Medicaid Industry Jobs Hunter 12/02/19

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Medicaid Jobs Hunter

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Anthem Nurse Case Manager I Medicaid (OB experience) - PS Job in Long Beach, CA

Nurse Case Manager I Medicaid (OB experience) - PS

Nurse Case Manager I Medicaid (OB experience) - PS28756

- *Location:** **United States**
- *Requisition #:** PS28756
- *Post Date:** Oct 31, 2019

Your Talent. Our Vision. **At Anthem, Inc.,** its a powerful combination, and the foundation
upon which were creating greater 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.
The **Nurse CaseManager I** is responsible for performing care management within the
scope of licensure for Tennessee Medicaid OB members with complex and
chronic care needs by assessing, developing, implementing, coordinating,
monitoring, and evaluating care plans designed to optimize member health care

across the care continuum. Performs duties telephonically and on-site such as
at hospitals for discharge planning. Primary duties may include, but are not
limited to:
+ Ensures member access to servicesappropriate to their health needs.
+ Conducts assessments toidentify individual needs and a specific care management plan to addressobjectives and goals as identified during assessment.
+ Conducts face-to-face visits with members (field based)
+ Coordinates internal andexternal resources to meet identified needs.
+ Monitors and evaluateseffectiveness of the care management plan and modifies as necessary.
+ Interfaces with MedicalDirectors and Physician Advisors on the development of care managementtreatment plans.
+ Performs High Risk OB assessments to determine level of care needed.
Requires:
+ BA/BS in a health related field;3 years of clinical experience; or any combination of education andexperience, which would provide an equivalent background.
+ Current, unrestricted RNlicense in the state of Tennessee required.
+ Certification as a Case Manageris preferred.
+ 50 - 75% travel required for face-to-face visits with members.
+ Experience in OB required.
Please note: this position must be located within 2 hours of driving distance to Knoxville, TN

- *_Anthem, Inc. is rankedas one of Americas Most Admired Companies among health insurers by Fortunemagazine and is a 2017 DiversityInc magazine Top 50 Company for Diversity. Tolearn more about our company and apply, please visit us atantheminc.com/careers. EOE. M/F/Disability/Veteran._**

CSVCG Director of Ambulatory Services | America's Health Insurance Plans (AHIP)

Source URL: https://www.linkedin.com/jobs/view/csvcg-director-of-ambulatory-services-at-america-s-health-insurance-plans-ahip-1632492240/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

CSVCG Director of Ambulatory Services

America's Health Insurance Plans (AHIP) Santa Fe, NM, US

The Director of Ambulatory Services is responsible for the overall operations, performance and success of the assigned practices / clinics. Working with the Physician Leads for CSVCG assigned practices as part of the leadership dyad oversees and manages the business and clinical operations. Works closely with Administrative leadership to develop, implement, and maintain programs that enhance quality of care and

achieve a high level of patient and clinician satisfaction as well as meeting budgeted financial performance. The position will also support and implement delegated responsibilities as assigned by the CSVCG Chief Operating Officer. Requirements MINIMUM QUALIFICATIONS: EDUCATION: Bachelors degree in health services, business administration or related field required. Masters highly preferred. Three or more years of healthcare/clinic management or related field can substitute degree. CERTIFICATION/LICENSES: Certified Medical Office Manager (CMOM) preferred. (if not presently certified will be required to become certified in first 12 months) SKILLS: Able to proceed on own initiative using independent judgement and discretion. Possess excellent verbal and written communication skills, leadership and organizational skills, and interpersonal and time management skills. Possess knowledge of budgets and budget process including mathematical and accounting skills, able to make sound financial decisions, and able to use a calculator. Knowledgeable of CPT/ICD-10 coding procedures and be familiar with Medicaid, Medicare, and commercial insurance billing procedures. Is familiar with the policies and procedures of the CHRISTUS St. Vincent Regional Medical Center and CHRISTUS St. Vincent Medical Group. In order to prepare publications, reports, and business correspondence, must possess working knowledge of common computer technology, including word processing, spreadsheet, database, and graphics software. Knowledgeable of office management and administrative procedures. Ability to develop and maintain strong working relationships with physicians, advanced practice clinicians, and leadership. Must be familiar with a variety of the concepts, practices, and procedures within the service line. Relies on experience and judgement to plan and accomplish goals, lead and direct the work of others, and perform a wide variety of tasks. A wide degree of creativity, latitude and autonomy is expected. EXPERIENCE: Five or more years of management

experience in clinics, hospitals, or related area. Additional appropriate education (e.g., MBA, MHA, MS) may substitute for three years of management experience.

Seniority Level

Director

Industry

- Non-profit Organization Management
- Insurance
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Management
- Manufacturing

Medicaid West Virginia Care Management Associate - Western in Charleston, West Virginia

Source URL: https://jobs.dailynurse.com/job/medicaid-west-virginia-care-management-associate-western-region/52000896/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid West Virginia Care Management Associate - Western Region

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Description:
Support comprehensive coordination of medical services including Care Team intake, screening and supporting the implementation of care plans to promote effective utilization of healthcare services. Promotes/supports quality effectiveness of Healthcare Services. Supports a telephone queue for member welcome calls, as assigned.

Fundamental Components:

- Responsible for initial review and triage of Care Team tasks.
- Identifies principle reason for admission, facility, and member product to correctly apply intervention assessment tools.
- Screens patients using targeted intervention business rules and processes to identify needed medical services, make appropriate referrals to medical services staff and coordinate the required services in accordance with the benefit plan.

- Monitors non-targeted cases for entry of appropriate discharge date and disposition.
- Identifies and refers outlier cases (e.g., Length of Stay) to clinical staff.
- Identifies triggers for referral into Aetna's Case Management, Disease Management, Mixed Services, and other Specialty Programs.
- Utilizes Aetna systems to build, research and enter member information, as needed.
- Support the Development and Implementation of Care Plans.
- Coordinates and arranges for health care service delivery under the direction of nurse or medical director in the most appropriate setting at the most appropriate expense by identifying opportunities for the patient to utilize participating providers and services.
- Promotes communication, both internally and externally to enhance effectiveness of medical management services (e.g. health care providers, and health care team members respectively).
- Performs non-medical research pertinent to the establishment, maintenance and closure of open cases.
- Provides support services to team members by answering telephone calls, taking messages, researching information and assisting in solving problems.
- Adheres to Compliance with Project Management Policies and Regulatory Standards.
- Maintains accurate and complete documentation of required information that meets risk management, regulatory, and accreditation requirements.
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.
- May assist in the research and resolution of claims payment issues.
- Supports the administration of the hospital care, case management and quality management processes in compliance with various laws

and regulations, URAQ and/or NCQA standards, Case Management Society of America (CMSA) standards where applicable, while adhering to company policy and procedures.
- Supports a telephone queue for member welcome calls, as assigned.

Background Experience:
- 2-4 years' experience as a medical assistant, office assistant.
- Familiarity with medical terminology. Managed care experience is preferred.
- Familiarity with Medicaid is desired.
- The highest level of education desired for candidates in this position is a High School diploma, G.E.D. or equivalent experience.

Additional Job Information:
* Exceptional customer service skills to coordinate service delivery including attention to customers, sensitivity to issues, proactive identification and resolution of issues to promote positive outcomes for members.
* Proficiency with personal computer is required. Demonstrated ability to navigate through internal/external computer applications/systems and use of keyboard and mouse. Proficient with MS Office suite applications, i.e., Word, Excel, Outlook, and SharePoint.
* Ability to effectively participate in a multi-disciplinary team including internal and external participants.* Familiarity with basic medical terminology and concepts used in care management.* Effective communication, telephonic and organization skills. Are you ready to join a company that is changing the face of health care across the nation? Aetna Better Health of West Virginia 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 our members. Our vision incorporates community-based health care that

works. We value diversity. Align your career goals with Aetna Better Health of West Virginia, and we will support you all the way.

Required Skills:
Benefits Management - Interacting with Medical Professionals, Service - Creating a Differentiated Service Experience, Technology - Leveraging Technology

Desired Skills:
General Business - Communicating for Impact, General Business - Maximizing Work Practices, Leadership - Fostering a Global Perspective

Functional Skills:
Administration / Operation - Data Entry, Administration / Operation - Document production & distribution, Administration / Operation - File Maintenance, Clinical / Medical - Direct patient care (hospital, private practice), Medical Management - Medical Management - Direct patient care

Technology Experience:
Desktop Tool - Microsoft Outlook, Desktop Tool - Microsoft SharePoint, Desktop Tool - Microsoft Word, Desktop Tool - TE Microsoft Excel

Potential Telework Position:
No

Percent of Travel Required:
0 - 10%

EEO Statement:
Aetna is an Equal Opportunity, Affirmative Action Employer

Benefit Eligibility:
Benefit eligibility may vary by position. Click here to review the benefits associated with this position.

Candidate Privacy Information:
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.

Supervisory Health Insurance Specialist | Centers for Medicare & Medicaid Services

Source URL: https://www.linkedin.com/jobs/view/supervisory-health-insurance-specialist-at-centers-for-medicare-medicaid-services-1598161602/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Supervisory Health Insurance Specialist

Centers for Medicare & Medicaid Services | Baltimore County, Maryland, United States

In this role, you will serve as the **Director of Division of Managed Care Plans** (DMCP)., and you will be responsible for planning and coordinating the functions related to developing, interpreting, implementing, evaluating, and reviewing Medicaid managed care programs and policies, as well as overseeing the staff.

Responsibilities:

- Leading staff and serving as a role model for leadership, including coaching, mentoring, providing ongoing feedback, providing formal and informal learning opportunities; , as well as addressing staffing issues/problems when they arise.
- Helping to lead the development, monitoring, enforcement, and

the evaluation regulations, policies, procedures, State Plan Amendments and other guidelines for States in the design and implementation of their Medicaid Managed Care programs.

- Leading and directing projects to analyze key Medicaid policy issues to support legislative, regulatory, policy, and/or operational initiatives.
- Participating and negotiating with high-ranking State and Federal officials on issues related to division work; Initiating and developing ongoing productive working relationships with relevant entities.
- Facilitating, managing and building relationships with all internal and external Stakeholder groups including States, drug manufacturers, pharmacists, other federal agencies and senior policy makers, developing regulations.

For more information regarding this exciting opportunity, click the "apply" button. Please be sure to submit your complete application package **no later than 11:59 pm on 12/17!!**

Health Plan Prior Authorization Coordinator - Government Programs

Source URL: https://www.linkedin.com/jobs/view/health-plan-prior-authorization-coordinator-government-programs-at-vprecruiter-1631974361/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Health Plan Prior Authorization Coordinator

Job Details

Let's do great things, together

Founded in Oregon in 1955, Moda is proud to be a company of real people committed to quality. Today, like then, we're focused on building a better future for healthcare. That starts by offering outstanding coverage to our members, compassionate support to our community and comprehensive benefits to our employees. It keeps going by connecting with neighbors to create healthy spaces and places, together.

Moda Health is seeking a Government Prior Authorization Coordinator. This position provides administrative support to the OHP Medical Management Team to include investigating and researching OHP OAR's and DMAP Guidelines regarding permitted codes and member disenrollment.

Primary Functions

- Researches Medicaid OAR's and DMAP Guidelines regarding DME and permitted codes.
- Reviews Medicaid ER claims to determine payment level and appropriate use of the ER (payment of billed charges vs assessment

fee). Perform a complete review of the ER claim and ensure communication with claims department regarding payment level.

- Reviews Medicaid and Medicare related referral and authorization requests routed to Healthcare Services to determine if Government CSS is able to complete them or if they require further review by the Government RN.
- Determines the requirement for referral or pre-authorization based on the plan type, ICD-9 code, CPT/HCPC code or place of service.
- Provides education to members and providers regarding appropriate use of ER as well as appropriate alternative levels of care.
- Reviews Medicaid cases for potential disenrollment.
- Trains Medical Review Specialists to complete Medicaid DME authorizations.
- Coordinates with providers to ensure consideration is given to unique treatment needs.
- Assists providers with coordination of capitated services and discharge planning.
- Utilizes appropriate community and social service resources as liaison to medical services.
- May be required to attend training, Regional Medicaid and Medicare meetings and case conferences involving aged, blind and disabled Medicaid members within the Moda service area.
- Works closely with patients, families and providers, usually by telephone.
- Consults the Medical Director on complex cases.
- Responsible for daily administrative functions of the Medicaid/Medicare team in Healthcare Services, ensuring deadlines are met to serve the needs of the nurses, members and providers as well as facilitates the timely processing of documentation submitted to the Medical Management department.
- Utilizes the Moda core systems for documentation of contact with

providers and Medicaid/Medicare members.

- Communicates effectively with Medical Management support staff.
- Communicates with the DMAP RN Hotline for non-code pairing to determine funding.
- Reviews the daily Medicaid/Medicare BO report and processes as appropriate.
- Effectively uses the Moda core systems to accurately determine eligibility, benefit plan, physician networks associated with the member plan.
- Reviews emergent admission requests pended by Medical Intake; contact providers to obtain appropriate ICD-9 code if one is not provided at time of request.
- Provides back up to Medical Intake department to process OHP faxed requests.
- Effectively uses the Moda core systems to accurately determine eligibility, benefit plan, physician networks associated with the member plan.
- Utilizes the contracts available within Moda whenever possible.
- Documents cost savings opportunities where appropriate.
- Writes accurate, readable narrative reports.
- Develops professional relationships with other Moda departments. Coordinates with Customer Service for complete and accurate benefit determination.
- Identifies and utilizes community resources as part of the ER review function.
- Provides approvals and denials of claims in a professional, positive manner.
- Identifies problems and researches alternative solutions.
- Contributes to the department as a team player.
- Performs other duties as assigned.

Are you ready to be a betterist?

If you’re ready to make a difference that matters, we want to hear from you. Because it’s time to discover what’s possible.

Together, we can be more. We can be better.

Moda Health seeks to allow equal employment opportunities for all qualified persons without regard to race, religion, color, age, sex, sexual orientation, national origin, marital status, disability, veteran status or any other status protected by law.

Major Purpose

This position will provide support to the Medical Management team by assisting in the investigation and research of prior authorization requests. Completes reviews or support the clinical staff in the review processes by preparing or completing the requests as assigned.

- High school education or equivalent.
- 2 - 4 years of experience in a medical office and/or insurance experience needed.
- Proficient in Microsoft Office applications.
- Type a minimum of 35 wpm and 10 key proficiency of 135 spm on computer number keypad.
- Excellent written, verbal and interpersonal communication skills including demonstrated business writing and grammar skills.
- Excellent organizational and detail orientation skills.
- Must present a professional business image in all settings.
- Ability to work well under pressure, work with frequent

interruptions and shifting priorities.
- Ability to come to work on time and on a daily basis.
- Ability to work independently, as well as part of a team, dealing with all levels of staff, members, providers, in a professional manner.
- Ability to maintain confidentiality.
- High level of understanding of medical terminology and coding, state and federal regulations for claims adjudication and provider contracting
- PC literacy
- Knowledge of Health Plan benefits.
- Ability to interpret complex benefit packages and contract language
- Strong problem solving skills and decision quality preferred
- Familiar with CMS (Medicare/Medicaid) rules and regulations.

Duties and Responsibilities

- Review and research referral and authorization requests received in Healthcare Services. Process or route per appropriate guideline.
- Determines the requirement for prior authorization based on the plan type, ICD-10 code, CPT/HCPC code or place of service.
- Provides education to members and providers regarding prior authorization process.
- Interacts with providers and provider offices to gather complete, accurate information in order to process prior authorizations and referrals and coordinates with providers to ensure consideration is given to unique treatment.
- Consults the RN, Manager or Supervisor on complex cases.
- Responsible for daily administrative functions of the clinical team in Healthcare Services, ensuring deadlines are met to support required processes of the clinical team, members and providers as well as facilitates the timely processing of documentation submitted to the Medical Management department.

- Utilizes the Moda Health core systems for documentation of contact with providers and members.
- Communicates effectively with other Medical Management support staff.
- Analyze claims and encounters according to the limits of authorization, benefit plan and provider contracts.
- Effectively uses the Moda Health core systems to accurately determine eligibility, benefit plan, and physician networks associated with the member’s plan.
- Completes approvals, and denials by the medical director, of claims and prior authorization requests in a professional, positive manner.
- Send proper correspondence to providers, members and other departments to either obtain additional information necessary for the review of claims or denial of requested services.
- Analyze authorizations for correct information, such as authorization maximums, limitations and special instructions for performance groups.
- Ensure adherence of Health Insurance Portability and Accountability Act (HIPPA) and other regulatory guidelines including privacy and security.
- Responsible for the auditing of individual daily work for accuracy, consistency and compliance based on Moda Health policies and procedures, state, federal and CMS (Medicare)/Medicaid regulations.
- Identifies problems and researches alternative solutions.
- Works with other team members to maintain the workflow to meet productivity and compliance standards.
- Completes other duties and special projects as assigned by the HCS Operations Supervisor and/or the HCS Manager.
- Maintains an established productivity based on the complexity and demands of a heavy workload, complex services agreements, provider contracts and complex benefit packages.

- Responsible for utilizing all applicable policies, procedures and materials used in determining the proper review of claims, review and processing of prior authorization requests for services.
- Enter data into appropriate system Facets UM or CT Dynamo must be able to accurately determine member eligibility and provider participation within a network.
- Maintain accurate patient note entry when not approving a request, when awaiting additional information or when routing the referral or pre-authorization request.
- Perform other tasks as assigned

Working conditions

The nature of the work environment, providing the applicant (or employee) with more specific information regarding the position, such as whether the work environment will be conducive to creativity or whether the workplace is noisy, hot, or dusty. Special working conditions cover a range of circumstances from regular evening and weekend work, shift work, working outdoors, working with challenging clients, and so forth. Contact with others.

Medical Director Medicaid LOB | Houston, TX | WellCare

Source URL: https://jobs.wellcare.com/search/jobdetails/medical-director-medicaid-lob/8d73fd76-e201-431a-b93f-7203b635fb7c?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medical Director Medicaid LOB

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

Oversees clinical direction of medical services and quality improvement functions at the health plan level. Provides medical management leadership for the health plan and, as applicable, manages all major clinical and quality program components under health plan operations. Oversees medical coordination required for effective utilization and quality management of the health plan network. Functions as medical leadership for effective care integration of WellCare pharmacy operations, utilization/case/disease Management activities, quality improvement activities, and provider relations functions.

Essential Functions:

- Collaborates with the organization's senior leadership to ensure medical compliance with all customer, regulatory, and accreditation requirements for clinical services.
- Provides current medical expertise and direction for clinical policies, procedures and programs.
- As required by business and operational priorities, establishes professional working relationships with providers and provider organizations to support the development of the highest possible provider partnerships.

- Manages day-to-day quality improvement and medical management activities.
- Establishes and is accountable for health plan utilization, OS applications and quality outcomes.
- Assures all internal and vendor medical review activities conform to company protocols, customer requirements, and professional standards.
- Ensures adherence to assigned budget accountabilities.
- Works closely with other medical directors and clinical services staff to attain and/or maintain compliance with company, customer, accreditation and regulatory requirements.
- Provides clinical expertise needed to effectively and efficiency resolve complex, controversial and/or unique administrative circumstances.
- Provides clinical guidance for sales, marketing, legal, regulatory affairs, financial, operational, and related business activities.
- As requested and needed, provides expert medical education, consultation, and supervision for the clinical staff.
- Provides medical leadership for development and attainment of the organization's goals.
- Support provider relations and risk contracting through education, provider visits and problem resolution
- Collaborates with corporate care management to establish and implement clinical programs to support and meet care management goals
- Manages the application of all clinical aspects of the Credentialing Program, Credentialing Committee and Peer Review activities at the state level.
- Shares responsibility for quality improvement and accreditation initiatives in the assigned market(s)
- Develops value propositions for clinical programs through

quantitative analytics, ROI and evidence-based data
- Initiates dialogue with providers, as necessary, to resolve differences in opinions concerning utilization management. Reviews and makes determinations regarding provider appeals.
- Ensure compliance with federal, state and NCQA standards
- Oversees provider education regarding pharmacy, utilization, quality improvement and responsible health care expenditures to improve clinical outcomes
- Establishes and maintains relationships with key stakeholders in partnership with the market leadership
- Provides medical accountability in fulfilling the company's compliance with customer audits and reports, and accreditation surveys.
- Performs other duties as assigned.

Additional Responsibilities:
Candidate Education:

- Required A Doctor in Medicine (MD) or D.O. from an accredited school of medicine recognized by national medical regulatory bodies in the United States

Candidate Experience:

- Required 5 years of experience in direct patient care
- Required Other Substantial experience and expertise in the development of medical policies, procedures and programs
- Required Other Demonstrated success implementing utilization and quality improvement strategies /techniques and experience with physician behavior modification
- Preferred Other Qualifications to perform clinical oversight for the services provided by the health plan to include but not limited to: Education, training or professional experience in medical or clinical

practice

- Preferred Other Past participation in a managed care UM committee

Candidate Skills:

- Advanced Ability to communicate and make recommendations to upper management
- Advanced Ability to effectively present information and respond to questions from families, members, and providers
- Advanced Ability to create, review and interpret treatment plans
- Advanced Demonstrated leadership skills
- Advanced Ability to work in a fast paced environment with changing priorities
- Advanced Demonstrated interpersonal/verbal communication skills
- Advanced Demonstrated organizational skills
- Advanced Demonstrated ability to deal with confidential information
- Advanced Ability to represent the company with external constituents
- Advanced Demonstrated negotiation skills
- Advanced Ability to influence internal and external constituents
- Advanced Other Ability to remain calm under pressure
- Advanced Other Must be able to apply medical knowledge and principles to business challenges in order to achieve significant member, business, and quality outcomes
- Advanced Other Must be detail-oriented and have a “hands-on” approach
- Advanced Other Clear understanding of the managed care field and managed care operating components, with emphasis on clinical management of health services, particularly within an integrated managed care model
- Advanced Other Clear understanding of regulatory systems and

processes that affect managed care health system

Licenses and Certifications:

- Required
- Required An unrestricted and current license to practice medicine in the state of employement (or the ability to obtain one)
- Required Board Certification

Technical Skills:

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

Languages:

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

Coordination of Benefits Specialist | Tampa, FL | WellCare

Source URL: https://jobs.wellcare.com/search/jobdetails/coordination-of-benefits-specialist/a8017655-e342-4dff-a766-13f8ff62fe85?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Coordination of Benefits Specialist

Initiates contact to other insurance companies to gather coordination of benefits (COB) data. Consolidates the activities that support the collection, management and reporting of other insurance coverage. Additionally, provides outreach screening services for WellCare

Medicare members who are potentially eligible for benefits through the Medicare Savings Program (MSP). Provides necessary telephone support for various Medicaid and Medicare programs.

Department: Ops-Payment Integrity

Reports to: Supv. Coordination of Benefits

Location: Tampa, FL

Essential Functions:

- Responsible for investigating and validating potential Third Party Liability (TPL) / Coordination of Benefits (COB) instances for WellCare membership.
- Validates primary insurance coverage for claims received by WellCare with attached EOBs.
- Maintains accurate member COB information within Xcelys and COB application.
- Demonstrates appropriate customer-care skills such as empathy, active listening, courtesy, politeness, helpfulness and other skills as identified.
- Performs skills necessary to create a high-quality stakeholder experience, as reflected through acceptable quality audit score and productivity.
- Conducts outreach phone calls and initial MSP eligibility screenings to potentially eligible members, Deeming members, and their families.
- Prepares information packets and Medicaid applications to mail to MSP eligible members.
- Submits Medicaid applications to state-agencies on behalf of members, when requested by member.

- Answers incoming calls from members, Customer Service, Case Managers and Benefits Consultants and provides information related to Medicare Savings Program, Extra Help Program, Medicaid status, Medicaid eligibility screening, and D-SNP Deeming status.
- Tracks status of MSP applications and approvals for accurate reporting to Finance, Special Populations, Case Management and Product/Sales teams.
- Answers incoming phone calls from Pre-Enrollment, Benefit Consultants or 1099 staff for Medicaid Verification.
- Provides Medicaid, Medicare and Low Income Subsidy (LIS) eligibility details to inbound caller and documents in SalesForce.
- Verifies Medicaid eligibility for any paper applications received by WellCare.
- Assists in the validation of continued DSNP eligibility for all current DSNP membership.
- Performs special projects, as requested by management.

Additional Responsibilities:
Candidate Education:

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

Candidate Experience:

- Required 1 year of experience in a call center or customer service environment
- Preferred Other Experience within a health care company

Candidate Skills:

- Advanced Demonstrated written communication skills
- Advanced Demonstrated interpersonal/verbal communication skills
- Intermediate Ability to multi-task Ability to multi-task, good

organizational and time management skills

- Intermediate Demonstrated organizational skills
- Intermediate Demonstrated time management and priority setting skills
- Intermediate Ability to effectively present information and respond to questions from peers and management Ability to effectively present information and respond to questions from management or other internal associates
- Intermediate Ability to effectively present information and respond to questions from families, members, and providers
- Intermediate Ability to identify basic problems and procedural irregularities, collect data, establish facts, and draw valid conclusions Ability to define problems collects data, establish facts and draw valid conclusions
- Advanced Demonstrated customer service skills Demonstrates appropriate customer-care skills
- Intermediate Other Ability to act on feedback provided by showing ownership of his or her own development
- Intermediate Other Ability to read, analyze, and interpret verbal and written instructions
- Intermediate Other Ability to write business correspondence
- Intermediate Other Seeks to build trust, respect and credibility with all partners through full, honest, consistent, and coordinated communication
- Intermediate Other Ability to work with people from diverse backgrounds
- Intermediate Other Perform skills necessary to create a high-quality stakeholder experience, as reflected through acceptable quality audit score and productivity
- Intermediate Other Demonstrates appropriate customer-care skills such as empathy, active listening, courtesy, politeness, helpfulness

and other skills as identified.

Licenses and Certifications:

A license in one of the following is required:
- Preferred Other Customer service, quality or training certifications

Technical Skills:
- Required Beginner Microsoft Outlook Knowledge of email systems such as Microsoft Outlook sufficient to communicate with both internal and external contacts
- Required Beginner Microsoft Word Knowledge of Word and/or Excel sufficient to enter data
- Required Beginner Microsoft Excel

Languages:
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

Chief Operating Officer - North Carolina | Raleigh, NC | WellCare

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Chief Operating Officer

Responsible for the overall operations of the health plan, including strategic direction, administration for all existing programs and the development of new programs to ensure goals and objectives are met or exceeded. Working closely with WellCare's executive leadership team, leads and directs the overall improvement of operations including: provider contracting and relations, sales and marketing, medical

management, regulatory compliance and finance, as well as interfacing with corporate office operations. Serves as the representative of the health plan to government entities and other external agencies and ensures compliance with all relevant regulatory agencies.

Reports to: State President

Dept.: NC Exec State

Location: Raleigh, NC

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.
- Directs and manages the organization's financial performance. Takes appropriate actions to increase revenue, leverage resources, manages and/or minimizes expenses and ensure compliance with all business and administrative regulations.
- Directs the development of annual budgets and presents the budgets for approval.
- Assist and leads where appropriate, with aspects of state and federal government relationships, including dealing with regulators, as necessary, to establish and continue effective working relationships. Ensures that all state and federal regulations are met.
- Oversees the development and maintenance of a viable provider network to ensure the health care needs of WellCare members. Develops and manages provider contracts and partnerships to

achieve quality and cost management objectives. Works closely with providers to enhance relationships and maximize their ability to effectively manage the cost of medical delivery.

- 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 and implements key components of business strategy
- Develops new models and processes to meet future business needs
- Sets company priorities
- Establishes reporting systems and controls to ensure compliance with company requirements
- Recommends, develops, and aligns policies and procedures with company objectives
- Provides problem analysis and problem resolution at both a strategic and functional level
- Recommends and leads improvement processes and initiatives

This position is contingent upon the bid award in the state of North

Carolina to WellCare Health Plans, Inc.

Education/Experience:

- Bachelor's degree in business administration, finance or a related field, with a master's degree strongly preferred
- Successful track record in: Provider Relations, ownership of top and bottom line P&L responsibility with a successful HMO (government program experience preferred), growing membership and revenue, and improving the MLR
- Extensive experience in provider contracting
- Minimum of five to seven years of senior management experience with P&L accountability for a managed care organization
- Broad knowledge of the managed care industry and proven experience leading governmental programs.
- Comprehensive knowledge of delivery system operations, provider contracting, strategic planning and overall service delivery
- Powerful leadership skills with a vision and understanding of the future and subsequent changes required to meet business needs
- Sales background preferred with ability to motivate a sales force
- Ability to retain confidentiality regarding privileged company information
- Provides proactive approach and support to emerging business activities established to remain competitive in the marketplace
- Proven ability to affect change and meet business goals, monitor progress and take corrective actions when necessary

Computer Skills:

- Knowledge of Microsoft Office including Word, Excel, Outlook Express

- Knowledge of and/or ability to utilize COGNOS for budgetary decisions or review.

Other:

- An extremely organized, disciplined, hands on and process oriented leader who is not afraid of digging into details when necessary
- A "failure is not an option" mentality and demonstrated proactive management style.
- Strong business acumen, intelligence, and capacity. Thinks strategically and implements tactically.
- Problem solves and approaches work from a "return on investment" perspective.
- Able to work in a matrixed reporting environment
- Ability to work in a high energy, fast paced and data driven environment
- Highly Flexible regarding schedules, priority shifts
- Ability to think creatively and out of the box.
- Ability to remain calm under pressure.

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.

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Marketing Outreach Specialist - Medicaid | Tampa, FL | WellCare

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Marketing Outreach Specialist

Develops, plans and implements the outreach (community and member) programs, and marketing strategy for events, activities and

outreach to interested candidates and members in compliance with CMS, state, federal and WellCare regulations for Medicaid and according to the prescribed rules and regulations of existing contracts. Implements community programs throughout the service area with the purpose of (1) providing meaningful programs for community residents including marketing and education of WellCare products directly resulting in membership growth, (2) strengthen member relations through specific marketing and education initiatives resulting in greater member retention (3) building community coalitions partnerships to specifically increase enrollment and member retention and (4) promoting WellCare programs and related initiatives. Promotes WellCare products and directly assists with accomplishing outreach and enrollment goals.

Reports to: Dir, Marketing Outreach

Department: FL-Sales-M'Caid-State

Position Location: Tampa, FL

Essential Functions:

- Compliantly markets Medicaid products to all interested eligible candidates.
- Identifies target organizations based on population served.
- Organizes and develops successful marketing enrollment events to prospect eligible members. Provides education on Wellcare benefits, passes out consent to contact cards, answers questions and schedules in-person appointments upon request.
- Develops and maintains relationships within the business and community organizations.
- Contacts facilities in service areas to arrange meetings, ensuring all

locations meet CMS requirements.

- Provides direct member outreach including education through multiple channels, i.e., telephone outreach, new member orientations, individual member meetings.
- Conducts compliant marketing and education presentations to individuals as well as targeted partners.
- Provides ongoing assistance to members as necessary, answering questions and/or directing inquiries to Customer Service.
- Ensures all member issues are documented and communicated clearly for issue resolution.
- Thoroughly and accurately documents all program activities regarding the effectiveness of the programs.
- Participates in strategy meetings as necessary and make recommendations regarding WellCare projects.
- Ensures all events, activities, communication, materials, media, promotions, etc. meeting corporate, state and CMS rules and regulations.
- Continually monitors activities of health industry competitors and provides information to management.
- Coordinates with Member Services and Enrollment departments regarding member issues.
- Assists in preparation of all marketing and education events, activities and all presentations to eligible candidates, community partners, provider partners, etc.
- Ensures necessary inventory levels of marketing and educational materials is maintained, including organizing and compiling marketing and educational packets and all giveaway, promotional items.
- Performs other duties as assigned.

Additional Responsibilities:

- In New York, builds relationship with FMOs and 1099s
- If Florida, builds relationship with in network provider groups.

Candidate Education:

- Required A Bachelor's Degree in Marketing or a related field
- Required or equivalent work experience

Candidate Experience:

- Required 2 years of experience in sales and/or marketing in HMO/Managed Healthcare or Insurance Industry
- Required Other Successfully completed all required Medicare state, federal and corporate compliance training

Candidate Skills:

- Intermediate Demonstrated interpersonal/verbal communication skills
- Intermediate Ability to work independently
- Intermediate Ability to work as part of a team
- Intermediate Ability to work in a fast paced environment with changing priorities
- Intermediate Knowledge of healthcare delivery
- Intermediate Ability to represent the company with external constituents
- Intermediate Demonstrated customer service skills
- Intermediate Ability to multi-task
- Intermediate Demonstrated time management and priority setting skills
- Intermediate Knowledge of community, state and federal laws and resources
- Intermediate Other Ability to work calmly under pressure

Licenses and Certifications:

A license in one of the following is required:

Technical Skills:

- Preferred Intermediate Microsoft Excel
- Preferred Intermediate Microsoft Access
- Required Intermediate Microsoft Word
- Required Intermediate Microsoft Outlook

Languages:

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Operations Support Specialist | Tampa, FL | WellCare

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Operations Support Specialist

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: Operations Enrollment and Billing

Location: Tampa, FL

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.

Additional Responsibilities:
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

Languages:
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