CARE COORDINATOR - DSNP

Position Status: Non-Exempt
Reports To: Medicare Care Management Manager
Effective Date: 08/12/25
Revised Date:
Job Level: S2

POSITION SUMMARY

Under general supervision, this position:

1. Supports the Medicare Dual Special Needs Plan (D-SNP) Care Management team with coordination of services and activities for members enrolled in D-SNP
2. Collaborates with internal and external partners to promote efficient care coordination and support members in navigating care transitions, appointments, and referrals
3. Contributes to the effective operation and improvement of Care Management D-SNP programs
4. Performs other duties as assigned

RESPONSIBILITIES

1. Supports the Medicare Dual Special Needs Plan (D-SNP) Care Management team with coordination of services and activities for members enrolled in D-SNP, with duties including but not limited to:
    - Conducting outreach calls to D-SNP members to assess appointment adherence, unmet needs, or barriers to care
    - Assisting with scheduling appointments, ordering durable medical equipment (DME), and coordinating transportation
    - Obtaining and entering authorization requests for services and performing follow-up to ensure and coordinate delivery of items such as hospital beds and complex DME
    - Tracking, initiating, and following up on prior authorization requests for D-SNP members, including hospital beds, DME, and long-term services and supports (LTSS) referrals
    - Helping ensure members receive timely services, DME, LTSS, and Enhanced Care Management (ECM)/Community Supports, where eligible
    - Documenting care coordination activities in care management systems accurately, within required timeframes, and in accordance with D-SNP and Medi-Cal regulatory requirements
    - Utilizing the Alliance computer system to complete tasks, update care plans, assessments and interventions
    - Collaborating with care managers and clinicians to ensure member-centered care plans are followed and updated
    - Supporting transitions of care, ensuring follow-up after emergency department visits or hospital discharge
    - Conducting telephone interviews with members, significant others, and family members to determine if care needs are being met or if additional services are needed
    - Supporting members in making and keeping scheduled medical appointments
    - Assessing members' ability to follow up and implement care plan activities
    - Facilitating prior authorization of services with provider offices and community agencies Identifying gaps in care for members and arranging appropriate and timely resolution with internal and external agencies

- Scheduling assessments, coordinating and obtaining medical records and authorizations and ensuring processes are completed within state and federal required timelines
- Attending Care Rounds as assigned and contributing updates to member's care plans, making recommendations for improvement in outcomes and following up with interventions and tasks as assigned
- May be assigned to back up the Intake Care Coordinators in reviewing and assigning internal and external referrals to appropriate staff
- May assist staff with transcribing clinical documentation

2. Collaborates with internal and external partners to promote efficient care coordination and support members in navigating care transitions, appointments, and referrals, with duties including but not limited to:
   - Acting as a liaison between the Alliance, provider offices, ECM providers, and community agencies
   - Developing and maintaining effective working relationships with provider offices, County departments, and other community agencies to help facilitate care coordination for members
   - Building strong community relationships to help establish community care networks that support coordination of care activities
   - Educating internal and external partners and community agencies on Care Coordination Management D-SNP programs
   - Requesting medical records and following up with providers and vendors to ensure timely service delivery
   - Building collaborative relationships to support member access to community-based services and D-SNP benefits
   - Attending interdisciplinary team meetings and contributing relevant updates

3. Contributes to the effective operation and improvement of Care Management D-SNP programs, with duties including but not limited to:
   - Participating in D-SNP team rounds, audits, and special projects to improve program efficiency and member outcomes
   - Identifying workflow or process gaps and recommending improvements to promote timely, coordinated care
   - Supporting reporting and tracking for regulatory audits and internal quality improvement initiatives
   - Recommending and assisting with implementation of program improvements that strengthen member access and health outcomes
   - Supporting special projects, as assigned

4. Performs other duties as assigned

EDUCATION AND EXPERIENCE

- High school diploma or equivalent and three years of experience in a health care setting that involved interacting with members, patients and/or providers in meeting service needs (an Associate's degree in Health, Social Services or a related field or current certification as a Medical Assistant may substitute for one year of the required experience); or an equivalent combination of education and experience may be qualifying

KNOWLEDGE, SKILLS, AND ABILITIES

- Working knowledge of the principles and practices of health care and health care systems
- Working knowledge of the principles and practices of customer service
- Working knowledge of the principles and practices of health education
- Working knowledge of and proficiency with Windows-based PC systems and Microsoft Word and Outlook
- Some knowledge of the diverse needs of the Medi-Cal and Medicare D-SNP populations
- Ability to quickly learn, understand, and communicate the workings of the Alliance, particularly the Utilization Management and Complex Case Management, Community Care Coordination, ECM, and Member Services departments
- Ability to quickly learn and competently navigate Microsoft Excel and Alliance computer systems
- Ability to communicate the program mission, vision and roles
- Ability to educate on care coordination for the D-SNP program and make presentations to individuals and groups
- Ability to interpret, explain, and apply policies, procedures, and guidelines
- Ability to clearly, completely, and independently document, summarize and resolve member's concerns and inquiries, and recognize those issues requiring escalation to a higher level
- Ability to organize and prioritize work, follow up as needed, meet timelines, and ensure compliance with regulatory requirements
- Ability to quickly and accurately assess a member's and/or family/significant other's ability to follow up with care plan details
- Ability to communicate effectively in writing and demonstrate proper grammar, spelling, punctuation, and formatting
- Ability to listen well and ask follow-up questions to gather complete information in order to problem-solve a variety of issues
- Ability to effectively conduct telephone interviews in a confidential and sensitive manner
- Ability to identify, maintain, and protect Personal Health Information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and follow Alliance policies and procedures to ensure the security of such information
- Ability to respond to sensitive or difficult issues with tact and diplomacy
- Ability to establish and maintain effective working relationships with providers, community agencies, and members, including individuals of varying socio-economic and/or cultural backgrounds, and with special needs populations
- Ability to assist a multidisciplinary team with educating members on health matters
- Ability to work independently with minimal supervision and as a member of a team

DESIRABLE QUALIFICATIONS

- Bilingual (English/Spanish or English/Hmong)
- Working knowledge of Medicare D-SNP, Medi-Cal managed care, ECM, and/or LTSS coordination
- Working knowledge of the principles and practices of care coordination
- Some knowledge of the Centers for Medicare & Medicaid Services (CMS) guidelines for care coordination for the D-SNP population
- Some knowledge of care coordination workflows
- Some knowledge of community care resources within the Alliance service area counties

WORK ENVIRONMENT

- Ability to sit in front of and operate a video display terminal for extended periods of time
- Ability to bend, lift and carry objects of varying size weighing up to 10 pounds
- Ability to work effectively in a remote work environment
- Ability to travel to different locations in the course of work
- Possession and ongoing maintenance of a valid Driver's License, transportation, and automobile liability insurance in limits acceptable to the Alliance

This position description, and all content, is representative only and not exhaustive of the tasks that an employee may be required to perform. Employees are additionally held responsible to the Employee Handbook, the Alliance Standard Knowledge, Skills and Abilities and the Alliance Code of Conduct. The Alliance reserves the right to revise this position description at any time.