Medicaid Industry Jobs Hunter 02/03/20

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Medicaid Jobs Hunter

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Executive Director of Managed Care Contracting EOGH | Prospect Medical Holdings, Inc.

Executive Director of Managed Care Contracting EOGH

Company Name Prospect Medical Holdings, Inc. Company Location East Orange, NJ, US

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

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Executive Director, Managed Care Contracting – Prospect Medical Holdings Coordinated Regional Care

The Executive Director, Managed Care is responsible for the oversight of fee-for-service and value-based contracting and their implementation and related activities for Prospect Medical Holdings Coordinated Regional Care (CRC)under the direction of the Vice President of Coordinated Regional Care, Pennsylvania, and New Jersey.

The ED Shall Have Primary Responsibility For

- Oversee fee-for-service and value-based contracting activities for EOGH, oversight of the managed care team, and manage payer contracts and relationships for all network hospitals, physicians and ancillary providers. Oversees negotiation of single case agreements, and communicates effectively with the billing department to ensure agreements are carried out appropriately. Develop payer strategies to ensure an optimal contracting and operational outcome for EOGH providers, advocating on behalf of the EOGH providers as issues, opportunities or disputes arise. Responsible for negotiating contracts with managed care payers on behalf of EOGH providers, including rates, payment methodologies, contract language, value-based and shared /full risk payment programs, following all internal controls for contract review, approval and signature and in alignment with EOGH vision, goals and objectives.
- Develop processes and manage the implementation and ongoing management of completed contracts, including identification and tracking of critical contract and renewal dates, ensuring that proper scanning, recording, and filing of contract documents occurs, oversee dissemination and communication of information to internal constituents and education on new /revised terms. Monitor contract performance regarding financial performance, payment integrity, value-based payment programs, compliance with contract terms and key performance indicators. Monitoring payer activity with respect to network development, product strategies, payment policies, and other relevant market intelligence.
- Oversee payer relationships with a focus on promoting proactive, professional and collaborative relationships, problem resolution and avoidance future of issues whenever possible.
- Promote enhanced use of Rubixis and other available contract management tools to support contract negotiations, revenue recovery, and contract performance, providing support to decision support, finance and budget on managed care issues.
- Ensure EOGH providers and payers comply with all contract provisions, via tracking of performance through a variety of means, including the audit of current performance via claims review, reports, etc.
- Work collaboratively with EOGH management, operating unit

departments and support areas such as patient access, central billing offices, and medical management areas to improve functions across departments and with payers.
- Prepare and provide training, materials, and tools for use by EOGH providers and their staff regarding key managed care contract provisions, market trends and opportunities for improvement in support of facility goals and objectives, consistent with the mission and values of EOGH. Proactively communicate and educate EOGH operational areas regarding contract changes, policy updates, etc., to ensure EOGH staff have the information needed to successfully implement and operationalize agreements.
- Perform other duties as assigned/required by supervisor.

Candidates Must Possess The Following Qualifications

- Master's degree in a related field with a minimum of 5 years of managed care contracting for multihospital system and reimbursement analysis in either a provider or payer setting required;. Excellent written and verbal communication skills required
- Extensive knowledge, experience and expertise in managed care contracting negotiations, language, modeling analytics, reimbursement methodologies for hospitals, physicians and ancillary providers, shared shavings and risk contracting, managed care regulations and quality/shared savings program metrics and methodologies.
- Excellent skills in Microsoft Office Excel (including advanced spreadsheet and formula manipulation), as well as in Word and PowerPoint. Access skills preferred but not required.
- Demonstrated skills in attention to detail, superior project management, implementation, and analytical ability as well as the ability to coordinate and lead activities using a collaborative and team approach.
- Ability to handle multiple projects and perform independently under tight deadlines with a focus on effective implementation, clear and consistent communication and follow-up.

Seniority Level

Director

Industry

- Hospital & Health Care
- Medical Practice
- Mental Health Care

Employment Type

Contract

Job Functions

- Management

Tribal Option Program Manager | NC Department of Health and Humar

Source URL: https://www.linkedin.com/jobs/view/1688989277/?eBP=CwEAAAFwIXTcltIAJw5KYzpmRW8jxjM7nKd1UuMGhQYulvYQRkq-J5Df_ID2as
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Tribal Option Program Manager

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

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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

Management prefers

- 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.

Manager Government Programs Regulatory | Blue Cross of Idaho

Source URL: https://www.linkedin.com/jobs/view/1714917855/?eBP=CwEAAAFwIXTclpI3mIbThIlhW170huqzSrtRL_SlpdMubNfykWyV_2xaMfcBKiWu
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Manager Government Programs Regulatory

Company Name Blue Cross of Idaho
Company Location Meridian, ID, US

Posted DatePosted 3 days agoNumber of applicants Be among the first 25 applicants

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Position Purpose

To manage the implementation of new products and to ensure that all contractual obligations to the State and CMS are met. Serve as the primary point of contact to the State on all regulatory requirements and guidance. Oversee and manage regulatory activities associated with government markets.

QUALIFICATIONS: (Minimum qualifications required for the job)

- Experience: Five years' in Medicare/Medicaid industry
- Education: Bachelor's degree (Business, Healthcare Administration preferred); OR equivalent work experience (Two years' work experience is equivalent to one year college)

Knowledge Of

Knowledge, Skills and Abilities (KSAs):

- Medicaid and Medicare state and federal regulations
- State regulatory processes and program requirements
- Health insurance industry
- Managed Care operations in cross-functional business segments and their integrated influences and relationships
- Unique aspects of providing services to a dual eligible population

Skills

- Excellent written and verbal communication
- Strong analytical, organizational and planning skills
- Ability to successfully lead program execution
- Microsoft Office Suite including working knowledge of SharePoint

Ability To

- Work effectively in a team environment
- Work under general direction
- Collaborate with internal business owners to resolve complex problems in a matrixed organization
- Promptly evaluate and escalate any identified potential regulatory risks to the organization
- Implement and manage an internal reporting structure to ensure the organization is meeting all regulatory obligations in a compliant manner
- Track and analyze new and revised State and Federal regulations to ensure compliance
- Participate in the development of company strategies and long range plans necessary to ensure the success of BCI's Medicare and Medicaid programs

Preferred Requirements

- Master's degree in related field

We are an Equal Opportunity Employer and do not discriminate against any employee or applicant for employment because of race, color, sex, age, national origin, religion, sexual orientation, gender identity, status as a veteran, and basis of disability or any other federal, state or local protected class.

BH Utilization Manager | Community Health Choice, Inc. | TX

Source URL: https://jobs.harrishealth.org/bh-utilization-manager/job/12264156?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

BH Utilization Manager

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
	JOB SUMMARY: Behavioral Health Utilization Manager will assist the Behavioral Health Program Manager and the Medical Director in the review of medical records submitted for appeals by providers due to an adverse determination. Utilizes nationally recognized evidenced based clinical criteria, approved medical guidelines, and company policies. Apply 3M Coding and reimbursement guidelines for DRG assignment. Provides written response of the outcome of the

appeal to the provider. Assists in the ongoing development and maintenance of a database for tracking, trending and reporting appeals cases.

MINIMUM QUALIFICATIONS:

- Masters Degree
- LCSW, LMFT, or LPC unrestricted Texas license
- Two (2) years experience in an acute psychiatric care setting.
- Two (2) years experience in utilization and appeal review in a managed care environment with Medicaid and Medicare members.

OTHER SKILLS:

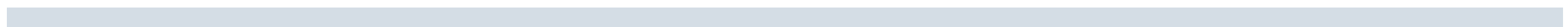
- Above Average Verbal (Heavy Public Contact)
- Writing /Composing (Correspondence / Reports)
- Analytical
- Medical Terminology
- Able to work independently under general instructions and working within a team environment
- Able to apply

	the appeal and medical necessity criteria and use critical thinking • Computer literate with knowledge of MS Word, MS Excel, Outlook, and telephone systems
	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 Professional

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



UnitedHealth Group Site Director Medicare Medicaid El Paso Health Plan Job in EL PASO, Texas

Source URL: https://www.glassdoor.com/job-listing/site-director-medicare-medicaid-el-paso-health-plan-unitedhealth-group-JV_IC1140105_KO0,51_KE52,70.htm?jl=3479986582&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Site Director Medicare Medicaid El Paso Health Plan

3.4 ★

UnitedHealth Group – EL PASO, Texas

Tuscany Enterprises CFO, Health Plan Job in Remote

Source URL: https://www.glassdoor.com/job-listing/cfo-health-plan-tuscany-enterprises-JV_KO0,15_KE16,35.htm?jl=3483980456&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Tuscany Enterprises CFO, Health Plan Job in Remote

CFO, Health Plan

Tuscany Enterprises – Remote

Employer Provided Salary:$250K-$280K

more

We're HiringTuscany Enterprises is actively hiring on Glassdoor

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Job

Company
CFO, Health Plan - REMOTE*(Multi-State experience and Medicare/Medicaid experience is a MUST)*

EXCELLENT OPPORTUNITY FOR A CHIEF FINANCIAL OFFICER TO WORK REMOTELY FROM ANYWHERE IN THE UNITED STATES!

Highly regarded integrated health plan is searching for a CFO to oversee all financial affairs for plan operations in 5 highly populated States. All candidates should have a strong background in Medicare and Medicaid as well as Multi-State experience.

This is a remote, home-office based role with travel.

Responsibilities:

- Oversee financial terms of all contracts including rate renewals, rate openers and settlements of contingencies, monitor balance sheet
- Reporting of monthly financial results
- Develop and maintain long term strategic plan for business including strategic initiatives, investment/capital deployment requirements and cost/benefit analysis
- Coordinate all cost of care analytics for business to guide operations and strategies to optimize care management activities.

Qualifications:

- Experience with Medicaid and Medicare health plan premium development, risk adjustment, medical cost data and administrative cost structures is a MUST.
- 15+ years in managed care, health care or insurance (The client wants a person coming out of a health plan background, NOT hospital or healthcare system background.)
- Multi-State experience with a health plan / insurance organization is a MUST.
- 8+ years in leadership/management positions
- Bachelors' degree in Finance, Masters' degree in Finance (preferred)
- CPA (preferred)
- Willingness to travel as required.

COMPANY OFFERS EXCELLENT OPPORTUNITY TO WORK FROM YOUR HOME OFFICE WITH COMPETITIVE COMPENSATION PLAN AND STABLE WORK ENVIRONMENT!

HOW TO APPLY FOR THIS CAREER OPPORTUNITY:

- PLEASE SEND RESUME IN WORD DOC FORMAT.
- PLEASE PROVIDE A WRITTEN SUMMARY OF YOUR ALIGNED SKILLS AND EXPERIENCE AS THEY SPECIFICALLY PERTAIN TO THE QUALIFICATION REQUIREMENTS OUTLINED ABOVE AND THE AREAS OF RESPONSIBILITY LISTED ABOVE.
- PLEASE PROVIDE INFORMATION REGARDING YOUR WILLINGNESS TO RELOCATE IF YOU ARE NOT LOCAL TO THE GEOGRAPHIC AREA NOTED FOR THIS OPPORTUNITY.
- PLEASE PROVIDE INFORMATION REGARDING YOUR TARGETED STARTING SALARY REQUIREMENTS.

Ohio Department of Transportation Medicaid Health Systems Specialist Job in OHIO-Franklin

Source URL: https://www.glassdoor.com/job-listing/medicaid-health-systems-specialist-ohio-department-of-transportation-JV_IC1145714_KO0,34_KE35,68.htm?jl=3482718091&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Health Systems Specialist

3.8 ★

Ohio Department of Transportation – OHIO-Franklin

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Job

Company

Rating

Salary

Benefits

Unless required by legislation or union contract, starting salary will be set at step 1 of the pay range.

Office: Managed Care

Bureau: Member Services, Managed Care Reconciliation

Working Title: Medicaid Health Systems Specialist (PN 20096590)

Job Preview:

The Ohio Department of Medicaid (ODM) is seeking a full time Medicaid Healthy Systems Specialist to join our Managed Care Reconciliation Unit. As a Medicaid Health Systems Specialist, your job responsibilities will include:

• Working with contracted managed Care Plans, providers, and other interested parties to ensure appropriate consumer enrollment in a managed care plan.

• Review Ohio Benefits System and MITS and make necessary changes to align Medicaid eligibility and managed care enrollment

• Identify and Implement changes in the Ohio Benefits System and Medicaid Information Technology System (MITS) to resolve challenges in and improve the process of managed care enrollment.

Job Description:

Under general direction, monitors & evaluates providers, projects, program (e.g., may include components) or service delivery by participation on or leads a team to &/or works independently to: Conduct complex analysis (e.g., researches & analyses policy, techniques & procedures for reconciliation & reimbursement strategies for Medicaid-contracting Managed Care Plans [MCPs] & eligible consumers) determines & implements necessary Ohio Benefits eligibility system /Medicaid Information Technology System (MITS) &

other programmatical changes & discrepancies; monitors & evaluates program policies & procedures to assure compliance with federal & state regulations; summarizes findings & recommendations for change on health care related issues using complex computer systems [e.g., MITS, Decision Support System (DSS) databases] & initiates & completes complex, technical reports related to these issues; interacts directly with consumers, MCPs, providers & other interested parties in the compilation of data to determine appropriate MCP enrollment eligibility actions; notifies affected parties of actions (e.g., approval/denial of enrollment); verifies with consumers & providers that MCP follow-up action is completed by tracking concerns & resolutions; responds to inquiries by consumers, providers, county agencies, MCP & government officials by telephone, correspondence &/or in person.

Provides consultative expertise & training & acts as liaison to both intra-agency & inter-agency providers (e.g., Medicaid-contracting MCPs); acts as team leader to gather & analyze data & in the design of required forms; consults with MCP officials, county agencies & other entities regarding current & forthcoming program changes; coordinates activities performed by other entities which are directly associated with the administration &/or implementation of policies pertaining to Medicaid-contracting MCPs; verifies reimbursements request & claims adjustments resulting from eligibility actions; represents agency at hearings, conferences, meetings & workshops; serves on committees & taskforces; prepares complex, technical reports, correspondences & memorandums.

Writes reports, position papers & research documents; operates personal computer to generate reports, correspondence &/or spreadsheets; researches information on mainframe &/or Internet; assists in other areas as needed (e.g., continuity of care, eligibility).

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

Completion of undergraduate core program in business administration, social or behavioral science, health or statistics; additional 24 months of experience specific to subject area of which 12 months experience in use of spreadsheet and database software.

-Or 24 months experience as Medicaid Health Systems Analyst, (65291)

-Or equivalent of Minimum Class Qualifications for Employment noted above may be substituted for the experience required.

Behavioral Health Medicaid Market Development Advisor | Jobs Interviewing Now from HCS

Source URL: https://www.linkedin.com/jobs/view/behavioral-health-medicaid-market-development-advisor-at-jobs-interviewing-now-from-hcs-1726459965/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Behavioral Health Medicaid Market Development Advisor

Company Name Jobs Interviewing Now from HCS Company Location Frankfort, KY, US

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

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DescriptionThe Market Development Advisor provides oversight and administration of the Behavioral Health benefits to support Medicaid health plans relative to Medicaid product implementation, operations, contract compliance, and federal contract application submissions. The Market Development Advisor works on problems of diverse scope and complexity ranging from moderate to substantial. The position serves as the resident BH subject matter expert available to all teams as necessary.

Responsibilities

The Market Development Advisor serves as the primary resource on regulations for all assigned health plans. Ensures that assigned health plans are meeting or exceeding corporate Medicaid performance benchmarks. Maintains relationships with regulators within a region. Advises executives to develop functional strategies (often segment specific) on matters of significance. Exercises independent judgment and decision making on complex issues regarding job duties and related tasks, and works under minimal supervision, Uses independent judgment requiring analysis of variable factors and determining the best course of action.

Duties And Responsibilities

- Work in collaboration with UM and CM Directors/Managers in coordinating clinical supervisory role for UM/CM of BH cases as part of the broader integrated medical and BH care coordination team. Operational supervision and direct report responsibilities to remain with UM/CM Directors/Managers. Will oversee, manage and participate in BH rounds and case conferences as well as co-coordinate integrated BH/medical rounds and case conferences with the UM/CM Directors/Managers. Provide cross-departmental assistance specific to management of BH services such as: assist in training and management of BH UM and CM and integrated BH/medical care coordination; work with Provider Services to review and insure network adequacy, provider satisfaction, specialty contracting, etc.; help Claims to insure appropriate configuration and payment for BH services; help train and advise Member Services regarding BH benefits and appropriate referral processes, assist Compliance and Government Contracting in interpretation and adherence to all BH regulatory and contractual obligations.
- Support CMO in coordination of necessary BH Medical Director role. In collaboration with the UM/CM Directors/Managers be responsible for coordination of BH Medical Director role in staffing cases, leading rounds, attending integrated care case conferences, training, etc.
- Provide collaboration and oversight of specific BH HEDIS measures, BH NCQA requirements, provider/member satisfaction and any other quality improvement or state audit activities specific to BH in conjunction with Market Quality team.
- Work collaboratively with UM/CM Directors/Managers to ensure appropriate inclusion of BH specific functions, roles and responsibilities, work flows, etc. within broader P&Ps and SOPs regarding general UM/CM.
- Participate in interviewing of candidates for all Behavioral Health positions; participate in final hiring decisions in collaboration with UM/CM Directors/Managers
- Serve as community liaison to BH advocacy groups, non-contracted community partners (e.g., community mental health centers),

service organizations, etc., specific to BH. Assist in community outreach activities to improve community awareness of Humanas involvement in BH service management and integrated whole person health promotion.
- Provide feedback as appropriate in performance and professional development to assist UM/CM Directors/Managers in performance evaluations of BH specialty staff.
- Assist senior management as requested to review, evaluate and potentially develop/implement new business opportunites, service expansion or other special projects specific to BH. Serve as DRI when requested for any such ventures.
- Communicate state and federal regulatory changes related to behavioral health benefits to CMO or VP/HCS
- Accountability to Humana Corporate BH Leadeship to ensure alignment with the Humanas vision for integrated behavioral health enterprise-wide
- Represent the health plan with state-wide stakeholders and officials on all issues relating to the provision of behavioral health benefits
- Other duties as assigned

Knowledge, Skills And Abilities

- Understanding of all elements of the full continuum of care spectrum of BH services (e.g., inpatient and outpatient services, community support services, substance abuse treatment programming, etc.).
- Familiarity of treatment modalities and programs across ages inclusive of child and adult specialty programming
- Excellent verbal and written communication skills
- Ability to abide by Humanas policies
- Ability to maintain attendance to support required quality and quantity of work
- Maintain confidentiality and comply with Health Insurance Portability and Accountability Act (HIPAA)
- Ability to establish and maintain positive and effective work relationships with coworkers, clients, members, providers and customers

RequiredQualifications

- Two years in managed behavioral healthcare setting
- Five years in clinical practice
- Three years of supervisory or management experience in a behavioral health setting
- Unrestricted Masters or doctoral level licensure as a behavioral health professional (PhD, PsyD, LCPC, LPC, LMFT, LCSW)
- Current or recent experience with Medicaid programs

Preferred Qualifications

- Five years in managed behavioral healthcare setting with at least 2

years clinical management experience
- More than five years of experience in clinical practice
- Unrestricted Doctoral level licensure as a behavioral health clinician (PhD, PsyD)
- Business development experience, specifically involving RFPs

Additional Information

- This is a work at home opportunity and can be in any location.

Scheduled Weekly Hours40

Tuscany Enterprises VP of Finance, Health Plan Job (Remote)

Source URL: https://www.glassdoor.com/job-listing/vp-of-finance-health-plan-remote-medicare-medicaid-experience-is-a-must-tuscany-enterprises-JV_KO0,71_KE72,91.htm?jl=3484016628&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

VP of Finance, Health Plan

Tuscany Enterprises – Remote

Employer Provided Salary:$250K-$280K

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We're HiringTuscany Enterprises is actively hiring on Glassdoor

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Job

Company
VP of Finance, Health Plan - REMOTE (Medicare/Medicaid experience is a MUST)

EXCELLENT OPPORTUNITY FOR A VP OF FINANCE / CHIEF FINANCIAL OFFICER TO WORK REMOTELY FROM ANYWHERE IN THE UNITED STATES! Opportunity offers competitive base salary,

+ 30% to 40% bonus + 50% LTI + excellent employee benefits!!

Highly regarded integrated health plan is searching for a VP of Finance / CFO to oversee all financial affairs for plan operations in 5 highly populated States. All candidates should have a strong background in Medicare and Medicaid as well as Multi-State experience.

This is a remote, home-office based role with travel.

Responsibilities:

- Oversee financial terms of all contracts including rate renewals, rate openers and settlements of contingencies, monitor balance sheet
- Reporting of monthly financial results
- Develop and maintain long term strategic plan for business including strategic initiatives, investment/capital deployment requirements and cost/benefit analysis
- Coordinate all cost of care analytics for business to guide operations and strategies to optimize care management activities.

Qualifications:

- Experience with Medicaid and Medicare health plan premium development, risk adjustment, medical cost data and administrative cost structures is a MUST.
- 15+ years in managed care, health care or insurance (The client wants a person coming out of a health plan background, NOT hospital or healthcare system background.)
- Multi-State experience with a health plan / insurance organization is a MUST.
- 8+ years in leadership/management positions
- Bachelors' degree in Finance, Masters' degree in Finance (preferred)
- CPA (preferred)
- Willingness to travel as required.

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HOW TO APPLY FOR THIS CAREER OPPORTUNITY:

- PLEASE SEND RESUME IN WORD DOC FORMAT.
- PLEASE PROVIDE A WRITTEN SUMMARY OF YOUR ALIGNED

SKILLS AND EXPERIENCE AS THEY SPECIFICALLY PERTAIN TO THE QUALIFICATION REQUIREMENTS OUTLINED ABOVE AND THE AREAS OF RESPONSIBILITY LISTED ABOVE.

- PLEASE PROVIDE INFORMATION REGARDING YOUR WILLINGNESS TO RELOCATE IF YOU ARE NOT LOCAL TO THE GEOGRAPHIC AREA NOTED FOR THIS OPPORTUNITY.
- PLEASE PROVIDE INFORMATION REGARDING YOUR TARGETED STARTING SALARY REQUIREMENTS.

Healthcare Insurance Coordinator at FRESENIUS

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Healthcare Insurance Coordinator

Job ID 200002TC

Available Openings 1

Position Specific Information The Insurance Coordinator travels throughout the greater Jackson area supporting our dialysis patients in 10 clinic locations. Mileage is reimbursed.
A Bachelor's degree is required

PURPOSE AND SCOPE:

Explores, recommends, and coordinates the insurance and potential financial assistance options available to kidney dialysis patients in a specified geographic area, while maximizing revenue for the company. Supports FMCNA's mission, vision, core values and customer service philosophy. Adheres to the FMCNA Compliance Program, including following all regulatory and company policy requirements

PRINCIPAL DUTIES AND RESPONSIBILITIES:

Meets regularly with dialysis patients at the clinic(s) in the assigned

region to educate and coordinate insurance options:

- Educates on the availability of alternative insurance options (i.e., Medicare, Medicaid, Medicare Supplement, State Renal programs and COBRA).
- Ensures patients have followed through with the application process.
- Obtains premium statements and signatures from patients.
- Discusses situation and options if employment status changes or other situations change.
- Completes and follows up with paperwork when claims are disputed for non-payment.
- Collects necessary documents to completed initial and annual indigent waivers.
- Discusses insurance options when insurance contracts are terminated.

Responsibilities involving Medicare and Medicaid include but are not limited to:

- Determining Medicare eligibility by meeting with the patients and contacting local Social Security offices to verify eligibility.
- Discussing the Medicare application with eligible patients and assisting with the application process.
- Acting as liaison between the patient and the local agents for Medicare terminations and re-in statements.
- Completing the annual open enrollment and Medicare reinstatement papers with the patients.
- Tracking 30-month coordinator period each month for those patients on employer Group Health Plans to ensure Medicare will be in place once coordination ends.
- Monitoring and verifying the Medicaid status of each patient on a monthly basis and determining the spend down amounts
- Works with patients to evaluate personal financial information and make determination for indigent program.
- Completes initial Indigent waiver applications.
- Tracks and completes annual indigent waiver applications.
- Monitors all patients' insurance information to ensure that it is updated and accurate for the Accounts Receivable Department.
- Addresses any identified anomalies or discrepancies, researches and answers questions as needed.
- Meets with patients receiving direct payments from insurance companies to ensure payment of dialysis treatments owed to Fresenius.
- Prepares, analyzes and reviews monthly reports to track work progress on caseloads; Analyzes patient reports from billing systems as an audit check to ensure the correct insurance information is entered into the billing system and that other changes are not overlooked. Researches and corrects any discrepancies identified.
- Provides QA team members with monthly information regarding the details of the patients' primary and secondary insurance status as well as documentation regarding the plans of actions currently in

place on a monthly basis as required by QA processes
- Completes monthly audit exam to stay current on internal policies.
- May present on insurance and financial assistance options to patients as necessary.
- Assist with various projects as assigned by direct supervisor.
- Other duties as assigned.

Additional responsibilities may include focus on one or more departments or locations. See applicable addendum for department or location specific functions.

PHYSICAL DEMANDS AND WORKING CONDITIONS:

The physical demands and work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Day to day work includes desk and personal computer work and interaction with patients and facility staff. The work environment is characteristic of a health care facility with air temperature control and moderate noise levels. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Extensive local travel to clinics in a specified geographic area; must have a valid Driver's License.

EDUCATION:

- Bachelor's Degree required; Social Work or other Healthcare focus preferred.

EXPERIENCE AND REQUIRED SKILLS:

- 2 – 5 years' related experience; healthcare industry preferred.
- Experience with Medicare, Social Security and Medicaid systems a plus.
- Past patient interaction a plus.
- Excellent written and communication skills.
- A strong customer service philosophy.
- Strong organizational and time management skills.
- Ability to work independently.
- Proficient with PCs and Microsoft Office applications.
- Valid Driver's License

EO/AA Employer: Minorities/Females/Veterans/Disability/Sexual Orientation/Gender Identity

Fresenius Medical Care North America maintains a drug-free workplace in accordance with applicable federal and state laws.