Medicaid Industry Jobs Hunter 10.07.19

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Medicaid Jobs Hunter

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Supervisory Health Insurance Specialist | Centers for Medicare & Medicaid Services

Supervisory Health Insurance Specialist

Centers for Medicare & Medicaid Services Washington, D.C., DC, US

Supervisory Health Insurance Specialist
Department of Health And Human Services
Centers for Medicare & Medicaid Services
Office of Communications (OC)

Overview

- Open & closing dates

10/02/2019 to 10/08/2019

- Service

Competitive

- Pay scale & grade

GS 15

- Salary

$137,849 to $166,500 per year

- Appointment type

Temporary - NTE 1 Year

- Work schedule

Full-Time
Location
1 vacancy in the following location:

Washington, DC
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), Office of Communications (OC), Partner Relations Group (PRG).
As a Supervisory Health Insurance Specialist, GS-0107-15, you will serve as the Deputy Group Director and as a technical expert and advisor to CMS leadership on partner relations facets of complex, visible, controversial, or politically sensitive national CMS initiatives.
Learn more about this agency
Responsibilities

- In collaboration with the PRG Director, plan work to be

accomplished by subordinates, set and adjust short-term priorities, and prepare schedules for completion of work.

- Serve as a technical expert and resource to CMS leadership and

other stakeholders to promote awareness of Medicare, Medicaid, Children's Health Insurance Program (CHIP), the Health Insurance Marketplace, and other Agency programs and initiatives.

- Oversee Agency-wide coordinated efforts to track and measure the

growth of CMS' grassroots partnerships and assessing the impact of using a partnership approach to achieve Agency program objectives.

- Negotiate schedule, cost, and deliverables with staff and

business partners within and outside of the Agency with regard
to sensitive program and project issues.
- Direct strategic planning for CMS' conference participation,

including identifying and prioritizing for CMS' participation at
critical partner experiences in the provider, beneficiary, and
advocate community.
Travel Required
Occasional travel - You may be expected to travel up to 10% for this
position.
Supervisory status
Yes
Promotion Potential
15
- 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-15**, 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-14 grade level in the Federal government, obtained in either the private or public sector, to include: 1) leading or managing the work of office staff; 2) developing or managing partnership strategies that support program or outreach goals; and 3) collaborating with internal or external stakeholders to coordinate work.
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/10611201

- NOTE: This position is being filled through a temporary promotion

that may not exceed one year. Only in rare instances are extensions

beyond one year granted. Management may end this opportunity at any time, and in such cases, the employee is returned to his/her previous position or to another position of equivalent grade and pay. In addition, this opportunity may be made permanent at any time without further competition.**

Education

This job does not have an education qualification requirement.

Additional information

- Bargaining Unit Position:** No - 8888
- Tour of Duty:** Flexible
- Recruitment/Relocation Incentive:** Not Authorized
- Financial Disclosure:** Required
- 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

- Building Coalitions/Communications
- Business Acumen
- Leading People
- Managing Change
- Results Driven

Background checks and security clearance
Security clearance
Not Required
Drug test required
No
Position sensitivity and risk
Non-sensitive (NS)/Low 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 10/08/2019 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 Heidi.vause@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 Heidi.vause@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
Heidi Vause
Email
Heidi.vause@cms.hhs.gov
Address
Office of Communications
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,10/08/2019, 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/547455600. Only
resumes
submitted according to the instructions on the job announcement listed
at www.usajobs.gov will be considered.

Medicaid Eligibility Advocate - Nashville | TriStar Skyline Medical Center

Source URL: https://www.linkedin.com/jobs/view/medicaid-eligibility-advocate-nashville-at-tristar-skyline-medical-center-1543836394/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Eligibility Advocate - Nashville

TriStar Skyline Medical Center Nashville, TN, US

Description

SHIFT: No Weekends

SCHEDULE: Full-time

Do you have exceptionalcustomer service and the ability to plan organize and exercise soundjudgment? Do you demonstrate communication, problem solving and casemanagement skills and the ability to act/decide accordingly? Now is the time to join our team of **motivated** and nurturing individualsworking to assist patients with their Medicaid Eligibility screening andenrollment. Ideal candidates will have a steady work knowledge ofmedical terminology, practices and procedures, as well as laws, regulations,and guidelines. You should also share a passion for our purpose, **"Toserve and enable those who care for and improve human life in theircommunity."**

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Does this sound likeyou? If so, APPLY TODAY. See what makes usa **fabulous place to work!**

What We Can Offer You

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

What You Will Do

- Responsible for conducting eligibility screenings, assessment of patient financial requirements, and counseling patients on insurance benefits and co-payments.
- Serve as a liaison between the patient, hospital, and governmental agencies; and you will be actively involved in all areas of case management.
- Screen and evaluate patients for existing insurance coverage, federal and state assistance programs, or hospital charity application.
- Re-verify benefits and obtains authorization and/or referral after treatment plan has been discussed, prior to initiation of treatment.
- Ensures appropriate signatures are obtained on all necessary forms.
- Obtain legal relevant medical evidence, physician statements and all other documentation required for eligibility determination, and complete and file applications.
- Initiate and maintain proper follow-up with the patient and

government agency caseworkers to ensure timely processing and completion of all mandated applications and accompanying documentation.
- Document progress notes to the patient's file and the hospital computer system.
- Participate in ongoing, comprehensive training programs as required.
- Required to make field visits as necessary.

Qualifications

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

About Us

Parallon is an **industryleader** in revenue cycle services. We partner with over 650 hospitalsand 2,400 physician practices nation-wide. Our parent company, HCA Healthcarehas been consistently named a **World's Most Ethical Company** byEthisphere and is ranked in the Fortune 100. We are dedicated to ensuring ourpatients have the best experience even after they leave our facilities.

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

status.

#ParallonBCOM

Medicaid Field Care Manager; Behavioral Health | Humana

Source URL: https://www.linkedin.com/jobs/view/medicaid-field-care-manager-behavioral-health-at-humana-1543696010/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Field Care Manager; Behavioral Health

Humana Louisville, KY, US

Description

The Medicaid Field Care Manager, Behavioral Health 2 assesses

and evaluates member's needs and requirements to achieve and/or maintain optimal wellness state by guiding members/families toward and facilitate interaction with resources appropriate for the care and wellbeing of members. The Medicaid Field Care Manager, Behavioral Health 2 work assignments are varied and frequently require interpretation and independent determination of the appropriate courses of action.

Responsibilities

Care Management is an overall approach to managing enrollees' care needs and encompasses a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage health conditions.

The Medicaid Field Care Manager Behavioral Health will perform telephonic or face to face assessments and evaluations of the member's needs and requirements to achieve and/or maintain an optimal wellness state by guiding members/families toward the appropriate resources for the care and overall wellbeing of the member. The Behavioral Health Care Manager will coordinate and collaborate with providers and community services to promote quality and cost effective outcomes. The Medicaid Field Care Manager Behavioral Health work assignments involving individuals identified by the Health Needs Assessment.

The Medicaid Field Care Manager Behavioral Health employs a variety of strategies, approaches and techniques to manage a member's physical, environmental and psycho-social health

issues by advocating, empowering and assisting the member in transforming their current state. The Medicaid Field Care Manager Behavioral Health identifies and resolves barriers and social determinants that hinder effective care and health outcomes. Ensures patient is progressing towards desired outcomes by continuously monitoring patient care through assessments and/or evaluations. The Role may include creating member's plan of care as well as influencing department strategy, decision making on cases and approaches for project components. The Medicaid Field Care Manager Behavioral Health will exercise considerable latitude in determining objectives and approaches to assignments. Knowledge of community health and social service agencies and additional community resources is a plus.

Required Qualifications

- Bachelor's degree
- Applicable State licensure in field of study: Licensed Masters Clinical Social Worker (LCSW), Clinical Social Worker (CSW, Licensed Professional Counselor (LPC) Registered Nurse (RN) Licensed Marriage Family Therapist (LMFT) or other professional license
- Health professionals with a degree in nursing must have at least three years practice experience in a behavioral-health field or setting.
- Minimum of 1 year of post-degree clinical experience in behavioral health setting
- This role is considered patient facing and is part of Humana/Senior Bridge's Tuberculosis (TB) screening program. If selected for this role, you will be required to be screened for TB.
- This role is part of Humana's Driver safety program and therefore requires an individual to have a valid state driver's

license and proof of personal vehicle liability insurance with at least 100/300/100 limits
- Must be passionate about contributing to an organization focused on continuously improving consumer experiences

Preferred Qualifications

- Master's Degree with Corresponding Masters Prepared Licensure
- Experience with working with KY Medicaid Population
- Manage Care Experience
- Minimum of 1 year of post-degree clinical experience in behavioral health setting
- Case Management Certification (CCM)
- Field Case Management Experience
- Experience with behavioral change, health promotion, coaching and wellness
- Bilingual (English/Spanish); speaking, reading, writing, interpreting and explaining documents in Spanish

Additional Information

- Medicaid Field Care Manager Behavioral Health (Field Care Manager, Behavioral Health 2)

As part of our hiring process, we will be using an exciting interviewing technology provided by Montage, a third-party vendor. This technology provides our team of recruiters and hiring managers an enhanced method for decision-making.

If you are selected to move forward from your application prescreen, you will receive correspondence inviting you to participate in a pre-recorded Voice Interview and/or an SMS Text Messaging interview. If participating in a pre-recorded interview, you will respond to a set of interview questions via your phone.

You should anticipate this interview to take approximately 10-15 minutes.

If participating in a SMS Text interview, you will be asked a series of questions to which you will be using your cell phone to answer the questions provided. Expect this type of interview to last anywhere from 5-10 minutes. Your recorded interview(s) via text and/or pre-recorded voice will be reviewed and you will subsequently be informed if you will be moving forward to next round of interviews.

Scheduled Weekly Hours
40

Director of Pharmacy | Medicaid Managed Care PBM | The Job Network

Source URL: https://www.linkedin.com/jobs/view/director-of-pharmacy-medicaid-managed-care-pbm-at-the-job-network-1542116583/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director of Pharmacy | Medicaid Managed Care PBM

The Job Network Omaha, NE, US

DIRECTOR OF PHARMACY | MEDICAID MANAGED CARE PBM-OMAHA

Establish the strategic vision, objectives and policies and procedures for the pharmacy program within this established health plan. Amazing opportunity for growth in this innovative organization.

Collaborate with Vice President of Medical Affairs in formulating and administering related organizational policies and procedures, including pharmacy service quality, pharmacy UM and achievement of Company goals for pharmacy and medical programs.

Engage with and support provider education initiatives such as counter detailing and incentive programs.

Act as the pharmacy contract administrator for the development and implementation of key contracts and ensure that relevant performance standards are met by vendors.

Resolve disputes, grievances and complaints involving pharmacy program issues.

Participate in external accreditation initiatives.

Participate in relevant boards, task forces, committees, meetings and other activities.

Manage relationships with key vendors such as pharmacy benefit management companies and pharmaceutical companies.

Manage and analyze operating costs and participate in preparing the annual budget for the assigned work function at both corporate and the health plans.

Review and analyze reports, records and directives, and confer with staff to obtain data required for planning work function activities.

Conduct statistical analysis of data related to assigned work function, and prepare reports and records on data and the assigned work function activities for management and corporate.

Qualifications

- DIRECTOR MUST HAVE PREVIOUS EXPERIENCE WITH A MEDICAID MANAGED CARE PBM
- Current NE Pharmacist license (or licensure in progress)
- Bachelors degree or advanced degree (PharmD., M.S) in pharmacy.
- 3+ years of clinical pharmacy care experience.
- 3+ years of recent contracting, quality improvement and management experience in a healthcare environment, preferably managed care.
- Previous leadership experiencePandoLogic. Keywords: Managed Care Director, Location: Omaha, NE - 68182

Manager, Ethics & Compliance at Centene Corporation

Source URL: https://jobs.centene.com/job/clayton/manager-ethics-and-compliance/17169/13633383?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic#job-content

Manager, Ethics & Compliance

Clayton, Missouri Apply Now
Job ID 1160490
Category Compliance
Organization Centene Corporation
Schedule Full-time
Description:
Position Purpose: Manage and implement strategies to ensure successful maintenance and implementation of compliance programs that meet regulatory requirements for assigned products across the entire company

Ensure all Medicare and Medicaid product and services are being tested for compliance with program regulations, insurance regulations, and regulatory requirements for business entities

Maintain and track laws and regulations, contract documentations, amendments, and various compliance measures
Develop policies, procedures, and process to comply with federal program regulations, and any applicable state regulations
Provide guidance to various departments regarding compliance issues and implementation of new compliance requirements with respect to regulatory and contract language
Conduct compliance audits, develop and implement corrective action plans
Perform plan risk assessments and report emerging trends, deficiencies and variances; report findings to other departments and teams as appropriate
Provide required Ethics, Compliance, Risk Management, FWA, privacy, and security training for existing and new employees and as required non-employees
Commercial Insurance (additional responsibilities):
Monitor Commercial product risks in accordance with the risk reporting policies
Manage Benefit Filings and entity licensures for all products to ensure compliance with state and federal regulatory requirements
Work in collaboration with Marketing teams to monitor Sales & Marketing representatives and materials used in advertisements
Medicare (additional responsibilities):
Monitor the FDR oversight program to ensure all Medicare and MMP plans are conducting the appropriate oversight in a timely manner
Report all Medicare and Medicaid product risks in accordance with the risk reporting policies
Partner with various departments as the local executive responsible for ensuring that state and/or federal regulatory requirements relating to business continuity and disaster recovery are communicated and met

Qualifications:
Education/Experience:

Bachelors' degree in related field or equivalent experience.
4+ years of compliance experience, preferably in a healthcare environment with at least 2+ years of Medicaid, Medicare or Commercial Managed Care experience.
Previous experience demonstrating effective interaction with federal and state regulatory agencies in a managed care or insurance environment preferred.
Centene is an equal opportunity employer that is committed to diversity, and values the ways in which we are different. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, veteran status, or other characteristic protected by applicable law.

Apply Now

Manager, Medicaid Program | Heatlh People Inc.

Source URL: https://www.linkedin.com/jobs/view/manager-medicaid-program-at-heatlh-people-inc-1543758474/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Manager, Medicaid Program

Heatlh People Inc. Renton, WA, US

Description

The Program Manager develops analytics and manages line of business specific projects and initiatives to improve operations and achieve sustainable growth in the Medicaid Lines of Business (LOB) within Kaiser Permanente's Washington region. This position applies analytics, researches economic trends and competitive intelligence in order to support LOB strategy and planning. He or she works closely with the Business Line Leader and Medicaid Medical Director in identifying and implementing cost and care delivery strategies and tactics to meet and exceed enrollment and financial targets. The Program Manager supports in developing line of business enrollment forecasts and monitoring ongoing enrollment results. The Program Manager conducts root-cause operational and financial analysis to improve LOB performance and financial targets. The position requires a high-degree of analytic skill, organization and project management expertise.

Essential Responsibilities

- Cross-Functional Team Support: Collaborate with a diverse group of LOB stakeholders from multiple areas including Finance, Program Office, and regional functional areas (i.e. Care Delivery operations and IT, Credentialing, etc.) to lead program specific initiatives and process improvement projects.
- Tactical Execution and Project Management: develops, performs, and tracks the tactical execution of strategic

initiatives across functional areas, including Community Benefit and Care Delivery. Manages projects from conception phase through execution with a heavy reliance on metrics to indicate progress and success.

- Sustainability: Program Manager develops projections and business plans to support sustainable growth in Medicaid. Oversee Medicaid Revenue Cycle processes in order to improve revenue collections - including improvements related to claims and denials.
- Line of Business Analytics: develops and maintains enrollment trends and forecasts. Identifies opportunities for LOB performance improvement and develops solutions to address the needs of the organization.
- Strategic Plans: in conjunction with the LOB Leader, the Program Manager helps in maintaining line of business strategic plans.

Experience

Basic Qualifications:

- Minimum three (3) years of experience in project or program management, preferably in health care/insurance industry, government programs, or public sector.

Education

- Bachelor's degree.

License, Certification, Registration

- N/A

Additional Requirements

- Experience in a managed care organization, health system, other health care related field.

- Knowledge of managed care products, regulations and features.
- Proven capability to execute on large, complex projects and programs.
- Ability to work with all levels of a highly matrixed organization to influence decision makers and obtain 'buy in'. Strong collaboration and teaming skills a must.
- Demonstrated ability to determine the key business issues and to develop appropriate action plans from multi-disciplinary perspectives.
- Strong communication/interpersonal skills.
- Facilitation/team coordination.
- Program and project management.
- Organization/planning skills.

Preferred Qualifications

Master's degree in Business Administration or Health or Business related field of study.
Washington,Renton,Renton Administration - Baker 1300 SW 27th St. **Scheduled Weekly Hours:** 40 **Shift:** Day **Workdays:** Mon - Fri **Working Hours Start:** Variable **Working Hours End:** Variable **Job Schedule:** Full-time **Job Type:** Standard **Employee Status:** Regular **Employee Group/Union Affiliation:** Salaried, Non-Union, Exempt **Job Level:** Individual Contributor **Job Category:** Sales and Marketing **Department:** Medicare, Medicaid and Public Programs **Travel:** Yes, 5 % of the Time 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.

Program Specialist V | Texas Health and Human Services

Source URL: https://www.linkedin.com/jobs/view/program-specialist-v-at-texas-health-and-human-services-1544109139/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Program Specialist V

Texas Health and Human Services Austin, TX, US

Job Description

Program Specialist V

The Health Plan Specialist V is selected by and reports to the Health Plan Manager located in the Health Plan Management Division of the Medicaid/CHIP Services Department. This position will be assigned to a team responsible to ensure compliance with contracts between managed care organizations (MCOs) and the agency. This position will participate in the training and mentoring of team members. This position performs highly complex analysis and continuous monitoring of MCOs to determine the effectiveness of operations and contract compliance. The position will evaluate MCO performance and manages corrective actions. This position coordinates the development and evaluation of Health Plan Management policies as they affect the MCO contracts and makes recommendations for changes as needed.

This position will work under limited direction with considerable latitude for the use of initiative and independent judgment and perform other duties as may be assigned or required.

Essential Job Functions

- Ensure compliance with contract standards and assess MCO performance by reviewing MCO contract deliverables, performance measures and MCO compliance with state and federal regulations.
- On a prompt and regular basis determine the effectiveness of MCO operational and contractual compliance by utilizing a standard set of assessment tools.
- Promptly inform the Health Plan Manager (HPM) of significant MCO

compliance and performance issues and provide recommendations for action.
- Facilitate collaboration with other Health Plan Management staff, the MCO, and other external/internal stakeholders to ensure contractual compliance by developing, monitoring, and updating action plans.
- Work promptly and collaboratively to assess and review recommended remedies for noncompliance of contractual requirements.
- Collaborate with HPM Research and Resolution promptly and timely on escalated MCO related issues.
- Respond to and review legislative, open records and audit requests within specified timeframes.
- Lead and facilitate functions related to operational on-sites, desk reviews, implementations, readiness reviews, information sessions, or other activities as required.
- Manage or facilitate special research/issues projects as assigned within timeframes.
- Develops materials and prepares reports based on findings from readiness reviews.
- Establishes and maintains effective working relationships and communications with HHS staff, and other internal/external stakeholders, and provide timely responses to requests and inquiries.
- Receive no more than 1-2 justified complaints per annual review period from internal or external customers regarding professional conduct, appropriate interactions with others, and/or timely responses to requests or inquiries.
- Demonstrates commitment to the goals of the Medicaid/CHIP services, shows initiative to take on new projects, is team-oriented and committed to outstanding customer service, and focuses on promoting efficiencies and accountability.
- Communicates with manager in a timely manner regarding

problematic situations and applies proper judgment to ensure action taken is appropriate.

- Attends work on a regular predictable schedule in accordance with agency leave policy. Performs other duties as assigned, timely and accurately.
- Participates in the development of RFPs and the evaluation of RFP responses within assigned timeframes. Reviews, analyzes and evaluates rules, bills and federal/state laws with implications for the Medicaid and CHIP programs as required.

Knowledge Skills Abilities

- Knowledge of subsidized health insurance, including Medicaid, Medicaid Managed Care, and/or CHIP.
- Knowledge of contract management and compliance principles.
- Ability to work under limited direction and to use initiative and independent judgment.
- Analytical and organizational skills and the ability to conduct investigations or audits; gather, assemble, correlate, and analyze facts and data; and devise solutions to problems.
- Knowledge of state and federal laws, regulations and processes regarding Medicaid Managed Care and CHIP.
- Skill in using personal computer application software such as Microsoft Word, Excel, Power Point, or other similar programs.
- Skill in written and oral communication, including the ability to make public presentations, write technical information in an understandable format, produce sophisticated research and analytical reports.
- Ability to research and evaluate policies and procedures.

Registration Or Licensure Requirements

Certified Texas Contract Manager Certification (CTCM), or must obtain

within 12 months upon hire. Must maintain CTCM certification.

Initial Selection Criteria

A minimum of 120 semester hours from an accredited college with major course work in a field related to health and human services. Graduation from an accredited four-year college or university with major course work in a field relevant to assignment is generally preferred. Experience and education may be substituted for one another. Minimum of two years of experience with Medicaid and CHIP managed care programs, policies, procedures, contracts, and service delivery models. Minimum of two years of experience of contract management and contract principles. Minimum of two years of demonstrable skills and abilities to research, analyze and create technical reports in an understandable format. Minimum of two years of experience in using a PC and Microsoft Office Suite including: Word, Excel, PowerPoint, Outlook.

Additional Information

Note: There are no direct military occupation(s) that relate to the initial selection criteria and registration or licensure requirements for this position. All active duty, reservists, guardsmen, and veterans are encouraged to apply. For more information see the Texas State Auditor's Military Crosswalk at http://www.hr.sao.state.tx.us/Compensation/JobDescriptions.aspx.

Req #434158

MOS Code

1574

HHS agencies use E-Verify. You must bring your I-9 documentation with you on your first day of work.

I-9 Form - Click here to download the I-9 form.

In compliance with the Americans with Disabilities Act (ADA), HHS agencies will provide reasonable accommodation during the hiring and selection process for qualified individuals with a disability. If you need assistance completing the on-line application, contact the HHS Employee Service Center at 1-888-894-4747. If you are contacted for an interview and need accommodation to participate in the interview process, please notify the person scheduling the interview.

Vice President & Chief Executive Officer Health Plan In | Banner Health System

Source URL: https://www.linkedin.com/jobs/view/vice-president-chief-executive-officer-health-plan-in-at-banner-health-system-1543063917/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Vice President & Chief Executive Officer Health Plan In

Company Name Banner Health System Company Location Tucson, AZ, US

VP & CEO Health Plan in Tucson, Arizona | Careers at Banner Health

VP & CEO Health PlanJob Number
252180Facility
Univ Physicians Health PlansDepartment
HP Statewide Plan AdminAddress : Street
2701 East Elvira RdAddress : Location
US-AZ-TucsonWork Schedule
DayPosition Type
FT: Full-TimePosting Category
Executive - Non-Clinical

If youre looking to leverage your abilities to make a real difference and real change in the health care industry you belong at Banner Health. With facilities in six western states, were committed to not only providing the finest care possible, but to advancing the way care is provided. To achieve our vision, we seek driven professionals who embrace change and who possess the passion and skills to make it happen. In this highly visible role of VP & CEO of the Banner University

Health Plan (BUHP), you will have the opportunity to lead an innovative, provider sponsored Medicare/Medicaid health plan. Serving over 220k members in the state of Arizona, you will interact with community leaders, state and federal regulators, and Banner Health leadership across the system. This is an excellent opportunity to make a difference and contribute to the successful growth and evolution of one of the nation's top fully integrated healthcare delivery systems. This position will require travel between Tucson and Phoenix. The incumbant can reside in either location. Your pay and benefits (Total Rewards) are important components of your Journey at Banner Health. Banner Health offers a variety of benefit plans to help you and your family. We provide health and financial security

Seniority Level

Executive

Industry

- Retail

Employment Type

Full-time

Job Functions

- Other

Prior Authorization/Utilization Review Nurse | iCare Independent Care Health Plan

Source URL: https://www.linkedin.com/jobs/view/prior-authorization-utilization-review-nurse-at-icare-independent-care-health-plan-1537315549/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Prior Authorization/Utilization Review Nurse

Company Name iCare Independent Care Health Plan Company Location Milwaukee, WI, US

Job Description

This professional position reviews the clinical appropriateness of prior authorization (PA) requests and ensures that all benefits authorized meet medical necessity and other Medicare and/or Medicaid criteria if applicable to promote cost-effective delivery of health care services. Works with the Chief Medical Officer (CMO)/Medical Director to review PA requests, and ensures appropriate information sharing takes place

between the PA Department and Care Management and/or other Departments to facilitate proper care management activities.

- Review PA requests for home health services, durable medical equipment, outpatient therapies, skilled nursing facility therapies, and all outpatient procedures pursuant to applicable Medicare and Medicaid criteria, *i*Care guidelines, and PA Department policies and procedures.
- Provide complete and accurate documentation specifying the rational for approval, or for forwarding to the CMO/Medical Director for further review.
- Create reduction/denial letters based on the CMO/Medical Directors review and applicable guidelines.
- Maintain a thorough understanding of Medicare and Medicaid guidelines and stay abreast of updates and changes.
- Work in collaboration with the PA staff to ensure timely and efficient completion of all workflows within the Department.
- Fully participate in *i*Cares Compliance Program, including compliance with *i*Cares Code of Conduct, policies and procedures, and all applicable Privacy and Security laws.

Required Experience

- Licensed as a Registered Nurse in the State of Wisconsin with at least two years of experience in clinical care in long term and rehabilitation care settings, related health care experience in a hospital or other clinical care setting, or previous prior authorization experience.
- Advanced clinical literacy and judgment in the residential care of individuals with a nursing home level of need.
- Ability to secure the cooperation and compliance of key nursing home leadership in requests for information and documentation.
- Ability to communicate and enforce best practice standards in the care of *i*Care members with nursing home levels of need.
- Strong analytical skills in tracking and reporting utilization, practice

patterns, and significant deviations.
- Ability to determine appropriateness of members care.
- Demonstrated flexibility, ability to effectively set priorities between daily demands and long-term work assignments and projects while consistently meeting deadlines and demonstrating accuracy in documentation.
- Experience in health care cost containment through innovative utilization review practices.
- Proficiency in effective communication of thoughts, ideas, and information both orally and in writing.
- Ability to use a personal computer and ability to quickly learn software applications necessary for the work of the position.
- A personal vehicle, valid State of Wisconsin motor vehicle operators license and conformity with insurance coverage limits are required.
- Must be able to travel to any location within iCare service area.

Keyword: Prior Authorization Utilization Review Nurse

Seniority Level

Associate

Industry

- Non-profit Organization Management
- Insurance
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Health Care Provider

Health Plan Specialist I (Inbound)

Source URL: https://jobs.harrishealth.org/health-plan-specialist-i-inbound/job/11658675?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Health Plan Specialist I (Inbound)

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
	The Inbound Call Center Health

	Plan Specialist is responsible for membership retention in all product lines offered by Community Health Choice. This position responds to inquiries from current and potential Community Health Choice members as well as appointed and potential brokers. QUALIFICATIONS: • High School Diploma or GED • Life and Health license within 90 days of hire date • One year experience in Medicaid and CHIP, Health	

	insurance, experience with nonprofit organization assisting low income population or customer service related, call center experience OTHER SKILLS: Above Average Verbal (Heavy Public Contact) Bilingual Skills Required: Languages: Spanish and English Correspondence / Reports
	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 Administrative

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

Click Here to

Apply Online

View Map

Posted: 10/7/2019

Job Status: Full Time

Job Reference #: 148160