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Medicaid Jobs Hunter

1. Sr Provider Network Representative - TMHP, TX Medicaid | Blue Cross and Blue Shield of Illinois, Montana, New Mexico, Oklahoma & Texas
2. Public Consulting Group Medicaid Program Director - Medicaid/Medicare Dual Eligibility Job in New York, NY
3. RN, Care Manager (Meridian DSNP) | Concerto Healthcare
4. Business Consultant Specialist, Care Coordination, Medicaid and Vulnerable Populations. - Oakland | Kaiser Permanente
5. Medicaid Medical Management Project Manager | Aetna, a CVS Health Company
6. Manager of Managed Care & Medicaid Affairs - Aurora | Numotion
7. AVP, Health Plan Operations | Molina Healthcare
8. Medical Director, Health Plan | Molina Healthcare
9. Care Manager - Medicare/Medicaid | Healthfirst
10. Health Insurance Specialist. | Centers for Medicare & Medicaid Services

Sr Provider Network Representative - TMHP, TX Medicaid | Blue Cross and Blue Shield of Illinois, Montana, New Mexico, Oklahoma & Texas

SourceURL: https://www.linkedin.com/jobs/view/sr-provider-network-representative-tmhp-tx-medicaid-at-blue-cross-and-blue-shield-of-illinois-montana-new-mexico-oklahoma-texas-1177915231/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Description

Located in Austin or Waco, this position is responsible for planning and directing provider recruitment and contracting activities for Texas medicaid (TMHP, STAR, STAR+,CHII,HHSC) ; educating providers, on-going provider service including annual provider visits for territory of 7 counties. Provides training to new and existing network staff.

Job Requirements

- Bachelor's Degree in Business OR 6 years Health Care experience.
- 4 years’ experience in Claims, Customer service, Physician office or Hospital or Healthcare environment.
- 3 years’ experience in a position which requires in-depth Physician/Provider relations, including but not limited to, Contracting and Reimbursement issues.
- Analytical and reporting skills.
- Platform skills; organizational and planning skills; and ability to take initiative and work independently.
- Ability to multi-task; meet deadlines and work well under pressure.
- Must have reliable transportation for travel within the region.
- Ability and willingness to travel within a region, including overnight stays on occasion.
- PC proficiency to include Microsoft Office.

Preferred Job Requirements

- Strong Medicaid background; STAR, STAR+, TMHP, CHII, HHSC.
- Strong Medicare Advantage PPO/Medicare Advantage HMO background.
- Skilled/experienced with Medicaid Expansion (Network Build/RFP response).

- Health claims, billing, recoupements, Grievances&Appeals for TX Medicaid.

This position must be located in Austin or Waco.

Public Consulting Group Medicaid Program Director - Medicaid/Medicare Dual Eligibility Job in New York, NY

SourceURL: https://www.glassdoor.com/job-listing/medicaid-program-director-medicaid-medicare-dual-eligibility-public-consulting-group-JV_IC1132348_KO0,60_KE61,84.htm?jl=3135553974

Position
Title Medicaid Program Director Division of Long Term Care Location Albany NY OR New York City Travel percentage TBDTravel will be between Albany & New York City NYS DOHs Office of Health Insurance Programs OHIP Division of Long Term Care is seeking a qualified individual to lead the day to day management of a large scale project to develop and implement programs that integrate Medicare and Medicaid coverage for persons dually eligible for Medicare and Medicaid NY Medicaid covers nearly 1000000 dually eligible members at an annual cost of225 billion 36 of total Medicaid spending in New York The candidate for this position will Work with DOH senior leadership to develop and design program features that integrate Medicare and Medicaid for persons dually eligibleBe responsible for the day to day management of the project ensuring that milestones and timeframes are metConvene stakeholders including but not limited to licensed health plans consumer organizations and providers of long term care and other services to gather input into program design and implementationAssist in the preparation of documents required to secure federal approvals where neededOther tasks as assigned related to coverage for persons dual eligible individualsThe ideal candidate would have the following experience Five or more years working on the development and operation of managed care programs for persons dually eligible for Medicare and Medicaid Sales and marketing of Medicare managed care plans to consumers shall not count toward this experience12 years of professional experience is requiredSupervisory experience is requiredUnderstanding of federal regulations and options available for integrating Medicare and Medicaid for to dual eligible persons including but not limited to Medicare Special Needs Plans including but not limited toD SNPs FIDE SNPSHIDE SNPS and PACEExcellent written and verbal communication skillsDemonstrated ability to manage large scale program development and implementation in a complex environmentExcellent interpersonal skillsAbility to work independently and manage multiple priorities

RN, Care Manager (Meridian DSNP) | Concerto Healthcare

SourceURL: https://www.linkedin.com/jobs/view/rn-care-manager-meridian-dsnp-at-concerto-healthcare-1199661643/?position=17&pageNum=0&trk=jobs_jserp_job_listing_text&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Concerto Health and its subsidiaries are an Equal Opportunity Employer. We do not and will not discriminate in employment or personnel practices on the basis of race, color, religion, national origin, ancestry, alienage or citizenship status, age, disability, sex, sexual orientation or any other characteristic protected by applicable federal, state or local laws.

Category: Healthcare
Posted Date: March 22, 2019
Schedule: Full-Time
Location: Southfield, MI, USA

About Concerto Health

ConcertoHealth Inc. is the leading provider of specialized primary care and supporting clinical services for complex, frail, elderly, and dual-eligible patients. Operating exclusively in value-based agreements, ConcertoHealth provides high-touch, individualized care for patients, and deploys wraparound clinical resources to extend the reach of primary care practices. This comprehensive medical management solution, elevated by Concerto's proprietary population health technology, improves overall healthcare quality and patient outcomes, benefitting payers and their provider networks.

Concerto delivers comprehensive care to Medicare, Medicaid, and complex-needs patients. The Concerto name reflects our unique approach to healthcare. It's about how we work in concert with patients, providers, and health plans. Our approach focuses on bringing harmony across the spectrum of a patient's care, health, and dignity.

The company is headquartered in Aliso Viejo, Ca. For more information, please visit:www.concertohealth.com

Job Summary

The care manager acts as an advocate to coordinate the continuum of care for our patients. This role requires a high level of interaction with our patients to:

- Perform effective telephonic outreach to complete necessary health and social assessments

- Engage them in the development of an integrated, patient-centered care plan that takes into account needs across the continuum of care (health, social, psycho-social)
- Support the patient in achieving their own goals as stated in their care plan as well as monitor adherence to treatment plans or other disease/chronic condition management programs
  The care manager works with a multi-disciplinary care team to develop interventions and changes to the care plan in response to patient's needs and promotes positive health outcomes.

  Essential Duties And Responsibilities
    - Perform comprehensive, team-based, and person-centered patient engagement.
    - Conduct patient onboarding, including performing health risk assessments in accordance with (health plan) model of care requirements.
    - Creates and develops patient care plans that addresses all problems, goals and interventions identified using appropriate mediums (e.g. historical claims data, outreach logs, completed assessments, etc.) in Concerto's care coordination record system.
    - Identify high risk patients (based on risk stratification criteria) who require a high frequency of care coordination and contact.
    - Identifies caregiver training needs and tracks impact of needs and or training.
    - Completes transition of care process in accordance with health plan guidelines; includes outreach during hospitalization and conducting assessments upon discharge to ensure successful transition to another setting.
    - Identify the appropriate utilization of resources across the continuum of care.
    - Participate in quality improvement and evaluation processes.
    - Work closely with the Pharmacy Benefit Manager and community pharmacies to help coordinate medication accessibility and medication refills.
    - Perform and document reassessments, revisions to care plans, and coordinate interdisciplinary care team meetings in accordance with the (health plan) model of care requirements.
    - Coordinate activities with Treating Providers, Utilization Management Team, Social Services Team and Disease Management Team as needed.
    - Complete all mandatory regulatory and other trainings required (including but not limited to: compliance training, first tier downstream and related (FWA) entity training, model of care training, etc.).
    - Knowledge of Healthcare Effectiveness Data Information Set (HEDIS) and engagement with members on care gap closure.
    - Regular and consistent attendance.
    - Other duties as assigned.

  Qualifications
    - Current RN or SW License in good standing in the state of practice required
    - Preferred Certified Care Manager (CCM) certification or commitment to completion within 1 year of hire.
    - Minimum of 3 years' experience in a clinical setting.
    - Demonstrates the ability to triage and apply critical thinking skills.
    - Ability to communicate effectively in writing and verbally.
    - Knowledge of Medicare and Medicaid care management requirements in accordance with CMS and MDHHS guidelines (or similar program for dual eligible beneficiaries).
    - Health Plan, Patient Centered Medical Home or CPC+ experience is preferred.
    - Proficient in computer skills to include Microsoft Office Suite (Outlook, Excel, PowerPoint, Word). knowledge and ability to navigate internet based tools, and proficient in computer typing with a minimum typing speed of 40 WMP.
    - Demonstrate ability to perform multiple concurrent tasks with minimal supervision and meet compliance deadlines.
    - Ability to work in fast-past environment.
    - Experience working in field-based role.
    - Reliable transportation is required.
    - Person-centered care plan preparation experience is required.

  Qualifications

  Licenses & Certifications

  Registered Nurse
  PI108711866

Business Consultant Specialist, Care Coordination, Medicaid and Vulnerable Populations. - Oakland | Kaiser Permanente

SourceURL: https://www.linkedin.com/jobs/view/business-consultant-specialist-care-coordination-medicaid-and-vulnerable-populations-oakland-at-kaiser-permanente-1199708780/?position=9&pageNum=0&trk=jobs_jserp_job_listing_text&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Company Location Oakland, CA, US
Business Consulting: Includes analysis/evaluation of business and/or system process and functional requirements, development of business cases, client support during system development and implementation, development and maintenance of service level agreements. Develops relationships with upstream and downstream business partners. Develops/maintains and changes business processes, and understands the business processes of assigned partners and how they relate to our functional areas. Develops and recommends changes to business processes.

Seniority Level

Associate

Industry

- Non-profit Organization Management
- Health, Wellness & Fitness
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Consulting
- Information Technology
- Sales

Medicaid Medical Management Project Manager | Aetna, a CVS Health Company

SourceURL: https://www.linkedin.com/jobs/view/medicaid-medical-management-project-manager-at-aetna-a-cvs-health-company-1171368801/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Job Description

Aetna Medicaid is hiring a Medical Management Project Manager to support our Medicaid Plans.

Our **Project Manager** responsible for supporting Medical Management leadership with various Medical Management Shared Services initiatives. Involves working with key stakeholders at the health plans and across shared services.

Telework Specifications: Considered for any US location

Fundamental Components

(*) Project Manager responsible for supporting Medicaid Medical Management projects.
(*) Projects include a variety of initiatives including: clinical cost savings, ABX , program design, system changes(replacement, new, or redesign), and continuous quality improvement initiatives.
(*) Flexible in working cross-functionally with a variety of subject matter experts and with key stakeholders at the health plans and within shared services.
(*) Ability to use available tools/programs to facilitate and track deliverables and key milestones to ensure successful project management and on-time execution. Ability to identify and execute risk mitigation strategies.
(*) Excellent negotiation and communication skills are a must.

BACKGROUND/EXPERIENCE Desired

(*) Proven track record to quickly and accurately interpret project needs, a self-starter in leading projects, negotiating for resources and meeting project milestones.
(*) Proven professional communication skills including written, verbal and presentation skills.
(*) Strength in communicating to provide clarity and direction to colleagues in varied positions, including senior leadership.
(*) Proven ability to affect change and motivate others, positive interpersonal skills.
(*) Past positions required acting a project lead and leading a team.

EDUCATION
The highest level of education desired for candidates in this position is a Bachelor's degree or equivalent experience.

LICENSES AND CERTIFICATIONS
Project Management/Project Management Professional, PMP is desired

Functional Experiences

Functional - Project Management/Cross-functional project management/1-3 Years
Functional - Project Management/Project Leader/1-3 Years
Functional - Project Management/Issue identification and analysis/1-3 Years
Functional - Communications/Employee communications/1-3 Years

Technology Experiences

Technical - Desktop Tools/Microsoft PowerPoint/1-3 Years/Power User
Technical - Desktop Tools/Microsoft SharePoint/1-3 Years/Power User
Technical - Desktop Tools/Microsoft Word/4-6 Years/Power User
Technical - Desktop Tools/TE Microsoft Excel/4-6 Years/Power User

Required Skills

General Business/Ensuring Project Discipline/ADVANCED
Leadership/Collaborating for Results/FOUNDATION
Leadership/Driving Change/ADVANCED

Desired Skills

General Business/Communicating for Impact/ADVANCED
General Business/Maximizing Work Practices/FOUNDATION
Service/Working Across Boundaries/FOUNDATION

Additional Job Information

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

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

Together we will empower people to live healthier lives.

Aetna is an equal opportunity & affirmative action employer. All qualified applicants will receive consideration for employment regardless of personal characteristics or status. We take affirmative action to recruit, select and develop women, people of color, veterans and individuals with disabilities.

We are a company built on excellence. We have a culture that values growth, achievement and diversity and a workplace where your voice can be heard.

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

Aetna takes our candidates's data privacy seriously. At no time will any Aetna recruiter or employee request any financial or personal information (Social Security Number, Credit card information for direct deposit, etc.) from you via e-mail. Any requests for information will be discussed prior and will be conducted through a secure website provided by the recruiter. Should you be asked for such information, please notify us immediately.

Req#
58561BR
Job Group
Management
EEO Statement
Aetna is an Equal Opportunity, Affirmative Action Employer
Primary Location
AZ-Phoenix
Additional Locations
AZ-Phoenix

Percent Of Travel Required

0 - 10%
Potential Telework Position
Yes
Full or Part Time
Full Time
Supervisory
No
Resource Group
2

Manager of Managed Care & Medicaid Affairs - Aurora | Numotion

SourceURL: https://www.linkedin.com/jobs/view/manager-of-managed-care-%26-medicaid-affairs-aurora-at-numotion-1197510011/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

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

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

The Manager of Manged Care & Medicaid Affairs works to improve department processes and keep current with federal and state provider policies, manage administrative staff and lead long term organizational planning.

Responsible for all administration aspects of Medicare/Medicaid Provider Programs with enrollment of government and state programs, management of all regulatory license requirements, management of company fleet as well as assisting in budgeting cost of vehicles and management of facility leases.

Responsible for the timely submission of license, Medicare and Medicaid enrollments, which have a significant, impact the company's revenue targets.

Manage the company business insurance, working directly with the broker to maintain required coverage, schedule of payments, claim reporting and tracking.

Liaison to the company's in house attorney and corporate attorney's to provide communication and support to our managers in the field, along with providing data and information for claims that enter into any legal litigation.

Essential Functions

- Overseer's and ensures all regulatory licenses from federal to state and city municipalities are obtained and kept current and renewed as needed for business functions.
- Ensures that all government requirement and regulations are met to submit Medicare and Medicaid provider enrollments.
- Manages a team to track of all submissions to ensure the applications are processed and a license and/or provider number is issued.
- Mentor and coach the Team Lead so he/she can provide support and give daily direction and prioritize work assignments to the team with regards to licensing, Medicare and Medicaid provider enrollments.
- Initiate business agreement with registered agent to keep our state annual reports current, and issue any other certification or license within our schedule of services.
- Manages all aspects of the company's business insurance including renewals with the assistance of the CFO, quarterly statement of value reporting, review of additional endorsements, reporting all updates and changes to all government, state, city and bank facilities as required, communicate insurance changes and updates to our internal employees as needed. Manage the payment schedule and invoice approvals.
- Oversees the execution of facility leases to the landlords, processing payments, amendments and work with our corporate attorneys and managers in the field on renewals, lease buy-outs and terminations. Communication of all facility lease changes, updates and renewals to the RVP's. Ensures a quarterly review of all storage unit facilities is reviewed with the EVP's to verify the space is still required.
- Oversees the scheduling of all building signage and approval's for our facility leases through our approved sign company.
- Responsible to oversee and coordinate vehicle ordering, tracking and maintaining company vehicles as well as assisting in budgeting and managing fleet expenses.
- Manage the services of our fleet leasing company.
- Oversee MVR (Motor Vehicle Reports), per ACHC accreditation standards on all employees who drive for the company.
- Oversee and coordinate tracking expired driver's license and proof of vehicle insurance coverage.
- Coordinate and manage with the Fleet Coordinator, the schedule of vehicle data reports to the field and upper management.
- Responsible for ordering/ issuing company credit cards and working with the card holder and bank on any fraud related issues or miss use of the cards.
- Track reported incident reports and if applicable put our insurance carrier and/or in house and corporate attorneys on notice.
- Initiates and schedules meetings with a team of employees in our HR, finance, Service & Repair, and in house legal departments, along with our, broker and corporate attorney to discuss and implement safety standards within our business and insurance needs.
- Provide department updates and reports as needed.

Qualifications

- College degree in Business Administration or related field with
- Proven management leadership skills, while taking a "hands on" implementation approach as needed.
- Excellent interpersonal and relationship building skills.
- Excellent written and verbal communication skills.
- Performs related duties as required.
- Ability to work in a fast-paced environment and juggle multiple priorities.
- Able to think quickly, assess a situation and make a sound decision.

At Numotion, we are committed to meeting the needs of those we serve, and our employees. Working for Numotion, you will receive a competitive wage and benefits, including medical, dental and vision insurance, short or long term disability, a 401 K plan and life insurance.

Numotion is an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, protected veteran status or disability status.

Numotion is a drug-free workplace. Candidates are required to pass a drug test before beginning employment.

AVP, Health Plan Operations | Molina Healthcare

SourceURL: https://www.linkedin.com/jobs/view/avp-health-plan-operations-at-molina-healthcare-1069678591/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Molina Health Plan Operations jobs are responsible for the development and administration of State Health Plan's operational departments, programs and services, in alignment with Molina Healthcare's overall mission, core values, and strategic plan and in compliance with all relevant federal, state and local regulatory requirements.

Knowledge/Skills/Abilities

- Under the leadership of the Plan President, this role directs and coordinates Health Plan Operations.
- Accountable for ensuring Health Plan Operating metrics consistently meet and/or exceed all compliance requirements as well as key performance targets and associated service level agreements
- This position plans, organizes, staffs, and coordinates the operations of state Medicaid/CHIP, Medicare and Marketplace Health Plan operations.
- Works with staff and senior management to develop and implement improvements and oversight for non-clinical Health Plan operations.
- Serves as the Senior Plan leader and liaison for MHI Service Operations, including: Claims, Configuration Information Management, Enrollment, Contact Center Operations, IT, Provider Configuration Management, Program Integrity, Risk Adjustment, Provider Resolution Team, Provider Appeal and Grievances, Member Appeals and Grievances, and other departments as required. These MHI shared services operations that support the Health Plan will have dotted line responsibility and accountability to this position.
- Proactively develops, tracks, and reports to Plan leadership MHI Service Operations performance relative to Plan compliance requirements, key performance targets and/or associated service level agreements. Quickly escalates performance issues to the Plan President and Plan leadership along with clear action plans to mitigate. This role requires the identification and adoption of best practices from across the enterprise for Health Plan and MHI Service Operations; developing strategies and tactics in partnership with MHI Service Operations to mitigate any issues or performance levels not meeting established service levels and provides corporate oversight including the efficacy of vendor management.
- Serves as liaison with Enrollment and Contact Center Operation leaders to ensure full and consistent compliance with Health Plan state contract and regulatory requirements. Works collaboratively with corporate business owners to mitigate risk related to enrollment processes and call center performance.
- Directs analytical activities to identify trends and potential opportunities with those Corporate Operations functions that may impact the functionality of Health Plan Operations.
- Directly manages the Plan's benefit configuration, claim payment policies and the maintenance or modification of such, to support accurate and timely claims payment. In addition, manages the Plan's Provider Configuration/Information activities to ensure compliance with regulatory requirements and accurate claims and encounter submissions.
- Partners to support Plan encounter submissions to Regulators.
- Leads efforts through local Data/Business Analysts to audit provider contract loads and claims payments to ensure compliance with provider contract requirements.
- May directly manage the Project Management and Process Improvement teams and resources.
- May directly manage the Health Plan main reception desk at Plans discretion.
- Other operational duties as assigned by the Plan President.**Job Qualifications**

Required Education

Job Qualifications

Bachelor's Degree in Business, Health Services Administration or related field, or comparable experience.

Required Experience

- 7-10 years' experience in Healthcare Administration, Health Plan Operations, Managed Care, and/or Provider Services.
- Experience managing/supervising employees.
- Demonstrated adaptability and flexibility to a rapidly moving business environment.
- Demonstrated experience with Medicaid and Managed Care.
- Experience working in Matrix environment.

Preferred Education

Master's Degree in Business, Health Administration or related field.

Preferred Experience

Experience with Medicaid and Medicare managed care plans.

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

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

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

Primary Location

US-MS-Jackson-ONEJACK

Medical Director, Health Plan | Molina Healthcare

SourceURL: https://www.linkedin.com/jobs/view/medical-director-health-plan-at-molina-healthcare-1076747514/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Knowledge/Skills/Abilities

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

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

Required Education

Job Qualifications

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

Required Experience

7 - 9 years relevant experience, including:

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

Required License, Certification, Association

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

Preferred Education

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

Preferred Experience

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

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

Board Certification (Primary Care Preferred).

Preferred License, Certification, Association

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Primary Location

US-IL-Oak Brook-OAKBROOK

Care Manager - Medicare/Medicaid | Healthfirst

SourceURL: https://www.linkedin.com/jobs/view/care-manager-medicare-medicaid-at-healthfirst-1176891355/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Position Summary

The Care Manager plans and manages behavioral and/or physical care with members and their beneficiaries and works with clinicians and health care team members. The Care Manager facilitates care and medical attention and addresses identified member needs across the continuum of care. The Care Manager is responsible for applying care management principles when engaging members and addressing coordination of the member's health care services. The Care Manager is assigned to a specific product line such as FIDA, CompleteCare, SNP, Medicaid/Medicare, PHSP, HARP, etc.

- Depending on one's residence and line of business, the Care Manager may be expected to make home, nursing home, and other related sites visits around downstate New York.

Duties/Responsibilities

- Advocates, informs, and educates beneficiaries on services, self-management techniques, and health benefits.
- Conducts assessments to identify barriers and opportunities for intervention.
- Develops care plans that align with the physician's treatment plans and recommends interventions that align with proposed goals.
- Generates referrals to providers, community-based resources, and appropriate services and other resources to assist in goal achievement.
- Collaborates with provider doctors, social workers, discharge planners, and community based service providers to coordinate care accordingly.
- Coordinates and facilitates with the multi-disciplinary health care team as necessary in order to ensure care plan goals are achieved and maximize member outcomes.
- Assists in identifying opportunities for alternative care options based on member needs and assessments.
- Evaluates service authorizations to ensure alignment and execution of the member's care and physician treatment plan.
- Contributes to corporate goals through ongoing execution of member care plans and member goal achievement.
- Documents all encounters with providers, members, and vendors in the appropriate system in accordance with internal and established documentation procedures; follows up as needed; and updates care plans based on member needs, as appropriate.
- Occasional overtime as necessary.
- Additional duties as assigned.

Minimum Qualifications

- NYS RN or
- LCSW, LMSW, LMFT, LMHC, LPC, licensed psychologist (any state)

Preferred Qualifications

- Strong interpersonal and assessment skills, especially the ability to relate well with seniors, their families, and community care providers, along with demonstrated ability to handle rapidly changing crisis situations.
- Fluency in Spanish, Korean, Mandarin, or Cantonese.
- Knowledge and experience with the current community health practices for the frail adult population and cognitive impaired seniors.
- Knowledge of InterQual and LOCADTR.
- Experience managing member information in a shared network environment using paperless database modules and archival systems.
- Experience and knowledge of the relevant product line
- Relevant work experience preferably as a Care Manager
- Demonstrated ability to manage large caseloads and effectively work in a fast-paced environment

  - Proficient with simultaneously navigating the Internet and multi-tasking with multiple electronic documentation systems
  - Experience using Microsoft Excel with the ability to edit, search, sort/filter and other Microsoft and PHI systems

WE ARE AN EQUAL OPPORTUNITY EMPLOYER. Applicants and employees are considered for positions and are evaluated without regard to mental or physical disability, race, color, religion, gender, national origin, age, genetic information, military or veteran status, sexual orientation, marital status or any other protected Federal, State/Province or Local status unrelated to the performance of the work involved.

If you have a disability under the Americans with Disability Act or a similar law, and want a reasonable accommodation to assist with your job search or application for employment, please contact us by sending an email to careers@Healthfirst.org or calling 212-519-1798 . In your email please include a description of the accommodation you are requesting and a description of the position for which you are applying. Only reasonable accommodation requests related to applying for a position within Healthfirst Management Services will be reviewed at the e-mail address and phone number supplied. Thank you for considering a career with Healthfirst Management Services.

EEO Law Poster and Supplement

Health Insurance Specialist. | Centers for Medicare & Medicaid Services

SourceURL: https://www.linkedin.com/jobs/view/health-insurance-specialist.-at-centers-for-medicare-%26-medicaid-services-1200346513/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Summary

This position is located in the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Consortium for Medicaid and Childrens Health Operations (CMCHO) .

As a Health Insurance Specialist, GS-0107-13, you will develop, evaluate and implement compliance, audit and oversight requirements, policies, operating procedures related to activities and processes involved with the monitoring and oversight of external CMS stakeholders.

Responsibilities

  - Develop, implement, and maintain a comprehensive program oversight strategy and processes.
  - Interpret established polices and provide technical assistance regarding Agency programs to internal and external stakeholders including responding to inquiries from Congress, oversight entities and the public.
  - Develop, evaluate, and refine regulations, manuals, program guidelines, program memoranda, policy letters and instructions to disseminate and effectively communicate policy to Agency internal and external stakeholders .
  - Prepare a variety of written products, including position papers, manuals, reports, correspondence, briefing materials, etc. for the assigned program area.
- Travel Required
- Occasional travel - You may be expected to travel up 25% for this position.
- Supervisory status
- No
- Promotion Potential
  13
- 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**
- **ALL QUALIFICATION REQUIREMENTS MUST BE MET WITHIN 30 DAYS OF THE CLOSING DATE OF THIS ANNOUNCEMENT.**
- **In order to qualify for the GS-13**, you must meet the following: You must demonstrate in your resume at least one year (52 weeks) of qualifying specialized experience equivalent to the GS-12 grade level in the Federal government, obtained in either the private or public sector, to include:1) developing, implementing, or evaluating health information technology; 2) conducting analytical studies to assess program operations or objectives; AND 3) preparing reports on project evaluations or findings to presentation to management .
- Experience refers to paid and unpaid experience, including volunteer work done through National Service programs (e.g., Peace Corps, AmeriCorps) and other organizations (e.g., professional; philanthropic; religious; spiritual; community, student, social). Volunteer work helps build critical competencies, knowledge, and skills and can provide valuable training and experience that translates directly to paid employment. You will receive credit for all qualifying experience, including volunteer experience.
- **Time-in-Grade:** To be eligible, current Federal employees must have served at least 52 weeks (one year) at the next lower grade level from the position/grade level(s) to which they are applying.
- **Click The Following Link To View The Occupational Questionnaire**

- Education
- This job does not have an education qualification requirement.
- Additional information
- **Bargaining Unit Position:** Yes (2268)
- **Tour of Duty:** Flexible
- **Recruitment/Relocation Incentive:** Not Authorized
- **Financial Disclosure:** Not Required
- CMS employees currently participating in 100% Full-Time Telework Program may be eligible to remain in the program. If an employee in this program is selected, the pay will be set in accordance with the locality pay for the applicable duty station. The listed salary range reflects the locality pay assigned to the duty location(s) listed in the vacancy announcement. For more information about pay based on locality, please visit the
- **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.
- **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.
- 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
- How You Will Be Evaluated
- You will be evaluated for this job based on how well you meet the qualifications above.
- Once the announcement has closed, your online application, resume, and CMS required documents will be used to determine if you meet eligibility and qualification requirements listed on this announcement. If you are found to be among the top qualified candidates, you will be referred to the selecting official for employment consideration. Please follow all instructions carefully. Errors or omissions may affect your rating.
  Your qualifications will be evaluated on the following competencies (knowledge, skills, abilities and other characteristics):
  - Analysis
  - Health Insurance
  - Oral Communication
  - Program Management
  - Written Communication
- Background checks and security clearance
- Security clearance
- Drug test required
  No
- Required Documents

  The Following Documents Are REQUIRED
- **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
- How to Apply

  Your complete application package, as described in the "Required Documents" section, must be received by 11:59 PM ET on 04/03/2019 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 (
- 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 Gregory.tate@cms.hhs.gov. The decision to grant reasonable accommodation will be made on a case-by-case basis.
- **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
- CMS employees who are currently appointed under Schedule A authority and are interested in applying for this position must submit their resume, Schedule A documentation, transcripts (if positive education required or qualifying through education substitution), and cover letter (optional) to Gregory.tate@cms.hhs.gov. You MUST include the Job Announcement Number in the subject line of the email to receive consideration for the position. For additional information regarding Schedule A authority
- Agency contact information
- Gregory Tate
- Phone
- Email
- Address
- Consortium for Medicaid and Childrens Health Operations
- 7500 Security Blvd
- Woodlawn, MD 21244
- US
- 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.
-

  Within 30 business days of the closing date,04/03/2019, 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.