Medicaid Industry Jobs Hunter 01/06/20

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Medicaid Jobs Hunter

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Field Care Manager | Miami Gardens, FL | WellCare

Field Care Manager

Do your best work. Live your best life. If you thrive in a fast-paced, growth-oriented environment, WellCare is the place for you. Our clinicians have the ability to guide, educate and support members facing a diverse set of health challenges. You will gain valuable experience as you positively affect the lives you touch every day. As a clinical professional on the WellCare team, you will enjoy many advantages, including competitive salaries, generous benefits, job stability, continuing education and all the resources you need to advance in your career.

To learn more about this position Click Here to see a video.

Works with Care Coordination MVP Team members to assess, plan, implement, coordinate, monitor, and evaluate services and outcomes to maximize the health of the Member. Coordinates, monitors and ensures that appropriate and timely primary, acute and long-term care services

are provided to members across the continuum of care. Promotes effective healthcare utilization, monitors health care resources and assumes a leadership role within the Interdisciplinary Care Team (ICT) to achieve optimal clinical and resource outcomes for member. Coordinates the care and services of selected member populations across the continuum of illness. Promotes effective utilization and monitors health care resources. Assumes a leadership role within the interdisciplinary team to achieve optimal clinical and resource outcomes. Works directly with the member in the field, i.e., inpatient bedside, member's home, provider's office, hospitals, etc. while collaborating with management to assess, plan, implement, coordinate, monitor and evaluate services and outcomes to maximize the health of the member.

Reports to: Supervisor of Field Care Management

Department: Children's Medical Services

Location: Miami Dade County, FL

Essential Functions:

- Evaluates members for case management services and determines appropriate level of care coordination/ management services for member.
- Completes a comprehensive assessment and develops a care plan utilizing clinical expertise to evaluate the members need for alternative services.
- Acts as a primary case manager for members identified as Complex as defined by Case Management Program Description.
- Develops and monitors members plan of care, to include progress toward meeting established goals and self-management activities.
- Interacts continuously with member, family, physician(s), and other providers utilizing clinical knowledge and expertise to determine medical history and current status. Assess the options for care including use of benefits and community resources to update the care plan.
- Supervises and/or acts as a resource for non-clinical staff (i.e., Service Coordinators and Field Social Workers).
- Act as liaison and member advocate between the member/family, physician and facilities/agencies.
- Maintains accurate records of case management activities in the Enterprise Medical Management Automation (EMMA) System using clinical guidelines.
- Coordinates community resources, with emphasis on medical, behavioral, and social services. Applies case management standards, maintains HIPAA standards and confidentiality of protected health information and reports critical incidents and information regarding

quality of care issues.
- Ensures compliance with all state and federal regulations as well as Corporate guidelines in day-to-day activities.
- Meets with clients in their homes, work-sites, physician’s or hospital to provide management of services.
- Adapts to changes in policies, procedures, new techniques and additional responsibilities.
- Participates with other Case Managers and Medical Directors in regular or special meetings such as Clinical rounds.
- Perform other duties as assigned.

Additional Responsibilities:
- Travel to inpatient bedside, member’s home, provider’s office, hospitals, etc required with dependable car. May spend up to 70% of time traveling with exposure to inclement weather and normal road hazards. May require climbing multiple flights of stairs to a member's home, provider's office, etc.

Candidate Education:

- Required A Bachelor's Degree in Health Services or Nursing
- Required or equivalent work experience

Candidate Experience:
- Required 2 years of experience in clinical acute care, post acute care, home health care, or maternity
- Preferred 1 year of experience in current case management
- Preferred Other Managed care experience
- Preferred Other Prior utilization management experience preferred in some geographic regions
- Preferred Other Experience in care of the elderly is required in some geographic regions
- Preferred Other Experience in home health, physicians office or public health
- Required Other Associates supporting Florida's Children’s Medical Services (CMS) must have a minimum of two (2) years’ experience in Pediatrics.
- Required Other Work experience requirements may be waived for associates engaged in Florida's CMS contract that worked in a similar capacity for Florida's Department of Health in 2018.

Candidate Skills:
- Intermediate Ability to multi-task
- Intermediate Ability to work independently
- Intermediate Demonstrated time management and priority setting skills
- Intermediate Demonstrated interpersonal/verbal communication skills

- Intermediate Ability to create, review and interpret treatment plans
- Intermediate Ability to implement process improvements
- Intermediate Ability to effectively present information and respond to questions from families, members, and providers
- Intermediate Other Ability to understands the business and financial aspect of case mgmt in a managed care setting
- Intermediate Knowledge of healthcare delivery
- Intermediate Knowledge of community, state and federal laws and resources
- Intermediate Demonstrated written communication skills
- Intermediate Demonstrated customer service skills

Licenses and Certifications:

A license in one of the following is required:
- Required Licensed Registered Nurse (RN)
- Required Other Maintain required contact hours to fulfill regulatory requirements
- Preferred Certified Case Manager (CCM)

Technical Skills:
- Required Intermediate Microsoft Word
- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft Outlook
- Required Intermediate Healthcare Management Systems (Generic)

Languages:
- Required Other In the state of NY, associates may be required to be proficient in one of two buckets of languages. Bucket one consists of the below:
- Required Bengali
- Required Other Bucket two consists of:
- Required Other Cantonese
- Required Other Fujianese

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

Medicaid Health Systems Administrator | Ohio Department of Medicaid

Source URL: https://www.linkedin.com/jobs/view/medicaid-health-systems-administrator-1-at-ohio-department-of-medicaid-1678707018/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Health Systems Administrator 1

Company Name Ohio Department of Medicaid Company Location Franklin County, OH, US

NewPosted DatePosted 21 hours agoNumber of applicants Be among the first 25 applicants

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UNLESS REQUIRED BY LEGISLATION OR UNION CONTRACT, STARTING SALARY WILL BE SET AT STEP 1 OF THE PAY RANGE

Office: Policy

Bureau: Behavioral Health Policy

Working Title: Behavioral Health Policy Administrator (PN 20097812)

Job Preview

The Ohio Department of Medicaid is seeking an experienced professional to be a part of our Behavioral Health Policy unit. As a Behavioral Health Policy Administrator, your responsibilities will include:

- working alongside a team of dedicated staff engaged in policy development and implementation
- assisting in the development and design of Medicaid Behavioral Health policies and initiatives
- evaluating and directing organizational compliance of Behavioral Health policies
- researching and analyzing the impact of state and federal legislation on Medicaid service delivery systems
- coordinating and directing the implementation of Behavioral Health policy and compliance initiatives in the fee for service and managed care delivery systems
- coordinating the review, preparation, clearance and filing of program rules, manuals and handbooks
- ensuring that policies and procedures comply with federal and state regulations
- participating in the coordination of policy development teams involving the delivery of services and access to care for individuals with behavioral health needs
- assisting in the development of state plan amendments and communicating policy changes to the Centers for Medicare and Medicaid Services
- providing technical assistance to managerial and supervisory personnel involved in the implementation of improvements or new programs

The preferred candidate will have a passion for learning, collaborating and contributing to the development of policies and programs that help improve the lives of Medicaid enrolled individuals who live with behavioral health conditions.

Job Description

Under general direction, serves as agency manager of Medicaid program(s), &/or initiatives to research, analyze & evaluate the ongoing implementation of one statewide component of Medicaid health systems (i.e., behavioral health services reimbursement and payment policy): Plans, manages, evaluates & directs organizational compliance of Behavioral Health Policy rules, policies & regulations related to Policy Development (e.g. development & design of initiatives regarding Medicaid behavioral health policies & procedures including consumer liability, prior authorization of medical services & third party liability); directs & coordinates interoffice teams assisting with the organizational development & design of operational processes; researches, evaluates/analyzes state & federal legislation impacting Medicaid service delivery systems; monitors status of pending legislation; develops, drafts & defends program rules, policies, & procedures for delivery system; participates in the development of response to legislative issues; recommends legislative changes.

Coordinates & directs the implementation of departmental policy & compliance initiatives involving the behavioral health policy; assists in the development & implementation of benefit plan policies & initiatives in both the fee for service & managed care delivery systems (e.g., cost containment initiatives which may include utilization management & care management strategies); coordinates review, preparation, clearance & filing of program rules, manuals & handbooks, ensures that policies & procedures comply with federal & state regulations by researching applicable regulations & working directly with appropriate federal & state agencies; participates in the coordination of policy development teams involving the delivery of services & access to care for consumers with behavioral health needs; assists in the development of state plan amendments communicating policy changes to the Centers for Medicare & Medicaid Services (CMS) in order to receive federal matching funds for the Medicaid program(e.g., formulation & coordination of research

documentation supporting the state plan amendment); advises supervisor regarding issues & problems; provides technical assistance to managerial & supervisory personnel involved in the implementation of improvements or new programs (e.g., researches & evaluates health care market developments & trends, analyzes value purchasing strategies involving fee for service & managed care delivery systems).

Prepares comprehensive written reports summarizing findings & recommendations of program policies; speaks to community groups, advocacy organizations, legal community, provider associations federal staff &/or public; responds in writing & verbally to sensitive inquiries & contacts from public, providers & government officials; provides assistance to teams to research, develop, analyze & evaluate strategic policies regarding the purchasing of services for Medicaid consumers (i.e., assists in the development & design of utilization management & quality assurance activities including the development & design of prior authorization of medical services for Medicaid consumers); writes requests for proposal & assists in the management of contractor activities).

Performs other related duties as assigned (attends staff meetings & training, coordinates & conducts public presentations, provides advice to public officials, maintains logs, records & files; travels to meeting sites).Completion of graduate core program in business, management or public administration, public health, health administration, social or behavioral science or public finance; 12 mos. exp. in the delivery of a health services program or health services project management (e.g., health care data analysis, health services contract management, health care market & financial expertise; health services program communication; health services budget development, HMO & hospital rate development, health services eligibility, health services data base analysis).

Or 12 months experience has Medicaid Health Systems Specialist, 65293.

Note: education & experience is to be commensurate with approved position description on file.

- Or equivalent of Minimum Class Qualifications for Employment

noted above.

Primary Location

United States of America-OHIO-Franklin County

Work Locations

Lazarus 5

Organization

Ohio Department of Medicaid

Classified Indicator

Classified

Bargaining Unit / Exempt

Exempt

Schedule

Full-time

Work Hours

8:00AM to 5:00PM

Compensation

$31.76/hour

Unposting Date

Jan 21, 2020, 10:59:00 PM

Job Function

Health Administration

Agency Contact Name

ODM Human Resources

Agency Contact Information

HumanResources@medicaid.ohio.gov

Medicaid Collector Job in Oak Brook, IL at Advocate Health Care

Source URL: https://www.ziprecruiter.com/c/Advocate-Health-Care/Job/Medicaid-Collector/-in-Oak-Brook,IL?jid=DO8632351dd10f97f15e6d3c0719638f96&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Collector

Advocate Health Care Oak Brook, IL

Posted: January 08, 2020
Full-Time
At Advocate Aurora Health we understand that a healthy environment is vital to human health. Nationally recognized for environmental excellence, we strive to mitigate environmental harm and contribute to the well being and health of our associates, patients, visitors and the communities we are privileged to serve. Be a part of a movement in health care invested in reducing its environmental impact and creating healthier spaces for our patients to heal, physicians to practice and associates to work.

Position Requirements:

High School Diploma or General Education Degree (GED)

2 - 3 Years previous Hospital Public Aid Patient Accounting or Collections Experience

Familiarity with medical terminology.

Excellent working knowledge of electronic billing systems.

Working knowledge of the healthcare revenue cycle process.

Basic understanding of CPT4, HCPCS, modifiers, ICD~9CM

Clear understanding of HIPAA regulations.

Typing 35 WPM

10 key calculator

Must be able to operate computer and software systems in use at the SRCO.

Able to operate a copy machine, facsimile machine, telephone/voicemail.

Ability to read, write, speak and understand English proficiently.

Strong interpersonal, communication and persuasion/negotiation skills required to effectively interact with patients and third parties.

Must be able to follow detailed instructions.

Ability to listen to and understand information and ideas presented verbally and in writing.

Consistently exercises critical thinking skills or uses logic and reasoning to assess and resolve problems.

Quickly makes sense of, combines and organizes information.

Consistently maintains a professional and approachable demeanor.

Able to work under pressure and meet stringent deadlines in a fast~paced environment.

Able to work independently

Pays strong attention to details and maintains high degree of accuracy

Successfully alternates between two or more activities or sources of information.

Accepts responsibility and maintains high level of accountability

Strong collaboration skills

Available to respond to patient/third party requests during scheduled shift.

Ability to work on a computer for extended periods of time

Ability to speak on phone throughout a daily assigned shift (with opportunity to alternate between sitting and standing if necessary).

Ability to work effectively in an open floor environment

Lifting a minimum of 10 pounds.

Purpose:

The Medicaid Collector is responsible for the efficient and timely follow up and resolution of accounts by collecting maximum reimbursement while minimizing the aged accounts receivable to attain a zero balance. Serves as a resource and liaison between internal Advocate departments, Illinois Department of Public Aid, Out of State Public Aid Providers, and external Advocate/SRCO vendors. Provide excellent customer services by creating seamless processes, communicate and eliminate process deficiencies and act in accordance with the current Advocate standards, policies, procedures, federal/state/local regulations, contractual obligations and any legal matters that may be applicable.

Accountabilities:

Maintain and collect designated portion of accounts receivable

Other duties as assigned by Collections Management. Assists in completing ad hoc projects and related job activities as assigned to support SRCO operations During periods of high volume and/or impending deadlines, assignments may include assisting with patient accounting activities and functions typically performed by other SRCO positions.

Responsible for personal and professional growth and development.

Resolution of all delinquent patient accounts, per guidelines, in order to secure payment

Utilizes the patient accounting claims and worklist systems and adjunct software systems proficiently in order to review, retrieve and update information as needed.

About Advocate Health Care

Advocate Health Care is the largest health system in Illinois and one of the largest Accountable Care Organizations in the country. A national leader in population health management, Advocate operates nearly 400 sites of care and 12 hospitals, including three of the nation's 100 Top Hospitals, the state's largest integrated children's network, five Level I trauma centers (the state's highest designation in trauma care), three Level II trauma centers, one of the area's largest home health and hospice companies and one of the region's largest medical groups. Advocate trains more primary care physicians and residents at its four teaching hospitals than any other health system in the state. As a not-for-profit, mission-based health system affiliated with the Evangelical Lutheran Church in America and the United Church of Christ, Advocate contributed $692 million in charitable care and services to communities across Chicagoland and Central Illinois in 2016. Advocate is part of Advocate Aurora Health, the 10th largest not-for-profit, integrated health system in the United States. We help people live well.

Advocate Health Care

Address

Oak Brook, IL

USA

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What email should the hiring manager reach you at?

Email Address

By clicking the button above, I agree to the ZipRecruiter Terms of Use and acknowledge I have read the Privacy Policy, and agree to receive email job alerts.

Medicaid Enrollment Rep I | New York, NY | WellCare

Source URL: https://jobs.wellcare.com/search/jobdetails/medicaid-enrollment-rep-i/4116dbe7-d3fb-4c8a-9c75-23193d6ee540?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

*Medicaid Enrollment Rep I

****Current, Active Accident & Health Sales Licensure Required****

Location: New York Office

Reports to: Manager, Medicare Sales

Prospects and markets the Medicaid product to interested eligible candidates in the service area, according to the prescribed rules and regulations of the Medicaid Contract. Meets the minimum enrollment goal of new members using event planning, presentation materials and sales techniques.

Essential Functions:

- Markets Medicaid products to all interested eligible candidates.
- Conducts individual presentations to perspective members.
- Coordinates and conducts approved marketing events.
- Generates referrals utilizing community resources, supplied company tools, event planning and community networking.
- Prospects for leads and converts leads into appointments.

- Converts appointments into enrollments.
- Provides ongoing assistance to Medicaid members, as necessary, answering questions and/or directing inquiries to Customer Service.
- Continually monitors activities of health industry competitors and provides information to management.
- Performs other duties as assigned.

Additional Responsibilities:

- Reviews and quality checks enrollment paperwork before processing.
- When needed, assists in the creation of materials such as flyers, pamphlets, event material etc.
- May be asked to support and travel to other territories from time to time.
- Conducts new member orientations.
- Contacts approved leads by telephone to set appointments.
- Required to use personal transportation for appointment with prospective members and events.

Candidate Education:

- Required A High School or GED

Candidate Experience:

- Required 6 months of experience in sales

Candidate Skills:

- Intermediate Demonstrated interpersonal/verbal communication skills
- Intermediate Ability to work independently
- Intermediate Ability to work in a fast paced environment with changing priorities
- Intermediate Knowledge of healthcare delivery
- Intermediate Knowledge of community, state and federal laws and resources
- Intermediate Ability to represent the company with external constituents
- Intermediate Demonstrated customer service skills
- Intermediate Demonstrated written communication skills
- Intermediate Ability to effectively present information and respond to questions from families, members, and providers
- Intermediate Demonstrated organizational skills
- Intermediate Demonstrated negotiation skills
- Intermediate Other Goal and result driven in sales
- Intermediate Other Ability to pay close attention to detail

Licenses and Certifications:

A license in one of the following is required:

- Required Other State required certification must be obtained within 90 days of hire

Technical Skills:

- Required Intermediate Microsoft Outlook
- Required Intermediate Microsoft Word
- Required Intermediate 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

UnitedHealth Group Site Director Medicare Medicaid El Paso Health Plan Job in El Paso, TX | Glassdoor

Source URL: https://www.glassdoor.com/job-listing/site-director-medicare-medicaid-el-paso-health-plan-unitedhealth-group-JV_IC1140105_KO0,51_KE52,70.htm?jl=3386232176&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Site Director Medicare Medicaid El Paso Health Plan

3.4 ★

UnitedHealth Group – El Paso, TX

$56K-$178K (Glassdoor est.)

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Why Work For Us

Benefits
For those who want to

invent the future of health care, here's your opportunity. We're going beyond

basic care to health programs integrated across the entire continuum of care.

Join us and help people live healthier lives while doing your life's best

work.(sm)

You will be located in the El Paso Health Plan office and

may have some flexibility to occasionally telecommute as you take on some tough challenges.

Primary Responsibilities:

Direct the activities of a team of

clinicians who are responsible for delivering care management to

individuals receiving Medicare or Medicaid services within the El Paso Health

service area

Services include comprehensive assessment,

development of individualized services plans, care coordination and

planning, and ongoing support and facilitation with other

interdisciplinary care team members

Directly supervise and develop assigned

leadership team and maintain accountability for team development and

performance

Partner with Talent Acquisition to

successfully identify and hire new employees according to set timeframes in

preparation for implementation dates for Medicare and Medicaid services

Actively participate in the implementation

and planning prior to program roll-out to ensure staff readiness and

flawless execution

Monitor program performance and compliance

metrics against targets and contractual expectations and make operational

adjustments as needed

Conduct regular meetings with staff to

address issues and concerns and to communicate corporate and program

updates

Implement operational initiatives in

conjunction with our client partner to meet program and client

expectations and ensure contract compliance

Attend and actively participate in onsite

meetings with our client partner developing strong rapport and

relationships with day to day contacts

Oversee the orientation, training, and

ongoing education and skill development of the Service Coordination team to

ensure operational readiness of all newly hired staff

Ensure compliance with State and Federal

regulations, contract requirements, URAC and NCQA standards, and company

policies and procedures

Collaborate cross-functionally to meet

goals and objectives and drive staff efforts in implementing activities to

meet business goals and client expectations

Attend meetings at El Paso Health office

and travel to member home visits in El Paso with staff as needed to attend

in-person assessments

Interact with multiple stakeholders internally

as well as with client partner and possible state regulators and

community-based providers

Youll be rewarded and recognized for your performance in an environment that will challenge you and give you clear direction on what it takes to succeed in your role as well as provide development for other roles you may be interested in.

Director Government Affairs - Medicaid LOB | Houston, TX | WellCare

Source URL: https://jobs.wellcare.com/search/jobdetails/director-government-affairs---medicaid-lob/65d05d43-d9dd-440c-8082-6acec46bf90c?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director Government Affairs

Join us at WellCare to build a better career while helping our members lead better, healthier lives. Our leaders have a strong passion and a clear mission at WellCare. Wherever you work within the organization, you will know that you are part of a larger, noble mission, dedicated to enhancing our members health and quality of life. Here, you will find a culture of empowerment, teamwork and commitment as we all work together to deliver cost-effective solutions that create positive outcomes for our more than 6.0 million members.

LOCATION: Houston, TX

DEPARTMENT: State

REPORTING TO: VP, Government Affairs

Provides policy direction and coordinates efforts of pertinent operating units in matters involving state and federal governments. Ensures the provision of service to the proper administration of Medicare and Medicaid contracts, and maintains effective and cooperative working relationships with federal and state officials. Keeps current on local, regional and national affairs, policies, and legislation affecting health care and specifically, the managed care plan. Advises, develops, coordinates and directs internal policies as they relate to external affairs. Organizes, directs and ensures the compliance of all plan managed care programs with multiple State and Regulatory bodies.

Assignments are broad in nature, usually requiring considerable creativity, originality and ingenuity.

Essential Functions:

- Oversees and manages policy development.
- Researches, monitors, and analyzes federal and state legislation and planning activities related to government funded initiatives and CMS regulatory changes.
- Reviews and monitors proposed and enacted Federal legislation impacting the managed care industry and develops business plans accordingly.
- Identifies, analyzes and makes recommendation regarding key legislative issues.
- Manages and directs the activity of federal and state government affairs.
- Works closely with CMS, state legislative leaders and any other government leaders to build coalitions to effect change that will have a positive impact on the managed care market.
- Assists and leads, where appropriate, with issues involving state and federal government relationships, including dealing with regulators to establish and continue effective working relationships.
- Manages and develops direct reports who include other management or supervisory personnel and/or exempt individual contributors.
- Plans, conducts and directs work on complex projects/programs necessitating the origination and application of new and unique approaches.
- Sets operational priorities and manages resources to operational goals and budgets.
- Develops strategies and ensures maximum efficiencies in the utilization of human and financial resources.
- With approval of Senior VP or VP establishes budget and monitors for adherence.
- Ensures corporate initiatives are implemented to achieve optimum results.
- Advises management in long-range planning for areas of specialization.
- Provides technical direction to functional managers, other directors and management.
- Recommends changes in area(s) policy and procedure.
- Performs other duties as assigned.

Candidate Education:

- Required A Bachelor's Degree in a related field or Business Administration

- Preferred A Master's Degree in a related field or Public Policy, Public Health, Political Science, Health Administration

Candidate Experience:

- Required 10 years of experience in planning, development, health policy, legislative affairs, health care consulting or managed health care, and a proven track record of leadership experience in the health care industry.
- Required 5 years of management experience
- Required Other In-depth knowledge of government programs and the managed care industry and proven experience leading and managing government programs through teamwork, collaboration and open communication.
- Required Other Extensive experience working with key government groups, and the ability to identify and build relationships with key leaders within government health agencies and senior staff on committees that effect healthcare legislation.

Candidate Skills:

- Intermediate Demonstrated leadership skills
- Intermediate Ability to lead/manage others
- Intermediate Demonstrated ability to deal with confidential information
- Intermediate Demonstrated written communication skills
- Intermediate Demonstrated interpersonal/verbal communication skills
- Intermediate Other Provide proactive approach and support to emerging business activities established to remain competitive in the marketplace.

Technical Skills:

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

About us

Headquartered in Tampa, Fla., WellCare Health Plans, Inc. (NYSE: WCG) focuses primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex medical needs primarily through Medicaid, Medicare Advantage and Medicare Prescription Drug Plans, as well as individuals in the Health Insurance Marketplace. WellCare serves approximately 5.5 million members nationwide as of September 30, 2018. WellCare is a Fortune 500 company that employs nearly 12,000 associates across the country

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Apply

Aetna Chief Medical Officer Aetna Better Health of KS (Medicaid) Job in Overland Park, KS | Glassdoor

Source URL: https://www.glassdoor.com/job-listing/chief-medical-officer-aetna-better-health-of-ks-medicaid-aetna-JV_IC1151049_KO0,56_KE57,62.htm?jl=3456752619&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Chief Medical Officer Aetna Better Health of KS (Medicaid)

3.4 ★

Aetna – Overland Park, KS

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Req ID: 61299BR

Job Description

POSITION SUMMARY

The Sr Director, Clinical Solutions MD (CMO) for Medicaid in Kansas is responsible for leadership of strategic medical management activities and processes which contribute to the performance of the markets and promotes quality of care for our members. These responsibilities include development and implementation of medical programs/policies, enhancing relationships with providers and facilities, plan sponsors and regulatory agencies.

The CMO acts as a key business partner in network development, product design, strategic planning, regulatory compliance and community outreach.

The ideal candidate will have previous Medicaid Managed Care experience having worked with state regulators and executed on strategic initiatives and programs. Strong leadership experience, strategic vision and a proven ability to execute on clinical initiatives are a "must have" in this position.

The CMO will act as the "Clinical Leader" for Aetna Better Health of Kansas and must be willing to travel throughout the state on an "as needed" basis.

The CMO for Aetna Better Health of Kansas will develop, implement, support, and promote Health Services strategies, tactics, policies, and programs that drive the delivery of quality healthcare to establish

competitive business advantage for Aetna.

Health Services strategies, policies, and programs are comprised of utilization management, quality management, network management, and clinical coverage and policies.

The CMO is responsible for all clinical activities including proper provision of covered services to members; UM activities, developing clinical practice standards and clinical policies and procedures.

Provide leadership of medical management activities. Develops and implements medical management programs/policies.

FUNDAMENTAL COMPONENTS

Leads, develops, directs and implements clinical and non-clinical activities that impact health care quality, cost and outcomes.

Direct the utilization review process and oversee the quality of utilization determinations.

Ensure compliance with clinical goals through monitoring care management performance.

Responsible for overall medical policies of the unit to ensure the appropriate and most cost effective medical care is received, and for the day-to-day management of medical management staff.

Responsible for recommending changes and enhancements to current managed care, review guidelines, and clinical criteria based on extensive knowledge of health care delivery systems, utilization methods, reimbursement methods, and treatment protocols.

Develops, implements, and interprets medical policy including medical

necessity criteria, clinical practice guidelines, and new technology assessments.

Leads clinical staff in the coordination of quality care.

Provides clinical expertise and business direction in support of medical management programs through participation in clinical team activities.

Acts as lead business and clinical liaison to network providers and facilities to support the effective execution of medical services programs by the clinical teams.

Responsibility for predetermination reviews and reviews of claim determinations, providing clinical, coding, and reimbursement expertise.

Expands Aetna's medical management programs to address members needs across the continuum of care.

Acts as a champion supporting continuous quality improvement efforts to improve the care and services delivered to all populations covered under KanCare.

Works directly with all other medical officers and department and business unit leads to promote excellence in care and service delivery.

Attracts, retains, measures, coaches and develops the talent to meet Aetna's current/future organizational goals.

Establishes and maintains strong and collaborative community and state governmental relationships.

Fosters an inclusive, engaged, success-oriented and accountable culture and working environment.

Seeks out, introduces and applies innovative ideas to Aetna with input from customers and active involvement in industry, professional, academic and community participation.

BACKGROUND/EXPERIENCE

3 to 5+ years of experience in the health care delivery system, e.g. clinical and health care industry required WITH 3 - 5 years of additional leadership and management experience managed care.

Demonstrated ability to create business strategy to drive competitive advantage and shift direction as market conditions dictate. - Demonstrated ability to interact successfully with external providers.

LICENSES / CERTIFICATIONS

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

Active and current KS state medical license without encumbrances or ability to obtain medical license in KS is a job requirement for this position.

EDUCATION

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

ADDITIONAL JOB INFORMATION

Are you ready to join a company that is changing the face of health care across the nation? Aetna Better Health of Kansas 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 KanCare members. Our vision incorporates community-based health care that works. We value diversity. Align your career goals with Aetna Better Health of Kansas, and we will support you all the way.

Aetna is about more than just doing a job. This is our opportunity to re-shape healthcare for America and across the globe. We are developing solutions to improve the quality and affordability of healthcare. What we do will benefit generations to come.

We care about each other, our customers and our communities. We are inspired to make a difference, and we are committed to integrity and excellence.

Together we will empower people to live healthier lives.

Functional Skills:

Clinical / Medical - Concurrent review / discharge planning, Clinical / Medical - Direct patient care (hospital, private practice), Medical Management - Medical Management - Administration/Management, Medical Management - Medical Management - Case Management, Medical Management - Medical Management - Managed Care/Insurance Clinical Staff

Technology Experience:

Desktop Tool - Microsoft Outlook, Desktop Tool - Microsoft Word, Desktop Tool - TE Microsoft Excel

Required Skills:

Finance - Delivering Profit and Performance, Finance - Profit and Quality Vigilance, General Business - Communicating for Impact

Desired Skills:

Benefits Management - Interacting with Medical Professionals, Benefits Management - Maximizing Healthcare Quality, Leadership - Fostering a Global Perspective

Additional Job Information:

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Benefit Eligibility

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

Job Function: Healthcare

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

Chief Medical Officer Aetna Better Health of KS (Medicaid) | Aetna, a CVS Health Company

Chief Medical Officer Aetna Better Health of KS (Medicaid)

Company Name Aetna, a CVS Health Company Company Location Overland Park, KS, US

Posted DatePosted 2 days agoNumber of applicants Be among the first 25 applicants

Job Description

POSITION SUMMARY

The Sr Director, Clinical Solutions MD (CMO) for Medicaid in Kansas is

responsible for leadership of strategic medical management activities and processes which contribute to the performance of the markets and promotes quality of care for our members. These responsibilities include development and implementation of medical programs/policies, enhancing relationships with providers and facilities, plan sponsors and regulatory agencies.

The CMO acts as a key business partner in network development, product design, strategic planning, regulatory compliance and community outreach.

The ideal candidate will have previous Medicaid Managed Care experience having worked with state regulators and executed on strategic initiatives and programs. Strong leadership experience, strategic vision and a proven ability to execute on clinical initiatives are a “must have” in this position.

The CMO will act as the “Clinical Leader” for Aetna Better Health of Kansas and must be willing to travel throughout the state on an “as needed” basis.

The CMO for Aetna Better Health of Kansas will develop, implement, support, and promote Health Services strategies, tactics, policies, and programs that drive the delivery of quality healthcare to establish competitive business advantage for Aetna.

Health Services strategies, policies, and programs are comprised of utilization management, quality management, network management, and clinical coverage and policies.

The CMO is responsible for all clinical activities including proper provision of covered services to members; UM activities, developing clinical practice standards and clinical policies and procedures.

Provide leadership of medical management activities. Develops and implements medical management programs/policies.

FUNDAMENTAL COMPONENTS

Leads, develops, directs and implements clinical and non-clinical activities that impact health care quality, cost and outcomes.

Direct the utilization review process and oversee the quality of utilization determinations.

Ensure compliance with clinical goals through monitoring care management performance.

Responsible for overall medical policies of the unit to ensure the appropriate and most cost effective medical care is received, and for the day-to-day management of medical management staff.

Responsible for recommending changes and enhancements to current managed care, review guidelines, and clinical criteria based on extensive knowledge of health care delivery systems, utilization methods, reimbursement methods, and treatment protocols.

Develops, implements, and interprets medical policy including medical necessity criteria, clinical practice guidelines, and new technology assessments.

Leads clinical staff in the coordination of quality care.

Provides clinical expertise and business direction in support of medical management programs through participation in clinical team activities.

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Responsibility for predetermination reviews and reviews of claim determinations, providing clinical, coding, and reimbursement expertise.

Expands Aetna's medical management programs to address members needs across the continuum of care.

Acts as a champion supporting continuous quality improvement efforts to improve the care and services delivered to all populations covered under KanCare.

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Additional Job Information

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Required Skills

Finance - Delivering Profit and Performance, Finance - Profit and Quality Vigilance, General Business - Communicating for Impact

Desired Skills

Benefits Management - Interacting with Medical Professionals, Benefits Management - Maximizing Healthcare Quality, Leadership - Fostering a Global Perspective

Minimum Functional Experience

Clinical / Medical - Concurrent review / discharge planning, Clinical / Medical - Direct patient care (hospital, private practice), Medical Management - Medical Management - Administration/Management, Medical Management - Medical Management - Case Management, Medical Management - Medical Management - Managed Care/Insurance Clinical Staff

Minimum Technical Experience

Desktop Tool - Microsoft Outlook, Desktop Tool - Microsoft Word, Desktop Tool - TE Microsoft Excel

Job Group

Healthcare

Primary Location (City, State)

KS-Overland Park

Additional Locations

KS-Overland Park

Potential Telework Position

No

Percent Of Travel Required

10 - 25%

Full or Part Time

Full Time

Supervisory Responsibilities

Yes

EEO Statement

Aetna is an Equal Opportunity, Affirmative Action Employer

Benefits Program

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.

Resource Group

2

Initiative Group

113

Req#

61299BR

Head of Products/Product Director | MetroPlus Health Plan

Source URL: https://www.linkedin.com/jobs/view/head-of-products-product-director-at-metroplus-health-plan-1679201294/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Head of Products/Product Director

Company Name MetroPlus Health Plan Company Location New York City, NY, US

NewPosted DatePosted 13 hours agoNumber of applicants Be among

the first 25 applicants

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Marketing Statement

MetroPlus Health Plan provides the highest quality healthcare services to residents of Bronx, Brooklyn, Manhattan, Queens and Staten Island through a comprehensive list of products, including, but not limited to, New York State Medicaid Managed Care, Medicare, Child Health Plus, Exchange, Partnership in Care, MetroPlus Gold, Essential Plan, etc. As a wholly-owned subsidiary of NYC Health + Hospitals, the largest public health system in the United States, MetroPlus' network includes over 27,000 primary care providers, specialists and participating clinics. For more than 30 years, MetroPlus has been committed to building strong relationships with its members and providers to enable New Yorkers to live their healthiest life.

Position Overview

Reporting to the Chief Operating Officer, the Head of Products/Product Senior Director provides the leadership, management, strategy and vision for MetroPlus 'product lines. Ensuring proper operational controls, administrative and reporting procedures and staff operate effectively and efficiently. The Head of Products/Product Senior Director provides overall management and oversight for the product lines of business; including operational performance improvement, competitive market analysis, marketing opportunities, regulatory and compliance adherence, vendor management, State and Federal advocacy. This role makes the Head of Products accountable for achievement of key corporate goals and objectives, thus contributing significantly to fulfillment of the Plan's mission and vision.

Job Description

- Recognizes, adopts, and implements operational best practices and metrics to obtain desired strategic and tactical results.
- Provides day to day leadership, directing, aligning and overseeing

the Product Teams and provides strategic leadership to existing and developing operations.
- Leads the strategy, development and management of all MetroPlus products, essentially owning the products.
- Coordinates and manages interrelated Plan operations into a seamless matrix collaborating with major product lines: Medicaid, Medicare, Exchange and Commercial.
- Responsible for the effectiveness and measurement of internal and external operations processes and outcomes, ensuring timely reporting.
- Develops innovative and supportable benefits designs and offerings to lead competitiveness in the Market.
- Tracks and coordinates regulatory changes and ensures compliant implementation.
- Ensures the operational integrity of the products by providing oversight through operational reporting.
- Participates in sales negotiations to promote products with prospective clients.
- Tracks and reports on market conditions.
- Performs competitive market analysis.
- Position the products' competitiveness in the market through advertising and marketing strategy.
- Participates in client and consumer facing role to build product partnerships with community-based organizations.

Minimum Qualifications

- Bachelor's degree from an accredited college or university in an appropriate discipline required.
- Master's degree in business, healthcare or public administration is strongly preferred.
- Minimum 8 years of product management experience in the healthcare field required.
- Minimum of 5 years of experience at a Health Plan in an operational or marketing role.
- Experience managing teams required.
- Thorough knowledge of management principles and practices, including process and quality improvement methods.
- Broad and deep knowledge of managed care operations, the interconnectivity of diverse and complex functions.
- Demonstrated knowledge and experience overseeing a diverse array of managed care product lines of business.
- Strong qualitative, quantitative and analytical skills, demonstrated by ability to identify and use information and data to set goals and priorities, make decisions and measure performance, while considering competing priorities and other perspectives within and outside the organization.

- Excellent writing and verbal communications skills, characterized by the ability to clearly articulate complex concepts.
- Creativity and resourcefulness demonstrated by ability to a) conceptualize and implement new policies, programs and procedures; b) set priorities for self and others; and c) achieve maximum functioning with available resources.
- Good judgment in a) seeking and using information to support decision-making; b) anticipating the consequences of decisions and actions; c) communicating information; d) interacting constructively with others both within and outside the organization; e) choosing actions that are beneficial to, and consistent with, the mission, goals, culture and style of the organization.
- Ability to take initiative and think independently.
- Must demonstrate understanding and acceptance of the MetroPlus' Mission, Vision and Values.

Professional Competencies

- Leadership
- Results driven
- Business acumen
- Systems orientation
- Process improvement
- Data driven decision making
- Customer focus
- Written/Oral Communication
- Able to work in a fast-paced environment with competing priorities
- Resourcefulness

Member Database Analyst

Source URL: https://jobs.communityhealthchoice.org/member-database-analyst/job/12111427?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Member Database Analyst

Job Description

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

	of every Community position. We strive every day to make sure that our Members have access to the high-quality health care they need and deserve. Community is accredited by URAC for its health plan operations. We offer care management programs for asthma, diabetes, and high-risk pregnancy. An affiliate of the Harris Health System (Harris Health), Community is financially self-sufficient and receives no financial support from Harris Health or from Harris County taxpayers.
	Job Profile
	The Member Database Analyst serves as the main support to Operations Director, deliver excellent customer service and meet both organization and state guidelines and requirements. Assists MS Leader/Trainer in training programs, elevated calls etc. The Member Database Analyst Is the primary Outbound Call Lead, ensuring excellent productivity and process improvement. QUALIFICATIONS:

	High School Graduate with two or more years of extensive experience within the medical field, preferably in the managed care and or Medicaid industry. Extensive knowledge of the Medicaid Product and or CHIP products, Eligibility and Benefits. Two years experience in a Health Care Call Center / Member Services Dept. with extensive group health insurance and Medicaid knowledge including but not limited to: claims, eligibility, cob, benefits, value added and vendor benefits, state entities, requirements and regulations. OTHER SKILLS: Above Average Verbal (Heavy Public Contact) Writing /Composing (Correspondence/Reports) Analytical, Mathematics, Research, Statistical, P.C., MS Word Multi-tasker with excellent mathematic and analytical skills Bachelors Degree Major: Preferable working towards completion Excellent understanding of all CHC systems, able to use applications.
	Benefits and EEOC

	Community employees' benefits are provided by Harris Health. These benefits are designed to provide you with flexibility and choices in meeting your specific needs. Community is an Equal Opportunity Employer.
	Job Category
	CHC Administrative

Application Instructions

Please click on the link below to apply for this position. A new window will open and direct you to apply at our corporate careers page. We look forward to hearing from you!

Note: Current Community Health Choice employees must log in to PeopleSoft via CITRIX to explore career opportunities as an internal candidate. Click HERE for instructions.

Apply Online