[consulting](#) | [training](#) | [free webinars](#)

clay@mostlymedicaid.com | 919-727-9231

Medicaid Jobs Hunter

In this packet....

1. Market Medical Director, Vivida Health Plan
2. Program Analyst. | Centers for Medicare & Medicaid Services
3. Assistant Vice President, Medicaid Managed Care - Columbia, SC - BCBS of South Carolina
4. Claims Team Lead - Medicaid Job in Bend, OR at PacificSource Health Plans
5. Senior Medicaid Specialist (Remote) | Consulate Health Care
6. Health Insurance Specialist | Centers for Medicare & Medicaid Services
7. Claims Analyst II - Medicaid Job in Bend, OR at PacificSource Health Plans
8. Director, Care Coordination for Medicaid and Vulnerable Popu
9. RVP I & President Medicaid Health Plan - PS24330
10. Medicaid Specialist I

Market Medical Director, Vivida Health Plan

SourceURL: https://jobs.thejobnetwork.com/CandidateNet/Job/123073319?SourceID=2&utm_campaign=google_jobs&utm_source=google_jobs&utm_medium=api&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=org

Evolent Health is looking for the Health Plan Market Medical Director of Vivida Health Plan, a new Florida Medicaid provider sponsored network (PSN) health plan, who is committed to removing barriers to care and keeping Floridians healthy in Region 8.

Evolent Health has a bold mission to change the health of the nation by changing the way health care is delivered. Our pursuit of this mission is the driving force that brings us to work each day. We believe in embracing new ideas, challenging ourselves and failing forward. We respect and celebrate individual talents and team wins. We have fun while working hard and Evolenteers often make a difference in everything from scrubs to jeans.

We have been named one of Beckers 150 Great Places to Work in Healthcare in 2017, and one of the 50 Great Places to Work in 2017 by Washingtonian. If youre looking for a place where your work can be personally and professionally rewarding, dont just join a company with a mission. Join a mission with a company behind it.

Overview

The Market Medical Director (MMD) is a key member of the Vivida Health Plan Senior Leadership Team. The selected candidate will act as the clinical thought leader responsible for developing and executing strategies that both improves the quality of health care delivered to our members and improves cost and efficiency. The MMD will be directly responsible for managing an integrated clinical operation that includes utilization management, care management, population health, quality and pharmacy management. The MMD will be responsible for all the clinical operations, and for establishing and maintaining clinical and medical policies that conform to optimal clinical practice standards. As a collaborative member of a team of nurses, clinicians, physicians, pharmacists, quality improvement, and other health plan leaders, the Market Medical Director will have the opportunity to make a profound impact on the lives of our members.

As a Provider Sponsored Network (PSN) health plan, critical functions of the role include engaging the physician network, organizing physician-led clinical governance and culture, and providing medical direction on all provider network issues. The MMD will have responsibility for managing total cost of care using a collaborative, multi-disciplinary approach, including using value based payment programs aligning to provider network clinical activities and outcomes and managing operational aspects of all clinical programs.

The Health Plan leadership team, including the MMD, will have the added strength of working with the clinical, financial, analytics, and operational services of both Evolent Health and the primary provider PSN entity, Lee Health, to support the local health plan needs and functions. Evolent Health is the primary operating partner supporting almost all clinical and health plan operations for Vivida Health.

Vivida Health is the only Provider Sponsored Network (PSN) health plan in Floridas managed Medicaid Managed Medical Assistance (MMA) program in Region 8 that includes Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota counties. Vivida Health headquarters and main office is in Fort Myers, Florida.

Reporting Relationship

The Health Plan Market Medical Director (MMD) will report directly to the Evolent Health Associate CMO but will set priorities and direction with the Lee Health VP Clinical Strategy and Population Health who is also the Vivida Health CMO. The Vivida Health Market Medical Director will be 100% dedicated to Vivida Health.

Responsibilities

Physician and provider relationship management

- Responsible leading change with physicians and other providers to improve the quality and efficiency of care in the network and integrate these providers into our clinical initiatives, including creating and maintaining a system that gives continuous feedback on these initiatives

- Visits network facilities on a regular basis, identifies key issues facing leaders and works collaboratively with leadership to accomplish mutually agreed upon goals
- Participates in the development of physician incentives, value based contracting arrangements, pay for performance and targeted network improvement programs
- Partners with Evolent Health analytics to provide meaningful and actionable information to physicians
- Lead and support activities related to communications, physician/provider engagement, and programming including outward facing membership growth and organizational visibility and success

Population Health collaborative care management leadership

- Provides clinical leadership and development for population health programs or functional areas within Medical Management
- Serves as a lead physician on the medical management team working closely with clinical and market leadership, in addition to providing direction for program development of the Medicaid line of business (LOB)
- Serves as the chairperson for the Physician Advisory Committee (PAC) and other physician-led committees
- Assists in assuring appropriate health care delivery for the assigned membership and managing the medical costs associated with the assigned population
- Promotion of managed care systems using evidence-based medicine to educate and facilitate best practices with care management staff and medical physicians/providers
- Participates in Physician/Practice Meetings

Utilization Management

- Responsible for executing and maintaining Evolent Healths benchmarked Utilization/Cost Management Program and relevant Clinical Quality Improvement Programs
- Participates as needed as part of Evolent Healths national UM Medical Director team to assure quality of care in all aspects of medical utilization and to assure that utilization is appropriate to meet the needs of the members and falls within recognized standards of efficiency
- Participate in the Appeals and Grievance process, as necessary, to assure timely and accurate responses to members
- Supports and leads, as needed, operational performance to develop and implement the health plans clinical guidelines and protocols that can be utilized through the quality improvement, utilization management, and case management processes to positively impact the delivery of care.
- Collaborates as needed with risk management, claim adjudication, pharmacy utilization management, catastrophic case review, outreach programs, HEDIS reporting, site visit review coordination, triage, provider orientation, and others

Quality of care and service delivery

- Provides guidance and interpretation on issues of medical appropriateness, benefit application as appropriate, level of care necessary to include out-of-network care
- Evaluates and ensures systems and processes to assist physicians/providers with adherence to evidence based protocols
- Assures compliance related to Federal (e.g., CMS), State (e.g., Insurance commission) and local rules and regulations
- Works closely with community provider leaders to ensure accurate understanding of the Companys mission and goals and quick response to any provider issues and questions regarding Company performance and progress
- Identifies and implements other strategies that insure quality care, access to care, and the financial success of the Company

Qualifications

Required:

- Graduate of an accredited medical school. M.D. or D.O.
- Active physician license without any restrictions
- 3-5 years of clinical practice in a primary care setting preferred and progressively responsible medical administrative experience
- Board certification in ABMS recognized specialty
- 3-5 years of managed care or population health experience

Preferred:

- Proven ability in medical leadership position possessing clinical credibility with peers and the ability to be a team player and team builder
- MBA or a Master's Degree in healthcare or other related fields of study
- Experience with population health management strategies and implementation
- Excellent interpersonal, verbal, and written communication skills
- Ability to navigate in a corporate matrix environment

Evolent Health is an Equal Opportunity/Affirmative Action Employer

Location/Region: Alturas, FL

Program Analyst. | Centers for Medicare & Medicaid Services

SourceURL: https://www.linkedin.com/jobs/view/program-analyst-at-centers-for-medicare-medicaid-services-1397323770/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

- **Summary**

  This position is located in the Department of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, Marketplace Eligibility and Enrollment Group, Div. of Enrollment Policy and Operations.

  As a Program Analyst, GS-0343-12, you will conduct policy analysis and program operations related to the provisions of the Affordable Care Act (ACA) which pertain to enrollment for health care coverage through the Marketplaces.

  Responsibilities
  - Analyze and evaluate routine program efficiency and effectiveness of a health care or related regulatory program.
  - Use qualitative and quantitative methods to assess progress towards program goals and objectives.
  - Provide technical and policy assistance to health insurance companies, to facilitate the operational needs of the Marketplace.
  - Write and review documents related to program functionality; reviews contents for accuracy, content, and appropriateness.
  - Prepare reports and briefs results and recommendations to program or higher-level management.
- Travel Required
-
- Occasional travel - You may be expected to travel up to 10% for this position.
-
- Supervisory status
-
- No
-
- Promotion Potential
-

  12
- Job family (Series)

  Similar jobs
- Requirements

  Conditions of Employment
  - You must be a U.S. Citizen or National to apply for this position.
  - You will be subject to a background and suitability investigation.
  - Time-in-Grade restrictions apply.
- **Qualifications**
-
- **ALL QUALIFICATION REQUIREMENTS MUST BE MET WITHIN 30 DAYS OF THE CLOSING DATE OF THIS ANNOUNCEMENT.**
-
- **In order to qualify for the GS-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) Developing health insurance or health care policy; 2) Advising on ACA-related program and operational activities; and 3) Analyzing established processes and procedures to identify issues and propose possible course of actions.
-
- 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.
-
- **Time-in-Grade:** To be eligible, current or former Federal employees and current or former Federal employees applying under the VEOA eligibility who hold or have held a permanent General Schedule position in the previous year must have served at least 52 weeks (one year) at the next lower grade level from the position/grade level(s) to which they are applying.
-
- **Click The Following Link To View The Occupational Questionnaire**
-
- Education
-
- 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
-
- **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.
-
- **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.
  - **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.
    - **Standard Form 61, Appointment Affidavits** - If selected, the Standard Form 61 will be required at the time of in-processing.
- **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
-
- How You Will Be Evaluated
-
- You will be evaluated for this job based on how well you meet the qualifications above.
-
- Once the announcement has closed, your online application, resume, 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):
    - Oral Communication
    - Project Management
    - Technical Competence
    - Writing
- Background checks and security clearance
-
- Security clearance
-
- Drug test required
-
- No
-
- Position sensitivity and risk
-

  Trust determination process
- Required Documents

  <u>The Following Documents Are REQUIRED</u>
- **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.
- **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
  <u>PLEASE NOTE:</u> 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.
  If you are relying on your education to meet qualification requirements:
  Education must be accredited by an accrediting institution recognized by the U.S. Department of Education in order for it to be credited towards qualifications. Therefore, provide only the attendance and/or degrees from
  Failure to provide all of the required information as stated in this vacancy announcement may result in an ineligible rating or may affect the overall rating.
- 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.

  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 07/31/2019 to receive consideration.

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

  <u>Please Ensure EACH Work History Includes ALL Of The Following Information</u>

  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 (
-
- 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 Flora.burgess@cms.hhs.gov. 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
-
- Agency contact information
-
- Flora Burgess
-
- Phone
-
- Email
-
- Address
-
- Center for Consumer Information and Insurance Oversight
- 7500 Security Blvd
- Woodlawn, MD 21244
- US
-
- 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,07/31/2019, you may check your status online by logging into your USAJOBS account (
- 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.

  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
-

  Legal and regulatory guidance

This job originated on

Assistant Vice President, Medicaid Managed Care - Columbia, SC - BCBS of South Carolina

SourceURL: https://www.theladders.com/job/assistant-vice-president-medicaid-managed-care-bluecross-blueshield-of-south-carolina-columbia-sc_40181616

Summary

Accountable for Medicaid HMO business segment, growth and profitability. Operates as primary coordinator and point of contact for the Medicaid HMO line of business. Responsible for interactions with Department of Health and Human Services and other contractual relationships associated with the Medicaid HMO line

of business.

Description

•30% Financial responsibility for the line of business, including financial planning, budget control, and profit and revenue forecasting.

•20% Operational oversight of the business including effective and efficient control of all functional operations of the unit, management of all vendor relationships, and ensuring all contractual and corporate standards/requirements are met and all corporate guidelines are followed. Develops and drives strategy, processes and practices for the department in collaboration with management.

•20% Develop, implement, and execute marketing strategies and plans to achieve annual and long-term goals. Initiate, develop, and coordinate effective advertising and promotion programs utilizing all media to publicize products and/or services.

•15% Provider network development and Clinical Program development; assist in the development of programs to grow and maintain the Medicaid provider network.

•15% Develop and manage a productive working relationship with the Department of Health and Human Services.

Required Education

- Bachelor's degree in Business Administration, Finance or other job-related field

Required Work Experience

- Ten years of **Medicaid** or related experience, including seven years management experience.

Preferred:

- Experience leading a Medicaid HMO line of business.

Required Skills and Abilities

- Excellent communication, decision-making and analytical skills.
- Demonstrated problem-solving skills, understanding of key health care financial and operational metrics.
- Proficiency with spreadsheet and database software applications.
- Ability to operate standard office equipment, such as computer, calculator, copier, fax machine, telephone and other applicable office equipment.

Preferred:

- Working knowledge of key health care metrics.
- Knowledge of financial reporting.

We participate in E-Verify and comply with the Pay Transparency Nondiscrimination Provision. We are an Equal Opportunity Employer.

Equal Employment Opportunity Statement

BlueCross BlueShield of South Carolina and our subsidiary companies maintain a continuing policy of nondiscrimination in employment to promote employment opportunities for persons regardless of age, race, color, national origin, sex, religion, veteran status, disability, weight, sexual orientation, gender identity, genetic information or any other legally protected status. Additionally, as a federal contractor, the company maintains Affirmative Action programs to promote employment opportunities for minorities, females, disabled individuals and veterans. It is our policy to provide equal opportunities in all phases of the employment process and to comply with applicable federal, state and local laws and regulations.

We are committed to working with and providing reasonable accommodations to individuals with physical and mental disabilities.

Claims Team Lead - Medicaid Job in Bend, OR at PacificSource Health Plans

SourceURL: https://www.ziprecruiter.com/c/PacificSource-Health-Plans/Job/Claims-Team-Lead-Medicaid/-in-Bend,OR

Overview

Supervise and provide leadership and guidance to Claims Analysts and support staff regarding company policies, procedures and workflow applicable to Medicaid clients. Manage claims production and quality that meets or exceeds company standards. Resolve claims adjudication issues. Responsible for hiring, training, coaching, counseling, and evaluating team member performance. Demonstrate effective leadership by coaching to improve individual performance, develop teamwork and team support, manage change and encourage innovation, build collaborative relationships, encourage involvement and initiative, and develop increased vision and commitment to goals in others.

Responsibilities

+ Provide supervision, coaching, training, evaluation and leadership to assigned staff. Assure Medicare claims processing, production and quality meet department and company standards.
+ Evaluate performance of team members. Analyze results of performance reports for each team member to determine training needs related to personal performance and department goals.
+ Oversee and assist team in providing exceptional claims processing service to members, providers, agents, and other insurance companies. Includes accurate interpretation of benefit and policy provisions for Medicaid medical policies.
+ Oversee and assist with review and research of medical claims and determine coverage based on contract, provider status and claims processing guidelines. Investigate and settle claims issues as needed. Relay information for dispute resolution, including research and response for grievances and appeals, to appropriate departments and personnel.
+ Communicate changes in business processes and procedures to ensure team members receive information in a timely manner.
+ Work collaboratively with department Training Coordinator in all aspects of initial and continued education for assigned staff.
+ Oversee and assist with answering inquiries received by mail or e-mail, providing exceptional service. Write original business letters and prepare reports as needed.
+ Serve on various interoffice committees as required or needed. Document and report any pertinent communications back to the team and/or department.

+ Actively participate in Claims leadership peer group to ensure cross-team communication, collaboration and process efficiency result in consistent, quality claims processing outcomes.
+ Follow the PacificSource privacy policy and HIPAA laws and regulations concerning confidentiality and security of protected health information.
Department Management
+ Coordinate business activities by maintaining collaborative partnerships with key departments.
+ Assist with hiring, staff development, coaching, performance reviews, corrective actions, and termination of employees. Provide feedback, including regular one-on-ones and performance evaluations, for direct reports.
+ Assist with process improvement and work with other departments to improve interdepartmental processes. Utilize lean methodologies for continuous improvement. Utilize visual boards and daily huddles to monitor key performance indicators and identify improvement opportunities.
+ Follow the PacificSource privacy policy and HIPAA laws and regulations concerning confidentiality and security of protected health information.
+ Actively participate as a key team member in department meetings.
+ Actively participate in various strategic and internal committees in order to disseminate information within the organization and represent company philosophy.
Supporting Responsibilities:
+ Actively participate in department or inter-departmental workgroups. Share information or issues with department leaders.
+ Regularly attend team meetings and daily team Visual Board huddle.
+ Meet department and company performance and attendance expectations.
+ Perform other duties as assigned.

Qualifications

Work Experience:Minimum of four years claims adjudication experience and qualified to take on leadership responsibilities, or equivalent experience in a related health field. Minimum of three years Oregon Medicaid experience.

Education, Certificates, Licenses:Requires high school diploma or equivalent.

Knowledge:. Thorough understanding of PacificSource products, plan designs, provider relationships and health insurance terminology. Basic working knowledge of Medicaid rules and regulations. Thorough understanding of claims processing system and operation. Advanced PC skills including, Microsoft Word and Excel. Ability to type using a standard keyboard, operate 10-key pad accurately, multi-line telephone system, and fax machine. Research skills and ability to evaluate claims in order to audit accurately. Advanced skills in medical terminology, CPT / ICD-10 coding. Effective and responsive leader. Current knowledge of changes in PacificSource business processes and procedures and relating that information to team members. Ability to work under time pressures and deal with difficult situations. Team player. Collaborates with others and helps to accomplish objectives. Strong work ethic and ability to work effectively with a variety of personalities at varying skill levels.

Competencies
Our Values

+ Building Trust
+ Building a Successful Team
+ Aligning Performance for Success
+ Building Strategic Work Relationships
+ Continuous Improvement
+ Facilitating Change
+ Leveraging Diversity
+ Driving for Results
+ Building Customer Loyalty
+ Decision Making

+ We are committed to doing the right thing.
+ We are one team working toward a common goal.
+ We are each responsible for our customer's experience.
+ We practice open communication at all levels of the company to foster individual, team and company growth.
+ We actively participate in efforts to improve our many communities-internal and external.
+ We encourage creativity, innovation, continuous improvment and the pursuit of excellence.

Environment:Work inside in a general office setting with ergonomically configured equipment. Travel is required approximately 5% of the time.

Physical Requirements:Stoop and bend. Sit and/or stand for extended periods of time while performing core job functions. Repetitive motions to include typing, sorting and filing. Light lifting and carrying of files and business materials. Ability to read and comprehend both written and spoken English. Communicate clearly and effectively.

Diversity and Inclusion: PacificSource values the diversity of the people we hire and serve. We are committed to creating a diverse environment and fostering a workplace in which individual differences are appreciated, respected and responded to in ways that fully develop and utilize each person's talents and strengths.

Disclaimer: This job description indicates the general nature and level of work performed by employees within this position and is subject to change. It is not designed to contain or be interpreted as a comprehensive list of all duties, responsibilities, and qualifications required of employees assigned to this position. Employment remains AT-WILL at all times.

PacificSource is an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to status as a protected veteran or a qualified individual with a disability, or other protected status, such as race, religion, color, national origin, sex, sexual orientation, gender identity or age.

Job ID2019-366
TypeRegular Full-Time
# of Openings2
StatusExempt

Senior Medicaid Specialist (Remote) | Consulate Health Care

SourceURL: https://www.linkedin.com/jobs/view/senior-medicaid-specialist-remote-at-consulate-health-care-1397611757/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Job Overview

Purpose of Your Job Position

As a Consulate Health Care employee, you are entrusted with the responsibility of carrying out your daily tasks and assigned duties while demonstrating Consulate's Core Values of Compassion, Honesty, Integrity, Respect and Passion. You are expected to provide innovative, responsible results with the creation and implementation of new ideas and concepts that continually improve systems and processes to achieve superior results. The primary purpose of your job position is to assist facility staff with the Pending Medicaid Application process and assist with guiding the other Medicaid Specialists through training and problem resolution.

Job Functions

As a Senior Medicaid Specialist, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Responsible for educating in regard to the process, validating the process is efficient once implemented and developing plans for reducing days in AR related to Pending Medicaid balances. This position is a non-supervisory function. This job description does not list all the duties of the job. You may be asked by supervisors or managers to perform other duties. You will be evaluated in part based upon your performance of the tasks listed in this job description. The employer has the right to revise this job description at any time, for any reason.

Duties And Responsibilities

- Assist with training the Medicaid Specialists
- Assist with development and implementation of policies and procedures
- Assist the Medicaid Specialists with focus care centers
- Serve as a subject matter expert on the Medicaid application process for assigned states
- Responsible for the oversight and success of the pending Medicaid application process for a group of assigned skilled nursing facilities.
- Educate Care Center staff regarding the pending Medicaid application process, including identification of all pending/recertification files, incomplete 3008 forms, timely completion of PASRR II assessments, citizenship issues, unsigned documents, missing financial information, evaluation of income & asset levels for potential admissions and residents already admitted.
- Provide guidance to Care Center staff in determining appropriate actions needed to resolve applicant status if ineligible.
- Assess high risk direct admit No Payer - Medicaid Pending with Executive Directors and Admission Directors through the pre-admission screening process.
- Assist with all levels of Disability application processes including assistance w/web based application and phone interviews.
- Ensure effective processes are in place at the Care Centers for processing Pending Medicaid application, recertification documentation and tracking the status of open pending Medicaid applications
- Troubleshoot previously denied files including obtaining previously unattained documentation, including advising on appeal processes and time restraints attached to appeal limits per state protocol
- Communicate with government agencies when needed
- Attend State sponsored seminars/trainings associated with the Skilled Nursing Facility Pending Medicaid processes; communicate and educate at the Care Center level
- Stay abreast of State updates to Skilled Nursing Pending Medicaid updates-communicate and educate to the Care Center level
- Determine and discuss the need for Medicaid service companies/attorney offices to address income levels, asset levels, Qualified Income Trust needs and Guardianship needs.
- Recommend to Care Centers when a 30 day notice should be considered to any resident or designated representative that non compliance with submission of documentation needed to complete the Medicaid application process as required by Department of Children and Families, Social Security Administration and other regulatory agencies.
- Identify underlying issues with Medicaid Pending policies and procedures on a Care Center level. Develop and implement training on procedures and provide support to Medicaid designated staff to streamline the application to eligibility process.
- Determining the best course of action to resolve issues in both the pending Medicaid files as well as recertification issues.
- Analyze the status of all Medicaid pending account balances and develop strategies for resolution of outstanding balances
- Provide status reports and develop action plans to resolve outstanding Medicaid pending balances.
- Perform all other duties, as assigned.

Education

  - Must possess, as a minimum, a high school diploma or its equivalent, two-year degree preferred.
  - Computer literacy skills (Microsoft Outlook, Microsoft Office, Internet).
  - Three to Five years of professional experience and/or training; or equivalent combination of education and experience.

Experience

  - Must have 5 years experience as one of the following: 1) Skilled Nursing Medicaid billing & eligibility screening or 2) Social Worker with Skilled Nursing Medicaid eligibility processing experience or 3) Other role serving as a Skilled Nursing Medicaid eligibility liaison with Skilled Nursing Medicaid eligibility processing experience.
  - Must have experience with Excel and Microsoft Office programs.
  - Must possess knowledge of and demonstrated skill with the pertinent billing software.

Specific Requirements

  - Knowledge of the structure and content of the English language including the meaning and spelling of words, rules of composition, and grammar.
  - Knowledge of principles and processes for providing customer services. This includes customer needs assessment, meeting quality standards for services, and evaluation of customer satisfaction.
  - Must possess the ability to prioritize duties and responsibilities.
  - Must be knowledgeable of computer systems, system applications, and other office equipment.
  - Effective verbal and communication skills
  - Understanding written sentences and paragraphs in work related documents.
  - Actively looking for ways to help people.
  - Communicating effectively in writing as appropriate for the needs of the audience.
  - The ability to read and understand information and ideas presented in writing.
  - Ability to prioritize multiple tasks, work effectively under stress, meet short deadlines, take direction and perform assigned duties with minimum supervision.

EEO/MFDV

Options

Apply for this job online Apply

Share

Refer this job to a friend Refer

Sorry the Share function is not working properly at this moment. Please refresh the page and try again later.

Share on your newsfeed

Connect With Us

Not ready to apply? Connect with us for general consideration.

Health Insurance Specialist | Centers for Medicare & Medicaid Services

SourceURL: https://www.linkedin.com/jobs/view/health-insurance-specialist-at-centers-for-medicare-medicaid-services-1396806066/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Competitive

- ##### Pay scale & grade

GS 14

- ##### Salary

$117,191 to $152,352 per year

- ##### Appointment type

Permanent

- ##### Work schedule

Full-Time
Location
1 vacancy 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 Clinical Standards and Quality (CCSQ), Quality
Measurement and Value-Based Incentives Group (QMVIG), Division of
Quality Measurement (DQM).
As a Health Insurance Specialist, GS-0107-14, you will be
responsible for coordinating and integrating data extracted from
electronic health records, from the external health care industry,
to CMS.
Learn more about this agency
Responsibilities

- Serve as a technical expert authority and recognized expert for

electronic clinical quality measure (eCQM) alignment, assessment
of eCQMs used in quality and payment programs, and public
reporting programs.

- Perform highly specialized reviews of clinical, legislative, and

administrative proposals affecting eCQMs and data sets and make
recommendations to senior management within and outside of the
government.

- Establish best practices that guide eCQM development across

programs.

- Collaborate across programs on measurement activities with other

CMS components and other HHS agencies.

- Recommend improved technologies and designs to increase the

effectiveness and efficiency of policies and operations related

Travel Required
Not required
Supervisory status
No
Promotion Potential
14

- #### 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.

- Time-in-Grade restrictions apply.

Qualifications

- ALL QUALIFICATION REQUIREMENTS MUST BE MET WITHIN 30 DAYS OF THE

CLOSING DATE OF THIS ANNOUNCEMENT.**

- In order to qualify for the GS-14** , 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-13 grade
level in the Federal government, obtained in either the private or
public sector, to include: (1) Developing eCQMs (electronic Clinical
Quality Measures) to report on quality and program performance;
and (2) Providing consultation to internal and external stakeholders
on eCQMs development across health care programs (e.g., alignment
and implementation of measures in CMS' quality and payment programs,
public reporting of quality measures).
Experience refers to paid and unpaid experience, including volunteer
work done through National Service programs (e.g., Peace Corps,
AmeriCorps) and other organizations (e.g., professional;
philanthropic; religious; spiritual; community, student, social).
Volunteer work helps build critical competencies, knowledge, and

Skills And Can Provide Valuable Training And Experience That

translates directly to paid employment. You will receive credit for
all qualifying experience, including volunteer experience.

- Time-in-Grade:** To be eligible, current Federal employees must

have served at least 52 weeks (one year) at the next lower grade
level from the position/grade level(s) to which they are applying.

Click The Following Link To View The Occupational Questionnaire

sastaffing.gov/ViewQuestionnaire/10553480
Education
This job does not have an education qualification requirement.
Additional information

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

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

- The Interagency Career Transition Assistance Plan (ICTAP) and

Career Transition Assistance Plan (CTAP)** provide eligible
displaced federal employees with selection priority over other
candidates for competitive service vacancies. To be qualified you
must submit the required documentation and be rated well-qualified
for this vacancy. Click here for a detailed description of the
required supporting documents. A well-qualified applicant is one

Whose Knowledge, Skills And Abilities Clearly Exceed The Minimum

qualification requirements of the position. Additional information

about ICTAP and CTAP eligibility is on OPM's Career Transition
Resources website at
www.opm.gov/rif/employee_guides/career_transition.asp.

Additional Forms REQUIRED Prior To Appointment

- **Optional Form 306, Declaration of Federal Employment and the

Background/Suitability Investigation** - A background and
suitability investigation will be required for all selectees.
Appointment will be subject to the successful completion of the
investigation and favorable adjudication. Failure to
successfully meet these requirements may be grounds for
appropriate personnel action. In addition, if hired, a
reinvestigation or supplemental investigation may be required at
a later time. If selected, the Optional Form 306 will be
required prior to final job offer. Click here to obtain a copy
of the Optional Form 306.

- **Form I-9, Employment Verification and the Electronic

Eligibility Verification Program** - CMS participates in the
Electronic Employment Eligibility Verification Program
(E-Verify). E-Verify helps employers determine employment
eligibility of new hires and the validity of their Social
Security numbers. If selected, the Form I-9 will be required at
the time of in-processing. Click here for more information about
E-Verify and to obtain a copy of the Form I-9.

- **Standard Form 61, Appointment Affidavits** - If selected, the

Standard Form 61 will be required at the time of in-processing.
Click here to obtain a copy of the Standard Form 61.

- Additional selections** may be made from this announcement for

similar positions within CMS in the same geographical location. For
Central Office vacancies, the "same geographical location" includes
Baltimore, Maryland; Bethesda, Maryland; and Washington, D.C.
If you are unable to apply online or need to fax a document you do
not have in electronic form, view the following link for information
regarding an Alternate Application.
How You Will Be Evaluated
You will be evaluated for this job based on how well you meet the

Qualifications Above.

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

(knowledge, Skills, Abilities And Other Characteristics)

Your qualifications will be evaluated on the following competencies

- Decision Making
- Oral Communication
- Planning and Evaluating
- Technical Competence
- Written Communication

Background checks and security clearance
Security clearance
Not Required
Drug test required
No
Position sensitivity and risk
Noncritical-Sensitive (NCS)/Moderate Risk
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

sajobs.gov/Help/faq/application/documents/resume/what-to-include/

- **CMS Required Documents (e.g., SF-50, DD-214, SF-15, etc.).**

Current CMS employees are REQUIRED to submit a copy of their most recent Notification of Personnel Action (SF-50) at the time of

Application. Additional Documents May Also Be Required 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.

- PLEASE NOTE:** A complete application package includes the online

application, resume, 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 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 08/02/2019 to receive consideration.

- IN DESCRIBING YOUR WORK EXPERIENCE AND/OR EDUCATION, PLEASE BE

CLEAR AND SPECIFIC REGARDING YOUR EXPERIENCE OR EDUCATION.**
We strongly encourage applicants to utilize the USAJOBS resume builder in the creation of resumes. Please ensure **EACH** work history includes **ALL** of the following information:

- 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 (sajobs.gov/Account/Login), 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: sajobs.gov/Help/how-to/application/status/.
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
Marci.Ephraim@cms.hhs.gov. 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 CMSCorpsJobs@cms.hhs.gov
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.
CMS employees who are currently appointed under Schedule A authority
and 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 Marci.Ephraim@cms.hhs.gov. 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
Marci Ephraim
Email
Marci.Ephraim@cms.hhs.gov
Address
Center for Clinical Standards and Quality
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,08/02/2019, you may
check your status online by logging into your USAJOBS account
(sajobs.gov/Account/Login). 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 www.usajobs.gov. For the full announcement and to
apply, visit www.usajobs.gov/GetJob/ViewDetails/540133500. Only resumes
submitted according to the instructions on the job announcement listed
at www.usajobs.gov will be considered.

Claims Analyst II - Medicaid Job in Bend, OR at PacificSource Health Plans

SourceURL: https://www.ziprecruiter.com/c/PacificSource-Health-Plans/Job/Claims-Analyst-II-Medicaid/-in-Bend,OR

Overview

Responsible for processing Government claims of moderate complexity applicable to plan enrollees.

Responsibilities

+ Work in assigned workflow role to process Government claims.
+ Accurately interpret benefit and payment provisions applicable to enrollees.
+ Review and resolve claim and system edits using multiple systems, processes and procedures.
+ Apply appropriate pricing guidelines and job aids for claims requiring manual pricing.
+ Responsible for entering system Notes to record pertinent information involving a claim or member.
+ Responsible for monitoring and working claims set aside to ensure claims are released in a timely manner.
+ Pursue answers to questions needed to process claim.
+ Route to appropriate workflow queues to resolve set up issues.

+ Work independently under time pressure, and maintain company compliance by resolving and processing claims within the timelines established by regulatory agencies and the plan.
+ Document and report issues that affect claims processing or accuracy to claims leadership team.
+ Identify and report suspected instances of fraud, waste and abuse to claims leadership team.
Supporting Responsibilities:
+ Provide back-up assistance for Claims Analyst I as needed.
+ Regularly attend team meetings and daily team Visual Board huddle.
+ Work collaboratively in an objective, professional, and diplomatic manner with all parties involved in a workgroup or project.
+ Meet department and company performance and attendance expectations.
+ Follow the PacificSource privacy policy and HIPAA laws and regulations concerning confidentiality and security of protected health information
+ Perform other duties as assigned.

Qualifications

Work Experience:One year of PacificSource work experience, one year work experience in a general office role required, or a combination of equitable work and education experience required. Experience in a health related field preferred.

Education, Certificates, Licenses:High school diploma or equivalent required.

Knowledge:Ability to develop a thorough understanding of PacificSource products, plan designs, provider/network relationships and health insurance terminology. Must have necessary research skills and the ability to evaluate claims in order to enter and process accurately. Preferred computer skills include keyboarding and 10-key proficiency, basic Microsoft Word and Excel. Ability to prioritize work and perform under time constraints with accuracy and speed. Must be a team player willing to collaborate and help others accomplish team objectives. A fundamental understanding of self-insured business is helpful. Basic knowledge of medical terminology and medical coding preferred. Knowledge of claims, authorizations, and provider network preferred. Basic knowledge of Government Programs (Medicare/Medicaid) structure preferred. Excellent Time Management, Critical Thinking and Research skills preferred.

Competencies
Our Values

+ Adaptability
+ Building Customer Loyalty
+ Building Strategic Work Relationships

+ Building Trust
+ Continuous Improvement
+ Contributing to Team Success
+ Planning and Organizing
+ Work Standards

+ We are committed to doing the right thing.
+ We are one team working toward a common goal.
+ We are each responsible for our customers' experience.
+ We practice open communication at all levels of the company to foster individual, team and company growth.
+ We actively participate in efforts to improve our communities-internal and external.
+ We encourage creativity, innovation, continuous improvement, and the pursuit of excellence.

Environment:Work inside in a general office setting with ergonomically configured equipment. Travel is required approximately 5% of the time.

Physical Requirements:Stoop and bend.Sit and/or stand for extended periods of time while performing core job functions. Repetitive motions to include typing, sorting and filing. Light lifting and carrying of files and business materials. Ability to read and comprehend both written and spoken English. Communicate clearly and effectively.

Diversity and Inclusion: PacificSource values the diversity of the people we hire and serve. We are committed to creating a diverse environment and fostering a workplace in which individual differences are appreciated, respected and responded to in ways that fully develop and utilize each person's talents and strengths.

Disclaimer:This job description indicates the general nature and level of work performed by employees within this position and is subject to change. It is not designed to contain or be interpreted as a comprehensive list of all duties, responsibilities, and qualifications required of employees assigned to this position. Employment remains AT-WILL at all times.

PacificSource is an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to status as a protected veteran or a qualified individual with a disability, or other protected status, such as race, religion, color, national origin, sex, sexual orientation, gender identity or age.

Job ID2019-370
TypeRegular Full-Time
# of Openings10
StatusNon-Exempt

Director, Care Coordination for Medicaid and Vulnerable Popu

SourceURL: https://www.linkedin.com/jobs/view/director%2C-care-coordination-for-medicaid-and-vulnerable-popu-at-jobs-%40-thejobnetwork-1401008014/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Share on LinkedIn Share in a post Other options Copy link Twitter Facebook Badge
Provide leadership, direction, and operational oversight for KP's organization-wide care coordination and care management strategy, services and operations for Medicaid and vulnerable populations, which include populations such as the dual-eligibles, Aged Blind and Disabled/Seniors and Persons with Disabilities (ABD/SPD), children with special health care need, and complex perinatal/high risk obstetrics, and that aligns with the organization's mission, strategies, and objectives. Collaborates with Regions and local areas within KP for the successful adaptation, deployment, and sustainability of care coordination and care management programs.

Essential Responsibilities

- Leads and directs the national implementation of care coordination and care management programs designed to address the needs of Medicaid and vulnerable members, improve the quality and services for their care and ensure the appropriate utilization of services available to them. Implements strategies and plans to meet organizational goals and objectives. Works closely with Regions to design, implementation, and evaluate care coordination programs. Supports the VP of Care Coordination on execution of strategies.
- Partners and collaborations with PMG, KFHP, KFH, key regional and program office leaders and stakeholders, and community and government agencies on efforts towards implementing care coordination and care management programs provided to Medicaid and vulnerable members and patients. Identifies and works with stakeholders to execute strategy nationally through effective partnerships with regions.
- Leads visible and complex projects focusing on performance improvement and transformation aimed at improving the care coordination and care management provided to Medicaid and vulnerable populations. Supports the development, implementation, and evaluation of effective pilots, programs and practices derived from market leading and evidence-based research and performance outcomes.
- Ensures standardization and optimization of workflows of models that are being spread and scaled. Provides operational oversight for care coordination and care management efforts throughout regions. Develops playbooks for care coordination/care management models that are ready for spread and scale; Works closely with clinical and operational leaders across the continuum. Organizes and facilitates meetings with key stakeholders involved in the execution of care coordination/case management programs.
- Serves as a national subject matter expert around care coordination and care management for vulnerable populations. Continuously evaluates market leading and evidence-based research focused on care coordination and care management programs.
- Works on design, implementation and evaluation of IT solutions to support care coordination and care mgmt. efforts. Facilitates and oversees standardized and optimized deployment of an administrative case management tracking system (ACMTS) across the KP regions.

Experience

Basic Qualifications:

- Minimum seven (7) years of experience in Medicaid programs to include experience with vulnerable populations and implementation of care coordination programs for vulnerable populations required.

Education

- Master's degree in business administration, economics, healthcare administration, public health, health policy and management, or related field required.

License, Certification, Registration

- N/A

Additional Requirements

- Demonstrated ability to determine the key business issues and develop appropriate action plans from multi-disciplinary perspectives.
- Proven leadership skills in project management and consulting, especially on highly visible, politically sensitive issues.
- Excellent skills in complex analytic problem solving, project management, change management, and group process.
- Must exhibit efficiency, collaboration, candor, openness, and results orientation.
- Demonstrated ability to lead professionals and manage others through influence and collaboration.
- Proficient in team building, conflict resolution, group interaction, project management, and cost effective and budget management.
- Understanding of and experience in business process improvement and the tools and data requirements for supporting an effective business process improvement practice.
- Demonstrated ability to conduct and interpret quantitative/qualitative analysis.
- Proven leadership skills in project management and consulting.
- Excellent skills in complex analytic problem solving, project management, change management, and group process.
- Must exhibit efficiency, collaboration, candor, openness, and results orientation.
- Proven ability to effectively manage in ambiguous situations with minimal direction.
- Must demonstrate an understanding of health policy trends and any applicable regulations related to the responsible technical area.
- Understanding of the operations of KP.
- Excellent verbal and written communications skills.
- Must be able to work in a Labor/Management Partnership environment.

Preferred Qualifications

- Registered Nurse (RN) License in one of the following states: California, Colorado, Hawaii, Maryland, Oregon, or Washington.

Kaiser Permanente is an equal opportunity employer committed to a diverse and inclusive workforce. Applicants will receive consideration for employment without regard to race, color, religion, sex (including pregnancy), age, sexual orientation, national origin, marital status, parental status, ancestry, disability, gender identity, veteran status, genetic information, other distinguishing characteristics of diversity and inclusion, or any other protected status.

External hires must pass a background check/drug screen. Qualified applicants with arrest and/or conviction records will be considered for employment in a manner consistent with federal and state laws, as well as applicable local ordinances, including but not limited to the San Francisco and Los Angeles Fair Chance Ordinances.

COMPANY: KAISER

TITLE: Director, Care Coordination for Medicaid and Vulnerable Populations

LOCATION: Oakland, California

REQNUMBER: 804569

External hires must pass a background check/drug screen. Qualified applicants with arrest and/or conviction records will be considered for employment in a manner consistent with Federal, state and local laws, including but not limited to the San Francisco Fair Chance Ordinance. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, protected veteran, or disability status. PandoLogic. Keywords: Clinical Services Director, Location: Oakland, CA - 94606

RVP I & President Medicaid Health Plan - PS24330

SourceURL: https://www.linkedin.com/jobs/view/rvp-i-%26-president-medicaid-health-plan-ps24330-at-jobs-%40-thejobnetwork-1401040191/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Location: Buffalo, New York, United States

New

Requisition #: PS24330

Your Talent. Our Vision. **At Anthem, Inc.,** its a powerful combination, and the foundation upon which were 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 atone of America's leading health benefits companies and a Fortune Top 50 Company.

This position must be onsite in the Buffalo, NY Office

Primary Duties May Include, But Are Not Limited To

Responsible for assisting the Market President in the fiscal, operational management, legislative and regulatory objectives of an assigned Health Plan, generally a Health Plan with lower complexity in product, geography, government relations and other operating factors.

- Manages the Profit & Loss of the assigned Health Plan.

- Establishes strategies that create or sustain a competitive advantage.
- Aligns strategy to achieve business goals and build a culture of accountability with people who are results driven, innovative and committed to excellence.
- Oversight of the operating gain, growth, cost of care commitments, revenue and quality accreditation goals.
- Collaborates with shared services support to reach Health Plan objectives.
- Ensures contract compliance, as well as oversight of risk management programs.
- Manages customer and regulatory relationships, including state regulatory and legislative processes.
- Hires, trains, coaches, counsels, and evaluates performance of direct reports.
- Requires a BA/BS in Business, Healthcare Administration or related field; 12 years relevant experience, including 8 years experience in government sponsored health insurance programs; leadership experience; or any combination of education and experience, which would provide an equivalent background.
- Masters degree preferred.
- Travel may be required.

Anthem, Inc. is ranked as one of Americas 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 antheminc.com/careers. An Equal Opportunity Employer/Disability/Veteran
PandoLogic. , Location: Montebello, CA - 90640

Medicaid Specialist I

SourceURL: https://www.governmentjobs.com/jobs/2521131-0/medicaid-specialist-i?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Characteristics of Work

This is investigative work involving the interpretation of policy to determine Medicaid eligibility for families and children and aged, blind, and disabled individuals. The incumbent makes the initial and continuing determinations of eligibility for Medicaid recipients who live in private and institutional settings. Limited supervision is received from administrative supervisors who oversee a regional office or Central Enrollment Office.

Examples of Work

Examples of work performed in this classification include, but are not limited to, the following:

Assumes responsibility for a Medicaid eligibility determination caseload for a designated territory within a region.

Investigates and verifies accuracy of information provided by recipients under the Medicaid programs to determine compliance with State and Federal laws, rules, and regulations.

Determines an applicant's eligibility for institutional care based on State and Federal guidelines and verifies the accuracy of information listed on the applicants' applications.

Maintains effective public relations with medical facilities and federal, state, county, and city agencies within assigned territory.

Verifies accuracy of information listed on applicants' applications including income, bank accounts, and any other assets.

Makes determination of an applicant's eligibility based upon established criteria.

Visits contact centers and medical facilities; assists other regional offices on an as-needed basis.

Performs related or similar duties as required or assigned.

Minimum Qualifications

These minimum qualifications have been agreed upon by Subject Matter Experts (SMEs) in this job class and are based upon a job analysis and the essential functions. However, if a candidate believes he/she is qualified for the job although he/she does not have the minimum qualifications set forth below, he/she may request special consideration through substitution of related education and experience, demonstrating the ability to perform the essential functions of the position. Any request to substitute related education or experience for minimum qualifications must be addressed to the Mississippi State Personnel Board in writing, identifying the related education and experience which demonstrates the candidate's ability to perform all essential functions of the position.
EXPERIENCE/EDUCATIONAL REQUIREMENTS:

Education:
A Bachelor's Degree from an accredited four-year college or university.

OR

Education:
An Associate's Degree or completion of sixty (60) semester hours from an accredited college or university;

AND

Experience:
Two (2) years of experience related to the described duties.

Substitution Statement:
Above an Associate's Degree or completion of sixty semester hours from an accredited college or university, related education and related experience may be substituted on an equal basis.

Essential Functions

Additional essential functions may be identified and included by the hiring agency. The essential functions include, but are not limited to, the following:

1. Maintains caseload for Medicaid eligibility.

2. Maintains good public relations and customer service.

3. Collects eligibility data information.

4. Visits Medicaid contact centers and/or long-term care facilities.