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# Medicaid Jobs Hunter

1. Health Insurance Specialist Job in GWYNN OAK, MD
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## Health Insurance Specialist Job in GWYNN OAK, MD

**SourceURL:** http://federalgovernmentjobs.us/jobs/Health-Insurance-Specialist-527527600.html?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

### Requirements

#### Conditions of Employment

- You must be a U.S. Citizen or National to apply for this position.
- You will be subject to a background and suitability investigation.
- Time-in-Grade restrictions apply.

## Qualifications

ALL QUALIFICATION REQUIREMENTS MUST BE MET WITHIN 30 DAYS OF THE CLOSING DATE OF THIS ANNOUNCEMENT.

In order to qualify for the GS-13 grade level, you must meet the following: You must demonstrate in your resume at least one year (52 weeks) of qualifying specialized experience equivalent to the GS-12 grade level in the Federal government, obtained in either the private or public sector, to include:

1) Analyzing program effects using quantitative and qualitative methods to determine if adopted regulations and policies increase or decrease burden on beneficiaries, stakeholders and regulated entities;

2) Evaluating program performance and industry compliance with Health Insurance and Portability Accountability Act (HIPAA) administrative simplification regulations and policies, or other Federal regulations and policies; including, the study of utilization rates of adopted standards, clarity of guidance to industry and effectiveness; and

3) Developing regulations, policies or operational guidance in order to facilitate the effective exchange of health care information, such as eligibility verifications, claims submissions, or claims payments among health care providers, payers and clearinghouses to support delivery of timely and appropriate care to patients.

Experience refers to paid and unpaid experience, including volunteer work done through National Service programs (e.g., Peace Corps, AmeriCorps) and other organizations (e.g., professional; philanthropic; religious; spiritual; community, student, social). Volunteer work helps build critical competencies, knowledge, and skills and can provide valuable training and experience that translates directly to paid employment. You will receive credit for all qualifying experience, including volunteer experience.

Time-in-Grade: To be eligible, current Federal employees must have served at least 52 weeks (one year) at the next lower grade level from the position/grade level(s) to which they are applying.

Click the following link to view the occupational questionnaire:
https://apply.usastaffing.gov/ViewQuestionnaire/10451578

## Education

This job does not have an education qualification requirement.

## Additional information

Bargaining Unit Position: Yes
Tour of Duty: Flexible
Recruitment/Relocation Incentive: Not Authorized
Financial Disclosure: Not Required

CMS employees currently participating in 100% Full-Time Telework Program may be eligible to remain in the program. If an employee in this program is selected, the pay will be set in accordance with the locality pay for the applicable duty station. The listed salary range reflects the locality pay assigned to the duty location(s) listed in the vacancy announcement. For more

information about pay based on locality, please visit the Office of Personnel Management (OPM) Salaries & Wages Page.

The Interagency Career Transition Assistance Plan (ICTAP) and Career Transition Assistance Plan (CTAP) provide eligible displaced federal employees with selection priority over other candidates for competitive service vacancies. To be qualified you must submit the required documentation and be rated well-qualified for this vacancy. Click here for a detailed description of the required supporting documents. A well-qualified applicant is one whose knowledge, skills and abilities clearly exceed the minimum qualification requirements of the position. Additional information about ICTAP and CTAP eligibility is on OPM's Career Transition Resources website at www.opm.gov/rif/employee_guides/career_transition.asp.

Additional Forms REQUIRED Prior to Appointment:

- Optional Form 306, Declaration of Federal Employment and the Background/Suitability Investigation - A background and suitability investigation will be required for all selectees. Appointment will be subject to the successful completion of the investigation and favorable adjudication. Failure to successfully meet these requirements may be grounds for appropriate personnel action. In addition, if hired, a reinvestigation or supplemental investigation may be required at a later time. If selected, the Optional Form 306 will be required prior to final job offer. Click here to obtain a copy of the Optional Form 306.
- Form I-9, Employment Verification and the Electronic Eligibility Verification Program - CMS participates in the Electronic Employment Eligibility Verification Program (E-Verify). E-Verify helps employers determine employment eligibility of new hires and the validity of their Social Security numbers. If selected, the Form I-9 will be required at the time of in-processing. Click here for more information about E-Verify and to obtain a copy of the Form I-9.
- Standard Form 61, Appointment Affidavits - If selected, the Standard Form 61 will be required at the time of in-processing. Click here to obtain a copy of the Standard Form 61.

Additional selections may be made from this announcement for similar positions within CMS in the same geographical location. For Central Office vacancies, the "same geographical location" includes Baltimore, Maryland; Bethesda, Maryland; and Washington, D.C.

If you are unable to apply online or need to fax a document you do not have in electronic form, view the following link for information regarding an Alternate Application.

## How You Will Be Evaluated

You will be evaluated for this job based on how well you meet the qualifications above.

Once the announcement has closed, your online application, resume, and CMS required documents will be used to determine if you meet eligibility and qualification requirements listed on this announcement. If you are found to be among the top qualified candidates, you will be referred to the selecting official for employment consideration. Please follow all instructions carefully. Errors or omissions may affect your rating.

Your qualifications will be evaluated on the following competencies (knowledge, skills, abilities and other characteristics):

- Oral Communication
- Project Management
- Written Communication

## Background checks and security clearance

**Security clearance**

Not Required

**Drug test required**

No

# Director of Managed Care & Medicaid Affairs with Numotion in Dallas, TX |

**SourceURL:** https://www.linkedin.com/jobs/view/director-of-managed-care-medicaid-affairs-with-numotion-at-not-just-a-job-search-1187728353

### Dallas, TX

Apply on company website

## Job description

The position listed below is not with Not Just a Job Search but with Numotion

Numotion is the leading provider of Complex Rehab Technology (CRT) in the United States. That means were helping thousands of people with individually configured, medically necessary mobility products and services. From manual and powered wheelchairs to disposable medical supplies that serve unique medical and functional needs, we are helping more people live more freely.

**Responsiblities**

The Director of Managed Care & Medicaid Affairs will be responsible for the following

Numotion is seeking a Director of Managed Care & Medicaid Affairs to join our growing team.

Directing and coordinating payer relations teams involvement in acquisition and integration activity. Directing and coordinating payer relations teams involvement in payer audits. Oversight of company relationships with Medicaid. Mitigating rate reductions with state Medicaid programs. Efforts to reverse or improve Medicaid policies or regulations that negatively impact Numotions ability to provide. Coordination of efforts to overturn or improve Medicare rules, laws, or procedures that negatively impact Numotions ability to provide. Coordination of legislative, public relations, and customer advocacy efforts as needed for state Medicaid activities. Coordinating and participating in federal legislative activities relative to CRT coverage and reimbursement as needed. Training and education for Directors of Payer Contracting. Onboarding of new Directors of Payer Contracting. Project management of IT enhancements, tracking, and new policy development to aid in gaining efficiencies for the Payer Relations team. Essential Functions:

**Qualifications**

Identifies reimbursement/ coverage problems with Medicare and Medicaid programs and acts accordingly Coaches and trains the Directors of Payer Contracting on Medicaid policy and regulation Assists VP of Contracting and EVP of Payer Relations in development of strategies for Commercial Payers and Medicaid Enlists the help of the Directors of Payer Contracting as needed to resolve Medicaid and Commercial Payer issues Follows up on escalated Medicaid/ customer

complaints which could affect Numotions relationship with state Medicaid Manages ongoing business development with state Medicaid programs (implementation of CEU courses) Works with RVP/ Area Manager of Sales to build stronger relationship with payer at the local level Maintains relationships with Medicaid staff Aids in the contact of legislators, clinicians and consumers to promote passage of the CRT Federal Legislation Participates in government relations meetings, such as those with legislators, when necessary Coordinates consumer advocacy efforts as needed Oversees Numotion attendance at hearings and state association meetings; acts on information obtained at meetings Evaluates rates and identifies areas of concern Understands and identifies coverage problems regarding reimbursement and payer processes Understands impact of Medicaid program changes on Managed Care payers Capable of executing professional phone calls and emails to legislators and legislative staff Identifies when CRT coverage and reimbursement issues may require legislative attention Initiates meetings with legislators and legislative staff when necessary Liaison for state fair hearings, and additional advocacy efforts related to assisting in obtaining equipment Perform related duties as required.

Experience working for a CRT provider or manufacturer in a high level position; and/ or Basic understanding of Medical Equipment billing and collection procedures and Medicare policies; and Knowledge of HCPC codes and how they are used; and Experience negotiating with state Medicaid programs; and Independent thinker; and Advanced problem solving skills; and Excellent relationship building skills; and Ability to work in a fast-paced environment and juggle multiple priorities; and Able to think quickly, assess a situation and make a sound decision; and Proficiency in electronic communication including PC, tablet, and smart phone At Numotion, we are committed to meeting the needs of those we serve, and our employees. Working for Numotion, you will receive a competitive wage and benefits, including medical, dental and vision insurance, short or long term disability, a 401 K plan and life insurance.
Numotion is an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, protected veteran status or disability status.
Numotion is a drug-free workplace. Candidates are required to pass a drug test before beginning employment.
Associated topics: advertise, cmo, demand, demand generation, event, festival, hospital, lead generation, regulatory, social media

- **Seniority level**

  Director

- **Employment type**

  Full-time

- **Job function**

  Health Care Provider

- **Industries**

  Medical DevicesHealth, Wellness and FitnessHospital & Health Care

# Optima Health hiring Medical Assistant Neurology Specialist - Obici in Suffolk, VA

**SourceURL:** https://www.linkedin.com/jobs/view/medical-assistant-neurology-specialist-obici-at-optima-health-1186798795

**Suffolk, VA**

Apply on company website

# Job description

Perform patient care and administrative/clerical related tasks and procedures based on training, education, and competency evaluations, and as delegated by and under the direction/supervision of the Physician, Nurse Practitioner/Physician Assistant (NP/PA), Registered Nurse (RN), or Licensed Practical Nurse (LPN)

Required Education

High School Grad or Equivalent

SDL2019-130

- **Seniority level**

  Entry level

- **Employment type**

  Full-time

- **Job function**

  Health Care Provider

- **Industries**

  Information Technology and ServicesInsuranceHospital & Health Care

Optima Health

- Insurance
- 501-1000 employees
- Founded 1984
- Nonprofit

About us
At Optima Health, our goal is to improve health every day, by providing our members with the services, tools, and information to make better choices about their healthcare. We offer innovative programs for members with chronic illnesses, customized wellness programs, integrated clinical and behavioral health services, and pharmacy management—as well as comprehensive health insurance plans. With more than 30 years of experience in the health insurance arena, Optima Health offers a suite of commercial products including consumer-directed, employer-owned and employer-sponsored plans, individual health plans, employee assistance programs, and plans serving Medicare and Medicaid enrollees. We provide health insurance coverage to over 500,000 members throughout Virginia. Our provider network features

26,000 providers including specialists, primary care physicians, and hospitals across Virginia. To learn more about Optima Health, visit optimahealth.com.

# Monroe Plan for Medical Care hiring Facilitated Enroller in Buffalo, NY |

**SourceURL:** https://www.linkedin.com/jobs/view/facilitated-enroller-at-monroe-plan-for-medical-care-1169256387

### Buffalo, NY

Apply on company website

## Job description

**Position Summary**

The Facilitated Enroller (FE) is responsible for identifying prospective members that do not have health insurance and enroll them into one of the Plan's products. The FE conducts interviews and screens potentially eligible recipients for enrollment into Government Programs such as Medicaid and Child Health Plus. Facilitated enrollers assist families with their applications, providing assistance with completing the application, gathering the necessary documentation and assist in selection of the appropriate health plan. The Enroller provides information on managed care programs and how to access care. The Facilitated Enroller is responsible for processing paperwork completely and accurately, including follow up visits documentation and other necessary reports. The FE is also responsible for assisting current members by recertifying them into their plan. Maintains professional, congenial relationships with local community agencies as well as county and state agency personnel who refer potentially eligible recipients.

**Essential Job Duties/Functions**

**% of Time**

**Essential Function**

**80 Enrollment**

- Interview, screen and enroll potentially eligible recipients into Child Health Plus and refers Medicaid eligible recipients to the local Department of Social Services.
- Assist individuals with the application process by explaining requirements and necessary documentation
- Identify and educate potential members on all aspects of the plan including answering questions regarding plan's features and benefits and walking client through the required disclosures
- Assist clients with choosing a managed care plan and primary care physician
- Submit all completed applications, adhering to submission deadline dates as imposed by NYS and Monroe Plan enrollment guidelines and requirements
- Responsible for identifying and assisting current members who are due to re-certify their healthcare coverage by completing member's annual recertification application including

adding on additional eligible family members
- Conducts and documents membership welcome calls
- Respond to inquiries from prospective members and members within the marketing guidelines

**20 Outreach Projects**

- Participate in any community outreach projects to other agencies as assigned by Management
- Establish and maintain good working relationships with external business partners such as hospital and provider organizations, city agencies and community based organizations where enrollment activities are conducted. Develop and strengthen relations in order to generate new opportunities
- Attend community health fairs as required
- Occasional weekend or evening availability for special events

**Other Functions And Responsibilities**

- Attend regularly scheduled departmental meetings
- Position may require overtime hours, evenings and weekends
- Extensive travel throughout the service region is required
- Performs other duties as assigned.

**Minimum Requirements/Licenses/Certifications**

- AA/AS – Associates degree
- A minimum of two years' experience as a facilitated enroller
- Demonstrated organizational skills, time management skills and ability to work independently
- Ability to meet deadlines
- Excellent written and oral communication skills; strong presentation skills
- Basic computer skills including Microsoft Word and Excel
- Strong interpersonal skills
- Must have reliable transportation and a valid NYS drivers' license with no restrictions
- Knowledge of Managed Care insurance plans
- Ability to work with a diverse population

**Preferred Qualifications**

- Bilingual - Spanish & English

- ## Seniority level

  Not Applicable

- ## Employment type

  Full-time

- ## Job function

  Other

- ## Industries

  Nonprofit Organization ManagementMental Health CareHospital & Health Care

Monroe Plan for Medical Care

- Insurance

- 51-200 employees
- Founded 1970
- Public Company

About us
Monroe Plan for Medical Care is a health care services organization, meeting the needs of low income and government sponsored populations in Upstate New York since 1970. Monroe Plan has been recognized nationally as a health care leader with a proven track record of improving health outcomes and reducing disparities through its partnerships with the health care provider and community based organizations. Today Monroe Plan has three distinct entities. Monroe Plan for Medical Care serves as the parent company for YourCare Health Plan, a non-profit pre-paid health services plan and MP Care Solutions, a for profit subsidiary that builds on the talents of our employees to service providers and government health insurance programs in diverse ways. Our employees take an active role in facilitating access to high quality health care services, empowering members to take an active role in their health, fostering strong partnerships between patients and providers, supporting caregivers in delivering high quality services, & collaborating with community groups on issues affecting the health needs of patients & their families. We treat our employees with the same respect and care with which we want them to treat our members, service receivers and providers. We offer a rich benefits package, a supportive environment and passionate co-workers. We are proud that our employees voted Monroe Plan a Top Workplace in Rochester in 2015! To learn about current employment opportunities, please visit: http://www.monroeplan.com/ Monroe Plan for Medical Care is an equal opportunity employer. Applicants are considered without regard to race, religion, gender, national origin, age, disability, sexual orientation, marital status, veteran status, arrest record, genetic predisposition or carrier status, or any other consideration made unlawful by applicable federal, state or local laws.

# Registered Nurse | Memphis, TN |

**SourceURL:** https://www.helpwanted.com/cf991b19a2f14-Registered-Nurse-job-listings?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

**UnitedHealth Group**

- **Job Type(s)**

**Full Time**

## Job Description

In this role, you will work in the field and coordinate care on behalf of health plan enrollees who are receiving Long Term Services and Supports (LTSS), Medicare and home and community services and Medicaid Home Health Agency and PDN services. Your experience with home health agency, hospital and long-term care facilities will be essential in relaying the pertinent information about the patient needs and advocating for the best possible care available. At times, your patience may be challenged. But in the end, your confidence, decisiveness and perseverance will help you positively impact the lives of the people we serve, and ensure more positive outcomes for all. This position is Field Based which requires travel in various counties:If you are located in the

Southwestern part of TN in or near Shelby or Tipton County, you will have the flexibility to telecommute* as you take on some tough challenges.**Primary responsibilities:**+ Assess, plan and participate in the implementation of care strategies that are individualized and directed toward the most appropriate, least restrictive setting+ Utilize both company and community-based resources to establish a safe and effective support plan for the people we serve+ Collaborate with people enrolled in the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), DSNP, LTSS and Medicaid programs, and healthcare providers to develop, modify, and update Individualized Care Plans inclusive of measurable goals and outcomes+ Work with the Case Manager to identify and initiate referrals for social service programs; including financial, psychosocial, community, and state supportive services+ Advocate for the people we serve, and their families as needed to ensure their needs are assessed and choices are fully represented and supported by the healthcare team+ Utilize approved clinical criteria to assess and determine appropriate level of care, document all telephonic and in-person encounters, assessments, and referrals.+ Participate in Interdisciplinary Care Team meetings and assist with safe transitions of care+ Understand health insurance products, benefits, coverage limitations, and governmental regulations as it applies to the health plan+ Accountable to understand role and how it affects utilization management benchmarks and quality outcomes+ Conduct field assessments around LTSS HCBS needs, SDOH, ADL/IADL needs, and skilled needs+ Conduct field review visits for authorization purposes around LTSS and Home Health/PDN requested servicesThis role involves approximately 75% travel and you ll need to be comfortable dealing with a full range of in-home and facility-based environments. Most of the time you ll work autonomously, so the ability to stay focused and motivated is essential.**Required Qualifications:**+ Current unrestricted RN licensure in TN+ 1+ year of home care/home health and/or other case management experience+ 3+ years of clinical experience+ Computer/typing proficiency to enter/retrieve data in electronic clinical records; experience with email, internet research, use of online calendars and other software applications+ Reliable transportation to travel to the person s home or other locations within service delivery area**Preferred Qualifications:**+ Bachelor's Degree in Nursing+ Medicaid experience specifically LTSS+ Medicare experience+ Experience working in a health plan or other managed care setting+ Experience with community health and/or public health+ Experience with utilization review or home health assessment work+ Bilingual skills+ Problem solving skills; the ability to systematically analyze problems, draw relevant conclusions and devise appropriate courses of action+ Ability to communicate complex or technical information in a manner that others can understand, as well as ability to understand and interpret complex information from others**Careers at UnitedHealthcare Community & State.** Challenge brings out the best in us. It also attracts the best. That's why you'll find some of the most amazingly talented people in health care here. We serve the health care needs of low income adults and children with debilitating illnesses such as cardiovascular disease, diabetes, HIV/AIDS and high-risk pregnancy. Our holistic, outcomes-based approach considers social, behavioral, economic, physical and environmental factors. Join us. Work with proactive health care, community and government partners to heal health care and create positive change for those who need it most. This is the place to do **your life's best work.** **SM***All Telecommuters will be required to adhere to UnitedHealth Group s Telecommuter Policy_Diversity creates a healthier atmosphere: UnitedHealth Group is an Equal Employment Opportunity/Affirmative Action employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, age, national origin, protected veteran status, disability status, sexual orientation, gender identity or expression, marital status, genetic information, or any other characteristic protected by law.__UnitedHealth Group is a drug-free workplace. Candidates are required to pass a drug test before beginning employment._Job Keywords: RN, Registered Nurse, case management, case manager, behavioral health, Care Coordinator, social services, community health, Medicaid, home care, community health, managed care, home health, public health, hospice, health care, long term care, mental health, LTC, LTSS, Medicaid, Medicare, ID, IDD, Tipton, Haywood, Shelby, Fayette, Hardeman, McNairy, Hardin, Wayne, Chester, Perry, Hickman, Lewis, Memphis, Somerville, Savannah, Selmer, Bolivar, Decaturville,This is a field based role that will cover these counties: Tipton, Haywood,

Shelby, Fayette, Hardeman, McNairy, Hardin, Wayne, Chester, Perry, Hickman and Lewis, Tennessee, TN

# Jobs @ TheJobNetwork hiring Director Enterprise Clinical Quality (Medicaid) in Philadelphia, PA

**SourceURL:** https://www.linkedin.com/jobs/view/director-enterprise-clinical-quality-medicaid-at-jobs-%40-thejobnetwork-1185642441

**Philadelphia, PA**

Apply on company website

## Job description

At AmeriHealth Caritas, we're passionate about helping people get care, stay well and build healthy communities. As one of the nations leaders in health care solutions, we offer our associates the opportunity to impact the lives of millions of people through our national footprint of products, services and award-winning programs. AmeriHealth Caritas is seeking talented, passionate individuals to join our team. Together we can build healthier communities. If you want to make a difference, we'd like to hear from you.
Headquartered in Philadelphia, AmeriHealth Caritas is a mission-driven organization with more than 30 of experience. We deliver comprehensive, outcomes-driven care to those who need it most. We offer integrated managed care products, pharmaceutical benefit management and specialty pharmacy services, behavioral health services, and other administrative services. Discover more about us at www.amerihealthcaritas.com.

**Responsibilities**

Under the general direction of the Vice , Corporate Quality Management, the , Medicaid Clinical Quality provides operational and strategic leadership to the AmeriHealth Caritas Medicaid Quality Management program and initiatives. This position provides direction for the implementation of performance improvement initiatives to drive improvements in health outcome metrics including HEDIS, CAHPS and other industry metrics plan-level and corporate goals. Ensures consistency of all new and existing quality management policies, practices and programs across the company.

**Major Accountabilities**

- Drives excellence in improving provider and member satisfaction, HEDIS, achieving operational excellence;
- Provides direction for ongoing monitoring and updating of accreditation and medical management aspects of the enterprise infrastructure;
- Works collaboratively with all areas of the organization to integrate Quality Management initiatives and goals with organizational programs

- champions the use of and acts as a resource for the dissemination of the Quality Management best practices throughout the AmeriHealth Family of Companies.
- Participates in the development and response for new business opportunities.Provides support and resources for new business implementation.
- Provides leadership through both direct and indirect matrixes reporting structures.
- Collects and disseminates 'best practices' in performance improvement across the Medicaid LOB and the enterprise.
- Stays abreast of policy, measurement and accreditation evolution impacting the Medicaid Line of Business.

  **Education/Experience**
  - Bachelor's Degree in in health care, public administration or related field required.
  - 's Degree in health care, public administration or related field highly preferred.
  - Registered Nurse - state license required.
  - 8 –10 of progressive management experience (including staff management) in a managed care environment. Experience with Managed Medicaid programs highly desirable. Management experience with Quality programs, Case Management and Utilization management programs. Experience in QM, CM and UM program design, implementation. Should include experience in setting, communicating and implementing strategic direction.
  - Proven ability to navigate effectively and influence at the executive level in a matrixed, multi-business enterprise.
  - Demonstrated ability to interface, influence and made strategic and tactical decisions at the executive management level.
  - Strong background in managed care information systems, data collection and reporting,
  - High degree of operational and clinical expertise and knowledge of various managed care payment arrangements.

  PandoLogic. Keywords: Clinical Quality Management Director, Location: Philadelphia, PA - 19122

# UPMC Health Plan hiring Senior Medical Director- Pediatrics in Pittsburgh, PA

**SourceURL:** https://www.linkedin.com/jobs/view/senior-medical-director-pediatrics-at-upmc-health-plan-1187609610

**Pittsburgh, PA**

Apply on company website

## Job description

The Senior Medical Director will have the rare and exciting opportunity to join a senior team recognized as UPMC's best and brightest leaders. He/she will shape the way UPMC Health Plan manages all services for children. The success of UPMC Health Plan will rely upon this individual's creativity, discipline, detail and a passion to 'make a real difference' beyond conventional managed care. The Senior Medical Director will serve as a pivotal strategic and clinical leader, responsible for the medical role in products for all children, including those in CHIP, Medicaid and commercial, and will serve as the Senior Medical Director of our CHIP plan. . He/she will

possess wide-ranging expertise in chronic care, disease management, utilization management and government programs. Serving as a bridge builder and champion, the Senior Medical Director will have a dual focus: leading a clinical team of nurses and clinicians, and leading cutting-edge population health management, quality initiatives (HEDIS, NCQA), health analytics initiatives, and ultimately will work to impact the health of pediatric populations.

**Responsibilities**

- Passionately manage children's services in UPMC Health Plan's CHIP, and Medicaid lines of business, to include; leading, educating and mentoring, managing all strategic and clinical of Medical Management, Quality, Health Management, Utilization Management, Disease Management, Strategic Planning and Policy.
- Provide clinical leadership and support for Quality Improvement program, including study design for NCQA accreditation initiatives, coordination of HEDIS reporting, as well as meeting or exceeding all regulatory requirements. Serve as Clinical Leader for the UPMC pediatric programs.
- Collaborate with other relevant physician staff to engage all functional areas of the Health Plan from a clinical perspective to develop innovative programs.
- Interface with UPMC Health System cross-functional and shared resources to further the 'cause' to create a seamless healthcare patient- flow management process and insurance model.
- As a clinical 'thought leader' and member of the Medical Director community will participate in the creation of opportunities to consult, interact and elicit feedback with the physician community, then act upon this valuable information, raising proactive clinical intervention to unprecedented levels.
- Serve as an integral part in the design and implementation of medical management initiatives such as disease management to improve quality and cost effectiveness of care delivered to Commercial, CHIP and Medicaid members.
- Swiftly respond to challenges and/or opportunities as they arise.
- Develop and implement innovative programs to act on historical data, identifying new trends, retooling existing approaches, and analyzing the competition.
- Collaborate with Health Plan senior leadership in the development of short-term, mid-term, and long- range strategic planning for the Health Plan.
- Partner with physician leaders, and hospital and business executives to exceed clinical, operating, financial, quality, and market share objectives.
- Deliver executive level presentations for UPMC senior management and other designated groups.
- Collaborate with physicians to develop clinical programming by accessing and mining clinical data, devising methods to manage populations.
- Partner with physicians to improve reimbursement model and performance based physician incentive programs.
- Influence medical cost trend in partnership with network services and medical management team, including development of trend- specific initiatives, provider fee schedule review, and identification of medical management best practices.
- Create opportunities to integrate pharmaceutical and medical strategy with innovative solutions.
- Assist with the development of a clinical organization which prioritizes the retrieval and intuitive interpretation and evaluation of statistics and medical trends in order to establish aggressive preventative health targets and objectives.
- Ensure continuous improvement strategies are established and implemented for Health Management outcomes and processes encouraging a culture which initiates intensive and persistent case management for members.
- Serve on physician committees and work with each Health Management program to monitor, assess and ensure the program's clinical success.
- Establish best practices for care programs including Diabetes, Asthma, Pediatric, and Maternity Programs.
- As an integral member of UPMC Health Plan's leadership team, serve as a 'role model' and 'health advocate' within the Western Pennsylvania community, including active

participation with UPMC sponsored activities, public events and community outreach programs.
- Nurture personal and professional growth/development by attending seminars, workshops, and establishing professional affiliations to keep abreast of latest trends in field of expertise.

**Qualifications**

- Minimum 10 years clinical experience.
- Doctor of Medicine or Doctor of Osteopathy from an accredited school.
- Unrestricted License in Pennsylvania.
- Post residency clinical experience.
- It is preferred that the Senior Medical Director will possess extensive experience with products within a progressive managed care organization, ideally having created and driven innovative clinical program initiatives as well as having initiated quality accreditation and certification.
- Experience in Behavioral Health treatment and program development.
- At least 5 years of management experience preferred.
- Experience in managed care setting preferred.
- Ability to implement medical policies, and to enforce those policies through appropriate action.
- Ability to maintain effective professional liaison with all levels of executive and medical staff, including professional and institutional providers of care.
- Ability to implement programs of quality care analysis, peer review, and professional education.
- Operates effectively in a 'matrix' environment. Views the various matrix partners within UPMC as customers.
- Possesses the appropriate level of patience, and persistence, to move issues forward while competing in a highly complex, turbulent, and market- driven industry.
- Board Certification in Psychiatry required
- Act 33 Child Clearance with Renewal
- Act 34 Criminal Clearance with Renewal
- Act 73 FBI Clearance
- Doctor of Osteopathy or Medical Doctor

# UPMC Health Plan hiring AVP Government Products Operations Support in Pittsburgh, PA

**SourceURL:** https://www.linkedin.com/jobs/view/avp-government-products-operations-support-at-upmc-health-plan-1187610883

**Pittsburgh, PA**

Apply on company website

## Job description

The AVP will have the exciting opportunity to join a growing and diversifying integrated delivery and financing system as a clinical leader in the transformation to a population health management care and operating model for the Government Product Line of the UPMC Insurance Division. He/she will serve as a change agent in the way UPMC Health Plan manages all clinical operating aspects of Government Product and serve as a member of the team leading the transformation to a population health service delivery model that addresses health access and other important matters of Govt Product. As an integral part of the organization, it is paramount that this role exhibits leadership qualities and expertise that will raise UPMC Health Plan to new levels of excellence and execution for underserved and deprived member populations. The success of UPMC Health Plan will rely upon this individual's creativity, discipline, detail and a passion to 'make a real difference' beyond conventional managed care.

**Responsibilities**

- Creates clinical archetypes based on population profiles of health status, health risks, health engagement activities and outcomes building expertise in the clinical trends of member populations.
- Designs and recommends new chronic condition care management pathways that structure longitudinal care over time with holistic quality and cost measures.
- Establishes new and enhance care management models of care associated with complex members requiring higher levels of coordination and management of chronic and acute care clinical services.
- Establishes, in collaboration with the Quality Department, the advancement of population health oriented, medical standards and member outcome measures that inform improvement opportunities and guide the formation of more responsive network models for managing chronic conditions/disease and promoting health.
- Oversees the progressive improvement and overall management of the combined utilization and care management of special needs children.
- Participates in the development of new, value based design products and strategies with employers and members to advance health outcomes. Participates in research and educational activities that promote new knowledge development and action in the clinical field that promotes the effective transformation to a population health management model.
- Recommends medical policies that promote the transformation from conventional payer-provider services towards both individual and population based improvements in medical outcomes over time.
- Responsible for coordinating clinical responses for Medicaid Requests for Proposals. Works with the network leaders to evaluate performance of value based payment arrangements; serves as a mentor to network physician members in the performance improvement and transformation to a high performing provider network and managing populations at risk.
- Responsible for meeting clinical Medicaid UPMC strategic goals and initiatives. Responsible for implementing programs and strategies to meet strategic goals, identifies barriers, escalated issues to executive management and reports at least annually accomplishments related to strategic goals
- Responsible for oversight of the Special Needs Coordinator (SNU Coordinator) and the related PRC initiatives.
- Serves as a clinical administrative, executive liaison with the Department of Health and Human Services. Participates and leads the quality review and improvement meetings (QQRM). Works with product line leaders to orchestrate strategies targeted to enhance member services and strengthen regulatory compliance.
- Serves as a community leader and positive professional influence in the knowledge development, communication and change process towards an accountable community that promotes health. Leads innovative medical/clinical programs through early ideation, development and early implementation. Develop and implement business process design, business process transformation and business process with continuous improvements. Assemble and implement decision support systems for top executives, managers, and procurement heads.

- Works with health plan leaders in clinical operations to improve the performance and utility of non-physician, clinical services impacting gaps in care closure, transition of care outcomes and longitudinal management of high risk members. Works with advanced practice nurses to establish prescribing protocols and medical management strategies with member populations in the home and community based environment.
- Works with physician and administrative leaders within the network and product line to assess health disparities and related socioeconomic factors impacting members and prospective members. Studies health disparities; identifies goals to reduce health disparities and establishes health plan related strategies to positively impact them.

**Qualifications**

- Bachelors and Masters Degree required in health care or related field.
- Minimum of five or more years of proven experience and innovation managing the health needs of CMS or like insurance products or state based services and a demonstrated passion for enhancing the access, quality and cost of health services for Medicaid populations.
- Experience in Medicaid healthcare insurance, State Medicaid or related organizations; ideally having created and driven innovative clinical program initiatives or similar experience.
- Health insurance industry experience preferred within a health plan, an integrated delivery and financing system that has truly developed a relationship with the physician and patient community; genuinely collaborative in nature, value-added versus commodity-driven, cross-functionally efficient and consumer-driven.
- Will possess a passion and commitment to help change the way healthcare is delivered, a track record of developing leading-edge Health Plan clinical strategies while motivating an organization to achieve stretch goals to drive innovation, and do what is right today, rather than tomorrow.
- Ability to lead, motivate and mentor superior staff in pursuit of progressive programming.
- Solicit support, evaluate, direct and hold ones self and employees accountable, while maintaining high morale and productivity during favorable and unfavorable conditions.
- Expert managed care clinical leadership skills, leveraging a broad knowledge base in managed care.
- Must possess a global understanding of the industry and Medicaid policy and services: legislative/regulatory developments, national product and delivery trends, maintenance of key industry relationships and tracking competitors.
- Highly developed interpersonal and communication skills, both written and verbal, and an executive demeanor which interacts effectively with all organizational stakeholders regarding sensitive and/or complex topics.
- Will need to manage multiple tasks and projects, and forge strong interpersonal relationships within the department, with other departments and with external audiences.
- Must achieve results ahead of schedule and within budget. Highly developed analytical skills.
- Operates effectively in a matrix environment.
- Views the various matrix partners within UPMC as customers.
- Possesses the appropriate level of patience, and persistence, to move issues forward while competing in a highly complex, turbulent, and market-driven industry.
- Ability to work in a fast-paced environment required.
- Must demonstrate a high degree of professionalism, enthusiasm and initiative on a daily basis.
- Exudes a leadership style emphasizing collaboration, teamwork, participation and communication.
- Willingness and ability to delegate responsibility to senior subordinates while allowing them room to identify ways and means to `take action and accomplish specific goals and objectives.
- Contributes imaginative and innovative ideas; encourages idea generation of others; open, accessible and communicative

# Molina Healthcare hiring Medical Director, Health Plan in Oak Brook, IL

**SourceURL:** https://www.linkedin.com/jobs/view/medical-director-health-plan-at-molina-healthcare-1076747514

**Oak Brook, IL**

Apply on company website

## Job description

**Description**

**Knowledge/Skills/Abilities**

Provides medical oversight and expertise in appropriateness and medical necessity of healthcare services provided to Plan members, targeting improvements in efficiency and satisfaction for patients and providers, as well as meeting or exceeding productivity standards. Educates and interacts with network and group providers and medical managers regarding utilization practices, guideline usage, pharmacy utilization and effective resource management.

- Facilitates conformance to Medicare, Medicaid, NCQA and other regulatory requirements.
- Reviews quality referred issues, focused reviews and recommends corrective actions.
- Conducts retrospective reviews of claims and appeals and resolves grievances related to medical quality of care.
- Attends or chairs committees as required such as Credentialing, P&T and others as directed by the Chief Medical Officer.
- Evaluates authorization requests in timely support of nurse reviewers; reviews cases requiring concurrent review, and manages the denial process.
- Monitors appropriate care and services through continuum among hospitals, skilled nursing facilities and home care to ensure quality, cost-efficiency and continuity of care.
- Ensures that medical decisions are rendered by qualified medical personnel, not influenced by fiscal or administrative management considerations, and that the care provided meets the standards for acceptable medical care.
- Ensures that medical protocols and rules of conduct for plan medical personnel are followed.
- Develops and implements plan medical policies.
- Provides implementation support for Quality Improvement activities.
- Stabilizes, improves and educates the Primary Care Physician and Specialty networks. Monitors practitioner practice patterns and recommends corrective actions if needed.
- Works with Contracting Department in contract negotiation.
- Fosters Clinical Practice Guideline implementation and evidence-based medical practice.
- Utilizes IT and data analysts to produce tools to report, monitor and improve Utilization Management.
- Actively participates in regulatory, professional and community activities.

**Job Qualifications**

- Doctorate Degree in Medicine
- Board Certified in Pediatrics or Family Practice.

**Required Experience**

7 - 9 years relevant experience, including:

- 5+ years clinical practice.
- 2 years previous experience as a Medical Director.
- 3 years experience in Utilization/Quality Program management.
- 2+ years HMO/Managed Care experience.
- Current clinical knowledge.
- Experience demonstrating strong management and communication skills, consensus building and collaborative ability, and financial acumen.
- Knowledge of applicable state, federal and third party regulations

**Required License, Certification, Association**

Current state Medical license without restrictions to practice and free of sanctions from Medicaid or Medicare.

**Preferred Education**

Master's in Business Administration, Public Health, Healthcare Administration, etc.

**Preferred Experience**

- Peer Review, medical policy/procedure development, provider contracting experience.

Experience with NCQA, HEDIS, Medicaid, Medicare and Pharmacy benefit management, Group/IPA practice, capitation, HMO regulations, managed healthcare systems, quality improvement, medical utilization management (UM), risk management, risk adjustment, disease management, and evidence-based guidelines.

**Board Certification (Primary Care Preferred).**

**Preferred License, Certification, Association**

To all current Molina employees: If you are interested in applying for this position, please apply through the intranet job listing.

Molina Healthcare offers a competitive benefits and compensation package. Molina Healthcare is an Equal Opportunity Employer (EOE) M/F/D/V.

To learn more about Molina Healthcare Careers, follow us on LinkedIn , Twitter & Facebook . You can also visit Molina Cares to view interactive tutorials on resume & cover letter writing, interviewing and more!

**Primary Location**

US-IL-Oak Brook-OAKBROOK

**Job**

Medical

**Organization**

Health Plans

# PacificSource Health Plans hiring Claims Team Lead Medicaid in Bend, OR

**SourceURL:** https://www.linkedin.com/jobs/view/claims-team-lead-medicaid-at-pacificsource-health-plans-1184937473

### Bend, OR

Apply on company website

## Job description

**Overview**

Supervise and provide leadership and guidance to Claims Analysts and support staff regarding company policies, procedures and workflow applicable to Medicaid clients. Manage claims production and quality that meets or exceeds company standards. Resolve claims adjudication issues. Responsible for hiring, training, coaching, counseling, and evaluating team member performance. Demonstrate effective leadership by coaching to improve individual performance, develop teamwork and team support, manage change and encourage innovation, build collaborative relationships, encourage involvement and initiative, and develop increased vision and commitment to goals in others.

**Responsibilities**

- Provide supervision, coaching, training, evaluation and leadership to assigned staff. Assure Medicare claims processing, production and quality meet department and company standards.
- Evaluate performance of team members. Analyze results of performance reports for each team member to determine training needs related to personal performance and department goals.
- Oversee and assist team in providing exceptional claims processing service to members, providers, , agents and other insurance companies. Includes accurate interpretation of benefit and policy provisions for Medicaid medical policies.
- Oversee and assist with review and research of medical claims and determine coverage based on contract, provider status and claims processing guidelines. Investigate and settle claims issues as needed. Relay information for dispute resolution, including research and response for grievances and appeals, to appropriate departments and personnel.
- Communicate changes in business processes and procedures to ensure team members receive information in a timely manner.
- Work collaboratively with department Training Coordinator in all aspects of initial and continued education for assigned staff.
- Oversee and assist with answering inquiries received by mail or e-mail, providing exceptional service. Write original business letters and prepare reports as needed.
- Serve on various interoffice committees as required or needed. Document and report any pertinent communications back to the team and/or department.
- Actively participate in Claims leadership peer group to ensure cross-team communication, collaboration and process efficiency result in consistent, quality claims processing

outcomes.
- Follow the PacificSource privacy policy and HIPAA laws and regulations concerning confidentiality and security of protected health information.

Department Management

- Coordinate business activities by maintaining collaborative partnerships with key departments.
- Assist with hiring, staff development, coaching, performance reviews, corrective actions, and termination of employees. Provide feedback, including regular one-on-ones and performance evaluations, for direct reports.
- Assist with process improvement and work with other departments to improve interdepartmental processes. Utilize lean methodologies for continuous improvement. Utilize visual boards and daily huddles to monitor key performance indicators and identify improvement opportunities.
- Follow the PacificSource privacy policy and HIPAA laws and regulations concerning confidentiality and security of protected health information.
- Actively participate as a key team member in department meetings.
- Actively participate in various strategic and internal committees in order to disseminate information within the organization and represent company philosophy.

**Supporting Responsibilities**

- Actively participate in department or inter-departmental workgroups. Share information or issues with department leaders.
- Regularly attend team meetings and daily team Visual Board huddle.
- Meet department and company performance and attendance expectations.
- Perform other duties as assigned.

**Qualifications**

**Work Experience:** Minimum of four years claims adjudication experience and qualified to take on leadership responsibilities, or equivalent experience in a related health field. Minimum of three years Oregon Medicaid experience.

**Education, Certificates, Licenses:** Requires high school diploma or equivalent.

**Knowledge:** . Thorough understanding of PacificSource products, plan designs, provider relationships and health insurance terminology. Basic working knowledge of Medicaid rules and regulations. Thorough understanding of claims processing system and operation. Advanced PC skills including, Microsoft Word and Excel. Ability to type using a standard keyboard, operate 10-key pad accurately, multi-line telephone system, and fax machine. Research skills and ability to evaluate claims in order to audit accurately. Advanced skills in medical terminology, CPT / ICD-10 coding. Effective and responsive leader. Current knowledge of changes in PacificSource business processes and procedures and relating that information to team members. Ability to work under time pressures and deal with difficult situations. Team player. Collaborates with others and helps to accomplish objectives. Strong work ethic and ability to work effectively with a variety of personalities at varying skill levels.

**Competencies**

**Our Values**

- Building Trust
- Building a Successful Team
- Aligning Performance for Success
- Building Strategic Work Relationships
- Continuous Improvement
- Facilitating Change

- Leveraging Diversity
- Driving for Results
- Building Customer Loyalty
- Decision Making
- We are committed to doing the right thing.
- We are one team working toward a common goal.
- We are each responsible for our customer's experience.
- We practice open communication at all levels of the company to foster individual, team and company growth.
- We actively participate in efforts to improve our many communities-internal and external.
- We encourage creativity, innovation, continuous improvment and the pursuit of excellence.

**Environment:** Work inside in a general office setting with ergonomically configured equipment. Travel is required approximately 5% of the time.

**Physical Requirements:** Stoop and bend. Sit and/or stand for extended periods of time while performing core job functions. Repetitive motions to include typing, sorting and filing. Light lifting and carrying of files and business materials. Ability to read and comprehend both written and spoken English. Communicate clearly and effectively.