groups. A successful incumbent will build the depth and operating environment that can achieve annual operating goals and support long-term growth for our business and our associates. Building strong, deep and highly functioning teams is a requirement.
Achieve Annual Operating and business objectives – Leader must be adept at managing P&L to include revenue, cost management, SG&A and forward-looking product growth opportunities. Plan leader should have actively led or participated in Cost Management, budget building and forecasting and successful premium rate management and renewals. Annual goals focus around:
a. Operating Gain

b. Growth

c. Cost of Care commitments

d. Revenue

e. Meeting or exceeding Quality and accreditation goals

Experience and deep understanding of health plan operations to include:

a.Health Services and Quality– Oversight and participation in medical management, including hospital census review, medical staffing, seasonality issues, detailed communications with the medical director and nurse leader and monthly accrual analysis. The incumbent should also have experience with Medicaid and/or CMS quality program management and Accreditation process. This should include a working knowledge of Population Health programs that are common to Managed Medicaid.

b.Product growth/Sales and Community Outreach– Oversight and participation in the development of growth strategies and retention initiatives for health plan. Oversee marketing and product growth strategies, business initiatives, school-based, faith-based, community-based and special needs initiatives. Experience in Complex Population administration, working with stakeholders and new program implementation and growth which may include one or more of the following:

I. LTSS – Long-term Services and Supports

II. BH – Program integration across populations and execution as part of overall plan operation.

III. FHK- Florida Healthy Kids Program

IV. Other complex populations as may apply

c.Provider Collaboration, Contracting and Service– Oversight and/or direct participation in relationships with key hospital, large physician practices/clinic and key ancillary providers such as dental and vision contractual relationships. Drive provider collaboration and engagement in the areas of service and Payment Innovation. Expect the incumbent would have that requisite network experience.

d.Plan Operations– Successful health plans have maintain a strong operating team with an ability to establish operating process, remediate service issues, implement new programs and support all areas of a health plan to accomplish established business goals. This includes: interfacing with Regional Operations Team, National Service Centers and Shared service operations.

Strategic planning/competency – Leader must be adept at the development of the health plan's business plan, quarterly reviews, and Business Operating Reviews and course corrections. Oversee resulting health plan budgeting and financials, including management of expenses, financial reports delivered to the State, capital budget planning and management. Incumbent must also possess strong strategic thinking and problem solving skills.
Manage Customer and Regulatory Objectives – The successful incumbent will have a proven track record of developing and managing key State regulatory and legislative relationships and processes, including premium rates, covered populations, eligibility, benefit design, networks, administrative requirements, and new products.
a. Ensure plan maintains "preferred" position for our State customer – Responsible for establishing and leading an environment with the plan and senior leadership team that continually and effectively seeks to engage the state at multiple levels to meet and exceed service and performance goals while also driving innovation and trust.

b. Collaborate with GR (Government Relations) to achieve goals – Work in matrix model with GR officers to offer thought leadership in the political and legislative processes, and direction relative to contract negotiations with the state. Also aspire to create solutions for our state customers that achieve state and plan objectives that may also include new policy and product solutions.

c. Provide leadership to drive optimal consumer experiences – Work in matrix model with regional leaders and shared services partners to address and resolve claims, provider data, customer service needs and enhancements to meet and/or exceed customer service metrics. Also aspire to create solutions for our state customers that achieve state and plan objectives.

Successfully support and operate within the broader organization's Business model –Incumbent is required to work successfully in a matrix model business environment to include:
a. Work successfully across all lines of business – Market requires collaboration and teamwork with other GBD lines of business.

b. Work across matrix "shared service" business model – This includes Finance, Quality, Operations, Marketing, Health Care Management, HR, IT, Finance, Actuarial, Underwriting, Legal, compliance, Shared Services and National Service Centers.

c. Leverage Anthem Foundation – Strategic understanding of common interests among key constituents.

d. Successful internal and external communications – Liaison with

corporate teams and external communications with the State, providers, members, community groups and the media.

Compliance and Risk Management – Ensure contract and HIPAA compliance, including securing and coordinating resources necessary for such compliance. Certify monthly and quarterly financial statements, encounter reporting, quality audits, HEDIS/EPSDT and other required regulatory reports. Oversight of risk management program, including fraud and abuse program compliance, and reporting responsibilities. Identify threats to financial assets, reputation, human resources and actively teach risk management to health plan leadership.

Promote Anthem mission and culture – Demonstrated success in building and leading successful teams with a culture that is committed to execution, collaboration, communication and a positive growth and learning environment for our associates. The application of regular coaching, timely performance management and active mentoring. Assess and develop bench strength and retain talent in accordance with Plan-level retention and development goals. Ensure Sarbanes-Oxley (SOX) compliance and meet other key manager goals and responsibilities as defined by annual Major Job Objectives (MJO).

KEY RESPONSIBILITIES

1.Build the depth and operating environment that can achieve annual operating goals and support long-term growth for our business and our associates. Keen attention to development of strong, deep and highly functioning teams is a requirement.

2.Achieve annual operating and business objectives through adept P&L management to include revenue, cost management, SG&A and forward-looking product growth opportunities.

3.Oversight and participation in medical management, including hospital census review, medical staffing, seasonality issues, detailed communications with the medical director and nurse leader and monthly accrual analysis.

4.Oversight and participation in the development of growth strategies and retention initiatives for health plan. Oversee marketing and product growth strategies, business initiatives, school-based, faith-based, community-based and special needs initiatives.

5.Oversight and/or direct participation in relationships with key hospital, large physician practices/clinic and key ancillary providers such as dental and vision contractual relationships.

6.Drive provider collaboration and engagement in the areas of service

and Payment Innovation.

7.Maintain oversight of a strong operating team with an ability to establish operating process, remediate service issues, implement new programs and support all areas of a health plan to accomplish established business goals, to include interfacing with national service centers and shared service operations.

8.Navigate seismic growth in the state-sponsored business environment and ongoing state fiscal pressures that pose significant challenges to our existing infrastructure to meet demand for revenue capture opportunities with a potential top line business. This includes, dynamic provider environment with rapid consolidation of providers, threats to our unit cost position and access to services for our members, and competitive threats to our business model by emerging provider delivery models.

9.Evaluate changing market conditions and determine necessary changes to our value proposition to meet state needs/requirements, including understanding new financial, business relationship models and contractual agreements required, and evolving our business strategy and capabilities. Develop existing talent to meet changing market conditions and recruit new talent as required.

10.Convince Regional President of required strategic direction to meet health plan goals, including potential investments required. Convince enterprise program leadership to adopt product solution strategies that are beneficial to the plan.

- Bachelor’s degree inrelevant area of study; Master’s degree preferred.
- Experiencehavingled or participated in cost management, budget building and forecasting andsuccessful premium rate management and renewals. Annual goals focus around:
- Operating Gain
- Growth
- Cost of Carecommitments
- Revenue
- Meeting or exceedingQuality and accreditation
- Experience in Complex Populationadministration, working with stakeholders and new program implementation.
- Significant network experience (10 plusyears)
- A minimum of 15years’ work related experience within the government healthcare programs sectorwith a minimum of 8 years of experience in government-sponsored healthinsurance programs.
- Proven success in influencing executives and managers. Display personal agility to work across awide array of businesses and stakeholders to develop the credibility to achieveresults.