Medicaid Industry Jobs Hunter 04/13/20

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Medicaid Jobs Hunter

In this packet….

Client Services Associate | Farragut Square Group

Client Services Associate

McDermott+Consulting (McDermottPlus) is a healthcare consulting firm with offices in Washington, D.C. and New York, New York. McDermott plus provides a spectrum of advisory services across the healthcare continuum.

Farragut Square Group (Farragut), its research and advisory entity, provides strategic policy analysis, prognostications, and longer range advisory diligence on developing federal, state and commercial payor related matters to private equity investors, bankers, lenders, and healthcare corporates across the U.S. We also work with C-suite level professionals at healthcare companies on assignments ranging from portfolio analysis to assessment of regulatory and legislative risk to projects geared toward advising on product or geographic expansion strategy.

Farragut is looking to expand by hiring an Associate-level Client Services Professional. Our ideal candidate has a healthcare policy, a

Wall Street or a consulting background and is looking to use that base of knowledge/market understanding to branch out within the capital markets by working with Private Equity clients within a highly sought after critical M&A niche. The person will provide support to our clients at the direction of Farragut's Business Development team and work in coordination with our research analysts on client communications at the direction of Farragut's Director of Research.

About the company:

Farragut Square Group was eight years old when it was acquired in July 2019 by McDermottPlus Consulting, the Washington, D.C.-based advisory subsidiary of McDermott Will & Emery. The company is a healthcare research and advisory firm that works with Private Equity investors and their portfolio companies, as well as with bankers, lenders and healthcare corporates, helping them get clarity and confidence around regulatory, reimbursement and payment risk. We are the authority in the U.S. in predictive diligence for institutional investors, helping them execute deal strategy and achieve their investment plans. Our client roster includes some of the most influential and sophisticated healthcare investors in the country. This is an ideal position for someone with a background in healthcare policy to stand at the intersection of policy formulation and research that leads to actionable, financially-backed outcomes.

The Founders and staff are extremely passionate about what we are building and have left Capitol Hill, banking and large consulting firm jobs to establish the kind of company they've always wanted to work for. We are looking for similarly minded folks who want to learn, grow, and like what they do every day.

About the candidate:

This hire will be a part of an expanding team responsible for delivering exceptional service to Farragut's existing clients and new prospects. This hire will work closely with the Business Development team and the Director of Research on prompt and appropriate communication for client inbounds and follow-ups. The hire will also help with Business Development efforts where appropriate and with managing existing relationships to optimize brand value. Candidates should have three or more years of experience in healthcare policy, with a solid understanding of Medicare and Medicaid, or experience with healthcare services payment systems, or annual regulations that govern those systems. The ideal team member is independent, creative, and driven to succeed – with exceptional writing, oral communication, and networking skills. Client interaction and or positions with a client communication focus a plus.

Qualifications:

3-5 years of healthcare policy and communications experience. Years of relevant experience determine level of responsibility.

· Healthcare-related Capitol Hill, banking, consulting company, agency, advocacy, or association background ideal.

· Interest in working with healthcare-focused institutional investors.

· Excellent oral communication and writing skills, along with a desire to turn complex legislation and regulations into digestible summaries for investors. This role involves working in the intersection of policy and business development and supporting the account management efforts of senior business development executives.

· Provide end-to-end support of Farragut's work streams with private equity and corporate clients.

· Maintain relationships to address clients' strategic and operational challenges during the due diligence process.

· Collaborate with the research and business development teams to generate market focused research material for our prospective and current clients.

· Provide support to business develop team in meeting organization and set up

· Strong desire to perform research on healthcare services sectors and construct marketing communication helpful to clients and their portfolio companies as they navigate reimbursement and regulatory headwinds and take advantage of tailwinds.

· Must be flexible, team-oriented, and proactive, with a can-do attitude to take on tasks as needed.

The position offers a competitive salary, commensurate with experience, and benefits.

Please include a resume, in addition to a cover letter stating salary requirements.

Senior Lab Credentialing Specialist | Pave Talent

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Senior Lab Credentialing Specialist

Pave Talent New York City Metropolitan Area

New Posted 8 hours ago Be among the first 25 applicants

Pave Talent is hiring a Senior Lab Credentialing Specialist. Our client is a highly successful biotech company with leading technology in genetic testing in the women's health space.

If you want to lead an organization and see your efforts make a profound impact, this opportunity may be for you. The Senior Lab Credentialing Specialist is responsible for ensuring that the lab is properly credentialed across commercial and government providers in the United States.

RESPONSIBILITIES OF SENIOR LAB CREDENTIALING SPECIALIST

- Medicare and Medicaid facility credentialing
- Credentialing for the license of the facility
- Track and ensure timely renewal of all licenses and certifications
- Maintain CLIA certificate

REQUIREMENTS OF SENIOR LAB CREDENTIALING SPECIALIST

- 3-5 years of lab credentialing experience
- Knowledge of CLIA
- High School

Operations Analyst, Health Practice | Public Consulting Group

Operations Analyst, Health Practice

Public Consulting Group Austin, TX, US

Posted 15 hours ago

Overview

About Public Consulting Group

Public Consulting Group, Inc. (PCG) is a leading public sector solutions implementation and operations improvement firm that partners with health, education, and human services agencies to improve lives. Founded in 1986 and headquartered in Boston, Massachusetts, PCG has over 2,500 professionals in more than 60 offices worldwide. PCG's Health practice offers in-depth programmatic knowledge and regulatory expertise to help state and municipal health agencies respond to regulatory change, improve access to health care, maximize program revenue, improve business processes, and achieve regulatory compliance. Using industry best practices, PCG's Health team helps organizations deliver quality services with constrained resources to promote improved client outcomes. To learn more, visit http://www.publicconsultinggroup.com/health/ .

Responsibilities

PCG is seeking candidates for Operations Analyst positions located in

Austin, TX. These positions will be members of a dedicated team of data and operations professionals who focus on data analysis, data management, data validation, quality control, and first-line client service ("Data Team.") The Data Team supports a portfolio of projects that currently spans more than 10 states and two product lines, school bases services and emergency medical services. Both product lines seek to complete financial cost reports for public sector clients who receive Medicaid revenues.

As part of this team, the Operations Analyst will work with both internal teams and external clients and be assigned day-to-day operational tasks arising from project work. The Operations Analyst will be trained on the specific product lines and internal software but are expected to have a strong analytical and operational focus as well as the ability to provide front line client service.

Responsibilities

Data Analysis and Validation

- Conduct financial analysis of cost reports including trend analysis, variance analysis, and root cause data investigations.
- Gathering and interpreting cost and/or ratio data to identify variances and trends, create reports and perform advanced analysis when necessary
- Perform "desk audits" of cost reports, validating data submitted against supporting documentation

Quality Control

- Monitor and track data received for projects
- Complete quality assurance checks for assigned projects

Client Service

- Communicate with internal and external clients about data discrepancies, missing information, needed documents, upcoming deadlines, and status.
- Appropriately escalate issues within the Team.
- Provide first line client support via group email box and shared phone help line.

Operational Improvement

- With guidance, identify, document, and review opportunities for operational improvements
- Assist in the development of standard materials to execute

operational improvements such as trainings, standard operating procedures, and job aids

Other

- Special projects as assigned

Qualifications

Required Skills:

- Strong interpersonal, organizational, research, and time management skills
- Demonstrate a detailed and process-oriented approach to problem-solving
- Demonstrate sound judgment in completing tasks and in seeking guidance when needed
- Demonstrate a positive attitude and demeanor; showing initiative, enthusiasm, and strong willingness to learn
- Demonstrate a commitment to deliver exceptional client service for internal and external clients
- Ability to report and track findings, review documentation, and notify upper level management of key issues.
- Ability to embrace change and flexibility
- Ability to juggle multiple assignments at once, seeking prioritization when necessary.
- Ability to work both in a team situation and autonomously.
- Proficiency in Microsoft applications

Required Experience

- Bachelor's Degree is required
- 1-3 years of relevant work experience is required
- Proficiency with Excel is required
- Experience with or knowledge of Medicaid, Healthcare, Education, and/or customer support is beneficial

Other Requirements

- Full Time, 40 hours per week
- Low to No Travel Required (maximum travel of 10%)

Options

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Regulatory Affairs Analyst, Health IT | American College of Physicians

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(2) Regulatory Affairs Analyst, Health IT

The American College of Physicians (ACP), a prestigious medical membership association for doctors of internal medicine, is seeking an Analyst, Regulatory Affairs (Health IT) for our Washington, DC office.

The Analyst will conduct research and assist with the analysis of health policy and regulatory payment and delivery reforms as it relates to the development, implementation, and use of Health Information Technology (IT).

Responsibilities include, but are not limited to:

- Assists ACP staff in supporting College representatives in activities relevant to College policy and member interests; and develops and maintains educational tools, online resources, guides, and templates. Provides staff support to several ACP committees on issues in their content area and as needed in other areas.
- Assists with the analysis of the impact of federal legislation and regulations on health policy and the practice of internal medicine andserves as a key point of contact for member and other inquiries regarding a wide range of issues relating to Health IT and other relevant policy and regulatory priorities of the College.

The successful candidate will have:

- A bachelor's degree with two years of Health IT experience.
- Good writing skills with a demonstrated ability to summarize health issues in a succinct manner highlighting key points.
- Basic understanding of the legislative and executive branch of government and executive regulatory agencies involved in public health policy.
- Familiarity with the Centers for Medicare and Medicaid Services and Office of the National Coordinator for Health IT policies preferred.
- Experience with electronic health records and other health IT preferred
- Basic understanding of research and analytical procedures.
- Solid experience in MS Office including Word, Excel and PowerPoint.

ACP offers a competitive salary, superior benefits and a supportive work environment. Find out more about ACP at: https://www.acponline.org/working_at_acp/. Interested candidates should apply online: https://www.acponline.org/working_at_acp/jobs/.

ACP is an Equal Opportunity Employer that does not discriminate against any of the following classes: veterans, any disability, national origin, race, color, religion, sex, sexual orientation, gender identity.

Team Lead, Pharmacy | Lockton Dunning Benefits

Team Lead, Pharmacy

Lockton Dunning Benefits Houston, TX, US

Posted 3 hours ago

Lockton Dunning Benefits acquired Excelsior Solutions in 2012. Excelsior Solutions is a nationally recognized consulting firm focused on pharmacy benefits and specialty pharmacy. We are currently seeking a Vice President, Pharmacy Team Lead to join a Pharmacy Consulting Team managing health plan clients. The ideal candidate will demonstrate a high level of professionalism; possess the ability to work well in a fast-paced environment and the flexibility to easily adapt to changing priorities.

- Develop rapport and enhance the “team approach and service delivery to all existing accounts and prospective accounts.
- Overall responsibility for unit performance including growth and persistency.
- Allocate resources/assign cases and prospect projects within the unit.
- Primary role in continued training, development and primary resource for team members.
- Manage Associates and complete performance evaluations for unit (including salary and bonus review).
- Assist Producer in sales opportunities to prospective clients.
- Determine when Producer involvement is necessary in problem resolution.
- Assist Producer in establishing and meeting target revenue goals for existing and new business.
- Attendance of internal meetings/educational programs.
- Participate in Management Team.
- Work collaboratively with PBMs to manage RFPs for clients.
- Work with clients to set a pharmacy strategy and help execute the strategy with the client’s pharmacy vendors.
- Facilitate client service meetings.
- Assist in review and accuracy of all vendor agreements.
- Build relationships with PBMs, specialty pharmacies, and other pharmacy vendors.

Requirements

- Minimum of Bachelor's Degree in business related field.
- Minimum 15 years' experience in the industry, specifically experience in PBMs or health plans.
- Management experience preferred.
- Excellent organization, communication and negotiation skills.
- Excellent computer skills, including word processing and spreadsheet expertise.
- A complete working knowledge of pharmacy benefits in multiple product lines (i.e. Medicare, Medicaid, commercial Health Plan, employer).
- Complete working knowledge of differing financial arrangements and products available to clients
- Must be knowledgeable on compliance requirements and federal legislation.
- Must be available for travel and willing to accept responsibility for client/vendor entertainment.

Deputy Director, Program Integrity | Covered California

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Deputy Director, Program Integrity

Covered California Sacramento, California Area

Posted 6 hours ago

Join the Covered California Team!

At Covered California, we recognize our employees are our most

valuable asset. Our employees are the vital link that ensures that our vision, mission and values are fully realized. We are currently seeking an accomplished leader to join our team as the new Deputy Director, Program Integrity.

Do you have a strong leadership background in health care program auditing or public accounting? Do you have experience in strategic planning and policies related to fraud waste and abuse prevention and detection, enterprise-wide risk management, and data integrity initiatives? Are you effective at establishing relationships, building trust, and influencing key dialogue with a diverse group of stakeholders?

Under administrative direction of the Director, Program Integrity, the Deputy Director, Program Integrity serves as the Chief Audit Executive and also as the Chief Compliance Officer of Covered California over the Program Oversight & Compliance Branch and the Reconciliation of Enrollment of Membership Branch. The Deputy Director is responsible for the strategic oversight of these Branches within the Program Integrity Division.

The Deputy Director, Program Integrity role is essential to the Program Integrity Division fulfilling its responsibility to continuously improve Covered California's consumer-focused operations. The Program Integrity Division encourages accountability, transparency, and effectiveness, as well as efficiencies and risk management. It independently reviews key business areas to help ensure compliance with federal and state laws, regulations, and policies and procedures to achieve Covered California's mission, vision, and goals. This includes independent oversight for the enterprise-wide risk management process and all external and internal audit functions.

Desirable Qualifications

- BA/BS Degree in Accounting, Finance, Health Care or closely related field
- Certified Government Auditing Professional (CGAP), Certified Internal Auditor (CIA), Certified Public Accountant (CPA), and/or Certified Information Systems Auditor (CISA)

1. Minimum of 5 years of related leadership management experience, preferably in health care program auditing or public accounting.
2. Strong leadership and management skills with a demonstrated ability to train, mentor and evaluate high-level staff members.
3. Experience establishing relationships with diverse groups of internal and external stakeholders, in order to foster 2-way open communication, build trust and influence key dialogue.

4. Demonstrated experience with strategic planning and management of internal and external audits, and experience working collaboratively with internal stakeholders and external agencies, such as the Center for Medicare and Medicaid Services (CMS), the California State Auditor (CSA), the Internal Revenue Service (IRS) and the Office of Inspector General (OIG).
5. Demonstrated ability and/or experience in strategic planning and policies related to fraud waste and abuse prevention and detection, enterprise-wide risk management, and data integrity initiatives.
6. Demonstrated experience in developing, monitoring and measuring performance goals, and establishing key performance indicators.
7. Strong political acumen skills with proven ability to work effectively with stakeholders - specifically, Board of Directors, Committees, and/or Commissions.

Employee Benefits

Covered California provides incredible benefits for our employees, including healthcare, retirement and savings, work life services, leave benefits, and work life balance. To learn more, copy and paste this link into your browser: **http://hbex.coveredca.com/jobs/benefits/**

Application Deadline: Monday, May 4, 2020 @ 11:59pm PDT

If you have any questions regarding the application process and/or are interested in learning more about this position, please contact Elizabeth Mosley at elizabeth.mosley@covered.ca.gov.

IL Medicaid Medical Director, RVP | Humana

Source URL: https://www.linkedin.com/jobs/view/1825808980/?eBP=NotAvailableFromVoyagerAPI&recommendedFlavor=IN_NETWORK&refId=24a1f89f-3413-43e2-844f-f820958ba1e7&trk=d_flagship3_search_srp_jobs

IL Medicaid Medical Director, RVP

Humana Chicago, IL, US

Posted 14 hours ago

Description

The IL Medicaid Medical Director, RVP relies on medical background to create and oversee clinical strategy for the region. The IL Medicaid Medical Director, RVP requires an in-depth understanding of how organization capabilities interrelate across segments and/or enterprise-wide.

Responsibilities

Job Posting Title: IL Medicaid Medical Director, RVP

Location: Chicago, IL (Schaumburg)

Job Description

The IL Medicaid Medical Director, RVP will provide medical leadership and strategy for the Illinois Medicaid Market with fiscal responsibility for trend management.

- Oversee regional utilization management and case management for Long Term Services and Supports (LTSS) Program which includes Home and Community Based Services, Long Term Care, and SNFist program according to the Humana Clinical Model of Care.
- Participate in Quality Operations including chair Quality Management Committee, complete initial peer review on quality of care complaints, complete peer-to-peer written and verbal communications.
- Oversee Quality Improvement and HEDIS/STARS metrics improvement with PCP offices and IPAs
- Participate in regional level committees and meetings setting medical necessity strategies.
- Provide oversight and direction for the implementation of regional clinical programs and strategies, as well as, developing and

implementing market level strategies.
- Manage internal operational/functional relationships related to profitability.
- Assist with network development and provider contracting with various providers and ancillary providers.
- Serve as clinical liaison with inpatient facilities and joint operating committees to maintain facility relationship and problem solve; especially reviewing contracts as to clinical services.
- Well-versed on financial aspects of various levels of risk bearing contracts and possess the ability to gain traction and adoption of the providers.
- Ability to thrive in a highly matrix environment.

Required Qualifications

- 8 or more years of management experience
- A current and unrestricted license in at least one jurisdiction and willing to obtain license, as required, for various states in region of assignment
- MD or DO degree
- Board Certified in an approved ABMS Medical Specialty
- Excellent communication skills
- 5 years of established clinical experience
- Medicaid experience
- Knowledge of the managed care industry including Medicare and Commercial products
- Possess analysis and interpretation skills with prior experience leading teams focusing on quality management, utilization management, discharge planning and/or home health or rehab
- Must be passionate about contributing to an organization focused on continuously improving consumer experiences

Preferred Qualifications

- Medical management experience, working with health insurance organizations, hospitals and other healthcare providers, patient interaction, etc.
- Internal Medicine, Family Practice, Geriatrics, Hospitalist, ER, PM&R clinical specialists
- Master's Degree

#PhysicianCareers

Scheduled Weekly Hours

40

Vice President, Medical Economics | CareSource

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Vice President, Medical Economics

CareSource Dayton, OH, US

Posted 16 hours ago

Description

Role and Responsibility:

- Lead and develop the Medical Economics and Informatics function for the organization
- Develop the talent of a diverse team of healthcare analysts and drive a culture of high performance
- Lead the analysis of utilization and cost analysis of trend, variation and outliers. Recommend related strategies and initiatives to improve performance.
- Lead population and epidemiological analysis of disease, social determinants of health and other clinical factors. Collaborate with Clinical Programs to identify related programs and interventions that improve outcomes.
- Provide ongoing analysis of clinical programs, claims processes and quality measures to ensure efficiency and efficacy
- Provide analytical insight into provider network performance and value-based reimbursement initiatives
- Provide ad-hoc analytic support for key business areas to include business development, pharmacy, behavioral health, clinical programs, and operations

- Collaborate with Data Solutions to develop innovative ways to analyze and present data
- Perform any other job-related instructions, as assigned

Cross Functional Interactions

- Interacts with all departments across the organization

Requirements

Education / Experience:

- Bachelor of Science/Arts (BA/BS) degree in Actuarial Science, Mathematics or Finance
- An advanced degree is strongly preferred
- A minimum of ten (10) years of experience in a Health Plan environment with a minimum of five (5) years of director-level experience is required
- A minimum of five (5) years of experience in government healthcare programs
- Experience leading teams of 20 or more analysts
- Experience working with managed Medicaid and Medicare Advantage products
- Experience leading the design of enterprise reporting and dashboards related to medical and pharmacy utilization/cost
- Experience analyzing population health factors such disease incidence and social determinants of health
- Experience identifying, quantifying and determining root cause for adverse trends and variation in medical and pharmacy cost

Required Competencies / Knowledge / Skills

- Excellent PC skills, including advanced Excel, Word and PowerPoint
- Excellent and proven Leadership skills
- Ability to organization and prioritize
- Ability to translate strategy to plan and execute
- Strong analytical skills
- Strong problem solving and critical thinking skills
- Ability to articulate and defend complex ideas and strategies to non-technical audiences
- Collaborative, with the ability to effectively influence others
- Fact-based decision maker
- Excellent oral, written and interpersonal communication skills
- Strong managerial and team-building skills, with proven track record of hiring and developing high performers
- A proven track record of achievement and integrity

Working Conditions

- General office environment; may be required to sit/stand for long periods of time

This job description is not all inclusive. CareSource reserves the right to amend this job description at any time. CareSource is an Equal Opportunity Employer, including disability and veteran status. We are committed to a diverse and inclusive work environment.

Director, Network Management (65622BR) | Aetna, a CVS Health Company

Source URL: https://www.linkedin.com/jobs/view/1785518650/?eBP=JOB_SEARCH_ORGANIC&recommendedFlavor=IN_NETWORK&refId=24a1f89f-3413-43e2-844f-f820958ba1e7&trk=d_flagship3_search_srp_jobs

Director, Network Management (65622BR)

Aetna, a CVS Health Company Kenner, LA, US

New Posted 14 hours ago Be among the first 25 applicants

Job Description

Leads and manages teams of employees who develop, negotiate, contract, and enhance provider networks of high quality, are cost efficient and will improve healthcare for our customers. Oversees the development of programs to maintain and enhance collaborative provider relationships and operational effectiveness. Maintains accountability for related compliance, quality and financial goals. Manages a high functioning team responsible for ensuring overall

network competitiveness and profitability for a given geographical area or assigned provider type. The Director's responsibility and complexity may vary by market size and the need for units may be organized around services such as hospitals, providers, providers, or both; the type of contract, such as fee for service or value based, compliance functions and or cost management efforts.

Fundamental Components

Leads a team of Network Managers, Consultants and Contract Negotiators who design, develop, manage and/or implement strategic network configurations and effective managed care network relationships. Manages the activities of the network development team, including effective strategies to build progressive provider partners and relationships. Effectively negotiates the most complex, competitive contractual relationships with providers according to prescribed financial guidelines with all provider types including at risk, IPA/IPO, hospital and large provider/provider groups. Ensures necessary review; oversee and support network filings in compliance with state and federal regulations. May include value-based agreements depending on market requirements. Accountable for cost arrangements and contract performance in support of network quality, availability and financial strategies to achieve P-Model, discounts and cost management goals. Ensures network coverage adequacy and implements action items to close gaps. Responsible for advancing the adoption of value-based payment models. May work with VBC Engagement managers to develop VBC arrangements and collaborative agreements. Develops and presents value proposition; presents the potential for network performance results in sales meetings or to external constituents. Analyzes data and is responsible for understanding medical cost issues and trends; collaborates with Medical Economics to monitor and identify scorable action plans; works closely with Population Health to enable and improve clinical outcomes. May oversee Network Relations teams that manage the service needs for providers including network/provider relations policy, recruitment, education and training, as well as improved workflows. Required to communicate w/internal/external parties by phone/in person; may require travel to offsite location.

Background Experience

8 – 10 years related experience in account management, health operations, network relations and development, command of financials and pricing strategies, and sales interface. Experience building and maintaining relationships with provider systems. A successful track

record managing and negotiating major provider contracts In depth knowledge of various reimbursement structures and payment methodologies for both hospitals and providers preferred. Knowledge of managed care business, regulatory /legal requirements preferred. Solid leadership skills, including staff development and talent management. Bachelor's degree or equivalent work experience. MBA/Master's degree preferred.

Additional Job Information

Job description may also be used for other products besides Commercial medical: e.g., dental, worker’s comp, behavioral health, Medicare, Medicaid, etc.; systems and tools mentioned in the description would align and reflect appropriate product, segment.

Job Group

Healthcare

Primary Location (City, State)

LA-Kenner

Additional Locations

LA-Kenner

Potential Telework Position

No

Percent Of Travel Required

0 - 10%

Full or Part Time

Full Time

Supervisory Responsibilities

Yes

EEO Statement

Aetna is an Equal Opportunity, Affirmative Action Employer

Benefits Program

Benefit eligibility may vary by position.

Candidate Privacy Information

Aetna takes our candidate'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.

Resource Group

2

Req#

65622BR

Lead, Provider Enrollment Coordinator | ChenMed

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Lead, Provider Enrollment Coordinator

ChenMed Miami Gardens, FL, US

Posted 2 hours ago

ChenMed is transforming healthcare for seniors. We provide big answers to big problems in health care delivery. ChenMed is a full-risk primary care market leader with an innovative philosophy, unique physician culture and end-to-end customized technology. These things allow us to provide world-class primary care and coordinated care to the most vulnerable population – moderate- to low-income seniors who have complex chronic diseases.

Through our innovative operating model, physician-led culture and empowering technology, we are able to drive key quality and cost outcomes that create value for patients, physicians and the overall health system. Our model allows us to practice medicine the way it should be practiced. By recruiting focused physicians and reducing their doctor-to-patient ratios, we increase patients' "face time" during each monthly appointment and help foster stronger doctor-patient relationships. Our model also drives and enhances compliance with treatment plans.

As a result of our efforts, our patients realize lower hospital admissions. Their overwhelming response to our approach is reflected in our aggressive, organic growth and net promoter scores in the low to mid 90s, which is unheard of in any industry. Read more about our results and the value of the ChenMed model.

As a company, we are making a difference in the lives of seniors and the health care system overall.

Essential Job Duties/Responsibilities

- Leads weekly calls with provider enrollment third party partner to ensure enrollment and recredentialing is being processed in a timely

fashion.

- Coordinates and monitors credentialing activities processed by provider enrollment partner to ensure timely processing of provider payor and facility applications, including supporting the collection of any required documents from providers, as needed.
- Manages the acquisition of professional state licenses through ChenMed's third-party provider enrollment partner.
- Conducts monthly payer rosters validations to ensure accurate primary practice locations, panel status and directory visibility with health plans and Provider Enrollment vendor, ensuring alignment.
- Provides credentialing status updates to markets on new providers.
- Maintains current credentialing requirements and point of contact with each payor.
- Supports Credentialing Manager with new market projects
- Fields and resolve credentialing related questions and issues from markets.
- Identifies process improvement opportunities and presents recommendations to Credentialing Manager and other leadership stakeholders.
- Identifies issues that require additional investigation and evaluation, validates discrepancies with provider payor participation statuses and ensures appropriate follow up.
- Implements improvement opportunities by creating or updating documentation and training resources.
- Serves as the primary point of contact to work with Legal, Risk, Compliance and Billing departments to ensure seamless submission of enrollment and recredentialing occurs.
- Serves as the primary point of contact for PCP recruiters on providing clinical ready effective dates for incoming providers.
- Compiles and maintains current and accurate credentials information for all providers using Workday
- Obtains provider information for web-based applications and credentialing databases such as PECOS and CAQH during initial new hire/onboarding of clinicians.
- Obtains professional liability insurance for provider and forwards to Provider Enrollment vendor.
- Completes provider applications for expiring provider credentials to maintain active credentials necessary to maintain enrollment with payors (DEA, State Licensure, National Board Certification, and CDS as applicable).

Knowledge, Skills And Abilities

- Knowledge of Medicare, Medicaid, and Commercial Payer Provider Enrollment rules, regulations and guidelines
- Knowledge of credentialing requirements such as those outlined NCQA, AAAHC and / or URAC

- Knowledge and understanding of the credentialing process
- Ability to effectively communicate, both verbally and in writing, with team members, supervisors, providers, clinicians and insurance contacts
- Ability to maintain complete confidentiality in handling sensitive enrollment issues.
- Professional, motivated and pleasant demeanor
- Excellent organizational, interpersonal and follow-up skills with attention to detail and accuracy
- Informational research skills
- Strong problem-solving skills are essential. Database management skills including querying, reporting, and document generation
- Ability to organize and prioritize work and manage multiple priorities simultaneously to meet deadlines
- Ability to work independently with minimal supervision
- Ability to establish and maintain effective working relationships with external vendors/contacts and internal stakeholders including providers, management, staff
- Proficient in Microsoft Office Suite products including Word, Excel, PowerPoint and Outlook, plus a variety of other word-processing, spreadsheet, database, e-mail and presentation software
- Ability and willingness to travel locally, regionally and nationwide up to 10% of the time
- Spoken and written fluency in English

At ChenMed, If you are an innovative, entreprenuerial minded, over-achiever who is extremely passionate in helping people and revolutionizing Healthcare again, we are that dynamic and exciting company you are looking for!

After applying, we encourage you to "follow" us on LinkedIn (ChenMed) as well! This way you can stay informed and up to date on what’s happening around our organization and start your path to becoming part of our FAMILY!