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Medicaid Jobs Hunter

Feb 18, 2019

In this packet...

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Medicaid Behavioral Health Outreach Coordinator - Four Corners Region, CO job - UnitedHealth Group - Cortez, CO

SourceURL: https://www.nexxt.com/jobs/medicaid-behavioral-health-outreach-coordinator-four-corners-region-co-cortez-co-836278071-job.html?utm_campaign=google_for_jobs&utm_source=google&utm_medium=organic&aff=2ED44C72-8FD2-4B5D-BC54-2F623E88BE26&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Behavioral Health Outreach Coordinator - Four Corners Region, CO

UnitedHealth Group • Cortez, CO 81321

Job #836278071

Doing the right thing is a way of life at Rocky Mountain Health Plans (RMHP). As part of the UnitedHealthcare family of plans, RMHP provides innovative health insurance coverage and personalized attention to individuals of all ages and business of all sizes throughout Western and rural Colorado. RMHP

is continually striving to improve the health and wellness of our Members and partners in the state where we live, work, and play - because we're Colorado, too.

You push yourself to reach higher and go further. Because for you, it's all about ensuring a positive outcome for patients. In this role, you'll work in the field and coordinate the long-term care needs for patients in the local community. And at every turn, you'll have the support of an elite and dynamic team. Join UnitedHealth Group and our family of businesses and you will use your diverse knowledge and experience to make health care work better for our patients.

In this Medicaid Behavioral Health Outreach Coordinator role, will be an essential element of an Integrated Care Model by relaying the pertinent information about the member needs and advocating for the best possible care available, and ensuring they have the right services to meet their needs.

If you are located In the "Four Corners Region" of Colorado , you will have the flexibility to telecommute* as you take on some tough challenges.

Primary Responsibilities:

- Assess, plan and implement care strategies that are individualized by patient and directed toward the most appropriate, lease restrictive level of care
- Identify and initiate referrals for social service programs; including financial, psychosocial, community and state supportive services
- Manage the care plan throughout the continuum of care as a single point of contact
- Communicate with all stakeholders the required health-related information to ensure quality coordinated care and services are provided expeditiously to all members
- Advocate for patients and families as needed to ensure the patient's needs and choices are fully represented and supported by the health care team
- Act as a resource to other team members as it relates to behavioral health issues

Expect to spend up to 80% of your time in the field visiting our members in their homes or in long-term care facilities. You'll need to be flexible, adaptable and, above all, patient in all types of situations

Required Qualifications:

- HS Diploma

- 3+ years of experience working within the community health setting in a health care role (or experience as mandated by the state contract)
- Experience in case management or care coordination
- 1+ year of experience in Behavioral Health
- Experience working with MS Word, Excel and Outlook
- The ability to travel in assigned region to visit Medicaid members in their homes and/or other settings, including community centers, hospitals or providers' offices

Preferred Qualifications:

- LPN/LVN, CNA, licensed social worker and/or behavioral health or clinical degree
- A background in managing populations with behavioral health needs
- Experience with electronic charting
- Prior field based work experience

Doing the right thing is a way of life at Rocky Mountain Health Plans (RMHP). For more than 225,000 members of our unique, physician-founded health care organization, we provide innovative health insurance coverage and personalized attention to individuals of all ages and business of all sizes throughout Western and rural Colorado. As a part of Optum, the fastest growing part of the UnitedHealth Group family of businesses, we've enhanced our offerings through sophisticated tools and technologies, superior customer service and a commitment to striving to improve the health and wellness of our Members and partners in the state where we live, work, and play - because we're Colorado, too. From a career perspective you couldn't do better. We're all about quality and making a difference. And can make our opportunities your opportunity to do **your life's best work.(sm)**

*All Telecommuters will be required to adhere to UnitedHealth Group's Telecommuter Policy

Diversity creates a healthier atmosphere: UnitedHealth Group is an Equal Employment Opportunity/Affirmative Action employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, age, national origin, protected veteran status, disability status, sexual orientation, gender identity or expression, marital status, genetic information, or any other characteristic protected by law.

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

Job Keywords: Behavioral Health, Medicaid, Community health, Case management, Care Coordination, Four Corners Region, Durango, Cortez, Bayfield, Colorado , CO, telecommute, telecommuting, telecommuter

Dir Medicaid Plan Marketing in Indianapolis IN USA - Anthem, Inc - 01F542 | Recruit.net USA

SourceURL: https://www.recruit.net/job/dir-medicaid_indianapolis-in_jobs/01F54291197B366E?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Dir Medicaid Plan Marketing in Indianapolis IN USA

Dir Medicaid Plan Marketing
Location: Indianapolis, Indiana, United States
New
Field: Marketing
Requisition #: PS17245
Post Date: 3 hours ago
Your Talent. Our Vision. At Anthem, Inc., the Government Business Division is focused on serving Medicaid, Medicare and uninsured individuals. Our commitment and focus on government health programs is the foundation upon

which we're creating better care for our members, greater value for our customers and better health for our communities. Join us and together we will drive the future of health care.
Join one of the fastest growing businesses in a company with the largest and most successful Medicaid business in the nation.
As a member of our Central Region Marketing Leadership team, the Director, Medicaid Marketing will be accountable for executing marketing strategies in a Medicaid Health Plan environment. This leader will work in conjunction with other Medicaid Health Plans, key business partners, and key corporate staff all to enhance national corporate branding efforts. This position will also develop objectives, policies and programs for marketing activities that directs and coordinates the efforts of marketing associates toward the accomplishment of corporate and key partnership objectives.
Primary duties may include, but are not limited to
+ Coordinates with key partner marketing leadership to ensure alignment of strategy and tactics.
+ Strategically plans and executes strategies, outreach and education activities for products to extend and increase membership growth and marketing.
+ Executes and leads a team on short and long-term strategic directives for the corporation, plans campaigns and programs to meet goals; reviews department performance in relation to established goals, implementing changes to effect improvement or react to a change in the organization or industry.
+ Researches and evaluates trends related to membership growth patterns.
+ Develops, recommends and presents short and long-term outreach strategies; develop projections of estimated usage and cost benefits of services.
+ Maintains and constantly improves the corporation's competitive position and ensures maximum productivity within budget guidelines.
+ Prepares presentations regarding marketing and outreach programs for senior management groups.
+ Develops and maintains favorable relationships with key decision-makers and influencers in the community.
+ Develops and recommends department operating budgets; reviews and revises financial reports, and prepares departmental statistics.
+ Directs and coordinates activities of the marketing operation in accomplishing corporate outreach activities, and periodically evaluates and reports results.
+ Ensure compliance with state and municipal laws, rules, and guidelines for marketing and outreach; organizes and directs training and orientation for all associates.
+ Develops, approves and/or secures approval of objectives, policies and programs for corporate marketing activities, and evaluates and reports results.

+ Directs outreach planning and activities, which includes maintaining favorable relations with members, analysis of competitive products and outreach techniques, consumer research, marketing legislation, outreach budget and goals.
+ Makes recommendations to appropriate functions to achieve product modifications or improvements derived from market research, technical service work or Marketing feedback.
+ Identifies and implements activities/services that promote member attendance and participation, member retention and growth, member health education and promotion.
+ Develops education materials which address the cultural and educational diversity of membership.
+ In partnership with Marketing Communications, responsible for identifying appropriate media opportunities and developing media relationships to assist in developing brand recognition.
+ Participates in appropriate Board(s) and or committee(s) which will assist in the development of brand recognition.
+ Other duties as requested or assigned.
Required:
· Bachelor's Degree in Marketing, Business Administration or similar field.
· Years and Type of Experience: 10 years of sales, marketing or healthcare experience.
· 5 years of experience in a supervisory level.
· Proven track record of designing, developing and managing sales, marketing, and community relations functions. Knowledge of Protocols and Process Regulations.
Preferred:
· Master's Degree in Business, Health Care Administration or a similar field.
_Anthem, Inc. is ranked as one of America's Most Admired Companies among health insurers by Fortune magazine and is a 2017 DiversityInc magazine Top 50 Company for Diversity. To learn more about our company and apply, please visit us at antheminc.com/careers. EO

Brigham & Women's Hospital(BWH)

SOCIAL WORKER - MEDICAID ACO (LCSW)/ 40 HOURS/ DAYS/ BWH BROOKSIDE COMMUNITY HEALTH JAMAICA PLAIN Job in Brookline, MA

SOCIAL WORKER - MEDICAID ACO (LCSW)/ 40 HOURS/ DAYS/ BWH BROOKSIDE COMMUNITY HEALTH JAMAICA PLAIN

3.9 Brigham & Women's Hospital(BWH) – Brookline, MA 1 day ago
Applied 2/19/19
Apply on Company Site

1 day ago

New

Get ahead of others. Apply now.

Job

Company

Rating

Salary

Reviews

Benefits

The Social Worker for the Medicaid Accountable Care Organization (ACO) is a key member of the Primary Care team, providing clinical services and overseeing the coordination of care for high risk, complex patients with significant utilization of medical and/or psychiatric services and facilities.

The Social Worker for the Medicaid ACO will be expected to serve as the primary coordinator of patient care for a panel of patients, ensuring communication among providers and patient. The patients are predominantly covered by Massachusetts Medicaid and are part of the innovative Medicaid ACO strategy at Brigham and Women's Hospital.

The Social Worker for Medicaid ACO will be embedded in a BWH primary care practice and be responsible for establishing, implementing, monitoring, and evaluating high quality cost effective, patient-centered care plans.

The Social Worker for the Medicaid ACO collaborates with the interdisciplinary team in creating and improving the system of care, in determining which interventions have been most helpful, and in outlining the essential elements of these interventions so the team can develop a model that may be used by others. The Social Worker for the Medicaid ACO remains knowledgeable about performance targets.

The Social Worker for the Medicaid ACO will partner with key state and community agencies to manage patients.

The Social Worker for the Medicaid ACO will work to support the practice-based population health manager.

This position requires a broad knowledge of clinical care and systems' management, case management expertise, strong clinical judgment, health care reimbursement, excellent organizational and interpersonal skills, creativity, flexibility, and the ability to multi-task.

This role is supported by 1 year of pilot funding, with potential for renewal.

PRINCIPAL DUTIES AND RESPONSIBILITIES

Behavioral Health

Provides comprehensive psychosocial assessment of patients to evaluate the mental health/psychiatric history/emotional issues/coping style, understanding of illness/adjustment/compliance, barriers to care, cultural issues, interpersonal

violence. Provides mandated assessments when abuse or neglect is suspected (child, disabled adult, elder). Files reports as indicated

Meets with patients/families in person, virtually and/or provide interventions over the phone. Utilizes evidence based practice and national standards to manage high-risk patients in the community.

Provides short-term crisis intervention counseling for patients as needed.

Continually assesses patient's behavioral health status, and provide evidence based interventions and strategies to improve patient/family functioning and /or medical adherence.

Provides recommendation and coordination of external and/or urgent psychiatric/social resources based on assessment and collaboration with patient/family.

Provides risk assessment and intervention as part of the interdisciplinary team, with emphasis on harm reduction. When necessary, refers to and coordinates with appropriate emergency services.

Provides care management around psychosocial/behavioral health needs using an evidence-based collaborative care management approach.

Acts as the lead liaison between patient and psychiatrist and other key treatment providers for patients receiving care management.

Works and collaborates with the Clinical Director for the Medicaid and the BWPO Medicaid ACO team on program intervention and design.

Health Behavior
Provides clinical assessment with patients around chronic disease and health behavior self management obstacles.

Provides health behavior interventions to support and increase patient/family self-efficacy that include, but are not limited to, health action plans, change interventions, and motivational and problem solving techniques that address obstacles to goals.

Care Management

Reviews and assists in triaging new patients with the PCP and other primary care team members, as appropriate.

Works to optimize the mental health of the high-risk medical and psychiatric patient population and to maintain these patients in the community, avoiding hospitalization when appropriate.

Improves patient and/or family understanding of and adjustment to the medical/psychiatric diagnoses to maximize benefits of medical/psychiatric intervention and enhance patient functioning throughout the course of illness. Ensures that the patient is involved in all phases of the patient care process.

Provides psycho education to patient/family regarding mental illness recovery and relapse. Works with patient/family to develop relapse prevention strategies.

Identifies resources as needed to encourage patient's progress, and provides evidence based psychotherapeutic interventions to assist patient in accomplishing treatment goals.

Conducts family meetings as needed to support patient progress, collaborates with various medical providers and/or additional service providers to coordinate care.

Works effectively as part of the interdisciplinary health care team, communicating regularly with the PCP, RNCC and other members of the patients care team through the continuum of care.

Monitors the patient's progress and plan of care with the aid of internal and external utilization and quality guidelines. Identifies, documents and reports issues and system barriers. Intervenes as necessary and appropriate to ensure that the plan of care and services provided are patient focused, of high quality, efficient and cost effective.

Monitors patients in non-acute facilities in collaboration with the medical team.

Acts as a resource to staff and works on a case by case basis, to coach and mentor on techniques and approaches to management of psychosocial issues in a high risk population.

Exemplifies program teachings and acts as a role model for patients by practicing behaviors consistent with goals of the program.

Presents and/or discusses clinical work in formal and informal case reviews and seminars as indicated.

May participate in research projects. May initiate/implement psychosocial programs based on patient/family identified need as indicated by the Medicaid ACO initiative. Programs may be intermittent/informal or ongoing.

Performs other duties as assigned.

Quality, Utilization Management: High Risk Psychosocial:

Intervenes with appropriate individuals/departments/agencies regarding delays in service that may have an impact on quality of patient care, length of stay or inappropriate patient admissions.

Interacts with home care, community agencies and facilities to ensure safe and timely patient care transitions

Negotiates follow-up contact with patient/family, community agency or facility to evaluate the effectiveness of the patient care transitions and identifies problems in service delivery

Ensures coordination of the communication process with patient/family concerning the plan of care, including coordination of family meetings and warm handoffs.

Ensures that patient/family is involved in all phases of the care process to the greatest extent possible.

Maintains current knowledge of and identifies needs in service delivery within social, governmental, protective services and legal agencies.

Participates in data collection for departmental quality assessment activities in collaboration with the care coordination department.

Participates in quality assessment/improvement activities designed to evaluate the appropriateness and effectiveness of the service delivery system in which care coordination operates.

Ensures that the patient and family receive consistent information regarding all aspects of care.

Leadership, Teaching and Education:

Assesses patient/family learning needs, styles and readiness. Educates patients/families based on treatment plan, identifies barriers to care, diversity issues and learning styles.

Mentors and may supervise students and staff. May teach in Departmental and Hospital seminars, workshops and rounds.

Demonstrates expert social work clinical practice within the department and with interdisciplinary staff. Provides education and consultation to interdisciplinary health care providers, social work staff and community on psychosocial issues for patients.

Demonstrates active, ongoing commitment to professional growth and development of self and creates an environment conducive to the professional growth of others.

Participates in Departmental and Hospital committees. May participate in social work research.

Organizational/Administrative Skills:

Takes responsibility for own administrative duties, including timely and appropriate documentation in patient medical records, timely and accurate daily reporting of activities and Hospital's scheduling systems, and accurate reporting of time worked.

Provides clinical documentation including psychosocial assessment, progress notes, and billing compliance (if appropriate).

Attends and participates in Staff Meetings and interdisciplinary meetings/rounds.

Professional Conduct:

Adheres to and fosters compliance with NASW Code of Ethics, and Department and Hospital clinical, quality, compliance and safety standards, policies and procedures.

Supervisory:

Expected to mentor, precept, teach social workers and social work residents

Fiscal:

Meets Department productivity and standards. Ambulatory staff, ED and ED on-call are responsible for billable hours.

Hospital-Wide Responsibility:

Works within legal, regulatory, accreditation and ethical practice standards relevant to the position and as established by BWH/Partners; follows safe practices required for the position; complies with appropriate BWH and Partners policies and procedures; fulfills any training required by BWH and/or Partners, as appropriate; brings potential matters of non-compliance to the attention of the supervisor or other appropriate hospital staff.

Qualifications
QUALIFICATIONS

Education: Master's of Social Work Degree from an accredited program required
Licensure: Current Massachusetts Licensed Certified Social Worker (LCSW) required.
Experience: Previous clinical social work experience in a hospital setting preferred.

Bilingual (English/Spanish) strongly preferred.

COMPETENCIES

- Clinical experience, understanding of, and comfort working with adults who suffer complex medical and psychiatric problems; ability to work with the families of such patients, and ability to help patients and families understand and access the resources required to support care.
- Ability to provide rapid clinical psychosocial assessments and brief, short or long term treatment/management with individuals, families, couples and/or groups.
- Advanced crisis intervention/treatment/management skills; strong assessment and treatment skills.
- Differential diagnosis and treatment with all modalities
- Competence in abuse/neglect/violence, trauma, grief loss and bereavement
- Cultural sensitivity and demonstrated competency in age specific behaviors
- Knowledge of specific medical/psychiatric illnesses, procedures and treatments

- Excellent clinical social work assessment and crisis intervention knowledge and skills
- Strong understanding of psychiatric and family system problems, and ability to use this understanding to formulate succinct case summaries.
- Knowledge of community agencies/resources. Ability to advocate/negotiate systems for/with patients and families.
- Demonstrated ability to understand the role of social worker in a complex, fast-paced medical environment
- Demonstrated ability to consult/teach
- Demonstrated ability to communicate effective orally and in writing. Excellent interpersonal skills including negotiation skills necessary to collaborate within a multi-disciplinary team.
- Tolerance for ambiguity; analytical skills and computer literacy
- A sense of humor

WORKING CONDITIONS/PHYSICAL REQUIREMENTS

Social Workers provide clinical care in various settings: at the bedside, in treatment areas and offices; and in patient's homes.

- The Department of Care Coordination /Social Work will operate 7 days per week. Hours and work schedule will be flexible to meet the needs of patients, families, hospital and staff.
- Must be prepared to come in to work or stay at work during a hospital emergency.

  Patient Population:
  Staff member must be able to demonstrate the knowledge and skills necessary to provide care appropriate to the age of the patients served on his/her assigned areas.

EEO Statement
Brigham and Women's Hospital is an Equal Opportunity Employer. All qualified applicants will receive consideration for employment without regard to race, sex, color, religion, national origin, sexual orientation, protected veteran status, or on the basis of disability.
Brigham and Women's Hospital I CARE Standards

Partner's Healthcare is acting as an Employment Agency in relation to this vacancy.

Medicaid Care Advocate - Field Based in San Diego County - Telecommute for Washington State job - UnitedHealth Group - San Diego, CA

SourceURL: https://www.nexxt.com/jobs/medicaid-care-advocate-field-based-in-san-diego-county-telecommute-for-washington-state-san-diego-ca-836277605-job.html?utm_campaign=google_for_jobs&utm_source=google&utm_medium=organic&aff=2ED44C72-8FD2-4B5D-BC54-2F623E88BE26&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Care Advocate - Field Based in San Diego County - Telecommute for Washington State

UnitedHealth Group • San Diego, CA 92108

Job #836277605

You're looking for something bigger for your career. How about inventing the future of health care? UnitedHealthcare is offering an innovative new standard for care management. We're going beyond counseling services and verified referrals to behavioral health programs integrated across the entire continuum of care. Our growth is fueling the need for highly qualified professionals to join our elite team. Bring your skills and talents to a role where you'll have the opportunity to make an impact on a huge scale. Join us. Take this opportunity to start doing **your life's best work.(sm)**

As a Behavioral Health Care Advocate you will be responsible for case management and utilization review of behavioral health and substance abuse cases. You'll have a direct impact on the lives of our members as you recommend and manage the appropriate level of care throughout the entire treatment plan.

This position is both field-based and telephonic. Field based and telephonic for San Diego County, California and telephonic only for Washington State. When not in the field, this will be a telecommute / work from home position.

If you are located within commutable distance of San Diego County, California, you will have the flexibility to telecommute* as you take on some tough challenges.

What makes your clinical career greater with UnitedHealth Group? You can improve the health of others and help heal the health care system. You will work within an incredible team culture; a clinical and business collaboration that is learning and evolving every day. And, when you contribute, you'll open doors for yourself that simply do not exist in any other organization.

Primary Responsibilities:

- Make patient assessments and determining appropriate levels of care
- Obtain information from providers on outpatient requests for treatment
- Determine if additional clinical treatment sessions are needed
- Manage inpatient and outpatient mental health cases throughout the entire treatment plan
- Administer benefits and review treatment plans
- Coordinate benefits and transitions between various areas of care
- Identify ways to add value to treatment plans and consulting with facility staff or outpatient care providers on those ideas

Required Qualifications:

- Licensed Master's degree in Psychology, Social Work, Counseling or Marriage or Family Counseling, OR Licensed Ph.D. Licenses must be active and unrestricted in the states of California and Washington
- 2+ years of post - Masters experience in a related mental health environment
- Proficient Microsoft skills (Word, Excel, Outlook)
- Ability to travel within San Diego County California
- Access to high speed internet from home / Broadband cable or DSL
- Dedicated workspace from home

Preferred Qualifications:

- Dual diagnosis experience with mental health and substance abuse
- Experience working in an environment that required coordination of benefits and utilization of multiple groups and resources for patients
- Medicaid experience
- Reside in a commutable distance of San Diego County, California

Careers with Optum. Here's the idea. We built an entire organization around one giant objective; make the health system work better for everyone. So when it comes to how we use the world's large accumulation of health-related information, or guide health and lifestyle choices or manage pharmacy benefits for millions, our first goal is to leap beyond the status quo and uncover new ways to serve. Optum, part of the UnitedHealth Group family of businesses, brings together some of the greatest minds and most advanced ideas on where health care has to go in order to reach its fullest potential. For you, that means working on high performance teams against sophisticated challenges that matter. Optum, incredible ideas in one incredible company and a singular opportunity to do **your life's best work.(sm)**

*All Telecommuters will be required to adhere to UnitedHealth Group's Telecommuter Policy

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

Job Keywords: Behavioral Health, Mental Health, Case Manager, Care Coordinator, Care Advocate,Telecommute, Work From Home, Virtual, Nurse, RN, Social Worker, Psychologist, Medicaid, California, San Diego, Washington, Counselor, :PC, LCSW, LMFT, LMHC,

(1) Care Manager_LVN_LPN | WellCare Health Plans | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/care-manager-lvn-lpn-at-wellcare-health-plans-1128420377/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

(1) Care Manager_LVN_LPN

Utilizes care coordination tools, criteria and protocols to provide care coordination to lower acuity members with acute and chronic health care needs. Provides education and support in assisting members to achieve optimal level of wellness. Works with member to support compliance with care and treatment plans in collaboration with the interdisciplinary care team.

Essential Functions

- Perform member interviews to assist with gathering of information
- Perform follow up with members engaged in case management
- Facilitate provider contact as needed to coordinate member's care needs. Initiates appropriate referrals and inputs authorizations as needed for members active in case management.
- Support the identification of high-risk members for disease or case management needs and works with member, physician and other Health care providers to meet the member's individual needs.
- Identifies and escalates member cases with complex medical needs to Supervisor or Manager.
- Act as liaison and member advocate between the member/family, physician and facilities/agencies.
- Coordinates community resources, with emphasis on medical, behavioral, and social services. Applies case management standards, maintains HIPAA

standards and confidentiality of protected health information and reports critical incidents and information regarding quality of care issues.
- Instructs the member on how to access the program resources, suggest and/or arrange follow-up including mailing of educational materials, contact with community resources, facilitate physician visits.
- Documents all contacts in the Health Services clinical documentation system.
- Manage members in disease management program, completing and revising as necessary, the information in clinical documentation system.
- Ensures compliance with all state and federal regulations as well as Corporate guidelines in day-to-day activities.
- Meets with clients in their homes, work-sites, physician's or hospital to provide management of services.
- Adapts to changes in policies, procedures, new techniques and additional responsibilities.
- Participates with other Case Managers and Medical Directors in regular or special meetings such as Clinical rounds.
- Complies with all guidelines established by the Centers for Medicare and Medicaid (CMS) and guidelines set forth by other regulatory agencies, where applicable, and Corporate and department policies and procedures.
- Identifies potential quality of care issues and appropriately refers to the quality department.
- Assists in the implementation of specific strategies that improve the quality and outcomes of care.
- Educates members and facilitates HEDIS gap closure.
- Performs all other duties assigned.
- Works under direct supervision of a Registered Nurse

Additional Responsibilities:

- Travel to inpatient bedside, member's home, provider's office, hospitals, etc required with dependable car. May spend up to 70% of time traveling with exposure to inclement weather and normal road hazards. May require climbing multiple flights of stairs to a member's home, provider's office, etc.

Candidate Education:

- Required A High School or GED
- Preferred An Associate's Degree in nursing

Candidate Experience:

- Required 2 years of experience in utilization management and/or case management in a hospital or home health setting or with a managed care organization.

- Preferred Other prior experience working with a geriatric population
- Required Other In the Florida market, 4 years in pediatric experience
- Required Other Work experience requirements may be waived for associates engaged in Florida's CMS contract that worked in a similar capacity for Florida's Department of Health in 2018.

Candidate Skills:

- Intermediate Ability to drive multiple projects
- Intermediate Ability to multi-task
- Intermediate Ability to work in a fast paced environment with changing priorities
- Intermediate Ability to work independently
- Intermediate Demonstrated time management and priority setting skills
- Intermediate Demonstrated interpersonal/verbal communication skills
- Intermediate Other Ability to provide input to care/treatment plan
- Intermediate Demonstrated negotiation skills
- Intermediate Ability to effectively present information and respond to questions from families, members, and providers
- Intermediate Ability to implement process improvements

Licenses and Certifications:

A License In One Of The Following Is Required

- Required Other Current unrestricted LPN/LVN state license

Technical Skills:

- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft Word
- Required Intermediate Microsoft PowerPoint
- Required Intermediate Microsoft Outlook

Languages:

About Us

Headquartered in Tampa, Fla., WellCare Health Plans, Inc. (NYSE: WCG) focuses primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex medical needs primarily through Medicaid, Medicare Advantage and Medicare Prescription Drug Plans, as well as individuals in the Health Insurance Marketplace. WellCare serves approximately 5.5 million members nationwide as of September 30, 2018. WellCare is a Fortune

500 company that employs nearly 12,000 associates across the country and was ranked a "World's Most Admired Company" in 2018 by Fortune magazine. For more information about WellCare, please visit the company's website at www.wellcare.com. EOE: All qualified applicants shall receive consideration for employment without regard to race, color, religion, creed, age, sex, pregnancy, veteran status, marital status, sexual orientation, gender identity or expression, national origin, ancestry, disability, genetic information, childbirth or related medical condition or other legally protected basis protected by applicable federal or state law except where a bona fide occupational qualification applies. Comprehensive Health Management, Inc. is an equal opportunity employer, M/F/D/V/SO.

Health Insurance Specialist Job in CHICAGO, IL

SourceURL: http://federalgovernmentjobs.us/jobs/Health-Insurance-Specialist-524676100.html?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Health Insurance Specialist Job in CHICAGO, IL

Requirements

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) Evaluating health insurance program vulnerabilities to detect fraud, waste, or abuse; AND (2) Collaborating across organizational lines on investigations, audits, or oversight of health insurance programs; AND (3) Proposing policy changes relating to program integrity.

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

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

Click the following link to view the occupational questionnaire:
https://apply.usastaffing.gov/ViewQuestionnaire/10420562

Education

This job does not have an education qualification requirement.

Additional information

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

CMS employees currently participating in 100% Full-Time Telework Program may be eligible to remain in the program. If an employee in this program is selected, the pay will be set in accordance with the locality pay for the applicable duty station. The listed salary range reflects the locality pay assigned to the duty location(s) listed in the vacancy announcement. For more information about pay based on locality, please visit the Office of Personnel Management (OPM) Salaries & Wages Page.

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

Additional Forms REQUIRED Prior to Appointment:

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

processing. Click here for more information about E-Verify and to obtain a copy of the Form I-9.
- Standard Form 61, Appointment Affidavits - If selected, the Standard Form 61 will be required at the time of in-processing. Click here to obtain a copy of the Standard Form 61.

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

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

How You Will Be Evaluated

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

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

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

- Oral Communication
- Policy Analysis
- Program Integrity
- Written Communication

Background checks and security clearance

Security clearance

Not Required

Drug test required

No

(1) Integrated Care Mgr (RN) | Optima Health | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/integrated-care-mgr-%28rn%29-at-optima-health-1128515992/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Integrated Care Mgr (RN)

Company Name Optima Health Company Location Norfolk, VA, US

New Posted Date Posted 14 hours ago Number of applicants Be among the first 25 applicants

Job Description

Responsible and accountable for the provision and facilitation of comprehensive care coordination services and quality outcomes for patients across the continuum. Promotes effective utilization and monitoring of health services, collaborates and communicates with the healthcare team and patient/caregiver

to manage care and transitions. Develops and/or implements a comprehensive care plan based on assessment and evaluation of patient/caregiver needs. Functions in one of the following practice settings: Acute Care, Service Lines, Ambulatory/Community-based, Home Health, and Long Term Care.

Physical Location

Norfolk

Department Number and Name

766122328 Government LTSS

Employment Status

Full time

Shifts

First (Days)

Job Category

Optima Health

Job Posting

Optima Health Community Care is hiring a Integrated Care Manager (RN) for the LTSS/Government Authorizations team in Norfolk, VA.

Degree: ADN OR BSN

Hours/Shift

Monday - Friday, 8am-5pm

Department/Position Overview

In this office-based position the Registered Nurse (RN) will be responsible for providing thorough evaluation and superior service to our valued members. The Registered Nurse (RN) will be responsible for the review for the following:

Responsible and accountable for the provision and facilitation of comprehensive care coordination services and quality outcomes for patients across the continuum. Promotes effective utilization and monitoring of health services, collaborates and communicates with the healthcare team and patient/caregiver to manage care and transitions. Develops and/or implements a comprehensive care plan based on assessment and evaluation of patient/caregiver needs. Functions in one of the following practice settings: Acute Care, Service Lines, Ambulatory/Community-based, Home Health, and Long Term Care.
Minimum BSN degree required and at least 3 years of RN experience, preferably in case management.

Division Highlights

Optima Health Community Care is a Commonwealth Coordinated Care Plus (CCC Plus) Medicaid plan for many older people and those with disabilities. CCC Plus is a Medicaid managed care program through the Virginia Department of Medical Assistance Services (DMAS).

With Optima Health Community Care, members benefit from an individualized, fully-integrated program with a state-wide network of providers. As an Optima Health Community employee, you will join a care team committed to providing customized and personalized support and services in the community that our members can count on. Optima Health is a service of Sentara Healthcare, so joining Optima is joining the Sentara Healthcare family.

Sentara Benefits

Sentara employees strive to make our communities healthier places to live. We're setting the standard for medical excellence within a vibrant, creative, and highly productive workplace. For more information about our employee benefits, CLICK HERE!

Join our team, where we are committed to quality healthcare, improving health every day, and provide the opportunity for training, development, growth!

Required Education

RN-Associate's or Bachelor's Level Degree

Experience

Required: Nursing - 3 years

Preferred: None, unless noted in the "Other" section below

Licenses and Certifications

Required: Basic Life Support, Registered Nurse

Preferred: None, unless noted in the "Other" section below

Required

Skills

Preferred: None, unless noted in the "Other" section below

Other

BLS (if in a clinical setting). 3 years ¿ Nursing ¿ directly working with individuals who meet the long term and support services population criteria. For Integrated Care Management departments, specialty certification required within one year of eligibility (ACM, CCM, CCCTM or RN-BC). For other service lines, certification based on specialty area required within one year of eligibility. 3 years Case Management experience preferred.

City

Norfolk, VA

Seniority Level

Associate

Industry

- Insurance
- Health, Wellness & Fitness
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Health Care Provider

(1) Administrative Assistant and Office Coordinator | Independent Care Health Plan | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/administrative-assistant-and-office-coordinator-at-independent-care-health-plan-1129808785/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Administrative Assistant and Office Coordinator

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

New Posted Date Posted 2 hours ago Number of applicants Be among the first 25 applicants

This position serves as an Administrative Assistant to the Vice-President, LTC-Community Inclusion and our Dane County office as well as the Office Coordinator for our Dane County office. Work may include greeting guests, processing mail, assembling and submitting proposals, maintaining meeting schedules, serving chartered committees, and related duties.
Administrative Assistant Responsibilities
Provide administrative support for assigned departments and functions within the iCare organization.
Serve as a liaison between assigned iCare functions and/or principals and varying internal and external contacts.
Assist with the planning, scheduling, coordinating, and implementing organizational activities and meetings.
Professionally prepare, proof read, wordsmith, organize, assemble, and prepare for submission official organizational documents.

Office Coordinator Responsibilities
Present a professional \"face of iCare\" when greeting guests, vendors and employees in person, assist and direct clients and visitors to the area; carefully and accurately check clients/visitors in and out.
Maintain a professional environment in the lobby and front desk area.
Prepare all outgoing certified mail on a daily basis and log/route any returned certified mail to the appropriate department/person.
Acts as primary contact for all conference room scheduling and assists staff with conference room conflicts.
Maintains/orders office supplies for the entire Dane County location. Verifies accuracy of incoming supply orders and distributes to appropriate staff.
Prepares setup for new employee workstation and provide support for new employee orientation and training.
Conducts general office overview orientation for new employees.
Maintain positive, professional and friendly communication practices.
Fully participate in iCare's Compliance Program, including compliance with iCare's Code of Conduct, policies and procedures, and all applicable Privacy and Security laws.
Perform related duties as assigned.
Expertise in the use of Word, Excel, PowerPoint, Adobe Acrobat Pro, Outlook and other Microsoft office solutions.
Professional error-free document organizational and preparation skills.
Skill in managing document, scheduling and meeting detail.
Proficiency in organizing and managing office and principal support functionality.
Ability to protect, organize and manage confidential documents and information.
Ability to accomplish and manage multiple tasks and conflicting priorities in a timely manner.
Professional composure under stress.
\"Do whatever it takes\" teamwork attitude.
Effective consumer relationship skills.
Knowledge of and ability to follow sound business practices and work rules.
Related Keywords: Administrative Assistant and Office Coordinator

Seniority Level

Entry level

Industry

- Insurance

- Medical Practice
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Administrative

(1) DIRECTOR CLINICAL ACCOUNT MANAGEMENT - MEDICAID | Beacon Health Options | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/director-clinical-account-management-medicaid-at-beacon-health-options-1127303162/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

DIRECTOR CLINICAL ACCOUNT MANAGEMENT - MEDICAID

Company Name Beacon Health Options
Company Location Massachusetts, MA, US

Posted Date Posted 2 days ago Number of applicants Be among the first 25 applicants

Location
MA: Woburn

Job Family
Account Management

Job Brief

The Director of Clinical Account Management - Medicaid is responsible for providing consultative and strategic oversight for assigned strategic Beacon Health Options Care Management accounts to meet the needs of the customer.

About The Position

The **Director of Clinical Account Management - Medicaid** is responsible for providing consultative and strategic oversight for assigned strategic Beacon Health Options Care Management accounts to meet the needs of the customer. In collaboration with the Regional Sales, Account Management, and Clinical teams, cultivates relationships, liaise with vendors and service accounts to support custom clinical/medical management program(s). Responsible for identifying clinical, operational and financial gaps utilizing client data/metrics to develop clinical opportunities. The Director, Clinical Account Management, will collaborate in development and execution of clinical programs and solutions as a dedicated resource for this assigned account and champion communication to the client. This role will focus on enhancing the client relationship and serve as a clinical consultant for overall service delivery for clinical programs This person will represent the client internally and coordinate with other departments, including the assigned regional account partnership and clinical team to implement client systems, complete projects, and address ongoing needs. This individual will be relied upon to provide proactive clinical recommendations, information regarding clinical trends, programs and industry changes and to foster consultative relationships to the client and their members, with the overall goal of increasing the client experience.

Duties And Responsibilities

- Provide superior clinical consultation and clinical account management with a focus on client and member satisfaction, client retention, and trend management
- Comprehends and effectively explains clinical program changes
- Stays aware of and provides clinical market intelligence to clients
- Makes clinically sound recommendations to clients based on trend
- Able to incorporate treatment & practice guidelines into client presentations
- Will demonstrate strong leadership skills and able to adapt quickly to new and changing situations
- Evaluate and make recommendations for business development and expansion opportunities within assigned territories
- Provide continual process improvement including all clinical processes and/or services
- Ensure all operational services meet clinical regulatory and quality standards
- Actively participate in the preparation and delivery of business development presentations to potential sponsors and clients.
- Actively participate in the generation of proposals, bid defenses and client presentations.
- Perform other duties as assigned.

Position Requirements

Education: Master's degree in the Behavioral health field required.

Licensure: Current valid and unrestricted license in a state or territory of the United States in a mental health field (RN, Ph.D, LMSW/LCSW, MHC, LLP, LPC, etc.

Years and Type of Relevant Work Experience: At least five (5) years of management experience in a healthcare managed care behavioral health setting preferred). Additionally, at least five (5) years of experience in psychiatric or substance abuse treatment setting that included inpatient, partial, and /or outpatient care is required. Management experience in an organization serving publicly funded clients preferred. Deep understanding of clinical development process

Skills

- Exceptional written and verbal skills, particularly in client presentations.
- Previous experience in managed care quality programs preferred.
- Ability to maintain confidentiality and adhere to regulatory compliance requirements.

- The candidate must combine a hands-on management style with the ability to lead, empower and mentoring staff.
- He/she must be a dedicated self-starter with a high energy level and able to achieve results.

TO APPLY

Click below on **"Apply for this Position"** to create a profile and apply for the position

Beacon Health Strategies, LLC., a Beacon Health Options company, is proud to be an Equal Opportunity Employer as well as a Drug Free Work Environment. EOE/M/F/Veterans/Disabled

$REM

#GD

#CB

PM16

AAP Reporting Location:

MA - Woburn

ID (Req #):

56466

FTE Status

Full Time

Schedule

8:30 - 5 pm

Exempt

(1) PATIENT SERVICES COORD | Optima Health | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/patient-services-coord-at-optima-health-1128518133/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

PATIENT SERVICES COORD

Company Name Optima Health Company Location Virginia Beach, VA, US

New Posted Date Posted 14 hours ago Number of applicants Be among the first 25 applicants

Job Description

Patient Service Coordinator works in a collaborative role with all members of the professional health care team and with community service agencies to coordinate care for members to improve health outcomes. Assists with gathering information for the health care team regarding barriers or other health information. Implements the interventions to promote improved health and compliance with recommended plan of care, as approved by the Health Care Team. This includes functions associated with the screening for changes in health status, coaching for improved self-management, reminders of necessary testing as determined by clinical guidelines, and support of the professional clinical staff in Health Care Services.

Physical Location

Optima Health - Va Bch

Department Number and Name

706502313 Health Care Services

Employment Status

Full time

Shifts

First (Days)

Job Category

Clinical - Non Nursing, Optima Health

Job Posting

Optima Health, Virginia Beach, has an opening for a Patient Services Coordinator. This position is full time, day shift.

This position is a collaborative role with all members of the professional health care team and with community service agencies to coordinate care for members to improve health outcomes.

Optima Health is a service of Sentara Healthcare, so joining Optima is joining the Sentara Healthcare family. Optima Health offers a full suite of commercial health insurance products including employee-owned and employer-sponsored plans, as well as Individual and Family health plans, employee assistance plans and plans serving Medicare and Medicaid enrollees. We offer programs to support members with chronic illnesses, customized wellness programs, and integrated clinical and behavioral health services.

As a nationally recognized provider of health plan coverage and innovative wellness programs, we live our mission "to improve health everyday." This same commitment and dedication directs our philosophy as an employer. When you join Optima Health, you will experience our deep passion for heal and service excellence while benefiting from a culture of opportunity, learning, career growth, and support --every day.

Sentara employees strive to make our communities healthier places to live. We're setting the standard for medical excellence within a vibrant, creative, and highly productive workplace. For more information about our employee benefits, CLICK HERE!

Join our team, where we are committed to quality healthcare, improving health every day, and provide the opportunity for training, development, growth!

Required Education

High School Grad or Equivalent

Experience

Required: Clinical - 2 years

Preferred: None, unless noted in the "Other" section below

Licenses and Certifications

None, unless noted in the "Other" section below

Required

Skills

Preferred: None, unless noted in the "Other" section below

City

Virginia Beach, VA

Seniority Level

Entry level

Industry

- Insurance
- Health, Wellness & Fitness
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Health Care Provider

(1) Director Enterprise Clinical Quality (Medicaid) - Philadelphia | Apploi | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/director-enterprise-clinical-quality-%28medicaid%29-philadelphia-at-apploi-1128753185/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director Enterprise Clinical Quality (Medicaid) - Philadelphia

Company Name Apploi Company Location Philadelphia, PA, US

New Posted Date Posted 10 hours ago Number of applicants Be among the first 25 applicants

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

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

Drives excellence in improving provider and member satisfaction, HEDIS, achieving operational excellence;

Provides direction for ongoing monitoring and updating of accreditation and medical management aspects of the enterprise infrastructure;

Works collaboratively with all areas of the organization to integrate Quality Management initiatives and goals with organizational programs; champions the use of and acts as a resource for the dissemination of the Quality Management best practices throughout the AmeriHealth Family of Companies.

Participates in the development and response for new business opportunities.Provides support and resources for new business implementation.

Provides leadership through both direct and indirect matrixes reporting structures.

Collects and disseminates ‘best practices’ in performance improvement across the Medicaid LOB and the enterprise.

Stays abreast of policy, measurement and accreditation evolution impacting the Medicaid Line of Business. Education/Experience:

Bachelor’s Degree in in health care, public administration or related field required.

’s Degree in health care, public administration or related field highly preferred.

Registered Nurse - state license required.

8 –10 of progressive management experience (including staff management) in a managed care environment. Experience with Managed Medicaid programs highly

desirable. Management experience with Quality programs, Case Management and Utilization management programs. Experience in QM, CM and UM program design, implementation. Should include experience in setting, communicating and implementing strategic direction.

Proven ability to navigate effectively and influence at the executive level in a matrixed, multi-business enterprise.

Demonstrated ability to interface, influence and made strategic and tactical decisions at the executive management level.

Strong background in managed care information systems, data collection and reporting,

High degree of operational and clinical expertise and knowledge of various managed care payment arrangements.

(1) RN Case Manager-Medicaid Experience - Part Time | Discovery Senior Living | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/rn-case-manager-medicaid-experience-part-time-at-discovery-senior-living-1127824469/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

RN Case Manager-Medicaid Experience - Part Time

Company Name Discovery Senior Living
Company Location Tampa, FL, US

New Posted Date Posted 22 hours ago Number of applicants Be among the first 25 applicants

Discovery at Home is comprised of a team of professionals with extensive experience in senior living personal care. We're always nearby, including our senior management team, accessible to our clients and their families, and have direct authority to make decisions right where we are. We know local healthcare issues and procedures, and how to deliver the best care possible to our clients. Discovery at Home is Medicare certified and has earned the Community Health Accreditation Program's (CHAP) coveted accreditation.

Responsibilities

The RN Case Manager will be responsible for health care management and coordination of the staff in order to achieve optimal clinical, financial and quality of life outcomes; will work with all staff to create and implement a collaborative plan of care; will perform on going monitoring of the plan of care to evaluate effectiveness; will adhere to nursing guidelines, clinical protocols, company policies and procedures and all state and federal regulations

Qualifications

- Must be a graduate from an accredited School of Nursing.
- Must be licensed in the state of Florida as a Registered Nurse.
- Must have a minimum of three years experience in a home health agency and at least one year of supervisory experience (2 years preferred).
- Must have knowledge of Medicare and Medicaid guidelines.
- Must have a working knowledge of home health care and the principles and techniques of professional nursing and required documentation that pertains to it.
- Demonstrated ability to communicate, problem solve and work effectively with people.
- Excellent organizational skills with the ability to multi-task.
- Knowledge of applicable state and federal regulations.
- Skilled at establishing and maintaining positive and effective work relationships with coworkers, clients, and patients.

Benefits

In addition to a rewarding career and competitive salary, Discovery offers a comprehensive benefit package.
Full-time team members are offered a comprehensive benefit package including medical, dental, vision, life and disability insurances, paid time off and paid holidays. Both full and part-time team members are eligible to participate in our outstanding 401k plan with company match our Employee Assistance Program and accident insurance policies.
EOE/M/F/D/V

(1) CTM Coordinator, Sr | WellCare Health Plans | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/ctm-coordinator%2C-sr-at-wellcare-health-plans-1128420375/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

(1) CTM Coordinator, Sr

Responds to member, provider, CMS, SPAP and SHIP inquiries received via phone, CTM (Complaint Tracking Module) and email regarding PDP, CCP and Medicaid lines of business, including Claims, CIU, Enrollment, Pharmacy, Billing, Case Management, and Appeals in a professional, timely, accurate and caring manner-while consistently meeting all CMS guidelines and requirements. Assists in completing activities related to various departmental and cross functional assignments in support of the CTM Department's goals and strategies.

Instrumental in providing suggestions to reduce complaints and increase WellCare's Star Ratings.

Essential Functions

- Responds to member, provider, CMS, SPAP and SHIP inquiries via telephone, CTM (Complaint Tracking Module) and email, while meeting all corporate, regulatory and CMS guidelines and performance standards. Independently evaluates and assesses allegations to determine those criteria, including federal and state regulations, Centers for Medicare & Medicaid Services ("CMS") guidelines, and internal policies, procedures, and standards that are alleged to have been violated.
- Cross function metrics including, but not limited to, escalations, plan request, RCA inquires, HPMS Download and assignment of cases. Also, daily updates on the case spreadsheet, updating Xcelys to match CMS systems (MARX and HPMS), communication activities, internal investigations and makes recommendations accordingly. Prepares presentations for departmental and improve processes, metrics/ratings.
- Handles calls that require additional research and/or special handling- including regulatory, congressional, Swift, Press Hill, marketing, sales, executive office, Centers for Medicaid and Medicare Services (CMS), etc. Responsible for the intake and assignment of CTM complaints through HPMS/Inbound phone intake.
- Investigates problems of an unusual nature in the area of responsibility. Presents proposed solutions in a clear and concise manner.
- Identifies risks, interprets investigation results, and recommends and communicates remedial actions to mitigate future potential risks.
- Drives and supports WellCare initiatives at the team level by interacting with peers and other internal and external business partners, such as RCA inquiries, Governance weekly meetings, Quality Audit calibrations, CMS Call Audits, and CSQIW/QIC while demonstrating a willingness to conform to WellCare policies and procedures.
- Demonstrates appropriate customer-care skills such as empathy, active listening, courtesy, politeness, helpfulness, and other skills as identified. Assist in the education of new members and in the re-education of existing members regarding health plan procedures.
- Records, investigates and resolves complaints as detailed in the CMS Standard Operating Procedure (SOP), Chapter Manuals and CTM Policies and Procedures.
- Works on Good Cause Reinstatement cases and making sure members make full payment and are reinstated by our Enrollment Department within Medicare Guidelines.

- Plans, develops, and leads multiple projects, including prioritizing and managing through execution. Thoroughly documents, organizes, and reviews case files electronically, relative to each investigation in accordance with Company policy and ensures remediation activities are implemented. Interact with other departments including Enrollment, Pharmacy, Billing, etc. to resolve member and provider issues.
- Logs, tracks and follow-ups on all inquiries, utilizing on-line systems and procedures, according to the established guidelines.
- Demonstrates expertise of all WellCare Medicare PDP, and CCP lines of business.
- Performs skills necessary to create a high-quality customer experience, as reflected through acceptable Quality scores.
- Develop and present ideas for performance and process management improvement within the department.
- Supports the development and maintenance of Corporate Compliance policies and procedures and workflows.
- Conducts and documents with beneficiaries, providers, interdepartmental investigatory purposes.
- Acts as a primary contact for escalated calls and/or escalated issues in which special care is required to enhance WellCare relationships with members, providers, CMS Caseworkers, SPAPs and SHIPs.

Additional Responsibilities:

Candidate Education

- Required A High School or GED
- Preferred An Associate's Degree in a related field
- Preferred A Bachelor's Degree in a related field

Candidate Experience:

- Required 3 years of experience in Contact Center and/or Customer Service Environment
- Required 2 years of experience in Experience within a Healthcare company
- Required 1 year of experience in CTM or Escalations Experience
- Preferred Other Assisting with project coordination in a fast paced and/or growing organization and experience balancing multiple projects and influencing others in a matrix environment.

Candidate Skills:

- Advanced Demonstrated written communication skills
- Advanced Demonstrated interpersonal/verbal communication skills

- Advanced Ability to multi-task Ability to multi-task, good organizational and time management skills
- Advanced Demonstrated organizational skills
- Advanced Demonstrated time management and priority setting skills
- Advanced Ability to effectively present information and respond to questions from families, members, and providers
- Advanced Demonstrated analytical skills Ability to read, analyze and interpret verbal and written instructions
- Advanced Other Ability to work with people from diverse backgrounds
- Advanced Other Ability to act on feedback provided by showing ownership of his or her own development
- Advanced Other Ability to define problems collects data, establish facts and draw valid conclusions
- Advanced Other Seeks to build trust, respect and credibility with all partners through full, honest, consistent, and coordinated communication

Licenses and Certifications:

A License In One Of The Following Is Required

- Preferred Other Customer service, quality, or training certifications

Technical Skills:

- Required Intermediate Microsoft Outlook
- Required Intermediate Microsoft Word
- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft PowerPoint
- Required Intermediate SharePoint
- Required Intermediate Xcelys
- Required Intermediate Other HPMS, MARx

Languages:

- Preferred Spanish

About Us

Headquartered in Tampa, Fla., WellCare Health Plans, Inc. (NYSE: WCG) focuses primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex medical needs primarily through Medicaid, Medicare Advantage and Medicare Prescription Drug Plans, as well as individuals in the Health Insurance Marketplace. WellCare serves approximately 5.5 million members nationwide as of September 30, 2018. WellCare is a Fortune

500 company that employs nearly 12,000 associates across the country and was ranked a "World's Most Admired Company" in 2018 by Fortune magazine. For more information about WellCare, please visit the company's website at www.wellcare.com. EOE: All qualified applicants shall receive consideration for employment without regard to race, color, religion, creed, age, sex, pregnancy, veteran status, marital status, sexual orientation, gender identity or expression, national origin, ancestry, disability, genetic information, childbirth or related medical condition or other legally protected basis protected by applicable federal or state law except where a bona fide occupational qualification applies. Comprehensive Health Management, Inc. is an equal opportunity employer, M/F/D/V/SO.

Medicaid Program Manager

SourceURL: https://www.governmentjobs.com/jobs/2358567-0/medicaid-program-manager?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Program Manager

Only applicants who meet the Minimum Qualification Requirements and meet all selective requirements (listed below) will be placed on the eligible list.

The Department of Human Services - Central Office is looking to fill a Management Analyst 3 position to assist the state Medicaid Program Manager.

The Iowa Medicaid Enterprise (IME) establishes the state Medical and Long Term Care Services and Supports programs and policies defining covered services, qualifications for eligible providers and establishing reimbursement standards. The IME Policy Analyst (MA3) positions continuously conduct analysis of complex managed care and fee for service plans to ensure adherence to contractual provisions and to evaluate performance outcomes. These positions analyze, develop and update IME policies and procedures based on contractual changes based driven by state or federal requirements. These positions monitor the implementation of policy to ensure providers meet established contractual scope of services such as payment processing, satisfaction of delineated deliverables for Managed Care and Fee for Service (FFS).

Data Analysts exercise considerable independent judgement to adapt and manage payment reimbursement guidelines for general and specific situations. The role requires continual analysis of data to assess contractual compliance for MCO, and to formulate solutions for DHS leadership to discern, discuss and approve. This role would effectively communicate procedural or contractual changes to both internal and external parties, and establish the tools to monitor and evaluate compliance. An important aspect of the role is to actively engage the IME Medicaid Management Information Systems (MMIS) group to design, test, and implement systems to obtain requisite data or for the design of systematic changes to meet programmatic needs.

These positions collaborate with the Centers for Medicare and Medicaid Services (CMS), Legislators, constituency groups, health care providers, Medicaid members and the Attorney General's office in order to prepare and present programmatic policy to internal and external audiences inclusive of the Council on Human Services, providers, consumer advocates, legislative committees, and state and national work groups. The Analysts draft language for changes to the Code of Iowa, promulgate changes to the Iowa Administrative Code, participate in the preparation and submission of state plan amendments (SPA) for CMS, authoring provider manuals and informational communications.

Successful candidates will have critical thinking/analysis skills and the ability to strategically apply quality improvement techniques within policy development inclusive of IT system structure supports. Preference will be given to those candidates with experience in the application of medical coding procedures and reimbursement.

Applicants may attach a resume/cover letter to the online application.