Medicaid Industry Jobs Hunter 01/27/20

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Medicaid Jobs Hunter

In this packet….

Utilization Management Coordinator - Registered Nurse (RN) | Blue Cross and Blue Shield of Illinois, Montana, New Mexico, Oklahoma & Texas

Utilization Management Coordinator - Registered Nurse (RN)

Company Name Blue Cross and Blue Shield of Illinois, Montana, New Mexico, Oklahoma & Texas Company Location Richardson, TX, US

Posted DatePosted 1 week agoNumber of applicants Be among the first 25 applicants

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Description

**** THIS POSITION IS BASED IN-OFFICE IN RICHARDSON, TX. ****

Basic Function

This position is responsible performing initial, concurrent review activities; discharge care coordination for determining efficiency, effectiveness and quality of medical/surgical services and serving as liaison between providers and Medical and Network Management Divisions. This position reviews service requests, collects clinical and non-clinical data, verifies eligibility, determines benefit levels in accordance to contract guidelines, prepares reports on quality of care, identifies and reports cases, and provides information regarding utilization management requirements and operational procedures to members, providers and facilities.

Job Requirements

* Registered Nurse (RN) with valid, current, unrestricted license in The State of Texas.

- 3 years of clinical experience in a physician office, hospital/surgical setting or health care insurance company.
- Knowledge of medical terminology and procedures.
- Verbal and written communication skills.
- Willingness and ability to travel, on a rare occasion, if needed.

Preferred Job Requirements

- 3+ years of Utilization Management experience is a plus.
- 3 years of clinical experience in various environments including: acute hospital setting, physician office, LTACH/SNF, home health, surgical setting or health care insurance company.
- In-patient nursing experience.
- Specialty RN experience - Oncology, NICU, O/R, Cardio, etc. - a variety of clinical experience is preferred - NOT limited to NICU or Maternal Health
- Intensive Care and/or Critical Care experience is preferred.
- Case Management, Care Management, Condition Management and/or Disease Management experience is a plus.
- MCG Certification is a plus.

- *CA*

Government & Medicaid Business Development Leader | Mercer

Source URL: https://www.linkedin.com/jobs/view/1505192683/?eBP=CwEAAAFv6TUu0gGSYDplyRvQE_nv9y2gQT5l67lMCqydtD0Bo0Z7dnlB6Zut9jjiZNSCEzjCttDMVlXl1pqR5eu_d8AR3SlcOb2nJC9cw3cten_bnfekrBCVTZaiz6ET3ys1WYmsEQTXg_E-ZUEnTEaeryTUuj1N4WDxYuJ7SwLJhB9qJESCTSgj3pg2OuJhv7sMBv-TRSX2N0y3694K1L9TPFdOfVLSp9U7p9rJ2OEBfnkbMu6jprpPJAMrX3496sjhPXhObR6LAHi4DnvpefQFAw&recommendedFlavor=IN_NETWORK&refId=077e323f-8eaa-4bfb-95c9-40486d2f1fcGpSaMYGp1VZAbCDcpRiabDAuD8WzrDAmg9JoQ&trk=d_flagship3_search_srp_jobs

Government & Medicaid Business Development Leader

Company Name Mercer Company Location Phoenix, AZ, US

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

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Have you dedicated your career to the Medicaid programs and want to broaden your ability to make a significant impact in the lives of millions of people? Mercer is the National leader, consulting with dozens of states Medicaid programs spanning actuarial services, data/systems analysis, clinical services, policy design, operational improvement, and procurement efficiency. As a Client Sales Leader you will open the doors for Mercer to share our deep resident knowledge and expertise and make a difference that matters.

As you develop and utilize your current relationships with Medicaid directors you will have a deep consulting team of subject matter experts that will help you create the “wow” moments as you expand ideas and concepts to help states innovate their Medicaid programs . Mercer’s

consulting capabilities will ask you to be professionally nimble, dedicated to finding difficult solutions and to leverage a massive array of intellectual capital.

If this describes you and your career apply and be prepared to talk about the following questions.

- Your personal brand and relationships among Medicaid directors and the Medicaid community.
- Which Medicaid agencies are most influential in your mind and why, as it relates to the consulting industry?
- Which influencers do you feel are most important when selling to the Medicaid Agency beyond the Medicaid Director.

Responsibilities

- Generation of new business and expansion current revenue.
  - Organize and execute a multi-faceted sales plan to include: building effective and collaborative relationships with key decision-makers within target organizations; conducting a minimum number of face to face meetings with prospects; and participating in professional organizations and informal networks to develop, build and sustain a network to obtain prospects
  - Proactively evaluates the existing sales portfolio to identify areas for growth and expansion so as to facilitate adaptation to the external business environment and optimize value from new or different offerings.
  - Develops an expansion strategy or an area of specialization and identifies sales priorities by gaining insight on major or nuanced market developments, new or improved internal offerings, specific account developments and an expansive professional networks.
  - Delegates, attends, speaks and/or presents at relevant industry conferences, publishes white papers, and maintains a large professional network.

- Continuously develop expertise in Medicaid Health Policy, including financial and operational aspects of Medicaid programs, federal regulatory issues, and health care reform. Consider the implication of policy, law, political, etc. changes impact client and client's programs.

Qualifications

- BA/BS degree
- Relevant consulting experience required with 5 years of recent experience in governmental healthcare

- Knowledge and experience dealing directly with State Medicaid Directors and Programs
- Demonstrated professional network of Medicaid relevant relationships including national organizations and state specific.

Mercer delivers advice and technology-driven solutions that help organizations meet the health, wealth and career needs of a changing workforce. Mercer's more than 22,000 employees are based in 43 countries and the firm operates in over 130 countries. Mercer is a wholly owned subsidiary of Marsh & McLennan Companies (NYSE: MMC), the leading global professional services firm in the areas of risk, strategy and people. With more than 60,000 colleagues and annual revenue over $13 billion, Marsh & McLennan helps clients navigate an increasingly dynamic and complex environment.

Marsh & McLennan Companies is also the parent company of Marsh, which advises individual and commercial clients of all sizes on insurance broking and innovative risk management solutions; Guy Carpenter, which develops advanced risk, reinsurance and capital strategies that help clients grow profitably and pursue emerging opportunities; and Oliver Wyman, which serves as a critical strategic, economic and brand advisor to private sector and governmental clients. For more information, visit www.mercer.com. Follow Mercer on Twitter @Mercer.

Mercer LLC and its separately incorporated operating entities around the world are part of Marsh & McLennan Companies, a publicly held company (ticker symbol: MMC).

Marsh & McLennan Companies offers competitive salaries and comprehensive benefits. For more information about our company, please visit us at: http://www.mmc.com/. We embrace a culture that celebrates and promotes the many backgrounds, heritages and perspectives of our colleagues and clients. For more information, please visit us at: www.mmc.com/diversity.

Marsh & McLennan Companies and its Affiliates are EOE Minority/Female/Disability/Vet/Sexual Orientation/Gender Identity employers.

Tribal Option Program Manager | NC Department of Health and Humar

Source URL: https://www.linkedin.com/jobs/view/1688989277/?eBP=CwEAAAFv6TUu0qp4o_gML-_CeYYFddyKSrWsb0kmjw6QP8AeCj2tj7COpD80NLL93gfloDGYzj2WDO8pjWSKMcvUWev401WTg7nrZf8iCvCJzEqsTvORuR7be8dmFAHluoyZsE8FhUHsujLuOrNd2JZC1ACtKX3mmBG-HFyOzn5k57yTTolRokSBYA03653MFjVqYXeByogoh_vG8H_xZFiLl6AGdriDSSfEPBc0_BSXjdEjkK5BjX5ahs63TJC66SlfgrSCg2mokc3Ls3GhzMav4bVmktQ4AHF3yPpw3KgY&recommendedFlavor=IN_NETWORK&refId=077e323f-8eaa-4bfb-95c9-40486d2f1fd5&spSrc=CwEAAAFv6TUu78bJCulAJjZi6WfpsjfihpUlLSevlCTfLVbZM_b5RbIUqZ0ieicl6HBjBgA82VPzrnbRqaehdW5IKA&trk=d_flagship3_

Tribal Option Program Manager

Company Name NC Department of Health and Human Services Company Location Wake County, North Carolina, United States

Posted DatePosted 1 week agoNumber of applicants Be among the first 25 applicants

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The Tribal Option Program Manager is responsible for managing the business and technology implementation and ongoing oversight of the Eastern Band of Cherokee Indians (EBCI) Tribal Option program. The EBCI Tribal Option will be an Indian Managed Care Entity (IMCE) that will serve federally-recognized tribal members and their families, primarily in the western part of North Carolina. The Division of Health Benefits will contract with the Cherokee Indian Hospital Authority (CIHA) to manage the EBCI Tribal Option, which will operate as a primary care case management (PCCM) entity. The EBCI Tribal Option is targeted to go live in July 2021. This position will have both pre-launch and post launch job responsibilities.

Job Specific Responsibilities

- Serve as the Business Lead for the EBCI Tribal Option project and be accountable for all aspects of EBCI Tribal Option project management, implementation, and oversight
- Work across DHB business areas and other partners to implement EBCI Tribal Option business and technology processes
- Develop and maintain business requirements documents for EBCI Tribal Option
- Oversee EBCI Tribal Option PCCM contract responsibilities

- Work with the DHB quality team to develop measures and oversee quality improvement activities for Tribal Option members
- Collaborate with DHB and federal partners to obtain authority to implement EBCI Tribal Option
- Review EBCI Tribal Option policies and procedures, working closely with subject matter experts across DHB
- Oversee readiness review process for EBCI Tribal Option implementation, including coordination of desktop & on-site review with appropriate DHB subject matter experts and submitting reporting to the Centers for Medicare and Medicaid Services (CMS)
- Develop and implement communications and training plans for EBCI Tribal Option implementation, working closely with DHB teams, EBCI partners, and other Department of Health and Human Services (DHHS) partners
- Coordinate activities to ensure program compliance with Federal and State requirements
- Integrate oversight of EBCI Tribal Option across DHB business areas
- Collaborate with EBCI partners, DHB leadership, and DHB business units on ongoing enhancements of the EBCI Tribal Option program
- Conduct oversight of Prepaid Health Plans (PHPs) with respect to contractual requirements related to tribal members and Indian Health Care Providers
- Support oversight of PCCM programs and align program requirements across PCCMs at DHB

Knowledge, Skills and Abilities / Competencies

- Familiarity with Medicaid and health care and associated rules, regulations and standards
- Demonstrated abilities in in project management, including ability to manage projects and programs consistent with objectives, timelines, standards and regulations
- Working knowledge of contract management practices and requirements
- Strong analytical skills for data analysis, program development and evaluation
- Effective communication skills, both verbal and written
- Exceptional organization and time management skills
- Proven ability to develop and implement programs and procedures and to evaluate their effectiveness
- Ability to exercise judgment and discretion in establishing, applying, and interpreting policies and procedures
- Demonstrated ability establishing and maintaining effective working relationships with agency personnel, officials, and stakeholders

<u>Management prefers</u>

- Experience working with federally-recognized tribes and/or knowledge of Medicaid rules specific to tribal populations.
- PMP or CAPM certification, or at least two years of experience in project management.

- Master's degree in a relevant field or strong business, management, or policy background with a bachelor's degree in hospital or health care administration, public or health policy administration, or business administration.

NC Department of Health and Human Services: Overview

Source URL: https://www.linkedin.com/company/ncdhhs/

Medicaid Health Systems Administrator 2

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

Posted DatePosted 2 days 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: Operations

Bureau: Network Management

Working Title: Provider Compliance Manager (PN 20046512)

Job Preview

This position is the agency Provider Compliance Manager, and is part of the Bureau of Network Management. This area at the Ohio Department of Medicaid is collectively responsible for healthcare provider screening, enrollment, and initial compliance verification for all providers as they seek to become Ohio Medicaid providers. This position manages the Compliance team and various compliance activities including site visits for high and moderate risk providers, background checks for owners of high-risk provider types, and a variety of specialized compliance activities for providers of Home and Community Based Services. Additionally, this position works closely with the Ohio Attorney General's Office, specifically the Medicaid Fraud Control Unit.

Job Description

Under general direction, plans, evaluates and directs activities of one work unit or multiple teams related to multiple statewide components of Medicaid health care delivery systems (e.g., health systems program policy analysis and development): manages provider compliance matters related to state and federal requirements, with a focus on federal regulations (e.g., Affordable Care Act) for additional provider screening requirements and revalidation of provider agreements; develops and implements work area procedures and systems (e.g., MITS, OMES) design to capture all necessary screening information including site visits as necessary and depending on the risk status of the provider; acts as team lead on new initiatives from the federal (e.g.: Affordable Care Act) regulations related to Medicaid providers and interface with Medicare, other state agencies, CMS, Attorney General's Office, and the Medicaid Fraud Control Unit; plans, implements, evaluates and directs compliance initiatives and activities for all Medicaid providers; analyzes program integrity information from the Attorney General's office, from CMS, and from various licensing boards, to make sure that Ohio Medicaid providers meet all enrollment requirements. Supervises assigned staff (e.g., makes recommendations for hire of staff; assigns work and provides direction; reviews work and provides feedback; establishes goals and monitors and evaluates performance; encourages staff development; approves/disapproves leave; conducts staff meetings; recommends disciplinary action).

Acts as liaison with agency personnel, providers, legislative committees, state and/or federal agencies; and external stakeholders; represents Ohio Medicaid Provider Compliance in meetings and/or conferences; manages additional screening requirements for providers identified as

high or moderate risk of Medicaid fraud; conducts on-site screening visits as necessary, interfaces with Medicaid Policy areas to represent Provider Compliance (statewide) and provide operational input in policy decisions.

Advises bureau chief and/or deputy director regarding various issues and problems; acts as lead and subject matter expert on various systems (e.g., MITS) design sessions related to provider compliance (i.e., interface with all licensing boards in Ohio for health care providers; 5 year time limited provider agreements and revalidation); works with CMS as appropriate on compliance activities (i.e., attends webinars and other forums to represent Ohio as provider compliance programs); responds to questions related to excluded Ohio Medicaid providers; works with state auditors, federal auditors and any other program integrity bodies to respond to questions, findings for Ohio Medicaid providers (active, inactive); develops and implements internal control procedures and quality assurance processes as necessary.

Performs other related duties (e.g., attends staff meetings & training; travels to meeting sites; maintains records logs & files).

Completion of graduate core program in business, management or public administration, public health, health administration, social or behavioral science or public finance; 24 months of experience in planning & administering 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 analysis).

- Or 24 months experience as a Medicaid Health Systems Administrator 1, 65295.
- Or equivalent of Minimum Class Qualifications for Employment noted above.

Primary Location

United States of America-OHIO-Franklin County

Work Locations

Lazarus 4

Organization

Ohio Department of Medicaid

Classified Indicator

Classified

Bargaining Unit / Exempt

Exempt

Schedule

Full-time

Work Hours

8am -5pm

Compensation

$34.89/hour

Unposting Date

Jan 30, 2020, 11:59:00 PM

Job Function

Health Administration

Agency Contact Name

ODM Human Resources

Agency Contact Information

HumanResources@medicaid.ohio.gov

Seniority Level

Entry level

Industry

- Government Administration

Employment Type

Full-time

Job Functions

- Information Technology

Healthcare Recruiter | UAB Medicine

Source URL: https://www.linkedin.com/jobs/view/1694902870/?alternateChannel=jymbii&alternateCode=seturl&eBP=CwEAAAFv6TUdXfQhX2FrOWascr_goFkl6VXkyYjl9JMKZ9_vjFP7JOmQ1eWx5SkV7pgwkt_m3V4b5S1HsLBTUkStJrfwFq95QxbQpIM8WSLFBbt2mJsL6Xxk0mtibQH4no2CF7fl_fTh0LQ4earhCDeYiNBZVCZGjZdJz-rt8if92rc3el3oawA1wC2vLISTAvu5cBdItopTmT12A4yNi1j-OUfKmh1CSn3KOzzxzfR6MYJ_VPAwTl1O_6In_Gyd7OSwYN6CENWmQ7O-ZxYCY9ML-l4qpESm1COioPtnvqfMa60g5cylL_hvptbaGWwyyNGrC9uNMxVzAnJeS11fEShgGeoVdZTq0VQd2gheGX7yvE-UD8c3tvDA&recommendedFlavor=SCHOOL_RECRUIT&refId=26060fdd-b853-4fc5-99f4-ce3584d8418c&trk=d_flagship3_job_home

Healthcare Recruiter

Company Name UAB Medicine
Company Location Birmingham, Alabama, United States

Posted DatePosted 1 week agoNumber of applicants126 applicants

Position Description:

Under general supervision and according to established policies, procedures and in compliance with federal and state laws, performs applicant screening, and employment-related processes. Interviews and assess qualifications of applicants, and refers qualified candidates to user departments. Administrative responsibilities to maintain confidential records associated with the employment process. Conducts pre-employment computer testing on selected applicants. Meets with new hires and finalizes new employee paperwork as part of the Onboarding process.

Position Requirements:

EDUCATION AND EXPERIENCE:

Required: Position requires a Bachelor's degree in Human Resources or field relevant to Human Resources. Two years of experience in employment/recruitment including experience in interviewing/screening applicants. Excellent verbal/written communication skills, sound judgment and exceptional listening skills required. Must be able to accurately assess issues and determine appropriate next steps. Must be proficient in Microsoft Office Suite, email, and internet applications.

Preferred: Previous experience working in Human Resources in a healthcare recruitment setting or healthcare leadership experience.

LICENSE, CERTIFICATION AND/OR REGISTRATION:

Required: None

Preferred: PHR certification preferred

TRAITS & SKILLS:

Must be self-directed / self-motivated; must have good communication

and interpersonal skills. Must be able to: (1) perform a variety of duties often changing from one task to another of a different nature without loss of efficiency or composure; (2) accept responsibility for the direction, control and planning of an one's own work; (3) work independently; (4) respect and preserve the confidential data to which this position has access,(5) relate to others in a manner which creates a sense of teamwork and cooperation; (7) communicate effectively with people from every socioeconomic, cultural and educational background; (8) exhibit flexibility and cope effectively in an ever-changing, fast-paced healthcare environment; (9) perform effectively when confronted with emergency, critical, or unusual or situations; (10) demonstrate the quality work ethic of doing the right thing the right way; and (11) maintain a customer focus and strive to satisfy the customer's perceived needs.

UA Health Services Foundation (UAHSF) is proud to be an AA/EOE/M/F/Vet/Disabled employer.

Medicaid Health Systems Administrator 2 | Ohio Department of Medicaid

Source URL: https://www.linkedin.com/jobs/view/medicaid-health-systems-administrator-2-at-ohio-department-of-medicaid-1707424010/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

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evaluates and directs compliance initiatives and activities for all Medicaid providers; analyzes program integrity information from the Attorney General's office, from CMS, and from various licensing boards, to make sure that Ohio Medicaid providers meet all enrollment requirements. Supervises assigned staff (e.g., makes recommendations for hire of staff; assigns work and provides direction; reviews work and provides feedback; establishes goals and monitors and evaluates performance; encourages staff development; approves/disapproves leave; conducts staff meetings; recommends disciplinary action).

Acts as liaison with agency personnel, providers, legislative committees, state and/or federal agencies; and external stakeholders; represents Ohio Medicaid Provider Compliance in meetings and/or conferences; manages additional screening requirements for providers identified as high or moderate risk of Medicaid fraud; conducts on-site screening visits as necessary, interfaces with Medicaid Policy areas to represent Provider Compliance (statewide) and provide operational input in policy decisions.

Advises bureau chief and/or deputy director regarding various issues and problems; acts as lead and subject matter expert on various systems (e.g., MITS) design sessions related to provider compliance (i.e., interface with all licensing boards in Ohio for health care providers; 5 year time limited provider agreements and revalidation); works with CMS as appropriate on compliance activities (i.e., attends webinars and other forums to represent Ohio as provider compliance programs); responds to questions related to excluded Ohio Medicaid providers; works with state auditors, federal auditors and any other program integrity bodies to respond to questions, findings for Ohio Medicaid providers (active, inactive); develops and implements internal control procedures and quality assurance processes as necessary.

Performs other related duties (e.g., attends staff meetings & training; travels to meeting sites; maintains records logs & files).

Completion of graduate core program in business, management or public administration, public health, health administration, social or behavioral science or public finance; 24 months of experience in planning & administering 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 analysis).

- Or 24 months experience as a Medicaid Health Systems Administrator 1, 65295.

- Or equivalent of Minimum Class Qualifications for Employment noted above.

Primary Location

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Work Locations

Lazarus 4

Organization

Ohio Department of Medicaid

Classified Indicator

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Bargaining Unit / Exempt

Exempt

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Agency Contact Name

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Agency Contact Information

HumanResources@medicaid.ohio.gov

Seniority Level

Entry level

Industry

- Government Administration

Employment Type

Full-time

Job Functions

- Information Technology

Supervisor, Field Care Management - Medicaid LTC / LTSS Experience Preferred | Jacksonville, FL | WellCare

Source URL: https://jobs.wellcare.com/search/jobdetails/Supervisor,-Field-Care-Management---Medicaid-LTC---LTSS-Experience-Preferred/0ade8a98-966a-4066-af62-876f9dc51364?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Supervisor, Field Care Management - Medicaid LTC / LTSS Experience Preferred

Apply

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.

KEY DETAILS

- This is a field-based role serving supervising field-based individuals in the following counties: Nassau, Duval, Baker, Clay, St. Johns, Flagler, and Volusia.
- Strong preference for individuals that have a background doing Medicaid LTC or LTSS work for a health plan / insurance plan / or other managed care entity.
- 35% travel in the above mentioned area.

Supervises staff, ensures appropriate workload distribution and oversees day to day workflow processes. Ensures team is compliant with all model of care regulatory requirements, and produces optimal clinical, socio economic and resource outcomes. Ensures the case management process of assessing, planning, implementation, coordination, monitoring, and evaluating services and outcomes is pursued to maximize the health of the Member. Oversees the socio economic needs and services of selected member populations across the continuum of illness. Carries an assigned case workload and assumes a leadership role within the interdisciplinary team. Works directly with the member in the field, i.e., inpatient bedside, member's home, provider's office, hospitals, etc. to assess, plan, implement,

coordinate, monitor and evaluate services and outcomes to maximize the health of the member.

REPORTS TO: Mgr, Field Care Management

DEPARTMENT: FL Care Management - Health Services

POSITION LOCATION: Jacksonville, FL

JOB TYPE: Salaried/Exempt

Essential Functions:

- Supervises daily activities of the Field Service Coordination staff ensuring performance standards are met.
- Implements case management work flows and policies & procedures.
- Proactively monitors appropriate metrics to drive up efficiency.
- Perform audits of assessments, care plans and service notes to verify cases are properly established and that member coordination activities are occurring and appropriately documented.
- Carries an assigned case workload. Completes a comprehensive assessment and develops a care plan utilizing clinical expertise to evaluate the members need for alternative services. Assess short-term and long-term needs and establish case management objectives.
- 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.
- 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.
- Conducts performance evaluation, hiring and termination decisions for associates in work group.
- Reviews time records, sets schedules and approves all vacation/time off requests for subordinate associates.
- Provides training and guidance to new and current Field Service Coordinators and/or Social Workers regarding policy & procedure, systemic tools, workload and care plan development.
- Answers all questions and assists peers and management with delegated tasks or projects.
- Takes the lead in preparing and submitting projects, reports or assignments as needed to meet department initiatives and/or objectives.
- Ensures phone or team coverage due to fluctuations in staffing levels.
- Ensures regulatory requirements and accreditation standards are applied to all activity and reporting.

- Plays active role in creating, applying and utilizing accepted policies and procedures.
- Attends company meetings in absence of manager.
- Ensures compliance with all state and federal regulations as well as Corporate guidelines in day-to-day activities.
- 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.

Candidate Education:

- Required A Bachelor's Degree in Nursing, Health Administration or a directly related field
- Required or equivalent work experience
- Required Other For Illinois' Children with High Needs program, a Master’s degree in Nursing, social sciences, social work or related field and a minimum of three (3) years of supervised experience in a human services field.

Candidate Experience:

- Required 4 years of experience in case/behavioral management and/or clinical acute care experience
- Required 3 years of experience in managed care
- Required 1 year experience in leading/supervising others
- Required Other Experience in care of the elderly is required in some geographic regions
- Required Other Understands the business and financial aspect of case/behavioral management in a managed care setting
- Preferred Other Prior utilization management experience preferred in some geographic regions
- Preferred Other Home health, physicians office or public health experience a plus
- Required Other Associates supporting Florida's Children’s Medical Services (CMS) will have a minimum on three (3) years of management/supervisory experience in a healthcare setting and one of the following: An RN License must have a minimum of two (2) years’ experience in Pediatrics -OR- A MA degree in Social work with at least 1 year of related professional experience

Candidate Skills:

- Intermediate Ability to communicate and make recommendations to upper management
- Intermediate Demonstrated time management and priority setting skills
- Intermediate Ability to multi-task
- Intermediate Ability to lead/manage others
- Intermediate Ability to create, review and interpret treatment plans

- Intermediate Demonstrated negotiation skills
- Intermediate Demonstrated interpersonal/verbal communication skills
- Intermediate Demonstrated problem solving skills
- Intermediate Knowledge of community, state and federal laws and resources
- Intermediate Ability to effectively present information and respond to questions from families, members, and providers
- Intermediate Ability to effectively present information and respond to questions from families, members, and providers
- Intermediate Ability to work independently
- Intermediate Other Previous experience working with treatment teams to meet the healthcare needs of participants
- Intermediate Demonstrated written communication skills
- Intermediate Other Ability to lead and manage others in a metric driven environment
- Intermediate Ability to implement process improvements
- Intermediate Other Strong clinical knowledge of broad range of medical practice specialties
- Intermediate Knowledge of healthcare delivery
- Other

Licenses and Certifications:

A license in one of the following is required:
- Required Licensed Registered Nurse (RN)
- Required Licensed Certified Social Worker (LCSW)
- Preferred Other For NJ LTC, licensed RN or licensed behavioral health professional
- Preferred Certified Case Manager (CCM)

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

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

Anthem, Inc Nurse Case Manager I - Medicaid Case Management Job in Maitland, FL

Source URL: https://www.glassdoor.com/job-listing/nurse-case-manager-i-medicaid-case-management-anthem-JV_IC1154238_KO0,45_KE46,52.htm?jl=3473822591&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Nurse Case Manager I - Medicaid Case Management

3.4 ★

Anthem, Inc – Maitland, FL

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Job

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Salary

Benefits

Nurse Case Manager I - Medicaid Case Management

- *Location:** **United States**
- *New**
- *Requisition #:** PS29035
- *Post Date:** 1 day ago

Your Talent. Our Vision. At **Anthem, Inc** ., its a powerful combination, and the foundation upon which were creating greater access to care for our members, greater value for our customers, and greater health for our communities. Join us and **together we will drive the future of health care.**

This is an exceptional opportunity to do innovative work that means more to you and those we serve at one of America's leading health benefits companies and a Fortune Top 50 Company.

- *Nurse Case Manager I (Field) - Tampa, FL**
- *Location: Tampa, FL - This position is 80% Field and 20% Work-At-Home. Work from home ability is begins after 60-90 days of training in the Tampa office**

Responsible for performing care management within the scope of licensure for 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 or on-site such as at hospitals and in the community for discharge planning.

- *Primary duties may include, but are not limited to:**

+ Ensures member access to services appropriate to their health needs.

+ Conducts assessments to identify individual needs and a specific care management plan to address objectives and goals as identified during assessment.

+ Implements care plan by facilitating authorizations/referrals as appropriate within benefits structure or through extra contractual arrangements.

+ Coordinates internal and external resources to meet identified needs.

+ Monitors and evaluates effectiveness of the care management plan and modifies as necessary.

+ Interfaces with Medical Directors and Physician Advisors on the development of care management treatment plans.

+ Negotiates rates of reimbursement, as applicable.

+ Assists in problem solving with providers, claims or service issues.

- *Qualifications:**

+ Requiresa BA/BS in a health related field; 3 years of clinical experience; or anycombination of education and experience, which

would provide an equivalentbackground.

+ Current,unrestricted RN license in applicable state(s) required.

+ Certificationas a Case Manager is preferred.

+ ForURAC accredited areas the following applies: Requires a BA/BS; 3 years ofclinical care experience; or any combination of education and experience, whichwould provide an equivalent background.

+ Current and active RN license required inapplicable state(s).

+ 5years of experience, certification as a Case Manager from the approved list ofcertifications, and a BS in a health or human services related field preferred.

+ Previoushospital experience preferred.

Anthem, Inc. is ranked as one of Americas Most Admired Companiesamong health insurers by Fortune magazine and is a 2018 DiversityInc magazineTop 50 Company for Diversity. To learn more about our company and apply, pleasevisit us at antheminc.com/careers.

An Equal Opportunity Employer/Disability/Veteran

Director, Medicaid Care Management Job in New York, NY - EmblemHealth

Source URL: https://www.careerbuilder.com/job/J3V5SV735395BZV25SW?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director, Medicaid Care Management

EmblemHealthNew York, NYFull-Time

Apply Now

Oversee a team of care coordinators and outreach workers responsible for person-centered care planning, addressing social determinants of health, and improving access to care. Develop, implement and monitor care coordination programs and processes, and quality improvement

initiatives specifically designed to improve Medicaid member engagement, access to care, CHAPS scores, and overall quality performance. Develop and implement strategies designed to improve PDPQI performance. In collaboration with the Quality team, develop rewards and incentive programs for Medicaid members. Develop dashboards to evaluate and monitor performance and outcomes achieved by the care coordinators. Collaborate with the Director of Medicaid Strategy to implement innovations around social determinants of health. Ensure that Care Coordinators are implementing EmblemHealth Health plan policies, procedures and all regulatory mandates, consistent with EmblemHealth Plan's mission, vision, purpose and value statement in collaboration with departments across the enterprise. Report on program metrics, collecting all data needed.

Responsibilities:

- Ensure all Medicaid members care is coordinated for all physical and mental health diagnoses, including communicating referrals to medical providers, behavioral health providers, and community-based referrals.
- Direct the day-to-day operation and performance of the Care Coordination unit.
- Effectively communicate with and guide the Care Coordinators to accomplish the Medicaid program's goals and objectives and facilitates clinical insight on Medicaid operational and member issues.
- Educate and work collaboratively with community partners, i.e. Health Homes, on member referrals, engagement and case conferencing
- Provide comprehensive outreach program planning with follow-through to members and an on as-needed, ongoing basis.
- Work collaboratively with enrollment and retention to ensure care coordinators assist in member recertification and retention.
- Develop and manage a plan of care program that ensures the health of all Medicaid members, including field-based outreach and visits, telephonic outreach to members, telephonic outreach to providers and community-based organizations, connections to health home services, and regulatory reporting.
- Design and implement Care Coordination and quality initiatives reporting requirements required by NYS DOH, OMH, OASAS.
- Working with LDSS, identify Medicaid members, develop their plans of care and update local government agencies in routine care conferences through discharge planning.
- Maintain contract obligations for all aspects of care to Medicaid members.
- Develop a dashboard with quality measures tracking Care Coordination to oversee PDI/PQI requirements to support organizational deliverables.
- Deliver disease management coordination and support to Medicaid members, including managing the coordination of treatment and services among providers and community groups and services.

- Grow Medicaid membership at EmblemHealth, and in doing so meet expectations by each member to receive treatment and support—including medication.
- Develop optimal workflows with each business area within EmblemHealth to meet compliance with the Medicaid contract.
- Direct and manage treatment and services across EmblemHealth departments to align treatment best practices.
- Develop and report results across the enterprise for Key Performance Indicators describing care coordination for Medicaid patients.
- Provide education to community-based organizations on large scale trends by disease category affecting members.
- Provide education to community-based organizations on specific diseases on a case by case basis.
- Direct strategy and initiatives to engage the Medicaid population, ensuring that Care Coordinators meet all requirements for annual visits with providers.
- Design a member-incentive program with leaders of the Quality Management department.
- Develop survey methodologies to gain data directly from members and evaluate the effectiveness of EmblemHealth's care coordination of Medicaid population health.
- Address findings of surveys across departments in EmblemHealth to improve services and ensure health issues are fully addressed.
- Collaborate with LDSS and VFCA's and ensure liaisons are ensuring access to care and community partners for the medically fragile and foster care children.
- Manage committee meetings across all operational groups to inform the business areas on what they are doing and to improve interdepartmental cross-functional ability.
- Lead and build effective, tight clinical relationships across the enterprise to ensure consistent delivery of services and resolution of obstacles and issues.

Qualifications:

- Bachelor's Degree in healthcare, business, finance, mathematics, engineering, applied stats/economic or any other related analytical fields; Master's preferred
- RN preferred
- Minimum 10 years' experience in the healthcare or managed care industry, or related field required
- Minimum 3 – 5 years' experience managing staff/processes in Medicaid function or related required
- Industry level proficiency in all applicable Medicaid-related areas, including HEDIS/QARR/CAHPS, CMS Star Ratings, and Accreditation process required
- Thorough knowledge of State and/or Federal program operations and regulations required
- Experience managing performance and processes to improve performance required
- Excellent communication skills, written and verbal required

- Proven ability to establish and maintain relationships of trust with department staff and management required
- Proficient handling data, analytics, metrics; ability to interpret data and develop cohesive findings and summaries for senior management required
- Proficient in Microsoft Office (Word, PowerPoint, Excel, Access) required

Additional Information
- Requisition ID: 1919K

EEOC Statement
We are committed to leveraging the diverse backgrounds, perspectives and experiences of our workforce to create opportunities for our people and our business. We are an equal opportunity/affirmative action employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability, protected veteran status or any other characteristic protected by law.

Sponsorship Statement
Depending on factors such as business unit requirements, the nature of the position, cost and applicable laws and regulations, EmblemHealth may provide work visa sponsorship for certain positions.

Recommended skills

Managed Care

Performance Management

Healthcare Effectiveness Data And Information Set

Medicaid

Health Care

Microsoft Access

Health Plan Specialist II (Field) CHC | Texas

Source URL: https://jobs.harrishealth.org/health-plan-specialist-ii-field-chc/job/12217019?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Health Plan Specialist II (Field) CHC

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 Health Plan Specialist II is responsible for leading activities to achieve membership/enrollment goals in all product lines offered by Community Health Choice through various means, including, but not limited to, marketing projects and

new market initiatives, reporting and analysis of marketing data for service areas, identifying new sites and community partners, discovering new community activities and member retention activities, brand visibility, vendor outreach and networking opportunities.

QUALIFICATIONS:

- High School Diploma, some college preferred, Life and Health license within 90 days of hire date
- Two years experience in Medicaid and CHIP, Health insurance or similar experience with nonprofit organization assisting low income population

OTHER SKILLS:

- Above Average Verbal (Heavy Public Contact)
- Exceptional Verbal (e.g., Public Speaking)
- Writing /Composing /Correspondence / Reports
- MS Word
- MS Excel
- Must be familiar with health insurance programs and their components,

	including STAR Medicaid/CHIP programs and Health Insurance Marketplace
	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!

Apply Online

Click Here to

Apply Online

Houston, TX

Posted: 1/27/2020

Job Status: Full Time

Job Reference #: 149504