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Medicaid Jobs Hunter

Jan 7, 2019

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7. MVP Health Care REPRESENTATIVE, CARE CENTER MEDICAID Job in Tarrytown, NY
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9. Family Care Partnership Supervisor | Independent Care Health Plan
10. Supervisory Health Insurance Specialist. | Centers for Medicare & Medicaid Services

SourceURL: https://www.linkedin.com/jobs/view/program-specialist-at-arizona-health-care-cost-containment-system-ahcccs-1048898682/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Arizona Health Care Cost Containment System (AHCCCS)

Req ID: 43826
Salary: 39,983.00-55,773.00

Arizona Health Care Cost Containment System

Accountability, Community, Innovation, Leadership, Passion, Quality, Respect, Teamwork

Program Specialist

Apply By: 01/13/19

Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency, is driven by the passion to deliver comprehensive cost effective health care to Arizonans in need. AHCCCS is nationally acclaimed as a model for other Medicaid programs and recipient of multiple awards for excellence in workplace effectiveness and flexibility.

All Arizona state employees operate within the Arizona Management System (AMS), an intentional, results-driven approach for doing the work of state government whereby every employee reflects on performance, reduces waste, and commits to continuous improvement with sustainable progress. Through AMS, every state employee seeks to understand customer needs, identify problems, improve processes, and measure results. State employees are highly engaged, collaborative and embrace a culture of public service. Visit our **careers page** to learn more about AHCCCS. Use your skills to benefit others; join the AHCCCS Team!

Job Summary

The **Division of Member Services (DMS)** is looking for a highly motivated individual to join our team as a Program Specialist with PS Office of Eligibility Compliance and Oversight . This position is the primary liaison with DES leadership regarding case specific eligibility issues; researches DES eligibility activity related concerns, trends or issues; responds to surveys and participate in audit reviews by federal, state, data collection and educational entitles, develop policies, procedures and other materials as necessary to support the eligibility process; researches laws, regulation, codes and policies in order to provide policy clarifications and technical. Major duties and responsibilities include but are not limited to:

- Monitors and evaluates DES reports and work activities for compliance with the AHCCCS/DES IGA. Identify problem areas, conduct research, and

recommend corrective measures or improvements to areas of concern. Coordinate with DES to develop procedures related to AHCCCS programs. Research and interpret manuals, laws and regulations in order to make decisions and provide written policy clarifications.
- Responds to surveys and participate in audit reviews by responding to inquiries, providing information, researching questions; reviewing cases; keeping notes and coordinating with the auditors.
- Draft issue papers and policy impact statements as appropriate. Provide subject matter assistance for rules revisions. Confer with automation and other system development staff regarding impact of system changes and draft system requirements for enhancements or modifications.
- Review and evaluate the impact of proposed or planned changes in Federal and State laws and regulations on eligibility policies and procedures, forms, websites and brochures.
- Develop/revise policies, procedures, forms, and other materials as necessary to support the eligibility process for Medicaid/CHIP programs. Write instructional manuals for eligibility staff to implement eligibility policy subject to the guidelines and regulations set forth by superiors, laws, regulations and computer programs.
- Lead, contribute to and/or participate on training, Arizona Management System (lean) and system development/enhancement teams.
- Phase 1 of the Candidate selection process requires completion of a writing exercise within a required timeframe. Candidates are contacted by email

KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

- Knowledge of Federal and State rules and regulations governing the Medicaid (Title XIX) programs and an understanding of how they are implemented
- Knowledge of technical writing and reading level specific writing
- Knowledge of how to analyze, research, interprets sand correctly applies Federal statutes and regulations and State statue, rules , policies and procedures
- Knowledge of project development, organization and prioritization
- Knowledge of researching techniques, data collection and analysis
- Knowledge of Arizona Management System and lean concepts
- Skilled in effectively communicating in writing, speaking and interaction with other, including listening and providing feedback
- Skilled in management; able to lead, plan, negotiate, make decisions, meet deadlines and specified goals using discretion and good judgement
- Skilled in computer systems; able to identify problems and troubleshoot computer issues
- Ability to interpret, evaluate, research and problem solve

- Ability to prioritize work and assignments
- Ability to operate a variety of office equipment, such as computer systems and software to access, input, review and analyze information

Selective Preference(s)

- A Bachelor's degree in visual communications, English, technical writing, graphic design, OR related field; OR 3 years of experience in a Medicaid program with skills that include determining Medicaid financial eligibility; OR 3 years of experience in editing, technical writing and/or graphic design; computer assistance; management and project development; and data or situational analysis.
- Must possess a current and valid Arizona driver's license

Benefits

At AHCCCS, we promote the importance of work/life balance by offering workplace flexibility and a variety of learning and career development opportunities. Among the many benefits of a career with the State of Arizona, there are 10 paid holidays per year, accrual of sick and annual leave, affordable medical benefits and participation in the Arizona State Retirement Plan. **Click here** to learn more about benefits.

Arizona State Government is an EOE/ADA Reasonable Accommodation Employer. Persons with a disability may request a reasonable accommodation such as a sign language interpreter or an alternative format by calling (602) 417-4497. Requests should be made as early as possible to allow sufficient time to arrange the accommodation. AHCCCS is an Equal Employment Opportunity Employer. All newly hired employees will be subject to E-Verify Employment Eligibility Verification.

Click the APPLY NOW button to submit your application.

For technical assistance, email ** or call 602-542-4700.

SourceURL: https://www.linkedin.com/jobs/view/medical-management-quality-examiner-at-metroplus-health-plan-1051021679/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medical Management Quality Examiner

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

Posted Date Posted 1 day ago Number of applicants Be among the first 25 applicants

Marketing StatementMetroPlus Health Plan provides the highest quality healthcare services to residents of Bronx, Brooklyn, Manhattan, Queens and Staten Island through a comprehensive list of products, including, but not limited to, New York State Medicaid Managed Care, Medicare, Child Health Plus, Exchange, Partnership in Care, MetroPlus Gold, Essential Plan, etc. As a wholly-owned subsidiary of NYC Health + Hospitals, the largest public health system in the United States, MetroPlus network includes over 27,000 primary care providers, specialists and participating clinics. For more than 30 years, MetroPlus has been committed to building strong relationships with its members and providers to enable New Yorkers to live their healthiest life. Position OverviewUnder the supervision of the Director of Accreditation, the Medical Management Quality Examiner will be directly responsible for evaluating regulatory guidelines applicable to the medical management department and monitoring to assure that the Medical Management Department for all lines of business (LOBs) is compliant with applicable requirements. The Medical Management Quality Examiner provides feedback, both verbally and in writing, to the Medical Management team concerning audit findings and processes necessary to ensure compliance with regulatory requirements. The Medical Management Quality Examiner responsible for reviewing all existing applicable policies at least annually, or more often, if necessary. The Medical Management

Quality Examiner assists the operational area representatives in updating/revising policies and processes to bring them into compliance with regulatory and accreditation requirements, as needed. The Medical Management Quality Examiner maintains a collaborative relationship with allied departments within the company, working closely with Regulatory and Compliance on regulatory changes impacting the Medical Management Department. The Medical Management Quality Examiner is also responsible for supporting delegation oversight. They work closely with the MetroPlus departmental SMEs to ensure the delegates comply with regulatory, accreditation and contractual guidelines, acts as a resource to delegates regarding applicable contract and regulatory requirements, and works closely with Contracting, Regulatory and Compliance for dissemination of new or revised regulatory requirements applicable to the delegates. The Medical Management Quality Examiner recommends corrective actions plans to satisfy regulatory, accreditation and plan requirements, and assist the departmental SMEs to ensure completion of corrective action plans by the delegate.Job DescriptionProcess ReviewReviews various Medical Management Area Program Descriptions, Program Evaluations and Work Plans for compliance with Accreditation and Regulatory requirements. Proposes revisions to bring into compliance with requirements, if necessary.Conducts routine audits to monitor the Medical Management Department s compliance with Accreditation and Regulatory requirements. Provides detailed report of findings to the Medical Management teams through informal meetings and presentations to the established committee(s).Assists in evaluating existing audit tools and revising to incorporate both accreditation and regulatory requirements. Assists in the development of automated reports to monitor compliance with these requirements.Conducts routine audits of existing Quality Management Committees/Subcommittees documentation to ensure compliance with each committee/subcommittee s respective charter, as well as, regulatory and accreditation requirements. Review all Medical Management policies and processes for compliance with accreditation and regulatory requirements at least annually or more frequently, if necessary. Propose revisions to bring into compliance with these regulations.Reviews and assesses regulatory changes impacting Medical Management. Assists Operational Area Representatives to revise policies or develop new policies to demonstrate compliance with these regulatory changes.Delegation OversightAssists in evaluating pre-delegation medical management audit tools to assess a delegate s ability to comply with State, accreditation and regulatory requirements. Participates in pre-delegation assessments, as needed.Conducts, and documents medical management delegation assessments as necessary to comply with accreditation, regulatory and any other applicable requirements.Participates in on-site and desk-top audits and/or schedules ad hoc on-site meetings and reviews, as needed, to address

specific compliance issues or support implementation of new policies and regulations.Develops corrective action plans when deficiencies are identified in medical management processes, and documents follow-up to resolution. Participates in joint operating committee meetings with other MetroPlus business owners and delegated vendors. Participates in meetings with delegates to provide medical management performance metrics feedback. AccreditationCollaborates with the accreditation team to assure that all Medical Management documents are in compliance with regulatory and accreditation standards. Identifies deficiencies and recommends revisions to bring documents into compliance.Collaborates with the accreditation team to assure delegates documentation is in compliance with accreditation standardsMinimum QualificationsCollaborates with the accreditation team to assure that all Medical Management documents are in compliance with regulatory and accreditation standards. Identifies deficiencies and recommends revisions to bring documents into compliance.Collaborates with the accreditation team to assure delegates documentation is in compliance with accreditation standardsBachelor s Degree required, Master s Degree in Health Care, Business or related field preferred. A minimum of 3-5 years experience in a Managed Care setting. Experience with regulatory requirements specifically CMS and NYS DOH.Experience with accreditation requirements for NCQA and URAC preferred. Project management skills with ability to handle multiple projects with various priorities and deadlinesAbility to work independently in a fast-paced environment with changing priorities.Strong interpersonal and human relations skills and ability to establish and maintain strong positive working relationships.Proficient in understanding and speaking the English language, with strong written communication, verbal in person and telephonically and presentation skills. Ability to use software to review documents and files and to produce required documentation and reportsProfessional CompetenciesIntegrity and TrustCustomer FocusFunctional/Technical skillsWritten/Oral CommunicationHow To ApplyIf you wish to apply for this position, please apply online by clicking the /"Apply Now/" button or forward your resume, noting the above Job ID #, to:MetroPlus Health PlanHuman Resources Department160 Water Street 8th FloorNew York, NY 10038Attn: Recruitment Unit Associated topics: care physician, family, family practice, general practice, outpatient, physician, practice physician, primary, primary care, urgent care

Seniority Level

Entry level

Industry

- Health, Wellness & Fitness
- Medical Practice
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Other

SourceURL: https://www.linkedin.com/jobs/view/care-manager-registered-nurse-rn-at-metroplus-health-plan-1051016818/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Care Manager - Registered Nurse (RN)

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

Posted Date Posted 1 day ago Number of applicants Be among the first 25 applicants

Marketing StatementMetroPlus Health Plan provides the highest quality healthcare services to residents of Bronx, Brooklyn, Manhattan, Queens and Staten Island through a comprehensive list of products, including, but not limited to, New York State Medicaid Managed Care, Medicare, Child Health Plus, Exchange, Partnership in Care, MetroPlus Gold, Essential Plan, etc. As a wholly-owned subsidiary of NYC Health + Hospitals, the largest public health system in the United States, MetroPlus network includes over 27,000 primary care providers, specialists and participating clinics. For more than 30 years, MetroPlus has been committed to building strong relationships with its members and providers to enable New Yorkers to live their healthiest life. Position OverviewThe primary goal of the Care Manager is to optimize members health care and delivery of care experience with expected cost savings due to improved quality of care. This is accomplished through engagement and understanding of the member s needs, environment, providers, support system and optimization of services available to them. Using the information obtained from the Uniform Assessment System (UAS) completed by the Assessment Nurse, identify the risk factors, strengths, challenges and service needs of members to keep them in their community setting. The Care Manager is expected to evaluate member s needs, be a creative, efficient and resourceful problem solver. This will be accomplished through review of the UAS, developing a Patient Centered Service Plan (PCSP), field work in member s homes and interactions with providers, care giver and home care agencies involved in the member s care. This is a hands on, involved, department of health contractual program which requires at least one visit per calendar year for membersJob DescriptionReview and evaluate the assessment and UAS information. Physically meet the members where they are to gain deep understanding of their situation and needs.Problem solve member s problems and needs: clinical, psychosocial, financial, environmental.Develop a PCSP with member, caregivers, and health care providers, integrating concepts of cultural sensitivity and privacy practices. With the member s care team, develop an individual member disaster plan. Monitor by phone and face to face at minimum once a calendar year the condition of members. Identify clinical issues that require immediate clinical assessment and/or treatment to reduce the risk of unnecessary hospitalization ER visits or nursing home admissions. Communicate plan of care to Primary Care Physician and other members of the care team as appropriate. Assist members with the coordination of services both within network and outside network as appropriate. This includes facilitating discharge from acute and alternate settings.Optimize both the quality of care and quality of life for members receiving PCS services. Assess risks and gaps in

care.Maximize member s access to available resources Insure member caregiver understanding as it relates to language barriers, stress reaction or cognitive limitations/barriers using verbal and nonverbal techniquesPerforms all PCS and Long-Term Support Services (LTSS) management activities in compliance with all regulatory agency requirements. Employ critical thinking and judgment when dealing with unplanned issuesAbility to use data as a tool in tracking and trending outcomes and clinical informationMaintain accurate, comprehensive and current clinical and non-clinical documentsComply with all orientation requirements, annual and other mandatory trainings, organizational and departmental policies and procedures, and actively participate in evaluation processMaintain professional competencies as a Case ManagerOther duties as assigned by Manager.Minimum QualificationsClinical background: RNBachelor s Degree requiredAn equivalent combination of training, educational background and experience in related fields and educational disciplines.Prior experience in Certified home health agency(CHHA), Lombardi program or MLTC) required. Case Management in a health care and/or Managed Care setting strongly preferredProficiency with computers navigating in multiple systems and web based applicationsConfident, autonomous, solution driven, detail oriented, high standards of excellence, nonjudgmental, diplomatic, resourceful, intuitive, dedicated, resilient and proactiveStrong verbal and written communication skills including motivational coaching, influencing and negotiation abilitiesTime management and organizational skillsStrong problem solving skillsAbility to prioritize and manage changing priorities under pressureMust know how to use Microsoft Office applications including Word, Excel, and PowerPoint and Outlook.Ability to proficiently read and interpret medical records, claims data, pharmacy and lab reports, and prescriptions requiredAbility to travel within the MetroPlus service area making home visits to members, facility visits to clinical providers, and visits to community, faith and other social service based agencies.Ability to work closely with member and caregiver. Ability to form effective working relationships with a wide range of individuals.Professional CompetenciesIntegrity and TrustCustomer FocusFunctional/Technical skillsWritten/Oral CommunicationHow To ApplyIf you wish to apply for this position, please apply online by clicking the /"Apply Now/" button or forward your resume, noting the above Job ID #, to:MetroPlus Health PlanHuman Resources Department160 Water Street 8th FloorNew York, NY 10038Attn: Recruitment Unit Associated topics: care, domiciliary, hospice, infusion, intensive, neonatal, nurse rn, psychatric, registed, unit

Seniority Level

Mid-Senior level

Industry

- Health, Wellness & Fitness
- Medical Practice
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Health Care Provider

SourceURL: https://www.linkedin.com/jobs/view/clinical-reviewer-%28seasonal%29-at-metroplus-health-plan-1051267869/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Clinical Reviewer (Seasonal)

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

Posted Date Posted 1 day ago Number of applicants Be among the first 25 applicants

Marketing StatementMetroPlus Health Plan provides the highest quality healthcare services to residents of Bronx, Brooklyn, Manhattan, Queens and Staten Island through a comprehensive list of products, including, but not limited to, New York State Medicaid Managed Care, Medicare, Child Health Plus, Exchange, Partnership in Care, MetroPlus Gold, Essential Plan, etc. As a wholly-owned subsidiary of NYC Health + Hospitals, the largest public health system in the United States, MetroPlus--- network includes over 27,000 primary care providers, specialists and participating clinics. For more than 30 years, MetroPlus has been committed to building strong relationships with its members and providers to enable New Yorkers to live their healthiest life.--Postion OverviewThe primary function of the Clinical Quality Reviewer - Seasonal is to conduct audit of medical charts for compliance with HEDIS, QARR, Medicare Advantage Star measure specifications. This position will be an integral part of the annual Medical Record Review project required to report HEDIS/QARR measures to the NYS Department of Health and Centers for Medicare & Medicaid Services (CMS). The role is seasonal and will be needed from November of the measurement year through May of the reporting year, approximately seven months.The position may require travel within the five boroughs.Job Description

- Maintain knowledge of medical record review and EMR systems.--
- Maintain up-to-date knowledge of HEDIS, QARR and Star specifications
- Distribute requests for records and schedules appointments with provider offices to ensure timely completion of duties to meet internal and regulatory standards and requirements.
- Perform clinical audits via EMR, in-house paper medical records, on-site provider visits to collect documentation of measure compliance.
- Data enter accurate and timely findings in the appropriate system(s) in accordance with established documentation standards for MetroPlus Health Plan to ensure integrity of member services provided over the continuum of care and over time.Minimum Qualifications
  - Clinical background: Health Educator, LPN, RN, LMSW or LCSW with a minimum of two years HEDIS review experience.
  - Experience with medical record review working on HEDIS/QARR in a managed care or health plan setting.
  - Proficient in Microsoft Office applications including Word, Excel, PowerPoint and Access.

    Licensure--and/or Certification Required

    - License: Health Educator, LPN, RN, LMSW or LCSWProfessional Competencies:

- Integrity and Trust
- Customer Focus
- Functional/Technical skills
- Written/Oral CommunicationHow To ApplyIf you wish to apply for this position, please apply online by clicking the "Apply Now" button or forward your resume, noting the above Job ID #, to:

  MetroPlus Health Plan
  Human Resources Department
  160 Water Street 8th Floor
  New York, NY 10038
  Attn: Recruitment Unit

SourceURL: https://www.linkedin.com/jobs/view/call-center-and-claims-representative-at-independent-care-health-plan-1051597688/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Call Center and Claims Representative

Company Name Independent Care Health Plan Company Location Milwaukee, WI, US

New Posted Date Posted 17 hours ago Number of applicants Be among the first 25 applicants

The position of the Customer Service?Representative is intended to meet the needs of iCare members, potential enrollees and providers by providing a resource by phone, to answer member and provider inquiries related to benefits, eligibility and claims, coordinate/assist with member transportation needs, assist in care coordination by working with iCare staff, and perform other duties as assigned.

Provides program, benefit, eligibility, claims information and describes iCare services to potential and new members via telephone and in writing.
Provide responses to provider inquiries submitted to the dedicated Provider email box on spreadsheets within the designated timeframes based on the volume of claim reviews submitted by the provider.
Arranges for translators and translation services, when necessary.
Address phone calls from iCare members.
Assists with transportation services for members to Medicaid approved locations when necessary.
Research issues and uses judgment for obtaining relevant information.
Develops and maintains positive customer relations and coordinates with various functions within the company to ensure customer (member or provider) requests and questions are handled appropriately and in a timely manner (24 hours in most cases, longer as needed and customer is provided daily status updates until issue addressed)
Documents member information, including demographics and contacts made with customers within the Trizetto Call Tracking system.
Meets individual performance and quality goals

2-3 years of demonstrated customer service experience in a health insurance setting with a general understanding of claims processing and benefits.
Previous experience in Medicaid and / or Medicare environment.
Experience in managed health care systems and customer service business practices.
Strong interpersonal skills and ability to work effectively with persons with disabilities and a wide variety of ethnic, cultural, and socio-economic backgrounds.
Ability to develop and maintain effective working relationships with providers, members, other agencies and organizations.
Ability to effectively and satisfactorily resolve member and provider issues within specified timelines.

Possess Knowledge And Experience Of Appropriate Telephone Skills.

Related Keywords: Customer Service, Call Center

Seniority Level

Entry level

Industry

- Health, Wellness & Fitness
- Medical Practice
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Finance
- Sales

SourceURL: https://www.linkedin.com/jobs/view/administrative-sales-assistant-at-independent-care-health-plan-1051594230/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Administrative Sales Assistant

Company Name Independent Care Health Plan Company Location Milwaukee, WI, US

New Posted Date Posted 17 hours ago Number of applicants Be among the first 25 applicants

JOB REQUIREMENTS: Job Description: The Administrative Sales Assistant is responsible for coordinating all activities related to growing and retaining the Medicare Advantage enrollment. The primary responsibilities include providing assistance to the Sales & Marketing Manager and the Medicare Benefits Consultants. 1.Prepare reports on a daily and monthly basis. The monthly reports feed into the Monthly Dashboard Report that the Sales Manager prepares for Senior Management. 2.Calculate commissions for the Medicare Benefits Consultants for new sales on a monthly basis and for retention on a quarterly basis. Calculate commissions for our brokerage network on a monthly basis. 3.Check eligibility in ForwardHealth and MARx for the daily business reply cards, etc. 4.Enter Sales Notes from the Medicare Sales Representatives into TruCare on a daily basis. 5.Enter tracking numbers for gift cards and store in managers locked file cabinet. Receive requests for additional gift cards from the Medicare Sales Representatives, obtain cards, assign on spreadsheet. Enter names of recipients of the gift card on the tracking spreadsheet. Ensure the data is complete and that no person receives over $50.00 per calendar year. 6.Maintain the broker database and provide assistance to the brokerage network. 7.Monitor the daily TR/R to ensure that SNP members maintain their Medicaid eligibility. 8.Assist individuals in enrolling in the Medicaid Assistance Purchase Plan (MAPP). 9.Monitor the monthly Medicaid Recertification Report and assist members as needed with their recertification and re-enrollment into iCare Medicaid as needed. 10.Answer questions from team members, internal staff, and appointed brokers concerning Medicaid and Medicare eligibility. 11.Respond to reply cards received from non-qualified SNP people to potentially enroll in SSI. iCare is an Equal Opportunity Employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity or national origin. **OTHER EXPERIENCE AND QUALIFICATIONS: Experience and Skills: 1.Associate Degree or equivalent job related experience. 2.Ability to maintain strict confidentiality. 3.Highly skilled organizational abilities, skill/ability to effectively manage personal work time with high level of flexibility, skill/ability to meet deadlines for multiple projects/assignments with ongoing interruptions. 4.Strong skills in Excel, Word, PowerPoint and Outlook skills. Knowledge of ACT! Database helpful. 5.Knowledge of**

general business practices. 6.Skill/ability to work effectively and cooperatively as a member of a team. APPLICATION INSTRUCTIONS: Apply Online: ipc.us/t/8DE4C2452B0B4E05

Seniority Level

Entry level

Industry

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

Employment Type

Full-time

Job Functions

- Administrative

SourceURL: https://www.glassdoor.com/job-listing/representative-care-center-medicaid-mvp-health-care-JV_IC1132438_KO0,35_KE36,51.htm?jl=2902225724&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

REPRESENTATIVE, CARE CENTER MEDICAID

3.3 MVP Health Care – Tarrytown, NY 1 day ago
Applied 1/6/19
Apply on Company Site

1 day ago

New

Get ahead of others. Apply now.

Job
Company
Rating
Salary
Reviews
Benefits
Provides optimum customer service as required to maintain existing members and prevent cancellations. The Care Center Representative must take full responsibility for every call to ensure callers concerns are met. Provides world class customer care to internal and external customers while consistently adhering to all call handling objectives, i.e. hold time, talk time, after call work, schedule adhere and quality assurance. Correctly responds to all Department of Health audit calls on a consistent basis. Acts as a liaison between our internal and external customers. Responds promptly, accurately and effectively to all calls in a polite and professional manner. Responds to all calls timely and have a clear understanding of call avoidance, such as but not limited to: short calls, intentional disconnects, inappropriate transfers and inappropriate use of hold button. Performs data input in a highly accurate and timely manner on all customer contacts. Simultaneously accesses multiple databases while addressing customer's needs. Researches information needed to accurately respond to customers concerns. Asks appropriate questions to ensure a clear understanding of customers concern. Clearly explains all policies and procedures on both incoming and out-going calls. On an ongoing basis, educates members about their benefits and Hudson's procedures. Develops a comprehensive understanding of all lines of business. Has the technical skills required to be able to perform task efficiently. Delivers information in a clear and confident manner. Performs other duties as assigned.

POSITION QUALIFICATIONS

Minimum Education:

High School diploma or equivalent when possesses customer service employment experience.

Post high school education (Associates degree, college courses) preferred

Minimum Experience:

Minimum 1 – 3 years customer service experience and/or relevant office experience required

Experience in positions where adherence to strict confidentiality is required

Healthcare, health insurance experience preferred Call Center experience preferred

Required Skills:

•Must be bilingual (Spanish speaking)

•Strong problem solving skills with effective oral and written communication skills.

•Have strong interpersonal skills and exhibit good judgment.

•Demonstrated excellent customer service skills including superior accountability and follow through

•Demonstrated PC skills using Microsoft applications

Preferred Skills:

•Excellent telephone/communication skills

SourceURL: https://www.linkedin.com/jobs/view/family-care-partnership-supervisor-at-independent-care-health-plan-1051595179/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Family Care Partnership Supervisor

Company Name Independent Care Health Plan Company Location Milwaukee, WI, US

New Posted Date Posted 17 hours ago Number of applicants Be among the first 25 applicants

JOB REQUIREMENTS: Job Description: This position is responsible for ensuring that the Interdisciplinary Team provides case management services in compliance with the Family Care Partnership program model and contract. 1.Participate in the hiring and training of new staff 2.Supervise and evaluate the performance of employees assigned to their teams 3.Convene staff meetings to share information 4.Convene meetings for each IDT to provide case staffing 5.Provide problem solving and coaching to staff to meet member needs 6.Utilize established systems to monitor member records and documentation to ensure quality and contract compliance 7.Assist staff in adapting to changes as they occur within the Family Care Partnership model, the program structure or as the company needs demand 8.Communicate with program management about the challenges faced by the IDT and work with management to address these challenges 9.Work with other areas of the company to resolve case specific issues with the IDT 10.Collaborate with the Best Practice Committee to provide training to staff, ensuring staff stay current with the Family Care Partnership model and other best practices or other program development initiatives 11.Collaborate with Department and Company Management to provide leadership to IDT Staff iCare is an Equal Opportunity Employer. All qualified applicants will receive consideration for employment without regard to race,

color, religion, sex, sexual orientation, gender identity or national origin. **OTHER EXPERIENCE AND QUALIFICATIONS: 1.Bachelor's degree required in nursing, social work or related social services field. Master's degree preferred. 2.2-3 years of Case management experience, Family Care experience preferred 3.1-2 years of supervisory experience preferred 4.Management and leadership skills with proven ability to assist in employee development 5.Ability to effectively communicate thoughts, ideas, and information both orally and in writing. 6.Ability to demonstrate flexibility, set priorities that manage daily demands with long-term work assignments and projects. 7.Strong interpersonal skills and ability to effectively interact with members and co-workers from a variety of different backgrounds and experiences in a professional and courteous manner. 8.Ability to work effectively as a team member and cooperate in achieving company goals. 9.Problem solving ability to seek solutions using appropriate methodologies. 10.General knowledge of Medicaid and Medicare benefits. 11.Previous experience working with Microsoft office programs** APPLICATION INSTRUCTIONS: Apply Online: ipc.us/t/74FB2ECBA5AA441D

Seniority Level

Mid-Senior level

Industry

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

Employment Type

Contract

Job Functions

- Other

SourceURL: https://www.linkedin.com/jobs/view/family-care-partnership-supervisor-at-independent-care-health-plan-1051595179/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

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JOB REQUIREMENTS: Job Description: This position is responsible for ensuring that the Interdisciplinary Team provides case management services in compliance with the Family Care Partnership program model and contract. 1.Participate in the hiring and training of new staff 2.Supervise and evaluate the performance of employees assigned to their teams 3.Convene staff meetings to share information 4.Convene meetings for each IDT to provide case staffing 5.Provide problem solving and coaching to staff to meet member needs 6.Utilize established systems to monitor member records and documentation to ensure quality and contract compliance 7.Assist staff in adapting to changes as they occur within the Family Care Partnership model, the program structure or as the company needs demand 8.Communicate with program management about the challenges faced by the IDT and work with management to address these challenges 9.Work with other areas of the company to resolve case specific issues with the IDT 10.Collaborate with the Best Practice Committee to provide training to staff, ensuring staff stay current with the Family Care Partnership model and other best practices or other program development initiatives

11.Collaborate with Department and Company Management to provide leadership to IDT Staff iCare is an Equal Opportunity Employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity or national origin. **OTHER EXPERIENCE AND QUALIFICATIONS: 1.Bachelor's degree required in nursing, social work or related social services field. Master's degree preferred. 2.2-3 years of Case management experience, Family Care experience preferred 3.1-2 years of supervisory experience preferred 4.Management and leadership skills with proven ability to assist in employee development 5.Ability to effectively communicate thoughts, ideas, and information both orally and in writing. 6.Ability to demonstrate flexibility, set priorities that manage daily demands with long-term work assignments and projects. 7.Strong interpersonal skills and ability to effectively interact with members and co-workers from a variety of different backgrounds and experiences in a professional and courteous manner. 8.Ability to work effectively as a team member and cooperate in achieving company goals. 9.Problem solving ability to seek solutions using appropriate methodologies. 10.General knowledge of Medicaid and Medicare benefits. 11.Previous experience working with Microsoft office programs** APPLICATION INSTRUCTIONS: Apply Online: ipc.us/t/74FB2ECBA5AA441D

SourceURL: https://www.linkedin.com/jobs/view/supervisory-health-insurance-specialist-at-centers-for-medicare-medicaid-services-1053449171/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Supervisory Health Insurance Specialist.

Company Name Centers for Medicare & Medicaid Services Company Location Woodlawn, MD, US

Posted Date Posted 1 day ago Number of applicants Be among the first 25 applicants

- Duties

  Summary

  This position is located in the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Center for Medicare (CM), Medicare Plan Payment Group (MPPG), Division of Payment Reconciliation (DPR).

  As a Supervisory Health Insurance Specialist, GS-0107-14, you will provide executive leadership in the operational review and administration of key national program policies and procedures.

  Responsibilities
  - Cultivate ways to improve production or increase the quality of the work directed and develops performance standards.
  - Plan work to be accomplished by subordinates, sets and adjusts short-term priorities, and prepares schedules for completion of work.
  - Represent the division in consultations with the local, state, and U.S. government officials, and the public regarding the interpretation and impact of health plan and other policy matters.
  - Direct the policies, procedures and operations associated with the annual Part D payment reconciliation, including data collection, reconciliation calculation, reporting and payment adjustment, appeals and reopenings, and internal controls.
  - Strategically plans and directs short-and long-term projects analyzing on critical legislative, regulatory, policy and operational initiatives related to Part D and other health policy matters.

- Travel Required
-
- Not required
-

- Supervisory status
-
- Yes
-
- Promotion Potential
-

  14
- Job family (Series)
- 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**
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- **ALL QUALIFICATION REQUIREMENTS MUST BE MET WITHIN 30 DAYS OF THE CLOSING DATE OF THIS ANNOUNCEMENT.**
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- **In order to qualify for the GS-14** , 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-13 grade level in the Federal government, obtained in either the private or public sector, to include: (1) Developing policy and operational procedures related to health care programs or payment systems; (2) Evaluating and interpreting laws, regulations, or policies relating to the government health care programs; and (3) Assigning, directing, and coordinating the work activities of subordinate employees.
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- 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.
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- **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.
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- **Click The Following Link To View The Occupational Questionnaire**
-

- Education
-
- This job does not have an education qualification requirement.
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- Additional information
-
- **Bargaining Unit Position:** No
- **Tour of Duty:** Flexible
- **Recruitment/Relocation Incentive:** Not Authorized
- **Financial Disclosure:** Required
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- **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.
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- **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.
  - **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.
  - **Standard Form 61, Appointment Affidavits** - If selected, the Standard Form 61 will be required at the time of in-processing.

- **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.
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- 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
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- How You Will Be Evaluated
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- You will be evaluated for this job based on how well you meet the qualifications above.
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- 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.
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  Your qualifications will be evaluated on the following competencies (knowledge, skills, abilities and other characteristics):
  - Building Coalitions/Communications
  - Business Acumen
  - Leading People
  - Managing Change
  - Results Driven

- This position is being filled through a temporary promotion that may not exceed one year. Only in rare instances are extensions beyond one year granted. Management may end this opportunity at any time, and in such cases, the employee is returned to his/her previous position or to another position of equivalent grade and pay. In addition, this opportunity may be made permanent at any time without further competition.
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- Background checks and security clearance
-
- Security clearance
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- Drug test required
-
  No
- Required Documents

  <u>The Following Documents Are REQUIRED</u>
- **Resume showing relevant experience; cover letter optional**. Your resume must indicate your citizenship and if you are registered for Selective Service if you are a male born after 12/31/59. Your resume must also list

your work experience and education (if applicable) including the start and end dates (mm/dd/yy) of each employment along with the number of hours worked per week. For work in the Federal service, you must include the series and grade level for the position(s). Your resume will be used to validate your responses to the assessment tool(s). For resume and application tips visit:

- **CMS Required Documents (e.g., SF-50, DD-214, SF-15, etc.).** Current CMS employees are REQUIRED to submit a copy of their most recent Notification of Personnel Action (SF-50) at the time of application. Additional documents may also be required to be considered for this vacancy announcement.
  PLEASE NOTE: A complete application package includes the online application, resume, and CMS required documents. Please carefully review the full job announcement to include the "Required Documents" and "How to Apply" sections. Failure to submit the online application, resume and CMS required documents, will result in you not being considered for employment.
- Benefits

  A career with the U.S. Government provides employees with a comprehensive benefits package. As a federal employee, you and your family will have access to a range of benefits that are designed to make your federal career very rewarding.

  Eligibility for benefits depends on the type of position you hold and whether your position is full-time, part-time, or intermittent. Contact the hiring agency for more information on the specific benefits offered.
- How to Apply

  To apply for this position, you must complete the occupational questionnaire and submit the documentation specified in the "Required Documents" section below. A complete application package (to include resume, occupational questionnaire, and other applicable supporting documents) must be received by 11:59 PM ET on 01/09/2019 to receive consideration.

  IN DESCRIBING YOUR WORK EXPERIENCE AND/OR EDUCATION, PLEASE BE CLEAR AND SPECIFIC REGARDING YOUR EXPERIENCE OR EDUCATION.

  Please Ensure EACH Work History Includes ALL Of The Following Information

We strongly encourage applicants to utilize the USAJOBS resume builder in the creation of resumes.

- Official Position Title (include series and grade if Federal job)
- Duties (be specific in describing your duties)
- Employer's name and address
- Supervisor name and phone number
- Start and end dates including month, day and year (e.g. June 18, 2007 to April 05, 2008)
- Full-time or part-time status (include hours worked per week)
- Salary

- **Determining length of general or specialized experience is dependent on the above information and failure to provide ALL of this information WILL result in a finding of ineligible.**
    - To begin, click **Apply** to access the online application. You will need to be logged into your USAJOBS account to apply. If you do not have a USAJOBS account, you will need to create one before beginning the application.
    - Follow the prompts to **select your resume and/or other supporting documents** to be included with your application package. You will have the opportunity to upload additional documents to include in your application before it is submitted. Your uploaded documents may take several hours to clear the virus scan process.
    - After acknowledging you have reviewed your application package, complete the Include Personal Information section as you deem appropriate and **click to continue with the application process**.
    - You will be taken to the online application which you must complete in order to apply for the position. Complete the online application, verify the required documentation is included with your application package, and submit the application.

- To verify the status of your application, log into your USAJOBS account (
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- This agency provides reasonable accommodation to applicants with disabilities. If you need a reasonable accommodation for any part of the application or hiring process, please send an email to Dana.dessesow@cms.hhs.gov. The decision to grant reasonable accommodation will be made on a case-by-case basis.
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- **Commissioned Corps Officers** (including Commissioned Corps applicants that are professionally boarded) who are interested in applying for this

position must send their professional resume (not PHS Curriculum Vitae) and cover letter to

-
- Agency contact information
-
- Dana Dessesow
-
- Phone
-
- Email
-
- Address
-
- Center for Medicare
- 7500 Security Blvd
- Woodlawn, MD 21244
- US
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- Next steps
-
- Once your online application is submitted, you will receive a confirmation notification by email. Your application will be evaluated to determine your eligibility and qualifications for the position. After the evaluation is complete, you will receive another email notification regarding the status of your application.
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  Within 30 business days of the closing date,01/09/2019, you may check your status online by logging into your USAJOBS account (
- Fair & Transparent

  The Federal hiring process is setup to be fair and transparent. Please read the following guidance.

  Equal Employment Opportunity Policy

  The United States Government does not discriminate in employment on the basis of race, color, religion, sex (including pregnancy and gender identity), national origin, political affiliation, sexual orientation, marital status, disability, genetic information, age, membership in an employee organization, retaliation, parental status, military service, or other non-merit factor.

  Reasonable Accommodation Policy

Federal agencies must provide reasonable accommodation to applicants with disabilities where appropriate. Applicants requiring reasonable accommodation for any part of the application process should follow the instructions in the job opportunity announcement. For any part of the remaining hiring process, applicants should contact the hiring agency directly. Determinations on requests for reasonable accommodation will be made on a case-by-case basis.

A reasonable accommodation is any change to a job, the work environment, or the way things are usually done that enables an individual with a disability to apply for a job, perform job duties or receive equal access to job benefits.

Under the Rehabilitation Act of 1973, federal agencies must provide reasonable accommodations when:

- An applicant with a disability needs an accommodation to have an equal opportunity to apply for a job.
- An employee with a disability needs an accommodation to perform the essential job duties or to gain access to the workplace.
- An employee with a disability needs an accommodation to receive equal access to benefits, such as details, training, and office-sponsored events.

- You can request a reasonable accommodation at any time during the application or hiring process or while on the job. Requests are considered on a case-by-case basis.
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