Nurse Medical Management I - Medicaid HCMS | Anthem, Inc.

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Medicaid Jobs Hunter

Nurse Medical Management I - Medicaid HCMS | Anthem, Inc.

Nurse Medical Management I - Medicaid HCMS

Anthem, Inc. Nashville, TN, US

NewPosted DatePosted 14 hours agoNumber of applicants Be among the first 25 applicants

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.

The Nurse, Medical Management is responsible for collaborating with external and internal healthcare providers to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources in the in-patient setting.

Primary duties may include, but are not limited to:

- Ensures medically appropriate, high quality, cost effective care through assessing the medical necessity of inpatient admissions, elective surgical procedures, and out of network services by evaluating the appropriateness of the treatment setting by utilizing the applicable medical policy and industry standards, accurately interpreting benefits and managed care products, and steering members to the appropriate providers and level of care, as well as programs or community resources needed at discharge. Applies clinical knowledge to work with facilities and providers for care coordination.
- Works with medical directors in interpreting appropriateness of care and accurate claims payment.
- Conducts **the review of initial & concurrent authorization**

requests; retro reviews; elective procedures/in-patient stay reviews; coordination of care and discharge planning in collaboration with the acute care facility Case Management staff, as well as the internal Home Health & Sub-Acute Teams.

- Ensures member access to medical necessary, quality healthcare in a cost effective setting according to contract.
- **Routes and/or pends cases requiring second level review to the Health Plan Medical Director** to ensure medically appropriate, high quality, cost effective care throughout the medical management process.
- **Communicates determinations to acute care facility and c**ollaborates with providers to assess members' needs for early identification of and proactive planning for discharge.
- 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.
- **Supports local and corporate cost of care initiatives.**

Qualifications:

- Requires 2 years of acute care clinical experience; or any combination of education and experience, which would provide an equivalent background.
- Current unrestricted RN license in Tennessee is required. AS/BS in nursing preferred.
- Prior Utilization Management, Case Management or managed care experience preferred

An Equal Opportunity Employer/Disability/Veteran

Association of State and Territorial Health Officials Medical Director Medicaid LOB Job in Detroit, MI

Source URL: https://www.glassdoor.com/job-listing/medical-director-medicaid-lob-association-of-state-and-territorial-health-officials-JV_IC1134644_KO0,29_KE30,83.htm?jl=3392496094&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medical Director Medicaid LOB

3.6 ★

Association of State and Territorial Health Officials – Detroit, MI

$166K-$265K (Glassdoor est.)

Apply Now

This position is contingent upon the bid award in the state of Texas to WellCare Health Plans, Inc

Oversees clinical direction of medical services and quality improvement functions at the health plan level. Provides medical management leadership for the health plan and, as applicable, manages all major clinical and quality program components under health plan operations. Oversees medical coordination required for effective utilization and quality management of the health plan network. Functions as medical leadership for effective care integration of WellCare pharmacy operations, utilization/case/disease Management activities, quality improvement activities, and provider relations functions.

Essential Functions:

- Collaborates with the organization's senior leadership to ensure medical compliance with all customer, regulatory, and accreditation requirements for clinical services.
- Provides current medical expertise and direction for clinical policies, procedures and programs.
- As required by business and operational priorities, establishes professional working relationships with providers and provider organizations to support the development of the highest possible provider partnerships.
- Manages day-to-day quality improvement and medical management activities.
- Establishes and is accountable for health plan utilization, OS applications and quality outcomes.
- Assures all internal and vendor medical review activities conform to company protocols, customer requirements, and professional standards.
- Ensures adherence to assigned budget accountabilities.
- Works closely with other medical directors and clinical services staff to attain and/or maintain compliance with company, customer, accreditation and regulatory requirements.
- Provides clinical expertise needed to effectively and efficiency resolve complex, controversial and/or unique administrative circumstances.
- Provides clinical guidance for sales, marketing, legal, regulatory affairs, financial, operational, and related business activities.
- As requested and needed, provides expert medical education, consultation, and supervision for the clinical staff.
- Provides medical leadership for development and attainment of the organization's goals.
- Support provider relations and risk contracting through education, provider visits and problem resolution
- Collaborates with corporate care management to establish and implement clinical programs to support and meet care management goals
- Manages the application of all clinical aspects of the Credentialing

Program, Credentialing Committee and Peer Review activities at the state level.
- Shares responsibility for quality improvement and accreditation initiatives in the assigned market(s)
- Develops value propositions for clinical programs through quantitative analytics, ROI and evidence-based data
- Initiates dialogue with providers, as necessary, to resolve differences in opinions concerning utilization management. Reviews and makes determinations regarding provider appeals.
- Ensure compliance with federal, state and NCQA standards
- Oversees provider education regarding pharmacy, utilization, quality improvement and responsible health care expenditures to improve clinical outcomes
- Establishes and maintains relationships with key stakeholders in partnership with the market leadership
- Provides medical accountability in fulfilling the company's compliance with customer audits and reports, and accreditation surveys.
- Performs other duties as assigned.

Additional Responsibilities:

Candidate Education:
- Required A Doctor in Medicine (MD) or D.O. from an accredited school of medicine recognized by national medical regulatory bodies in the United States

Candidate Experience:
- Required 5 years of experience in direct patient care
- Required Other Substantial experience and expertise in the development of medical policies, procedures and programs
- Required Other Demonstrated success implementing utilization and quality improvement strategies /techniques and experience with physician behavior modification
- Preferred Other Qualifications to perform clinical oversight for the services provided by the health plan to include but not limited to:

Education, training or professional experience in medical or clinical practice
- Preferred Other Past participation in a managed care UM committee

Candidate Skills:
- Advanced Ability to communicate and make recommendations to upper management
- Advanced Ability to effectively present information and respond to questions from families, members, and providers
- Advanced Ability to create, review and interpret treatment plans
- Advanced Demonstrated leadership skills
- Advanced Ability to work in a fast paced environment with changing priorities
- Advanced Demonstrated interpersonal/verbal communication skills
- Advanced Demonstrated organizational skills
- Advanced Demonstrated ability to deal with confidential information
- Advanced Ability to represent the company with external constituents
- Advanced Demonstrated negotiation skills
- Advanced Ability to influence internal and external constituents
- Advanced Other Ability to remain calm under pressure
- Advanced Other Must be able to apply medical knowledge and principles to business challenges in order to achieve significant member, business, and quality outcomes
- Advanced Other Must be detail-oriented and have a "hands-on" approach
- Advanced Other Clear understanding of the managed care field and managed care operating components, with emphasis on clinical management of health services, particularly within an integrated managed care model
- Advanced Other Clear understanding of regulatory systems and processes that affect managed care health system

Licenses and Certifications:
- Required

- Required An unrestricted and current license to practice medicine in the state of employement (or the ability to obtain one)
- Required Board Certification

Technical Skills:

- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft Word
- Required Intermediate Microsoft PowerPoint
- Required Intermediate Microsoft Visio
- 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.

Anthem Health Plans of Virginia Network Relations Consultant Manager (NC Medicaid Alliance Operations) Job in Cary, NC

Source URL: https://www.glassdoor.com/job-listing/network-relations-consultant-manager-nc-medicaid-alliance-operations-anthem-health-plans-of-virginia-JV_IC1138945_KO0,68_KE69,100.htm?jl=3393132058&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Network Relations Consultant Manager (NC Medicaid Alliance Operations)

4.0 ★

Anthem Health Plans of Virginia – Cary, NC

Salary
Your Talent. Our Vision. **AtHealthy Blue, a strategic alliance of Blue Cross NC and Amerigroup, an Anthem Inc. company**, it's a powerful combination, and 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 at one of America's leading health benefits companies and a Fortune Top 50 Company.

Network Relations Consultant Manager

Cary, NC Anthem office

- Responsible for supporting the day-to-day overseeing of the Network Relations Consultants.
- As a knowledge and resource expert, handles escalated provider issues impacting provider satisfaction, researches and resolves the most complex provider issues and appeals for prompt resolution.
- Identifies deficiencies and recommends corrective actions.
- Identifies and reports on provider utilization patterns which have a direct impact on the quality of service delivery.
- Ensures Network Relations Consultants are meeting provider visit requirements.
- Attends provider meetings as needed. Monitors department metrics, provider assignments.
- Oversees daily activities and provides feedback to manager on performance management, day-to-day training, guidance, and workflow.
- Leads and facilitates team meetings.
- Serves as subject matter expert who may be assigned major projects within the department.

Requires a Bachelor's degree; 7 years of network relations and leadership experience; or any combination of education and experience, which would provide an equivalent background. Some travel may be required.

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.

Health Insurance Specialist | The Job Network

Source URL: https://www.linkedin.com/jobs/view/health-insurance-specialist-at-the-job-network-1566149872/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Health Insurance Specialist

Health Insurance Specialist

Department of Health And Human Services

Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation (CMMI)

Overview

- ##### Open & closing dates

10/11/2019 to 10/25/2019

- ##### Service

Competitive

- ##### Pay scale & grade

GS 12

- ##### Salary

$83,398 to $108,422 per year

- ##### Appointment type

Permanent

- ##### Work schedule

Full-TimeLocation

2 vacancies in the following location:
Woodlawn, MD

Relocation expenses reimbursed

No

Telework eligible

Yes as determined by agency policy- Videos- Duties

Summary

This position is located in the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI), Policy and Programs Group (PPG), Division of Alternative Payment Model Infrastructure (DAPMI).

As a Health Insurance Specialist, GS-0107-12, you will serve as an analyst for model development and model maintenance with specific focus on legal aspects of models.

Learn more about this agency

Responsibilities

- Serves as an expert in interpreting statutes and developing Federal regulations, model governing documentation, and other program guidance relating to national health insurance programs.
- Conducts analyses of legal policy issues and topics by researching background information, the origin of laws, and the intended impact to make effective agreements and policy recommendations.
- Reviews, evaluates, and recommends Medicare, Medicaid, and CHIP policy subject issues to senior staff, with an emphasis on legal analyses.
- Responds to inquiries regarding program policies, with an emphasis on legal issues, from a variety of internal and external stakeholders.

Travel Required

Occasional travel - You may be expected to travel 5% for this position.

Supervisory status

No

Promotion Potential

12

- #### Job family (Series)

0107 Health Insurance Administration- 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.

Qualifications

ALL QUALIFICATION REQUIREMENTS MUST BE MET BY THE CLOSING DATE OF THIS ANNOUNCEMENT.

In order to qualify for the GS-12, 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-11 grade level in the Federal government, obtained in either the private or public sector, to include: (1) Identifying and analyzing legal issues to present solutions; (2) Drafting regulations, legislative proposals, waivers, policy memoranda, agreements or terms and conditions, or program guidance; and (3) Evaluating potential impacts of laws, legislative history, court decisions, and policies on health or health insurance programs and proposing legislative, regulatory, policy, or operational changes.

Substitution of Education for Experience: There is no substitution of education to meet the specialized experience requirement at the GS-12 grade level.

Combination of Experience and Education: There is no combination of experience and education to meet the specialized experience requirement at the GS-12 grade level.

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.

Click the following link to view the occupational questionnaire:

****

Education

This job does not have an education qualification requirement.

Additional information

Bargaining Unit Position: Yes 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
****

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.

If You Meet The Minimum Qualifications And Education Requirements For This Position, Your Application And Responses To The Online Occupational Questionnaire Will Be Evaluated Under Category Rating And Selection Procedures For Placement In One Of The Following Categories

- Best Qualified - for those who are superior in the evaluation criteria
- Well Qualified - for those who excel in the evaluation criteria
- Qualified - for those who only meet the minimum qualification requirements

The Category Rating Process does not add veterans' preference points or apply the 'rule of three' but protects the rights of veterans by placing them ahead of non-preference eligibles within each category. Veterans' preference eligibles who meet the minimum qualification requirements and who have a compensable service-connected disability of at least 10 percent will be listed in the highest quality category (except in the case of professional or scientific positions at the GS-09 level or higher).

Once the announcement has closed, your online application, resume, transcripts 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): - Health Insurance - Oral Communication - Policy Analysis - Written Communication

This is a competitive vacancy announcement advertised under Delegated Examining Authority. Selections made under this vacancy

announcement will be processed as new appointments to the civil service. Current civil service employees would therefore be given new appointments to the civil service; however, benefits, time served and all other Federal entitlements would remain the same.

Background checks and security clearance

Security clearance

Not Required

Drug test required

No

Position sensitivity and risk

Moderate Risk (MR)

Trust determination process

Credentialing, Suitability/Fitness- Required Documents

The Following Documents Are REQUIRED

Resume showing relevant experience; cover letter optional. Your resume must indicate your citizenship and if you are registered for Selective Service if you are a male born after 12/31/59. Your resume must also list your work experience and education (if applicable) including the start and end dates (mm/dd/yy) of each employment along with the number of hours worked per week. For work in the Federal service, you must include the series and grade level for the

position(s). Your resume will be used to validate your responses to the assessment tool(s). For resume and application tips visit:
****
CMS Required Documents (e.g., SF-50, DD-214, SF-15, etc.). Required documents may be necessary to be considered for this vacancy announcement. Click here for a detailed description of the required documents. Failure to provide the required documentation WILL result in an ineligible rating OR non-consideration.
College Transcripts. Although this position does not require a degree, you may substitute college credit in whole, or in part, for experience at specified grade levels. You must submit a copy of your transcript at the time of application in order to substitute your education for the required experience. If you do not submit a transcript, your education will not be considered in determining your qualifications for the position. You may submit an unofficial transcript or a list of college courses completed indicating course title, credit hours, and grades received. An official transcript is required if you are selected for the position.

College Transcripts and Foreign Education: Applicants who have completed part or all of their education outside of the U.S. must have their foreign education evaluated by an accredited organization to ensure that the foreign education is comparable to education received in accredited educational institutions in the U.S. For a listing of services that can perform this evaluation, visit the National Association of Credential Evaluation Services website. This list, which may not be all inclusive, is for informational purposes only and does not imply any endorsement of any specific agency.

PLEASE NOTE: A complete application package includes the online application, resume, transcripts (if qualifying through education substitution or a combination of education and experience) and CMS required documents. Please carefully review the full job announcement to include the 'Required Documents' and 'How to Apply' sections.

Failure to submit the online application, resume, transcripts (if applicable) and CMS required documents, will result in you not being considered for employment.- Benefits

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

Review our benefits

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

Your complete application package, as described in the 'Required Documents' section, must be received by 11:59 PM ET on 10/25/2019 to receive consideration.

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

Please Ensure EACH Work History Includes ALL Of The Following Information

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

- Official Position Title (include series and grade if Federal job)
- Duties (be specific in describing your duties)
- Employer's name and address
- Supervisor name and phone number

- Start and end dates including month, day and year (e.g. June 18, 2007 to April 05, 2008)
- Full-time or part-time status (include hours worked per week)
- Salary

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

To verify the status of your application, log into your USAJOBS account (********** all of your applications will appear on the Welcome screen. The Application Status will appear along with the date your application was last updated. For information on what each Application Status means, visit: **********

This agency provides reasonable accommodation to applicants with disabilities. If you need a reasonable accommodation for any part of the application or hiring process, please send an email to **********. The decision to grant reasonable accommodation will be made on a case-by-case basis.

Commissioned Corps Officers (including Commissioned Corps applicants that are professionally boarded) who are interested in applying for this position must send their professional resume (not PHS Curriculum Vitae) and cover letter to ********** in lieu of applying through this announcement. The cover letter should specifically explain how you are qualified for this position and draw specific attention to your resume that demonstrates these qualifications. In the subject line of your e-mail please include only the Job Announcement Number. In the body of your e-mail please include your current rank name and serial number. Failure to provide this information may impact your consideration for this position.

Applicants eligible under Schedule A authority who are interested in applying for this position must submit their resume, Schedule A documentation, transcripts (if positive education required or qualifying through education substitution), and cover letter (optional) to **********. You MUST include the Job Announcement Number in the subject line of the email to receive consideration for the position. For additional information regarding Schedule A authority click here.

Agency contact information

Ashton Bundy

Email
Address

Center for Medicare and Medicaid Innovation 7500 Security Blvd
Woodlawn, MD 21244 US

Learn more about this agency

Next steps

Once your online application is submitted, you will receive a confirmation notification by email. Your application will be evaluated to determine your eligibility and qualifications for the position. After the evaluation is complete, you will receive another email notification regarding the status of your application.

Within 30 business days of the closing date,10/25/2019, you may check your status online by logging into your USAJOBS account (********** We will update your status after each key stage in the application process has been completed.- Fair & Transparent

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

Equal Employment Opportunity Policy

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

- Equal Employment Opportunity (EEO) for federal employees & job applicants

Reasonable Accommodation Policy

Federal agencies must provide reasonable accommodation to applicants with disabilities where appropriate. Applicants requiring reasonable accommodation for any part of the application process should follow

the instructions in the job opportunity announcement. For any part of the remaining hiring process, applicants should contact the hiring agency directly. Determinations on requests for reasonable accommodation will be made on a case-by-case basis.

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

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

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

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

Learn more about disability employment and reasonable accommodations or how to contact an agency.

Legal and regulatory guidance

- Financial suitability
- Social security number request
- Privacy Act
- Signature and false statements
- Selective Service
- New employee probationary period

This job originated on **********. For the full announcement and to apply, visit ********** Only resumes submitted according to the instructions on the job announcement listed at ********** will be considered.PandoLogic. Keywords: Health Insurance Agent, Location: Gwynn Oak, MD - 21207

Managing Consultant - Healthcare Value Transformation CMS-64 State Medicaid/Medicare Audit Services | Navigant

Managing Consultant - Healthcare Value Transformation CMS-64 State Medicaid/Medicare Audit Services

Navigant Chicago, IL, US

With a unique blend of large firm resources and an entrepreneurial collaborative culture, Guidehouse is where your purpose, passion, and expertise transform organizations. Guidehouse is a leading global provider of consulting services to the public and commercial markets with broad capabilities in management, technology, and risk consulting. We help clients address their toughest challenges with a focus on markets and clients facing transformational change, technology-driven innovation and significant regulatory pressure. Across a range of advisory, consulting, outsourcing, and technology/analytics services, we help clients create scalable, innovative solutions that prepare them for future growth and success.

Headquartered in Washington DC, the company has more than 7,000 professionals in more than 50 locations. If you're passionately motivated to make a difference and deliver exceptional work, we invite you to learn more about your career opportunities at www.guidehouse.com Interested in working with talented people to help develop innovative solutions to some of society's most complex and challenging problems?

We are Guidehouse, a leading consulting firm serving the public sector and commercial clients with specialized capabilities in strategy, technology, and risk management.

You may not yet know our name, but we have a rich history.

Guidehouse is a combination of PwC's former public sector practice and Navigant's deep expertise in energy, financial services and healthcare. We offer an exciting, fast-paced environment that fosters intellectual growth and rewards individuals based on impact, not tenure. Our firm is at the forefront of an emerging model solving complex problems that stretch across government and private companies, affording our

people the opportunity to be on the cutting edge of the consulting profession. By focusing on markets facing transformational change, technology-driven innovation, and significant regulatory pressure, our employees also develop and deploy world class knowledge and problem solving that leads to breakthrough solutions. Our healthcare segment is comprised of consultants, former provider administrators, clinicians, and other experts with decades of strategy, operational/clinical consulting, managed care services, digital health, revenue cycle management, and outsourcing experience. Professionals collaborate with hospitals and health systems, physician enterprises, payers, government, and life sciences entities, providing performance improvement and business process management solutions that help them meet quality and financial goals.

You will make an immediate impact from day one, working with a team to provide end-to-end solutions. We don't simply put band-aids on our client's issues, we are working side-by-side with them.

Are up for the challenge? **This role can be based in any of the following locations: Atlanta, GA; Austin, TX; Boston, MA; Chicago, IL; Dallas, TX; Denver, CO; Indianapolis, IN; Los Angeles, CA; Minneapolis, MN; New York, NY; Philadelphia, PA; Phoenix, AZ; Princeton, NJ; San Francisco, CA; Seattle, WA; Tampa, FL; Washington, DC.** Managing Consultants own client engagements from cultivation to completion.

In this role, you will be accountable for the activities of the project team and support the day-to-day management of the client relationship. You are expected to effectively develop and manage work plans, staffing, deadlines and budgets for multiple complex projects simultaneously.

Work products are expected to be high-quality and client-ready.

In this visible role, you will lead team meetings, and guide, manage, and coach consultants and senior consultants, providing constructive feedback on project participation and overall career development.

Managing Consultants work closely with Directors and Managing Directors to keep them abreast of project progress and important developments. Managing Consultants support sales initiatives and practice development. We encourage career development and hiring for the long term. As a Managing Consultant, you will follow a clearly defined career path and continue to develop your project management and client relationship skills. As you are ready drive strategic solutions across multiple complex workstreams and become more involved in business development, you will have the opportunity to progress to the Associate Director level. **Required:** + BA/BS degree in Health Policy, Economics, Finance, Data Science or other Healthcare/Science/Finance related disciplines, Master's degree preferred + 5+years of experience working on hospital-based financing for Medicaid payments (IGT, CPE, CMS-64, DSH assessments, etc.) + 5+ years of previous work experience in the health care industry or with a consulting firm + 5+ years of experience working with Medicaid/Medicare or other health care claims data + 5+ years of experience working in a variety of State Medicaid Programs (Rate Setting, CMS 64, cost reporting, UPL, DSH, other payment initiatives) + 5+ years of experience preparing deliverables for healthcare payment and pricing projects, payment incentive models, hospital payment adequacy analyses, federal compliance for Medicaid programs, and federal revenue enhancement programs + 5+ years of experience using the CMS-2552-10, Medicare acuity, and Medicaid quality scores in assessing hospital performance and hospital reimbursement through Medicaid + Must have 5+ years of federal reporting experience in Medicaid + Ability to work overtime and travel, as necessary +

Frequently communicates with clients and coworkers and must be able to share information effectively +

Strong conceptual, as well as quantitative and qualitative analytical skills +

Work as a member of a team as well as be a self-motivator with ability to work independently +

Flexibility and responsiveness in managing multiple projects in sometimes high-pressure situations simultaneously +

Able to travel via airplane with minimal assistance to client sites across the US and potentially internationally +

Usually remains stationary for the majority of the day +

- Regularly uses close visual acuity and operates computer equipment to prepare and analyze and transmit data **A** dditional Requirements** + This position requires successful completion of a background check and employment verification. + The successful candidate must not be subject to employment restrictions from a former employer (such as a non-compete) that would prevent the candidate from performing the job responsibilities as described. Guidehouse is an Equal Employment Opportunity / Affirmative Action employer. All qualified applicants will receive consideration for employment without regard to race, color, national origin, ancestry, citizenship status, military status, protected veteran status, religion, creed, physical or mental disability, medical condition, marital status, sex, sexual orientation, gender, gender identity or expression, age, genetic information, or any other basis protected by law, ordinance, or regulation. Guidehouse will consider for employment qualified

applicants with criminal histories in a manner consistent with the requirements of applicable law or ordinance including the Fair Chance Ordinance of Los Angeles and San Francisco. If you have visited our website for information about employment opportunities, or to apply for a position, and you require an accommodation, please contact Guidehouse Recruiting at 1-571-633-1711 or via email at RecruitingAccommodation@guidehouse.com . All information you provide will be kept confidential and will be used only to the extent required to provide needed reasonable accommodation. **_Guidehouse does not accept unsolicited resumes through or from search firms or staffing agencies. All unsolicited resumes will be considered the property of Guidehouse and Guidehouse will not be obligated to pay a placement fee._** **Rewards and Benefits** Guidehouse offers a comprehensive, total rewards package that includes competitive compensation and a flexible benefits package that reflects our commitment to creating a diverse and supportive workplace. Benefits include: + Medical, Rx, Dental & Vision Insurance + Personal and Family Sick Time & Company Paid Holidays + Parental Leave and Adoption Assistance + 401(k) Retirement Plan + Student Loan Paydown + Basic Life & Supplemental Life + Health Savings Account, Dental/Vision & Dependent Care Flexible Spending Accounts + Short-Term & Long-Term Disability + Tuition Reimbursement, Personal Development & Learning Opportunities + Skills Development & Certifications + Employee Referral Program + Corporate Sponsored Events & Community Outreach + Emergency Back-Up Childcare Program

Behavioral Health Care Coordinator

Source URL: https://jobs.harrishealth.org/behavioral-health-care-coordinator/job/11340702?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Behavioral Health Care Coordinator

Job Description

	About Us
	Community Health Choice, Inc. (Community) is a non-profit managed care organization (MCO), licensed by the Texas Department of Insurance. Through its network of more than 10,000 providers and 94 hospitals, Community serves over 400,000 Members with the

	following programs: • Medicaid State of Texas Access Reform (STAR) program for low-income children and pregnant women • Children's Health Insurance Program (CHIP) for the children of low-income parents, which includes CHIP Perinatal benefits for unborn children of pregnant women who do not qualify for Medicaid STAR • Health Insurance Marketplace Plans that offer individual health coverage that includes preventive care, emergency services, prescription drugs, and	

hospitalization available to all, regardless of pre-existing conditions.

Improving Members' experiences is at the heart of every Community position. We strive every day to make sure that our Members have access to the high-quality health care they need and deserve.

Community is accredited by URAC for its health plan operations. We offer care management programs for asthma, diabetes, and high-risk pregnancy. An affiliate of the Harris Health System (Harris Health), Community is

	financially self-sufficient and receives no financial support from Harris Health or from Harris County taxpayers.
	Job Profile
	Provides telephonic services to Members and their families for purposes of, identifying members with behavioral healthcare needs and provide available resource assistance. Works with the Member or the Member's legal representative to develop a service plan. Monitors Member's behavioral healthcare needs as per HHS guidelines. Assists with outreach to Members recently discharged from

		inpatient level of care for post discharge assistance with a goal to contact members who may be at risk of follow up shortly after an inpatient Behavioral Health admission. Makes SSI referrals to outside vendor and follow up on the eligibility process with financial and eligibility departments according to established guidelines. Works closely with case managers, team leads and Manager of Behavioral Health to coordinate care for Members with a behavioral health diagnosis. Outreach Members for special projects to assist with quality initiatives.

QUALIFICATIONS:

- Bachelor's Degree in Sociology, Social Work, or Psychology preferred
- Three (3) years experience in a healthcare setting such as medical clinic, hospital, and managed care facility

Communication Skills:

Above Average Verbal (Heavy Public Contact)

Writing /Composing Yes (Correspondence / Reports)

MS Word

MS Excel

MS Office products, filing, telephone skills, working independently.

	Bilingual (English/Spanish) preferred
	Benefits and EEOC
	Community employees' benefits are provided by Harris Health. These benefits are designed to provide you with flexibility and choices in meeting your specific needs. Community is an Equal Opportunity Employer.
	Job Category
	CHC Clinical

Application Instructions

Please click on the link below to apply for this position. A new window will open and direct you to apply at our corporate careers page. We look forward to hearing from you!

Apply Online

Assistant Director, Provider Relations - Contracts Administration - The Health Plan

Source URL: https://texaschildrenspeople.org/career/?job_id=18616&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Assistant Director, Provider Relations - Contracts Administration - The Health Plan

About Texas Children's Hospital

Founded in 1996, Texas Children’s Health Plan is the nation's first health maintenance organization (HMO) created just for children. We provide STAR/Medicaid and Children's Health Insurance Program (CHIP) to pregnant women, teens, children and adults in Houston and surrounding areas. Currently, the Health Plan has more than 375,000 members who receive care from our network of more than 1,100 primary care physicians, 3,200 specialists, and 70 hospitals. Texas Children's Health Plan is also the largest combined STAR/CHIP Managed Care Organization in the Harris County service area. To join our community of 14,000+ dedicated team members, visit texaschildrenspeople.org for career opportunities. You can also learn

more about our amazing culture at infinitepassion.org.
Summary:

We are searching for an Assistant Director of Provider Relations — someone who works well in a fast-paced managed care setting. In this position, you will provide educational development to network providers through continuing medical educational offerings, performing strategic planning and partnering with academic research opportunities from the community on areas impacting child health, managed care, or women and family issues. You will provide supervision for Provider Relations staff responsible for the operational support needed to develop and maintain the network of hospitals, physicians and other healthcare providers who provide care to the members of our health plan.

Think you've got what it takes?

Responsibilities :

Job Duties & Responsibilities

HOU123

- Serve as an internal and external liaison to resolve managed care issues, provider communications, and claims research to maintain positive relationships with providers
- Participate in community and interdepartmental groups to represent academic partners, and continuing medical education
- Serve as a liaison with community agencies and other groups and organizations which impact member health services
- Maintain current knowledge and contact with alternate sites for appropriate health care delivery within the community and the state needed for member population
- Develop management programs in response to analysis and research of managed care trends and benchmarks as well as the strategic goals of the health plan and the Integrated Delivery System
- Support and develop programs aligned with health plan strategic

goals through effective and timely assessments and equitable distribution of resources and assignments, and the education and implementation of processes and procedures that provide and maintain a cost-effective provider network

Qualifications:

Skills & Requirements

- Bachelor's degree in business, health care administration, public health, nursing or a related field
- A minimum of 5 years' experience in managed care experience in a managed care organization
- A minimum of 2 years' supervisory experience

Apply Now
To: From: Message:

Registered Nurse, Atlanta, Georgia

Source URL: https://topgeorgiacareers.com/jobs/registered-nurse-atlanta-georgia/113855527-2/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Registered Nurse

Positive Healthcare, AIDS Healthcare Foundation's Managed Care Division, has provided people living with HIV quality health care since 1995 when it started the nation's first Medicaid health plan for HIV-

positive people living in Los Angeles. Today, Positive Healthcare cares for more than 7,000 lives in California and Florida.

PHP (HMO SNP)

PHP is a Medicare Advantage Prescription Drug health plan specifically for Medicare beneficiaries who are living with HIV and reside in Duval, Broward and Miami-Dade Counties.

PHP is the first HIV-specific special needs health plan approved by the Centers for Medicare & Medicaid Services (CMS). This plan covers routine doctor and specialist office visits, emergency and urgent care, hospitalization, and more. It also includes a prescription drug benefit for no monthly premium.

PHC Florida

PHC Florida is a Medicaid managed care plan designed specifically for HIV-positive individuals who are eligible for Medicaid and live in Broward, Miami-Dade and Monroe Counties. PHC Florida is a Managed Medical Assitance (MMA) plan offered through Florida's statewide Medicaid Managed Care Program

AMAZING INDIVIDUALS WORKING FOR POSITIVE PEOPLE at AIDS Healthcare Foundation!

Does the idea of doing something that really makes a difference in people's lives while being well-compensated intrigue you? Are you looking to work for an organization that encourages growth and success from each and every one of its employees?

If so, AIDS Healthcare Foundation is the place for you!

Founded in 1987, AIDS Healthcare Foundation is the largest specialized provider of HIV/AIDS medical care in the nation. Our mission is to provide cutting edge medicine and advocacy, regardless of ability to pay. Through our healthcare centers, pharmacies, health plan, research and other activities, AHF provides access to the latest HIV treatments for all who need them.

AHF's core values are:

• Patient-Centered

• Value Employees

• Respect for Diversity

• Nimble

• Fight for What's Right

STILL INTERESTED? Please continue!

BENEFITS

AHF offers comprehensive benefits to help our employees do and be their very best! These benefits are intended to enhance our employee's physical, financial, spiritual, and professional wellbeing.

The RN Care Team Manager (RNCTM) achieves AHF's mission by demonstrating strong clinical skills, proactive thinking, and comprehensive knowledge of healthcare rules and supportive services with a special focus dedicated to HIV/AIDS members.

By utilizing core principles of nursing, you will meet our members

where they are, identify strengths and opportunities for growth and assist them with realistic goal setting. With skills of collaboration and engagement, you will work with our providers and interdisciplinary team to educate, reinforce, rehabilitate, and support our members to heal and grow to potentiate their health status and improve their quality of life. Your input will directly contribute to the review for medical necessity, under and over utilization and as a result improve member's health outcomes.

You, as the RNCTM, are the first line of support for both members and providers. You establish connections necessary to provide education so members may obtain realistic healthcare goals, services and objectives; collaborate with the member and PCP in developing personalized care plans which set specific interventions which impact the member's health & wellbeing; educate members and providers regarding preventative wellness activities, incentives and resources; and promote achievement of mutually agreed upon goals maximizing their best clinical outcomes.

By engaging in opportunities to increase knowledge of community, government, grant funded programs and health plan resources, the RNCTM can ensure the member optimizes all available health care resources. You also assist in improving member focused HEDIS measures, such as preventative wellness, which ensure our members keep healthy or Risk Adjustment which allows us to allocate services to members who are more at risk for poor health outcomes than other members.

Enhance the experience of all Managed Care employees when you collaborate with other departments to ensure member needs are addressed. Improve relations with the AHF Healthcare Centers by integrating in the office and opening lines of communication between the member, health plan, and providers.

We at AIDS Healthcare Foundation believe that each individual is entitled to equal employment opportunities without regard to race, color, creed,

gender, sexual orientation, gender identity, marital status, national origin, age, veteran status or disability. The right of equal employment opportunity extends to recruiting, hiring selection, transfer, promotion, training and all other conditions of employment.

i2i Population Health | Product Solutions Specialist

Source URL: https://app.trinethire.com/companies/3390-i2i-population-health/jobs/20409-product-solutions-specialist

Product Solutions Specialist

i2i Population Health is looking for an exceptional individual to join the Growth team as a **Product Solutions Specialist** in our Franklin, TN corporate office.

Are you a looking to be a subject matter expert for a healthcare software company's product and solutions?

Do you have the ability to showcase software solutions in support of a growth team working to build business?

Do you believe in taking ownership of your individual responsibilities, but also value the opportunity to work with a dynamic and collaborative team?

Do you like the idea of working for a smaller company where culture and

work life balance is a top priority?

Our mission is to serve others for healthy communities. We are dedicated to serving healthcare providers for the best of their patients.

Our flagship product is a Population Health Management platform that drives positive, sustainable outcomes for patients and providers. It connects EMRs to extract clinical and financial data, identify at-risk patient populations, assign action plans, and engage patients in interventions across care teams. i2i delivers the promise of population health management that consistently demonstrates quality improvements, lower costs, revenue enhancements, and patient satisfaction.

PURPOSE OF THE POSITION

This primary role of the Product Solutions Specialist is to support Growth team members by showcasing i2i solutions to Community Health Centers, Health Systems, Provider Networks and Health Plans.

ESSENTIAL JOB DUTIES AND RESPONSIBILITIES

·Act as subject matter expert on products and solutions offered by i2i with the ability to conduct product demonstrations to customers and prospects, focusing on value add

·Act as liaison between the growth and product management team, facilitating product feedback and staying current on product development, enhancements and delivery timelines.

·Be well versed in current quality programs and initiatives issued from US Department Health and Human Services.

·Must stay current on all regulatory changes that impact how i2i provider customers who utilize i2i products (example: annual UDS report changes, MIPS/MACRA, HEDIS reporting).

·Support prospect clients and staff with go-live process and play a key role in promoting solution adoption.

·Assist with testing to ensure i2i solutions performs as designed.

BASIC QUALIFICATIONS

Education:

Bachelor's degree required; Masters a plus

Experience:

·3-5 years of healthcare experience

·Prior experience and knowledge of EHRs

·Prior experience and understanding of Tableau, a plus

·Prior experience working with Federally Qualified Health Centers (FQHC), a plus

Knowledge and Skills:

·Must be able to present to senior level executives in person, or via phone, with the ability to adjust presentation content and style based on the audience and scenario.

·Demonstrated ability in successfully presenting a software solution's value proposition

·Be a team player, willing to support all areas of the growth team.

·Detailed oriented, with experience with Microsoft office and Adobe

·Must be able to manage multiple projects/tasks utilizing strong

organizational and planning skills.

i2i Population Health Offers:

·A dynamic culture where collaboration, respect, and integrity are valued!

·A relaxed work environment, with flexibility and a work-life balance focus.

·A competitive salary

·Career growth opportunity

·Comprehensive benefits package including flexible time off, medical, dental, vision, 401(k), life, disability

Nurse Medical Management I - Medicaid HCMS in Fort Worth, Texas, United States

Anthem Nurse Medical Management I - Medicaid HCMS in Fort Worth, Texas

Nurse Medical Management I - Medicaid HCMS

Location:United States

New

Requisition #: PS29019

Post Date: 3 hours ago

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.

The Nurse, Medical Management is responsible for collaborating with external and internal healthcare providers to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources in the in-patient setting.

Primary duties may include, but are not limited to:

- Ensures medically appropriate, high quality, cost effective care through assessing the medical necessity of inpatient admissions, elective surgicalprocedures, and out of network services by evaluating the appropriateness of the treatment setting by utilizing the applicable medical policy and industry standards, accurately interpreting benefits and managed care products, and steering members to the appropriate providers and level of care, as well asprograms or community resources needed at discharge.Applies

clinical knowledge to work with facilities and providers for care coordination.
- Works with medical directors in interpreting appropriateness of care and accurate claims payment.
- Conducts **the review of initial & concurrent authorization requests; retro reviews; elective procedures/in-patient stay reviews; coordination of care and discharge planning in collaboration with the acute carefacility Case Management staff, as well as the internal Home Health & Sub-Acute Teams.**
- Ensures member access to medical necessary, quality healthcare in a cost effective setting according to contract.
- Routes and/or pends cases requiring second level review to the Health Plan Medical Directorto ensure medically appropriate, high quality, cost effective care throughout the medical management process.
- **Communicates determinations to acute care facility and c** ollaborates with providers to assess members' needs for early identification of and proactive planning for discharge.
- 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.
- **Supports local and corporate cost of care initiatives.**

Qualifications

- Requires 2 years of acute care clinical experience; or any combination of education and experience, which would provide an equivalent background.
- Current unrestricted RN license in Tennessee is required. AS/BS in nursing preferred.
- Prior Utilization Management, Case Management or managed care experience preferred

EOE.M/F/Disability/Veteran

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