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Medicaid Jobs Hunter

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Deputy Director, Medicaid | State of Maryland

SourceURL: https://www.linkedin.com/jobs/view/deputy-director-medicaid-at-state-of-maryland-1130363432/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

LOCATION OF POSITION

MDH, Office of the Medicaid Director, Baltimore, MD

Main Purpose of Job

The main purpose of this position is to assist the Maryland Medicaid Director on behalf of the Health Secretary to lead and manage the $13 billion Medicaid program that includes health and home and community based services for 1.4 million Marylanders. It is the largest health services plan in the state of Maryland covering 1 in 5 Marylanders. This position will act as the Medicaid Director, when the Medicaid Director is unavailable.

This position develops and leads innovation in the Medicaid program. This innovation will contribute to the Total Cost of Care objectives that support the All Payer Model. Innovation will improve quality and lower cost through process change and re-engineering. The position applies principles of insurance risk and understanding of pharmacy supply chain to manage costs. It also uses policy research and informatics to drive innovation and change like behavioral health integration.

This position focuses on the organizational management to create quality outcomes, customer service, and internal controls to ensure program integrity. The position ensures effective and consistent use of rate setting across all programs to assure budget planning and cost based rates.

This position develops and manages coordination mechanisms with all divisions of the Maryland Department of Health to assure that the Medicaid program leverages its resources to achieve Maryland's Health priorities. This position will also develop strategies to streamline over 80 chapters of State regulations, the Maryland Medicaid State Plan, and numerous home and community-based waiver applications that implement Federal Centers for Medicare and Medicaid Services reimbursement policy/methodology changes (State Plan Amendments) and home and community-based waiver services.

Responsibilities include contract process oversight to ensure timely management of contracting life cycle to include Medicaid's Utilization Control Vendor contract, the REM contracts, the EPSDT program, and Dental Administrative Services Organization (ASO) contract Behavioral Health Administrative Services Organization (ASO) contract. Long term care responsibilities include the development of strategies that reduce nursing facility admissions through state plan and seven Medicaid home and community-based services waiver programs.

This position oversees planning, coordinating and implementing high priority cross cutting policies; responding to audits and compliance issues; and supervising Medicaid State Plan and State and federal regulatory modifications and updates.

Minimum Qualifications

Qualified candidates must possess a Bachelor's degree from an accredited college or university and 6 years of executive level health services experience, 3 of which must have involved working with medical care and 3 years of which must have been at a management or supervisory level.

SELECTION PROCESS

This is an Executive Service position, and serves at the pleasure of the Appointing Authority. A resume must accompany your application.

Applicants who meet the minimum (and selective) qualifications will be included in further evaluation. The evaluation may be a rating of your application based on your education, training and experience as they relate to the requirements of the position. Therefore, it is essential that you provide complete and accurate information on your application. Please report all related education, experience, dates and hours of work. Clearly indicate your college degree and major on your application, if applicable. For education obtained outside the U.S., any job offer will be

contingent on the candidate providing an evaluation for equivalency by a foreign credential evaluation service prior to starting employment (and may be requested prior to interview).

Complete applications must be submitted by the closing date. Information submitted after this date will not be added.

Candidates may remain on the certified eligible list for a period of at least one year. The resulting certified eligible list for this recruitment may be used for similar positions in this or other State agencies.

Benefits

STATE OF MARYLAND BENEFITS

FURTHER INSTRUCTIONS

Online applications are highly recommended. However, if you are unable to apply online, the paper application (and supplemental questionnaire) may be submitted to MDH, Recruitment and Selection Division, 201 W. Preston St., Room 114-B, Baltimore, MD 21201. Paper application materials must be received by 5 pm, close of business, on the closing date for the recruitment, no postmarks will be accepted.

If additional information is required, the preferred method is to upload. If you are unable to upload, please fax the requested information to 410-333-5689. Only additional materials that are required will be accepted for this recruitment. All additional information must be received by the closing date and time.

For questions regarding this recruitment, please contact the MDH Recruitment and Selection Division at 410-767-1251.

If you are having difficulty with your user account or have general questions about the online application system, please contact the MD Department of Budget and Management, Recruitment and Examination Division at 410-767-4850 or Application.Help@maryland.gov.

Appropriate accommodations for individuals with disabilities are available upon request by calling: 410-767-1251 or MD TTY Relay Service 1-800-735-2258.

We thank our Veterans for their service to our country.

People with disabilities and bilingual candidates are encouraged to apply.

As an equal opportunity employer, Maryland is committed to recruitment, retaining and promoting employees who are reflective of the State's diversity.

Seniority Level

Associate

Industry

- Non-profit Organization Management
- Government Administration
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Other

Community Health Services Representative I | Sunflower Health Plan

SourceURL: https://www.linkedin.com/jobs/view/community-health-services-representative-i-at-sunflower-health-plan-1233283447/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Description

Position Purpose: Responsible for delivering of a range of activities for individuals who are enrolled in the health plan for Medicaid or and Medicare in order to impact individual health outcomes and provide assistance to the clinical team of nurses and social workers. Activities include, but are not limited to outreach, community education, informal guidance and member support.
Educate, coach and support members to understand disease prevention and achieve good health outcomes, including diabetes, high blood pressure, mental health, substance use, etc.
Participate in coordination and resolution of medical and non-medical needs, including appointment tracking, documentation of member information, referrals and follow up, facilitating transportation to services, etc.
Participate in meetings with external providers and community organizations to build partnerships for our members to be able to leverage member care services. Provide key information to providers for improving members care based on member's home environment and communities.
Conduct non-clinical general health assessments in order to refer members to appropriate services, resolve concerns on member's behalf, and gather information for medical providers and staff working within the organization.
Conduct non-medical assessments such as home safety, assessment of the community/environment resources, transportation, employment, and others to be able to refer to appropriate services, resolve concerns on member's behalf, and gather information for medical providers in staff working within our organization.
Coordinate and implement community events such as baby showers, health fairs, and other health education events.
Conduct telephonic and in-person outreach to locate individuals and families in the community who are hard to reach.
Work with other community health workers internally and externally to share best practices, strengthen education and outreach.
Participate in large scale community assessments including resource mapping, community surveys, and community meetings to discuss findings and resolutions to key member concerns.
Make frequent visits to individual homes and community organizations.

Qualifications

Education/Experience: High school diploma or equivalent. 2+ years of community health, social work, social services, community advocacy, community outreach, member services, or education, experience. Understanding of the community in designated region through shared experiences or strong desire to help people in vulnerable communities. Bilingual skills preferred.

Licenses/Certifications: Valid driver's license and proof of insurance. Community Health Worker Training/Certification must be successfully completed within 15 weeks of hire date.
Centene is an equal opportunity employer that is committed to diversity, and values the ways in which we are different. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, veteran status, or other characteristic protected by applicable law.
Apply Now

Medicaid Eligibility Specialist | Olympia, WA

SourceURL: https://www.helpwanted.com/88cadb8d6b3a4-Medicaid-Eligibility-Specialist-MAS3-MEDS-Perm-job-listings?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

- **Job Type(s)**

  Full Time

- **Job Description**

  Description

  MEDICAID ELIGIBILITY SPECIALIST (MEDS-Perm)

  Full-Time Permanent

  Olympia, WA

  Who We Are:

  The Health Care Authority (HCA) is Washington's largest health care purchaser, responsible for providing comprehensive health coverage to more than 2 million residents through the Public Employees Benefits and Medicaid programs. The agency provides health purchasing leadership, benefiting both public and private sectors with a focus on moving the health delivery system away from volume toward higher value and better outcomes.

  This position supports the HCA mission to provide access to medical care for all eligible Washington citizens.

  The position determines initial eligibility and/or ongoing individual and family medical eligibility for Medicaid Title XIX, Children's Health Insurance Program (CHIP) Title XXI program, and other Medicaid and state funded medical assistance programs available in Washington State.

  Duties:

  In the Medicaid Eligibility and Community Support division, independently analyze applications, determine initial and/or ongoing eligibility and authorize benefits for

Medicaid programs administered by the Medical Eligibility Determination Services (MEDS) office.

Answer inquiries, resolve questions, update eligibility records and otherwise maintain and expand access to medical care for eligible Washington citizens.

Tasks:

Independently determine initial and/or ongoing eligibility for Health Care Authority Medicaid Title XIX, CHIP Title XXI, and other Medicaid and state funded medical assistance programs administered by the MEDS office.

Apply complex federal and state eligibility regulations published in WAC and RCW to specific household circumstances resulting in accurate eligibility decisions.

Use and manage multiple interdependent electronic systems including but not limited to the Automated Client Eligibility System (ACES), HealthPlanFinder (HPF), ProviderOne, Barcode, WebAx, MEDS Verification Program (MVP), SharePoint, Microsoft Office, SOLQ, Document Management System (DMS) and Employment Security Department (ESD).

Analyze, research and resolve complex eligibility issues applying proper rules and procedures with a high degree of independence. Work on programs such as but not limited to:

Post Eligibility Reviews (PER's) Complex Error Codes Alien Emergency Medical (AEM) Citizenship/ Immigration Retroactive eligibility Spenddown Appeals Title XXI CHIP Take Charge. Conduct interviews over the telephone, in person, and/or through written correspondence with clients, providers and/or third parties to obtain information for required documentation and verification to support program eligibility. Establish effective working relationships with clients and their advocates and manage difficult interactions with tact and diplomacy. Educate clients on qualified health plans.

Work in partnership with advocates, providers, Heath Benefit Exchange, other state agencies, community based organizations and other units within HCA to provide clarification, resolve disputes, solve problems, coordinate referrals and/or answer inquiries.

Using excellent written and oral communication skills, apply effective customer service techniques and principles to all interactions with customers, their advocates and other stakeholders. Maintain current and thorough knowledge of rules of eligibility for Medicaid programs, managed care and other areas in the Health Care Authority to provide comprehensive responses to questions or concerns from the public and our customers.

Take part in trainings and other development opportunities to enhance communication skills.

Preferred/Desired Qualifications:

A Bachelor's degree

OR

Three years of experience performing the following duties: researching and analyzing complex rules, regulations or policies utilizing research and analysis to make determinations, solve problems or complete work providing direct customer service either in person or via the telephone Candidates must have three years' experience performing each of the duties, but experience may be gained concurrently.

Other desired qualifications include:

* experience performing conflict resolution with customers knowledge of Medicaid programs and eligibility Proficiency at computer keyboarding, Outlook and Word.

How to Apply:

Only candidates who reflect the minimum qualifications on their State application will be considered. Failure to follow the application instructions below may lead to disqualification. To apply for this position you will need to complete your profile and attach:

* A cover letter

* Current resume

* Three professional references

If you have questions about the process, or need reasonable accommodation, please contact the recruiter before the posting closes. The candidate pool certified for this recruitment may be used to fill future similar vacancies for up to the next six months.

Washington State is an equal opportunity employer. Persons with disabilities needing assistance in the application process, or those needing this job announcement in an alternative format may call the Human Resources Office at 360.###.#### or email ...@hca.wa.gov

Please Note the Following:

This position is covered by the Washington Federation of State Employees (WFSE).

* Persons under final consideration for initial appointment with HCA are subject to a background check*

Nurse Medical Management I - Medicaid (Eastern Time Zone)

SourceURL: https://www.helpwanted.com/f2a8a6199e364-Nurse-Medical-Management-I-Medicaid-Eastern-Time-Zone-PS19523-job-listings?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Anthem

- **Job Type(s)**

  Full Time

- **Job Description**

Your Talent. Our Vision. At Amerigroup, a proud member of the Anthem, Inc. family of companies focused on serving Medicaid, Medicare and uninsured individuals, it's a powerful combination. It's the foundation upon which we're creating greater access to care for our members, greater value for our customers and greater health for our communities. Join us and together we will drive the future of health care.

This is an exceptional opportunity to do innovative work that means more to you and those we serve.

Location: Columbia, South Carolina; St. Louis, Missouri; or Plano, Texas areas.

Work Hours: Work hours are 8am - 5pm, Monday through Friday, EST.

The Nurse Medical Management l collaborates with healthcare providers and members to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources. Ensures medically appropriate, high quality, cost effective care through assessing the medical necessity of inpatient admissions, outpatient services, focused surgical and diagnostic procedures, out of network services, and appropriateness of treatment setting by utilizing the applicable medical policy and industry standards, accurately interpreting benefits and managed care products, and steering members to appropriate providers, programs or community resources. Works with medical directors in interpreting appropriateness of care and accurate claims payment. Primary duties may include, but are not limited to:

* Conducts pre-certification, continued stay review, care coordination, or discharge planning for appropriateness of treatment setting reviews to ensure compliance with applicable criteria, medical policy, and member eligibility, benefits, and contracts.

* Ensures member access to medical necessary, quality healthcare in a cost effective setting according to contract.

* Consult with clinical reviewers and/or medical directors to ensure medically appropriate, high quality, cost effective care throughout the medical management process.

* Collaborates with providers to assess members' needs for early identification of and proactive planning for discharge planning.

* Facilitates member care transition through the healthcare continuum and refers treatment plans/plan of care to clinical reviewers as required and does not issue non-certifications.

* Facilitates accreditation by knowing, understanding, correctly interpreting, and accurately applying accrediting and regulatory requirements and standards.

Requires:

* Current active unrestricted RN license to practice as a health professional within the scope of practice in the state of South Carolina, or within the state of residence if you reside if outside of South Carolina.

* BA/BS; 2 years of acute care clinical experience and minimum 2 years CSR (inpatient) experience; or any combination of education and experience, which would provide an

equivalent background.

* Prior authorization and Concurrent Review experience.

* Managed Care, Medicaid strongly preferred.

* Also requires strong oral, written and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.

Anthem, Inc. is ranked as one of America's Most Admired Companies among health insurers by Fortune magazine and is a 2018 DiversityInc magazine Top 50 Company for Diversity. To learn more about our company and apply, please visit us at careers.antheminc.com. An Equal Opportunity Employer/Disability/Veteran.

Managed Care Medicaid Credentialing Specialist | Brentwood, TN

SourceURL: https://www.helpwanted.com/8f7b35073ad44-Managed-Care-Medicaid-Credentialing-Specialist-job-listings?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

- **Job Type(s)**

Full Time

Job Description

Overview

Every day is an opportunity for our associates to deeply connect with people in a profound and personal way. Our associates are the core of our mission and we know that offering them genuine rewards and heart filling job satisfaction is the key to our success as a company. Here you'll find opportunities to grow your career at any level whether you have direct contact with resident or support someone who does, and be inspired personally. With over 60,000 associates, there's a place for you to make a difference in lives of the families we serve throughout our continuum of care.

Responsibilities

Responsible for coordinating, monitoring, and maintaining the credentialing and re-credentialing process. Facilitates all aspects of credentialing, including initial application and re-credentialing for Managed Care Organizations (MCOs) and State Medicaid programs. MCOs include but are not limited to Medicare Advantage Plans, HMOs, PPOs, Third Party Intermediaries, Medicaid and Accountable Care Organizations. Ensures

interpretation and compliance with credentialing requirements while developing and maintaining a working knowledge of applicable statutes and regulations. Responsible for the accuracy of credentialing applications submitted and the integrity of the credentialing database and related applications.

Documents status of work to ensure tracking of open items and timely completion. Leads, coordinates, and completes review and analysis of facility applications and accompanying documents, ensuring accurate and timely submission. Conducts thorough background investigation, research and collection of documents from various Brookdale departments for accrediting agencies and in keeping with regulations. Identifies issues that require additional investigation, evaluation or document updates. Evaluates discrepancies and ensures appropriate resolution. Prepares and completes credentialing files for presentation to MCO credentialing committees, ensuring timely and accurate submission. Processes requests for network participation, including interface with Contracting Managers, ensuring compliance with Departmental procedures and criteria outlined in contracting descriptions. Responds to inquiries from MCOs; interfaces with internal and external customers on day-to-day credentialing issues as they arise. Assists with delegated credentialing audits; conducts internal file audits. Performs query, report and document generation; submits and retrieves database reports in accordance with Health Care Quality Improvement Act. Monitors the initial, reappointment and expiry process for all lines of business and ensures compliance with regulatory bodies (Joint Commission, NCQA, URAC, CMS, National Practitioner Data Base, federal & state agencies), as well as any rules and regulations, policies and procedures, and delegated contracts as they apply to Brookdale's lines of business. Performs miscellaneous Managed Care contracting duties as assigned. Develops/maintains current or future credentialing databases (computerized and otherwise) including information and credentialing initiatives as they relate to MCOs and State Medicaid programs. Assist Director, Managed Care Contracting and Credentialing and other team members in development and revision of policies and procedures to improve effectiveness and efficiency of contracting and credentialing processes.

This job description represents an overview of the responsibilities for the above referenced position. It is not intended to represent a comprehensive list of responsibilities. An associate should perform all duties as assigned by his/her supervisor.

Qualifications

Education and ExperienceHigh school diploma or GED required. Four years of healthcare or senior housing experience with two years at aprovider or MCO. A higher degree from an accredited institution may partially substitute for experience. Work experience at an accrediting organization a plus.

Certifications, Licenses, and Other Special RequirementsCredentialing specialist a plus

Management/Decision MakingApplies existing guidelines and procedures to make varied decisions within a department. Uses sound judgment and experience to solve moderately complex problems based on precedent, example, reasonableness or a combination of these.

Knowledge and SkillsWorking knowledge of the healthcare and senior housing industry. Ability to communicate effectively, both orally and in writing. Program planning and implementation skills. Knowledge of related accreditation and certificationrequirements. Knowledge of medical credentialing and privileging procedures and standards. Ability to analyze, interprets and draws inferences from research findings, and prepares reports. Working knowledge of clinical and/or hospital operations and procedures. Informational research skills. Ability to use independent judgment to manage and impart confidential information. Database management skills including querying, reporting, and document generation. Ability to make administrative/procedural decisions and judgments.

Physical Demands and Working Conditions

* Standing

* Requires interaction with co-workers, residents or vendors

* Walking

* Sitting

* Occasional weekend, evening or night work if needed to ensure shift coverage.

* Use hands and fingers to handle or feel

* On-Call on an as needed basis

* Reach with hands and arms

* Talk or hear

* Ability to lift: Up to 25 pounds

* Vision

Brookdale is an equal opportunity employer and a drug-free workplace.

Care Coordinator | Independent Care Health Plan

SourceURL: https://www.linkedin.com/jobs/view/care-coordinator-at-independent-care-health-plan-1233933861/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Job Description

This professional position provides managed care coordination services to meet medical, behavioral health and social needs of Independent Care members in Dane County while promoting and maintaining the quality of care for members.

- Conducts initial and annual assessments of members' medical, behavioral health and social needs to develop a care plan for each individual. The Care Coordination assessment is typically conducted in the member's home, office or other community setting.
- Coordinates and organizes information about members' medical, behavioral health and social needs based on an assessment. Develops a formal care plan for each member to address these needs with review/assistance by the case manager.
- Communicates care plan information about members to healthcare and other providers.
- Builds constructive working relationships with physicians, social service providers and others by involving them in the Care Coordination process, and assists in problem resolution involving members and providers, including information for the member grievance process.

- Provides information to members and providers regarding benefits, service providers and access protocols and educates members on appropriate use of medical services. Provides referrals for community resources and social services as necessary.
- Assures adequate documentation of member information, contacts made regarding member's care and services provided.
- Serves as a member advocate to ensure appropriate medical, behavioral health and social services are provided.
- Updates care plan per policy.

Experience And Skills

- Bachelor's degree in social service, rehabilitation, psychology or other related degree.
- Related health care or social work experience.
- A personal vehicle, valid State of Wisconsin motor vehicle operator's license and conformity with insurance coverage limits are required.
- Ability to effectively communicate thoughts, ideas, and information both orally and in writing.
- Ability to demonstrate flexibility, set priorities with daily demands and long-term work assignments and projects. Ability and willingness to change priorities when necessary.
- Strong interpersonal skills and ability to effectively interact with members and coworkers from a variety of different backgrounds and experiences in a professional, diplomatic and courteous manner.
- Ability to work effectively as a team member and cooperate in achieving company goals.
- Knowledge of physical and mental impairments and related medical conditions.
- Interest and willingness to travel to all locations of Dane County to serve persons with severe disabilities.

Program Coordinator I | IlliniCare Health

SourceURL: https://www.linkedin.com/jobs/view/program-coordinator-i-at-illinicare-health-1232644292/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Description

Position Purpose: Assist in activities related to the medical and psychosocial aspects of utilization and coordinated care.

- Initiate authorization requests for output or input services in keeping with the prior authorization list. Research claims inquiry specific to the department and responsibility.
- Perform tasks necessary to promote member compliance such as verifying appointments, obtaining lab results. Assess and monitor inpatient census.
- Screen for eligibility and benefits. Identify members without a PCP and refer to Member Services. Screen members by priority for case management (CM) assessment. Perform transition of care duties to include but not limited to, contact the member's attending physician, member or medical power of attorney, other medical providers (home health agencies, equipment vendors) for information pertaining to special needs.
- Coordinate services with community based organizations. Attend marketing and outreach meetings as directed to represent the plan. Produces and mails routine CM letters and program educational material.
- Data enter assessments and authorizations into the system.

Qualifications

Education/Experience: High school diploma or equivalent. 2-3 years managed care or physician's office experience. Thorough knowledge of customer service, utilization review or claims processing practices in a managed care environment and operation of office equipment such as a personal computer. Knowledge of medical terminology.
Centene is an equal opportunity employer that is committed to diversity, and values the ways in which we are different. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, veteran status, or other characteristic protected by applicable law.
Apply Now

Medicaid Eligibility Advocate

SourceURL: http://healthcarecareers.cha.com/jobs/12237597

HealthONE

Job Code: 26573 163186

Full time

No Weekends

Do you have exceptional customer service and the ability to plan organize and exercise sound judgment? Do you have demonstrated communication, problem solving and case management skills and the ability to act/decide accordingly?

Now is the time to join our team of motivated and nurturing individuals working to assist patients with their Medicaid Eligibility screening and enrollment. Ideal candidates will have a steady work knowledge of medical terminology, practices and procedures, as well as laws, regulations, and guidelines. You should also share a passion for our purpose, **"To serve and enable those who care for and improve human life in their community."**

Does this sound like you? If so, APPLY TODAY. See what makes us a **fabulous place to work!**

Parallon is now seeking a Full Time Medicaid Eligibility Advocate

WHAT WE CAN OFFER YOU:

- We offer you an excellent total compensation package, including **competitive salary** , excellent benefit package and **growth opportunities** . We believe deeply in our team and your ability to do excellent work with us.
- Your benefits package allows you to select the options that best meet the needs of you and your family. **Benefits** include 401k, paid time off medical, dental, flex spending, life, disability, tuition reimbursement, employee discount program, employee stock purchase program and student loan repayment.

WHAT YOU WILL DO:

- Responsible for conducting eligibility screenings, assessment of patient financial requirements, and counseling patients on insurance benefits and co payments.

- Serve as a liaison between the patient, hospital, and governmental agencies; and you will be actively involved in all areas of case management.
- Screen and evaluate patients for existing insurance coverage, federal and state assistance programs, or hospital charity application.
- Re verify benefits and obtains authorization and/or referral after treatment plan has been discussed, prior to initiation of treatment. Ensures appropriate signatures are obtained on all necessary forms.
- Obtain legal relevant medical evidence, physician statements and all other documentation required for eligibility determination, and complete and file applications.
- Initiate and maintain proper follow up with the patient and government agency caseworkers to ensure timely processing and completion of all mandated applications and accompanying documentation.
- Document progress notes to the patient's file and the hospital computer system.
- Participate in ongoing, comprehensive training programs as required.
- Required to make field visits as necessary.

EXPERIENCE AND EDUCATION NEEDED:

- College degree preferred or high school diploma (equivalent).
- Minimum three years of hospital/medical business office experience with insurance procedures and patient interaction
- Understanding of patient confidentiality to protect the patient and the clinic/corporation.
- Ability to collect, synthesize and research complex or diverse information.

ABOUT US

Parallon believes that organizations that continuously learn and improve will thrive. That's why after more than a decade we remain dedicated to helping hospitals and hospital systems operate knowledgeably, intelligently, effectively and efficiently in the rapidly evolving healthcare marketplace, today and in the future. As one of the healthcare industry's leading providers of business and operational services, Parallon is uniquely equipped to provide a broad spectrum of customized revenue cycle services.

We are an equal opportunity employer and we value diversity at our company. We do not discriminate on the basis of race, religion, color, national origin, gender, sexual orientation, age, marital status, veteran status, or disability status.

Business Analyst II- Medicaid Programs

SourceURL: https://careers.upmc.com/jobs/3919948-business-analyst-ii-medicaid-programs

Job Description
Job Title: Business Analyst II- Medicaid Programs
Job ID: 772548
Status: Full-Time
Regular/Temporary: Regular
Hours:
Shift: Day Job
Facility: UPMC Health Plan
Department: HPLAN Medicaid Programs
Location: 600 Grant St, Pittsburgh PA 15219

Description

UPMC Health Plan is hiring a full-time Business Analyst II to help support the Medicaid Programs Department for its downtown Pittsburgh location at the US Steel Tower. This is a Monday through Friday daylight position.

The successful candidate performs analysis of data and information for various UPMC products. Take leadership role in the enhancement, development, documentation, and communication of identified variances.

Responsibilities:

- Identify trends in expenses, utilization, medical quality, and other areas.
- Investigate variances and derive solutions to cost increases and quality issues.
- Manage special projects.
- Meet deadlines and turnaround times set by managers and department director (these deadlines and turnaround times will, at times, require the employee to work until the project is completed, meaning extended daily work hours, extended work weeks, or both).
- Monitor business unit operating performance against regional, national and international benchmarks.
- Perform cost/benefit analysis.
- Perform statistical analyses, and then explain this analysis to a non-technical audience of both internal and external customers and, at times, senior management.

Qualifications

- Bachelors degree in mathematics, statistics, health care, management, or related business field required.
- Masters degree preferred.
- Extensive related experience will be considered.
- Minimum of two years of related work experience in financial and/or medical analysis required.
- Experience in health care insurance or health care industry preferred.
- Previous experience with SQL is highly preferred
- Strong computer skills, with expert knowledge in Access, Excel, Crystal Reports, Cognos Reports, and other financial & statistical software packages.
- Ability to work in a fast-paced environment a must.
- Ability to manage multiple tasks and projects, and forge strong interpersonal relationships within the department, with other departments, and with external audiences.
- Attention to detail is critical to the success of this position.
- Excellent planning, communication, documentation, organizational, analytical, and problem solving abilities.
- Advanced mathematical skills.
- Ability to interpret and summarize results of various analyses in a timely and meaningful way.
- Ability to effectively approach problem solving.
- Ability to re-engineer processes to positively impact productivity in terms of timeliness and accuracy.
- Ability to analyze financial & clinical results and to comprehend forecasting models.
- Knowledge and good understanding of all products and benefit designs of UPMC Health.

Licensure, Certifications, and Clearances:
UPMC is an equal opportunity employer. Minority/Females/Veterans/Individuals with Disabilities

Salary Range: $23.28 to $40.28

Union Position: No

Registered Nurse | Covington, TN

SourceURL: https://www.helpwanted.com/d9f449fd51c34-Registered-Nurse-job-listings?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

- **Job Type(s)**

  Full Time

Job Description

In this role, you will work in the field and coordinate care on behalf of health plan enrollees who are receiving Long Term Services and Supports (LTSS), Medicare and home and community services and Medicaid Home Health Agency and PDN services. Your experience with home health agency, hospital and long-term care facilities will be essential in relaying the pertinent information about the patient needs and advocating for the best possible care available. At times, your patience may be challenged. But in the end, your confidence, decisiveness and perseverance will help you positively impact the lives of the people we serve, and ensure more positive outcomes for all. This position is Field Based which requires travel in various counties:

If you are located in the Southwestern part of TN in or near Shelby or Tipton County, you will have the flexibility to telecommute* as you take on some tough challenges.

Primary responsibilities:

+ Assess, plan and participate in the implementation of care strategies that are individualized and directed toward the most appropriate, least restrictive setting

+ Utilize both company and community-based resources to establish a safe and effective support plan for the people we serve

+ Collaborate with people enrolled in the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), DSNP, LTSS and Medicaid programs, and healthcare providers to develop, modify, and update Individualized Care Plans inclusive of measurable goals and outcomes

+ Work with the Case Manager to identify and initiate referrals for social service programs; including financial, psychosocial, community, and state supportive services

+ Advocate for the people we serve, and their families as needed to ensure their needs are assessed and choices are fully represented and supported by the healthcare team

+ Utilize approved clinical criteria to assess and determine appropriate level of care, document all telephonic and in-person encounters, assessments, and referrals.

+ Participate in Interdisciplinary Care Team meetings and assist with safe transitions of care

+ Understand health insurance products, benefits, coverage limitations, and governmental regulations as it applies to the health plan

+ Accountable to understand role and how it affects utilization management benchmarks and quality outcomes

+ Conduct field assessments around LTSS HCBS needs, SDOH, ADL/IADL needs, and skilled needs

+ Conduct field review visits for authorization purposes around LTSS and Home Health/PDN requested services

This role involves approximately 75% travel and you'll need to be comfortable dealing with a full range of in-home and facility-based environments. Most of the time you'll work autonomously, so the ability to stay focused and motivated is essential.

Required Qualifications:

+ Current unrestricted RN licensure in TN

+ 1+ year of home care/home health and/or other case management experience

+ 3+ years of clinical experience

+ Computer/typing proficiency to enter/retrieve data in electronic clinical records; experience with email, internet research, use of online calendars and other software applications

+ Reliable transportation to travel to the person's home or other locations within service delivery area

Preferred Qualifications:

+ Bachelor's Degree in Nursing

+ Medicaid experience - specifically LTSS

+ Medicare experience

+ Experience working in a health plan or other managed care setting

+ Experience with community health and/or public health

+ Experience with utilization review or home health assessment work

+ Bilingual skills

+ Problem solving skills; the ability to systematically analyze problems, draw relevant conclusions and devise appropriate courses of action

+ Ability to communicate complex or technical information in a manner that others can understand, as well as ability to understand and interpret complex information from others

Careers at UnitedHealthcare Community & State. Challenge brings out the best in us. It also attracts the best. That's why you'll find some of the most amazingly talented people in health care here. We serve the health care needs of low income adults and children with debilitating illnesses such as cardiovascular disease, diabetes, HIV/AIDS and high-risk pregnancy. Our holistic, outcomes-based approach considers social, behavioral, economic, physical and environmental factors. Join us. Work with proactive health care, community

and government partners to heal health care and create positive change for those who need it most. This is the place 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: RN, Registered Nurse, case management, case manager, behavioral health, Care Coordinator, social services, community health, Medicaid, home care, community health, managed care, home health, public health, hospice, health care, long term care, mental health, LTC, LTSS, Medicaid, Medicare, ID, IDD, Tipton, Haywood, Shelby, Fayette, Hardeman, McNairy, Hardin, Wayne, Chester, Perry, Hickman, Lewis, Memphis, Somerville, Savannah, Selmer, Bolivar, Decaturville,

This is a field based role that will cover these counties: Tipton, Haywood, Shelby, Fayette, Hardeman, McNairy, Hardin, Wayne, Chester, Perry, Hickman and Lewis, Tennessee, TN